Norfolk and Suffolk
NHS Foundation Trust

Discharge from In-patient Care	
Purpose:	• To support discharge planning that commences on admission • To minimise delays in discharge • To ensure that the discharge process meets the needs of the service user, involves the service user, community team and family/carer, maximises safety and reduces potential readmission. • To provide guidance where discharge is not fully planned, to ensure that it is as safe as possible for all concerned
Approved By & Date:	Quality Committee – 16/09/2020
For Use By (Area/Staff):	Trust-wide
Reference No:	**C70a**
Version:	09
Summary of Changes	Limited review only to support the implementation of the 72hr contact following discharge from an inpatient unit. This contact will replace the 48hr telephone support and 7 day face to face contact following discharge.
Published Date:	16th September 2020
Review Date:	January 2022
Equality Assessment:	January 2019

Contents

Discharge from In-patient Care – Summary of Key Points

This is a summary only of the key points from this policy and staff should refer to the main text of the policy if in any doubt.

Principles for safe and effective discharge	• Discharge planning should commence at the point of admission • Discharge planning must involve the service user and **all** those providing care for the service user • Community teams and Care Coordinator/Lead Care Professional (LCP) retain their role for the duration of admission, there must be ongoing collaboration between in-patient and community teams • If an informal service user requests discharge against medical advice see Section 8
Early planning	• Complete assessment of the person's personal, social, safety and practical needs • Inform Community Team and Care Coordinator/Lead Care Professional of admission • Refer to Community Team as clinically necessary • Service users should be directly involved in preparing for their discharge as soon as possible • Whenever possible and with their consent, the service user's family/carer should be involved in discharge planning
An agreed care plan	• Staff should work with all service users care providers to coordinate discharge planning • Ensure the discharge plan is communicated to everyone involved in providing support to the service user • The care plan should reflect the risk assessment, taking in to account what led to admission as well as the individual discharge plan • An agreement between the service user and the multi-disciplinary team must be made to ensure the service user is clearly aware of the support that will be provided immediately after discharge. It is essential that the service user knows when their first appointment will be and what to do if they need to contact services before that
On day of discharge	• The Nurse in Charge must check that the risk assessment is up to date • Make sure the service user (family/carer as appropriate) are provided with a copy of the care plan (including crisis and contingency planning), details of follow up appointments, Care Coordinator/LCP details, and information about medication • Teams must have clearly agreed processes for considering and checking that all reasonable steps have been completed to ensure safe and effective discharge • Two week's medication (one week as required/'PRN') would usually be provided for the service user on discharged. A smaller amount may be needed based on individual assessment of the risk of overdose • **Wards using eDischarge**, complete Inpatient Discharge Medication form within 24 hours of discharge, complete Inpatient Discharge Summary within 7 days. When completed correctly these are automatically sent electronically to GP, copies should be given/sent to service user, see Section 5 • Prior to leaving the ward a clinician must be identified and agreed as appropriate to conduct the immediate support after discharge. The 72hr contact must be planned and seen within the 48hr periods following discharge. In exceptional circumstances the service user can be seen the following day but must be within the 72hr period.

Follow up

- The Keyworker is responsible for identifying the **team, date** and **time** of the appointment and, **where possible**, the practitioner, as part of the discharge planning procedure. All relevant health and social care professionals must be made aware of the discharge
- Within 72 hours service users will receive contact from a clinical team. This contact will be agreed before discharge and should be agreed by the multidisciplinary team and carers as clinically safe but led by the service user's preference of contact. Face to face visit is preferable however telephone contact, Attend Anywhere.
- Within 72 hours of discharge there **must** be review with the service user (see section 7)

Document/Form to	Location	Guidance
Discharge Prescription	Available on Intranet here	
Discharge Checklist	Lorenzo – 'in-patient' chart – 'discharge' tab – select 'notes'	Services may agree local procedures to complete safety checks before discharge
Discharge Against Clinical Advice	Lorenzo – 'in-patient' chart – 'discharge' tab – select 'notes'	Complete for all discharges against clinical advice
Teams using eDischarge See here for full guidance on Inpatient Discharge Medication Form and Inpatient Discharge Summary.		

