Admission, Discharge & Transfer of Patient Care Procedure

Procedure Author:	Head of Infection Prevention Control/Resuscitation/ Communicable Diseases
Procedure Reference Number:	CL034
Date Approved:	25 April 2019
Expiry Date:	25 April 2022

Procedure Statement/Key Objective:

The Trust requires arrangements to be in place for the effective discharge, transfer and handover of patients between care providers. This procedure provides clinical staff with guidance on the discharge, transfer and hand over of patients between wards, teams and services whether within Lancashire Care NHS Foundation Trust (LCFT) or other service providers. For mental health services it complements the Care Programme Approach Policy & Procedures (CL012) which provides the overall framework for the management of care across mental health inpatient and community settings.

Supporting Health and Wellbeing

Summary

Title of Procedure:	Discharge/Transfer & Handover of Patient Care Procedure
Applicable to:	All clinical staff involved in the discharge, transfer and handover of patients
Governance group responsible for approving and monitoring implementation *This group is responsible for approving that the document is fit for purpose and for monitoring adherence to the policy and for keeping an eye on the review date.*	☐Safety and Quality Governance Group ☐Drugs and Therapeutics Committee ☐Medication Safety Group ☐Safeguarding Group ☐Promoting Health, Preventing Harm Group ☐Infection, Prevention and Control Group ☐Mental Health Law Group ☐People and Leadership Group ☒Other: Quality and Safety Sub Committee
Linked Sub-Committee *Each group above is linked to a subcommittee and an Executive Director who has delegated responsibility to approve policies and procedures.*	☒Quality and Safety Subcommittee ☐People sub-committee ☐Mental Health Law Subcommittee ☐Other: _____
People / Groups Consulted:	Senior Clinicians/Senior Management Team across all networks
To be read in conjunction with:	CL012 Care Programme Approach Policy & Procedures CL012E Protocol for the Transfer of Patients from Lancashire Care Foundation Trust to an Acute Hospital Provider PHA048 Protocol for the use of Leave and Discharge Prescriptions CL048 Policy for the Implementation of the Mental Capacity Act and Obtaining Authorisation for Deprivation of Liberty CL027 Professional Clinical Record Keeping Policy IMT 004 Health Records Service Security and Confidentiality Policy Bluelight 34 Discharging patients against medical advice. Bluelight 76 Accessing senior advice

Version Control

Version number and date approved	Title	Date reviewed	Reason(s) for change
V.1 2010	Discharge, Transfer and Handover of Patient Care Protocol	N/A new policy	Reviewed and updated
V.2 Feb 2012	Discharge, Transfer and Handover of Patient Care Protocol	Feb 2012	Reviewed and updated
V.3 June 2013	Discharge, Transfer and Handover of Patient Care Protocol	June 2013	Reviewed and updated
V.4 Dec 2013	Discharge, Transfer and Handover of Patient Care Protocol	Dec 2013	Reviewed and updated
V.5 April 2017	Discharge, Transfer and Handover of Patient Care Protocol	April 2019	Reviewed and updated to include admission
V.6 April 2019	Admission, Discharge & Transfer of Patient Care Procedure		

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MCA COMPLIANCE FORM

Please complete the questions below:	Yes/No/ Unsure	Notes
Does the procedure relate to Clinical practice?	☒ Yes ☐ No	*If 'Yes', the procedure must be compliant with the MCA. Please complete the questions below.*
Does the procedure refer all users to the MCA policy?	☒ Yes ☐ No	*If 'No' refer back to author – all clinical procedures should be read in conjunction with the MCA policy.*
Does the procedure refer to any form of consent to treatment?	☒ Yes ☐ No	*If 'Yes' is this MCA compliant?*
Does the procedure stipulate a specific method of consent is required?	☒ Yes ☐ No	*If 'Yes' is this MCA compliant?*
Does the procedure exclude service users unable to consent?	☐ Yes ☒ No	*If 'Yes' procedure is not MCA compliant – refer back to author*
Does the procedure require staff to use any form of restraint / restrictive practice?	☐ Yes ☒ No	*If 'Yes' refer procedure to MCA lead who should review it (name)*

Policy for Implementing the Mental Capacity Act and Obtaining Authorisation for Deprivation of Liberty CL048

1.0 Introduction

To be able to ensure safe, effective, efficient discharge and handover of care, clinical staff and managers have to understand process steps and services in their clinical area but more importantly across the interface of acute and community settings. Consideration needs to be given to the many services available to support patients' discharge; therapy services, transport, district nursing, intermediate care and crisis care.

