Cornwall Partnership NHS Foundation Trust

Document Reference Code: CG/004/21

Title:	**Discharge Policy (Adult Mental Health Inpatients only)**
Purpose:	The purpose of this policy is to ensure that all patients have a planned safe discharge from Adult Mental Health Inpatient Units
Target Audience:	This policy is applicable to all Adult Mental Health Inpatient Units
Document Author:	Lindsay Parkin, Nurse Consultant, Mental Health Inpatient Service Heidi Core, Discharge Liaison Co-ordinator
Document Definition:	Policy
Supporting Committee and Chair:	Author to add
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Freedom of Information:	**This document CAN be released under the Freedom of Information Act 2000**
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Ratified by and Date:	Adrian Flynn – Joint Medical Director 2 February 2021
Review Date:	August 2023 *6 months prior to the expiry date*
Expiry Date:	February 2024 *3 years after ratification unless there are any changes in legislation or changes in NICE Guidance / National Standards*

Related legislation and national guidance:	• **Carers Trust** (2013) The Triangle of Care: Carers included: A Guide to Best Practice in Mental Health Care in England. • **CSIP** (2007) A Positive Outlook; A good practice toolkit to improve discharge from inpatient mental health care. • **Department of Health** (1991) The Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services. HC 23 LASSL: HMSO, London • **Department of Health** (2006) Dual Diagnosis in mental health inpatient and day hospital settings. The Stationery Office, London • **Department of Health** (2008) Refocusing the Care Programme Approach: Policy and Positive Practice Guidance. The Stationery Office, London

	• **Department of Health** (2010) Ready to go? Planning the discharge and transfer of patients from hospital and intermediate care • **Department of Health** (2015) Mental Health Act 1983, Code of Practice • **NICE** (2011) Quality Standard (QS 14) Service User experience in Adult Mental Health Services • **NICE 2016** (NG 53) Transition between inpatient mental health settings and community or care home settings • **NHS England** (2018) Why not home? Why not today? Monthly Delayed Transfer of Care Situation Report • **Rapid Response Report NPSA**/2009/RRR003: Preventing harm to children from parents with mental health needs. May 2009. • The NHS Long Term Plan • The National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report (2018)
Associated Trust Policies and Documents:	• Multi-Agency Adult Safeguarding Policy • Adult Safeguarding Policy • Section 117 Mental Health Act 1983 Policy • Section 17 Leave of Absence Policy • Bed Management Policy • Purposeful Inpatient Admission (PIPA) pathway • Holding Powers – Section 5 Mental Health Act 1983 • Guidance for the Management of Patient's who Lack Capacity (including Deprivation of Liberty Safeguards)
Equality Impact Assessment:	The Equality Impact Assessment Form was completed on 18th April 2019
Training Requirements:	All Registered staff on all Adult In-patient Mental Health Units to be orientated to this policy during their Ward induction. *The organisation trains and educates staff in line with the requirements set out in its Training Needs Analysis (TNA) and applied to individual training records on the Trusts Learning Management System (LMS) Training which is categorised as mandatory must be completed in line with the TNA. Staff failing to complete this training will be accountable and could be subject to disciplinary action.* *Compliance with mandatory training is monitored through the Education and Training team with reports monthly to managers, bimonthly to the Education Delivery Group and quarterly through the Trust Quality and Governance Committee Meeting.*
Monitoring Arrangements:	The standards set out in this policy will be monitored as set out in the Service Line Clinical Audit programme. The Service Line

	Clinical Quality Operational Assurance Group will consider and approve relevant recommendations and monitor the completion of any subsequent actions.
Implementation:	This policy will be implemented by Ward Managers; cascaded to ward team members via Line Management Supervision and Ward Meetings.

Version Control

Version	Date	Author / Reviewer	Page No.	Changes
	August 2013	Jane Pitts / Sharon Linter		Appendix 4 added
	January 2016	Lindsay Parkin / Heidi Core		Flowchart removed, policy updated and appendices added
	April 2019	Lindsay Parkin / Heidi core		Policy updated, RAG rating added (purposeful inpatient PIPA) and appendices added
	July 2020	Ellen Wilkinson		Reviewed as changes to the discharge documentation
	September 2020	Lucy Baguley	21	Appendix 1c updated Discharge Checklist
	December 2020	Phil Belcher		Add Against Medical advice form and links to other policies

This document Replaces:

- CG/004/20 – Discharge Policy (Adult Mental Health Inpatients) (*ratified in August 2020*)

Contents

1. Introduction

This policy sets the key steps to be taken to ensure that patients are discharged in a safe, timely and effective way from Cornwall Partnership NHS Foundation Trust's Services. It concentrates on the Adult Inpatient Mental Health wards as these patients are complex and require safe and effective discharge back into the Community setting.

2. Discharge from Services other than Adult Inpatient Mental Health services

The discharge of patients from all other areas will be based on the individual patients care pathway, involvement of the patient, and where relevant carer and / or advocate and their individual Clinician's clinical opinion. However, the key principles outlined within this policy must be considered when discharging any patient from Cornwall Partnership NHS Foundation Trust's services.

3. Principles

The decision to discharge someone from hospital must be in keeping with the Care Programme Approach (CPA), (DH 1991, 2008) and governed by the following principles:

- The goals for an inpatient episode of care should be considered at point of referral to the receiving ward and shared and agreed with the multi-disciplinary team at the first clinical review after hospital admission.
- Planning for discharge should begin as soon as possible following, or for known service users prior to, admission, to facilitate the completion of a comprehensive treatment and discharge plan to avoid any delay to discharge or transfer where possible.
- For continuity of care, the care co-ordinator must be involved/ allocated at the earliest opportunity.
- The patient, and / or carer and / or advocate, must be actively involved in all aspects of the discharge plan, where practicable. Arrangements for discharge should be negotiated with everyone likely to be concerned with the service user's aftercare.
- Every person, prior to a planned discharge, will receive a care plan.
- That people who use mental health services who may be vulnerable are given due attention when planning discharge.
- Where possible funding decisions (if relevant) are made in a way that does not delay discharge.

4. Duties

Doctors, Inpatient and Community Teams have a collective responsibility in ensuring that people who leave hospital or are transferred after or during an In-patient episode do so safely.

It will be the responsibility of the named nurse with the care co-ordinator to ensure prior to discharge that plans as agreed by the Multi-Disciplinary Team (MDT) are in place.

5. Discharge planning procedure (See Appendices 1A, 1B & 1C for guidance)

Active discharge planning begins following hospital admission and should include the completion and / or review of the RiO Core assessment, incorporating historical factors, mental state examination, physical examination, risk assessment, consideration of relapse indicators together

with crisis and contingency information. This is required in order to develop a care plan that defines presenting problems, sets goals and identifies a preliminary discharge date, with a focus on reducing distress, promoting social inclusion and recovery.

Simultaneously, the MDT should take into account the needs of the patient for return to community living, together with their carers views (with patient consent) as part of the CPA review / discharge planning meeting. Issues that might affect hospital discharge should be identified at an early stage and acted upon, these can be identified using the *Identifying Barriers to Discharge Checklist* (Appendix 1A) and include:

- Safeguarding
- Homelessness (see below)
- Threat of eviction
- No security of tenure
- Finance
- Rent arrears
- Inadequate state of home e.g. no utilities, damage
- Neighbour harassment
- The need for family support or interventions
- Any additional support needs

The accommodation and support tool checklist **(Appendix 2)** should be followed for patients where there is a concern about whether they can return home following their admission. The accommodation and support tool flowchart **(Appendix 3)** will identify an appropriate *'discharge pathway'*.

