Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

Clinical

Admission, Discharge and Transfer Policy

Document Control Summary			
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Associated Policy or Standard Operating Procedures	• Admission of a patient aged under 18 to an adult ward SOP • Risk Screening Process for Admission to Milford • People who 'self-present' at hospital sites SOP • Mental Health Wards Admission, Transfer & Discharge SOP • Forensic Directorate Admission, Transfer & Discharge SOP		

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Change Control – Amendment History

Version	Dates	Amendments
V.1.0	18/2/19	Amendments made following STP Mental Health Efficiency Program 18/2/19. Section added on Zero Tolerance to out of county admissions for acute and PICU patients.

1. Introduction

Midlands Partnership NHS Foundation Trust 'The Trust' will ensure that the admission, discharge or transfer of service users within services is effective, consistent and encompasses a whole systems approach to care, which should provide a positive experience for service users and carers and involves a seamless process between teams, services and organisations. It reiterates that care must be organised around the needs of individual service users and carers; and that the transfer between services includes negotiation and agreement and that the process is well managed.

2. Purpose

The purpose and outcome of this policy is to ensure that the Trust has an approved documented process for managing the risks associated with the discharge/transfer of service users within the care planning process that is implemented and monitored. It also outlines the responsibilities of all staff members involved in the service users discharge/transfer and highlights the need for there to be clear and effective communication between all staff involved.

3. Scope

This policy applies to all service users being admitted to and discharged / transferred from all Mental Health in-patient services provided by the Trust, including

• Specialist Services (Including Mother and baby inpatient facility)

• Forensic Mental Health Services

• Mental Health Services

4. Definitions

A patient is admitted as soon as the Nurse in Charge agrees to accept the patient for admission. It is from this point onwards the Trust inpatient staff have a "duty of care" to the individual.

The second edition of the Mental Health Act Code of Practice (Para 8.4) offered the following definition *"inpatient: one who has understood and accepted the offer of a bed, and who has freely appeared on the ward and cooperated with the admission procedure"*

An **admission** for the purpose of this Policy is where a service user/patient requires the intervention of an in-patient multi-disciplinary team (MDT) in a hospital setting.

A **discharge** for the purpose of this policy is where the service user/ patient no longer requires to be an inpatient to have their needs met. The service user/patient may be discharged to return home or their care transferred to another appropriate level of care.

A **transfer** for the purpose of this policy is where the service user/patient has different physical health or mental health care 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.

5. Admission, Transfer and Discharge Principles

The Trust is clear that the process and practice of planning for the admission, discharge or transfer of service users should be based on the principle that 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 contributing to the review and decisions made relating to their care.

The use of common assessment and care planning processes within the Trust's services allow for effective sharing of information, which is supported by the effective use of electronic patient record system RiO.

Admissions to hospital should always be as close to a patients home as possible. Staffordshire's Sustainability and Transformation Plan (STP) advocates a **Zero Tolerance** for Patients to be admitted outside of their own County into Adult Acute and PICU beds. Therefore in the event that all options of accommodating locally have been exhausted a South Staffordshire Mental Health Bed should be sourced via North Staffordshire Combined NHS Trust. In the event that no beds can be sourced within Staffordshire, the on call manager should be contacted prior to pursuing alternative provisions.

The Gatekeeping Team should complete an incident form for any patients admitted outside of Staffordshire. There will be a local investigation undertaken for any patients admitted outside of this catchment .

This reflects the Trusts aspiration to ensure effective discharge planning and family/ carer involvement in care.

6. Admission Principles

Referral Information must be sufficiently detailed to enable the safe and effective care and treatment of patients coming into in-patient services.

The Nurse in Charge facilitating the admission to the inpatient area will obtain relevant information from referrer, patient and carer where applicable. This information will include as a minimum reason for admission, presenting problems and a full history of any risk assessments undertaken. Consideration of a patient's dependents/ children must be made to ensure they being cared appropriately whilst the patient is in hospital

Medical Assessment/Physical examination will be undertaken as part of the admission process.

The admitting nurse will welcome the patient to the ward and inform the appropriate medical practitioner that the patient has arrived - this is to arrange a psychiatric assessment, which will include a physical examination within 6 hours of admission. If a physical examination is not undertaken within 6 hours of admission by a doctor, the reason must be documented as per the physical health pathway.

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/ responsible is received as soon as possible (on the same day for Mon to Fri 9-5, next working day for nights and weekends) and scanned into RiO. This should form the basis of the medicines reconciliation process which ***must be completed within 24hrs for patients admitted Mon-Fri and within 72hrs for patients admitted Fri 5pm-Sun.*** In the event this procedure is not completed this will be documented in the patient's records.

The assessment process should begin immediately

This will include mental health signs and symptoms, physical, psychological, social and spiritual / cultural), risks (review of present assessment) and observation requirements. All patients 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 (see Mental Health Act policy for details on scrutiny of detention papers), the patient is informed of their rights and this is recorded in RiO. If the patient subject to a Community Treatment Order (CTO) and has been admitted as a result of formal recall, the nurse in charge must ensure that a copy of the recall form **(CTO3**) is placed in the patient's notes (this is the authority to detain the patient) and must complete formal receipt of the recall by completion of CTO4.

The Provision of Patient/Carer Information

Patients / carers or relatives are given information and / or welcome packs. Information is also given with regards to advance statements / decisions and sharing information / agreement. Patient and Carer phone numbers (inc Mobile) taken and documented.

Patient Property is offered for storage

Any cash, valuables, clothes or medication are checked with the patient and recorded and stored appropriately.