It is recognised that, for patients, transfer and discharge can be distressing and is associated with increased risk factors in relation to physical health, mental health and social well-being.

This procedure provides all clinical staff with the guiding principles of safe discharge and transfer planning.

It is expected that, where required, any procedural guidance will be produced locally and approved through Network governance arrangements.

This procedure must be considered in the context of the following LCFT policies and statutory documents*:*

- The Care Programme Approach
- Professional Clinical Record Keeping
- Professional Codes of Conduct
- Information Sharing and Information Governance

2.0 Scope

This procedure is not limited to discharges from bedded units. A separate procedure is in place for the transfer of care when a child reaches adulthood and requires adult services. It is applicable to all clinical services provided by LCFT. It encompasses where a patient is: -

- referred for treatment,
- admitted for care,
- discharged from an LCFT service,
- handover of clinical care to another LCFT service,
- handover of clinical care to another health or social care provider.

Whilst there may be procedural differences between services and business units this procedure applies throughout LCFT.

3.0 Definitions

Patient- throughout this document the term patient means those who are in receipt of treatment or care and includes the terms client, service user and child.

Inpatient services – all areas that include overnight care

Referral- request made for another service/ provider to provide treatment or care

Transfer- where the service user/patient has different physical health or mental health needs which are better met in an alternative service. Internal transfers of care occur between different wards and between wards and community teams. External transfers of care occur from the Trust to external inpatient facilities both NHS and non NHS and community services. Transfers may be routine and pre-planned or arranged as an emergency

Admission- entering into receipt of treatment or care by an LCFT service

Clinical handover- transfer of a patient's care, by clinicians, from one service to another. This could be internal between teams/ wards, or external to GP, acute hospital or out of area transfer.

Discharge- the end of a period of care or treatment by a service, where the treatment is complete. Ongoing care may be required but is being delivered by another service (such cases will involve clinical handover).

4.0 The Procedure

The process and practice of planning for the admission, discharge or transfer of service users should be based on the principle that the service users are equal partners in their care and are able to fully participate in the planning process, actively collaborate in the development of their discharge plans and contribute to the decisions made relating to their care.

Admissions to hospital should always be as close to a service users home as possible, unless specialist services are clinically indicated then this may not be feasible.

4.1 Admission

Being admitted onto a caseload, service or into a care setting can be a stressful event for the patient, family or carer. It is essential that staff are compassionate, confident and professional, offering reassurance, explanation and information.
All services must have an agreed process and agreed documentation in terms of assessment and care-planning for admission of a patient. As a minimum, details will contain:
Patient's full name
Date of birth NHS number
Address and telephone number
Next of kin details including address and contact details
GP address and contact number
Reason for admission
Documentation of consent to share appropriate information with other health and social care providers as necessary.
Current medication
Current HAI status

