|  |  |  |
| --- | --- | --- |
| DPT NHS Right Aligned logo 2017 | | |
|  | | |
| **Inpatient Admissions, Transfer**  **and Discharge Policy v3.10– COVID-19** | | |
|  | | |
| **Policy: C40** | | |
|  | | |
| **Policy Descriptor**  This policy describes the service people admitted to inpatient wards whether formally or informally can expect with regard to their admission and welcome to the ward environment through to their preparation for and subsequent discharge. | | |
|  | |  |
| If you require this document in a different format or language  please speak to a member of Trust staff. | | |
|  | | |
| If you would like to provide feedback about our services  Contact PALS – 01392 675686 or email dpn-tr.pals@nhs.net | | |
| **This policy has been updated during the COVID19 pandemic. Text Marked in RED show deviation from the existing policy which is only in place during the Pandemic.** | | |
| **Document Control** | | |
| Policy Ref No & Title: | C40 Admission, Transfer and Discharge policy | |
| Version: | v3.10 Dec 20 update. Appx2 replaced March 2021 | |
| Replaces / dated: | Previous policy dated November 2016 | |
| Author(s) Names / Job Title responsible / email: | Chris Whitehead, Managing Partner chris.whitehead@nhs.net  Kay Stratford Operational Transformation Manager kay.stratford1@nhs.net | |
| Ratifying committee: | Trust Executive Committee | |
| Director / Sponsor: | Director or Nursing and Professions | |
| Primary Readers: | All staff involved in patient referral, admission, transfer and discharge | |
| Additional Readers |  | |
| Date ratified: | 13th June 2019 | |
| Date issued: | June 2019 | |
| Date for review: | June 2021 | |
| Date archived: |  | |

Contents

[**1 Introduction 3**](#_Toc67310817)

[**2 Purpose 3**](#_Toc67310818)

[**3 Scope 3**](#_Toc67310819)

[**4 Definitions 3**](#_Toc67310820)

[**5 Duties 5**](#_Toc67310821)

[**6 General Principles for Admission 8**](#_Toc67310822)

[**7 Observations and restrictions 13**](#_Toc67310823)

[**8 Informal Admission to Inpatient Units 14**](#_Toc67310824)

[**9 Admission Protocol 21**](#_Toc67310825)

[**10 Referrals to the Eating Disorder Inpatient Service (“The Haldon”) 24**](#_Toc67310826)

[**11 Referrals to PICU 26**](#_Toc67310827)

[**12 Referrals to the Additional Support Unit (ASU) for Adults with Learning Disabilities 26**](#_Toc67310828)

[**13 Referrals to the Mother & Baby Unit (Jasmine Lodge) 27**](#_Toc67310829)

[**14 Referrals to Secure 28**](#_Toc67310830)

[**15 Multiple Admissions Protocol 28**](#_Toc67310831)

[**16 Transfer of Patients 28**](#_Toc67310832)

[**17 General Discharge Planning and Facilitation Principles 31**](#_Toc67310833)

[**18 COVID-19 Testing requirements prior to discharge 35**](#_Toc67310834)

[**19 Follow-up support on Discharge: 37**](#_Toc67310835)

[**20 Prescribing for Discharge and Leave 38**](#_Toc67310836)

[**20.5 Patients taking leave or Discharge from an Out of Area Placement 38**](#_Toc67310837)

[**21 Patients who wish to take their own discharge (DAMA) 39**](#_Toc67310838)

[**22 Reluctant Discharges 40**](#_Toc67310839)

[**23 Monitoring 41**](#_Toc67310840)

[**24 References 41**](#_Toc67310841)

[**Appendix 1 – Letter to Nearest Relative 43**](#_Toc67310842)

[**Appendix 2 – Practice standards & principles at interface points 45**](#_Toc67310843)

[**Appendix 3 – Self-Discharge of a Patient: Checklist 48**](#_Toc67310844)

[**Appendix 4 – Self-discharge release from responsibility for discharge 49**](#_Toc67310845)

[**Appendix 5 – Reluctant Discharge: Letters to enact discharge 50**](#_Toc67310846)

[**Appendix 6 – Devon Delayed Transfer of Care (DTOC) guidance 53**](#_Toc67310847)

[**Appendix 7 – AMH Social Work Strategy 57**](#_Toc67310848)

[**Appendix 8 – Junior Doctor Tasks 58**](#_Toc67310849)

[**Appendix 9 – Prioritisation tool 61**](#_Toc67310850)

[**Appendix 10 – Example of patient information leaflet to be shared in the testing area 62**](#_Toc67310851)

[**Appendix 11 – Junior Doctor Clerking and Nursing Admission processes in Testing Wards 67**](#_Toc67310852)

[**Appendix 12 – Legal Framework and decision support for isolation and testing 70**](#_Toc67310853)

[**Appendix 13 – COVID-19 Outbreaks (including communication with contacts of those confirmed positive) 71**](#_Toc67310854)

[**Appendix 14 – Secure Services Referral Guidance 75**](#_Toc67310855)

# Introduction

* 1. When adults are experiencing an acute and serious mental health problem, they may be admitted to a mental health ward similar to when a person suffering from a serious physical health problem is admitted to a general hospital.
  2. The purpose of an admission to a ward is to keep people safe and provide them with a supportive and healing environment. Whilst the term ‘people who use Trust services’ is more commonly used in Trust policies and literature, the word Patient will be used here for clarity between this policy and the Mental Health Act 1983 Act amended 2007.
  3. Sometimes individuals are admitted to support treatment (for example: specific procedures, medication changes) that are more effectively supported within an inpatient environment.

|  |
| --- |
| **At a Glance**  **Planned Admissions:**  If admission is being planned for a treatment episode, involve:   * the person who is being admitted * their family members, parents or carers * Community accommodation and support providers.   When planning treatment for people being admitted, take account of the expertise and knowledge of the person's family members, parents or carers.  If it is not possible for the person to visit the inpatient unit that they will be admitted to in advance, consider using accessible online and printed information to support discussion about their admission. |

# Purpose

* 1. This policy provides a framework for admissions, transfers and discharges in all Trust inpatient units. The units provide support to individuals whose primary care and treatment needs relate to a mental disorder; individuals may also have other support needs such as drug & alcohol use, a learning disability / difficulty and physical health concerns. This policy also contains signposting information for admission to out of area beds.

# Scope

* 1. This policy applies to all patients that come into the Trust services or Trust purchased services.
  2. The principles and processes within this policy generally apply to the Trust Inpatient services. However, it also covers transfers between other Trust services and discharges from the Trust to external health and social care services, including discharges back to primary care. For assistance in identifying the lead service for adults with social care needs see on the intranet [Service Responsibility Protocol](http://daisy.dpt.nhs.uk/media/1568185/service_responsibility_protocol_may18.pdf)

# Definitions

* 1. **Formal Inpatient**
     1. Mental Health Act: A person admitted to a Trust ward as an inpatient under a Section of the Mental Health Act 1983 (amended in 2007). When that person is discharged from a ward it does not always mean that they have been discharged from the section under which they were detained.
     2. Mental Capacity Act: Where a person lacks capacity to consent to admission; their care and treatment is provided within the framework of the Mental Capacity Act with the provisions of the Deprivation of Liberty Safeguards. The mental capacity of a person to consent to admission as an informal patient is likely to include consideration of (a) the relevance of the admission for the relevant purpose, (b) to stay in hospital whilst its purpose is carried out and (c) to the circumstances relating to a possible deprivation of liberty that might prevail during that admission. A patient who lacks capacity to consent to admission should not be admitted to hospital informally if the admission constitutes a deprivation of liberty.
  2. **Informal Patient** – Compulsory admission under the Mental Health Act has always been intended to be the exception, not the rule. The Mental Health Act does not prevent people being admitted to hospital without being detained. This is expressly stated in Section 131. Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient’s independence should be encouraged and supported with a focus on promoting recovery wherever possible. (For further information see the least restrictive option and maximising independence guiding principle in the [Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF), especially paragraphs 1.2-1.6.)
  3. **Nearest Relative** – legally defined and as such has certain rights in relation to a patient’s detention under the Mental Health Act 1983 amended 2007. See [*Reference guide to the Mental Health Act 1983*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf)*, Section 2.2 Figure 5* for more information.
  4. **Digital Care Record (DCR)** – An individual’s medical files and information such as progress notes, risk assessments and other information stored in secure centralised computer system available to clinicians in the Trust.
  5. **Digital Care Record System** – A secure centralised computer system available to clinicians in the Trust such as Carenotes, HALO, IAPTUS or System One.
  6. **Delayed Transfers Of Care (DTOC)** – A delayed Transfer of Care (DTOC) is a specific DoH definition referring to patients who have been fully assessed and are ready for discharged. It is important to remember, that medically optimised is not the same as a delayed transfer of care. The determination that a patient is medically optimised is from a medical perspective. The patient has not received a MDT decision at this point and, indeed, may need further therapy or social care in-put prior to a MDT decision being made, this means it is not a reportable delay. Please see Appendix 6 for details of reporting guidance.
  7. **The Health Protection (coronavirus) regulations 2020** – legislation that allows the secretary of state or a registered public health consultant (for the purposes of screening, assessment, isolation) to detain for up to 48 hrs for screening purposes, and up to 14 days for isolation purposes, someone who is suspected of being infected with the virus causing COVID19 and who may infect others.
  8. **COVID19** – an infectious disease caused by the virus Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).
  9. **Discharge to assess model** – In MH inpatient settings good practice dictates that discharge planning should begin a the point of admission. Relevant social care team should be notified of admissions as early as is practical. However, should no plan be in place when a patient is medically optimized, the patient should not remain solely for the purpose of assessments. These, where possible should be undertaken in a different care setting.

# Duties

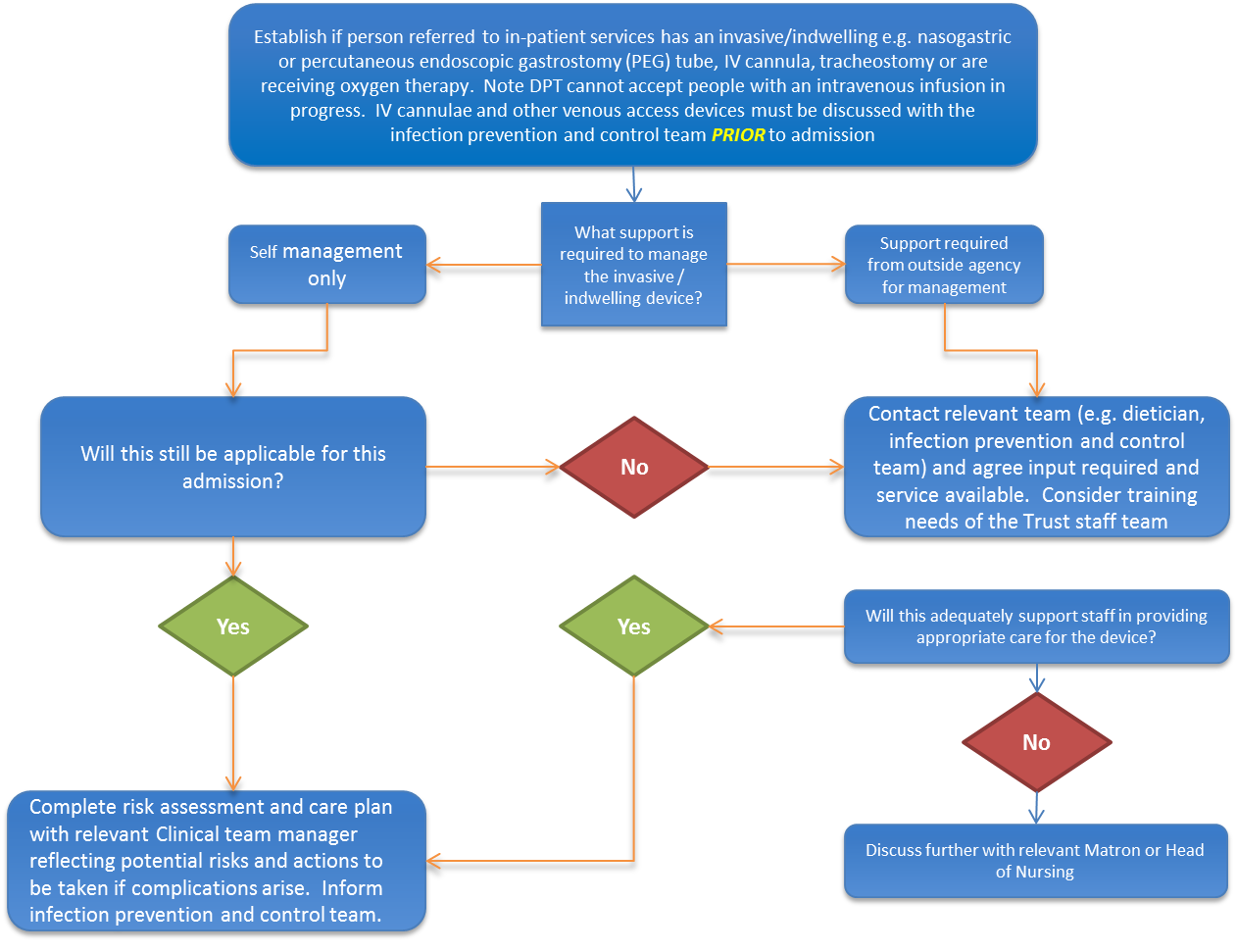
* 1. **Responsible Clinician** – responsible for the clinical care and treatment of a detained person once admitted to a ward.
  2. **Junior Doctor** – responsible, on admission, for completing necessary documents, physical assessment checks and relevant investigations (VTE, bloods & cardiac assessment), prescription of medication. [See C34 Physical Health Monitoring](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/physical-health-monitoring)
  3. **Mental Health Act Office** – receive and process admissions and legal documentation. Will also receive appeals and requests for tribunals.
  4. **Ward Manager** – manages resources and staffing, ensures maintenance of high standards of quality and practice, provides leadership for the ward team and is often involved in the management of complex care cases
  5. **Ward Based Registered Nurse** – will be responsible for working with the patient and the multi-disciplinary team to assess plan and implement a pathway for care and recovery. Will oversee transfer and discharges of patient. All nurses support the therapeutic environment by engaging in ward activities and enabling escorted leave as per the care plans. Nursing staff enable recovery and reorientation to the person’s community by supporting carers and promoting contact with the families.
  6. **Nurse in charge** – responsible for leading safety and quality of care provided during a shift. The Nurse in charge is responsible for the coordination of the shift, delegation of duties and completion of the tasks.
  7. **Named Nurse –** is responsible for organising an initial meeting with the patient (and where possible and appropriate the patient’s circle of care) and discussing with them what they hope to achieve during the admission. They will be the primary individual to build a therapeutic relationship with the client and coproduce and record holistic care plans throughout the patient’s admission. All patients will have a Named Nurse and the patient will be informed of who their Named Nurse is on admission. The named nurse will need to facilitate the CPA review meeting within their routine, were appropriate. Ensuring that the meeting is held as planned. Where the meeting is within the weekly review; the nurse will record in the person’s electronic care record as normal. There may be time where this meeting’s timing means that this also provides the opportunity for relevant parties to agree a discharge plan or consider 117 needs.
  8. **Allocated Nurse** – the first point of contact for the individual and to ensure that their care plans are coordinated and implemented on a shift-by-shift basis (if on shift, this will be the Named Nurse). The person will be informed of who their Allocated Nurse is by the daily allocation board. The Allocated Nurse is expected to make themselves known to the patient at the beginning of their shift.
  9. **Unqualified Nursing Staff** – support the therapeutic environment by engaging in ward activities and enabling escorted leave as per the care plans. Nursing staff enable recovery and reorientation to the person’s community by supporting carers and promoting contact with the families.
  10. **Named Occupational Therapist** – completes Model of Human Occupation Priority Checklist within 72 hours of admission to assess patient’s level of functioning in activities of daily living and identify any issues with home environment/accommodation and may carry out further specialist assessments including home visits, to assess individual in home context. OT Reports identify interventions to facilitate a timely discharge and any support an individual requires for successful discharge and to sustain community living; this informs funding applications for care packages. They work closely with the Discharge Facilitators to plan and ensure safe and successful discharges and may liaise with social care occupational therapy team where adaptations or equipment is indicated. See on the intranet [Acute In-patient OT Process map and guidance](http://daisy.dpt.nhs.uk/media/1567618/strategic-delivery-plan-for-occupational-therapy-2018-2021.pdf) for further details of occupational therapy assessment and input during admission
  11. **Occupational Therapy support staff** – will provide meaningful occupations and therapeutic activity both on and off the ward and support the occupational therapists with individual interventions to enable the person’s recovery and discharge to the community.
  12. **Discharge Facilitator –** will work closely with patient and MDT to ensure safe and timely discharge. They will support individuals to access community resources and local provision to meet their needs in addition to supporting the brokerage process to obtain appropriate funding to move patients on to agreed placements or support packages. This may also include services to support homelessness, dual diagnosis and other considerations. [Not all services have this role, and note the function becomes part of the Named nurse role to coordinate].
  13. **Accommodation Officer** – will work with adult patients in the community to offer advice, information and supporton housing benefits, housing options in the community, advice on housing related issues, support to access Local Authority Housing/Emergency Accommodation/BB, Direct payments, Devon County Council Financial Assessment and Benefit teams. [list not exhaustive]. **NB: MH accommodation Officers can only take referrals from Mental Health Assessment Teams or Care Coordinators (CPN’s, OT’s, SW’s).**
  14. **Urgent and Emergency Repatriation Coordinators –** Work with people placed in wards/hospitals for acute assessment and treatment outside of Devon. They support Devon Care Coordinators, by monitoring of hospital placements, monitoring of providers, supporting timely repatriation to Devon, facilitating involvement of people who use these services and by being the link between the provider, patient care coordinator and other Trust services.
  15. **The Medicines Optimisation Team** – The safe and effective use of medicines and the impact that this can have on a person’s experience and outcomes plays a significant role in the care we offer. Clinical pharmacists and medicine optimisation technicians are experts in the therapeutic use of medicines. <https://www.dpt.nhs.uk/resources/policies-and-procedures/pharmacy/medicines>
      1. The team use their knowledge of medication (including dosage, drug interactions, side effects, effectiveness, cost etc.) to determine if a medication treatment plan is appropriate for the individual. If it is not, they will talk to the person and their clinical team to ensure that the person is on the right medication treatment plan for them.
      2. Although not based on the ward the Medicine Optimisation team visits regularly and are available to meet with people at all stages of their care with us to talk to them about their treatment choices and the importance of taking, finishing and or/ asking questions and making sure that their medications are reviewed regularly. The Medicines Optimisation team should be involved as soon as possible after admission to ensure full medicines reconciliation is completed, support the timely supply of medicines and to ensure that we get the medicines right at transfer and discharge they should be involved in all leave and discharge planning activities.
  16. **Care/Recovery Coordinator** – The Care/Recovery Coordinator has the overall responsibility for Coordinating all aspects of the care and treatment of the patient, whether admitted to a Trust bed or out of area bed, at all stages of their journey through the care pathway (for services that are not covered by the Care Program Approach (CPA) these responsibilities are synonymous with the responsibilities of the named nurse) See [C05 Care Coordination policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/care-coordination-including-the-care-programme-approach) (NB for an out of area acute inpatient admission this will be done in collaboration with the repatriation coordinator.) Key responsibilities are listed below:
* For monitoring the delivery of care
* To identify that the CPA review is due and coordinate the meeting to occur at a suitable time within the ward routine (mostly this will be at the weekly review meeting of the individuals care)
* To invite relevant individuals to the CPA review; attaining formal feedback from those unable to attend
* Record the CPA review meeting on the appropriate electric forms
* Maintain contact with the patient and/or their relative/carer(s), this is especially important for patient not admitted to a Trust bed
* Ensuring effective communication with and between all relevant others involved in the care, treatment and support of the patient, and reassessing the person’s needs and current situation as required.
* Where known, the Care/Recovery Coordinator alert relevant other services and practitioners about any issues related to safeguarding adults/children or MAPPA, particularly those that may impact on safe and effective discharge planning.
* Ensure that any identified relative/carer(s) are well informed with regards to issues related to the discharge process and care options, including interim or intermediate placements.
* Ensure that all practitioners and agencies, including non-statutory agencies, involved in the planning and preparation of the patient’s discharge are aware of the care plan and discharge arrangements.
* Ensure that appropriate follow up arrangements are made within the required timescales in line with this policy.
* Works with the patient and ward team in planning care. They must be involved in discharge and planning and ensure a care plan is in place that includes a 48 hours follow-up in order that the patient can be discharged.
* Ensure [48 hour follow up](http://daisy.dpt.nhs.uk/media/1570608/c40_48_hour_protocol_jul19.docx) is appropriately completed, following discharge
  1. **Inpatient Psychologist** – Part of the inpatient Multi-Disciplinary Team and provides psychological assessment and interventions through the provision of direct clinical individual and group work and by supporting the competencies and capabilities of other staff
  2. **Social Worker** – A qualified person who will undertake social care assessments of individuals on the ward, will support with funding applications and sourcing appropriate accommodation. Within AMH social care teams are integrated into DPT services and sit within the localities. For OPMH social work provision sits with the relevant local authority. There should be a named individual to which social care related issues can be escalated.
  3. **Peer Support Worker** – A member of staff with lived experience of mental health challenges employed in the peer support worker role. Through sharing wisdom from their own experiences, peer support workers will inspire hope and belief that recovery is possible in others.
  4. **Volunteer** – An unpaid person who may be supporting individuals or groups of individuals with their recovery journey.