If housing needs are identified, make referrals to both of the following:

- **Homeless Patient Advisor** – Colette Jolly, collettejolly@nhs.net (07969 801 807) and
- **Housing Support and Development Co-ordinator** – Ian Cleary, cpn-tr.supportedhousing@nhs.net (07879 641287)

All patients need to be involved in the decision around consent to share information, where they decline or are unable to give consent then a best interest meeting must be undertaken and further advice sought from the Caldicott Guardian.

http://intra.cornwall.nhs.uk/DocumentsLibrary/CornwallFoundationTrust/WebDocuments/Intranet/PatientRecords/RiO/StandardOperatingProcedures/RecordingConsentToShareInformationSOP2011.pdf

6. Multi-Disciplinary Meeting

At the first Multi-Disciplinary meeting following admission, in line with the Purposeful Inpatient Admission (PIPA) pathway, a RAG rating (Red, Amber, Green or Blue) should be agreed and the following identified / commenced:

- The reason for admission
- The development of a formulation

- A clear plan identifying the goals to be achieved to facilitate early discharge (when clinically appropriate).
- The expected discharge date
- The risk assessment reviewed, updated and a risk management/contingency care plan developed
- The suitability for home treatment and the facilitation of early discharge in conjunction with a representative for the Home Treatment Team.
- The patient and carer must be advised of an expected date of discharge in timely manner to enable preparations to take place, as well as an opportunity for family support needs to be identified.

In the absence of an identified Care Coordinator the Consultant will act as the link person with the Community Mental Health Team and will help to identify any barriers for discharge.

7. Discharge Facilitation

Where goals of admission have been met as agreed by the Multi-Disciplinary Team, the discharge can be facilitated by the named nurse in partnership with the patient and carer.

At the point of hospital discharge, or prior to leave periods, the risk summary and care plan must be reviewed and updated.

The following discharge documentation must be completed and distributed as appropriate:

- Admin staff to send an email the patient's GP confirming discharge and advising the surgery they will receive a discharge letter once complete.
- 24 hour Discharge Summary and prescription – to be sent to GP by admin staff once completed by the junior doctor
- Transfer letter – on out of county transfer letter to be sent with patient or emailed to receiving unit / team

The following information must be given to the patient and their carer, where relevant and with patient consent, upon discharge or if transferred out of county:

- Copy of care plan including Discharge Care Plan to patient (staff record in care plan distribution)
- A copy of their Safety Plan (Crisis contingency plan)
- Patient to be given a copy of their TEP if completed during their inpatient stay
- Information regarding their medication, including anti-coagulants, insulin and lithium therapy
- Appropriate contact details for services available to patient.

8. Preventing harm to children from parents with mental health needs:

All discharge planning documentation and procedures should prompt staff to consider if the patient is likely to have, or to resume contact with their own child or other children in their network of family and friends, even when the children are not with the patient. The RiO *safeguarding child in the client network* form must be completed and reflected in the risk summary screen under child contact.

Referrals should be made to Children's Social Care Services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met. A referral must be made:

a. If patients express delusional beliefs involving their child *and / or*
b. If patients might harm their child as part of a suicide plan.

9. Leave from hospital

Periods of home leave from hospital should be planned through negotiation with the care team after discussion with patient and carers, where appropriate. (Please see **Appendix 4** for detailed guidance on the leave process).

Section 17 Leave (refer to Section 17, Leave of absence policy)
Leave of absence can be an important part of a detained patient's care plan, particularly when considering hospital discharge.

Leave of absence for patients detained under the Mental Health Act can only be authorised by the patient's Responsible Clinician and in accordance with the provisions of Section 17 of the Mental Health Act (1983). (Please see **Appendix 4** for detailed guidance on the leave process).

10. Section 117 aftercare (refer to Section 117 Mental Health Act 1983 policy)

Section 117 requires Clinical Commissioning groups and Local Authorities to provide or arrange the provision of after care to patients who have been detained under Section 3, 37, 45A, 47 or 48 of the MHA (including patients who are then granted Section 17 leave or placed on a CTO or who become informal before discharge from this admission or any previous).

After-care services are those that have the purpose of meeting a need arising from or related to the patient's mental disorder and reducing the risk of deterioration of the patient's mental health and therefore the risk of requiring a further admission for treatment of mental disorder.

After-care for all patients should be planned within the framework of the CPA, because of statutory obligation it is important that all patients who are entitled to after-care under Section 117 are identified and the care and services planned under Section 117 is recorded. All patients eligible for an assessment of needs under Section 117 **must** be given a Section 117 leaflet **(Appendix 5).**

In order to ensure after-care plans reflect the full needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. Subject to patient views, this may include, the RC, inpatient team, GP, Nearest Relative, Multi-agency public protection arrangements (MAPPA) co-ordinator (where appropriate), IMHA or IMCA, housing, voluntary organisation, patients attorney or deputy (see Code of Practice, paragraph 34.12).

The after-care plan requires a thorough assessment of the patients' needs and wishes and is likely to include:

- continuing mental healthcare, whether in the community or on an outpatient basis
- the psychological needs of the patient and, where appropriate, of their carers
- physical healthcare
- daytime activities or employment

- appropriate accommodation
- identified risks and safety issues
- any specific needs arising from, e.g. co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder
- any specific needs arising from drug, alcohol or substance misuse (if relevant)
- any parenting or caring needs
- social, cultural or spiritual needs
- counselling and personal support
- assistance in welfare rights and managing finances
- involvement of authorities and agencies in a different area, if the patient is not going to live locally
- the involvement of other agencies, e.g. the probation service or voluntary organisations (if relevant)
- for a restricted patient, the conditions which the Secretary of State for Justice or the first-tier Tribunal has – or is likely to – impose on their conditional discharge, and
- contingency plans (should the patient's mental health deteriorate) and crisis contact details

Please see (**Appendix 6**) for flow chart and further guidance on identifying and recording S117.

11. Community Treatment Order (CTO) section 17A of the MHA

CTO must be considered if patient detained under S3 (or an unrestricted Part 3 patient) is considered for S17 leave of over 7 days. A CTO must also be considered if a Tribunal makes a recommendation.

Patients do not have to give formal consent to a CTO but should be involved in decisions about the treatment to be provided.

The RC must inform the patient of the reasons for using a CTO the conditions attached to the CTO, and the services available to them (including access to IMHA).

The RC and care coordinator must ensure that the patient and their nearest relative are made aware of their rights and take all practicable steps to help them understand these rights (including introducing an IMHA is the patient is unable to understand).

It is important that carers are included in the discharge planning process (where appropriate) and know how to contact the responsible team if they have any concerns that the patient is not complying with the conditions of the CTO or that the patient's mental health is deteriorating.
If it is decided a CTO is the best option the RC is to complete a CTO1 and provide it to inpatient administrative staff to process. Once a CTO1 form has been received it initiates the admin discharge process. This process will ensure the GP is advised the patient's discharge from hospital and will mitigate the risk of the 24hr Discharge Summary breaching the target.

12. Homelessness

Where it has been identified that a patient is of No Fixed Abode, a referral should be made to the:

a. Homeless Patient Advisor, Collette Jolly, colettejolly@nhs.net (07969 801807), and

b. Housing Support and Development Co-ordinator, Ian Clearly, cpn-tr.supportedhousing@nhs.net (07879 641287).

In the event of accommodation being declined at the point that a person is assessed as fit for discharge; following the assessment of risk, their capacity in relation to this decision, suitability and with Multi-Disciplinary Team agreement, discharge will not be delayed. A date for discharge will be set and the Homeless Patient Advisor informed.

This will not impede a community care package and 72 hour follow-up arrangements. An appointment should be given to the patient on discharge at a mutually agreed venue or base.

13. Delayed Transfers / Discharges

A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed. A patient is ready to go home when all of the following three conditions are met:

a. A clinical decision has been made that the patient is ready for transfer home AND
b. A multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home AND
c. The patient is considered to be safe to discharge/transfer home.

For clarification on whether the criteria for a delayed transfer of care / discharge has been met, refer to the Delayed Transfer of Care (DTOC) poster **(Appendix 7)**.

