

Admission, Transfer and Discharge Policy for Mental Health Service

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Version Control Summary

Version	Date	Author	Status	Comment
1.0	Sept 2008	Duncan Gilbert, Clinical Effectiveness Facilitator	Final	Consolidation and update of admission and discharge policies.
1.1	May 2011		Final	Addition of Appendix J to provide staff with clear practical guidelines for managing safe internal transfer of patients.
1.2	March 2015		Final	Reviewed and updated in light of changes in relevant national policy and local practice.
1.3	November 2018	Trust Lead for Recovery Medical Director		Reviewed the Admission and Discharge Policy consolidation with the reviewed Transfer Policy.
1.4	March 2022	Director of Nursing		Updated in light of new processes and timelines for procedures. Outline of actions to be taken for out of area discharge planning and safety. RIO documentation NODF update discharge plans.
1.5	Feb 2024	Director of Nursing		Updated in line with changes to new standards- 72 Hr. follow up care, clinically Ready for Discharge process Enhanced considerations and actions to be taken when there is no capacity to admit. Enhanced structures for oversight of OOA including considerations for support to family/carers. Enhanced process of decision making in relation to discharge from services including information to be considered

Table of Contents

Version Control Summary.....	1
1 Introduction.....	4
2 Purpose of the Policy.....	5
3 Duties 5.....	5
4 Referring Agencies for Admission to Hospital	6
5 Admissions Management.....	6
6 General Principles of Managing resources	7
7 Managing Beds within your locality.....	10
8 When there is no bed is available within the Trust	12
9 Monitoring patients placed away from their home ward	12
10 Principles of Transfer and Discharge.....	13
11 Documentation to accompany the patient on external transfers.....	14
12 Out of hours transfer arrangements	14
13 Infection Control	14
14 Physical Health.....	14
15 Transfer Guidelines.....	14
16 Overview of the Discharge Process	18
17 Discharge Planning and Procedure	19
18 Training	22
19 Process for Reviewing, Approving and Archiving this Document	23
20 Dissemination, Implementation and Access to this Document	23
21 References	23
Appendix A – Safety and Well Being Check 72 Hours	24

1.0 Introduction

- 1.1 Throughout a person's individual and unique care pathway, admission and discharge from services are inevitable aspects of a person's experience of mental health care. However, it is recognised that admission and discharge can be difficult and distressing for patients and can also present risks to their recovery and care if not managed with consideration and sensitivity. Staff and service users should be aware that CCTV is in use across inpatient sites to support with maintaining safety and security. Coverage includes communal areas only, with the level of coverage variable across sites.
- 1.2 Service users should be cared for in the least restrictive environment possible, consistent with their clinical needs and assessed level of risk. All alternatives to admission to hospital should be explored and equity of access to those alternatives ensured.
- 1.3 Proper gate keeping of inpatient services and timely, safe and appropriate admission to, and discharge from, hospital are vital to the wellbeing of service users and the efficient and effective functioning of the organisation.
- 1.4 Admission to acute inpatient mental health services should be appropriate, purposeful, therapeutic and safe, and be part of their recovery plan.
- 1.5 Admission to an inpatient setting, a period of assessment, care, and treatment, and a timely discharge to a community setting should be a planned and cohesive process in line with the new Recovery Care pathway and part of a care planning process.
- 1.6 In order to deliver the best outcomes, discharge must be seen as a process not an event, and indeed an appropriate Dialog+ Care Plan should not be seen as an end in itself, but rather an aid to the provision of appropriate outpatient care, as the location of care delivery moves from one place to another.
- 1.7 The Discharge Process for all service users should begin on admission with the clinical team and may include agreeing an estimated discharge date (EDD) as soon as possible.
- 1.8 Throughout a person's recovery journey, they may be referred to and receive care from a variety of services.
- 1.9 The development of specialist teams and services within the mental health system has meant that patients are now more likely to undergo a number of transfers between services and this can cause uncertainty and anxiety as well discontinuity of care.
- 1.10 Transfers may take place between inpatient and community services; involve specialist teams as well as transfer or discharge to care settings outside the Trust. Transfer of care may be made more difficult if prompted by deterioration in a person's mental health.
- 1.11 Although discharge from a service is usually prompted by an improvement in a person's mental health, some, such as discharge from an inpatient unit, may still take place at a difficult time. Other forms of discharge, such as that from secondary to primary care, may result in a reduction in the level of care that people receive. Discharge from secondary care mental health services raises important questions for patients and carers about how they can access services again should the need arise.
- 1.12 Failure in communication between staff in different services can increase the difficulty experienced by patients in response to transfer and discharge and also compromise the safety and quality of care. It is well recognised that patients' vulnerability is increased following discharge from services and that levels of suicide are higher in the period immediately following discharge from inpatient mental health care (NICE 2011).

- 1.13 In order to ensure a smooth and safe transition between various services, it is important to set out clear arrangements in terms of the process together with information requirements
- 1.14 This Policy should, therefore, be read in conjunction with the following Trust Policies and documents:
- The eCPA Care Programme Approach Policy Recovery Care Pathway Operational Guidance;
 - Clinical Risk Assessment and Management Policy;
 - Physical Healthcare Policy;
 - Record Keeping Policy;
 - Safeguarding Adults/Children Policy;
 - Trust Equality and Diversity Scheme;
 - Advance Decisions to Refuse Treatment Policy;
 - RIO agreed outcomes:
[http://elcmhtintranet/uploads/uploads/RiO/RiO%20Deployment/RiO_Go - Live_ToBe_Standards_Process_Maps_20070216_v2.pdf](http://elcmhtintranet/uploads/uploads/RiO/RiO%20Deployment/RiO_Go-Live_ToBe_Standards_Process_Maps_20070216_v2.pdf)
- 1.15 This Policy is informed by Care Programme Approach, National Service Framework, Mental Health Act 1983: Code of Practice, DoH (2002) Policy Implementation Guide: Adult Acute In-patient Care Provision, NIMHE / CSIP (2006) Guidance Statement on Fidelity and Best Practice for Crisis Services, NIMHE / CSIP (2007) A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care, and DoH (2002) Discharge From Hospital: A good practice checklist. It has been constructed to promote compliance with the NHSLA (CNST) Risk Management Standards (NHSLA, 2007) Transition between inpatient mental health settings and community or care home settings. NICE Guideline 53, 2016.

2.0 Purpose of the Policy

- 2.1 The purpose of this Policy is to provide service users, carers and Trust staff with a framework for enabling timely, safe and appropriate admission to, and discharge from, in-patient or residential settings:
- To establish standards of practice in admission, care planning and discharge;
 - To make clear individual and service roles and responsibilities, and timescales for action;
 - To minimize variation in service user experience;
 - To minimize the occurrence of 'Delayed Discharge'.
- 2.2 This also includes: appropriate arrangements are in place when those receiving care and treatment from the Trust either are transferred between services that the Trust provides or are discharged from the Trust, which may involve the transfer of care elsewhere. It aims to draw attention to the potential risks involved in transfer and discharge and to emphasize the need for adequate planning in order that those risks are minimized and that continuity of care is provided.