# General Principles for Admission

* 1. Admission
  2. Admission to a **psychiatric** inpatient unit should usually be in exceptional circumstances and when no other option that is less restrictive is available.
  3. The NHS COVID-19 Emergency Hospital Discharge Service Requirements is part of the government response to Covid-19 and guides change in practice, most notably stating clearly, “unless required to be in hospital, patients must not be in an NHS bed”
  4. Devon Partnership Trust **will, as always seek to avoid any unnecessary admission to its wards.**

*(ATD Policy, June 2019) “Admission to a psychiatric inpatient unit should usually be in exceptional circumstances and when no other option that is less restrictive is available”*

* 1. Additional patient risk factors to consider:
  + Higher risk of transmission in ward is possible
  + Increased restrictions on patients admitted e.g. leave, visitors, smoking
  + Ability of informal patient to agree to increased restrictions
  1. Additional service level risk factors to consider:
  + Requirement to reduce bed capacity (proportion of beds occupied) to reduce transmission
  + Requirement to reduce bed capacity (proportion of beds occupied) to reduce staffing requirements to allow maintenance of safe nurse:patient ratio
  1. When Prioritization is necessary (as determined by GOLD) patients will be admitted to available capacity ONLY at Priority Levels determined by GOLD (see combined priority matrix in appendix)
  2. People should only be admitted to wards within the correct gender specific areas in line with national policy. Any single sex admission breeches must be reported via the Trust online incident reporting system. (For Trans-gendered patients, units need to demonstrate that consideration is given to an individual patient needs and agreements/decision about meeting these needs are met within their care plan.) See [C49 Eliminating Mixed Sex Accommodation (EMSA) Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/eliminating-mixed-sex-accommodation-emsa)
  3. Any person needing admission where their primary issue is related to their diagnosis of dementia, regardless of age, is admitted to the specialist Dementia ward
  4. Children must not be admitted to adult wards (with the exception of Haldon (Eating Disorders Unit) and the Mother & Baby Unit, who take individuals from 16 years). Admissions of people under the age of 18 must be reported as a serious incident. See [R01 Incident Reporting](https://www.dpt.nhs.uk/resources/policies-and-procedures/risk/incident-reporting)
  5. Individuals referred to inpatient services must be physically assessed to establish if they have an invasive/indwelling device e.g. nasogastric or percutaneous endoscopic gastrostomy (PEG) tube, IV cannula, tracheostomy or are receiving oxygen therapy. If so, they will require additional care planning, and admission to a Trust inpatient unit may not always be appropriate. The Trust will not usually (will not usually replaces ‘cannot’) accept people with an intravenous infusion in progress.
  6. Individuals who have or may require an invasive device require a number of issues to be considered, including referral to the Infection Control team. The following flow chart guidance should be followed before the admission/transfer is accepted. Discussion with the Senior Nurse Manager for the service is essential to ensure that this clinical need has been considered, support or training arranged and the device will be managed safely and effectively. In exceptional circumstances such as the Trust being asked to admit a patient with a vascular access device/central line, the Director of Nursing or Deputy should be contacted.



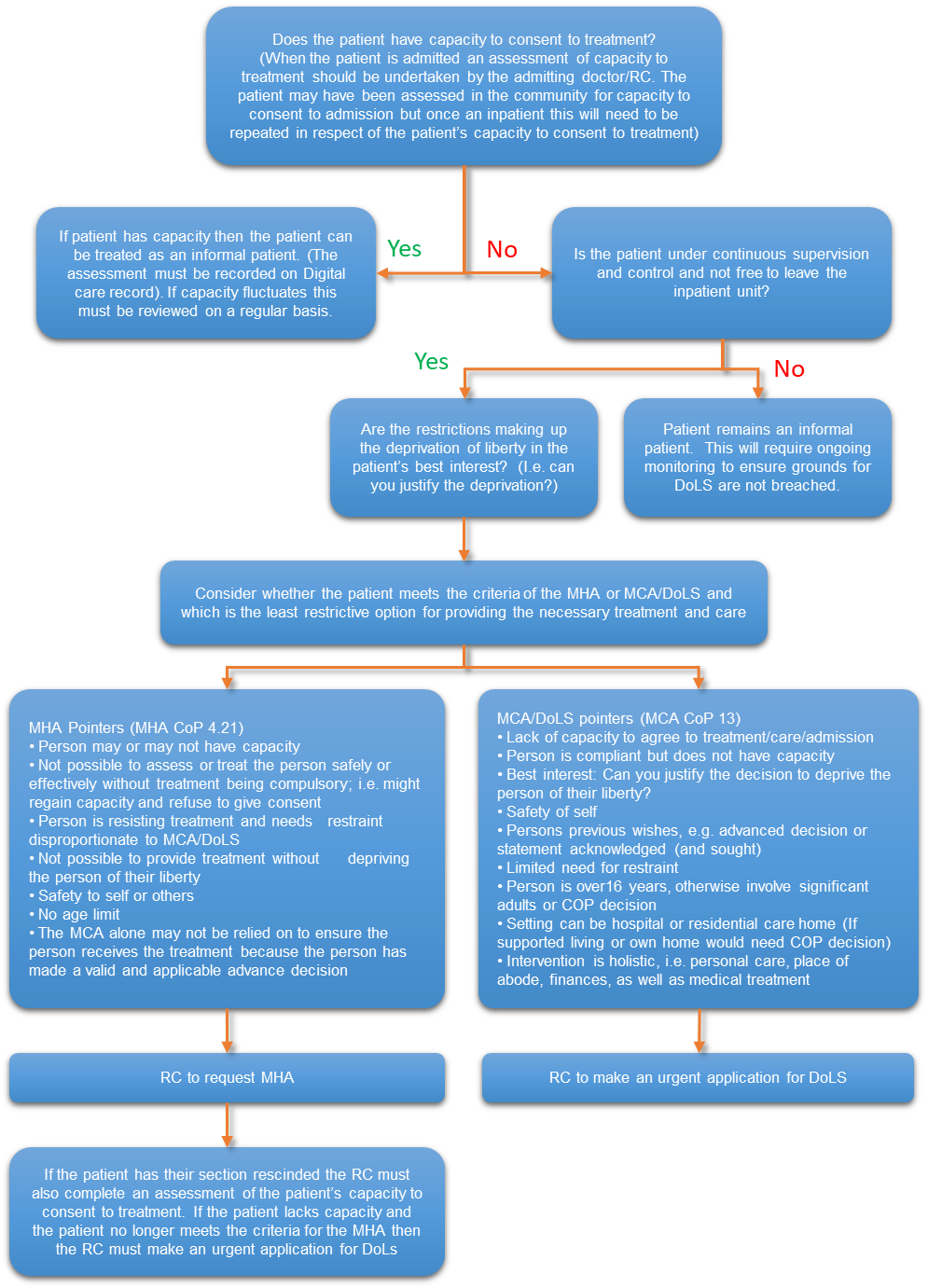
* 1. If patients are admitted with medication, for medication titration or for ECT as soon as possible guidance should be sought on how best to support the person. For example it can be dangerous not to have the correct medication or dose of medication to give to a patient and therefore a delay in sourcing the medication should be avoided. See [P01 Medicine Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/pharmacy/medicineshttps:/www.dpt.nhs.uk/resources/policies-and-procedures/pharmacy/medicines)
  2. For plus size patients’ staff should refer to their local ward protocols prior to accepting admission
  3. When a patients is admitted to a Trust bed or is transferred to an out of are bed, the team responsible for the admission or transfer need to ensure the following information is clearly noted in the digital care record:
* Time they left the assessment area/ward .i.e Liaison, custody, POS, wards
* Their destination
* How they was transported and name of transport provider
* Breech Times
  1. Prior to admission patients should be screened for the presence of COVID19 symptoms and details taken of any possible face to face contacts, living with a household member with actual or suspected cases of COVID19 – this should be documented.
  2. If possible swabbing of patients (for the presence of COVID19) should occur prior to admission to allow stratification of patients. This should be recorded on COVID Treatment Escalation Plan
  3. Testing areas have been established for all admissions by locality (of all ages of functional patients) in:
* North Devon – Ocean View
* South Devon – Torbay POS
* East Devon – Coombehaven
  + 1. In some instances such as LD and OPMH the patient may be admitted straight to the admitting ward and isolated on the unit.
  1. Patient will be transferred from a Testing area to a treatment area depending on their test result and presence of symptoms of COVID-19 and contacts with suspected or confirmed cases of COVID-19. Please see latest flow chart for details of this and local practice.
  2. An isolation unit has been established where all confirmed COVID19 positive patients will be transferred / admitted.
  3. Admissions to OPMH dementia inpatient beds are made via the safer staffing/bed management team with agreement from the senior inpatient manager/Directorate Manager (and out of hours via the on call manager and duty consultant).
  4. **On admission to testing area**
     1. When the person arrives at the testing area they will be orientated to the area and given relevant information (see appendix 10 for example). The member of nursing staff who is admitting the individual will explain the following:
* The name of the Allocated Nurse who will complete the admission assessment and support the person to settle on the ward.
* The name of their allocated Responsible Clinician and / or Consultant Psychiatrist.
* Have the reason for being admitted to the ward explained.
* If detained, explain the reason for detention, the powers used and their extent, and the person’s right of appeal.
* Informed of their rights with regard to consent to treatments, complaints procedures and access to independent help and advocacy. The person will be given time to settle and then orientated to the ward by the Allocated Nurse.
* Signposted to advocacy services which may include IMHA/IMCA/Care Act or independent advocacy. This should be documented on the electronic patient record.
* On the duration of their period of observation, the purpose of the assessment period and the process of swabbing and the possible outcomes (see appendix 10)
  + 1. The admitting nurse will check any advance directives, for example:
* Treatment Escalation Plan (TEP)
* Lasting Power of Attorney for Finances (LPAF)
* Lasting Power of Attorney for Health & Wellbeing (LPAHW)
* Advance decision in My Future Plan and ensure that these are clearly communicated, noted and actioned.
  + 1. People admitted who are identified to be at risk of disturbed/violent behavior may have an advance directive on admission that is required to be reviewed and used.
    2. Following swab results and based on clinical assessment a decision to transfer will be made (please refer to the latest flow chart for information)
    3. Test results should be document in the electronic patient record including use of alerts and relevant careplans
    4. Patients who test positive should be encouraged to inform close or household contacts of their positive status to allow those persons to take the appropriate steps and make use of any available test and trace system.
    5. The legal framework associated with isolation and swabbing for a refusing capacitated or incapacitated person is complex and it is recommended to take advice where the situation is unclear. A flow chart is included in Appendix 12 to guide this.
    6. A limited doctor ‘clerking’ and nurse admission process will begin within 4 hours of arrival – (see appendix 11 Junior Doctor Clerking Tasks and Nurse Admission Tasks in Testing Ward) this will include:
* Physical health examination
* Risk assessment for VTE
* Meds rec stage 1 and completion of drug chart and RT if required
* Initial presentation
* Presenting situation
* Mental State Examination
* Risk Factors
* Risk Summary
* Assessment and documentation of capacity to consent to an informal admission (which should include the enhanced restrictions of the Leave restrictions (see DAISY for latest version) and Visitor Restrictions (see DAISY for latest version)
* Identification of a patients COVID-19 symptoms
* Information gathering about close or Household contacts of suspected or confirmed cases of COVID19
* Identification of a patients vulnerability status
  + 1. A limited nurse ‘admissions’ process will begin which will follow the usual admissions process but take into account the limited time present in the testing area and the need to prioritise physical health assessment and risk assessment and engagement and legal rights. See appendix 11 Junior Doctor Clerking Tasks and Nurse Admission Tasks in Testing Ward .
  1. **On admission to treatment ward:**
     1. When the person arrives at the testing area ward they will be orientated to the ward and given a welcome to the ward pack. Any information leaflets provided to the individual or their carers must be recorded in the person’s Digital Care Record. The member of nursing staff who is admitting the individual will check the following has been explained :
* The name of the Allocated Nurse who will complete the admission assessment and support the person to settle on the ward.
* The person will be informed of their Named Nurse and Named Occupational Therapist within the first 24 hours of admission.
* Have the reason for being admitted to the ward explained.
* If detained, explain the reason for detention, the powers used and their extent, and the person’s right of appeal.
* Informed of their rights with regard to consent to treatments, complaints procedures and access to independent help and advocacy. The person will be given time to settle and then orientated to the ward by the Allocated Nurse.
* Signposted to advocacy services which may include IMHA/IMCA/Care Act or independent advocacy. This should be documented on the electronic patient record.
  + 1. The admitting nurse will check any advance directives, if not already done so, for example:
* Treatment Escalation Plan (TEP)
* Lasting Power of Attorney for Finances (LPAF)
* Lasting Power of Attorney for Health & Wellbeing (LPAHW)
* Advance decision in My Future Plan and ensure that these are clearly communicated, noted and actioned.
  + 1. People admitted who are identified to be at risk of disturbed/violent behavior may have an advance directive on admission that is required to be reviewed and used.
  1. **Once admitted to treatment ward:**
     1. The person will be fully assessed by the Duty Doctor within 4 hours of arrival on the treatment ward (and documented on the Digital Care Record within seven hours) for both their physical and mental health issues. Where there is a delay in the medical assessment, the Ward Nurse will arrange the most appropriate care available to mitigate any further decline in the person’s physical or mental health. At this point, any missing data will be updated.
     2. The physical assessment will include a review of infection control issues, deep vein thrombosis and any history of heart problems that may lead to cardiac arrest. Further for patients with a diagnosis of serious mental illness should be screened using the Lester tool. Results of the assessment must be recorded on Digital care record and ward staff notified of any findings, and agreed actions to be taken and clearly communicated. See [C34 Physical Health Monitoring Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/physical-health-monitoring" \t "_blank)
     3. Between Midnight and 07:00 hours the on-call medical assessment may be delayed. The admitting nurse can request a priority medical assessment following a full risk assessment of psychiatric and physical health.
     4. It may be appropriate for junior doctor assessments to occur remotely (or by another clinician) – please see appendix 8 – Junior Doctor Tasks
     5. The available night staff Multidisciplinary Team (MDT) will review and make the decision to request the On-Call doctor to prioritise. If there are any concerns about the access and timeliness of a medical assessment the On-Call consultant can be contacted.
     6. Demographic and personal details need to be checked with the person within 12 hours of admission. Digital care record will be amended accordingly by the person collecting the information
     7. The Duty Doctor/Night Nurse Practitioner and Ward nurse will agree and document the person’s initial care plan; this will include the engagement level, risk management plan and any other care planning information. If the person is able to engage in agreeing their care plan at this point this will be noted on their care plan.

# Observations and restrictions

* 1. The admitting nurse or person responsible should tell the person and if applicable and consent is obtained the persons circle of support, what level of observation they are under and:
* explain what being under observation means
* explain clearly the reasons why the person is under observation and when, or under what circumstances, this will be reviewed
* explain how they will be observed and how often
* explain how observation will support their recovery and treatment
* discuss with the person how their preferences will be respected and how their rights to privacy and dignity will be protected
* The additional restrictions as a consequence of COVID19:
  + - * + Leave restrictions (daisy.dpt.nhs.uk/covid-19/coronavirus-related-policies-guidance-and-training)
        + Visitor Restrictions (daisy.dpt.nhs.uk/covid-19/coronavirus-related-policies-guidance-and-training)
        + Social Distancing Guidelines
        + Information on why staff may be wearing Personal Protective Equipment
        + Any further testing requirements they may be subject to e.g. retest in seven days
* offer the person an opportunity to ask questions.
  1. Ensure that restrictions, including restrictions on access to personal possessions:
* are relevant and reasonable in relation to the person concerned
* take into consideration the safety of the person and others on the ward
* are explained clearly to ensure the person understands:
* why the restrictions are in place and under what circumstances that would be changed
  1. Other restrictions such as the [S11 Security and Safety Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/safety/security-safety-and-bomb-threats) and [S13 Smoke Free Environment](https://www.dpt.nhs.uk/resources/policies-and-procedures/safety/smoke-free-environment) Policy are discussed and documented on the person’s Digital Care Record.
  2. The Shift Planner will be completed by the Nurse in Charge for all shifts. The shift planner must clearly identify which member of nursing staff is allocated to which patients. This will be retained as a hard copy for five years with the allocation sheet for Level 1 engagement and supportive observations and the duty rota to ensure there is a clear audit trail of responsibilities.

# Informal Admission to Inpatient Units

* 1. All people admitted informally, not under a Section of the Mental Health Act, must have an assessment of Capacity to Consent to Treatment assessment completed on the Digital care record by the admitting doctor within 24 hours of admission. This should include the additional restrictions applicable under the COVID19 pandemic (Principles and Guidance on the use of S17 Leave for detained patients and leave for informal patients on DPT Adult, Older Adult, Specialist Directorate Wards During Period of Covid Pandemic v3.0 (reference to smoking)) and the requirement for swab testing. This must be confirmed by the Responsible clinician. If the patient lacks capacity or is refusing to agree to the restrictions then consideration must be given to applying the appropriate legal framework. See below.
  2. People who are admitted informally would be those people who have capacity and would meet the criteria for detention under the MHA, but who agree to an informal admission. Those people who wish for an informal admission, who would not meet the criteria for detention under the MHA, should be supported under the CRHT or other crisis service.
  3. SAFTI (Self Accessed Flexible Treatment Intervention) is a program of brief, self-accessed admissions to the acute service which are not gate-kept by CRHT for people with Emotionally Unstable Personality Disorder. These informal admissions follow a separate [SAFTI procedure](http://daisy.dpt.nhs.uk/media/1568200/c40_appx_safti_procedure_reviewed-2018.doc)



* 1. **Formal admissions:**
     1. If a person is being admitted under the Mental Health Act 1983 (amended 2007), Section papers will be completed on arrival to first area to which the patient is admitted, this may be a testing bed or in the case of a transfer from an acute ward, the Section papers will have been made to the Acute Trust and will have been scrutinised and stored already by the DPT MHA office in line with Service Level Agreement.
     2. The Nurse in Charge will review and ensure the Mental Health Act documentation is in line with policy and act accordingly to ensure correct storage and recording of information. See [M14 Receipt and Scrutiny of Detention Papers](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/receipt-and-scrutiny-of-detention-papers)
     3. Original paperwork should be sent to the MHA office and copies kept, unless it is expected that they may imminently transfer to another, out of area bed. Where it is likely that transfer of care outside of the Trust bedstock is planned, wards should secure the Medical Recommendations & Application in a SAFE & SECURE place (Ward safe in a sealed named envelop / message to all staff in diary identifying whereabouts of papers) and email scanned copies to the MHA office. The original paperwork will then accompany the person on transfer.
     4. If the person is being transferred from an acute ward to which they were detained, the MHA paperwork may already be uploaded on the patients care record. Nursing staff should check the correspondence MHA detentions section of Carenotes for uploaded section papers.
     5. The person must be informed of their rights as a patient under Section 132 of the Act and their rights to apply for a tribunal. See [M10 Section 132 - 133 Duty of managers to give information to detained patients](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/section-132-133-duty-of-managers-to-give-information-to-detained-patients)
     6. People who are admitted and placed on a Section under the Mental Health Act need to have a Capacity to Consent to Treatment assessment completed within 24 hours of admission (starting from the point of first admission) in accordance with the Mental Health Act Code of Practice 23.27. If the assessment is undertaken by a Junior Doctor, the assessment should be repeated by the Responsible Clinician within the first seven days. See [C09 Consent to Treatment](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/consent-to-treatment)
     7. The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should:
* use clear language
* discuss rights and restrictions with the person
* provide written and verbal information
* make the discussion relevant to the ward the person is being admitted to
* explain whether they are under observation and what this means (see observations and restrictions).
  + 1. A senior health professional should ensure that discussions take place with the person being admitted to check that:
* they have understood the information they were given at admission
* they know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish
* they understand that any changes to their legal status and treatment plans will be discussed as they occur.

|  |
| --- |
| **Good Practice Tips:**  **Addressing personal concerns of people during an admission**  To support the person's transition to the ward the admitting nurse or person responsible should make the following items available if the person needs them:   * a toothbrush * hygiene products * nightwear   This is particularly important for people who have been admitted in crisis. Give the person verbal and written information about ward facilities and routines  At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:   * physical healthcare needs * brief advice around smoking or alcohol, where indicated * pregnancy, breastfeeding or the need for emergency contraception * advice about immediate addiction issues, treatment and support * mental health treatment.   The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements and liaise with the appropriate agencies. This may include:   * people they have a responsibility to care for, such as: * children * frail or ill relatives * domestic arrangements, in particular: * home security * tenancy * benefits * home care service * pets.   On admission, ensure people (particularly children and young people) know who they can talk to if they are frightened or need support. Look at the NICE guideline on patient experience in adult mental health services section on hospital care for more information.  Identify whether the person has any additional need for support, for example, with daily living activities. Work with carers and community-based services, such as specialist services for people with learning or physical disabilities, to provide support and continuity while the person is in hospital. |