14. The 24 hour Discharge Summary

It is a Trust target to ensure all discharge summaries and medication on discharge are received by GPs within 24 hours of discharge. Failure to achieve this will result in financial penalties. This is a safety and quality issue and this swift communication with the GP should result in better continuity of care for the service user. The guidance for discharge process is required to achieve this goal **(see Appendix 8).**

Emailing Letter to GPs procedure

Junior doctors to access the editable letter and prescription in the patients case record on RiO.

a. Part of the administration admission process is to produce and send a letter to the GP to inform them of the patient's admission to hospital and to request that no medication is prescribed or dispensed until they have been advised that the patient has been discharged. The letter is sent by the admin team from the generic NHS.net email account.
b. From the moment the patient has been admitted the junior doctor is able to update information relating to their time on the ward and discharge plan into a form on RiO. At the point of discharge the information from this form can be generated into the inpatient discharge letter. Once the doctor is happy with the information contained in the letter they advise the admin team it is ready to be sent to the GP and upload to RiO.
c. ALL other discharge information will be completed by the junior doctor at the time of the **decision** for discharge and before the junior doctor leaves the ward. The discharge

summary must be emailed to the relevant inpatient unit generic NHS.net email account, either:

Bodmin Hospital: cpn-tr.BodminHospital@nhs.net (patients discharged from Bodmin mental health inpatient wards – Monday to Friday 9am – 5pm – with the exception of Bank Holidays).

Longreach House: cpn-tr.longreach@nhs.net (patients discharged from Longreach House at any time and also Bodmin letters to be sent to this address during weekends or Bank Holidays)

Once the admin team have been advised that the discharge letter is complete and ready to send to the GP, they will check and scrutinise the letter to ensure that patient demographics information, the GP address and the admission and discharge dates are correct and that an ICD10 code has been added. Admin will email the discharge summary to the relevant GP surgery and upload the document to Clinical Documentation on RiO. Admin will also advise the patient's Care Coordinator and any other NHS professionals that the discharge letter is available to view on RiO Admin staff will inform the Medical Secretary if a completed summary has not been received within 24 hours after discharge.

a. Each discharge summary must be sent from the generic email accounts in order to create an audit trail and proof of sending.
b. Where the junior doctor is not available or discharge occurs unexpectedly out of hours, the cross-covering junior doctor, or Duty Doctor must complete the discharge summary and follow the protocol.
c. If a discharge occurs over a weekend or Bank Holiday, the junior doctor is responsible for completing the discharge summary (for patients at Longreach House or mental health wards at Bodmin Hospital) and ensuring it is emailed to Longreach Reception staff at: cpn-tr.Longreach@nhs.net

15. Discharge against Clinical Advice

There are times when a patient requests to take their early discharge from hospital. On these occasions and in the best interest of an individual who wishes to leave hospital '*against clinical advice'* and in a unplanned and ad hoc manner, the discharging nurse will be required to make a decision in conjunction with the ward doctor / duty doctor to consider capacity issues and the use of the Mental Health Act. It is crucial to ascertain the reason why an '*early discharge'* is required and whether or not the expressed difficulties are solvable. In those circumstances where the *'discharge against clinical advice'* route is taken, the following actions should be taken:

- Mental state assessment
- Mental Capacity assessment in relation to discharge and the risks involved in discharge. see Mental Capacity Policy.
- Review of risk assessment
- Consideration of Mental Health Act Assessment consider use of s5 of MHA and refer to that policy
- Review with medical practitioner
- Consider social situation and whether the service user has considered the need for food, electricity etc.
- Consider medication needs.
- Establish contact details, i.e. current address, telephone numbers.

- Establish whether there is agreement to inform carers / relatives of the decision to take their discharge.
- Update the RiO, include situation regarding medication and update risk assessment.
- Inform the General Practitioner.
- Consider referral to safeguarding team
- If the person is already known to Community Mental Health Services, the Care Coordinator / CMHT must be contacted promptly to arrange a follow up visit with 48 hours of discharge.
- If the person is not previously known to Community Mental Health Services, a referral to the Home Treatment Team must be made to enable follow up within 48 hours of discharge.
- If the service user is not to be prevented from leaving, please request that he / she sign the 'against clinical advice form';

Please remember to complete the '*Against Clinical Advice Form'* (Appendix 9), document within RiO progress notes and upload to Rio Clinical documentation.
NB – People are entitled to HTT / CMHT follow-up whether they have been discharged in line with their Multi-disciplinary care plan or in circumstances where they abruptly self-discharge without a CPA review, thus invoking the *'against clinical advice process'.*

16. Follow up contacts times

All patients discharged to their place of residence, temporary residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 72 hours of discharge. All avenues need to be explored to ensure patients are followed up within this time span.. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.

Exemptions:

- Patients who die within 72 hours of discharge.
- Where legal precedence has forced the removal of a patient from the country
- Patients transferred to NHS psychiatric inpatient wards.

17. Audit and Evaluation

Documentary evidence of discharge will be audited:

17.1 72 hour follow up via performance management within each Service Line and provide feedback to each team on their quality of discharge planning.

17 2 Monitoring of 24 hours GP discharge letter is managed through performance reported and reported to service lines and the Trust Board

Appendix 1A – Identifying Barriers to Discharge Checklist

Name: NHS No.:

Benefits and Money	Yes	No	Comments
Do you receive any benefits?			
Are you currently in debt?			
Do you feel able to budget appropriately?			
Do you have any concerns about your finances at the moment?			
Housing			
Is your current housing situation stable?			
Who is your housing provider? Do you have a housing officer? Or do you have a mortgage or privately rent?			
Are you in arears with your rent or mortgage? Do you have any arrangements already in place with this?			
Is the mortgage or tenancy agreement in your name or is it in joint names?			
Do you have your house keys? Is your door locked / house secure?			
Do you have any other concerns about your housing situation?			
Is there anything in your home environment that may be a concern when you are ready for discharge? i.e. • Do you have a lot of belongings around your home that may cause a trip or fire hazard? • Have you been able to look after your home environment e.g. cleaning and tidying up? • Do you have water, gas electric, heating?			

Are you homeless? If yes, • Have you had any support with this? • Have you made a homeless application to Cornwall Housing? if yes what was the outcome? • Do you have a housing officer?			
Have you been served a notice of eviction? If yes, when? Have you had any support or advice about this yet?			
Support that I receive and provide			
Do you have a carer? If yes, do you give consent; • For us to contact them to discuss your support needs (which means asking some of the same questions that you have been asked?) • To involve them in planning your discharge and invite them to ward reviews and relevant meetings about your care? • Are there any other people who support you in the community e.g. Friends or neighbours?			
Do you have any other agencies that regularly provide support that we can contact to help plan your discharge? i.e. • Social worker? • Support workers? • Children's social workers?			
Are you a carer? Do you have children that are dependants/living at home with you?			
My Mental Health support			
Do you have any current support in the community? Are you able to attend appointments?			
My Physical health support			
Do you have any physical health needs that you have or need support with? Are you able to attend appointments?			

Managing my prescribed medication.	Yes	No	Comments
Do you order and pick up your own prescribed medication? Do you remember to take this when it is due to be taken? Do you need any support to order, and remember when to take your prescribed medication? Do you already have any support in place with any of this?			
My daily living support needs			
Do you feel able to manage; • Your personal care – washing, bathing or showering and having clean clothes? • Planning for meals, shopping and cooking? • Drinking and eating enough?			
Feeling part of my community and included in it.			
Are you able to go out and about in your community? What type of transport do you use? Do you feel safe in your community? If not can you tell us more about this?			
Do you feel isolated in your community? If yes, would like some more information about things you can do/groups etc.?			
Other things that may concern me			
Is there anything that we haven't asked you about that worries you or that you feel you need support with?			

Completed by: .....

Date: .....

Signature: .....

Appendix 1B – Planning your Discharge from Hospital

Discharge planning (CPA) meeting

- Before you are discharged your CPA meeting will be held with you.
- If you have been detained under a treatment order of the Mental Health Act, you may be entitled to S117 after care . You will be given a leaflet about this if this applies to you. Your CPA meeting will also be your S117 meeting.
- People involved in your care and the people who are important to you will also be invited to attend, or contribute, with your consent.

When you are discharged

- You will receive a copy of your care plan and relevant contact numbers.
- Your discharge summary will be sent to your G.P surgery. It will include details of any medicines that you are prescribed.
- We will also need your contact number so we can telephone you within 7 days of your discharge. This is to ask how you are and if you have any queries or concerns since your discharge from hospital.

Comments and concerns

We welcome your views, feedback and suggestions about how we can improve our service. The PALS office takes calls Monday to Friday, between 9.30am and 4.30pm.