3.0 Duties

- 3.1 The Trust Board - The Trust Board has a responsibility to ensure there is a framework in place to promote the effective management of the problems and risks associated with the admission transfer and discharge of patients.
- 3.2 Directorate Management - The Borough/Specialist Service and Clinical Directors are responsible for ensuring that all operational managers are aware of this protocol, understand its requirements and support its implementation with relevant staff.

- 3.3 Clinical Team Managers - Are responsible for ensuring their clinical staff have a good working knowledge of this protocol and that their clinical staff adhere to the principles and standards within it. Team managers should have good clinical systems in place for effectively managing the admission transfer and discharge of patients and support adherence to this protocol.
- 3.4 Clinical Staff - Clinical staff have a responsibility to ensure they have a good working knowledge of the principles, standards contained within this protocol, and that they comply with the requirements of this and associated policies with regards to the transfer and discharge of patients.

4.0 Referring Agencies for Admission to Hospital

- 4.1 The Trust may receive referrals for admission from a variety of sources including the following:
- General Practitioner (GP);
 - Accident & Emergency (A&E);
 - Medical Ward;
 - Police / Section136;
 - Community Mental Health Team / Care Coordinator (CMHT);
 - Home Treatment Team (HTT);
 - Early Intervention Service (EIS);
 - Prison / In-reach Team;
 - Court Diversion Service;
 - Crisis Services including Street Triage;
 - Other Mental Health NHS Trust / Care Provider.

5.0 Admissions Management

5.1 Gatekeeping

- 5.1.1 In principle, the local Home Treatment Team (HTT or CRHT) should assess all referrals to inpatient services prior to admission. The purpose of this assessment is to determine if admission to the care of the HTT or CRHT is a reasonable and safe alternative to inpatient care. Anyone with a learning disability and/or autism should have a pre-admission care plan and treatment review C(e)TR. Where not known to place based commissioners, contact should be made with the appropriate commissioner to request a C(e)TR and review of care.
- 5.1.2 Possible exceptions to this model of gate keeping are referrals from Prison or Court Diversion Services.
- 5.1.3 There are other less restrictive alternatives to inpatient admission that may also be considered at this point by the HTT (should admission to HTT be deemed inappropriate):
- a) Increased CMHT input (where the individual is known to a CMHT);
 - b) Early appointment with the CMHT (where the individual is not known);
 - c) Referral to EIS;
 - d) Bringing forward of out-patients appointment;
 - e) Admission to Crisis House or Step Up provisions (where available);
 - f) Referral for extra crisis care such as a crisis café or specific crisis team.
- 5.1.4 Decision-making is likely to be based upon available knowledge and understanding of the individual, support networks available to them and resulting needs and risk assessments. The person if known to services they should have a Safety Plan, which will highlight agreed contingency interventions and (an advance directive) to follow when

in a crisis. The aim is to care for the individual in the least restrictive environment possible.

- 5.1.5 There may be some patients where an elective admission is part of their Recovery Care Plan (as highlighted in their safety plan as a contingency intervention when they are experiencing a crisis). This intervention can be useful for patients who have a diagnosis of Emotionally Unstable Personality (EUPD) and part of a multi-disciplinary approach to reduce harm and possibly usage of inpatient beds.

5.2 Specialist Admission

- 5.2.1 Service users who are detained under the Mental Health Act 1983 must be admitted to an identified bed for the required care and treatment.
- 5.2.2 There may be service users who are not felt to be suitable for acute services:
- Service users with a primary diagnosis of learning disability who are not experiencing an acute mental health problem;
 - Service users acutely intoxicated with alcohol or with a primary diagnosis of substance misuse who are not experiencing an acute mental health problem;
 - Service users with a primary diagnosis of dementia who are not experiencing an acute mental health problem;
 - Service users who are assessed to pose a level of risk to themselves or others that cannot be safely managed within acute services (including PICU).
- 5.2.3 Any decision not to accept a referral must be made following multi-disciplinary discussion and agreed by the relevant Consultant Psychiatrist (either covering the catchment area in office hours, on-call Consultant outside of office hours).
- 5.2.4 Specialist services such as CAMHS, Older Persons, Peri-natal and Forensics may have their own admission protocols and care pathways (which will fall within the wider CPA framework). Whilst there may be procedural differences, the underpinning principles are consistent with those set out in this policy document.
- 5.2.5 Please refer to individual operational policies for admission transfer and exclusion criteria for these services.

6.0 General Principles of Managing Resources

- 6.1 All Adult Acute Inpatient beds are allocated according to GP catchment area. Exceptions to this are PICU where available admission is linked to the area in which they reside.
- 6.2 During office hours, the responsibility for finding an appropriate bed will lie with the Duty Senior Nurse, or appointed deputy or, where applicable, the Bed Manager. Outside of those times, the Duty Senior Nurse will co-ordinate this process.
- 6.3 For service users who are of No Fixed Abode (NFA), each locality will have an NFA Rota which will determine which catchment area is responsible for the service user's care. If it is subsequently found that the responsibility for the care of the service user lies with a different catchment area, whether within or outside the Trust, all efforts should be made by the ward on which the service user is admitted to transfer to the appropriate locale as soon as practicable.
- 6.4 Admission to hospital is likely to be a stressful and anxiety provoking event for any service user. A key role for all inpatients and community-based staff is to manage the process in a way that minimizes that stress and anxiety.
- 6.5 Effective communication is essential for the efficient admission of service users to inpatient settings. With the service user and named carer (where there is consent to share

information), it is essential for an efficient admission.

- 6.6 Prompt and clear communication between community and inpatient care teams is essential for effective bed management.
- 6.7 Prior to arrival of a service user on the ward, all professionals involved should have a clear idea of the purpose of admission and what is required to facilitate discharge.
- 6.8 Information giving must be comprehensive and accurate. Information must be passed on from the referrer and then from HTT/CRHT at the point of gate keeping. It is the responsibility of the professional making the decision to admit to forward such information, verbally and in writing (usually via RIO), to ward staff.
- 6.9 All clinicians involved in the person care pathway must follow the Recovery Care Pathway documentation process and ensure that clinical documentation is completed on RIO as stated in that guidance. This allows for timely and comprehensive communication and avoids a duplication of tasks.

6.9.1 Recovery Care Pathway Process

Process – Inpatient Admission

WHAT NEEDS TO BE COMPLETED

On Admission to Inpatient Care

- A new History and Context form must be created when the patient is admitted to the ward. This will pull the information through from the previous form and this can be updated throughout the inpatient stay as more information becomes available.
- A new Clinical assessment/ Review form must be completed on Admission.
- An Entry to be made in Progress Notes – **which will include the initial plan.**
- Dialog+ to be started on admission for new patients.
- For patients already known to services the Dialog+ should be updated.
- Commencing Dialog+ or updating for existing patients happens within **72 hours of admission.**
- Physical health assessment and care planning for any physical health conditions.
- My Safety Plan – to be commenced or updated on admission and completed for the Discharge CPA.
- Updated risk assessment.