* 1. **On-going Assessment and Treatment** 
     1. **Within 72 hours** – Within the first three days of admission the initial care plan will be reviewed by the Responsible Consultant and Multi-Disciplinary team. The HoNos/clustering should be completed along with their provisional ICD10
     2. The care plan will be updated and all relevant staff, including the Care/Recovery Coordinator and where appropriate a social worker, informed. The patient will be part of that review and be given a copy of their care plan.
     3. A discussion and documentation should occur where clinically appropriate regarding Treatment Escalation Plans and for all those in shielding categories and where otherwise clinically appropriate.
     4. A Medicines Reconciliation part 2 check will be completed by the Doctor or Senior Night Nurse Practitioner (for a night time admission) and any medicine prescribed on admission is checked with the person’s GP. A full medicines history including allergies will be documented on Digital care record. If admission occurs out of hours the Night Nurse Practitioner must ensure that if the medicines reconciliation part one cannot be competed that the ward doctors are informed and this is completed the following morning.
     5. The patient and appropriate others such as a family member or the Nearest Relative will be provided with information about the person’s mental health status and review and agree next steps in their care.
     6. Staff will ensure the patient is made aware of the confidentiality policy.
     7. The Named Nurse will inform other agencies about the person’s admission to hospital which will include the person’s GP and social services if required.
     8. All patients in hospital will be placed on CPA. Therefore all reviews that take place in hospital will also be a CPA and recorded as such.
     9. New patients should be referred for urgent allocation of a Care/Recovery Coordinator.
     10. The ward Discharge Facilitator/other appropriate staff member will inform social care services of the patients admission if it is possible social care needs will arise.
     11. The ward Discharge Facilitator / other appropriate staff member will meet with the patient to discuss their home situation and establish any barriers to discharge such as accommodation, finances / benefits, care package within the first 72 hrs (where clinically possible). See appendix 7. These will be shared with the first MDT to inform the questions as to why the patient requires to remain in hospital and what assessments should occur outside of hospital)
     12. The Discharge Facilitator will discuss with the relevant Social Worker within the first 72 hrs any likely delays or social need requirements and prepare a plan to support the first MDT to achieve a safe discharge to assess if possible or key steps required to avoid any delays.
     13. An estimated date of discharge will be created.
     14. A [Discharge Administration Form](http://daisy.dpt.nhs.uk/media/1543720/discharge-administration.pdf) available on the intranet will be completed by the Discharge Facilitator, or another nominated member of the MDT, including an Estimated Date of Discharge as agreed in the ward MDT meeting. This form is then updated to reflect any delays in the discharge and for DTOC (Delayed Transfer of Care) recording. See Appendix 6.
     15. Every patient will have their ward discharge standards completed for each day of their admission. See on the intranet [CareNotes Standard Operating Procedures (SOP) for recording](http://daisy.dpt.nhs.uk/working-here/trust-systems/carenotes/carenotes-recording-standards.aspx)
     16. Adult: [UIC Cedars](http://daisy.dpt.nhs.uk/media/1568183/uic_cedars-exeter_op_jul15.doc) / [UIC NDDH](http://daisy.dpt.nhs.uk/media/1568182/uic_nddh-north_devon_op_dec18.doc)
     17. Torbay and South Devon inc. Sycamore ward
     18. Older Adult: [Organic](http://daisy.dpt.nhs.uk/media/1568179/dementia_organic_op_aug18.pdf) / [Functional](http://daisy.dpt.nhs.uk/media/1568184/opmh_functional_aug18.pdf) / [Community](http://daisy.dpt.nhs.uk/media/1568180/opmh_cmht_op_17.docx)
     19. [PICU](#_Referrals_to_PICU" \t "_blank)
     20. [Eating Disorders](http://daisy.dpt.nhs.uk/media/1569068/haldon-operational-policy-v80-feb19.docx)
     21. [LD/ASU](https://www.dpt.nhs.uk/our-services/learning-disability/how-we-can-help/additional-support-unit)
     22. **7 day assessment** - By the end of the first week of admission the following will have occurred:
* Weekly clinical review dates arranged as best practice, but where weekly is not possible they should be no further apart than bi-weekly.
* The Care Programme Approach (CPA) should be instigated for all patients admitted to the wards. Allocation for a Care/Recovery Coordinator made if not already in place
* Mental Health Act Section status reviewed. The patient informed of their right to appeal as many times as required to ensure they understand their rights as fully as possible. See [M10 Section 132 - 133 Duty of managers to give information to detained patients](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/section-132-133-duty-of-managers-to-give-information-to-detained-patients)
* Housing needs agreed and planned
* Relatives or carers contacted and involved in care discussions. See Appendix 1 for a template letter and form.
* All decisions, care plans and relevant information recorded in Digital care record.
* Provisional discharge date agreed and Discharge Planning meeting date agreed.
* The carer’s assessment agreed and completed. This can be completed by the Ward MDT or the Care Co-coordinator and may already be in place.
* Specific 120 hour multidisciplinary team meetings exist for patients with a primary diagnosis of personality disorder.
* A formal discharge planning meeting invitation to the community workers and other relevant professionals including 117 meeting being set up.

|  |
| --- |
| **At a Glance:**  **Best Practice: Accommodation**  Before discharging people with mental health needs, discuss their housing arrangements to ensure they are suitable for them and plan accommodation accordingly. This should take into account any specific accommodation and observation requirements associated with risk of suicide.  Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation.  This should:   * be started before discharge * continue after discharge for as long as the person needs support to stay in settled accommodation * focus on joint problem-solving, housing and mental health issues.   DPT will follow a discharge to assess model whereby if safe to do so the patient will be discharged to a non-hospital care setting to allow further assessments to continue. |

* 1. **Minimum Review Timescales:**
     1. **Inpatient Risk assessment** – minimum of weekly reviews or whenever necessary due to changes within person’s presentation, engagement levels or situational changes.
     2. **Risk Assessment –** minimum updates at the start and end of admission period; significant risk events should be reflected in a timely manner to this core risk assessment. See [R04 Clinical Risk Assessment and Management Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/risk/clinical-risk-assessment-and-management)
     3. **MDT –** within 72hrs following admission.
     4. **MDT Meetings –** bi-weekly.
     5. **Clinical meetings to include a brief review of each patient's risk and care plan with a formulation of actions and clearly identified member of the MDT who will carry out those actions**. – Daily.
     6. The daily clinical meetings will explicitly need to answer the following questions:
* Does the person required the level of care that they are receiving, or can if be provided in another setting?
* What value is being added to the patients care against the risk of being away from home
* What do they need next?
* If the patient cannot be discharged home today, when can they be discharged home?
* What needs to be done to facilitate their discharge
  + 1. **Ward Team 1-1 time –** minimum of three sessions per week with Named Nurse.

|  |
| --- |
| **At a Glance**  **Best Practice – Psychoeducation for people with psychotic illnesses**  Before discharge, offer a series of individualized psychoeducation sessions for people with psychotic illnesses to promote learning and awareness.  Sessions should:   * start while the person is in hospital * could be commenced digitally via a platform such as Attend Anywhere * continue after discharge so the person can test new approaches in the community * And cover: * symptoms and their causes * what might cause the person to relapse, and how that can be prevented * psychological treatment * coping strategies to help the person if they become distressed * risk factors * how the person can be helped to look after themselves * be conducted by the same practitioner throughout if possible. |

# Admission Protocol

* 1. **Functional Admission -** Most functional adult and older adult admissions come through face to face assessment by CRHT.

|  |
| --- |
| **At a Glance:**  Role of the Crisis Resolution Home Treatment Team  **Gatekeeping by CRHT**  The Department of Health (DH) requires that all admissions into adult acute psychiatric inpatient wards for patients are gate kept by the Crisis Resolution and Home Treatment (CRHT) teams in order to prevent hospital admissions and give support to informal carers. An admission is deemed to have been gate kept if the CRHT team has assessed the person before admission and they were involved in the decision-making process that resulted in admission (DH, 2011)2.  Exceptions to the CRHT gatekeeping requirement are listed below:   * Patients transferred from another NHS hospital for psychiatric treatment * Internal transfers between wards in the Trust for psychiatric treatment * Patients under a Ministry of Defence (MoD) contract * Planned admissions for psychiatric care from specialist units such as eating disorder units.   For admissions from out of the Trust area, where the patient was seen by the local crisis team (out of area) and only admitted to this Trust due to the lack of available beds in the local area, the Trust’s CRHT team should assure themselves that gatekeeping was carried out prior to the referral into the Trust service. This can be recorded as gate kept by CRHT teams.  Self Accessed Flexible Treatment Intervention (SAFTI) where care planned – See [SAFTI Procedure](http://daisy.dpt.nhs.uk/media/1568200/c40_appx_safti_procedure_reviewed-2018.doc) |

* 1. Mental Health Act Assessments assessed by the Approved Mental Health Practitioner (AMHP); the AMPH and CRHT services should aim to provide a joint assessment to agree the least restrictive option for care before admission is considered.
  2. The ‘Practice standards & principles at interface points between Liaison Psychiatry, CRHTT, AMHPs and Bed Capacity’ outlines the roles and expectations of each service where admission is indicated. See Appendix 2.
  3. The referrer makes a decision that community treatment is not currently a viable option and intensive treatment is required (Home Treatment Team or Inpatient Care).
  4. Discussion with the Home Treatment Team for them to make a decision as to whether they are able to support the individual to remain at home.  This decision should take into account the additional risks associated with admitting a patient to an area where social isolation may not be guaranteed and the associated risk of COVID-19 infection. It should also take into account the additional support available during the pandemic.
  5. Additional support available may include urgent discussion with Social Care Workers or use of step up facilities or other creative solutions to support patient care.
  6. If in a stage of prioritization then admissions will only be permitted in line with prioritization levels set by GOLD.
  7. If Home Treatment cannot be offered then the Home Treatment Team will identify a bed in their locality and inform Bed Management, otherwise they will inform Bed Management of the need for a bed to be identified.
  8. CRHT identify the goals of admission and ensure a clinical discussion including handover of risk with the relevant Nurse In charge and agree the admission process / time.
  9. CRHT to process swabbing if possible prior to admission.
  10. Where the Nurse In Charge is concerned about the safety of the admission taking into account the acuity and staffing on the ward or the suitability of the admission for other reasons this should be discussed with the referring clinician.
  11. Where agreement cannot be reached in hours this should be escalated to the ward manager and relevant consultant and CRHT manager.  The Ward Manager and Consultant should express a viable alternative plan including, for example, the option for review of the patient, attendance at urgent professionals meetings, personal liaison with CRHT consultant etc which may be agreed by the referring clinician.
  12. Where agreement cannot be reached this should be escalated to the SNM and / or ACD for the admitting ward.
  13. Where agreement cannot be reached this should be escalated to the relevant clinical director or locality medical lead for that admitting ward, then to the deputy medical director. The directorate manager should be alerted to the clinical disagreement and seek to foster a resolution.
  14. Where agreement cannot be reached out of hours this should be escalated to the NNP or other senior nurse and on call consultant.  Options should be considered including a holding position until day time services are available.
  15. Where agreement cannot be reached out of hours this should be escalated through the usual on call tiers.
  16. The following information is required by the ward:
* The patient’s name and date of birth
* Presentation and level of risk further to assessment
* Goals for admission
* Estimated time of arrival
* Safer Staffing levels
* Covid Screening information including symptoms and contacts with suspected or confirmed cases and whether patient is in an extremely clinically vulnerable category
  1. In the absence of an available adult or older adult local bed the Bed Capacity and Safer Staffing team will support finding an appropriate bed for a person to be admitted to. For more information please refer to [C41 Bed Management Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/bed-management)
  2. The adult or older adult inpatient ward will notify the relevant Community Team of a person’s admission within 24 hours of their admission. If the person admitted does not have a care coordinator, the inpatient ward will follow the protocol for priority allocation for Adult and OPMH Services.
  3. OPMH wards will consider the need for a referral to social services within 7 days of admission.

**Flow chart for options when patients are in an acute phase of care and require more intense support**



* 1. **Organic [Dementia] Admission –** We are commissioned to support anyone aged 18 or above with a diagnosis of Dementia. An organic inpatient ward is focused on stabilising a person’s mental health and sometimes physical health, allowing them to return home or to access appropriate housing and/or care options.
  2. Most organic admissions will be as a result of a Mental Health Act Assessment.

|  |
| --- |
| **At a Glance:**  Gatekeeping  Unlike functional admissions, currently the CRHT’s do not gate keep the organic beds.  Instead the gate keeping function is undertaken by one of the Senior Managers in the Older Persons Mental Health Team [OPMH]. Initial contact should be made with the Senior Inpatient Manager, then either of the Community Service Managers; failing their response you should contact the Managing Partner or Clinical Director.  Mental Health Act Assessments assessed by the Approved Mental Health Practitioner (AMHP) cannot be directly accepted to the relevant ward without the input of a Senior Manager from the OPMH directorate.  **Out of Area Bed Organic Patient Process**  The process is the same for all other admissions other than the responsibility for undertaking the referral when the following should be followed:   * During office hours Monday – Friday 0900-1700 * OPMH or AMH CMHT’s to complete the referral [whichever team the person would normally be seen by, whether they are open to the team or not] * Out of office hours whilst the Bed Capacity Team is working Monday to Friday 1700-2200 and Weekends 0900-1700 * Clinical staff in the Bed Capacity Team to complete the referral, where clinical staff are present and they have capacity * Out of office hours and out of Bed Capacity Team hours Monday to Friday * 2100-0800 and weekends 1700-0800 * NNP’s to complete the referral, where they have capacity |

# Referrals to the Eating Disorder Inpatient Service (“The Haldon”)

* 1. As an NHS England commissioned The Haldon offers admission to individuals from across Devon and the wider Southwest Region.

|  |
| --- |
| **At a Glance:**  The Service provides for 12 inpatient beds for the assessment and treatment of those with an eating disorder, this includes up to two 16-18yr olds with education provision provided by the Royal Devon & Exeter Hospital.  The service is commissioned to provide intensive supportive nursing interventions that may involve Nasogastric tube (NG) feeding for up to 2 people at any one time.  The service is commissioned to also provide for up to 8 spaces on a non-residential basis(day treatment) .This is facilitated via step-down community accommodation (Redhills House – 6 beds), which is unstaffed but with 24/7 telephone support and full access to the same inpatient therapy programme, and 2 Non-residential day treatment space r for individuals to access who live more locally, and can access The Haldon for their own home.  The service accepts planned admissions only  For patients who have a registered GP within the Devon Partnership Trust catchment areas:  Referrals for an inpatient eating disorder admission within the DPT catchment area are managed via the Community Eating Disorders Service (CEDS).  Individuals referred to CEDS are required to have an allocated Care Coordinator with a Community Mental Health Team. This is to ensure that the intensive treatment sits as part of a wider community treatment plan and that support is available pre and after treatment in the community  Patients who have a registered GP outside of the Devon Partnership Trust catchment area:  Referrers from outside of Devon Partnership Trust, and for young people under the age of 18 (within or outside of Devon Partnership Trust) will need to complete The Haldon intensive treatment Referral Form – available on the service page on Trust Website, or via the service on request). |

* 1. Referrals for Community Eating Disorders Service are available on the intranet or on request.
  2. Referrals are considered at the weekly referrals/triage meeting. With initial assessment dates set. .Individuals will be informed of the date whenever possible by telephone. An appointment letter will follow within 10 working days from acceptance of referral.
  3. Urgent referrals can be considered outside of this meeting by the Consultant Psychiatrist and Senior Nurse and urgent initial assessment arranged as soon as possible, depending on staff availability. If individuals are severely physically compromised, recommendation for urgent general hospitalization is made.
  4. Where an MHA assessment is being considered the step above must occur first.
  5. Admission will be arranged within an appropriate timescale, depending on individual’s physical and mental health, and bed availability. If no beds are available at The Haldon or STEPS Bristol within an appropriate timescale, The Haldon will endeavor to source an alternative placement in accordance with the Southwest Specialist Services Provider Guidelines.
  6. Only planned admissions are accepted to ensure the team is fully aware of physical and mental health risks and suitability and safety of the clinical environment.
  7. Clinical review meetings for individuals are held a minimum of fortnightly.
  8. [The Core Nursing Team Haldon Protocol](http://daisy.dpt.nhs.uk/media/1568134/the-haldon-core-nursing-teams-protocol-v2_jan19.docx) on the intranet provides guidance as to key roles for nursing staff.

# Referrals to PICU

* 1. A psychiatric intensive care unit (PICU) is an inpatient unit for people with severe mental health needs who are unable to be supported on an adult acute unit.
  2. The Junipers is a 10 bedded unit for men and women serving the population of Devon. Livewell Southwest will be funding 3 beds and Devon Partnership Trust will be funding 7 beds.
  3. Please refer to the [PICU protocol](http://daisy.exe.nhs.uk/media/1568815/picu_access_protocol_mar19.docx) on the intranet for details of admission criteria and process.

# Referrals to the Additional Support Unit for Adults with Learning Disabilities (“The ASU’’)

* 1. The ASU is a planned admissions unit for adults with a learning disability from across Devon excluding Plymouth.
  2. Referrals are usually considered by the multidisciplinary team as part of the transforming care blue light processes. Urgent referrals can be considered by the Consultant Psychiatrist and Senior Nurse and urgent initial assessment arranged as soon as possible, depending on staff availability.

|  |
| --- |
| **At a Glance:**  The ASU is a 5 bed in-patient unit providing assessment and/or treatment for adults with a learning disability who:   * are experiencing acute and complex mental illness * Clinically present an immediate risk to those around them and/or themselves * Whose behaviours and/or mental state are such that assessment and/or treatment cannot be provided safely and effectively in the community setting.   **The ASU provides the following core functions of support:**   * Assessments, including the potential for mental illness, of the causes of distressed/challenging behaviour and where it cannot be delivered in a community setting. * Treatment of mental illness, where this is the cause of challenging behaviour complimented by other interventions as appropriate including the Active Support Model within the framework of positive behavioural support and also include information around interventions for Mental Health as per [NICE guidelines (NG54)](https://www.nice.org.uk/guidance/ng54) as well as [Challenging Behaviour (PBS NG11)](https://www.nice.org.uk/guidance/ng11) Reintegration of the individual into a community setting, including support for carers and providers.   **The care pathway in and out of the unit Admissions**  Referrals to the ASU are received from the NEW (North/East/West) Devon and South and Torbay clinical commissioning groups; the Intensive Assessment and Treatment community Teams (IATTS) and/or transfer from other DPT inpatient/community services.  **The interface with the Urgent Care Pathway**  Admission to the ASU should only occur where assessment and treatment in mainstream in-patient services is not possible. |

# Referrals to the Mother & Baby Unit (Jasmine Lodge)

* 1. The Mother & Baby Unit (MBU) provides an inpatient service for women during the perinatal period & who are experiencing mental illness &/or significant attachment difficulties. Comprehensive medical, nursing and psychological assessment will be provided on the MBU. The overall aim is for recovery of maternal mental health whilst promoting the care and developing mother infant relationship (or unborn child).
  2. Referrals are received by the Outreach Team Monday to Friday 9-5 & by the MBU Nurse in Charge outside of these hours.

|  |
| --- |
| **At a Glance:**  The MBU is currently a 4 bed in-patient unit due to move to an 8 bedded unit on 01-04-2019, providing assessment and treatment for mothers who are within the following NHS England criteria.  **Pregnant women 32 weeks + and women within the 1st year post-partum, who are either currently suffering from or have a history of:**   * Bipolar Disorder * Post-partum psychosis and other psychoses * Serious affective disorder and other serious non-psychotic conditions. * Antenatal and postnatal anxiety disorders impacting on pregnancy and childbirth such as Tokophobia, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder arising from pregnancy/childbirth. * Mothers experiencing bonding disorders (infants under 1 year) that can no longer be managed in the community. * Pregnant and post-partum women over 16 years for inpatient admission. * Mothers of infants up to the age of twelve months maximum.   **The MBU will provide:**   * Assessment, care and treatment for pregnant and post-partum women who cannot be safely or effectively managed by the Outreach Service, Community Perinatal Teams, Community Mental Health/Crisis Teams or Primary Care. * The MBU core principle is to promote the best care by avoiding the unnecessary separation of mother and infant when admission is necessary. * The Outreach Team is responsible for the assessment, treatment and care of pregnant and post-partum women who are admission vulnerable &/or post MBU discharge. * The MBU is staffed by multidisciplinary professionals who have specialised knowledge, skills, experience and competencies to offer expert advice, treatment and care for mothers. (Nursery Nurses, Mental Health Nurses, Perinatal Psychologists, Perinatal Psychiatrist etc.) * The MBU works in a way that respects the individual needs of mothers from all ethnic, cultural and religious backgrounds, the needs of the baby/infant will always be paramount within this. Ethnicity and diversity will be respected and information/guidance will be made available in a language or form that is accessible and recognises the full range ofethnic and cultural differences.   **The Care Pathway for Admissions to the MBU**  Referrals are initially received & are triaged by the Outreach Service (M-F 9-5) or by the Nurse in Charge on the MBU outside of these hours. An NHS England referral form is routinely used. Our catchment area is Cornwall, Devon & Somerset however, if we have beds & mothers meet the MBU criteria admission can be arranged.  Arrangements are in place with DPT Contracting & NHS England should we admit mothers from Wales, Scotland or the Channel Islands.  **The interface with the Urgent Care Pathway**  Mothers open to DPT Acute Services can be referred to the MBU if they meet the specified criteria, clinical case discussion is always available 24/7. If mothers require an admission for their mental health but do not wish to be admitted with their baby a clinical discussion would need to take place with the relevant Crisis Team. |

# Referrals to Secure

* 1. All referrals to the Secure Service will follow a Procedural route via <https://swpc.cambiouk.co.uk/pfm/> that focuses on the patients need.
  2. All referrals must be submitted on the agreed New Care Model electronic form to ensure all key data is recorded in a consistent manner (see appendix for details)

# Multiple Admissions Protocol

* 1. The definition of multiple admissions; is when an admission takes place for a patient who has been admitted 3 times or more in the last 18 months.
  2. This would not normally be expected to happen if the patient has an in-depth my future plan, which has been agreed with the patient, their circles of support and across the multidisciplinary team [MDT].
  3. In the event this were to occur, a special MDT meeting should be called to review the my future care plan with consideration to expand the attendance to other professionals i.e. Police, SWAST, Fire brigade, third sector; who maybe able to support the individual to remain well in the community.