Telephone: 01208 834620

Email: cpn-tr.palscft@nhs.net

To get this information in another format email:
cpn-tr.communications@nhs.net

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Cornwall Partnership NHS Foundation Trust

Planning your discharge from hospital

Information to assist your care team with planning what happens next

Please read, complete this leaflet and bring it to your ward round.

The questions in this leaflet will help you and your care team to plan your discharge from hospital.

If you would like support with this you can ask your named nurse, care coordinator, family member or advocate (if you have one).

Your Named Nurse is……

Your Consultant is ……

Find us online at cornwallft

Assessing your needs

During your hospital admission, your care team will work with you to identify your health and social care needs. This is in preparation for your discharge from hospital and will help to identify your support needs in the community under the Care Programme Approach (CPA).

This can involve a social needs assessment or occupational therapy assessments being completed with you. Please speak with your named nurse, care coordinator, a member of your care team or advocate if you have any questions about this.

People close to you that you would like to be involved

Please can you tell us who you would like to be involved in planning your discharge from hospital?

People that support you in the community

Please can you tell us about any other people or agencies that support you in the community?

What is important or a priority for you?

Is there anything concerning you, or that you feel you need support with that may delay your discharge from hospital?

For example:

Housing:

Money and benefits:

Social activities; leisure, education; work or training:

Mental health and support needs:

Physical health and support needs:

Daily activities (washing; dressing; eating; shopping and cleaning):

Spiritual, religious or cultural:

Other:

Appendix 1C – Discharge Planning Checklist

Name: NHS No.

Admission Date:

DISCHARGE PLANNING CHECKLIST (start on admission)	Date	Yes / No / NA
Has a social inclusion / discharge planning checklist been completed?		
Are there any identified barriers to discharge?		
Have relevant referrals been made (with service user consent) i.e. homeless patient advisor?		
Does the service user have a copy of **planning your discharge leaflet** and have they identified people important to them to engage with discharge planning and any concerns they have about what could be a barrier to their discharge?		
Has this service user been offered OT assessment of functional needs, home assessment etc. where applicable? Have these been planned or completed?		

Identified Needs / Care Act Needs Assessment		
Do they have a care co-ordinator identified? If no, has a referral been made? Does this need to be chased?		
Is there are safeguarding issues identified? Has a referral been completed? Have the team been invited to discharge planning meetings?		
Will this patient require additional support on discharge i.e. Package of care, Residential / Nursing home. Have you requested consent to share from patient with regards to potential providers?		
Is this patient eligible for an assessment of needs under S117? Do they have a copy of S117 Aftercare leaflet if so?		
If patient is over 65, under 18, has a LD, dementia or brain injury diagnosis, please liaise with adult social care. If they do not have an allocated social worker, have they been referred to adult social care for a social worker and needs assessment? Have you gained consent to share info / make referral? Tel 0300 1234 131 Option (3) for Social Care Access team. Temporary amendments during Covid-19 pandemic refer via SERF as opposed to Access Team. Complete SERF link (found on intranet) 18- 65yrs Ward Team to complete needs assessment and liaise with CFT Personal budget team.		
Are they declining care? Do they have capacity to do this?		

Will this patient require advocacy services? (IMHA, IMCA or Care Act Advocate)? Has this been discussed with them and if consented to a referral has this been made?		
Has the carer been offered / provided with a S117 Aftercare leaflet?		
Has a care & support plan been completed and submitted to personal budgets in regards to additional support needed with providers identified to meet those needs?		

Discharge Planning Meeting		
Is a Best Interests Meeting (BIM) indicated? Is there a clear, decision specific capacity assessment in Rio's capacity section relating to this? for each decision? Has a BIM been arranged? Has the BIM been held?		
Has consideration been given to the self-neglect pathway if patient has capacity and is declining support?		
Has their Discharge Planning CPA or S117 been arranged **prior** to discharge with all relevant professionals, agencies proposed providers etc. and family members invited to attend? i.e. safeguarding, adult social care, housing providers, support workers / care agencies. Have any unavailable invitees been asked to contribute? (Consider telephone conference/Video Call to enable their input)		
Have HTT been contacted if indicated / relevant?		
Has the outcomes been from the Discharge Meeting/S117 meeting been clearly documented on RiO? Does it clearly identify the patient's support needs and what services will be offered / signposted to support? If S117 provision is identified as required or not, has the rationale for this been clearly documented.		

OVERNIGHT LEAVE / EXTENDED LEAVE CHECKLIST	**Date**	**Yes / No / NA**
Have any barriers to leave been addressed?		

Discharge Planning Meeting / S117 Meeting		
Ensure that the Discharge Meeting/S117 meeting has been held prior to leave. If it hasn't been held arrange to be held in next MDT meeting. **If CFT are not commissioned for social care a representative from ASC must be present / have contributed otherwise it cannot be deemed a S117 & the Patient must attend.**		

Medication		
If a compliance aid needed? Has this been ordered?		
Has the patient's medication care plan been reviewed?		
Have the TTO's been ordered and delivered? Have they been checked?		
Are they and/or their carer aware of treatment plan?		
Is a depot prescribed? Are depot administration arrangements confirmed and care planned?		
Are medications prescribed where they require monitoring books / information packs? e.g. lithium therapy, anti-coagulants		
If this is extended leave are there plans in place for their continued medication supplies?		

Risk Assessment / Management		
Has their risk assessment been updated?		
Does it acknowledge changes to risk level to self, others and from others due to their transfer from inpatient to community setting?		
Is there a risk management plan in place if needed?		

Safeguarding		
Is there a current safeguarding alert relating to this patient?		
Have you liaised with relevant safeguarding agencies to advise of leave?		
Is there a clear management plans in the context of period of leave (following discussion with safeguarding)?		

Package of Care / Additional Support		
Are all relevant agencies aware of leave period, including care agencies, housing providers, care coordinator, family members etc.		
Have all referrals to specialist services in the community been made and accepted? e.g. diabetic nurses, community nurses		
If patient is transferring to a supported, residential or nursing setting, do they have all the relevant documentation?		
Has confirmation of funding been agreed in writing for packages of care, or supported, residential and nursing settings?		
Are they under appointeeship? If so are there arrangements in place regarding their money during the leave period?		

Care Planning		
Does the patients care plan reflect all need including mental health, physical health, social and risk		
Are the contact details for services and plans for appointments during leave period identified in the care plan		
Are the patient and carers/family members (if appropriate) aware of the date and time of the review following the leave period?		

Does the patient have a copy of the leave care plan? Are they in agreement? Have their comments been documented?		
Has the care plan distribution been completed on RiO?		
Have inpatient care plans been closed or put on hold where appropriate?		

Mental Health Act (only applicable if patient is detained)		
Is there valid Section 17 leave? Is the patient aware of the conditions of their leave?		
Have they been given a copy of their S17 leave form?		
Have they signed their S17 leave from prior to commencing leave?		

Leaving the ward		
Ensure all property is returned to the patient		
Check any valuables are returned to them from reception		
Check that there is a current accurate contact number for the patient documented on RiO		
Has the leave address been documented if differs from their usual address?		
Give them their original TEP form and advise them to keep it somewhere visible.		
Document leave commencing on RiO		

Internal Ward Communication		
If there is a request to hold a leave bed has this been discussed with the ward manager and documented on RiO?		
Are bed management and reception aware of leave period?		

Name: NHS No.

Discharge Date:

DISCHARGE CHECKLIST	Date	Yes / No / NA
Discharge Against Medical Advice		
Is the patient taking discharge against medical advice (ACA)? If yes, the ACA checklist and ACA form must be signed and uploaded onto RiO.		
Have any barriers to discharge been addressed?		

Medication		
If a compliance aid needed? Has this been ordered?		
Has the patient's medication care plan been reviewed?		
Have the TTO's been ordered and delivered? Have they been checked?		
Are they and / or their carer aware of treatment plan?		
Is a depot prescribed? Are depot administration arrangements confirmed and care planned?		
Are medications prescribed where they require monitoring books / information packs? e.g. lithium therapy, anti-coagulants		
Is the patient aware they will need to contact their GP for further supplies of meds?		

Risk Assessment / Management		
Has their risk assessment been updated?		
Does it acknowledge changes to risk level to self, others and from others due to their transfer from inpatient to community setting?		
Is there a risk management plan in place if needed?		