Finding documents/forms

1. Definitions

Discharge from In-patient Care. The end of an episode of care, discharge may be to Trust community-based services or back to Primary Care/GP.

Planned Discharge. Preparations for the service user leaving hospital have been agreed by the in-patient and community teams, the service user and their family/carer (as appropriate) and are in place.

Discharge against Clinical Advice. When an informal service user makes a decision to leave hospital; despite advice from staff that they should stay.

Medical Discharge. The clinical decision that the service user is ready for/safe for discharge from hospital.

Advanced Clinical Practitioner. In the context of this policy, this refers to a ACP/tACP working to an agreed job description, in line with their competencies (for the tACP) or scope of practice document (for ACP).

2. Core Principles of a safe and effective discharge

Discharge is a process and not an isolated event at the end of the service user's stay. Discharge planning should commence at the point of admission. If factors relating to discharge are not identified and addressed early on this has implications for the safety and timeliness of the discharge. (DoH 2010).

Discharge planning must involve the service user and **all** the individuals and services providing care for the service user. Community teams and Care Coordinators/Lead Care Professionals must retain their role for the duration of a service user's admission and there must be ongoing collaboration between in-patient and community teams.

Nice (2016) identify that hospital discharge problems occur:

- When discharge is not planned
- When the person and their carer(s) are not involved in planning
- When people's rights to information, advocacy and support are not observed
- When the person and their carer(s) have not been helped to manage the mental health symptoms and other problems which contributed to the admission
- When the community services which address the different needs of the person are not involved in planning and reintegration

Recent findings from the National Confidential Inquiry into Suicide and Safety in Mental Health (2019) showed that most post-discharge deaths by suicide occurred in the first week after leaving inpatient care, with the highest frequency on the third day after discharge. Many of these people died by suicide before their first follow-up appointment. Based on this new evidence all NHS Trusts are now to complete follow-up within 72 hours post discharge.

3. Early planning for discharge

Keyworkers should carry out a thorough assessment of the person's personal, social, safety and practical needs on and throughout the admission to support and guide discharge and help manage any associated risks that may be exacerbated on discharge.

Ward staff **must** also ensure the service users Community Team and Care Co/LCP are informed of the admission, details of the admission and details of any planned discharge planning or MDT meetings.

Care coordinators/Lead Care Professionals must retain their role for the duration of a service user's admission. There must be ongoing collaboration between in-patient and community teams and any other relevant agencies involved in supporting the service user towards discharge.

The MDT should refer to Community Mental Health Team as clinically necessary.

Discharge preparations should:

- Relate directly to the setting the person is being discharged to.
- Assess the suitability of the discharge accommodation.
- Cover aftercare support, in line with section 117 of the Mental Health Act 1983.
- Consider housing, benefit and finance issues.
- Consider pre-existing family, social issues and stressors that may have contributed to the admission.
- Explore ways in which the person can manage their own condition.
- Who is best to provide immediate follow up upon discharge.

Service user and family/carer involvement

Service users should be directly involved in preparing for their discharge as soon as possible and staff should consider:

- capacity issues.
- learning disabilities, (see **NSFT Green Light Toolkit page**)
- time needed to absorb information/discuss further.
- any vulnerabilities.
- suitability of the venue.
- advocacy services.
- interpreting services.
- PALS.

Whenever possible and with their consent, the service user's family/carer should be involved in the discharge preparation and planning processes throughout the inpatient stay. Working more closely with families can also improve suicide prevention. (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2015).

If there is an identified risk, contact can be made without the service user's consent (see **C10: Confidentiality** and **C82: Clinical Risk Assessment and Management)**. This decision/rationale must be fully documented in the health record.

Care must be taken to make sure that contact details for next of kin/family as appropriate is recorded appropriately.

4. An agreed discharge plan

Ensure that there is a designated person responsible for developing the discharge plan in collaboration with the MDT and with the person being discharged (and their carers if the person agrees).