# Transfer of Patients

* 1. When a person is moved from one service to another service, care must be taken to provide comprehensive information to ensure the health and wellbeing of the patient as the transfer could occur at any time of night or day and maybe to another health provider or care setting. The nurse co-ordinating the transfer should ensure risk information is conveyed both verbally and in writing, with a current care plan, including current medication information and Mental State Examination [MSE]. Where appropriate a medical summary should be sent with the person to the place of transfer, along with basic information such as details of next of kin, section papers, and any other specific information, other health providers or the care setting has requested. If an internal transfer medication charts need to be transferred.
  2. COVID19 Swabbing – patients transferred between DPT wards will require a swab result to be documented (use the COVID Treatment Escalation Care Plan).
  3. Patients may require transfer to the Isolation Unit if they test positive for COVID19 during their admission. Patients who are contacts of that person need to be notified of the contact with someone who is COVID19 positive (see appendix 13 – COVID19 Outbreaks).
  4. Patients transferred from another service provider e.g. NHS acute hospital, private sector mental health provider will ideally be swabbed prior to admission with the outcome known and recorded. Where a swab and outcome has not been possible prior to transfer the patient will be admitted into the testing area.

|  |
| --- |
| **At a Glance:**  To support TRANSFER recording on the electronic patient record; the following pre-populated note is available:  Transfer  Mental State Exam  Transferred to (name of hospital):  Via transport:  Time of Leaving Unit:  Discharge Summaries completion and where sent: dd/mm/yy @ xx:xxhrs  Notification of CMHT: xxTeam via xxx dd/mm/yy @ hrs  COVID19 Swab result and Date (not prepopulated):  Date and Time of Resolution of Fever and Respiratory Symptoms if transfer from Covid Positive Ward (patient should be afebrile for 48 hrs and at least 7 days post onset of symptoms) – See IPCT briefing sheet (not prepopulated):  \*\* Staff Reminder: complete / update or close; care plans, risk assessments and discharge administration forms Ensure any documents with patient possessions are sealed in an envelope marked confidential. |

* 1. Consideration must be given to the future planning for the patient following the transfer. Expected outcomes of the transfer must be recorded in the patient’s Digital Care Record.
  2. Family and carers should be notified of the transfer as per the patient’s request and consent. This should be done before the transfer when at all possible.
  3. The handover of a patient should be recorded within their Digital Care Record which should include discharge plans as appropriate and contact details of the receiving service.
  4. Whilst this information will be transferred within Devon Partnership NHS Trust units via the Digital Care Record care record system, staff should record using the prompt on for patient transfer; external providers will receive this information in paper copy as well as all parties having a verbal handover from the nurse in charge or nominated person. Ward staff are to ensure that all personal property is transferred with the person or stored for safe keeping.
  5. A registered provider must ensure that it provides suitable and sufficient information on a patient’s infection status whenever it arranges for that person to be moved from the care of one organisation to another or from the patient’s home so that any risks to the patient and others from infection may be minimised. If appropriate, providers of patient transport should be informed of any infection.
  6. Once complete the transfer must be verified.
  7. This form should be completed for transfer of patients that are classed as ‘outliers’ returning to a Trust bed [this includes Trust internal transfers] and a copy uploaded to the patient’s Digital Care Record.



**Patient Transfer Form**

|  |  |
| --- | --- |
| **Name of Patient:** |  |
| **DPT ID Number:** |  |
| **NHS Number:** |  |
| **Current Ward:**  **[Full address and phone number]** |  |
| **Admission/transfer to:**  **[Full address and phone number]** |  |
| **Expected date of Admission/transfer:** |  |
| **Any special considerations?**  **e.g equipment for plus size patients, additional medications, ECT** |  |
| **Define transport arrangements:** |  |
| **Risk assessment requested/received?** |  |
| **Infection control status?** |  |
| **Care plan requested/received?** |  |
| **Medication information requested/received?** |  |
| **Clinical/medical handover required?** |  |
| **MHA documents requested/received?** |  |
| **Record transfer details in care notes** |  |
| **Patient consent obtained?** |  |
| **Family, care manager/social worker advised?** |  |
| **Property received and documented?** |  |
| **Does the ward have sufficient staff?** |  |
| **Advise CRHT and bed capacity** |  |

# General Discharge Planning and Facilitation Principles

* 1. **COVID-19 contacts being discharged to a nursing/residential home or a community hospital, or any other inpatient facility must be tested and prior to transfer. The onward care facility must be informed of the exposure and need to keep the patient isolated for the remaining isolation period.**
  2. Discharge today should be the default pathway for patients during the COVID19 pandemic. A good discharge process gives the person the best opportunity to remain well and reduce the likelihood of readmission or suicide from all inpatient areas however and risks need to be carefully considered. Steps must be taken to ensure a discharge is safe.
  3. The date for the discharge planning meeting should be arranged within the first seven days (72 hours during COVID-19 Pandemic) of admission with the patient, the Care/Recovery Coordinator, carers and other professionals attendance at this meeting must be prioritised, so that all aspects of discharge can be discussed including CPA, and Section 117 aftercare. See [M01 Section 117 And After Care](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/section-117-and-aftercare).
  4. The ward needs to ensure availability of conference call facilities (either phone or MS Teams).
  5. Discharges should generally not take place out of hours unless in an emergency or for the convenience of the carer and patient. During the COVID19 pandemic out of hours this restriction does not apply.
  6. From the start of admission discharge needs will be considered and reviewed with the patient and carers to prepare them with a good discharge plan. All preparation and reviews must be recorded on the person’s Digital care record; this will include the risk assessments, Mental Capacity Assessments and care plans.
  7. All discharge planning needs to include as a minimum the following:
* Devon Partnership Trust operates a discharge to assess model (see above) whereby further assessment could be completed post discharge and will be prioritized.
* Follow up community support is in place and a clear plan for monitoring the person’s mental health.
* The requirements of Section 117 of the Mental Health Act (and good discharge planning) are met.
* Risk management and contingency plans.
* The home situation is clear and the person knows where they are to be discharged to
* Consideration of 24 hour housing options.
* Treatment plans including medication both for discharge and for follow up prescriptions.
* A named Care/Recovery Coordinator in place, with a date for the first community follow up review in place.
* Counseling, therapies and personal support (budgets).
* Finances.
* Meaningful daily occupation.
* Completion of assessments such as continuing health care [CHC] where appropriate. NHS CHC assessment should proceed but may be delayed and completed elsewhere if the patient can be discharged from hospital. *(\*The Trust is awaiting guidance on CHC assessment and discharge process. For now those with a positive CHC checklist should be discussed with the local CHC office – Sept 20.)*
* Where appropriate, physical health monitoring
* Appropriate isolation and physical health information being provided
* Consideration of COVID-19 Testing requirements (see below)

|  |
| --- |
| **At a Glance**  **Best Practice – My Future Support Plan**  Send a copy of the care plan to everyone involved in providing support to the person at discharge and afterwards. It should include:  Future Support Plan   * possible relapse signs * recovery goals * who to contact * where to go in a crisis * Additionally: * budgeting and benefits * handling personal budgets (if applicable) * social networks * educational, work-related and social activities * details of medication (see the recommendations on medicines-related communication systems in NICE's guideline on medicines optimisation) * details of treatment and support plan * physical health needs including health promotion and information about contraception * date of review of the care plan. |

* 1. Social care needs will be agreed and required paper work completed, sent to the relevant panel and funding agreed (dependant on the panel processes and eligibility) before discharge takes place. The arrangements for social care should be in place before discharge. For assistance in identifying the lead service for adults with social care needs. See on the intranet [Service Responsibility Protocol](http://daisy.dpt.nhs.uk/media/1568185/service_responsibility_protocol_may18.pdf). This is significantly updated during the COVID19 Pandemic – see 15.7.
  2. Panel processes are significantly streamlined during Covid and your social worker will be able to ensure that there are no funding delays
  3. The Crisis Resolution Home Treatment Team (CRHT) will support early discharge. The CRHT will provide some short term follow up for people who are at significant risk of breakdown of mental state on discharge from hospital to support a successful discharge process.
  4. CPA and aftercare under section 117 of the Act should be considered if the patient is eligible. A section 117 and CPA review meeting with the key people to discuss aftercare will be held (changed to should be held for the duration of the COVID19 pandemic) before discharge (this should be done digitally).
  5. A ‘my future support plan’ will be completed with the patient and where appropriate the patients circle of support. Additionally a Section 117 care plan if appropriate that identifies their Section 117 rights
  6. It is good practice for family members and carers to be advised of transfer and discharge. However there may be times where the client may withdraw consent. Think carefully about mental health capacity. Relatives and Carers must be informed of the discharge date in advance and notified if there is to be any delay/change of date. Effort must be made to ensure there is someone available to receive the person upon discharge. If the patient consents, they must be invited to attend discharge / 117 meetings. See [M01 Section 117 And After Care](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/section-117-and-aftercare)

|  |
| --- |
| **At a Glance**  **Best Practice – Carers Needs**  With the patient’s consent, engagement with relatives/carers is an essential aspect of the discharge process. Good care must follow the principles of the Triangle of Care. These are that :   1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter. 2. Staff are ‘carer aware’ and trained in carer engagement strategies. 3. Policy and practice protocols re confidentiality and sharing information are in place. 4. Defined carer lead roles responsible for carers are in place. 5. A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway. 6. A range of carer support services is available.   The named nurse/care coordinator or nominated deputy should ensure that the following takes place:   * The carer is provided with information on external and other non-statutory agencies that offer support to carers. The carer is invited to the discharge planning meeting, with the patient’s consent where appropriate. The carer is given a verbal explanation of the discharge care plan and offered a copy. * The carer is given information on the patient’s needs and how to help them maintain engagement with the treatment plan. The carer is given explanation of what may be involved in being a carer. Provide information on benefits and the financial implications of caring. * That a carer’s assessment is provided when appropriate. |

* 1. The HoNOS/clustering assessment will be completed as well as the medical ICD10 coding completed with the diagnosis recorded both recorded on Digital care record along with the discharge medication summary and prescription, as part of the discharge planning meeting.
  2. On the day of discharge the following will be given to the patient and or carer where appropriate:
* Contact details for the CRHT
* Single Point of Access
* Details of their local Moorings and open hours
* Details of who will contact them post discharge and where and when they will be A copy of the care plan or S117 Aftercare plan
* Any personal property that has been kept safe by the ward office
  1. The discharging nurse should ensure the record the individuals Mental State Examination [MSE] prior to leaving; confirmation of the follow up plan agreed with the person including contact details. The address for discharge and time of departure. The note will provide confirmation that administrative tasks such as informing other services has taken place.

|  |
| --- |
| **At a Glance:**  **To support DISCHARGE recording the following pre-populated note is available**  **Discharge Note**  Mental State Exam  Plan for follow up  Contact Number  In the event that we are unable to contact you; alternate point of contact (name/number/address):  Time of Discharge  Address discharged to:  Transport used:  Discharge Summaries completion and where sent:  dd/mm/yy @ xx:xxhrs  Notification of CMHT:   xxTeam via xxx dd/mm/yy @  hrs  Quantity of medications provided at discharge:  xx days  discharge pack provided: Y/N  COVID19 Test status and date (not in prepopulated form):  COVID19 isolation advice given (not in prepopulated form):  \*\* *Staff Reminder: complete / update or close; care plans, risk assessments and discharge administration forms* |

* 1. Take home medication should be ordered, ready and checked on receipt. The patient will be offered an opportunity to talk to a member of the Medicines Optimisation Team about their medicines; who may also be able to offer support with self-administration of medicines in preparation for discharge. The appropriate entry will be made on the person’s Digital Care Record, using the discharge prompt to ensure all information is recorded as required. Actual medication and a list of their up to date medicines will be given to the patient just before they leave the ward. [See P01 Medicines Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/pharmacy/medicines)
  2. The Nurse in Charge will complete or delegate completion of a 24 hour nursing discharge information summary using the standard Trust template (see DAISY COVID19 Tab and <https://daisy.dpt.nhs.uk/media/1572264/24-hour-discharge-information-for-gp-v113.docx>) and forward it to the GP surgery within 24 hours of the patient being discharged. The patient will be given a copy of the discharge summary. They do not have to accept it. Their response is recorded in the appropriate field of the discharge summary.
  3. A full medical discharge summary to the GP will follow ideally within 10 working days; this will be completed by the Ward Doctor or the Consultant Psychiatrist using the standard Trust Medical Discharge Summary template from the Digital Care Record.
  4. An up to date list of medications should be included within these documents. This list should be a scanned copy of the clinically screened discharge prescription to ensure accuracy. It should not be typed in.
  5. All patients will have a face to face contact within 48 hours of leaving hospital, no matter which ward they have been on. This contact must be recorded on Digital care record and any concerns raised directly with the Care/Recovery Coordinator. The Care/Recovery Coordinator, ward and CRHTT will agree who will undertake the review prior to the patient being discharged. [See the 48 hour follow up protocol on the intranet](http://daisy.dpt.nhs.uk/media/1570608/c40_48_hour_protocol_jul19.docx)

# COVID-19 Testing requirements prior to discharge

* 1. **Discharge to a single occupancy room in care facility, including nursing homes and residential homes**
     1. Patients who have NOT been diagnosed with COVID-19 require a negative swab, taken within the preceding 24 hours, prior to discharge to a nursing or residential home, or other long term care facility
     2. Contacts of COVID-19 can be discharged to care facilities but require a negative swab as above and should complete a 14 day isolation from the last known contact
     3. If a swab is positive then the patient cannot be routinely discharged to a care facility for a further 10 days.
     4. Some care providers will be able to accommodate individuals with a confirmed COVID-19 positive status, through effective isolation strategies or cohorting policies. If appropriate isolation or cohorted care is not available with a local care provider, the Local Authority may provide alternative appropriate accommodation and care for the remainder of the required isolation period, utilising NHS community and primary care assistance as needed.
     5. The timing of discharge can be modified in palliative situations with agreement from the facility receiving the patient
     6. Care facilities should manage discharged patients in single rooms with isolation and personal protective equipment (gloves, apron, fluid-resistant surgical mask, +/- eye protection if risk of splashing) for the duration of any ongoing isolation period.
  2. **Discharge to any facility with shared living space where there is commissioned care e.g. multiple occupancy housing with support.**
     1. Patients who have NOT been diagnosed with COVID-19 will be tested, taken within the preceding 24 hours, prior to discharge

* + 1. Contacts of COVID-19 can be discharged but require a negative swab as above and should complete a 14 day isolation from the last known contact
    2. If a swab is positive then a discussion should occur between the providers, Infection Control and Social Care commissioners to determine whether the discharge can continue with infection prevention and control measures.
  1. **Discharge of patients to another ward or hospital, COVID-19 positive or suspected**
     1. Patients who have been diagnosed with COVID-19 should not be transferred to a non-COVID-19 ward until the isolation period has been observed.
     2. In exceptional circumstances a negative repeat test may be used to allow transfer to a non-COVID ward within the isolation period. This requires senior discussion with the Infection Control Team.
     3. Patients with ongoing requirement for AGPs should be discussed on an individual case basis with the Infection Control Team prior to transfer.
     4. Patients can only be transferred to another hospital following discussion with the receiving centre or for emergency transfer via SWAST. In this case the COVID-19 status must be given to the ambulance service and the receiving area.
  2. **Discharge of contacts of COVID-19**
     1. Patients identified as contacts should observe a 14 day isolation period in all settings.
     2. Contacts are still able to be discharged home without testing, but should complete a 14 day isolation in line with ‘stay at home’ guidance.
     3. Contacts require a negative swab taken in the preceding 24 hours prior to transfer to a care facility such as nursing or residential home, in line with the discharge guidance of all patients to such facilities.
  3. **How to transfer patients home**
     1. The need for isolation of discharged patients with COVID-19 should be communicated with any transport staff (e.g. ambulance crews, taxi drivers, relatives). Regardless of route of transport:
* patients should wear surgical face masks for the duration of the journey if still infectious
* patients should sit in the back of the vehicle with as much distance from the driver as possible
* vehicle windows should be (at least partially) open to facilitate a continuous flow of air
* any rubbish (tissues, etc) should be taken by the patient out of the vehicle via a waste bag and disposed of in the patient’s house
* vehicles should be cleaned appropriately at the end of the journey, according to local protocols

# Follow-up support on Discharge:

* 1. Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:
* contact details, for example of:
* a community psychiatric nurse or social worker
* the out-of-hours service
* support and plans for the first week
* practical help if needed
* Employment support.
  1. Consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.
  2. At discharge, the hospital psychiatrist should ensure that:
* Within 24 hours, a [discharge letter](https://www.nice.org.uk/guidance/ng53/chapter/terms-used-in-this-guideline#discharge-letter) is emailed to the person's GP. A copy should be given to the person and, if appropriate, the community team and other specialist services.
* Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care (see recommendation 1.5.20).
* Within a week, a [discharge summary](https://www.nice.org.uk/guidance/ng53/chapter/terms-used-in-this-guideline#discharge-summary) is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should include information about why the person was admitted and how their condition has changed during the hospital stay.
  1. If the person has a learning disability, dementia or is on the autistic spectrum, the hospital team should lead communication about discharge planning with the other services that support the person in the community. This could include:
* older people's services
* learning disability services
* the home care service.
  1. If a person is being discharged to a care home, hospital and care home practitioners should exchange information about the person. An example might be a hospital practitioner accompanying a person with cognitive impairment when they return to the care home to help their transition (see also [sharing information about a resident's medicines](https://www.nice.org.uk/guidance/SC1/chapter/1-Recommendations#sharing-information-about-a-residents-medicines) in NICE's guideline on managing medicines in care homes).
  2. In collaboration with the person, identify any risk of suicide and incorporate into care planning.
  3. Follow up a person with a face to face meeting within 48 hours of discharge, no matter from which ward they have been discharged. Where patients are going home alone or to family, 48hr follow up should normally be carried out face to face. Where patients are being discharged to a care setting such as a care home, then there should be an individual risk assessment that balances the potential risk of harm to the individual if the 48 hour follow-up is delivered remotely, with the potential increased risk of COVID transmission both to the patient and the staff member.
  4. Consider contacting adults admitted for self-harm, who are not receiving treatment in the community after discharge, and providing advice on services in the community that may be able to offer support or reassurance **if they want, how to get in touch with them.**

# Prescribing for Discharge and Leave

* 1. A discharge or leave prescription will be completed by the prescriber and dispensed by the Trust Supply Pharmacy. Every attempt must be made to pre-empt the requirement for discharge prescriptions but when discharge hasn’t been predicted, and it is outside of pharmacy opening hours, or is at short notice, discharge prescriptions may be provided via alternative routes.

|  |
| --- |
| SOP [MM33 FP10 Prescriptions in Inpatient Units](https://daisy.dpt.nhs.uk/media/1569700/mm33-fp10soninpatientunits.pdf)  SOP [MM37 Prescribing and Supply of Medication for Periods of Leave](https://daisy.dpt.nhs.uk/media/1569849/mm37-medicationforleave.doc)  SOP [MM10 Exceptional Dispensing from Ward Stock](http://daisy.dpt.nhs.uk/media/1566943/mm10-exceptionaldispensing.doc)  Remote Prescribing https://daisy.dpt.nhs.uk/covid-19/medicines-optimisation/remote-prescribing-resources.aspx |

* 1. The quantity of medicine prescribed should take into consideration the risk of suicide, likelihood of non-adherence and waste, ability of person to get further supplies from GP, future appointments and any locally negotiated agreements with GPs. Where the individual is assessed as at high risk of suicide or self-harm the quantity of medicine supplied on discharge will not generally exceed a 14 day supply particularly for opiates and psychotropic drugs.
  2. Drug charts should be uploaded to CareNotes on the day of discharge from an in-patient unit as community teams rely upon the prompt availability of this information to support their safe practice with medicines e.g. CRHTS facilitating urgent discharge.
  3. Particular care must be taken with:
* Depots to ensure clarity regarding date of next injection, source of prescription and person who will be administering the medication
* Clozapine to ensure transfer of responsibility to community prescriber on CPMS and clear arrangements for supply and blood tests

|  |
| --- |
| SOP [MM43 Prescribing and supply of Clozapine to community patients](https://daisy.dpt.nhs.uk/media/1468761/mm43-prescribingclozapine.docx)  https://daisy.dpt.nhs.uk/media/1572104/cv001-covid-19-clozapine-v20.doc |

* + 1. The following SOPs detail the procedure for ordering medication on discharge or for periods of leave.

|  |
| --- |
| [MM37 Medication for Leave](https://daisy.dpt.nhs.uk/media/1569849/mm37-medicationforleave.doc)  [MM48 Prescribing, Ordering and Supplying Medication on Discharge from an Inpatient Unit](https://daisy.dpt.nhs.uk/media/1468631/mm48-prescribing-ordering-and-supplying-medication-on-discharge-from-an-inpatient-unit.doc)  https://daisy.dpt.nhs.uk/covid-19/medicines-optimisation.aspx |

# Patients taking leave or Discharge from an Out of Area Placement

* + 1. The same standards apply as if the person were on a Trust ward. I.e. The expectation is that any provider (in or out of area) shall provide the individual with an appropriate supply of current medication. A discharge or leave prescription, which has been issued by the providers prescriber and/ or dispensed by their Supplying Pharmacy. Every attempt must be made to pre-empt the requirement for discharge prescriptions, but when discharge hasn’t been predicted, and it is outside of pharmacy opening hours, or is at short notice, discharge prescriptions may be provided via alternative routes. Medication should be dispensed in original packaging and contain sufficient medication for two weeks post discharge [unless a risk assessment deems otherwise]. The out of area provider must ensure the person is fully aware of what medications they are receiving when to take them, side effects, how and when to request further medication etc prior to the leave or discharge. This information must also be clearly included in all handover and transfer communications between provider clinical teams.