Safeguarding		
Is there a current safeguarding alert relating to this patient?		
Have you liaised with relevant safeguarding agencies to advise of discharge?		
Is there a clear management plans in the context discharge (following discussion with safeguarding)?		

Package of Care / Additional Support		
Are all relevant agencies aware of discharge, including care agencies, housing providers, care coordinator, family members etc.		
Have all referrals to specialist services in the community been made and accepted? e.g. diabetic nurses, community nurses		

If patient is transferring to a supported, residential or nursing setting, do they have all the relevant documentation?		
Has confirmation of funding been agreed in writing for packages of care, or supported, residential and nursing settings?		
Are they under appointeeship? If so are there arrangements in place regarding their money after discharge?		
Have you liaised with Community Mental Health Team (iCMHT) and arranged for 72hour follow up? If the patient is not under the iCMHT the 72hour follow up will be the responsibility of the discharging ward.		

Care Planning		
Does the patients care plan reflect all need including mental health, physical health, social and risk		
Are the contact details for services and plans for appointments after discharge included?		
Are the details of 72hour follow up included in the care plan?		
Does the patient have a copy of the discharge care plan? Are they in agreement? Have their comments been documented?		
Has the care plan distribution been completed on RiO?		
Have inpatient care plans been closed?		

Mental Health Act (only applicable if patient is detained)		
Has all the relevant MHA paperwork been completed including discharge order		
Are they subject to a CTO? If so do they have a copy of the conditions?		

Leaving the ward		
Ensure all property is returned to the patient		
Check any valuables are returned to them from reception: • Check Inpatient Services (Reception) • Check property box • Check property cupboard • Check laundry • Check ward office		
Check that there is a current accurate contact number for the patient documented on RiO. **This is extremely important for 72hour follow up**		
Has the discharge address been documented if differs from their usual address?		
Give them their original TEP form and advise them to keep it somewhere visible.		
Document discharge on RiO progress note		
Take patient of bed state and close on entry / exit.		

Internal ward Communication		
Have you informed the relevant admin team to ensure 24 hour discharge summary is sent to GP		
Are bed management aware of discharge		

Appendix 2 – Accommodation and Support Tool Checklist

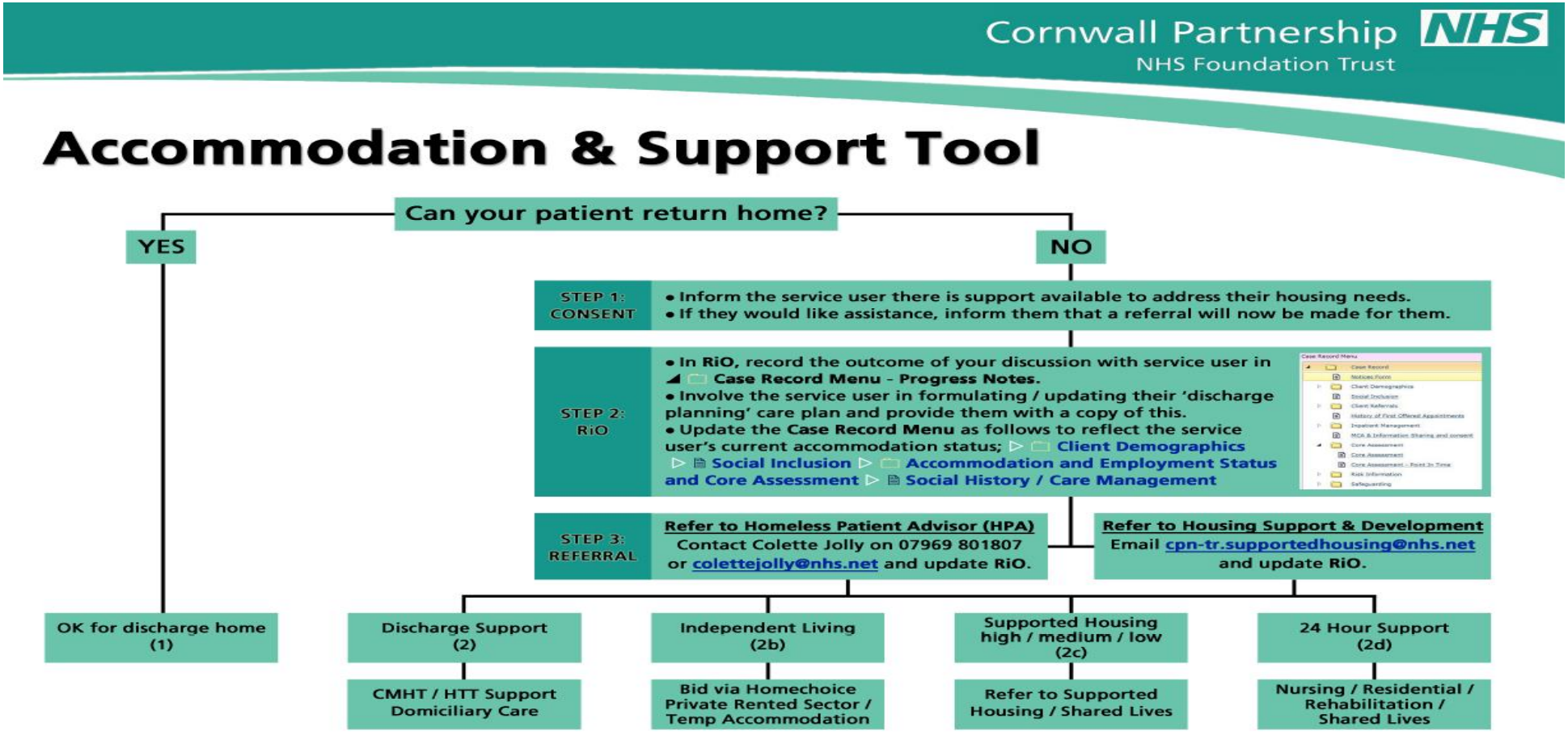
Please complete for patients where there is a concern about whether they can return home following their admission

Can your patient return home following their admission?	Yes	No
There is support available to address their housing needs please seek the patients consent to make a referral		
Have you obtained consent to make a referral and recorded this?	Yes	No
Which of the following categories do you feel the patient currently fits?		
1 – OK for discharge home with little or no support	Yes	No
2 – Has a home but needs extra support from CMHT / HTT / Domiciliary Care	Yes	No
2b – Has no home and little or no extra support needs and would be suitable for accessing independent / temporary accommodation	Yes	No
2c – Has no home and would benefit from supported housing	Yes	No
2d – has no home and would need 24/7 support from residential / nursing care	Yes	No
If housing needs are identified please: **Refer to Homeless Patient Advisor** – Colette Jolly colettejolly@nhs.net (07969 801807) **and** **Refer to Housing Support and Development Co-ordinator** – Ian Cleary cpn-tr.supportedhousing@nhs.net (07879 641287)	Yes	No