On Discharge from Inpatient Care

- A discharge CPA should be arranged for each patient prior to discharge.
- For those patients who are being discharged on CPA. Their 'My Recovery Care Plan', which includes my safety plan, will be produced following their discharge CPA. A copy will be given to the patient.
- My Recovery Care Plan' uploaded on RIO as a CPAT.
- For patients who are discharged from the ward not on CPA 'my safety plan' must be completed, a copy given to the patient and the discharge plans recorded on RIO.
- All service users will be followed up within 72 hours of their discharge; the 72-hour follow up plan will be formulated at the discharge-planning meeting including delegation of responsibility for 72-hour follow-up contact.

Who Completes These Forms?

- History and Context Screen - completed by the clerking in Doctor.
- Clinical assessment/ Review - completed by the clerking in Doctor.
- DIALOG+ - started by the admitting Nurse. Any member of the Ward MDT can input into the form.
- My Safety Plan - started by the admitting Nurse. Any member of the Ward MDT can input into the form.
- For patients being discharged on CPA the Dialog+ needs to be developed in time for the Discharge CPA, so that a new My Recovery Care Plan can be created for the CPA Meeting. This needs to be agreed with the Care Coordinator in the CPA Meeting.
- All service users will be followed up within 72 hours of their discharge; the 72 hour follow up plan will be formulated at the discharge planning meeting including delegation of responsibility for 72 hour follow-up contact (Appendix 2)

OUTPUTS

On Discharge from Inpatient Care

- My Recovery Care Plan.
- My Safety Plan.
- Discharge Liaison Form (NODF) sent to the GP - uploaded on RiO.

Please note there will be other paperwork and processes that occur on admission and Discharge.

- 6.10 An assessment of the risk of a service user's physical health or infection control status may pose to themselves or the community mental health professionals pre-admission must carry out other users of the inpatient ward. Any risks identified should be discussed with the catchment area ward and a management plan formulated.
- 6.11 Where service users are admitted from General Hospital following medical care, the ward should ensure they receive a full handover of current assessment of physical and infection control risks, and plan their care accordingly. There must be a clear plan in place to manage any ongoing physical health concerns, an agreed ability to take on any enhanced physical health care within the ward setting and documented evidence that the person has been medically cleared. Liaison psychiatry will be involved in most medical ward cases and can support safe discharge planning.
- 6.12 The physical health of all service users should be assessed on admission in line with current standards set out in the Trust's Physical Health Policy and compliant with any CQUIN targets.
- 6.13 Service users should, where possible, be accompanied to the ward by their care coordinator and/or other staff who have been involved in the decision to admit. When admission is under the Mental Health Act, the AMHP should accompany the service user and provide a report for the case notes.
- 6.14 Once the decision to admit has been taken, a service user should be considered to be admitted as soon as they arrive on their designated ward/in-patient area.
- 6.15 On admission, a search should be conducted of the individual's belongings and if there are risk concerns this should include a pat down search. This should be recorded in the Trust search document and uploaded to RIO. This should be repeated following a transfer between wards or sites.
- 6.16 The care co-ordinator and General Practitioner (GP) should be informed of admission as soon as is practicable.
- 6.17 As part of their gate-keeping role, HTT must have identified a clear purpose of admission and communicate this both to the service user and the ward staff.
- 6.18 Care teams must seek to work collaboratively with the service user at all times. They should also seek to work with relatives/carers where this is appropriate and is agreed by the service user.
- 6.19 All service users must receive a Trust Welcome Pack on admission.
- 6.20 Individual wards may wish to develop local protocols for admission. These should reinforce the admission standards outlined above; they should serve to ensure that these standards are adhered to and provide guidance for staff in the practicalities of delivering those standards.

7.0 Managing Beds within your locality

7.1 Allocation of Beds

- 7.1.1 Each Locality will have its own local arrangements for managing their beds. This will include regular bed management meetings and daily updates especially when experiencing bed pressures.
- 7.1.2 It should not be custom and practice to transfer an existing stable patient to another ward to create an admission bed. This can be disruptive to the patient being moved, especially their relationship with their Primary Nurse and wider MDT.

- 7.1.3 In the event of a bed not being available on the patient's home ward, a suitable bed must be sourced within the same locality/unit if possible. It is essential that patients are cared for within a locality that is close to their home community to enable community connections to be maintained and discharge to be facilitated in a smooth manner.

7.2 Internal Transfer of patients

- 7.2.1 It should not be custom and practice to transfer an existing, stable patient to another ward to create an admission bed.
- 7.2.2 As far as possible, patients should not be transferred between wards throughout their inpatient admission as this can disrupt relationship building with their multi-disciplinary team. Trusting relationships are essential for the patients' recovery and there are a number of factors that are positively influenced by this approach, including improving communication and links with community services that can contribute to reducing inpatient stay, collaborative working with social care to meet identified needs and taking proactive measures to manage identified and emerging risks.
- 7.2.3 There are, however, exceptional occasions where transfer is necessary. The reason for the transfer must be clearly identified and discussed with the service user if they have capacity, for example, risk of harm from other service users if other interventions fail dynamic issues between service users on the ward and cannot be safely managed by the team, and admission bed capacity issues.
- 7.2.4 There are other exceptional circumstances when clinical needs will justify the transfer of a patient between acute wards. Patients should only be identified for transfer following discussions between Matrons, Clinical Nurse Managers and, if possible, Consultant Psychiatrists. Reasons for transfer must be clinically driven (e.g., where there are complex mental health and social care needs best addressed if admitted to catchment area ward where joint working may be better coordinated with community services; physical health needs involving follow up or treatment at patient's Acute Trust sites and patient best interests). Patients and their next of kin/carers will be informed of the decision to transfer and reasons clearly explained.
- 7.2.5 Sleeping out on another ward should only occur in extreme situations such as to immediately safeguard a service user. This will need to be discussed and agreed with the senior clinical team on the ward (Matron/Manager and Consultant); out of hours, this needs to be discussed with the DSN and on call manager. When it occurs, there needs to be an account recorded in the DSN records and an email alert sent to the borough lead nurse for review. When a patient is moved for one night, and returns to their home ward during day, this is considered a sleepover. When it is agreed between the wards that a patient will stay for a longer set period, this will be considered a transfer. Nursing responsibility always lies with the ward the patient is sleeping in, however, the patient's consultant stays the same when patients transfer within the same unit (exceptions are PICU and triage/specialist ward transfers)
- 7.2.6 The decision to transfer should be recorded in the progress notes on RiO. The transferring ward must ensure that all assessments are up to date and any Word documents are uploaded. A verbal handover must be given to the receiving ward by the transferring ward; all patient property must move with them and be checked and recorded on transfer.