# Patients who wish to take their own discharge (DAMA)

* 1. The safety of patients in our care is of the upmost importance to the Trust. We wish to support both the patient and the staff members involved when a patient expresses a wish to self-discharge from hospital against medical advice.
  2. In this event the involved staff should ask the patient the reasons why they want to self-discharge against medical advice and will ensure all relevant information is made available to assist the patient in this decision making process. The checklist in appendix 3 will support staff to ensure all appropriate steps have been taken in the process.
  3. **Consideration regarding mental capacity to make the decision**
     1. The [Mental Capacity Act Policy guidelines on best interest decisions making and the Deprivation of Liberty Safeguards](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/mental-capacity-act) requires us to take the default position of assumption of capacity. The person wishing to take their self-discharge therefore must not to be treated as unable to make that decision unless all practicable steps to help them to do so have been taken without success.
     2. When a patient expresses a wish to self-discharge it must be taken into account that they can make unwise decisions and a lack of capacity must never be assumed. If the patient wishing to self-discharge is giving cause for concern regarding their mental capacity and there is a belief that they may lack capacity with regard to their decision to self-discharge a robust mental capacity act assessment must be completed alongside other relevant risk assessments on their Digital Care record.
  4. **The patient assessed as lacking mental capacity to self-discharge**
     1. Detaining a patient against their will is a significant act that must be justified. Whilst so doing the registered nurse in charge must ensure that any best interest decision is proportionate to the risks that would otherwise occur and are in keeping with the [Mental Capacity Act Policy guidelines on best interest decisions making and the Deprivation of Liberty Safeguards.](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/mental-capacity-act)
     2. If the patient is assessed as lacking capacity to make the decision to self-discharge and it is within their best interests to remain in hospital or if they are detained under the Mental Health Act the registered nurse in charge, utilising the relevant policies and procedures must take on any further responsibility for initiating subsequent actions to ensure the patient remains as an in-patient under our care. This may include a mental state examination to consider whether they meet the threshold for detention under Section 5(2) and 5(4) of the Mental Health Act 1993 see [Holding Powers under Section 5 (2) and 5 (4)](https://www.dpt.nhs.uk/resources/policies-and-procedures/mental-health/holding-powers-under-section-52-54)
     3. During these assessments attention should be paid to the person’s mental state over the past 24/48 hours rather than just in the moment and views of family and friends should be sought where possible [including previously expressed and documented views]
  5. **The patient assessed as having mental capacity to self-discharge**
     1. If the patient has been assessed as *having capacity to decide to take their discharge from hospital against medical advice* and is not detainable under the Mental Health Act or Mental Health Act, they have the right to make what others may see as an unwise decision, and if they choose to self-discharge their decision, although against medical advice, must be accepted and the procedure as outlined below followed:
* A doctor and/or the registered nurse must talk to the patient and reinforce the reasons for, and the benefits of, the patient remaining in hospital.
* If the patient still wishes to self-discharge, it may be appropriate to involve friends or family, who may help to dissuade the patient against this course of action. (This can only be done with consent of the patient)
* Prescribed discharge medications are to be supplied.
* Next of Kin or relatives are to be informed, if the patient has given his/her consent.
* Transport is to be arranged for the patient as per the [C48 Patient Transport Policy](https://www.dpt.nhs.uk/resources/policies-and-procedures/clinical/patient-transport-policy)
* The patient’s GP is to be informed by telephone, as well as via the usual discharge summary.
* As a best practice standard the patient must be requested to complete the self-discharge release from responsibility for discharge form appendix 4 which must then be scanned into the patient’s digital care record.
* If the patient refuses to sign the self - discharge release from responsibility for discharge form or has left the hospital before they can be asked to do so this information must be documented in the patient’s digital care record
* All details of the incident must be documented in the patient’s digital record and reported on RMS, the Trust’s incident reporting system by a Registered Nurse.
* Consideration should be given to raising a safeguarding concern where staff are concerned the patient is at risk of self-neglect or coercion, this should be added t6o the RMS, by ticking the safeguarding box and completing the section as required.

# Reluctant Discharges

* 1. An individual does not have the right to occupy a hospital bed where the sole reason for doing so is because the individual’s preferred choice is not available.
  2. During the COVID19 pandemic the timelines on the reluctant discharge policy will be changed.
  3. During the COVID-19 pandemic, patients will not be able to wait in hospital until their first choice of care home or support provider has a vacancy. This will mean a short spell in an alternative care home and the care coordinators will follow up to ensure patients are able to move as soon as possible to their long term care home.
  4. The MDT team will identify potential reluctant discharges and discuss these with the Senior Manager. Delayed transfers of care protocols will be followed and reluctant discharge letters will be implemented when appropriate. See Appendix 5 for example letters.

|  |
| --- |
| **At a Glance**  **Best Practice - Reluctant Discharge process**  There may be times a person or a person’s family/carers do not agree with discharge plans. At all times staff on the ward must work with patients and family to encourage a positive discharge however on occasion when it is evident no more discussion will move the discharge forward the Reluctant Discharge process can be implemented.  This process needs to be led by the Consultant Psychiatrist and/or the Senior Manager with support from the Ward Manager and the Named Community Practitioner  The process requires the following:   * An MDT discharge planning meeting that ensure family and person using services is invited, with patient consent * The person, family and carers are given the opportunity to agree and work with the team to find a solution for a good discharge using the best practice guidance outlined in this policy * Clear discharge plans are in place, any funding requirements resolved and all reports, care planning, risk assessments completed and up to date * The discharge date set * Once this work is completed and it is clear the person or family refuse to accept the final decision the letters can be enacted to support discharge [appendix 5] |

# Monitoring

* 1. Ward managers will use the process of supervision and audit to ensure that high levels of care and safe practice are maintained during Admissions, Transfer and Discharge.

# References

* 1. Refer to the relevant MHA policy and procedures, or to the Mental Health Legislation Manager/Locality Mental Health Act Administrator for guidance on the following:
* Scheme of Delegation under the MHA
* Receipt and Scrutiny of Detention Papers Policy
* Section 132/132a Reading of Rights Policy
* Working with Independent Mental Health Advocates (IMHA) Policy
* Section 26 The role of the Nearest Relative Policy
* Section 5(2)/5(4) Doctor/Nurse Holding Powers
* Section 58 Consent to Treatment Policy
* Mental Health Act Hearings Policy
* First Tier Mental Health Tribunal Hearings Policy
* Detained patients in Acute Hospital Policy
* Section 117 aftercare
* Supervised Community Treatment (Section 17A-G)
* Guardianship (Sections 7 and 37)
* Mental Capacity Act Multi Agency Policy
* Deprivation Of Liberty Safeguards (DoLS) Policy and Procedures

[Care Quality Commission Briefing re Supreme Court Ruling Cheshire West](http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf)

[NHS England, 5th October 2015, Monthly Delayed Transfer of Care Situation Reports- Definitions and Guidance](https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf)

[Transition between inpatient mental health settings and community or care home settings:](https://www.nice.org.uk/guidance/NG)

[NICE guideline full version (August 2016)](https://www.nice.org.uk/guidance/NG)

**Appendix 1 – Letter to Nearest Relative. An accessible letter is available on request**



|  |  |
| --- | --- |
| Name  Address 1  Address 2  Town  County  Postcode | Our Ref:  Your Ref:  Date |

Dear <Name of nearest relative >

**Re: {patient name} on {ward name}**

I am writing to ask you to please complete the attached form (which should be returned to the ward asap) to nominate a Primary (first) Point of Contact Person who staff from {ward name} can access to discuss or pass on information regarding {name of patient}. It would then be the responsibility of the Primary Point of Contact Person to share information with family members, friends, etc. You may also nominate an alternative Point of Contact Person who we can contact in the absence of the Primary Contact.

This information is requested in order to minimise any risk of information being shared with someone who should not be given information (i.e. sensitive details) and also to ensure accuracy in information being disseminated. It also ensures clarity with the nursing staff as they do not have to try to ascertain whether or not we can speak to someone phoning for information, etc., however can direct them to speak to a nominated person.

**If you have any questions or complaints**

If you want to ask something in relation to the patient’s care, you should direct your concerns to the RC or the ‘nurse in charge’ on the ward. If you are not happy with the response or wish to make a complaint you may write to the hospital managers. Their address is:

The Hospital Managers

Wonford House Hospital

Dryden Road

Exeter

EX2 5AF

Alternatively you can contact the DPT PALS (Patient Advice and Liaison Service) team at:

Wonford House Hospital

Dryden Road

Exeter

EX2 5AF

Their telephone number is: 01392 675686

The e-mail address is: [dpn-tr.pals@nhs.net](mailto:dpn-tr.pals@nhs.net)

If you require any further advice or guidance, please contact the Ward at the address at top of letter or on any of the telephone numbers where a member of the team would be happy to answer your questions.

Yours faithfully,

**NAME**

**Job Title**

****

**PRIMARY CONTACT PERSON FORM**

|  |
| --- |
| Name of Patient: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Primary Contact Person (POC) |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Title of POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address of POC |
|  |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone Number of POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fax Number of POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email address of POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of Alternate POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Title of Alternate POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address of Alt. POC |
|  |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone No. of Alt. POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fax No. of Alt. POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email of Alt. POC |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



# Appendix 2 – Practice standards & principles at interface points between FRS, Liaison Psychiatry, HTT, AMHPs and Bed Capacity

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| Think MHM 24/7 and The Moorings first.  FRS 24/7 easy access crisis point of contact as an alternative to attending an ED for a mental health crisis (no physical health concerns) undertaking an initial triage using DPT’s Triage Scale.  First Responder Role provides a 4 hour face to face assessment response where capacity allows in all areas excluding North Devon currently. | The role of the HTTs is managed overnight by the Night Nurse Practitioner (NNP) in all localities | The role of LP is covered by the NNP where a 24/7 LP service is not in place | The AMHPs are available via DCC and Torbay’s assigned AMHP service within office hours and via the two Emergency Duty Services (EDS) outside these hours | Bed Capacity are available  08:00 -20:00 Mon – Fri  09:00 – 17:00 W/ends and BH’s  Now 08:00 – 20:00  7 days a week |
| Patients should not be told they can contact HTT unless the individual is currently accessing HTT input.  All new cases that require HTT involvement should be referred in the normal way. Please ensure purpose of involvement is clear – remember goal based care  HTT should not be used for follow up telephone contact for patients unless it is clinically indicated that they require formal HTT input.  A patient’s Nearest Relative (NR) has the right to have a request for MHA assessment considered by an AMHP. Before FRS / HTT and LP colleagues advise an individual’s Nearest Relative (NR) of that right, particularly when they themselves are declining a service, they should first contact the AMHP service themselves to establish the appropriateness of such a referral, what lawful alternatives might exist, and advise the NR accordingly. | | | | |
| **Step up in Care: Home-treatment** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| The FRS after a clinical triage will establish the outcome required in accordance with DPT’s Triage scale (A – G).  Where a face to face review / assessment is clinically indicated people meeting code B (4 hour response) and above, the person will be reviewed / assessed by either the FRS or the HTT where capacity allows. ..  If a person is open to a DPT CMHT and clinical records are in date, a full bio psychosocial assessment is not required. An SBAR within clinical records is sufficient.  If the FRS have undertaken the review / assessment and home treatment is indicated the FRS will contact the relevant HTT or NNP; handing over the case.  There may be occasions whereby a joint review / assessment is indicated with the FRS and HTT. | Where home-treatment is indicated, HTT will agree with the individual direct or via the referrer when the first contact will occur.  (HTT accept the referral ensuring that the person has their needs met, where there are reflections that an alternative plan may have been more appropriate then this should be discussed between team managers) | When LP identify that a person requires an intensive level of support (Home Treatment/ Admission) they refer to the relevant HTT to discuss the person’s needs. The HTT will reach a decision about the level of intervention based verbal handover and clinical record.  In circumstances where a consensus can’t be achieved; the HTT may wish to complete a face to face review to establish if presenting needs can be appropriately supported by Home Treatment Intervention.  LP will update DGH of outcome / plan | AMHP service will ensure local HTT aware of request for MHA assessment to discuss potential home treatment capacity to support the individual (where HTT are not the referrer).  Before an offer of home treatment is made to the patient during the MHA assessment process, the AMHP must first establish with HTT that they are able to facilitate the proposed plan. | Bed capacity do not have a role at this point |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Access to Psychiatric Acute Care and the Gatekeeping Role /  Mental Health Act Assessment (MHAA)** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| When FRS\* considers that a person requires a Mental Health Act Assessment; the care needs should be considered with HTT in the first instance.  Principles outlined in SOPS regarding Capacity & Consent should be considered and decisions recorded in the care record.  \*Where contact has been via tele-coaching and not face: face assessment; FRS / HTT should consider options and include AMHP colleagues were applicable | HTT are the ‘gatekeepers’ to psychiatric acute care, this includes home treatment and admission  Principles outlined in SOPS regarding Capacity & Consent should be considered and decisions recorded in the care record.  Consideration of the suitability & capacity for HTT to be part of the MHAA or how outcomes of the assessment will be shared / consider jointly. | When LP considers that a person requires a Mental Health Act Assessment; the care needs should be considered with HTT in the first instance.  Principles outlined in SOPS regarding Capacity & Consent should be considered and decisions recorded in the care record. | In considering request for a MHA assessment, when concluding that one should proceed the AMHP must discuss the case with the HTT shift co-ordinator to consider what role the HTT might have in reducing the need for admission.  Consideration of the suitability & capacity for HTT to be part of the MHAA or how outcomes of the assessment will be shared / considered jointly. | Bed capacity will locate a bed only if there is no local bed available.  They are not gatekeepers to the beds.  n.b. during Covid incident bed capacity should be approached re every admission |
| Where the discussion between FRS and HTT results in a view that MHAA is the most appropriate way to proceed; FRS will contact the AMHP service to consider clinical information and request the MHAA. | Following an AMHP’s consideration of the case, HTT will be contacted to establish their potential involvement or role in bed finding. | Where the discussion between LP and HTT results in a view that MHAA is the most appropriate way to proceed; LP will contact the AMHP service to consider clinical information and request the MHAA. | AMHPs will inform HTT when a MHA assessment is considered appropriate in order to consider home treatment options and to ensure their involvement for bed finding purposes. | Bed Capacity should be kept updated for potential admissions by HTT.  They have overall knowledge of who is awaiting admission within DPT and this is shared within the daily conference calls and on-call bed state report. |
| **Inpatient Care** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (CRHTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| Where admission to a psychiatric bed is agreed then HTT will manage the patient in the situation that a bed cannot be identified, handover of care will be agreed by discussion. | If inpatient care is indicated, HTT will ensure by discussion with LP / FRS that capacity to consent to voluntary admission has been assessed and documented.  Where this is the outcome of an MHA assessment, the first assessing doctor should record this in Care Notes. | At the point that a decision to admit to a psychiatric bed has been made LP remain responsible for reviewing the clinical care of the person and supporting the DGH staff until they are discharged from the DGH. | If the admission awaited is a formal admission under the MHA, doctors making the recommendations & the AMHP will ensure an interim management plan is in place and documented. This may require input from HTT if the situation allows. | Bed Capacity should be alerted at the earliest opportunity by the assessing team re the potential need for a bed. |
| **Bed Locating and Communication** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| For a community based patient, an agreement should be reached as to who will remain the point of contact for the person / family whilst bed finding commences. | For a community based patient, an agreement should be reached as to who will remain the point of contact for the person / family whilst bed finding commences.  HTT should commence bed locating by looking at local stock and if not available, handing over to Bed Capacity to source an alternative,  as per agreed protocol  HTT will agree with Bed Capacity which team will maintain contact with LP/AMHP/FRS.  The agreed team will ensure clear communication is maintained and updates are documented on the electronic record case notes. | LP will be the primary point of contact for the DGH and the patient, whilst the patient remains in the DGH.  The relevant team will update LP once a bed has been located  LP liaise with agreed team (HTT/Bed capacity) to receive timely updates on progress and update the DGH as per the 12 hour breach SOP – a record will be kept on the 12 Hr Breach Reporting Form. | If requiring detention under MHA, the AMHP can only make the formal application once a bed is located.  The relevant team will update AMHP once a bed has been located. | Bed capacity will contact HTTs to determine local bed availability on a daily basis.  Bed capacity will inform HTT’s of where bed availability is within DPT.  If there are no DPT beds, Bed Capacity will take over the search for an out of area bed. Once the bed is identified Bed Capacity will inform the HTT/LP/FRS.  The assessing clinical team will make the clinical referral.  HTT will agree with Bed Capacity which team will maintain contact with LP/AMHP/FRS.  The agreed team will ensure clear communication is maintained and updates are documented on Care Notes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **HTT patient attends Emergency Department** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| No role in the situation | Actively engaged with HTT; Review by HTT if possible or LP if HTT cannot meet timely review and discharge from the DGH is delayed  Joint reviews should be considered | If actively engaged with HTT; review by HTT where possible; where timescale for timely review cannot be met by HTT; LP will assess  Joint assessment should be considered | No role for AMHPs, but available for advice. | No role for Bed Capacity |
| **Non-Devon Presentations to the DGH / AMHPs** | | | | |
| **Access & First Response (FRS)** | **Home Treatment Teams (HTT)** | **Liaison Psychiatry (LP)** | **Approved Mental Health Professionals (AMHPs)** | **Bed Capacity** |
| No role in the situation | No role in the situation | When LP assess an individual with a GP outside of the DPT locality, the team should address their discussion about onward acute care with the person’s local team.  If an admission is indicated, LP will inform Bed Capacity who will undertake the bed search in relevant locality. | If detention under the MHA is required AMHP will liaise with Bed Capacity who will undertake the bed search on the relevant locality. | Bed Capacity will liaise with the out of area bed capacity teams to request they identify a bed |
| Clinical handovers to the expecting ward will be undertaken by the assessing clinician / team | | | | |



**Appendix 3 – Self-Discharge of a Patient: Checklist**

**Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ward:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Capacity assessment to be completed if patient requests self-discharge from hospital against medical advice** | **Yes/ No** |
| Can the patient understand the information relevant to the decision? |  |
| Can the patient retain that information? |  |
| Can the patient use or weigh that information as part of the process of making the decision? |  |
| Can the patient communicate his/her decision? |  |
| **If YES to all 4 criteria above the patient has capacity** | |
| **If NO to ANY of the 4 criteria above the patient lacks capacity & must be prevented from leaving the hospital as per BOX 3** | |

|  |  |
| --- | --- |
| **To be completed when the patient has been assessed as having capacity to decide to self-discharge against medical advice** | **Tick** |
| Explanation of the necessary treatment required and the consequence of the patient refusing the treatment have been given and are understood |  |
| Other options which may be acceptable to both the clinicians and the patient have been explored with the patient |  |
| Where the consequences of refusing treatment are serious or life threatening discussion and assistance has been sought from the Consultant and other relevant professionals such as the Psychiatric Liaison Service |  |
| The **self-discharge release from responsibility for discharge form** is completed by the patient whenever possible and retained in their digital care record |  |
| Refer to safeguarding adults team if the adult is at risk. |  |

|  |  |
| --- | --- |
| **To be completed when the patient has been assessed as lacking capacity to decide to self-discharge against medical advice** | **Tick** |
| Staff involved prevent the patient from leaving the ward |  |
| Staff utilise persuasion, calming and de-escalation techniques |  |
| Referral to the Psychiatric Liaison team is considered as appropriate |  |
| Referral to the IMCA Service and DoLS is considered as appropriate |  |
| If the patient has left the ward staff utilise the Missing Persons Policy |  |
| Refer to safeguarding adults team |  |

**\* All relevant sections of this form must be completed and retained in the patient’s Digital Care Records.**



**Appendix 4 – Self-discharge release from responsibility for discharge**

To be completed with the patient whenever possible prior to the patient taking his/her

self-discharge from this hospital

**Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ward:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, the undersigned hereby declare that I am discharging myself from this hospital and that I understand the consequences of failing to follow the medical advice given to me which might result in significant disability or even death.