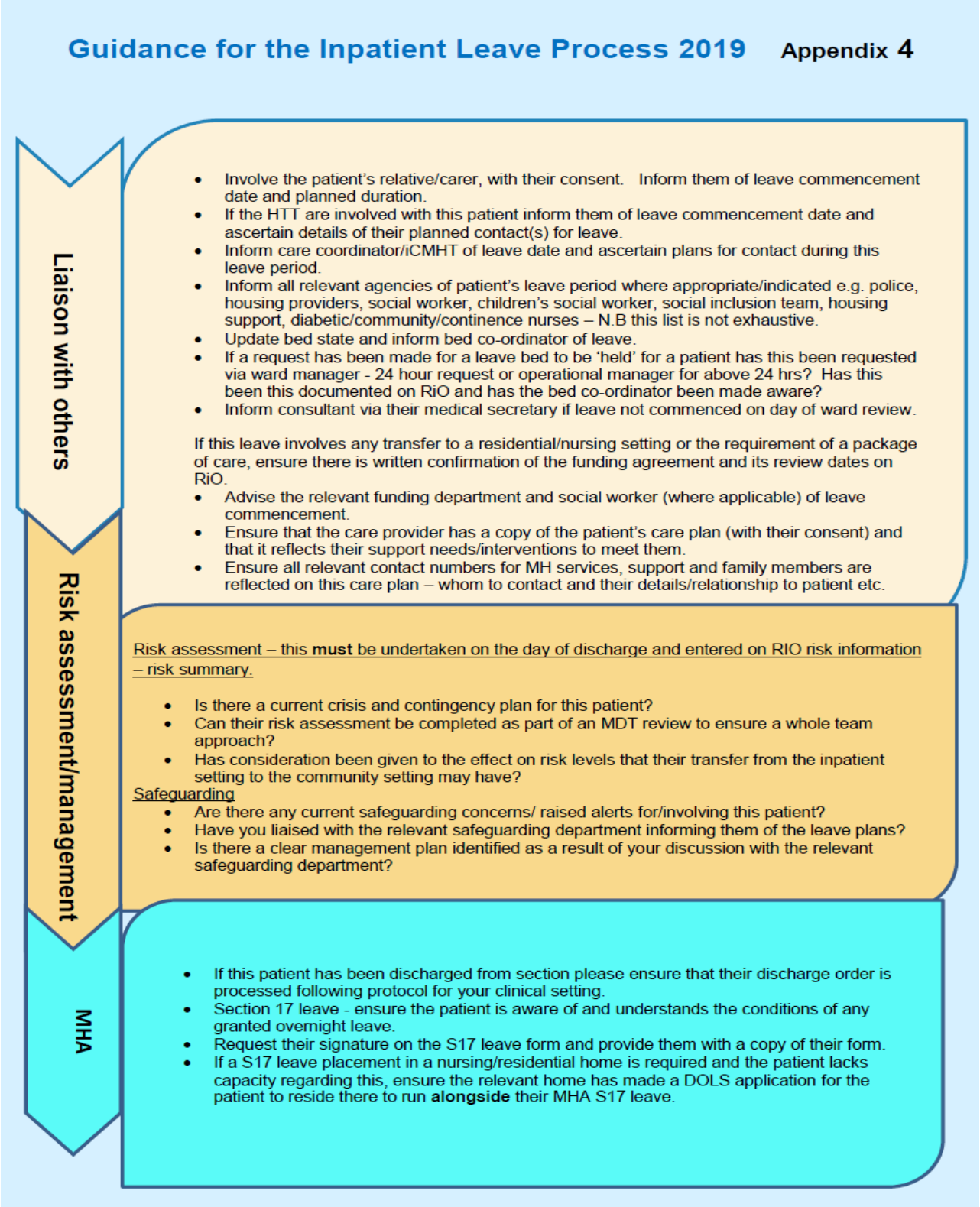
Signature:

Date Completed:

Appendix 3 – Accommodation and Support Tool



Appendix 4 – Guidance for Inpatient Leave Process



Guidance for the Inpatient Leave Process 2019

Care Planning

Care planning

N.B a leave care plan **must** be formulated on day that the patient commences leave.

Ensure that you close/place on hold all non-relevant/non-current care plans on RIO care planning

Complete the care plan with the patient, record their comments on the care plan and include;

- details in the leave care plan regarding leave duration,
- conditions (for S17 leave),
- the address where they will stay and their confirmed contact telephone number,
- support by ward and or community based services during leave,
- the date and time of their return and how they will return to the ward for their review.

Provide the patient with a copy of their care plan and enter this on the care plan distribution section of RIO

If the patient's leave is extended in the community setting, or they are unwilling or unable to wait for a care plan, please make arrangements with CFT community services to ensure they receive and agree with their care plan.

Medication

- Review the medication care plan and update where required.
- Are there any physical monitoring requirements to be considered e.g. bloods, blood pressure?
- Is anticoagulant therapy/lithium therapy/Insulin prescribed? **If yes**, check that the patient has a 'patient's information pack' and an updated record book.
- Check with the patient that they are safe with the quantity of medications to be supplied - has this been discussed at MDT and documented to that effect?
- Check with the patient that they are willing and able to take the medication(s) prescribed: give additional information as necessary. Is blister packed medication required?
- If a depot preparation is prescribed and due whilst on leave, ensure that arrangements for its administration are made and that the patient is aware of this via discussion and care planning.
- Check all TTO's against the current leave prescription, prior to giving these to patient, ensure that they /and or their carer are aware of prescribed medicines, dose, timings and frequency.
- Sign the leave TTO sheet to confirm these have been given to patient/carer/community staff and document within RIO progress and care planning.

Finances, property & environment.

- Has it been confirmed that the following are available / suitable for their return home? e.g. heating, food, electricity?
- Do they have finances available to them? Is there an identified appointee, power of attorney (POA)?
- If finances are managed by appointee or POA ensure that they are aware of the patient's leave?
- Is their property safe/suitable for return i.e. have any locks been fixed?
- Ensure the patient has all of their property returned to them.
- Contact reception/admin so they can provide them with their valuables/money from the safe if any present
- Ensure they have/can access the keys to their home.

Appendix 5 – Section 17 Aftercare

Ending section 117 aftercare services

When service providers believe that you no longer need aftercare, section 117 services may be withdrawn, but this will only happen when your needs and the services provided have been formally reviewed. Your views and those of any carer or relative will be considered.

Disputes about section 117 services

You or your carer may believe that you are being incorrectly charged for services that should be provided for free under section 117.

This is a complex area. If you feel that this may apply to you or the person you are looking after, it is best to get legal advice. Your ward nurse, community worker or advocate (if you have one) can help you to do this.

Comments and concerns

We welcome your views, feedback and suggestions about how we can improve our service. The PALS office takes calls Monday to Friday, between 9.30am and 4.30pm.

Telephone: 01208 834620

To get this information in another format email:
cpn-tr.communications@nhs.net

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Cornwall Partnership NHS Foundation Trust

Section 117 Aftercare

A guide to Section 117 Aftercare, and what to expect.

This leaflet is relevant to you if you are detained, or have previously been detained under any of the following treatment orders of the Mental Health Act (1983)

Section 3

Section 17A (Community Treatment Order) CTO

Section 7 (Guardianship)

Forensic Sections 37/41, 47/49, 48/49

Find us online at cornwallft

Why am I being given this leaflet?

As you have been detained for treatment under the Mental Health Act in a mental health hospital, after-care that you may need after you leave hospital should be provided free of charge. This free aftercare is provided to try to prevent your condition from getting worse and you needing to be re-admitted to hospital.

If you are being given this leaflet and are not currently detained under a treatment order of the Mental Health Act, this will be because you have been in the past and S117 responsibility has not been formally ended.

If you are entitled to free mental health aftercare it means that you will not need to have a financial assessment for any social or health services arising from, or related to your mental disorder.
This right to free services is set out in section 117 of the Mental Health Act (1983):

- Section 117 does not apply to people who have been detained in hospital for assessment under section 2 or people detained in an emergency under section 4 or 5
- Section 117 does not apply to people who have only been in a mental health hospital as a voluntary patient

How to access aftercare services

As you may be eligible for after-care, your needs will be assessed before you are discharged from hospital. You, and with your consent, your carer/family will be involved in identifying your needs ready for your discharge from hospital. A Care Programme Approach (CPA) /S117 meeting will be held for you. You will be informed of the date and time so you can invite whoever you want to attend with you.

What does after-care include?

After-care does not refer to any specific services, but the services must either arise from, or be related to your mental disorder and help you to live in the community. It could include social care support, day centre facilities or recreational activities.

There are some basic needs that are 'common needs' for everyone. This means they are not included in S117 Aftercare, e.g.

- accommodation – i.e. a roof over your head
- food and drink
- clothing
- employment (unless due to your mental disorder you have specific needs over and above the basic common need)
- money

Sometimes a person may need additional support so they can meet their 'common needs', it is the support you need that can be identified as an aftercare need e.g;

- ensuring that you are eating and drinking
- support with identifying and securing appropriate accommodation (as opposed to providing it)

Your needs will be assessed under the CPA and a care coordinator will be allocated to coordinate services and to review your needs. Any services provided under S117 will be included in your care plan.

