Keyworker

Procedure Responsibilities and Authorisation

Department Responsible for Procedure	Mental Health and Addictions
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Procedure Review History

Version	Updated by	Date Updated	Summary of Changes
04	Nicola Livingston	October 2022	Changed to Te Whatu Ora Waikato template and change of language from Waikato DHB to Te Whatu Ora throughout document Full document review Inclusion in 2.4 of statement about allocation of keyworker Consistent spelling of tāngata whaiora and whānau
03	Lynette Eade	August 2017	Addition of family / whānau as part of the client group. roles and responsibilities The process of mapping and clearly outlining of all interventions and clear identification of what, who and when the interventions will be completed.

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1 Overview

1.1 Purpose

This document sets out the role of the keyworker; the principal activities associated with key working and the keyworker allocation process required to meet the needs of tāngata whaiora and whānau.

1.2 Scope

Key working is a primary component of the role of designated registered health professionals / health practitioners working within clinical teams who have a central role in the oversight, development, coordination, implementation and review of tāngata whaiora treatment care / risk / recovery / relapse prevention plans in partnership with tanagat whaiora and whānau.

Keyworkers in community teams have a pivotal leadership role in managing, but not necessarily providing, all aspects of a tāngata whaiora care through the various phases of their illness and recovery journey. This includes the effective coordination, continuity, integration and communication of all care delivered by other services during certain phases of intervention.

Keyworkers work within their discipline and specific scope of practice integrating key working skills alongside those developed within their professional, clinical, education and experience. Additionally, keyworking skills will be delivered within the framework of a recovery oriented service and with due reference to usual clinical policies, procedures, guidelines and statutory requirements.

1.3 Patient / client group

Tāngata whaiora and whānau of the Mental Health and Addictions service.

1.4 Exceptions / contraindications

Nil exceptions.

1.5 Definitions and acronyms

Advocacy	Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to: • Have their voices heard on issues that are important to them. • Defend and safeguard people's rights. • Access information and services on person's behalf. • Explore choices and options
Allocation	The process of assigning a keyworker to tangata whaiora.
Coordination of Care	A collaborative process that promotes quality care, continuity of care and effective outcomes which enhance the physical, psychosocial and vocational health of individuals. It includes assessing, planning, implementing,

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	coordinating, monitoring and evaluating health and social care related service options across health and social care providers.
Keyworker	A registered health professional / health practitioner or social worker eligible for registration. He / she coordinates (but does not necessarily provide) all care for the tāngata whaiora, including external agency input. He / she is responsible for coordinating the treatment care/ recovery / relapse prevention planning process, including discharge planning, and documentation. He / she is the primary point of contact, within Te Whatu Ora Waikato, for tāngata whaiora and whānau and other service providers working with a tāngata whaiora.
Multi-disciplinary team	A group of registered health professionals / health practitioners who work together to determine goals, evaluate outcomes, and make recommendations and deliver holistic interventions and treatment to assist in the service user recovery at a particular point in time.

2 Clinical management

2.1 Roles and responsibilities

Keyworker

The functional responsibilities for a keyworker include:

- Facilitating the journey of tāngata whaiora through the integrated care pathway and acting as the first point of contact for the tāngata whaiora, whānau and other carers
- Working collaboratively with tāngata whaiora and their whānau in an inclusive, strengths based and recovery focus
- Acting as a communication resource and co-ordinator for other members of the multi-disciplinary team, services or agencies involved in the delivery of care
- Fostering an environment of continuity of care and managing transitions of care through the integrated care pathway within planned timeframes
- Ensuring appropriate knowledge and links with Mental Health and Addictions service, primary care services and other agencies to guide and inform tāngata whaiora and whanau.

Charge Nurse Manager / Team Leader

- Monitor the process of allocation to keyworkers to ensure appropriate management of caseloads based on workload, acuity and experience
- Monitor the movement of tāngata whaiora across the integrated care pathway
- Monitor the key performance indicators.

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Multi-disciplinary team members

- Collaborate with keyworker to ensure discipline specific interventions are included in the plan of care for the tāngata whaiora (occupational therapy, social work, psychology, registered nursing, medical)
- Discuss with medical staff at the multidisciplinary meeting any needs that require senior medical staff intervention.

2.2 Competency required

- A registered health professional / health practitioner or social worker eligible for registration.
- Staff will have completed the Mental Health and Addictions service orientation to their role and relevant mental health and addictions service education as defined with their line manager within a designated time period.