I understand I can change my mind at anytime and seek support for treatment via the Crisis Resolution Home Treatment Team.

Patient signature: …………………………………………………………..

Witness: ……………………………………………………………………..

Designation of witness: …………………………………………………….

Date: …./…./….

**\* This form when completed must be retained in the patient’s Digital Care Record and an RMS of the SELF-DISCHARGE event completed in every case by the relevant involved multi-disciplinary team member.**

**Appendix 5 – Reluctant Discharge: Letters to enact discharge**

**Please see chapter 12 before enacting**

**Letter One – For all people admitted to a ward who refuse to accept discharge plans to a new care setting. This is an example letter that could be amended to meet patient or family situation. An accessible version is available on request.**



|  |  |
| --- | --- |
| Name  Address 1  Address 2  Town  County  Postcode | Our Ref:  Your Ref:  Date **DAY DECISION IS MADE THAT SHOULD BE DISCHARGED** |

Dear <Name>

Following on from discussions with the team you have been assessed as being ready for discharge from hospital. It is now necessary to ask you to accept those discharge plans so you can start on the next stage in your care.

We know this might be an anxious time for you and are sorry that we have to ask you to do this, but it is important that you are able to leave hospital as soon as you are ready. The UK Government has made it clear that where safe, patients should be discharged to appropriate accommodation to enable further assessments to occur outside of hospital. It also enables the hospital to provide treatment for new patients that need hospital care and ensures you don’t remain in hospital longer than is needed.

We appreciate that this may be a difficult time for you, and your family, as the home of your choice/care package may not be available for you immediately. We will therefore arrange for you to be placed in alternative accommodation whilst you wait for a vacancy/care package or other assessments to become available.

You and your family will be supported throughout this time to ensure that the transfer is made as smoothly as possible. Please be assured that placement in alternative accommodation will hopefully be short-term and that when a vacancy does arise, arrangements will be made for you to transfer. We may also be able to help with the associated transport costs.

Throughout this period, the ward manager and (if needed) a named health or social care professional will be available to help you and answer any of your questions.

Yours sincerely

**NAME**

**Job Title**

**Letter Two – For all people admitted to a ward that refuses to accept discharge plans home. This an example letter that could be amended to meet patient or family situation. An accessible version is available on request. THIS LETTER WILL NOT BE USED DURING THE COVID PANDEMIC**



|  |  |
| --- | --- |
| Name  Address 1  Address 2  Town  County  Postcode | Our Ref:  Your Ref:  Date |

Dear <Name>

Following on from discussions with the team you have been assessed as being ready or discharge from hospital. It is now necessary to ask you to accept those discharge plans so you can start on the next stage in your care.

We know this might be an anxious time for you and are sorry that we have to ask you to do this, but it is important that you are able to leave hospital as soon as you are ready. It enables the hospital to provide treatment for new patients that need hospital care and ensures you don’t remain in hospital longer than is needed.

We appreciate that this may be a difficult time for you, and your family, and that things at home might still be difficult. We will do our best to support you home and throughout this time ensure that the move is made as smoothly as possible.

Throughout this period, the ward manager and (if needed) a named health or social care professional will be available to help you and answer any of your questions.

Yours sincerely

**NAME**

**Job Title**

**Letter TWO (previously letter Three) – For patients and/or carers 7 DAYS (during the COVID Pandemic 4 days after Letter 1). This is a letter for a patient, family or carers who are wanting to access a specific accommodation such as a specific nursing home or residential care home. This is an example letter that could be amended to meet patient or family situation. An accessible version is available on request.**



|  |  |
| --- | --- |
| Name  Address 1  Address 2  Town  County  Postcode | Our Ref  Your Ref:  Date |

**YOUR DISCHARGE FROM HOSPITAL**

Following on from our letter dated *(insert date)* we are pleased that you are now well enough to leave hospital and need to inform you that we will be discharging you on:

We understand that up to now, you have been unable to secure a place in the home or care setting of your choice or receive confirmation that you will be receiving social care supportive package. It may be that your home choice does not have a vacancy at this time or you want to consider alternative arrangements (this may require you or your family meeting the financial costs). We do not wish to cause you or your family undue anxiety or distress, but you will be aware that there are many people needing hospital care and we need to be able to offer treatment to others requiring care at the earliest opportunity.

We would like to complete your move out of hospital as smoothly as possible. This first move may be temporary and is there to support you to leave hospital quickly and safely. It may involve further disruption and distress if you have to be moved again but we will work with you to ensure that you have appropriate support.

All members of the multi-disciplinary team will assist you with the move, we will try to ensure you are placed in a home that is as near to where you want to live as possible and answer any questions about your care. Alternatively, if you, or someone representing you, would like to discuss this decision with a Senior Trust Manager, please do not hesitate to contact me at the above number.

Following your discharge you will continue to be supported by the community care team for an agreed period of time.

I would like to take this opportunity to offer you my best wishes for the future and to thank you for your co-operation. I hope that you will be happy in your new home.

Yours Sincerely,

**Name**

**Job Title**

# Appendix 6 – Devon Delayed Transfer of Care (DTOC) guidance

This abbreviated guidance relates to those patients in Acute and Community hospitals, including those with mental health issues. For full guidance please refer to: NHS England, 5th October 2015, Monthly Delayed Transfer of Care Situation Reports - Definitions and Guidance

1. **What is a DTOC**

**The national guidance is that a DTOC is only reportable when:**

* A clinical decision has been made that the patient is ready to transfer **AND**
* A multi-disciplinary team decision has been made that the patient is ready to transfer **AND**
* The patient is safe to discharge/transfer

An MTD in this context should be made up of people from different professions, including social workers where appropriate, with the skills and expertise to address the patient’s on-going health and social care needs. If there is any concern that a delay has been caused by the actions or inactions of a Local Authority (LA), they should be represented in the MDT. The way that the team is organised and functions is fundamental to timely discharge and to the patient’s wellbeing.

1. **What is not a DTOC**

It is important to remember, that medically optimised is not the same as a delayed transfer of care. The determination that a patient is medically optimised is from a medical perspective. The patient has not received a MDT decision at this point and, indeed, may need further therapy or social care in-put prior to a MDT decision being made, this means it is not a reportable delay.

For example, when a patient is referred for social care assessment as part of a complex hospital discharge, the MDT decision is yet to be made that a patient is ready for transfer and it is therefore not as yet safe for this transfer to progress. It is therefore imperative that this patient is not automatically reported as a DTOC, because the 3 national criteria, as set out above, for DTOC reporting have not been fulfilled.

1. **Assessment & Discharge notice**

The NHS should seek to give The LA as much notice as possible of a patient’s discharge, so a timely needs assessment can be completed and support set up to meet any eligible needs.

The assessment notice must be issued with a minimum 2 days’ (48 hours) notice.

The discharge notice must be issued at least the day before discharge (24 hours)

Either notice given after 2pm on any day is treated as being given on the following day

The NHS should issue an assessment notice no more than seven days before proposed discharge date from hospital but no less than 72 hours.

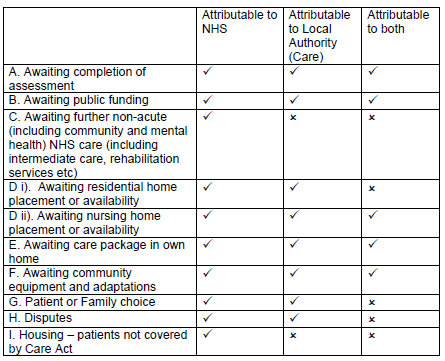
1. **Attributing the DTOC**

The patient delay needs to be attributed to The NHS, LA or both

|  |  |
| --- | --- |
| **Attributable to NHS** | E.g. NHS funded 28 day funded nursing home placement or a short term care offer |
| **Attributable to care and support by LA** | E.g. social care funded placement or package of care |
| **Attributable to both** | This is rare and primarily if a patient receives shared funding eg Section 117 after care |

1. **DTOC Codes**

The patient delay also needs to be coded against one of the criteria below. This table also gives examples of LA/NHS/both attributable delay possibilities



1. **The DTOC clock**

The ‘DTOC clock’, ie time after the assessment notice, does not start until there is a clear MDT decision, including Social Care, as required, that a safe transfer/discharge decision has been made. As per section 1.

If a Mental Capacity Act Assessment or Best Interest Decision is required these are a precursor to the formal MDT decision referred to in DTOC guidance. During this time DTOC is not reportable until the outcome of these processes are complete and lawful decision made regarding transfer.

1. **Operational guidance**

**MDT Decision making**

The MDT should be made up of relevant professionals with skills and expertise to support the patient to leave hospital safely. The MDT decision that a patient is ready for transfer should be made as soon as possible in the patient’s hospital stay and preferably to coincide with when the patient is medically optimised.

The decision should be based on relevant information and assessment outcomes such as; Mental Capacity Assessment regarding transfer decision, Best Interest Decision & minimal therapeutic assessment.

There are no definitive timeframes for this process, but ideally all assessments should be completed prior to the patient being medically optimised, so that transfer can take place on the day the patient is medically optimised - assuming the transfer is deemed safe.

In considering the safety of a transfer decision, it is important to consider:

Where the patient is transferring to and with what anticipated support- as this is the setting that a safe decision relates to.

**Self- funding delays –** Delays relating to individuals who are self-funding their onward care are categorised are attributed to health. There is no definitive guidance about timeframes when this delay becomes reportable. The recommended approach is that the individual/family is given a reasonable time to consider the best transfer options and source provision. This will be case specific and needs to relate to the relevant transfer setting, to enable a safe transfer. This potentially will be an area where there is variation between MDTs and some inconsistency in DTOC reporting.

**Reason for a delay –** In many cases the reason for a patient delay is clear and the relevant criteria can easily be identified and reported. However, in some cases there may be a number of reasons for a delay in transfer and then it is the decision of the MDT as to which is the most predominant/important reason that the person cannot leave hospital.

It also needs to be recognised that during any transfer it is possible there will be different causes of delay at different times, in which case the criteria allocated needs to be agreed by the MDT and changed, dependent on the most predominant reason on the specific day of reporting.

**Responsible Local Authority –** When identifying that a delay is the responsibility of The Local Authority, it is important to be clear which Local Authority is responsible for the delay. The vast majority of DPT cases will be the responsibility of Devon County Council or Torbay Council , because most transfers are for people who have ordinary residence in Devon or Torbay. However, this is not the case for every person, so the social care professional needs to ensure ordinary residence is clarified for each person where a delay is identified.

Devon County Council is informed by other Local Authorities of delays in other hospitals in England relating to patients with ordinary residence in Devon. This information is sent to The Head of Service who sends this to respective ADs for verification.

When a person in hospital has no fixed abode or is an asylum seeker or an overseas visitor, the responsible Local Authority is that in which the admission took place.

**Sign Off -** The DASS is accountable for the sign off of the monthly SitRep submission.

This submission is made up of SitRep submissions from across Devon for each provider in which a hospital delay may occur.

For every provider across Devon there needs to be clarity regarding delegated authority for the sign off at patient level, provider level and locality level.

**Older Adults**

The following delegated authority is in place across Devon County Council

**Eastern Devon**

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **The RD&E** | Deputy Assistant Director | Deputy Assistant Director |
| **Belvedere & Rougemont- Older adults** | Community Flow Manager | Deputy Assistant Director |
| **The ASU** | Community Flow Manager | Deputy Assistant Director |

**Northern Devon**

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **NDHT** | Pathfinder Team Manager | Assistant Director |
| **DPT Unit- Older people** | Pathfinder Team Manager | Assistant Director |

**South Devon**

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **Torbay Hospital** | Hospital Discharge Team Manager | Assistant Director |
| **DPT Unit- Older people** | Hospital Discharge Team Manager | Assistant Director |

**West Devon**

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **Derriford Hospital** | Hospital Discharge Team Manager/CSM | Assistant Director |

The following delegated authority is in place across Torbay

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **Torbay Hospital** | Service Manager | Service Manager |

**Younger Adults-**

The following delegated authority is in place across Devon County Council

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **Any** | Assigned Social Worker | Managing Partner for Social Care |

The following delegated authority is in place across Torbay

|  |  |  |
| --- | --- | --- |
| **Provider** | **Delegated authority at patient level** | **Delegated Locality sign off** |
| **Any** | Assigned Social Worker or RCO | Managing Partner for Social Care |

# Appendix 7 – AMH Social Work Strategy

**Social Care Pathway for Inpatients supported by Adult Mental Health.**

To Note:

* The Social Worker will be not be involved if it is/becomes a pure health need (e.g. Rehab) or if it goes above social care panel (i.e. IPP/ECRS). At this point the process will involve the CCO.
* The Social Worker will make the final decision on the support needed, however will link in/discuss with the ward staff and therefore ideally the recommendations will be the same

**Occupational Therapist**

Occupational Therapist (OT) to complete the OT report or supporting letter.

Occupational Therapist (OT) to liaise with the Social Worker to discuss support needed.

OT or DF to complete the Social Care Pathway Referral process if no allocated CCO**\***.

Occupational Therapist (OT) or Discharge Facilitator to complete the OT initial assessment and gather info.

**Discharge Facilitator**

Discharge Facilitator to support processes on the ward to facilitate the discharge process.

This includes: Notification of admission, DAF forms, accommodation checks, benefits checks, and step-down referrals and visits (not an exhaustive list).

Discharge Facilitator to support with accommodation assessments or visits.

Discharge Facilitator to advise the Social Worker in order to identify accommodation.

**Social Worker**

A Social Worker to be allocated following the Social Care Pathway Referral.

The Social Worker to complete their report/recommendations of the individuals Social Care needs.

The Social Worker to liaise with the Occupational Therapist (OT) to discuss support needed.

The Social Worker to complete an assessment with the individual on the ward.

The Social Worker to attend panel – to be supported by OT or Discharge Facilitator if needed.

The Social Worker to search for and apply for accommodation/ support provider.

The Social Worker to complete the RAS or other funding applications/forms needed.

# Appendix 8 – Junior Doctor Tasks

Approved by CAG: 01/04/20

Approved by Gold: 10/04/20

Amended by Dr. Colm Owens, CAG chair on 27/4/20

Version: 1.4



|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | | COVID-19: List of tasks performed by DPT junior doctors and delegation or delay recommendations when junior doctor not available v.1.3 | | | | | | | | | |
| Author | | David Richardson | | | | | | | | | |
| Date of Production | | 31 March 2020 | | | | | | | | | |
| Other Information | | Admission, transfer and discharge policy:  <https://www.dpt.nhs.uk/download/D8dxI51HqX>  Changes to the MHA and Applying the legal framework:  See latest guidance – changes may occur to the MHA in due course  PPE Guidance:  Please refer to latest guidance on Daisy <https://daisy.dpt.nhs.uk/covid-19/ppe.aspx>    Combined Prioritisation Tool: | | | | | | | | | |
| Principles:  Need to try to maintain best practice  Staff resources may become increasingly scarce meaning that best practice is not possible  Deviation from current best practice should occur only when necessary  A task can either be delayed (when not immediately necessary) or delegated (when immediately necessary) (or in some circumstance both)  Prioritisation should be undertaken on if demand for services is greater than the resources available to meet it  Although the priority matrix below is for a systems wide response it could be adapted to inform decision making elsewhere  Prioritisation should only be as long as necessary  Prioritisation consideration will be kept under constant review with regarding the dynamic response to wider system demands  Prioritisation will be based on the minimisation of harm to the population. Within this, we will prioritise reducing harm to others about that of harm to self, with consideration of the number of people likely to be impacted by the harm events | | | | | | | | | | | |
| **Prioritisation of service users and carers** | | | | | | | | | | | |
| **Priority 5** | **Priority 5** | | **Priority 4** | | **Priority 4** | **Priority 3** | | **Priority 2** | **Priority 1** | | **Priority 1** |
| Patients with minimal risk of deterioration in the short to mid term | Patients with moderate risk of deterioration in the short to medium term | | Patients at significant risk of harm to self due to current mental disorder | | Patients with rapid risk of deterioration and escalation of priority. | Patients whose physical health is at risk if mental health services are withdrawn. | | Patients who are a significant risk to others due to mental disorder | Patients requiring perinatal services with no alternative safe management plan | | Patients mandated by Ministry of Justice to be detained and those on civic sections in secure services |
|  | | | | |  | |  | | |  | |
| **Trainee Tasks and possible options** | | | | | | | | | | | |
| ***Task*** | | | | ***Options*** | | | | | | ***Other information*** | |
| **Complete admission initial assessment, including ALL sections of the CareNotes form within 4 hours** | | | | Remote assessment and documentation by Junior  B6/5/4 practitioner already on the ward to complete available sections  Remote assessment and documentation by Consultant | | | | | | Ensure that clinician referring to ward has provided adequate handover and initial management plan.  Ensure that clinician referring to the ward has used carenotes forms where able e.g. risk assessment, initial assessment form | |
| **Complete a physical examination within 4 hours**  **(except between 00.00 – 07.00 when can be delayed following night staff MDT review)** | | | | B6/5/4 practitioner already on the ward to complete NEWS in full and to discuss all with B6 (if not already discussed) concerns to NNP or similar for action  For concerns to be discussed with Medic – consider need for face to face assessment  For full physical to be completed when medical staff available | | | | | | Basic assessment is required and documented but could be delayed if an initial assessment identifies no problems | |
| **Complete a risk assessment for VTE** | | | | B6/5/4 practitioner already on the ward to complete and to discuss all with B6 (if not already discussed). For concerns to be discussed with Medic – consider need for face to face assessment  Remote assessment and documentation by junior | | | | | | VTE risk assessment is standardised process. Concerns will require prophylaxis which requires medical opinion and prescribing | |
| **Complete full risk assessment of presenting risks following discussion with the new admission and review of other information available** | | | | B6/5/4 practitioner already on the ward to complete with remote advice by junior  B6/5/4 practitioner already on the ward to complete with remote advice by consultant | | | | | |  | |
| **Document current medication in order to complete stage 1 of the medicines reconciliation** | | | | Nurse with relevant medication competency  Remote assessment and documentation by Junior  Remote assessment and documentation by Consultant | | | | | | Meds rec requires a clinician, doctor is not specified in SOP.  Second person needs to be a different one to part one. Ref: [MM25 Medicines Reconciliation Process](https://daisy.dpt.nhs.uk/media/1571790/mm25-medicines-reconciliation-process-for-inpatient-units.doc) | |
| **Document Rapid Tranquilisation on care notes** | | | | IF RT is considered likely to be needed before a doctor can arrive then a competent prescriber  If RT immediately required and no one available then remote prescribing is possible by Junior or Consultant | | | | | | Prescribing can be done remotely under exceptional circumstances (except Controlled Drugs) – must be done on  [MM04 Remote Prescribing](https://daisy.dpt.nhs.uk/media/1566120/mm04-remoteprescribing.doc) (or COVID equivalent when produced) | |
| **Documentation in ward round** | | | | Administrative colleagues  B4 / B5 / B6 staff  Consultant only | | | | | | This could be done via skype, facetime or other digital means  See: www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance/health-care-professionals | |
| **Responding to biological medical issues** | | | | Full NEWS 2 discussed with NIC (USE SBAR format for communication)  No delegation possible at present for anything other than ‘homely’ type presentations but consider delay or remote assessments | | | | | |  | |
| **Urgent diagnostics e.g. ECG, phlebotomy** | | | | Competent (those trained by DPT in those skills) or those who have achieved these competencies elsewhere. | | | | | |  | |
| **Seclusion reviews** | | | | Needs to be completed by medic – Junior or Consultant but could be done remotely | | | | | | This could be done via skype, facetime or other digital means  See: www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance/health-care-professionals | |
| **Doctors Holding Power** | | | | Must be examined by a doctor (so could include video face to face).  Should be performed by Clinician in charge of that person’s care or their nominated deputy or another doctor nominated by them and so could be performed by any available doctor inc. Consultant (remotely)  Please note that nurse holding powers are also available | | | | | | This could be done via skype, facetime or other digital means  See: www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance/health-care-professionals | |
| **Writing discharge TTA** | | | | Yes, Non medical prescriber.  Ward staff may transcribe medicines onto discharge prescription or leave prescription forms or the prescriber may generate the discharge prescription remotely.  This must then be sent with a copy of the chart to the prescriber and the pharmacist covering the ward electronically (by email).  If the chart has not been verified by a prescriber then all MM04a copies must also be supplied. | | | | | | If a non-prescriber has transcribed the discharge medication then the prescriber must confirm the medicines are transcribed correctly and communicate this to the pharmacist.  The pharmacist must send this to the ward or pharmacy depending on local arrangements for electronically screened prescriptions.  PLEASE NOTE REMOTE PRESCRIBING REQUIREMENTS MAY CHANGE – SEE LATEST GUIDANCE | |
| **Writing prescriptions including Rapid Tranquilisation** | | | | Non-medical prescriber  Medical staff remotely | | | | | | If a non-prescriber has transcribed the discharge medication then the prescriber must confirm the medicines are transcribed correctly and communicate this to the pharmacist.  The pharmacist must send this to the ward or pharmacy depending on local arrangements for electronically screened prescriptions.  PLEASE NOTE REMOTE PRESCRIBING REQUIREMENTS MAY CHANGE – SEE LATEST GUIDANCE | |
| **Medical Discharge Summary** | | | | Adapted Nursing Discharge Summary for period of COVID pandemic | | | | | |  | |
| **Initial Assessment of Section 136** | | | | Remote assessment possible initial NEWS and history taking by competent practitioner with discussion with medical colleagues.  Further physical by one of / the MHAA assessing doctor(s) | | | | | |  | |