- **Medical Assessment/Physical examination will be undertaken as part of the admission process.**
- **Medicines should be clearly documented and prescribed/ transcribed**. The nursing staff admitting a patient should ensure that a copy of all medication usually prescribed by the patient's GP is received as soon as possible.
- **The assessment process should begin immediately.** This will include mental health signs and symptoms, physical health, psychological, social and spiritual / cultural), risks (review of present assessment) and observation requirements. All patients admitted to a mental health unit will be screened to assess the need for a formal capacity assessment regarding the decision to be admitted. Patients detained under the Act who are prescribed medication will have their capacity and consent recorded in the notes. These assessments must be undertaken using agreed tools and must be recorded in the health records.
- **Mental Health Act compliance/ scrutiny**. For any patients being admitted under a section of the MHA, the Nurse in Charge must ensure that the Mental Health Act papers are received the patient is informed of their rights and this is recorded
- **The Provision of Patient/Carer Information.**
- **Patient Property is stored safely.** Any cash, valuables, clothes or medication are checked, recorded and stored appropriately.
- **Therapeutic Activities.** The patient is orientated to the unit and given information about therapeutic activities available.
- **Care and discharge planning** Recovery focussed care and discharge planning must begin from admission and have clear outcomes identified with the patient and where agreed, carers which will set out steps required to support discharge and plans for support following discharge home

4.2 Handover of Care (Planned)

Handover/ transfer of care will be a planned process unless an emergency transfer to another health care setting and when it is in the best interest of the patient. Transfers must not take place without an agreement or acknowledgement from the receiving care team that they are able to provide the care required.

All services must have agreed processes for the planned discharge of patients which clearly indicate how the patient's clinical care needs have been communicated to the

receiving team. Local staff induction must include these agreed processes

All agreed processes for discharge from services, where clinical handover of care is required, must include a clinical checklist as part of the discharge checklist. This will include, where relevant, confirmation that: -

- Patient records/ summary of ongoing care needs are transferred with the patient
- The handover of clinical care is documented within the patient's record electronically or hard copy.
- Current assessments with the identified risk levels for the patient e.g. falls risk, pressure damage risk, self-harm/ neglect risk, dietary requirements, nutritional status, are documented.
- Documentation that verbal discussion has taken place between the transferring and receiving service and that the transfer has been agreed. (provide names & dates)
- The patient has been informed of the transfer.

- That relatives and carers have been informed of the transfer.
- Assessment of equipment needs has been completed, records document that the patient has been given instruction and has demonstrated that they are able to use the equipment safely. Also that the equipment required has been ordered and is in place or will be delivered as agreed.
- Any medication required is transferred with the patient or alternative arrangements are in place.[3]
- Any identified services required by the patient have been arranged and are in place.
- Where the patient has a known or suspected communicable disease or infection, confirmation that the receiving unit/ service has been informed both verbally and by documentation.

4.3 Handover of care (emergency situation)

Where the transfer takes place because of an emergency staff must handover as much information as possible at the time, to the receiving healthcare professionals. All essential information listed in 4.2 must be given over to the receiving team as soon as possible afterwards. If there is an emergency situation where a transfer is necessary, a Datix report should be completed to ensure that this issue is recognised as an adverse incident and is immediately highlighted to managers.

Due to the nature of some services staff may not be aware that a transfer of care in an emergency has happened. As soon as it is known staff must contact the new care provider and provide a summary of the patient's care and an overview of the services provided as outlined in 4.2. A record of this contact must be documented in the electronic and/or paper patient record.

4.4 Transfer of patients from inpatient settings for diagnostic tests/ invasive treatments

Services are responsible for determining if an escort is required to accompany and/ or remain with the patient. Staff must ensure that all appropriate information required is with the patient or escort.

4.5 Discharge

Discharge from a service should for most cases be planned following a multidisciplinary care planning / review meeting in accordance with the service care- pathway, protocols and procedures. The planning must always consider and incorporate the views of patients, their family and carers.

Planned discharge can take place on any day including weekends. The time of discharge from inpatient services should take place during the day. Transfer of patients between wards and between hospitals must not be done during night time hours. Exceptions to this may occur in emergency situations, when it is in the patient's best interest and next of kin are informed.

All services must have agreed processes for discharge which include the agreed detail of completed documentation required. As a minimum this will be a discharge checklist.

The agreed service discharge process and documentation forms must be included in all staff local inductions.

[3] stock Controlled Drugs cannot be transferred.