2.3 Equipment

- Mobile phone
- Vehicle access
- Information Systems inclusive of and not limited to:
  - Access to Clinical Workstation
  - Community Dashboard
  - Flinders Board

2.4 Procedure

- Tāngata whaiora is accepted into Mental Health and Addictions Service
- Discussion will occur within the MDT as to the identified presenting needs of tāngata \whaiora. Once it is confirmed that a keyworker is required, the MDT will identify who is the most appropriate clinician to be the keyworker. This decision should take into consideration matching of clinician to the tāngata whaiora in terms of skill, discipline-specific strengths, gender and cultural considerations.
- Keyworker is allocated and detailed on iPM
- The Mental Health and Addictions Integrated Care Pathway Policy (1703) provides the overview of the pathway. Specifically, the keyworker is responsible for advocacy and coordination of care, ensuring the timeframes and movement of the tāngata whaiora across the pathway.

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Pathway component	Keyworker task
Initial engagement and transfer of care planning	• Introduce self and service to tāngata whaiora and whānau, and outline role as a keyworker, including their role as first point of contact. • If whānau are not present, discuss with tāngata whaiora about including whānau – identify who they are, what role they will play, what information can be shared with them • Gather information from the tāngata whaiora and whānau including goals, aspirations, strengths • Provide verbal and written information to tāngata whaiora and whānau on roles, responsibilities, the integrated care pathway, and education and support opportunities, including peer support services and whānau support services. • The mapping of requirements for transfer of care back to the Community / Primary Care is to begin from the entry phase into the service.
Assessment	• Complete a holistic and / or cultural assessment of health and social care. This will include gathering information from various sources (including whanau, carers, primary care, NGO's, government agencies etc.). The assessment process will inform: - recovery / relapse prevention planning - risk assessment - and diagnosis in collaboration with the multidisciplinary team • Formulation and management of the risk process using the Mental Health and Addictions Risk: the assessment and management of service users at risk of harm to self or others and child protection and Te Whatu Ora vulnerable person's policies and guidelines. • Whānau / carers needs will be considered and recorded, but any actions / outcomes must always be in the tāngata whaoira best interests. Where there are conflicting needs and /or a lack of agreement between tāngata whaiora and whānau, advice from the multidisciplinary team should be sought. • Whānau will be offered a referral to an NGO for their own support and education. • HoNOS rating should be completed at the time of assessment every 90 days thereafter. • HoNOS completed on admission from community to inpatient / inpatient to community. • Social Indicators are to be completed as per the service requirements.
Planning	• Identifies the goals, aspirations and strengths of tāngata whaiora, and interventions required to support tāngata whaiora journey through the integrated care pathway. This includes

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	identifying relevant members of the multidisciplinary team and appropriate external agencies to enact the interventions internally and externally. This also identifies the role of whānau in supporting tāngata whaiora journey. • All tāngata whaiora must be offered a recovery plan in an accessible and understandable language and format in accordance with the procedures and standards outlined below. The recovery plan will be in plain language and in the words of the tāngata whaiora. • Recovery care planning should be completed in collaboration with tāngata whaiora and their whānau. Recovery planning should be personalised and meaningful, putting the tāngata whaiora at the centre of the process. An holistic approach will have a positive impact on wellbeing and will support tāngata whaiora to make informed decisions regarding their care. • Recovery care plans should reflect both immediate and long term goals and will identify how and when they are achieved, and by whom. • The Keyworker has an important role in working with tāngata whaiora and whānau to identify stressors and/or early warning signs and identify strategies / put plans in place to manage and reduce risk. • The recovery care plan will outline the way in which tāngata whaiora, whānau, keyworker, clinicians and / or external agencies (where indicated) will work together to reach and maintain tāngata whaiora best possible level of comfort, dignity and wellbeing.
Interventions	• The keyworker will have oversight of and coordinate, not necessarily provide, the interventions to ensure that the recovery plan is meeting the needs of tāngata whaiora. • With consent of tāngata whaiora, interventions should include whanau. • Where the tāngata whaiora does not give consent for whānau to be included, the keyworker will explore, on an ongoing basis, the reasons tāngata whaiora does not want whānau involved, and will discuss the value whānau involvement can have on their journey. • If tāngata whaiora mental health deteriorates or there is a change in risk presentation, a review of the provision of care is to be completed immediately including a face to face review with tāngata whaiora and consultation with whānau / other services / clinicians involved in care. • Appointment planning supports and enables engagement. This includes discussing how follow-up / interventions will occur, including the frequency of contact, whether contact is face to face, phone or virtual and time of day planned follow-up / appointments will occur. How appointment reminders occur will also be agreed upon.