Appendix 6 – Needs identification / Section 117 Aftercare guidance

Needs identification - Further Guidance

DoH (2015) Mental Health Act 1983: Code of Practice - Chapter 33 Aftercare
'Their (aftercare services) ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible' (33.3)'. 'As well as meeting their immediate needs for health and social care, aftercare should aim to support them in regaining or enhancing their sills, or learning new skills, in order to cope with life outside hospital.'(33.5)

Common Needs

Some basic needs are common to everyone. Aftercare is not the provision of services to meet these needs i.e.

- accommodation – i.e. a roof over their head (see accommodation plus below)
- food and drink;
- clothing;
- employment (unless due to the patient's mental disorder they have specific needs over and above the basic common need).
- money

Please note that although the above are common needs it is the support required to meet these needs that may be an aftercare need i.e. ensuring a person is not at risk of dehydration and malnutrition / support with identifying and securing appropriate accommodation as opposed to the provision of food and fluid / accommodation.

'Accommodation-plus'

Examples where accommodation has been deemed to be an aftercare need include:

- Caring residential accommodation (such as supported living) (ensuring for example, that prescribed medication is taken, or providing intensive therapy and treatment).

Identifying needs

The clinical team may wish to consider the following needs which are commonly considered. This list of needs is by no means exhaustive and is for illustrative purposes):

- Activities of daily living
- Provision of medication / ordering, collecting and delivering medication / monitoring medication compliance
- Support with regards accessing the community whilst ensuring social inclusion
- Exercise / meaningful activity / occupation / interests
- Outpatient reviews /confirming, cancelling, rearranging and thereafter assisting the patient in attending for medical appointments
- Psychology
- Accommodation and physical environment
- Residential facilities (if accommodation-plus);
- Transport
- Contact with family / friends
- Payment of utility bills / managing finances
- Monitoring of general health, personal hygiene, food and fluid intake

Section 117 Aftercare CPA Review Process – (Appendix 4)

Preparation

Step 1 – Assessment of health and social care needs and arranging the CPA review meeting

- Give consideration to what health (physical and mental), social and 'common' needs the service user has.
- Consider what services could be offered to the service user to meet the needs arising from their mental disorder, and other general needs.
- Ensure all key professionals, a representative from Kernow CCG / Local Authority (where required) and any other relevant agencies are invited to attend CPA/ S117 review meeting. (N.B. CFT are not commissioned to provide social care services to those under 18 or over 65 years of age – Local Authority **must** be invited in these circumstances.
- Ensure that service user has been consulted regarding whom they would like to attend their meeting with them (nearest relative / carer/ friend / advocate / legal representative and invite them. Keep a record of these invitations by documenting in RiO progress note.

CPA Review meeting

Step 2 – Identify needs – Refer to the list on the reverse for further guidance

- Discuss identified needs and any assessments that have been undertaken to support needs identification.
- What are the interventions/ services required to support the service user with a focus on reducing distress, promoting social inclusion and recovery?
- What are the views / wishes of the service user and the family/ representative(s)?
- Discuss crisis, relapse and contingency plans for and with the service user / family etc.

S117 Assessment

Step 3 – Determining which are S117 aftercare needs

- If this service user is eligible for a S117 assessment, apply the following two-stage test for identifying an aftercare need/service to each of the assessed needs.
  - Is the need arising from or related to the patients mental disorder?
  - If it is met, will it reduce the service user's chance of being readmitted to hospital for treatment for that disorder?
- Any need that meets **both parts** of the above criteria is a S117 need and will not be financially assessed
- Any other needs **are not covered** under S117

Services

Step 4 – Identifying Services – What services could be offered to the service user to meet their identified needs?

- When considering appropriate services to meet the service users assessed needs, the clinical team should consider both primary and secondary health services, third sector services (such as citizens advice bureau, job centre and charities) and local authority services. The source of the service to meet the assessed need does not impact upon / determine whether an assessed need is an aftercare need or a general need.

Recording

Step 5 – Record your discussions, decisions and outcomes in RiO (CPA Review Tool)

- Document all of the service users needs that have been identified as S117 needs and the reasons for this decisions. NB some of those needs may be provided through the function of the CPA reviews, care coordinator role, medication review, diet advice and prompting etc.
- Equally, you are required to document the identified needs that do not arise from the service users mental disorder and the reasons for this.
- Remember to formally document if S117 is to continue and the reasons for this.

Review

When to review?

- Set a review date. Each need should be reviewed as it changes. The maximum time frame for review is six months.
- When there are no longer and S117 needs then eligibility to S117 is discharged, this can even be at the point of discharge from hospital if appropriate.

Appendix 7 – Delayed Transfer of Care (DToC)

Delayed Transfer of Care (DToC)

How do you identify who is a delayed transfer of care?

A patient is ready for transfer when:
a. A clinical decision has been made that the patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that the patient is ready for transfer AND
c. The patient is safe to discharge / transfer

What does this criteria mean?

a) A clinical decision has been made?
This means the patient is ready to transfer from their current ward setting but there is a barrier to this happening and is still occupying a bed.

b) A MDT decision made?
It needs to be documented on RiO progress notes as having been discussed and agreed as part of a MDT review as opposed to a single clinicians clinical assessment.

c) Safe to transfer?
If the patient is **informal** register them as an external DToC in the Delayed discharge RiO screens.
If they are **detained**, they are not meeting this part of the 3 criteria, but can still be recorded as 'internal delay' in the Delayed discharge RiO screens.

Why and when do we need to involve Adult Social Care?

If the patient experiencing a delay to their transfer from the ward is not NHS (CFT's) responsibility for social care, the codes and responsibility for DToC need to be agreed with social care. Refer to the Care act poster for guidance to determine who is responsible for social care.
Although its not applicable to Mental Health, the NHS in other areas of provision, can seek reimbursement from the local authority for delays attributable to social care.

Where is this recorded?

RiO **Case Record Menu/ Inpatient management /delayed discharge.**
A care plan will also need to be written.

Why is it important to report DToC's?

CFT submits 'Situation Reports' to NHS England about patients whose transfer of care is delayed beyond being fit to transfer. *'Reporting is irrespective of whether the delay is potentially reimbursable and which organisation is responsible for the delay. The data collected on this form should include all delays that occur. '*(NHS England., 2015).

Appendix 8 – Guidance for the Inpatient Discharge Process

Guidance for the Inpatient Discharge Process 2019 Appendix 8

Liaison with others

A discharge summary **must** be sent to the patient's G,P within 24 hrs of their discharge.

Please inform admin of any expected date of discharge in advance, where possible, or at the confirmed point that a patient will be discharged. Follow the protocol for your clinical setting.

Liaison with the care team, family and other agencies.

- Involve the relative/carer with consent from patient. Inform them of discharge and relevant contact numbers for community services where required.
- If the HTT are involved, inform them that this patient is being discharged and ascertain plans for contact post discharge/their 72 hour follow up plan.
- Inform care coordinator/iCMHT that this patient is being discharged - **establish time/date/venue for 72 hour follow up contact with patient.**
- Inform all relevant agencies of this patient's discharge where appropriate/indicated e.g. police, housing providers, social worker, children's social worker, social inclusion team, housing support, diabetic/community/continence nurses – N.B this list is not exhaustive.
- Update bed state to reflect discharge and inform bed co-ordinator.
- Inform consultant via their medical secretary if discharge has not happened on day of their ward review.

If patient's discharge involves any transfer to a residential/nursing setting or the requirement of a package of care, ensure there is written confirmation of the funding agreement and plans/timescale for their review on RiO.

- Advise the relevant funding department and social worker (where applicable) of discharge.
- Ensure that the care provider has a copy of the patient's care plan (with their consent) and that reflects their support needs/ interventions to meet them.
- Ensure all relevant contact numbers for MH services, support and family members are reflected on this care plan – whom to contact and their details/relationship to patient etc.

Risk assessment / management

Discharge against clinical advice (ACA)

If this patient is taking their discharge against clinical advice (ACA) an ACA form **must** be completed, signed then uploaded to RIO. Ensure you have followed the discharge ACA checklist for any informal patient that wishes to discharge ACA.

Risk assessment – this must be undertaken on the day of discharge and entered on RIO risk information – risk summary.

- Is there a current crisis and contingency plan for this patient?
- Can their risk assessment be completed as part of an MDT review to ensure a whole team approach?
- Has consideration be given to the effect on risk levels that the patient's transfer from the inpatient setting to the community setting may have?