7.3 Luton and Bedfordshire wards

- 7.3.1 There is also a specific local protocol used for the Luton and Bedfordshire wards in light of the specific issues that are relevant in that area, i.e., sites spread out with some stand-alone units. Please refer to the Transfer Protocol for Patients between Luton and Bedford Wards for further details on this.

8.0 When there is no bed is available within the Trust

- 8.1 All options for admission or alternatives to admissions within the Trust must be pursued before any out-of-Trust provider is approached for a bed. This must include alternative offers of support in their local community, e.g., access to the HTT or Crisis Café services, Crisis House, and a clear treatment plan must be formulated to mitigate against any immediate risks.
- 8.2 All options for providing adequate care and treatment and managing risk must be explored and considered with the referrer, service user and carer. Once these alternatives have been explored and no bed can be found within the Trust, then the Duty Nurse or person acting in the capacity of bed manager should contact the Director on Call to discuss the options.
- 8.3 Patients placed outside of the Trust, whether in another NHS facility or in the private sector, are considered “overspill” patients and are recorded under the virtual ward on RIO. Overall responsibility for these patients remains with the Trust, but day-to-day care is the responsibility of the out-of-Trust provider.
- 8.4 Patient Flow or Discharge Liaison leads in Directorates keep contact with out-of-Trust providers and support with linking them into the relevant community services to co-ordinate discharge, facilitate conveyance on discharge to local area or with inpatient clinical leads to coordinate transfer back to an ELFT inpatient bed dependent on availability and clinical need. They will attend clinical meetings and act as a conduit for sharing information across providers. They will ensure the virtual caseload is accurate and up to date.
- 8.5 DSNs in localities will hold and manage the list of service users awaiting transfer or admission to an inpatient bed. Lead Nurses and Clinical Directors or nominated deputies will get involved in creating capacity and determining priority for admission if needed.
- 8.6 Service users being treated in the community as an alternative to admission should have access to daily face-to-face reviews that consider presentation, risk and need for inpatient care and treatment. Emergency contact information must be provided to the service user and carer where appropriate. This information must be recorded in clinical progress notes on RiO and included in care and treatment plans.
- 8.7 Local services should offer support to families or carers to maintain contact. This can be either virtually or face-to-face; where face-to-face visits are supported, there will need to be an agreement in place about frequency and arrangements for re-imbursement or pre-paying for travel via public transport.

9.0 Monitoring patients placed away from their home ward

- 9.1 Patients admitted to another ward in the same locality, are to be kept on their home ward’s nominal roll (in practice, this means keeping the patient “on the board”).
- 9.2 The local catchment area Community Team will be informed when any of their patients are transferred or over-spilled to another facility within or outside the Trust.
- 9.3 Local services should offer support to families or carers to maintain contact. This can be either virtually or face-to-face; where face-to-face visits are supported, there will need to be an agreement in place about frequency and arrangements for re-imbursement or pre-paying for travel via public transport.

10.0 Principles of Transfer and Discharge

- 10.1 Where transfer or discharge is being considered, the service user's level of need should be assessed and referrals made to other services in a timely manner. This will include social care and physical health needs.
- 10.2 Assessment and planning associated with transfer or discharge should always incorporate thorough risk assessment and planning. Consideration should be given as to the risks involved in escorting patients as part of a transfer and the necessary level of skill and gender mix required.
- 10.3 It is important that patients are involved in the planning and decision-making about the transfer or discharge of their care, and that this should take account of any preferences the service user may have.
- 10.4 Patients should be given adequate notice, where possible, about transfer and discharge arrangements and given clear information about support options available following transfer or discharge, in order that joint and informed choices can be made.
- 10.5 Patients and carers should be provided with clear information about how they can access the service again if arrangements following transfer or discharge do not work out or deterioration occurs.
- 10.6 Patients and carers should have clear information provided about the referral pathways and processes for any services they are being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, timescale of intervention).
- 10.7 It should be acknowledged with patients that discharges and transfers are often an anxiety provoking time. Patients should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of treatment and transition from one service to another may evoke strong emotions and reactions, and staff should ensure that such changes are discussed carefully with the service user beforehand and are structured and phased.
- 10.8 Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where possible.
- 10.9 Involved family and carers should be notified before the service user is transferred or discharged.
- 10.10 Planning with regards to transfer and discharge should be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the reasons for transfer arrangements and refer to these when needed.
- 10.11 Clinical staff should engage with and communicate effectively and timely with others involved in the transfer and discharge process. This will include Trust staff, staff from other agencies, i.e., social care or NHS bodies, patients, their family and/or carers. Key information should be given to those who become responsible for treatment and care following transfer or discharge.
- 10.12 Where inter ward or service transfers occur, there should be a consultant-to-consultant handover, if out of hours handover should be conducted by the ward teams and followed up in normal working hours with consultant to consultant handover.
- 10.13 Where a transfer occurs, there needs to be a full handover of a service user's current risks and care plan, including their current observation status; if these are not accessible on RIO, they should be delivered with the service user as a hard copy. Where these are not available,

transfer should not occur, as safe handover cannot be made.

11.0 Documentation to accompany the patient on external transfers

11.1 As a minimum, the following records should accompany any external transfer:

- Assessment of current health & social care needs;
- Up to date clinical risk assessment;
- Up to date care plan which includes crisis & contingency arrangements;
- Current/ongoing medication and prescription chart;
- Legal status;
- For those detained under the Mental Health Act, relevant section papers for long-term transfer under Section 19.

12.0 Out of hours transfer arrangements

12.1 Transfer of patients out of hours is sometimes necessary but, where, possible transfer should happen during normal office hours. Any out of hours transfers should pay special regards to safe escort arrangements, prior risk assessment and adequate supporting documentation to accompany the transfer.

13.0 Infection Control

13.1 When planning transfers, discharges or re-admission of any suspected or confirmed infectious service user, advice must be sought from the Infection Control Nurse and Physical Healthcare Lead to ensure that risks of cross infection are assessed and minimised.

14.0 Physical Health

14.1 All transfers should include assessment and planning of patients' physical health care to ensure that physical health care is continued and consistent following transfer.

14.2 Full written information regarding physical health care should be provided at the point of transfer and, where possible, a verbal handover to the receiving service or team. Planning should take account of any special physical health care needs that may require additional planning on the part of receiving team or service.

15.0 Transfer Guidelines

15.1 General Principles

15.1.1 Transfers may occur internally to the Trust, for example, in the case of patients being discharged from inpatient care to a community team (or vice versa) or when someone moves from the Trust's adult services to the Mental Health Care of Older People (MHCOP). Each clinical team may have its own specific requirements in addition to the requirements contained within this protocol, for the transfer both in and out of its patients depending upon the patient group.

15.1.2 The decision to transfer should be recorded in the progress notes on RiO. The transferring ward must ensure that all assessments are up to date and any Word documents are uploaded.

15.1.3 There is also a specific local protocol used for the Luton and Bedfordshire wards in light of the specific issues that are relevant in that area, i.e., sites spread out with some stand-alone units. Please refer to the Transfer Protocol for patients between Luton and Bedford Wards for further details on this.