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	• If the tāngata whaiora is transferred to the inpatient service / home based treatment / respite service the keyworker continues with their networking and advocacy role to ensure goal attainment based on current tāngata whaiora needs. The keyworker plays a key role in actively engaging with the inpatient recovery journey and linking this with the community pathway for the tāngata whaiora. • When tāngata whaiora transfer from an episode of inpatient care to the community the keyworker will follow-up within 7 days, ideally within 3-4 days to support safe and effective transition to the community, then weekly for a further 3-4 weeks based on clinical need, discussion with tāngata whaiora / whānau and discussion in MDT Follow-up will be face to face as much as possible. • When tāngata whaiora experience a crisis episode, the keyworker will increase the frequency of follow-up, seeing tāngata whaiora / whānau face to face as frequently as necessary, in discussion with tāngata whaiora / whānau/ MDT to facilitate their recovery, prevent a relapse and manage risk. Frequency of ongoing follow-up should be discussed with tāngata whaiora and whānau, agreed upon, discussed in MDT and documented in CWS • Keyworking responsibilities can be allocated to another named clinician at any point during an episode of care, with the agreement of the new Keyworker and following discussion with the tāngata whaiora and team manager. The reallocation and responsibilities may be for a short period of time due to absence of the Keyworker or as a planned transfer in Keyworker role. At all times the tāngata whaiora and whānau is to be aware of who is acting as their Keyworker. • The keyworker handing responsibilities over should give a verbal handover of clinical information and ensure all documentation is updated including recovery plan, risk assessment, HoNOS and clinical notes. Where possible, the keyworker will introduce the new keyworker to the tāngata whaiora and whānau as part of the process
Review	• The Keyworker meets with the tāngata whaiora and whānau / support person regularly based on recovery plan timeframes. The Keyworker will ensure the planned interventions are progressing and are reviewed with the assigned clinician and / or external agency to ensure the current needs and goals of the tāngata whaiora are being met. The map of interventions identified from the recovery plan is to be evaluated and updated. Any barriers to achieving recovery aspiration will be advocated through coordination and negotiation by the Keyworker. The Keyworker needs to ensure that interventions are being provided: - at the right time - by the right person - in the right place

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	- in the right way • Organise multidisciplinary team review with the appropriate members of the team. • Ensure that there is a review with tāngata whaiora and their whānau planned every 90 days at a minimum or sooner if there is a change in circumstances. The recovery plan is to be utilised within the community pathway and links with any acute care goals for an acute intervention phase within this pathway. • Reformulate the goals and planned interventions if the tāngata whaiora requires this or progress to the Transfer of Care phase if the tāngata whaiora has met the goals and is ready for transfer to primary healthcare. • Reassess the assessment phase as this is a continuous process and information recorded at the initial assessment must be reviewed and updated.
Transfer of Care	• By the time the transfer of care to primary care is to be undertaken all required tasks for transfer must be completed inclusive of all supports for the tāngata whaiora and their whānau. • This includes liaison with the General Practitioner and any other relevant external supports ie non-government organisations. • Complete transfer of care documentation in accordance with transfer of care processes

3 Patient information

- Written information is provided to the tāngata whaiora outlining responsibilities, expectations of the service and contact information of their keyworker (look at letter to be given)
- Information is also provided to the whānau as to the above and information about support and education available for whānau.

4 Audit

4.1 Indicators

- Quality audit process

4.2 Tools

- Key Performance Indicators

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5 Evidence base

5.1 Associated Te Whatu Ora Waikato Documents

- Mental Health Integrated Care Pathway policy (1703)
- Mental Health Family Whānau Inclusive Practice guideline (0896)
- Risk: The assessment and management of service users at risk of harm to self or others procedure (5241)
- Te Whatu Ora vulnerable person's policies and guidelines

5.2 Legislation

twow Mental Health and Addictions service is required to meet and comply with the following legislation (this list is not exclusive):

- Alcoholism and Drug Addiction Act 1966
- Code of Health and Disability Services Consumers' Rights Act 1994
- Crimes Act 1961
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Employment Relations Act 2000
- Health and Disability Sector Standards NZS8134:2008
- Health and Disability Consumer Rights Act 1994
- Health and Safety at Work Act 2015
- Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003
- Land Transport Act 1998
- Mental Health (Compulsory Assessment & Treatment) Act 1992 and Amendment 1998
- Misuse of Drugs 1975 – section 24
- Privacy Act 2020
- Protection of Personal and Property Rights Act 1988
- Treaty of Waitangi Act 1975
- Victims' Rights Act 2002

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