Staff should work with all of the service users care providers to coordinate the discharge planning process and identify any issues that may impact on discharge at the earliest possible stage of the admission. The inpatient staff must demonstrate that there has been liaison and notification of the impending discharge. The inpatient staff must demonstrate that they have arranged a 72hr hour follow up with the relevant Community Service and that the date and time for the 72 hr follow up is communicated to the service user.

Care Coordinators/Lead Care Professionals retain their role for the duration of a service user's admission. There must be ongoing collaboration between in-patient and community teams and any other relevant agencies involved in supporting the service user.

The ward must ensure the discharge plan is communicated to everyone involved in providing support to the service user on the ward, at the point of discharge and afterwards.

NICE suggest discharge planning should take consideration of:

- possible relapse signs.
- recovery goals.
- who to contact for support.
- where to go in a crisis.
- any benefits issues.
- handling personal budgets (if applicable).
- details of medication.
- physical health needs, including health promotion.
- the date of review of the care plan.

The care plan should reflect the risk assessment, taking in to account what led to admission as well as the individual discharge plan.

The service user must be actively involved in stating what support should be provided to them immediately after discharge. It is essential that the service user knows when their first appointment will be and what to do if they need to contact services before their first appointment.

Staff must review the person's discharge plan and progress toward discharge at regular intervals, after any MDT decisions or in the event of any significant changes to risk or presentation.

5. On day of discharge

On discharge the following documentation/information must be offered/given to the service user and/or their family/carer (as appropriate).

- A copy of the care plan (including safety, crisis and contingency planning).
- Details of follow up appointments.
- Care Coordinator/Lead Care Professional contact details.
- Information about prescribed medication/medicines information /health promotion materials from Pharmacy.

Any infection control concern must be handed over for service users being discharged to another shared care environment.

The Nurse in Charge must check that the service users risk assessment is up to date and has been reviewed taking in to account the planned change in circumstances.

Consider the need to inform the Police of discharge where risk of harm to others is identified
Norfolk email: mentalhealth@norfolk.pnn.police.uk Suffolk email: mentalhealth@suffolk.pnn.police.uk
Teams must have clearly agreed processes for considering and checking that all reasonable steps have been completed. For example, this could include use of the Discharge Checklist on Lorenzo, or development of locally agreed checklists, safety huddles etc. as agreed by the service.

Lessons learnt show that contact details for those involved, letting the right people know, checking the service user/carer's have all the information they need, arrangements for follow up and supply of medication can be particularly important.

Discharge letters

Within 24 hours of discharge – complete the **Inpatient Discharge Medication Form**
When finished correctly this will produce an **Inpatient Discharge Medication Letter** that is automatically sent electronically to the GP. A copy should be given/sent to the service user.

Within 7 days of discharge – complete the **Inpatient Discharge Summary**. When finished correctly this will automatically be sent electronically to the GP. A copy should be given/sent to the service user.

Full guidance on how to correctly use eDischarge is available here

6. Discharge medication

Staff must consider the risk associated with discharge medication and risk of overdose.

Service Users will be provided with a minimum of 14 days' supply of the required medication unless risk assessment determines that a shorter supply is required for service user safety based on individual assessment, **this should be specified on the discharge prescription.**

Discharge medication **must** be ordered using **a** discharge prescription so as to ensure there will have been a final review of medication and that the service user receives the correct discharge medication.

7. Follow up contact

"The first 3 months after discharge remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks" (The National Confidential Inquiry into Homicide and Suicide by People with Mental Illness (2019) and although GPs have overall responsibility for service users following discharge from in-patient care, the Trust retains responsibility for the mental health care that it provides.

It is a national requirement for all service users (* for exceptions) discharged to their place of residence, care home, residential accommodation or to non-psychiatric care to be followed up within 72 hours of discharge. This includes service users where (based on risk assessment) it has been decided that no further contact with Trust services is deemed necessary, other than the 72hr follow-up contact. The Keyworker is responsible for identifying the **team, date** and **time** of the appointment and, **where possible**, the practitioner, as part of the discharge planning procedure. The decision as to who undertakes the 72hr contact should be made in close consultation with the Service User. All service users must be contacted within a 48hr period following discharge from the inpatient unit. In exception circumstances this timescale can be expanded but has to happen before the 72hr period.
All relevant health and social care professionals must be made aware of the discharge.