# Appendix 9 – Prioritisation tool

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Patients mandated by MoJ to be detained and those on civil sections in secure services | Patients requiring perinatal services with no alternative safe management plan. | Patients who are a significant risk to others due to mental disorder  Children and Young People at significant risk of harm to self (suicide) due to mental disorder | Patients whose physical health is at risk if mental health services are withdrawn. | Patients with risk of rapid deterioration and escalation of priority if treatment is discontinued. | Patients at significant risk of harm to self due to current mental disorder | Patients with moderate risk of deterioration in short to medium term | Patients with minimal risk of  deterioration in  Short to mid  term |
| Decision to be made | Priority 1 | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 4 | Priority 5 | Priority 5 |
| Consideration for use of MHA –admission or discharge |  |  |  |  |  |  |  |  |
| Consideration of informal admission or discharge |  |  |  |  |  |  |  |  |
| Services for people discharged under s42 MHA |  |  |  |  |  |  |  |  |
| Services for people subject to s17a MHA |  |  |  |  |  |  |  |  |
| Services for people in the community for first 48hours following IHT or inpatient episode. |  |  |  |  |  |  |  |  |
| Services for people who are at high risk of admission and require urgent response |  |  |  |  |  |  |  |  |
| Services required to prevent serious deterioration/escalation |  |  |  |  |  |  |  |  |
| Services for CYP presenting on Paediatric ward / requiring assessment within 7 days of discharge |  |  |  |  |  |  |  |  |
| Active treatment in the community |  |  |  |  |  |  |  |  |
| No active intervention Review only |  |  |  |  |  |  |  |  |

# Appendix 10 – Example of patient information leaflet to be shared in the testing area

**COVID-19 (coronavirus)**

This leaflet is about the COVID-19 (coronavirus) outbreak that began in China in late 2019.

The World Health Organization (WHO) has declared the outbreak a pandemic. This means that it has spread across the world.

This virus can cause a severe lung infection, and it can cause death.

**What is COVID-19?**

COVID-19 is a disease caused by a type of virus called a coronavirus. This is a common type of virus that affects both animals and humans.

Coronaviruses often cause symptoms like those of the common cold. But sometimes they can cause more serious infections.

The coronavirus that causes COVID-19 is a new type of coronavirus.

The virus has now spread to over 100 countries. The United States of America, Spain, Italy, France, the United Kingdom, Germany and Turkey have reported the most cases.

**How do people catch COVID-19?**

COVID-19 is able to spread from person to person. The virus seems to spread when people cough or sneeze, and when people touch objects and surfaces that have the virus on them.

The virus can survive for 24 hours on cardboard and for three days on stainless steel and plastic.

Infected people can spread this virus even if they don't have any symptoms yet.

You are more likely to catch the infection if:

• you live in, or have travelled to, an area where COVID-19 has been reported

• you have been in close contact with someone who has COVID-19

• you are having treatment for cancer

**What are the symptoms?**

It's thought that people can have the virus for up to 14 days without having any symptoms.

This time before symptoms develop is called the incubation period.

Most people who catch COVID-19 will have an illness like a bad cold or flu. Some people will have a more severe illness, like pneumonia.

You’re more likely to have a severe illness if you are older, if you smoke, or if you have certain other health problems. These include high blood pressure, diabetes, severe obesity, a weaker immune system, receiving an organ transplant, and diseases affecting the heart, lungs, liver or kidneys.

Children seem to be infected less frequently than adults. Most children who catch COVID-19 have had close contact with an infected person. It is likely that children have a very low chance of passing on the infection to others.

The most common symptoms of COVID-19 are:

• fever (high temperature)

• coughing

• shortness of breath

• loss of sense of smell

• reduced sense of taste

• aches and pains

• feeling tired

• diarrhoea

• feeling nauseous or vomiting, and abdominal (tummy) pain.

Less common symptoms can include:

• loss of appetite

• coughing up a lot of phlegm

• sore throat

• confusion

• dizziness

• blocked or runny nose

• conjunctivitis (red or watery eyes)

• headache

• skin rashes

• coughing up blood.

COVID-19 can also cause sepsis. This is when the body’s immune system reacts badly to an infection and attacks the body. It affects about 5 in 100 people with COVID-19. The symptoms of sepsis include:

• fever

• a fast heartbeat

• confusion

• not needing to urinate as much as usual, and

• mottled, patchy skin.

As you can see, many of the less serious symptoms of COVID-19 are similar to those of a bad cold or flu. So it is often not possible to diagnose COVID-19 without testing.

**Testing for COVID-19 in the mental health wards**

In order to try to keep you well and to reduce the chance of infection spreading to other patients you will be offered testing for COVID-19 by having a swab taken from your nose and throat in a special area called a ‘testing area’.

You will need to remain in their room until the results are back (this may take up to 24 hours but is usually much quicker).

Where you will then be moved to will depend not just on a swab result but will also be based on whether you have had contacts with others that may have COVID-19 infections.

It is important that you tell us whether you have had any contacts or live with anyone that may have symptoms of COVID-19 or have tested positive for COVID-19.

It is important to tell us if you have received a letter from the Government or your GP saying that you are someone who should be shielding or if you think you are at particular risk of developing problems if you get COVID-19.

It is important to tell us whether you have had any of these symptoms and when they were.

**How is a swab taken?**

A swab is like a long cotton bud. The bud end of the swab is put into the back of your throat by a nurse or doctor. It is then put deep into your nose and rotated.

This process is uncomfortable, sometimes painful but necessary to ensure a good sample is taken.

**What will happen after the swab result comes back?**

When the results come back the nurses and doctors will tell you the result and make a decision as to which part of the ward you will move to.

You may move to the usual mental health ward and be asked to maintain social distancing (please see below for prevention of spread)

You may move to another part of the ward and asked to follow something called modified social isolation. Modified Social Isolation means you will be expected to remain in your room as much as possible, have meals separate from others and not join in any group activities but there will be more opportunity to move around and get exercise. This may be for up to 14 days.

If the result of the swab is positive you will be moved to a ward in Exeter which has been set up to allow patients with a positive test to move around and receive as close to usual care. You cannot get more COVID-19 by spending tie with other patients who have tested positive so this is safe.

Whichever part of the ward you are in you will receive support from nursing staff, have access to doctors and have a named Consultant Psychiatrist or Responsible Clinician in overall charge of your care.

All our staff have been trained to help people with COVID-19 infection, to help them stay well and to help them receive excellent mental health care during your admission.

**Can I refuse the swab?**

There are some circumstances where you could be forced to have a swab or be isolated for up to 14 days but these circumstances are rare.

You can refuse the swab but this is not recommended.

If you refuse the swab in the testing area then this will mean that you will need to remain isolated in a single room for seven days.

**Prevention of spread of COVID-19**

You can take measures to reduce your risk of catching or transferring the infection. These include:

• washing your hands often and at least before and after any activity, eating with soap and water for at least 20 seconds

• avoiding touching your eyes, nose and mouth

• avoid close contact with other people by trying to keep at least 2 metres apart – part of social distancing.

**What is being done on the ward to reduce the spread of the virus?**

In order to reduce the chance of spreading the virus all staff will wear a mask. If nursing staff spend much time close to you they will wear other PPE including an apron and gloves. They may also wear some eye goggles.

Chairs and furniture have been moved to allow people to sit further apart.

Some group sessions have been stopped, others have smaller numbers of attendees.

Some contacts with health professionals such as Psychologists or Care Coordinators or Social Workers is not being done via telephone or video call.

Visitors are not allowed to come to the ward except for very exceptional circumstances. Birthdays, anniversaries or other special events are not considered exceptional circumstances. If there are very serious difficulties such as dementia or someone having a learning disability visits may be allowed.

You will have your temperature checked on a daily basis as this can be the first sign of having the illness. You will also be asked about whether you have symptoms of the illness. It is important to tell the Nurses and Doctors if you have developed these symptoms as they can then act quickly to help you and stop the virus spreading. Most people who have the virus do not become very unwell.

If you require to be seen by a Nurse or Doctor from the physical health hospital this will happen. You would be asked to wear a mask and other Protective Equipment such as gloves and an apron. If you spend a lot of time during your admission in one of the general hospitals you may be required to isolate in your room when you come back. Changes are being made to reduce the amount of times that people may need to go to other wards for special tests such as X-Rays, blood tests or heart tracings or for treatments for cuts for example.

**What treatments work for COVID-19?**

There is no cure for COVID-19. A vaccine is being developed, but it will be a long time before it is available. Different medicines are being tested to see whether they can help patients with COVID-19. The research is in the early stages, so these medicines are only given as part of a clinical trial. Another treatment is being developed from the blood of people who have recovered from COVID-19. Their blood contains proteins called antibodies, which can stick to the virus that causes COVID-19 and help to fight the infection. This treatment is called convalescent plasma.

**What if you need physical health treatment?**

The Nurses and Doctors on the mental health wards have received additional training and teaching on COVID-19 and have made very good plans with Doctors and Nurses in the general hospitals to treat people if they get bad symptoms of COVID-19. The NHS has enough physical health hospital beds to treat people.

The treatment for someone with COVID-19 is the same as for pneumonia or any other serious viral chest infection.

If you are treated in hospital, the treatment will consist of:

• rest

• making sure you get plenty of fluids, possibly through an IV (intravenous) drip

• medication to lower fever and reduce pain, if needed

• oxygen, if you need it

• close monitoring.

You might also be given antibiotics to begin with, in case you have a bacterial infection. But if testing shows that you have a viral infection, the antibiotics will be stopped, as antibiotics don’t work against viruses.

People with severe symptoms might be treated in an intensive care unit (ICU). If you need to be treated in intensive care, your treatment might also include:

• a tube passed through your mouth to your windpipe, called an endotracheal tube, and

• a ventilator to support your breathing.

**What danger is there if I get COVID-19?**

It’s not possible to say what will happen to someone infected with COVID-19. The outcome can vary. What we know so far is that:

• the infection is most likely to be serious in older people with existing long-term health problems. But most people with COVID-19 don't become seriously ill

• about 80 in 100 people with COVID-19 have a mild illness

• about 20 in 100 people develop more severe symptoms

• the virus affects men and women in roughly equal numbers, but men seem more likely to have severe symptoms

**Looking after your mental health**

It’s normal to feel worried about coronavirus. This is an uncertain time and you might be feeling bored, lonely, anxious, frustrated or low. It’s important to remember that, for most people, these feelings will pass. Here are some things that you can do to look after your mental health:

• stay connected with friends and family by phone or by Skype or Whatsapp – there is wifi on the wards

• talk about your worries with the Nurses and Doctors and try to follow their advice

• carry on trying to do things you enjoy whilst on the ward

• eat healthy meals and drink enough water

• exercise regularly – there is exercise equipment available

• try to maintain a regular sleeping pattern

**Appendix 11 – Junior Doctor Clerking and Nursing Admission processes in Testing Wards**

**Admission Checklist (for testing areas) – COVID Version**

Purpose – this document outlines the minimum standard of documentation and action required for those within the testing areas. **Identified responsibilities will need to be adjusted accordingly based on time of admission and available staffing.**

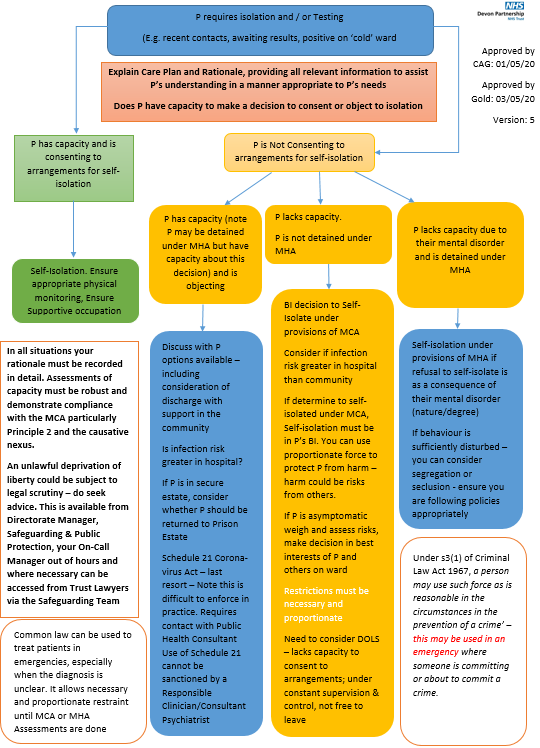
|  |  |
| --- | --- |
| **Actions to Complete (Non-CareNotes).**  **Responsible: Members of the Admitting Nursing Team [specifically identified below].** | **Necessary in Testing Area** |
| Add new admission to bed state board for fire evacuation purposes.  **HCA** | Yes |
| Add new admission to hourly observation checklist.  **HCA** | Yes |
| Add new admission to whiteboards both in and outside the office.  **HCA** | Yes |
| Ensure room is ready; write the name of the new admission onto their door and complete the notice in their room indicating who their named nurse and consultant will be. **HCA** | Yes |
| Orientate the new admission to the ward, undertake a search of their belongings & complete a same sex rub-down.  **HCA** | Yes |
| Inform the on-call SHO of the new admissions arrival.  **HCA** | Yes |
| Obtain GP summary if possible to complete medicines reconciliation – if out of hours, ensure this is put into the diary.  **Admin/HCA** | Yes |
| If relevant, accept any section papers and ensure that section 132 rights are read and review date is put into the diary. Ensure informal admissions are understanding boundaries of admission. **Nurse** | Yes |
| Qualified nurse on shift to complete patient’s own drugs assessment form and store these as the assessment indicates.  **Nurse** | Yes |
| Store any contraband, i.e. sharps, valuables, etc. in either the treatment room, the office safe or the patient’s belongings drawers. Ensure this is all clerked in on the correct documentation. **HCA** | Yes |
| **Complete Swab** | Yes |

|  |  |  |
| --- | --- | --- |
| **Actions to complete on CareNotes**  **Responsible: Admitting Junior Dr (Needs to be completed by Junior Dr covering ward if subsequently admitted from testing area or the following day if admitted overnight)** | **Where to find in CareNotes.** | **Changes to usual process whilst in Testing Area or when patient is admitted to a ward overnight (10PM-9AM) NB needs to be progress note stating brief admission notes completed only and handover to colleague to complete one admitted to ward/following day** |
| Complete admission initial assessment, including **ALL** sections of the CareNotes form. **Junior Dr** | - Select the ‘Assessments’ tab  - Create a new ‘initial assessment’ | Only fill these fields:   * Referral information * Presenting situation * Mental State Examination * Risk Factors * Risk Summary * Formulation / Diagnosis * Initial Contingency Plan * Personal and Family physical Health History |
| Complete a physical examination.  **Junior Dr** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘Physical Examination’ | External physical examination only (where this is appropriate). |
| Complete baseline bloods and ECG  Junior Dr |  | Can be completed on following day if no indications for urgent |
| Complete a risk assessment for VTE.  **Junior Dr** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘VTE assessment’ |  |
| Complete full risk assessment of presenting risks following discussion with the new admission and review of other information available. **Junior Dr** | - Select the ‘Risk’ tab  - create | Brief Risk Assessment only |
| Document current medication in order to complete stage 1 of the medicines reconciliation. **Junior Dr** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘Record of Prescribed Medication’ |  |
| Document Rapid Tranquilisation on care notes if a form has been completed. **Junior Dr** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘Rapid Tranquilisation’ |  |
| Complete Drug Chart  **Junior Dr** |  | -Can be completed remotely by downloading PDF Drug Chart from Covid 19 Section of Daisy, Meds Optimisation Tab |

|  |  |  |
| --- | --- | --- |
| **CareNotes Actions to Complete on Admission**  **Responsible: Admitting Nursing Team[specifically identified below].** | **Where to find in CareNotes** | **Necessary in the testing area?** |
| Create an ‘Inpatient episode’ for the new admission.  **Admin/HCA** | - Search for patient using any available details, i.e. name, DOB  - Click on the new admission  - Select the ‘Referrals/Admissions’ tab  - Create a new ‘Inpatient Episode’ and complete form | Yes |
| Create a ‘Ward stay’ for the new admission.  **Admin/HCA** | - Select the ‘Referrals/Admissions’ tab  - Create a new ‘Ward Stay’ and complete form | Yes |
| Check/Amend address and ensure up-to-date contact numbers are recorded.  **Admin/HCA** | - Select the ‘Core Information’ tab  - Either, create a new ‘Address’ if there is none existing or  - If it needs to be amended or a contact detail added, click on the existing address, select ‘Edit’ and change what is necessary before pressing ‘Save’ | Yes |
| Add a Next of Kin; ensure to include their contact details. **HCA** | - Select the ‘Core Information’ tab  - Create a new ‘Personal Contact’ & complete form | Yes |
| Document any information sharing preferences.  **HCA** | - Select the ‘Core Information’ tab  - Create a new ‘Information Sharing & Consent’ & complete form | Yes |
| Complete a family form to detail any children or dependents & screen for the need for any safeguarding alerts. **AP/Nurse** | - Select the ‘Core Information’ tab  - Create a new ‘Family Form’ & complete form | Yes |
| Ensure that the new admission’s named nurse & inpatient consultant is added to their file. **Admin** | - Select the ‘Referrals/Admissions’ tab  - Create a new ‘Allocated Staff’ & complete form | Yes |
| Complete and record physical observations (height, weight, BP, pulse, temp, respiratory rate). **HCA** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘Physical Observations’ & complete form | Yes |
| Complete Physical Description form.  **HCA** | - Select the ‘Core Information’ tab  - Create a new ‘Physical Description’ & complete form | Yes |
| Complete Preventing an AWOL Incident Interview.  **AP/Nurse** | - Select the ‘Assessments’ tab  - Create a new ‘Preventing an AWOL Incident’ & complete from | Yes |
| Complete an infection control risk assessment.  **AP/Nurse** | - Select the ‘Medication & Physical Health’ tab  - Create a new ‘Infection Control Risk Assessment’ & complete | Yes |
| Create an admission care plan, including any urgent immediate actions that need to be taken (for example urgent risk management plans for identified risks and MHA status). **AP/Nurse** | - Select the ‘Care Plans/Reviews’ tab  - Create a new ‘Inpatient Care Plan’, attach to current inpatient episode when prompted & complete initial form | Yes |
| Create new covid testing form | * Select the medication & physical health tab * Create a new COVID Testing Form | Yes |

|  |  |  |
| --- | --- | --- |
| **Actions to complete within 72hours of Admission**  **Responsible: Named Nurse.** | **Where to find in CareNotes** | **Necessary in Testing Area?** |
| Add any allergies or other alerts, i.e. physical health diagnoses likely to impact on functioning.  **AP/Nurse** | - Select the ‘Core Information’ tab  - Create a new ‘Alert’ & complete form; may require GP summary. | Yes |
| Contact IMHA/IMCA as appropriate; Ensure section 132 rights/informal ward stipulations are read, understood and documented. **Nurse** | - Contact IMHA/IMCA; document in IMHA folder.  - Select ‘MHA/MCA/DOLs’ tab; Create new ‘Section 132 Rights’ and complete. | Ensure section 132 rights/informal ward stipulations are read, understood and documented. |
| PODS must be double-bagged within clear plastic sealable bags to inform a medicines reconciliation check and subsequently safely managed in accordance with SOPs (may be reused after three days)  **AP/Nurse** |  | Yes |

**Appendix 12 – Legal Framework and decision support for isolation and testing**



**Appendix 13 – COVID-19 Outbreaks (including communication with contacts of those confirmed positive)**

**DEFINITIONS**

**Suspected Healthcare Associated Outbreak of COVID-19** – Identification of two or more cases of laboratory confirmed COVID-19, or test negative but clinically suspected infections in either staff or patients within 14 days from the same location (inpatient unit or specific team).

