

## Admission, Transfer and Discharge Policy for Mental Health Service

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### Version Control Summary

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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	Jane Kelly Trust Lead for Recovery  Dr David Bridle Medical Director		Reviewed the Admission and Discharge Policy consolidation with the reviewed Transfer Policy.

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## **1. 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

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 in-patient 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 in-patient mental health services should be appropriate, purposeful, therapeutic and safe and be part of their Recovery plan.

1.5 Admission to an in-patient 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 eCPA process. (Guidance available on Trust Intranet)

1.6 In order to deliver the best outcomes discharge must be seen as a process not an event, and indeed an appropriate eCPA My Recovery Care Plan should not be seen as an end in itself, but rather an aid to the provision of appropriate out-patient 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 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, like discharge from an inpatient unit, may still take place at a difficult time. Other forms of discharge, like 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

This Policy should therefore be read in conjunction with the following Trust Policies and documents:

- The new eCPA Care Programme Approach Policy Recovery Care Pathway Operational Guidance
- Clinical Risk Assessment and Management Policy
- Physical Healthcare Policy
- Record Keeping Policy
- Safeguarding 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)

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. 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 minimise variation in Service User experience.
- To minimise the occurrence of 'Delayed Discharge'.

2.2 This also includes: appropriate arrangements are in place when those receiving care and treatment from the Trust are either 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 emphasise the need for adequate planning in order that those risks are minimised and that continuity of care is provided.

### **3. 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 the principles and standards within it are adhered to by their clinical staff. 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 and 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. 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 Co-ordinator (CMHT)
- Assertive Outreach Team (AOT)
- 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. Admissions Management**

### **5.1 Gatekeeping**

5.1.1 In principle all referrals to in-patient services should be assessed prior to admission by the local Home Treatment Team (HTT). The purpose of this assessment is to determine if admission to the care of the HTT is a reasonable and safe alternative to in-patient 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 in-patient admission that may also be considered at this point by the HTT (should admission to HTT be deemed inappropriate):

- Increased CMHT input (where the individual is known to a CMHT)
- Early appointment with the CMHT (where the individual is not known)
- Referral to EIS
- Bringing forward of out-patients appointment
- Admission to Crisis House (where available)
- 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 General Principles of Managing resources**

6.1 All Adult Acute In-patient beds are allocated according to GP catchment area. Exceptions to this are PICU beds throughout the Trust, Ruby Triage in Newham (take all admissions) and Ruth Seifert ward in City and Hackney (take EIS male patients).

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 residing 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 in-patient, and community based staff is to manage the process in a way that minimises that stress and anxiety.

6.5 Effective communication is essential for the efficient admission of service users to in-patient settings.

6.6 Prompt and clear communication between community and in-patient 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 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.**
- My Safety Plan – to be commenced or updated on admission and completed for the Discharge CPA.

\*\*\*\*\* **Please also note that the inpatient Nursing Care plan is still required.**

##### 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.

#### WHO COMPLETES THESE FORMS

- History and Context Screen - completed by the clerking in Doctor and Nurse.
- Clinical assessment/ Review - completed by the clerking in Doctor and Nurse.
- 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.

#### OUTPUTS

##### On Discharge from Inpatient Care

- My Recovery Care Plan (for CPA patients only)
- My Safety Plan
- Discharge Liaison Form (NODF) sent to the GP - uploaded on RiO

6.10 An assessment of the risk a service user's physical health or infection control status may pose to themselves or other users of the in-patient ward must be carried out by the community mental health professionals pre-admission. 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 on going physical health concerns and documented evidence that the person has been medically cleared.

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 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, i.e. not after any bureaucratic process.

6.14 The care co-ordinator and General Practitioner (GP) should be informed of admission as soon as is practicable.

6.15 Service Users should, where possible, be accompanied to the ward by their care co-ordinator and/or other staff who have been involved in the decision to admit. When admission is under the Mental Health Act the ASW should accompany the service user and provide a report for the case notes.

6.16 HTT must have identified a clear purpose of admission and communicate this both to the service user and the ward staff.

6.17 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.

6.18 All service users must receive a Trust Welcome Pack on admission.

6.19 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.