Within 72hrs of discharge:

- A service user discharged from an inpatient unit would be assessed as RED under the Trust RAG Rating for Adult and Community Caseloads (Community caseload prioritisation during a pandemic Standard Operating Procedure (SOP). Therefore, the follow-up should aim to be a **face-to-face** meeting. There may be clear reasons for not doing so and this should be an MDT decision where possible and the reasons for the decision clearly documented and discussed with the service user and carers. Service users and carers should have a clear say in how they are assessed, and their wishes taken into consideration. If agreed to be clinically appropriate other methods of contact can be explored such as telephone support or virtual meetings (SKYPE, Attend Anywhere).
- The contact may be made by the Inpatient Team, Community Mental Health Team/Recovery Team, the Crisis Resolution/Home Treatment Team, Dementia Intensive Support Team, or other identified appropriate health professional. The contact will be with the most appropriate team or individual depending on the individual client's needs as determined at the Pre-discharge Meeting and in liaison with the relevant Community Team, from Inpatient Services.
- During the contact the clinician should conduct a mini mental health state assessment /review and try to establish how the person is coping following discharge. This should include how they are sleeping, appetite, motivation, thoughts of self-harm/ suicide, thoughts about the future, how they are coping since discharge from the inpatient unit. Where possible involve the carer to get their feedback on how the service user is coping.
- If a telephone conversation or virtual meeting is undertaken effort should be made to conduct a mini mental state triage/ review. Pay attention to tone, rate of speech etc. as directly observable indications will not be possible- seek confirmation from carers /relatives if service user is in

agreement.

- If you are satisfied that the person is managing well record the review as a follow up. If you have concerns about how the person is presenting escalate care as assessed appropriate.
- This arrangement/responsibility must be agreed prior to discharging the service user.
- If the service user does not attend/is not at arranged meeting place/ cannot be contacted, **Q12a Non Access Visits and Missed Appointments** policy **must** be implemented.
- The GP should be informed of the outcome of the 72 hours follow up – this may be done in a variety of ways e.g. by telephone call (non-complex cases) by letter, copy of any agreed care-plan etc.

Services will have clearly agreed processes where it is agreed that contact will be made earlier than detailed above, staff must be familiar with their wards standard operating processes.

Service users who are exempt are:

- Service users who have been transferred to prison.
- Service users who have been transferred of care to another NHS psychiatric hospital.
- Service users who have been removed from the country for legal reasons.

Service user discharged to the Trust from another mental health NHS organisation
The 72 hours follow up (72HFU) contact should be completed by the local NHS mental health provider that has responsibility for the service user's ongoing care. In the majority of cases, this will be the organisation that has been providing the inpatient care for the service user. An exception to this would be where the person has been placed out of area for their inpatient care due to a lack of a local available bed. In this case, the service user's home provider would be responsible for the 72HFU contact post discharge, not the organisation that delivered the inpatient care out of area.

Service user discharge to another Trust,
NSFT ward staff must make sure there is clear agreement on who is completing the 72hr follow up and seek confirmation that it has happened as planned (SI 888). The discharging service retains responsibility for the follow up.

Service user discharge to no fixed abode
Sometimes there are extenuating circumstances where the client has no fixed abode. In these instances, the in-patient teams and the community teams are advised to work with the client, prior to discharge to arrange a suitable time and place for follow up, it is advisable to include homelessness resources to assist with this.

8. Discharge against medical advice

If an informal service user requests discharge outside of the jointly agreed discharge plan;

- Ask why they wish to leave and if possible, resolve the problem/find alternatives.
- Request they wait and see a doctor (preferably their consultant if during regular working hours) and contact the service user's medical team/on-call doctor and request an urgent review.
- Ensure that the service user understands the implications of leaving hospital, including the risk that their mental health may deteriorate.
- Give a full explanation of what treatment/care had been recommended and why.
- Consider risks (to self and others).
- Contact any family/carers/friends as appropriate who may help resolve the issue.