- 15.1.4 To facilitate the transfer of specialist care, a joint review should take place between the teams involved, particularly important if the service user is on CPA and considered at significant risk. If, for transfers out of area, where distance/practicality precludes this, there should be full discussion by telephone and information provided.
- 15.1.5 Transfers should not take place unless there has been agreement or acknowledgement from the receiving care team to prevent people “slipping through the net”. Care may not be withdrawn until the receiving team has all the required information and accepts responsibility for the care. Where there are disputes, the current team will continue to provide care until the dispute is resolved. A service user should never be without or have gaps in care due to transfer between teams.
- 15.1.6 Where applicable eCPA documentation should be completed in line with the eCPA policy and recovery care documentation guidance.
- 15.1.7 For service users being transferred under S19 of the Mental Health Act, where possible, detention papers should be forwarded to the relevant receiving officer as per Scheme of Delegation for scrutiny prior to the transfer.

15.2 Adult Mental Health to Mental Health Care of Older People (MHCOP)

- 15.2.1 This type of transfer should follow the general principles and requirements described in this protocol and also adhere to the principles and guidance in the Protocol for the Transfer of Care from Adult Services to Older Adult Services.
- 15.2.2 Transfer will only be completed when all relevant CPA care planning and risk assessment; section 117 aftercare documentation and relevant electronic records/databases have been updated to reflect the transfer of care to Older Adult services. The relevant information should be disseminated to partner agencies, i.e. GPs.
- 15.2.3 On rare occasions, a request may be made to transfer a service user from an adult ward onto an older adult ward. The decision to do this should be based on clinical need and be discussed with the appropriate senior nurse and consultant looking at a risk/benefit analysis. Medical responsibility for the period of stay on an older adult ward should be agreed from the outset and communicated to the ward staff. The safeguarding risk to older adults needs to be considered alongside the needs of the individual.
- 15.2.4 Disagreement about transfers that cannot be resolved between the two teams should be referred to the Clinical Director to assist in deciding the service best placed to meet the needs of the service user.

15.3 CAMHS to Community Adult Mental Health

- 15.3.1 Staff involved in the transition of patients from CAMHS to adult mental health services should adhere to the procedures laid down in the Policy for Transition from Child and Adolescent Mental Health Services to Adult Mental Health Services. In most but not all cases, the transfer will be that of open cases which will involve long-term collaborative planning but more urgent transfers may be necessary, particularly following admission around a patient's eighteenth birthday.
- 15.3.2 Disagreement about transfers that cannot be resolved between the two teams should be referred to the Clinical Director to assist in deciding the service best placed to meet the needs of the service user.

15.4 Specialist Addiction Services to other Internal Services

- 15.4.1 It is important that any transfers from Specialist Addiction Services to any other services

incorporate communication of the following key pieces of information:

- Specific details of the prescription (what, how much, who is prescribing, list of side effect monitoring such as the frequency and type of side effect);
- Who is responsible for monitoring side effects, the date of expiry of current prescription, dispensing and administration requirements, and the pharmacy attended (with phone number of pharmacy);
- Significant therapeutic blind alleys recently explored (e.g., non-response to Hep C treatment, failed detoxification/rehab, on much higher dose of methadone which made no difference to injecting, failed benzodiazepine detoxification 6 months ago);
- Discharges/transfers to be accompanied by a copy of the most recent medical review (if not available on RiO);
- The latest physical health screening information as part of the transfer/discharge (if not available on RiO);
- Where the locality addiction service is not provided by ELFT, the local directorate should aim to establish a joint protocol with the local provider of the addiction service aiming to replicate the above principles.

15.5 Transfer to and from Psychiatric Intensive Care Units (PICU)

- 15.5.1 Patients assessed as requiring a PICU bed should be placed in the PICU in their own Locality. If no PICU bed is available, one will be sought within the Trust in another locality.
- 15.5.2 When full, all PICUs should endeavor to identify a service user who could be safely moved to an Acute Ward to create a bed if another service user is in greater need of the PICU bed. In such circumstances, multi-disciplinary risk assessment must be carried out and documented in the relevant progress notes by the PICU Consultant or nominated deputy.

15.6 Forensic Inpatient to Community

- 15.6.1 The majority of in-patients are discharged to the community with support and supervision from forensic services. Others are appropriately transferred back to prison after assessment or treatment is completed. Prisons generally have inreach mental health services who the hospital team would liaise with prior to re-admission.

15.7 Transfers to and from Acute Hospital

- 15.7.1 The planning of all transfers to and from an acute hospital should incorporate detailed planning of both mental and physical health care needs and treatment and a detailed plan of care should always accompany the patient and a verbal handover provided at the point of handing over the patient to the receiving care providers. Information provided should clarify the need for Psychiatric Liaison Services input and if this is indicated a Consultant to Consultant handover should take place.
- 15.7.2 The statutory obligations of the Mental Health Act must be considered where transfers occur with those who continue to be detained. Sections 17 and 19 of the Mental Health Act make provisions for the need for care requiring short and long-calls. Consideration of using S17 leave for a period of up to 7 days prior to transfer under S19 of the Mental Health Act should be made, dependent on the clinical needs of the service user, with agreement of the receiving hospital and confirmation of the new Responsible Clinician.

- 15.7.3 Term transfer. Patients subject to a restriction order should only be transferred with authorisation from the Secretary of State unless the transfer is for the purpose of urgent medical assessment and treatment (refer to the Ministry of Justice's Leave of Absence for Patients Subject to Restrictions - Guidance for Responsible Clinicians).
- 15.7.4 For patient transfers (or discharges) to and from the local acute hospital providers, please refer to the Inter-agency Agreement or Protocols regarding arrangements for Mental Health Inpatient Service users who require planned care in a local Acute Hospital).
- 15.7.5 For return transfers from local acute hospitals, the procedures within Section 9 of the Interagency Transfer should be followed: Mental Health Service Users returning to ELFT Inpatient Care From a Local Acute Hospital.
- 15.7.6 The Duty Senior Nurse (DSN) should be the first point of contact for the acute hospital, in order to discuss and make proper arrangements for the patient's care to be transferred back to ELFT. Contact details for the Duty Senior Nurse for each ELFT site are as follows:

Inpatient Unit	Area of Care Covered by the DSN	Contact Details
City and Hackney	Adult acute mental health care	07534-214074
Newham	Adult acute mental health care	07816-972297
Tower Hamlets	Adult acute and mental health care of older people	07811-453637
Forensics	John Howard Centre Wolton House	07572-154890 07908-805006
Coborn Unit	Child and adolescent mental health	07929-206630
Luton and Bedfordshire sites	Adult acute and mental health care of older people	07930445215
Evergreen	Child and Adolescent Mental Health, Luton	01582293555

- 15.7.7 Depending upon the complexity of the case, the Consultant Psychiatrist or Senior Duty Doctor on call and a nurse will assess the planning needs relating to the service user's transfer of care back to ELFT. Where there is disagreement or concerns about being able to safely meet the needs of service users with complex physical health needs in a mental health setting, this needs to be escalated to the Clinical Director and Borough Lead Nurse.
- 15.7.8 If a patient is suitable for discharge from an acute ward but requires ongoing medical care and treatment to be provided within an ELFT ward, there needs to be a clear management and crisis plan which should include what to look out for and what should be done for ongoing care and in care of an emergency. In such cases there must be a clinical case discussion with a medic on the receiving ward in hours or Duty Doctor out of hours and can include the locality Physical Health Lead Nurse.
- 15.7.9 A medical and nursing discharge summary should be sent to ELFT wards.
- 15.7.10 The discharge summary should be in the form of a transfer summary highlighting any ongoing care and follow up appointments that may be required.
- 15.7.11 The transfer summary should include detailed description of any wound care, clinical

observations or other management required.