[4] For patients receiving Clozapine include information about when next blood test due

Discharge from an LCFT service to another LCFT service or other health or social care provider will require a clinical handover of care. (See section 4.2)
Information to be given to all patients when they are discharged: Services are responsible for agreeing a checklist of information to ensure at the point of discharge the patient receives as a minimum: -

4.5.1 A written careplan/ discharge summary
4.5.2 Medication summary– summary details of all medication the patient has received, appropriate medication information leaflets and a supply of the prescribed
4.5.3 Information regarding any outpatient/ follow up appointments
4.5.4 Transport arrangements if required
4.5.5 Patient information leaflets which include information related to their condition and access to other services where appropriate
4.5.6 Advice and contact details in the event of any concerns or queries that may arise following discharge
4.5.7 Details of any suspected/confirmed HAI

All Trust services will ensure that when discharge occurs families, carers and the relevant agencies involved and necessary (particularly where safeguarding concerns have been raised) to the persons on-going care will be informed of the discharge and an appropriate level of information provided as is required.

Patient information in other formats should be provided on request, where available, e.g. large print, other languages and easy read.

4.6 Patient choice to decline LCFT services or leave an inpatient unit against clinical advice

A capable adult patient i.e. a person with mental capacity, and who is not detained under the Mental Health Act (MHA), has the right to choose to discharge themselves from the care of an LCFT service. The Trust has a duty to fully explain the risks involved, support the patient with this choice and where possible reduce risks[2].
Staff must advise the patient why it is in their best interest to remain as a patient.
Where the patient does not wish to take this advice staff should consider whether the MHA should be applied. The patient must be asked to sign the relevant service documentation.
If the patient meets the requirements of hospital/ patient transport provision this should be arranged, otherwise staff should assist the patient to access alternative arrangements.
Any medication required on discharge from an inpatient unit must be provided. If the patient refuses to wait for their medication, then all reasonable attempts must be made to ensure that the patient receives it e.g. using a courier service to deliver or asking a relative to collect it later that day.
If equipment is required for safe discharge and the patient declines to wait for this to be delivered before discharge, the risks of going home without it must be explained to the patient and delivery arranged for the item or equipment to be in place as soon as possible.
Relatives and social services should be informed, with the patient's consent. The GP must be contacted.
A discharge summary must be sent to the GP and a copy to the patient

within 48 hours of the patient leaving the inpatient unit / declining services.

5.0 Monitoring

Standard	Timeframe/Format	How	Whom
Local induction packs contain details of agreed service processes for admission, discharge, transfer and handover of care	6 monthly review of content of local induction packs	Documentation and agreed processes / local SOPs placed in induction packs	Team leader / service manager to check packs & agree contents
Development of a clinical management plan (care plan) is commenced for every patient within 24 hours of admission to ward or caseload.	Documented plan of care available for each patient at all times	By examination of patient record either during SEEL process or Record Keeping audit. Inpatient bed board information	Ward Managers Team Leaders
Clinical management plans/care plans are discussed with patients.	Daily	Patient/patient feedback responses during SEEL process or any additional patient feedback tools/activities.	SEEL Validation Team
Planned Discharges and transfers consider needs of patients including equipment and medication.	Quarterly Datix patient incident	Complaint or Datix incident monitoring in relation to discharge issues via Datix system.	Datix Risk Officer
Patients, carers and next of kin are kept informed of arrangements.	Daily	Scrutiny of complaints and feedback from patients, carers, relatives and other providers.	Ward Manager Team Leader

6.0 References

Department of Health (1999) Effective Care Co-ordination in Mental Health Services. The Care programme Approach London Department of Health

Department of Health (2008) Refocusing the Care programme approach. Policy and positive practice guidance. London Department of Health

Department of Health (2010) Exploring the principles of best practice discharge to ensure patient involvement

NHS Litigation Authority (2013) NHSLA Risk Management Standards 2013- 14

NICE Clinical Guideline 50 Acutely ill patients in hospital.

NPSA, BMA, NHS Modernisation Agency, Safe handover: safe patients. Guidance on clinical handover for clinicians and managers.