Consider assessment under the Mental Health Act 1983, initially under Section 5(2) or 5(4).

If discharge is to proceed against medical advice:

- Ask the service user to complete the **Discharge against Clinical Advice Form**. If they decline record this decision on form and detail in the health record (registered staff, including medical to complete).
- If the service user has declined to wait their medical team/on-call doctor should be informed (if out-of-hours, their Consultant must be informed at the earliest opportunity).
- Explain medication arrangements.
- Review risk assessment.
- Inform all relevant parties when a service user has discharged themselves against medical advice, i.e. CRHT, Care Co-ordinator, GP, relatives or carers, and all other agencies involved in their care at the earliest possible opportunity.
- If the service user has been referred to community services but not yet allocated, this should be raised urgently with the Community Team Manager.
- Contact family/carers others who may be at risk.
- 72hr follow up contact remains vital. Consider who is best placed to contact the service user.

Staff must ensure that they complete as much of the usual discharge process as possible to ensure that it is as safe and robust as it can be so as to reduce the level of risk (RCA 396).

All actions/interventions/decisions and the rationale must be comprehensively documented in the health record.

Note: As the service user is not complying with admission/is objecting, DOLS/Best Interests Decision **cannot** be used to continue the admission (See **C07: Mental Capacity Act and Deprivation of Liberty Safeguards**)

9. Discharge to acute general hospital

If an in-patient service user has been admitted to an acute hospital the decision to discharge should be based on assessment of mental state and likely need to return to NSFT in-patient care.

If they are to be discharged pre-discharge planning and discharge procedures- including the 72hrs contact must still be carried out, with the involvement of the service user wherever possible, and their family/carer (as appropriate) (SI 333) *See* **C32a Care for Inpatients who require treatment in acute general hospital**

10. Duties

Consultant Psychiatrist (In-patient):

- Ensuring that they or nominated deputy (Advanced Clinical Practitioner or Staff Grade Psychiatrist level or above) have reviewed the service user within the 72-hours prior to discharge.
- The consultant psychiatrist has overall responsibility for the decision to discharge from inpatient services and ensuring that discharge letters are completed. Actions can be delegated to a competent medical or Advanced Clinical Practitioner colleagues.

Key worker (In-patient):

- Maintaining and updating documentation throughout the admission.
- Referring to the appropriate community team and requesting a Care Coordinator/Lead Care Professional for service users new to the Trust.

- Organising MDT pre-discharge planning meetings, communicating with and updating professionals who are unable to attend reviews.
- Notifying the Care Coordinator/Lead Care Professional of admission as soon as possible.
- Considering NHS Continuing Health Care (CHC) and Fair Access to Care Services (FACS) requirements.
- Ordering discharge medication if required.
- Identifying the **team, method, date** and **time** of the appointment and, **where possible**, the practitioner to carry out the follow up contact within 72 hours.
- Liaison with the service user's family/carer pre-discharge.
- Ensuring that services are in place to support discharge.
- Providing information to service users and their family/carer.

Multidisciplinary Team:

- Participating in discharge planning.
- Agreeing processes to identify risks to safe discharge and addressing these.
- Contributing to risk assessment.

Ward Manager

- Responsible for ensuring the ward team deliver the standards of this policy.
- Responding to concerns and escalating these where needed.
- Making sure there is clear allocation of tasks to fulfil this policy, including when individual staff (such as keyworker) are unavailable.

Care Coordinator/Lead Care Professional

- Maintaining contact with the service user and their Keyworker whilst an in-patient.
- Ongoing collaboration with the service user, the in-patient team and other relevant agencies involved in supporting the service user towards discharge.
- To work with the ward team, service user and others to ensure discharge planning is safe and effective.
- Identify and raise any concerns as appropriate.