15.7.12 Infection control risks should be clearly reported and any management plan.

15.7.13 Breach of the above conditions should be reported as a clinical incident via InPhase electronic incident reporting system and liaison with the relevant acute trust should be incorporated into the incident management and investigation arrangements.

16.0 Overview of the Discharge Process

16.1 General Principles

16.1.1 For the purpose of this protocol and guidance, discharge will refer to the two main activities that involve a transfer of a patient's care from inpatient to community services (Trust and external) and discharge from Trust care.

16.2 Discharge from Inpatient care

16.2.1 Discharge decisions should be made by the Multi-disciplinary Team with identified responsibility for the service user as an in-patient, in collaboration with the service user, carer(s), Care Co-ordinator, and any other relevant agencies.

16.2.1 The Consultant Psychiatrist is ultimately responsible for the decision to discharge any given service user from an in-patient service.

16.2.2 It is the joint responsibility of the Ward Manager, Care Co-ordinator and Consultant Psychiatrist to ensure the implementation of the decision to discharge.

16.2.3 The discharge process for all patients should begin at the point of admission. In the majority of cases this is planned, following a multi-disciplinary care planning/review meeting actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care or support to the service user. Exceptions to this may occur when discharge is at short notice or is against medical advice.

16.2.4 The service user's primary nurse should work with the Care Co-ordinator to begin the process and identify any issues that may impact on discharge at an early stage.

16.2.5 When a service user is new to the service or not allocated to a Community Team, the inpatient service should refer them to the appropriate Community Team if appropriate, as soon as possible.

16.2.6 Community Care Co-ordinators retain their role for the duration of a service user's inpatient stay. There should be ongoing collaboration between in-patient and community workers. It is anticipated that this will include regular face-to-face contact and attend at ward rounds and CPA meetings.

16.2.7 Good assessment, including risk assessment, and care planning rely on information sharing and effective communication between those involved in care provision.

16.2.8 For patients being discharged on CPA the Dialog+ needs to be developed in time for the Discharge CPA, so that a new My Recovery Care Plan can be created for the CPA Meeting. This needs to be agreed with the Care Co-ordinator in the CPA Meeting (in accordance with the Trust's New Recovery Care Pathway documentation and eCPA process).

16.2.9 A discharge planning meeting should be arranged for each patient prior to discharge. For those patients who are being discharged on CPA, their Dialog+ which includes My Safety Plan will be produced following their discharge CPA.

- 16.2.10 Dialog+ must be completed on RIO and a copy will be given to the patient.
- 16.2.11 For patients who are discharged from the ward not on CPA 'My Safety Plan' must be completed, a copy given to the patient and the discharge plans recorded on RIO.
- 16.2.12 In the lead up to the CPA meeting, it may be appropriate for the service user to have periods of leave to the community to assist with the overall assessment process and to inform the formulation of the discharge care plan.
- 16.2.13 The statutory obligations of the Mental Health Act must be considered where appropriate, i.e., if the service user has been detained on a treatment section, the CCG and Local Authority's obligation to provide aftercare under Section 117 applies.
- 16.2.14 All patients discharged from adult acute inpatient wards should be followed up by a mental health professional within 72 hours of discharge. Such follow up may be face-to-face or by phone. This applies to both non-CPA and CPA patients.
- 16.2.15 Staff must comply with the Trust's Medicines Policy in respect of discharge medication and the information that should be given to patients when they are discharged.
- 16.2.16 Discharge notification should be completed and sent to the patient's GP within 24 hours of discharge.
- 16.2.17 Whilst individual service areas may develop local practice guidelines for discharge, it is important that they fit within the standards and practices of this policy. It is the stated aim of this Policy to achieve consistency in standards and process of discharge.

17.0 Discharge Planning and Procedure

17.1 Discharges to the Home Treatment Team (HTT/ CRHT)

- 17.1.1 The effect of discharge to home treatment is to shorten the length of inpatient stay of the service user. This should benefit the service user who is cared for in their own residence and will support service users to continue treatment in a less restrictive environment.
- 17.1.2 Consideration of the possibility of such discharge should be given at the earliest opportunity once clinically indicated.
- 17.1.3 All service users should be assessed on the ward prior to decisions being made about appropriateness for home treatment. Carers, relatives, Care Co-ordinators, etc., should be involved in the decision-making process.
- 17.1.4 Each HTT/CRHT should have a local procedure for discharge that fits with local resources and care delivery.
- 17.1.5 Where someone is being cared for in a different locality, the local HTT/ CRHT would assess and would share outcome of their assessment with the receiving team as part of a trusted assessment process.

17.2 Clinically Ready for Discharge (CRFD)

- 17.2.1 Clinically ready for discharge cases are decided by the treating team, where the service user has been assessed as “**medically optimised**” (does not require further inpatient admission for care and treatment). However, there is a barrier to them being safely discharged from hospital.

17.2.2 The CRFD criteria are:

- There is a clear plan for ongoing care and support post-discharge;
- That the service user's and their carer's views, including their views about discharge and the discharge plan, have been sought;
- Other stakeholders' views have been sought.

17.2.3 CRFD must be logged onto Rio. Local bed management forums will have oversight of this cohort of service users and support with escalations to partner agencies to remove or address the identified barriers. This is an essential part of ensuring their capacity to admit across inpatient services.

17.3.3 It is one of the stated aims of this Policy to minimize the impact on the service user and inpatient bed capacity where treatment is optimised but there are barriers to discharge.

17.3.4 There are a variety of means by which services should aim to reduce the impact of CRFD cases:

- Clear and comprehensive monitoring and data collection around CRFD to gain an understanding of the scale of the problem, likely causes and develop systems to address those causes;
- Close working between mental health services and other agencies such as social care and housing;
- Active collaboration between service user, carer, in-patient and community services during admission;
- Effective gate-keeping of acute services;
- Clear acute care pathways for service users;
- Identifying reasons for and goals of admission prior to admission and care planning accordingly at the earliest opportunity;
- Beginning the process of discharge planning at admission;
- Identifying any potential barriers to discharge as early as possible.