6.20 All patients should be admitted to their home ward whenever possible. A patient's home ward is the ward relating to the patient's community mental health team, which is usually based on their GP or place of residence. In the event that the patient is being treated on another ward, that ward will be referred to as the "host" ward.

## **7. 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 patients 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.

7.1.4 Where a patient is being admitted to a host ward will take responsibility for all aspects of care for the patient. This will include completion of all admission documentation; initial risk assessment and care plan, nursing care, CPA and discharges.

7.1.5 Medical responsibility will remain with the home team in all circumstances (including sleepovers, transfers and direct admissions) for the period of time the patient is present on the host ward with the exception of:

- When a patient is transferred between Localities.
- When a patient is transferred to a PICU.

7.1.6 The patient's home mental health team will continue to retain community responsibility for the patient and liaise with the host ward. This remains the case even when the patient has been moved to an inpatient facility in another locality.

### **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 fails, dynamic issue between service users on the ward and cannot be safely managed by the team, admission bed capacity issues etc. Under no circumstance should the same service user be moved or transferred twice in an episode of admission.

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 is 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 When a patient is moved for one night, and returns to their home ward during day, this is considered a sleep-over. When it is agreed between the wards that a patient will stay for a longer set period of time, 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.

### **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 When there is no bed is available within the Trust**

8.1 All options for admission within the Trust must be pursued before any out-of-Trust provider is approached for a bed.

8.2 When all options 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. Overall responsibility for these patients remains with the Trust, but day-to-day care is the responsibility of the out-of-Trust provider.

## **9. Monitoring patients placed away from their home ward**

9.1 Patients off the ward are to be kept on their home ward's nominal roll (in practice, this means keeping the patient "on the board"). This includes those patients admitted directly to another ward or facility out-side of the Trust, or are transferred or sleeping over on another ward, but who are considered appropriate to return to the ward as soon as a bed becomes available if it is clinically required.

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.

## **10. 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 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 things deteriorate.

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, time-scale 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 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 In many circumstances, transfer and discharge will follow similar procedures and general principles will apply to each activity.

## **11. Transfer Guidelines**

### **11.1 General Principles**

11.1.1 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.

11.1.2 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.

11.1.3 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.

11.1.4 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.

11.1.5 Transfers should not take place unless there has been agreement or acknowledgement from the receiving care team to prevent people "slipping through the net".

11.1.6 Where applicable eCPA documentation should be completed in line with the eCPA policy and recovery care documentation guidance.

### **11.2 Adult Mental Health to Mental Health Care of Older People (MHCOP)**

11.2.1 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.

11.2.2 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.

11.2.3 On rare occasions a request maybe 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.

11.2.4 Disagreement about transfers that cannot be resolved between the two teams should be referred to the Clinical Director to assist in arbitration.

### **11.3 CAMHS to Community Adult Mental Health**

11.3.1 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.

### **11.4 Specialist Addiction Services to other internal services**

11.4.1 It is important that any transfers from Specialist Addiction Services to any other services incorporate communication of the following key pieces of information:

11.4.2 Specific details of the prescription (what, how much, who's prescribing, list of side effect monitoring such as the frequency and type of side effect

11.4.3 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).

11.4.4 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)

11.4.5 Discharges/transfers to be accompanied by a copy of the most recent medical review (if not available on RiO).

11.4.6 The latest physical health screening info as part of the transfer / discharge (if not available on RiO)

11.4.7 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.

### **11.5 Transfer to and from Psychiatric Intensive Care Units (PICU)**

11.5.1 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.

11.5.2 When full, all PICUs should endeavour 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.

### **11.6 Forensic Inpatient to Community**

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. The service operates a prison in-reach team that was developed, in part, to support appropriate remissions to prison.



## 11.7 Transfers to and from Acute Hospital

11.7.1 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.

11.7.2 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-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).

11.7.3 For patient transfers (or discharges) to and from the local acute hospital providers, Homerton University Hospital NHS Foundation Trust and Barts Health NHS Trust, refer to Appendix 2 – the Inter-agency Agreement (Agreement Regarding Arrangements for Mental Health Inpatient Service Users Who Require Planned Care in a Local Acute Hospital)

11.7.4 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:

11.7.5 The reason for the initial transfer to the Local Acute Hospital should be fully resolved prior to transfer back to ELFT. If the condition is not fully resolved or stabilised and requires on-going care, a detailed pre-transfer discussion needs to take place.