Review and Amendment Log

Version Number	Reasons for Development/Review	Date	Description of Change(s)
01	Developed for merged Trust	Jan '12	New policy
02	NHLSA and service changes	Nov '12	Revised monitoring statement. Addition of the Discharge Facilitation and Bed management Team role
03	Reviewed following RCA 396	Dec '13	Requirement that the Care Coordinator/Lead. Professional must attend the pre-discharge planning meeting (Section 5.0). Clarification that the Key worker must identify the individual (not the team) responsible for carrying out the 7 day follow up. Amendments to Discharge Checklist (Appendix 1). Clarification on responsibilities for completing the checklist (this must be done for all service users being discharged including those going to CRHT) and on crisis-planning.
04	Early review	July '14	SI 383 and SI 333
05	Early review	May '15	Updated section on the Management of Medicines Requirement to identify the practitioner providing 7-day follow up removed. The **team, date** and **time** of the appointment **must** be planned and, **where possible**, the practitioner Revised for Lorenzo
06	Early review	Nov '15	Guidance on discharge medication / prescription updated Discharge Against Clinical Advice flowchart revised NB: format changes and removal of reference to inter-healthcare infection control

			transfer form, August 2016
07	Early review	Nov '16	SI 888 Additional information regarding 7 day follow up contacts (see section 6)
08	Planned review	Jan '19	Comprehensive review with Acute Services Forum and Localities. Emphasis on joint working, collaboration and communication. New summary of key points. Inclusion of Advanced Clinical Practitioner regarding discharge letters. Removal of guidance section when planning discharge for people from abroad' section.
08.1	Limited review	Feb '19	Limited review only to support Advanced Clinical Practitioners role in reviewing service users prior to discharge (06.06.19 Info on teams not yet using eDischarge removed)
	Early Review	July 2020	Change from 7 day follow up upon discharge to 72hr to support a safer discharge (omitting the need for a 48hr contact)

11. Monitoring Statement

Aspects of the policy to be monitored	Monitoring method	Individual/Team responsible for monitoring	Frequency	Findings: Group/Committee that will receive the findings/monitoring report	Action: Group/Committee responsible for receiving assurance that actions are completed
Completion of the key steps of the discharge process	Audit	Care Group Leadership Team	As determined by the Care Group Audit Schedule	Clinical Directors report	Quality Committee
Delayed transfers of care (for those CPA)	Data extracts from Lorenzo*	Informatics team	Monthly	Care Group Governance Meetings	Quality Performance Meetings
72 hr follow-up	Data extracts from Lorenzo*	Health Informatics team	Monthly	Care Group Governance Meetings	Quality Performance Meetings

12. Supporting Information

With reference to:	NSFT RAG Rating for Adult Community Caseloads Version 4.5 August 2020 NICE Guideline: Transition between inpatient mental health settings and community or care home settings. September 2017 CCQI, Standards for Inpatient Mental health Services, Royal College of Psychiatrists 2017. NHSLA Risk Management Standards The National Confidential Inquiry into Homicide and Suicide by People with Mental Illness (2019) Health and Social Care Act (2012) Ready to Go? – Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care. Department of Health (2010) CG136: Service User Experience in Adult Mental Health. National Institute for Health and Clinical Excellence (2011) Avoidable Deaths: 5 five-year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. University of Manchester (2014) Triangle of Care (2010) Risk assessment framework, updated August 2015. Monitor (2015)
Associated trust policies and documents	**C32: Transfer Between Clinical Teams** **C32a: Care for Inpatients who require treatment in acute general hospital** **C70b: Discharge from Trust Services.** **C82: Clinical Risk Assessment and Management** **C96a: Section 117 Suffolk** **C96b: Section 117 Norfolk** **C98: CPA and Non-CPA** **C07: Mental Capacity Act and Deprivation of Liberty Safeguards**
Written by:	Alison Hannah – Organisational Improvement Manger Helen Oatham – Governance Practitioner
Reviewed by:	Liz Howlett – Suicide Prevention Lead Rob Hitchcock - Governance Practitioner Kevin Germany – Senior Governance Practitioner Clinical Cabinet (regarding Advanced Clinical Practitioner role)
In consultation with:	Acute Service Forum Forum for Older Persons Services Locality/Service management teams Tiffany Cecchini – Carers Lead Central Locality Catherine Phillips – Carers Lead Suffolk Lucy King – Inspector, Norfolk Constabulary Dawn Collins – Deputy Chief Nurse