17.3.5 It is essential to work with external agencies such as housing and social care to ensure there is a safe, supportive discharge package. If a service user is ready for discharge and there are delays due to lack of external agency input or delivery, this should be escalated and there will be local protocols in place for escalation between agencies.

17.4 Unplanned discharge

17.4.1 In the event of an informal service user choosing to take discharge from hospital against medical advice the MDT should consider if appropriate assessment under the Mental Health Act 1983, initially under Section 5(2) or 5(4).

17.4.2 In circumstances where a service user does not meet the criteria for detention and there are self-discharges without a CPA meeting, the ward manager or nurse in charge of the shift must inform the responsible Neighbourhood Team Manager who will arrange for face-to-face follow-up to be made wherever appropriate either by the care co-ordinator if allocated, or by a nominated worker. These service users will have follow-up contact within 72 hours of discharge.

17.4.3 Where possible, a discharge meeting or discussion should still take place between the clinical team and involve the service user.

17.4.4 Discharge plans must be documented on RIO and may reflect reasons for requesting discharge, identified risk and mitigations agreed, arrangements for follow-up care and treatment (including medications and 72 hour follow up) and advice on crisis support/future

access to services.

- 17.4.5 Staff must comply with the Trust's Medicines Policy in respect of discharge medication and the information that should be given to patients when they are discharged. Where medications are prescribed but not available before the service user leaves the ward, the discharge documentation must outline arrangements for the supply of TTAs and note reasons where standards as outlined in the policy have not been met.
- 17.4.6 The nurse in charge must make arrangements to inform all relevant parties when a service user has discharged themselves against medical advice, i.e., Care Co-ordinator, GP, relatives or carers, etc., where medications are prescribed.
- 17.4.7 Discharge notification should be completed and sent to the patient's GP within 24 hours of discharge.

17.5 The Practicalities of Discharge

- 17.5.1 The nurse in charge should oversee the overall practical discharge. All services will have an identified system for oversight of this and will include completion and monitoring of discharge checklists. Completion of practical tasks may include:
- Withdrawing valuables and money for safe keeping, to be returned to the user;
 - Ensuring the service user has the means to travel home and has access to their accommodation;
 - Informing community services of discharge and carers (where there is consent);
 - Ordering discharge medications and checking these against prescribed TTAs before giving to service user;
 - Completion of CPA discharge documentation;
 - Notification to GP
- 17.5.2 Notification to the GP should include the service user's discharge address. Where this is not known due to housing instability or other reasons, this should be clearly indicated on the form and on RIO with up-to-date telephone contacts for the service user, their family/carers and agencies involved in supporting the service user in finding settled accommodation. Where possible before leaving the ward, the team agrees a 72-hour follow-up time/method which could include coming to a community mental team.
- 17.5.1 Information regarding the service user's physical state and any infection control risks should be communicated to those professionals taking over responsibility for their ongoing care.
- 17.5.2 These tasks may take some time to complete, and staff should be sensitive to service users who are eager to be discharged – to this end it is important for staff to communicate and explain any delays to minimize frustration.
- 17.5.3 Discharge plans and information should be clearly documented on RIO.

17.6 Tasks Post-Discharge

- 17.6.1 All service users will be followed up within 72 hours of their discharge; the 72-hour follow up plan will be formulated at the discharge planning meeting including delegation of responsibility for 72-hour follow-up contact.
- 17.6.1 Local services should follow their protocols for allocating and completing 72-hour follow up. Where an increased risk of harm to self or others has been identified during the course of admission, then face-to-face contact should be considered.

- 17.6.2 Post discharge follow up at 72 hours for service users who are being cared for outside of their locality requires good communication with the receiving team to ensure the follow up actions including 72-hour follow up will be undertaken. Where confirmation has not been received, the 72-hour follow up contact should be completed by the ward and communicated to the receiving team.
- 17.6.3 The notification of discharge liaison form should be completed on the day of discharge and sent to the service user's GP.

17.7 Discharge from the Trust

- 17.7.1 In the majority of cases, discharge from the Trust is planned following a care planning review involving multi-disciplinary discussion and actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care or support to the service user. Exceptions to this may occur if the service user disengages or moves away unexpectedly.
- 17.7.2 The statutory obligations of the Mental Health Act must be considered where appropriate, for example if Section 117 (aftercare).
- 17.7.3 Discharge from services must always be preceded by careful multi-disciplinary consideration. Information to be considered should include known risks and vulnerabilities. If a service user is assessed as not requiring secondary mental health services, then they should be discharged from services, ensuring that any further care is effectively transferred to the appropriate agencies.
- 17.7.4 Discharge planning should take into account the social care needs of individuals including settled housing, support system around the person, vulnerabilities and need for carers assessment.
- 17.7.5 The decision to discharge a patient from a service must always be taken in the context of a formal discharge planning meeting. The reasons must be recorded. There must be a clear record that relevant risk factors have been considered. A formal plan must always be drawn up which should clarify the role of any other agencies who might be involved and what action they are expected to take. Such expectations should be communicated to these agencies and documented. Regular audit of the notes of patients discharged from the service should be carried out to ensure compliance with this.
- 17.7.6 Appropriate discharge information, including medication needs, must still be provided to GPs within 24 hours or other agencies that may be providing any ongoing care to patients. A final care plan should be produced and with the service user's agreement, circulated appropriately indicating that discharge has taken place.
- 17.7.8 The decision to discharge from services must be communicated to the service user and family/ carer if there is shared consent to do so. It is essential that service users and carers understand how to obtain help if they are in crisis and how they can easily re access services in the future should they need to. Discharge communication must include this advice.

18.0 Training

- 18.1 Training is likely to be geared around CPA process and procedure, and reference should be aligned to Trust CPA Policy.
- 18.2 Staff will be introduced to CPA policy and standards through Corporate and Local Induction.

- 18.3 This audit should include documentation, training and service user feedback and monitor against this policy's requirements.

19.0 Process for Reviewing, Approving and Archiving this Document

- 19.1 This document will be reviewed every three years in line with Trust Policy or whenever national policy or guideline changes are required to be considered (whichever occurs first), primarily by the Lead Nurses Group for approval, following which it will be ratified by the Quality Committee. Archiving of this document and associated documentation should be conducted in accordance with the Trust's document: "Records Management: NHS Code of Practice, Records Retention and Disposal Schedules".

20.0 Dissemination, Implementation and Access to this Document

- 20.1 This policy should be implemented and disseminated throughout the organisation immediately following ratification and will be published on the Trust's intranet site. Changes in policy and procedure will be introduced locally via Matrons and Team Leaders. Access to this document is open to all.

21.0 References

- 21.1 Department of Health (1999) National Service Framework for Mental Health.
- 21.2 National Health Service Executive (1999) Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach: A policy booklet.
- 21.3 Department of Health (revised 1999) Mental Health Act 1983: Code of Practice.
- 21.4 Department of Health (2002) Policy Implementation Guide: Adult Acute In-patient Care Provision.
- 21.5 Department of Health (2002) Discharge from Hospital: A good practice checklist.
- 21.6 NIMHE/CSIP (2006) Guidance Statement on Fidelity and Best Practice for Crisis Services.
- 21.7 NIMHE/CSIP (2007) A Positive Outlook: A good practice toolkit to improve discharge from inpatient mental health care.