Safeguarding

Are there any current safeguarding concerns/ raised alerts for/involving this patient?

- Have you liaised with the relevant safeguarding department informing them of this patient's discharge?
- Is there a clear management plan identified as a result of your discussion with the relevant safeguarding department?

MHA

- If the patient has been discharged from section/hospital please ensure that their discharge order is processed following the protocol for your clinical setting.
- If the patient is discharged on a Community Treatment Order (CTO) ensure this CTO 01 form has been signed and dated by R.C and process form following protocol for your clinical setting.
- Ensure the patient has a copy of their CT01 form and are aware of /understand the conditions of this CTO. Enter their comments on their care plan.

Guidance for the Inpatient Discharge Process 2019

7 day follow up & Care Planning

Liaising with the patient and making plans for their follow up contact.

Before this patient leaves the ward you **must** ensure that you have completed the following and documented this on both RiO progress and their care plan;

- Ensure you have their correct telephone number or a number they can be contacted on.
- Ensure that their RiO 'Demographics- communications' section is updated to reflect this number on their case record sheet.
- Post discharge follow up calls **must** be planned for the day following discharge as any contact on the day of discharge will not count as a 72 hour follow up.
- If they do not have a telephone, or are of no fixed abode you **must** make alternative arrangements i.e. arrange a face to face contact by CMHT to be held within 48 hours of discharge.

Care planning - the patient's discharge care plan **must** be formulated on the day of discharge. Complete the care plan involving the patient and record their comments on the care plan;

- Close/place on hold all non-relevant/non-current care plans on RIO care planning
- Ensure that you include details of follow up contact arrangements -both 48hr & community 72 hour follow up.
- Confirm their discharge address and contact telephone numbers within this care plan.
- Include details of their discharge TTO medication and how to access/ensure continuity of supplies of prescribed medications (please also see medication section below).
- Include relevant contact number for community based services/support.
- Provide the patient with a copy of their care plan and enter this on the care plan distribution section of RiO. If they are unwilling or unable to wait for a care plan, please make arrangements with CFT community services to ensure they receive and agree with their care plan

Medication

- Review the medication care plan and update where required.
- Are there any physical monitoring requirements to be considered e.g. bloods, blood pressure?
- Is anticoagulant therapy/lithium therapy/Insulin prescribed? **If yes,** check that the patient has a 'patient's information pack' and an updated record book.
- Check with the patient that they are safe with the quantity of medications to be supplied - has this been discussed at MDT and documented to that effect
- Check with the patient that they are willing and able to take the medication(s) prescribed: give additional information as necessary. Is blister packed medication required?
- If a depot preparation is prescribed ensure that arrangements for its administration following discharge are confirmed and that the patient is aware of this via discussion and care planning.
- Check all TTO's against the discharge prescription, prior to giving these to patient, ensure that they /and or their carer are aware of prescribed medicines, dose, timings and frequency.
- Document that TTO's have been given to patient/carer/community staff within RIO progress and care planning.

Finances, property & environment.

- Has it been confirmed that the following are available / suitable for their return home? E.g. heating, food, electricity?
- Do they have finances available to them? Is there an identified appointee, power of attorney (POA)?
- If finances are managed by appointee or POA ensure that they are aware of the patient's discharge.
- Is their property safe/suitable for return i.e. have any locks been fixed?
- Ensure the patient has all of their property returned to them.
- Contact reception/admin so they can provide the patients valuables/money from the safe if any present

Guidance for the Inpatient Discharge Process 2019

Follow up contact – post discharge.

24 HOURS POST DISCHARGE

For 48 hour follow up contact

- Have you entered all attempts (including non-access events) and successful contacts by creating a diary appointment and ensuring you 'outcome' each, recording each contact type, date etc. on RIO diary?
- Have you documented all follow up attempts/actual contacts with an entry on RIO progress notes?
- Have you discharged this patient from inpatient 'case load' once successful follow up has been completed and entered/ 'outcomed' in RIO progress/diary?

Appendix 9 – Protocol for Patients wishing to discharge against clinical advice

Patient's Name:	
Date of Birth:	
Consultant:	
Named Nurse:	
NHS No:	
Date:	

		Signature	Designation
1.	a qualified Nurse to speak to person wishing to self-discharge.		
2.	Allocated nurse to spend time with patient to ascertain: a) Reasons why they wish to leave hospital b) Changes since hospital admission c) Levels of risk d) Capacity to make decision to discharge including understanding of risk e) Evidence of mental illness f) Willingness to see Duty SHO		
3.	If the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient's health or safety or the protection of other people, and it is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2 consider use of s5(4)		
4.	If it appears that MHA assessment could be appropriate request the RC or duty doctor to consider use of s5{2}		
5.	If the person is not to be prevented from leavingand wishes to leave hospital (ACA form to be completed). a) If the person is already known to the Community Mental Health Services, the Care Coordinator / CMHT to be contacted promptly to arrange a follow up visit within 48 hours of discharge. b) If the person is not previously known to the Community Mental Health Services, a referral to the Home Treatment Team must be made to enable		

	follow up within 48 hours of discharge.		
6.	Consider the social situation, do they have money, electricity, food, etc.		
7.	Consider medication needs.		
8.	If the person is deemed fit to leave hospital, please request that he / she signs the '*against clinical advice form'.*		
9.	Establish contact details, for example: • Address • Telephone numbers		
10.	Gain permission to inform carers / family of decision to leave hospital.		
11.	Inform General Practitioner		
12.	Update RiO; include situation regarding medication and update risk summary and care plan.		

Appendix 10 – Discharge against Advice Form

Name of Hospital **Ward**

I, (name of patient)

of, (address)

Wish to take my discharge. I appreciate that this is against the advice and wishes of the **Consultant psychiatrist* or deputy*** or **The Nurse in Charge***

I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising there from.

I consent* / do not consent* to my family / carer being informed of my discharge.

Signed **Date**

Patient

I confirm that I have explained to the patient the dangers that might arise out of his* / her* decision to take his* / her* own discharge

Name (print) **Date**

Medical Practitioner* / Registered Nurse*

Signed **Date**

Medical Practitioner* / Registered Nurse*

(* Delete as appropriate)

Appendix 11 – Discharging a Patient from Adult ICMHT and CFT

Outcome all Appointments
Go to the **Client Related Data View** > **Client Diary View**.
This will show you if there are any appointments that you may need to outcome.
Open **HCP Diary** page and go to the relevant dates
and ensure that all outstanding appointments are outcomed

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Ensure Risk Is Reviewed
Prior to discharge you must review the patient's risk.
Go to **Risk Information > Risk Summary** click **'Create New'**
and complete a post-discharge **Risk Summary**

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Close the Clustering Allocation
Go to **Clustering, Cluster Allocation**.
Click on the last dated **Cluster Allocation** and then click **'Edit Current.'**
You may also have to click on **'Activate All Fields.'**
At the bottom of the page complete the **Care Cluster End Date** and **Care Cluster End Reason**
and click **'Save'**
The Cluster Allocation is now closed.

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Crisis Relapse & Contingency Plan
Please review this to ensure that it is still current and relevant.

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Progress Note
Write a **Progress Note** to say you are discharging the client from the team and CFT

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Undertake a Discharge CPA Review
Click on the **Care Planning, CPA Review > Schedule CPA Review**.
Fill in all fields and click **'Save.'**
Outcome the **CPA Review** ensuring that you choose the ***Review Type – Discharge***

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Care Planning
Go to **Care Planning** and ensure that all of the Problem / Needs are closed.
To do this click into the relevant Problem / Need, when it turns pink click on '**Close Selected.'**
You may also need to click on **'Activate Fields.'**
Fill in Date and Closure Reason and click **'Close problem / need'**

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Discharge the Referral
Go to **Referral > Entry / Exit and Exit** the relevant referral.
To do this find the relevant referral, click on the arrow under '**To Discharge**' and follow the instructions.

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Remove the Patient from Your Caseload
Go back to your **Caseload** and you will now see that the client will be highlighted in green.
Click on the tick box at the right hand side of the patient line and click **'Remove'** at the bottom of the screen.
The patient is now removed from your caseload.

Equality Impact Assessment Proforma Initial Screening