11.7.6 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	07572-154890
	Wolfson House	07908-805006
Coburn Unit	Child and adolescent mental health	07929-206630
Luton and Bedfordshire sites	Adult acute and mental health care of older people	<b>07930445215</b>

11.7.7 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.

11.7.8 If a patient is still being actively treated then there needs to be a clear management and crisis plan which should include what to look out for and what should be done for on-going care and in case of an emergency.

11.7.9 A medical and nursing discharge summary should be sent to ELFT wards.

11.7.10 The discharge summary should be in the form of a transfer summary highlighting any on-going care that may be required

11.7.11 The transfer summary should include detailed description of any wound care, clinical observations or other management required

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

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

## **11.8 Documentation to accompany the patient on external transfers**

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 and CPA level as applicable
- For those detained under the Mental Health Act, relevant section papers for long-term transfer under Section 19.

## **11.9 Out of hours transfer arrangements**

11.9.1 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.

## **11.10 Infection Control**

11.10.1 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.

## **11.11 Physical Health**

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

11.11.2 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.

## **12. Overview of the Discharge Process**

### **12.1 General Principles**

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.

### **12.2 Discharge from Inpatient care**

12.2.1 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.

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

12.2.3 It is the joint responsibility of the Practice Innovation Nurse, Care Co-ordinator and Consultant Psychiatrist to ensure the implementation of the decision to discharge.

12.2.4 The discharge process for all patients should begin at the point of admission and in the majority of cases 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.

12.2.5 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.

12.2.6 When a Service User is new to the service or is not allocated to a Community Mental Health Team (CMHT) then the in-patient Named Nurse should refer the Service User to the appropriate CMHT/ Community Team as soon as practicable.

12.2.7 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.

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

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

12.2.10 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.( in accordance with the Trust's New Recovery Care pathway Documentation and eCPa process)

12.2.11 A discharge planning meeting 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.

12.2.12 My Recovery Care Plan' must be uploaded on RIO and a copy will be given to the patient

12.2.13 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.

12.2.14 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.

12.2.15 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.

12.2.16 All patients discharged from adult acute inpatient wards should be followed up by a mental health professional within 7 days of discharge. Such follow up may be face to face or by phone. This applies to patients both non-CPA and CPA patients.

12.2.17 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.

12.2.18 Discharge notification should be completed and sent to the patient's GP within 48 hours of discharge.

## **13 Discharge Planning and Procedure**

### **13.1 Discharges to the Home Treatment Team (HTT)**

13.1.1 The effect of discharge to home treatment is to shorten the length of in-patient stay of the service user. This should benefit the service user who is cared for in their own residence and will contribute to the easing of bed pressures on in-patient services.

13.1.2 Consideration of the possibility of such discharge should be given at the earliest opportunity.

13.1.3 All Service users should be assessed on the ward prior to decisions being made about appropriateness for home treatment and carers, relatives, care co-ordinators etc. should be involved in the decision-making process.

13.1.4 Each HTT should have a local procedure for discharge that fits with local resources and care delivery.

### **13.2 Delayed discharge**

13.2.1 Delayed discharge occurs when an in-patient remains in in-patient care after they have been assessed as clinically fit for discharge or transfer home or to another care setting

13.2.2 It is one of the stated aims of this Policy to minimise the occurrence of delayed discharges and it is hoped that implementation of this policy will in itself contribute to achievement of this.

13.2.3 There are a variety of means by which services should aim to tackle the issue of delayed discharges:

- Clear and comprehensive monitoring and data collection around delayed discharge 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

13.2.4 A local bed management meeting is likely to be the most effective forum within which to co-ordinate the response to delayed discharges.

13.2.5 Delayed discharges will be recorded on RIO.

### **13.3 Unplanned discharge**

13.3.1 In the event of a 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).

13.3.2 In circumstances where a service user abruptly self- discharges without a CPA meeting, the ward manager or nurse in charge of the shift must inform the responsible CMHT 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.

13.3.3 Ward staff should inform all relevant parties when a service user has discharged themselves against medical advice, i.e. Care Co-ordinator, GP, relatives or carers etc.