72 Hour Safety and Wellbeing Check

The Definition

All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 72 hours after discharge.

The 72 hour follow-up plan will be decided at the discharge planning meeting. It should be clearly documented on RiO in the progress notes and Discharge Liaison Form relating to the discharge meeting.

What service users want after discharge - online survey feedback

Based on a trustwide service user survey carried out on post-discharge follow-up care, the following themes were identified:

We would like:

- More **person centred** support
- More **protective conversations** pre-discharge
- More transparency and support around **what to expect**
- More support and information around **medication**
- More **support** following discharge from hospital
- Availability of **support/key worker**
- More **things to do** after hospital
- Include **family** support
- Know **where to go** if something happens
- **More contact** with Care Coordinator
- More **information and support with filling out forms** in hospital
- More understanding of **stigma faced by BME people** when they leave hospital within their communities
- **Continuity** of care conversations and plans

This is not a “Task”, this is at the Heart of What We Do

Having listened we know more about what service users want and need from us as health care professionals and as people:

- “please listen to me with an open heart”
- “please don’t judge me, take me seriously”
- A personal and empathic approach
- Time to talk, don’t rush things
- Collaboration: safety plans are joint efforts

If you experience difficulties in your efforts to connect with the service user, please ask others for help/support/advice.



Suggested questions to ask when delivering Safety and Wellbeing Check

These suggested questions have been tested in Newham as part of a QI project on 72 hour follow up and been approved at the Suicide Prevention Steering Group:

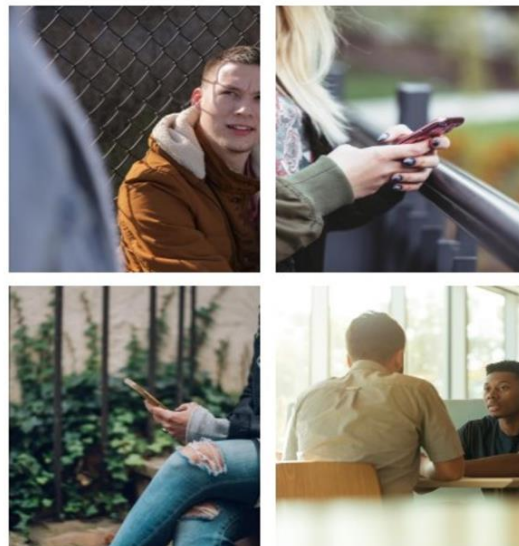
1. How are you **feeling** following your discharge?
2. Have you had **any difficulties** since your discharge from hospital?
3. Are you happy with your **care plan and follow up plan**?
4. Since your discharge from hospital, have you been **troubled by any thoughts** about not wanting to be alive anymore?
5. Do you have any other **concerns about your safety**?
6. Do you know how you would **access support** if you had a crisis?
7. Do you have **any questions** for me, or is there anything else I can help you with?

If you have a concern about a service user when making a follow up, please refer to your local protocols for providing further support.

Ways of following up

**Face to face
(where possible)**

Telephone



Demographic details

Our service user survey feedback found that many service users contact details were incorrect in RiO impacting on the ability to provide a follow up post discharge.

The National Spine holds demographic information for all patients. The National Spine can be accessed using a RiO card and icon is on the desktop of your computer.

By opening the NHS Spine and typing in some patient information, you can access further demographic details.

Find a patient Help Exit

Find a patient

Basic Advanced

Summary Care Record

Please search for a patient by either entering their details or NHS number

Enter patient details * Denotes required field

Gender ☐ Female ☐ Male

First name (First name or name the patient is known by)

Surname

Date of birth

Full postcode Address & Postcode Lookup

Find Clear

Find by NHS Number * Denotes required field

NHS Number

Find Clear

Tips on finding a patient using Basic search

- General search box
- Surname box
- Date box
- First name box
- Address finder box

Need more help?

» Help with this screen

» Tell me more about searching

Use of the NHS Summary Care Record is subject to confidentiality regulations. Some actions will raise a privacy alert.

» More about privacy alerts

Exemptions from the 72 Hour Safety and Wellbeing Check Process

Patients who have **died**.

Where **legal precedence** has forced the removal of a patient from the country.

Patients **transferred** to NHS psychiatric inpatient ward.

Patient **discharged from CAMHS** (child and adolescent mental health services).

Patients that have been **transferred to prison**. (evidencing prison in-reach team contact)

Patients **transferred to a non-NHS hospital** (evidencing contact with respective hospital post-discharge using progress notes)

Who should be responsible for 72 Hour Safety and Wellbeing Checks?

East London

All service users discharged: Followed up by inpatient staff by telephone.
For CPA or non-CPA service users known to community teams: To be followed up additionally by Recovery Team/CMHT/EIS, telephone or face-to-face.

Luton and Bedfordshire

All service users discharged: Followed up by community teams by telephone or face-to-face, except:

- if discharged from ward on Friday, CMHT passed to crisis team.
- or, if service user cannot be contacted by Friday, CMHT passes to crisis team.

How to Record a 72 Hour Safety and Wellbeing Check

Community/Recovery/EI Teams: Safety and Wellbeing Check is captured by outcoming an appointment in HCP diary/clinics. This is a four step process on RiO as per the screenshots below:

1

Schedule appointment by selecting appointment type "post discharge follow up"

2

Outcome the appointment as "achieved"

How to Record a 72 Hour Safety and Wellbeing Check

Community/Recovery/EI Teams: Safety and Wellbeing Check is captured by outcoming an appointment in HCP diary/clinics. This is a four step process on RiO as per the screenshots below:

3

In the Outcome screen, select "achieved".

4

Summarise the details of the call in the free-text box, please note this will automatically populate progress Notes with this information.

How to Record a 72 Hour Safety and Wellbeing Check

Inpatient Teams: Safety and Wellbeing Check is captured in Progress Notes by using the RCODE: **RCODEPOSTDISFU** in the heading.

5

Completing the progress note with **RCODEPOSTDISFU** at the start.

The screenshot shows the 'Progress Notes - Add New Note' interface in the NHS RIO system. The patient is ZZTEST, Dummy (M), 1 Mar 2005 (14 years), Female, NHS, 999 991 7690. The RCODE 'RCODEPOSTDISFU' is entered in the heading field and highlighted with a red box. The note content describes a 72-hour safety and wellbeing check.

RCODEPOSTDISFU

I spoke to user today and they were fine. We discussed if they had any issues regarding their safety and wellbeing and they confirmed that there were no issues or concerns. User was provided crisis information should they need any further assistance.

Validation Status: **Please Select** ☐ This is a significant event
☐ This Note contains third-party information ☐ Conceal from Client
☐ Add to Risk History ☐ Not Selected ☐ Selected

Save Changes
[Back to Progress Notes](#)