Primary Nurse Allocation

A primary nurse is allocated to the patient and a care co-ordinator is identified, where necessary

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.

7. Transfer Principles

Following any discharge or transfer between services or settings, the relevant documentation should be completed in full to enable effective care management for the service user i.e., risk assessment, health and social care assessment and care plan. For internal discharge or transfer this should be completed on RiO and ***for external transfer, copies of relevant screen shots and forms should be printed from RiO and sent with the patient.***

Where a transfer is part of an on-going treatment plan and has been identified through assessment, the usual CPA or care planning process should be followed, which involves discussion with the patient's family/ carers and care coordinator.

The transfer of service users should not take place immediately prior to a Mental Health Act review tribunal as this causes difficulty in the consistency and logistics involved in the Tribunal process.

Where a transfer happens as an emergency, in response to an acute physical or mental health emergency, the nurse in charge should always ensure that family/carers and any relevant agencies are informed as soon as possible after the transfer is agreed.

8. Discharge Principles

Discharge is planned as part of the assessment and treatment process via a multidisciplinary review and should begin as soon as is feasible after admission.

Any existing Care Co-coordinator/lead professional should work closely with the named nurse, having an active role in the service user's care, particularly in relation to supporting planning for discharge.

Service users and carers should have timely and appropriate information in order to make an informed choice on their care following discharge.

Any infection prevention and control information and care plans related to the care of the service user must be communicated to the clinical team and family/ carers following discharge

Any practical and social reasons for admission need to be addressed as part of the discharge plan. This includes ensuring that the needs of the carer are addressed and relevant information is provided to those in caring roles.

Staff must consider the safety of the any children, as part of any plans to discharge or transfer a service user if the service user is likely to have, or resume contact with their own child or any other children in their network of family and friends (even when the children are not living with the service user).

Involvement of family and carers is crucial to ensure smooth discharge and there should be regular liaison between the in-patient MDT and the care coordinator/ lead professional at all times.

Medicine management forms a crucial part of the discharge process – refer to Medicine Management Policy. Medication should be ordered in advance of the discharge date to ensure supply is available on the day of discharge. Service users should have an understanding of their medication prior to discharge, where and how to get further supply and how to take their medication. Carers should be advised of medication and given specific written details of any side effects and to whom to transmit any seen side effects.

As part of the discharge planning process (in line with regard to confidentiality considerations) all Trust services will ensure that when discharge occurs that families/ carer's and the ***relevant agencies*** **involved** ***and necessary – particularly where safeguarding concerns have been raised -*** *to* the person's on-going care will be informed of the discharge and an appropriate level of information provided as is required.

The date of discharge is discussed with the patient and carers and recorded. If a Deprivation of Liberty Safeguard (DoLS) authorisation is required following discharge, this should be applied for in advance.

Documents required for every service user and their family/ carer on discharge will include a copy of their care plan, including information on who to contact in a crisis. Service users who are discharged on a Community Treatment Order (CTO) must have a copy of the required conditions of the CTO as part of their care plan.

Appointments for the service user's next appointment are confirmed with them as appropriate and on completion of the above actions, recorded in the health records.

At the point of discharge, service users will be provided with 14 days' supply of medicine, unless following a risk assessment a smaller supply is deemed to be necessary.

At discharge the ward team will ensure the following are made documents are made available:

- Updated needs assessment which includes current mental health assessment
- Care plan and discharge plan
- Updated risk assessment and management plan
- Discharge letter to GP (to be sent after discharge)
- Plan for the provision of After Care under Section 117 for those admitted under the relevant sections of the Mental Health Act.
- Updated Advance decision (if appropriate)
- All discharge arrangements made or discussed must be recorded in the care record, together with a list of the documents forwarded to the receiving teams.

Discharge against medical advice

When service users decide to discharge themselves against medical advice, a risk assessment should take place prior to them leaving the inpatient unit to assess the risks involved. If a service user has been admitted on an informal basis to a mental health ward, consideration should be given to the use of powers under the Mental Health Act or Mental Capacity Act.

The risks of discharge before it is recommended must be explained by a member of the medical staff (or nurse in charge if the service user will not wait to be seen by a member of the medical staff) and an entry made in the care record. Service users' carers and family and relevant agencies must be informed where the service user has taken the decision to discharge them against medical advice to ensure risks are managed appropriately.

N.B. - A service user who chooses to take their discharge against medical advice should not be disadvantaged by doing so and the Trust will continue to have a duty of care for them following their discharge from hospital. The procedures for ensuring care continues in the community should still be applied where appropriate to do so (i.e. CPA 7 day follow up).

Seven day follow up after discharge from mental health inpatient units

In Mental Health services there are national requirements regarding community follow up of service users discharged from in patient wards. These procedures are designed to ensure that all vulnerable service users have access to face to face follow up as the first contact in the community within a maximum of 7 days following discharge. This includes those who take their own discharge.

Service users who are identified as particularly vulnerable or at risk should be followed up within 48 hours; this decision is to be taken in consultation with the ward MDT, crisis and home treatment team, service user and their family/ carers.

Procedural guidance as to how 7 day follow up works can be seen within the CPA 7 day follow-up SOP

9. Process for Monitoring Compliance and Effectiveness

The compliance with this policy will be monitored by periodically reviewing practice against the standards outlined in the associated SOP's. The review periods will be decided by ward managers and Matrons, dependent on clinical and operational data.

10. References

Department of Health (2015) Mental Health Act (1983): Code of Practice. The Stationary Office.

The University of Manchester (2015) National Confidential Inquiry into Homicide and Suicide by People with Mental Illness: Annual Report: England, Northern Ireland, Scotland and Wales**.** July 2015