13.3.4 In exceptional circumstances where a service user who requires input from the CMHT is not allocated a care co-ordinator at the point of discharge, the CMHT Manager will ensure that the case is given priority for follow-up face-to-face contact by a nominated worker.

## **13.4 Discharge from the Trust**

13.4.1 In the majority of cases, discharge from the Trust is planned following a care planning review involving multidisciplinary 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.

13.4.2 The statutory obligations of the Mental Health Act must be considered where appropriate, for example if Section 117 (aftercare).

13.4.3 Appropriate discharge information including medication needs should be provided to GPs 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.

13.4.4 Discharge from services must always be preceded by careful multi-disciplinary consideration.

13.4.5 If service user is no longer assessed to be eligible for services from secondary mental health care services, then they should be discharged from services, ensuring that any further care is effectively transferred to the appropriate agencies.

*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.*

*(Taken from the Panel Recommendations of a Trust SUI report August 2007)*

## **13.5 The Practicalities of Discharge**

13.5.1 The named nurse should oversee the overall practical discharge. In their absence this will be delegated by the Practice Innovation Nurse.

Completion of practical tasks may include:

- Withdrawing valuables and money for safe keeping, to be returned to the user.
- Arranging benefits
- Ensuring the service user has the means to travel home and has access to their accommodation
- Activating community support
- Ordering and collecting discharge medication to be taken home
- Negotiations with other members of the multidisciplinary team
- Completion of CPA discharge documentation
- Notification of GP

13.5.2 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 minimise frustration.

13.5.3 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.

13.5.4 Discharge plans and information should be clearly documented on RIO

### **13.6 Tasks post-discharge**

13.6.1 It is the joint responsibility of the care co-ordinator and CMHT Manager to ensure that the first face-to-face contact occurs within 7 days of discharge.

13.6.2 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 made by the Community Team within 48 hours of discharge.

13.6.3 The discharge liaison form should be completed on the day of discharge and sent to the service user's GP.

## **14 Training**

Training is likely to be geared around CPA process and procedure, and reference should be aligned to Trust CPA Policy.

Staff will be introduced to CPA policy and standards through Corporate and Local Induction.

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

## **15. Process for Reviewing, Approving and Archiving this Document**

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".

## **16. Dissemination, Implementation and Access to this Document**

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.

## **17. References**

Department of Health (1999) National Service Framework for Mental Health

National Health Service Executive (1999) Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach: A policy booklet

Department of Health (revised 1999) Mental Health Act 1983: Code of Practice

Department of Health (2002) Policy Implementation Guide: Adult Acute In-patient Care Provision

Department of Health (2002) Discharge from Hospital: A good practice checklist

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



**APPENDIX A**

**Impact Assessment Tool – Admission and Discharge Policy**

**Incorporating:  
Equality and Diversity; Human Rights and Environmental Issues**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

			<b>Comments</b>
<b>1</b>	<b>Briefly describe the policy/decision?</b>		A reviewed and updated Trust Policy providing guidelines for Admission to and Discharge from In-patient settings
1.1	<b>Briefly describe the purpose or objective of the policy/decision?</b>		<ol style="list-style-type: none"> <li>1. 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</li> <li>2. To establish standards of practice in admission, care planning and discharge</li> <li>3. To clarify individual and service roles and responsibilities and timescales for action</li> <li>4. To minimise variation in service user experience</li> <li>5. To minimise the occurrence of delayed discharge</li> <li>6. Provide guidelines for the transfer of service users from one clinical area to another</li> </ol>
1.2	<b>Does the policy/decision have a legitimate aim?</b>	<b>Yes</b>	The aims of the Policy are outlined above. The policy seeks to ensure consistency of experience for all service users, including equality of availability of less restrictive alternatives to in-patient admission
1.3	<b>Is the policy/decision necessary, proportionate and lawful?</b>	<b>Yes</b>	
<b>2</b>	<b>Will the policy/decision affect one group or a combination of groups less or more favourably than others on the basis of:</b>	<b>No</b>	The Policy is intended to support the individual and support equality of opportunity.

			<b>Comments</b>
	Race, Colour, Nationality, Gender, Age, Sexual orientation, Disability, Religion, Language  (Disability includes: learning disabilities, physical disability, sensory impairment and mental illness)		However, national and local statistics do suggest that some ethnic groups are more likely to be admitted to hospital than others, and more likely to be subject to the provision of the Mental Health Act 1983.
2.1	<b>List or describe the evidence that some groups will be affected differently?</b>		Inside Outside Breaking the circles of fear Trust statistics Local ethnicity reports
3	<b>Will the policy/decision affect or restrict anyone's human rights? (see attached list)</b>	<b>Yes</b>	
3.1	<b>If the answer to Q3 is yes, which rights will be affected or restricted?</b> <b>a) absolute right</b> e.g. the right to protection from inhuman & degrading treatment <b>b) limited right</b> e.g. the right to liberty  <b>c) qualified right</b> e.g. the right to respect for private and family life; freedom of expression; peaceful enjoyment of property etc;	<b>No</b>  <b>Yes</b>          <b>No</b>	Decisions to admit and discharge service users inevitably impact on their right to liberty. Such decisions are made with support from Professional Codes of Conduct, Operational and Trust Policies and the Mental Health Act 1983.
3.2	<b>Can the policy/decision be achieved without the infringement of human rights?</b>	<b>No</b>	
4	<b>Will this policy/decision:</b>  <ul style="list-style-type: none"> <li>• Reduce or increase waste</li> <li>• reduce or increase use of energy</li> <li>• Have an impact on the use of transport</li> <li>• Create community employment opportunities</li> </ul>	<b>No</b>  <b>No</b>  <b>No</b>  <b>No</b>	
5	<b>What action is to be taken to minimise the impact that the policy/decision will have on equality and diversity and human rights.</b>		

			<b>Comments</b>
5.1	<b>What action is to be taken to minimise the impact that the policy/decision will have on the environment</b>		
6	<b>Have you consulted with relevant groups around this policy/decision?</b> - Staff members - Service Users - Carers - Other agencies	<b>Yes</b> <b>No</b> <b>No</b> <b>No</b>	
6.1	<b>Do you have further plans to consult with the relevant groups</b>	<b>Yes</b>	Draft policy will be made available for discussion at Clinical Risk Group and Acute Care Forum where staff and Service Users are represented
7	<b>Will the policy/decision be monitored?</b>	<b>Yes</b>	A monitoring plan is included in the Policy
7.1	<b>Will the policy/decision be reviewed? If yes, when?</b>	<b>Yes</b>	A statement on review is included in the Policy
7.2	<b>Will this policy/decision and this Impact assessment be published?</b>  <b>If yes, list when and where this information will be available.</b>	<b>Yes</b>	There is a statement on dissemination and availability included in the Policy

This Impact Assessment Form must accompany the policy to the relevant committee.

### **HUMAN RIGHTS ACT 1998 Convention Rights**

- ❖ Right to life
- ❖ Right not to be tortured or treated in a inhuman or degrading treatment
- ❖ Right to be free from slavery or forced labour
- ❖ Right to no punishment without law
- ❖ Right to Liberty
- ❖ Right to fair trial
- ❖ Right to respect for private and family life, home and correspondence
- ❖ Right to freedom of thought, conscience and religion
- ❖ Right to freedom of expression
- ❖ Right to freedom of assembly and association

- ❖ Right to marry and found a family
- ❖ Right not to be discriminated against
- ❖ Right to peaceful enjoyment of possessions
- ❖ Right to education
- ❖ Right to free elections

#### Types of rights

**Absolute rights** such as the right to protection from torture, inhuman and degrading treatment and punishment, the prohibition of slavery and enforced labour and protection from retrospective criminal penalties – **can never be interfered with.**

**Limited rights** such as the right to liberty which are limited under explicit and finite circumstances, set out European Commission for Human Rights (ECHR) itself, which provides exceptions to the general right – can be restricted in some tightly defined circumstances.

**Qualified rights** which include the right to respect for private and family life, religion and belief, freedom of expression, assembly and association, the right to peaceful enjoyment of property and to some extent the right to education.

Interference with them is permissible only if what is done:

- A. has its basis in law, and
- B. Is done to secure a permissible aim set out in the relevant Article, for example for the prevention of crime, or for the protection of public order or health, and
- C. Is necessary in a democratic society, which means it must fulfil a pressing social need, pursue a legitimate aim and be proportionate to the aims being pursued.