**Confirmed Healthcare Associated Outbreak of COVID-19** – Two or more cases of laboratory confirmed COVID-19, or test negative but clinically suspected infections in either staff or patients within 14 days from the same location (inpatient unit or specific team), where the infection has spread between individuals within the health care setting

**CASE DEFINITION OF COVID-19 OUTBREAK**

In the context of COVID-19, an outbreak can be defined as the following:

* Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days,

and one of:

* + Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) or a proximity case during the infectious period of the likely index case. Appropriate PPE (face covering, hand hygiene and environmental cleaning) may modify this definition (e.g. in staff cases).

or

* + when there is no sustained community transmission or equivalent Joint Biosecurity Centre risk level - absence of alternative source of infection outside the setting for initially identified cases
* A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.
* Whole genome sequencing data supporting a localised outbreak

The definition of a cluster is two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days (in the absence of available information about exposure between the index case and other cases).

The declaration of the ending of a COVID-19 outbreak in a healthcare setting is as follows:

* **In an inpatient setting** - No confirmed cases with onset dates in the last 14 days in that setting (higher threshold for outbreaks compared to clusters). In most cases the outbreak will be declared over after 14 days but on a case-by-case basis this may be extended on review of the outbreak control group to 28 days.
* **In an outpatient or Primary Care environment** - No confirmed cases with onset dates in the last 14 days in that environment, unless an additional surveillance period of 28 days is recommended by the outbreak control group.

A service does not necessarily have to wait until the outbreak is closed before resuming services to patients (e.g. reopening a ward to admissions). The resumption of service is for local determination in line with PHE operational guidance on Communicable Disease Outbreak Management and local outbreak management arrangements including dynamic risk assessment by the “outbreak control team”.

1. **GUIDANCE**

The infection prevention and control team (IPCT) will use laboratory results from laboratories at the Royal Devon & Exeter Hospital, Torbay Hospital and North Devon District Hospital to alert to potential outbreaks, identifying two positive COVID-19 results (reported as SARS-CoV2 detected) from the same clinical area within a 14 day timeframe.

There may be scenarios when the IPCT are made aware of potential outbreaks including test negative but clinically suspected COVID-19 as well as cases in staff, this information would come via clinical teams and occupational health rather than laboratory testing.

When alerted to a potential outbreak, the IPCT will review the cases identified to establish the duration of the in-patient stay/case contact and if there is a link in time/place/person. Should the cases be deemed possible/probable/confirmed healthcare associated and a link between the cases established, an outbreak control group will be convened. If cases are deemed community associated or no link between cases established, then it does not meet the definition of a COVID-19 outbreak and no further investigation is required.

Previous laboratory results should be reviewed for each case to see if they have been tested for COVID-19 before. Negative admission swab can help distinguish between community and healthcare onset.

* > 14 days admission = healthcare associated infection case
* >24 hour to day 14 = **possible** case of healthcare associated infection (all cases over day 7 to have full root cause analysis review)
* <24 hours of admission = community case

**NOTIFICATION AND INITIAL ACTIONS**

A root cause analysis is required for every probable healthcare associated COVID-19 inpatient infection i.e. patients diagnosed more than 7 days after admission. The Trust will be required to report all healthcare associated infections through the sit-rep process. The IPCT will notify the NHS South West ICC (england.sw.incident1@nhs.net) of any suspected or confirmed outbreak of COVID-19 within 24 hours using the IIMARCH template at Appendix 1b.

1. **FURTHER MEASURES**

**Patient Isolation**

* As per the Trust guidance of management of a COVID-19 positive case, patients should be isolated in a side room or cohorted.
* Infection Control precautions must be instigated as per the [PHE guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) with transmission based precautions. The inpatient briefing sheet on Daisy can be also be referred to for summary guidance.

**Isolation of Patient Contacts**

* As per Public Health England guidance in-patients who are known to have been exposed to a confirmed COVID-19 patient should be isolated or cohorted until their hospital admission ends, or until 14 days after last exposure. The IPCT will advise the ward in conjunction with the ward manager/senior nurse.
* Details below under ‘**Process for Dealing with Confirmed COVID-19 Contact’**

which follows Trust and [PHE guidance](https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings).

* Following contact, if symptoms or signs consistent with COVID-19 occur, relevant diagnostic tests should be performed.
* On discharge, patients should be given written notice of their exposure with a copy of the [PHE self-isolation leaflet](https://daisy.dpt.nhs.uk/media/1572138/self-isolation_poster_for_patients.pdf).

**Designated admission/testing areas**

* Patients who have been isolated pending a test result in the same admission/testing area as an admission who tests positive for COVID-19 are **not** considered contacts if isolation has been maintained. If the positive patient has mixed with others please consult the IPCT to discuss if other patients should be treated as contacts.

**Definition of Contact**

(Excluding designated COVID-19 admission areas and COVID-19 positive cohort areas)

* If a patient tests positive for COVID-19, patients who have been in the same ward and have been sharing communal areas as the positive patient between a period 48 hrs before onset of symptoms (or positive test if asymptomatic) in the contact and 24 hours after the resolution of symptoms are contacts. The IPCT will advise who to consider contacts in the case that isolation has been achieved of either the positive patient or of potential contacts on the ward.

**Process for Dealing with Confirmed COVID-19 Contact**

following PHE Guidance: <https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings>

* These patients will be flagged using the Alert field on CareNotes indicating that they are a COVID-19 contact and the date of exposure
* A note will be added to the clinical alert box saying the patient is a COVID-19 contact with the date of when their contact time ends. Contact must also be recorded on the COVID-19 management form
* Contact patients should be isolated or cohorted together, away from the positive patient.
* Isolation is preferable to cohorting, but if cohorting or contacts will not remain isolated in their room, patients should wear masks if safe for them to do so.
* If a patient tests positive in an inpatient area, the ward will be closed (unless the patient has always been isolated) and patients in this area will be kept together in this contact cohort. The room the positive patient has vacated should receive a terminal clean (Chlorine based clean/Tristel and a curtain change).
* All horizontal surfaces within the communal spaces should be decontaminated using Chlorine based/Tristel.
* Staff should follow Trust and [PHE PPE guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe) with the use of gloves and aprons for direct care as per the guidance.
* COVID-19 contacts need to remain isolated/cohorted for 14 days from their exposure.
* Contacts must be verbally informed by ward staff that they have had contact with a case of COVID-19 and must remain isolated/cohorted for 14 days from their exposure to avoid secondary spread. They must be given a written “warn and inform” letter about the need to remain isolated for the remaining isolation period.
* If a patient is discharged home within the 14 day isolation period, they must be given a [self-isolation leaflet](https://daisy.dpt.nhs.uk/media/1572138/self-isolation_poster_for_patients.pdf) and a written “warn and inform” letter about the need to remain isolated for the remaining isolation period. This letter will also be sent to the patient’s GP. If the patient has already been discharged, the letter will be posted to the patient and GP.
* COVID-19 contacts being discharged to a nursing/residential home or a community hospital, any other inpatient facility or shared facility with communal areas must be tested and the result confirmed as negative prior to transfer. The onward care facility must be informed of the exposure and need to keep the patient isolated for the remaining isolation period even if PCR (swab) testing is negative.
* If a contact cohort is emptied, or amalgamated with another contact cohort, discuss the need for terminal cleaning with the IPCT.
* If a contact becomes symptomatic, they must be isolated in a single room, tested for COVID-19 and staff must follow the [PHE guidance](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control) and the inpatient briefing sheet on Daisy for a suspected case.
* Contacts who have completed their 14 day isolation/cohort period and are asymptomatic can be removed from the cohort and placed in another non-COVID-19 inpatient area

**Patient / Staff testing**

* The outbreak control group will review the situation and decide whether there should be screening to identify further cases which may include other patients in the ward and/or relevant staff or visitors

**Staff Contact**

* Ward managers are responsible for generating a contact list to send to Occupational health, who are then responsible for contacting staff to advise of their exposure to positive cases.

July 2020

# Appendix 14 – Secure Services Referral Guidance

****

X:\Logos\DPT.PNGX:\Logos\AWP.PNG

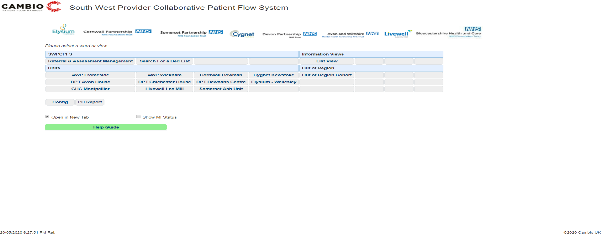
**Guide On How To Refer A Patient To The South West Provider Collaborative Patient Flow System**

**WELCOME TO OUR UNIQUE PATIENT FLOW SYSTEM**

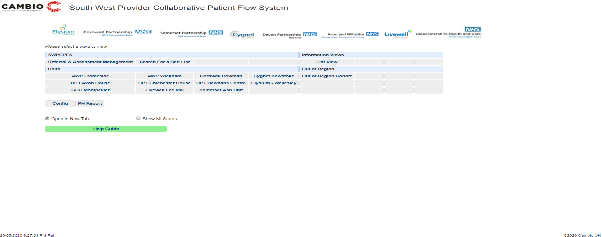
Over the past few months the South West Provider Collaborative (SWPC) has been working with a company called Cambio Healthcare Systems to develop a unique patient flow system that enables the ability to refer patients through an on line portal. This replaces the current system whereby you complete a word document as a referral and submit by email. This new on line resource will be live on **8th June 2020** so any patients you wish to refer for assessment by secure mental health clinicians will be through this new system.

**HOW TO REFER A PATIENT FROM ONE OF YOUR WARDS IN DEVON PARTNERSHIP TRUST**

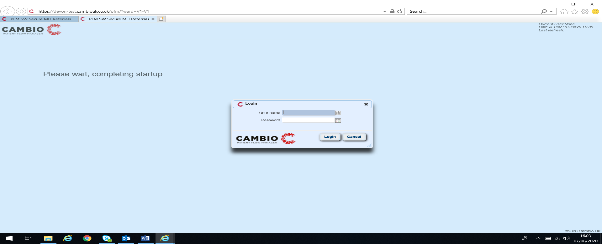
**Step 1** You will need to log onto the web address for the SWPC patient flow system which is: <https://swpc.cambiouk.co.uk>



**Step 2** Click on the tab that is entitled “Referral and Assessment management”



**Step 3** When prompted add your organisation user name and password.

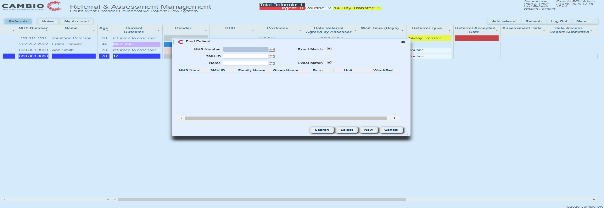


The DPT user name is: DPT

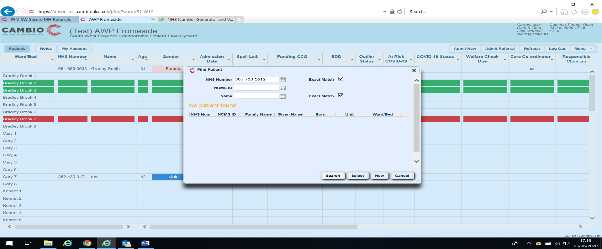
The DPT password is: tangotrain

When accessing the system please be mindful of GDPR and rules governing legitimate use of personal data.

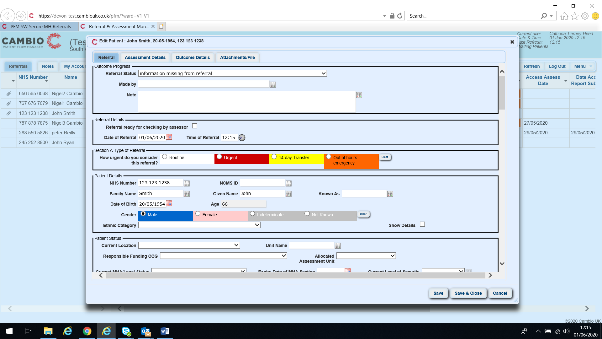
**Step 4** Click on the tab entitled “add referral” and the screen below will pop up.



**Step 5** Add the NHS number of your patient into the “find patient” box below. It is important to enter the NHS number with the correct spacing shown in figure 24 below, the system will show no patient found, so click “new” at the bottom of the page which will open a new window to allow you to add the patients details.



**Step 6** Enter patient details and complete **all** sections as you scroll down the page.

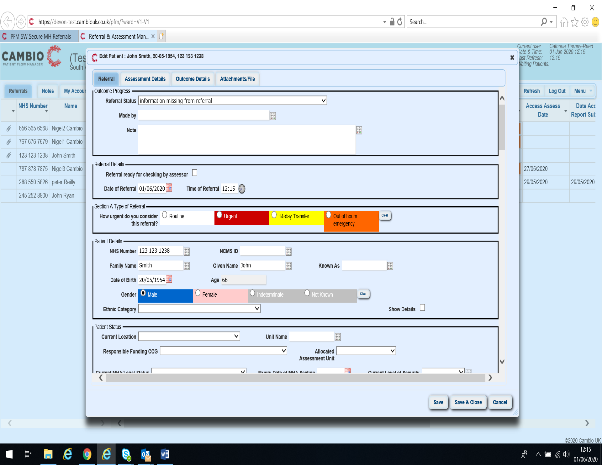


You can partially complete the referral and press “save” at the bottom of the page which will allow you to save what you have completed so far and then complete it at a later stage. However it is recommended that you aim to complete the referral in one go, there are mandatory fields and the system will not allow you to submit unless all the fields are completed.

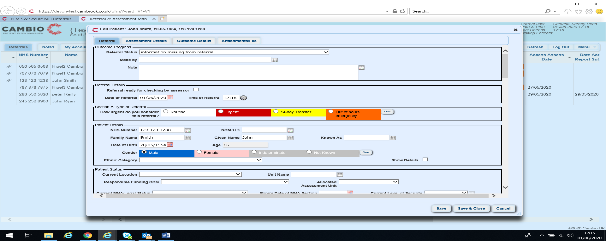
There is a drop down menu in the patient status box that replaces the information in the table below. This table is included here to remind you which units cover which CCGs.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Local Services**  **Referral Contact Information** | | | | |
|  | | | | |
|  | **CCG** | **Unit** | **Email** |  |
| Gloucestershire | Montpellier LSU  Fromeside MSU | [2gnft.Montpellier-Referrals@nhs.net](mailto:2gnft.Montpellier-Referrals@nhs.net)  [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| Bristol, North Somerset and South Gloucestershire | Wickham LSU / Fromeside MSU | [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| Bath and North East Somerset | Wickham LSU / Fromeside MSU | [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| Swindon | Wickham LSU / Fromeside MSU | [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| Wiltshire | Wickham LSU / Fromeside MSU | [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| Somerset | Ash LSU  Fromeside MSU | [sue.young10@nhs.net](mailto:sue.young10@nhs.net)  [awm-tr.FromesideReferrals@nhs.net](mailto:awm-tr.FromesideReferrals@nhs.net) |
| NEW Devon | Lee Mill LSU  Langdon MSU/LSU | [pchcic.leemill@nhs.net](mailto:emilyrowe1@nhs.net)  [dpn-tr.LangdonReferral@nhs.net](mailto:dpn-tr.LangdonReferral@nhs.net) |
| South Devon and Torbay | Lee Mill LSU  Langdon MSU/LSU | [pchcic.leemill@nhs.net](mailto:emilyrowe1@nhs.net)  [dpn-tr.LangdonReferral@nhs.net](mailto:dpn-tr.LangdonReferral@nhs.net) |
| Kernow | Bowman LSU  Langdon MSU | [darrennye@nhs.net](mailto:darrennye@nhs.net), [ian.hogbin@nhs.net](mailto:ian.hogbin@nhs.net), [Charles.curtis@nhs.net](mailto:Charles.curtis@nhs.net)  [dpn-tr.LangdonReferral@nhs.net](mailto:dpn-tr.LangdonReferral@nhs.net) |
| **Access Assessment Service for Pathfinder Service** | | |
| **CCG** | **Unit** | **Email** |
| Bristol, North Somerset & South Gloucestershire, Bath and North East Somerset, Gloucestershire, Somerset, Swindon, Wiltshire | Avon and Wiltshire Mental Health Partnership NHS Trust | [awp.pathfinder@nhs.net](mailto:awp.pathfinder@nhs.net). |
| Kernow, NEW Devon, South Devon & Torbay | Devon Partnership NHS trust | [dpn-tr.Pathfinder@nhs.net](mailto:dpn-tr.Pathfinder@nhs.net) |
| **Access Assessment Service for IDCFT/FIND services by CCG** | | |
| Bristol, North Somerset & South Gloucestershire, Bath and North East Somerset, Gloucestershire, Somerset, Swindon, Wiltshire | Avon and Wiltshire Mental Health Partnership NHS Trust | [awp.SecureServicesFINDTeam@nhs.net](mailto:awp.SecureServicesFINDTeam@nhs.net) |
| Kernow, NEW Devon, South Devon & Torbay | Devon Partnership NHS trust | [dpt.IDCFT@nhs.net](mailto:dpt.IDCFT@nhs.net) |

You must select the allocated assessment you want to review your referral, using the drop down menu.



Although the secure unit provider will check the portal on a daily basis, if your referral is urgent, please indicate this on the referral template and send an email to the provider stating **“there is an urgent referral for you to review on the bed flow website”.** Once you have completed all of the fields please tick the box entitled “referral ready for checking by assessor” and press “save and close” at the bottom of the page.



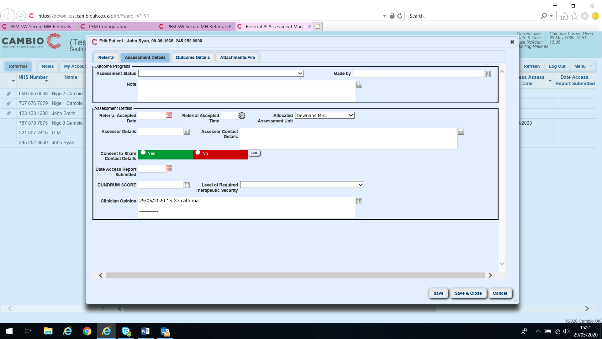
Please do not use the outcome progress box as this is the responsibility of the access assessor to review your referral and update the status. There are four choices that the assessor may choose from and there is a narrative box as that additional information relevant to the choice can be added.

1. Ready for access assessment and confirmation of urgency, 14 day or routine
2. Consultation offered so not for access assessment
3. Referral declined
4. Information missing from referral

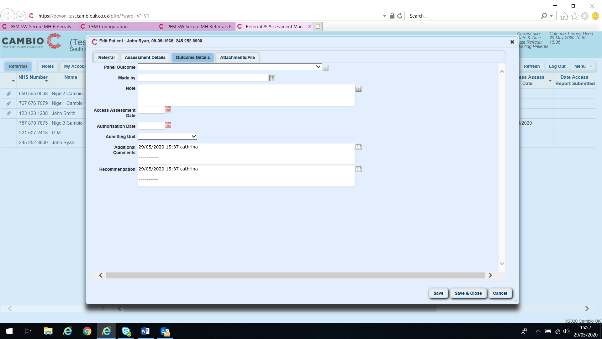
Please note if you do not provide all relevant information the access assessor will send you an email to advise you that there is missing information and you will need to log back onto the system, complete the relevant missing information and re submit your referral. The clock only starts at the point when the assessor indicates that the referral is ready for assessment so it is very important to complete all relevant fields.

**ONGOING MONITORING OF YOUR REFERRAL**

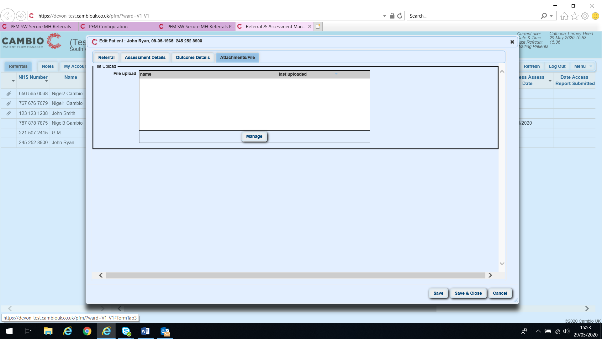
The system is set up to allow you access to certain pages but only to view your own patients. You will be able to track the progress of your referral by viewing each tab in the referral and assessment process and you can log onto the system as often as you wish to check progress. The access assessment tab shown below

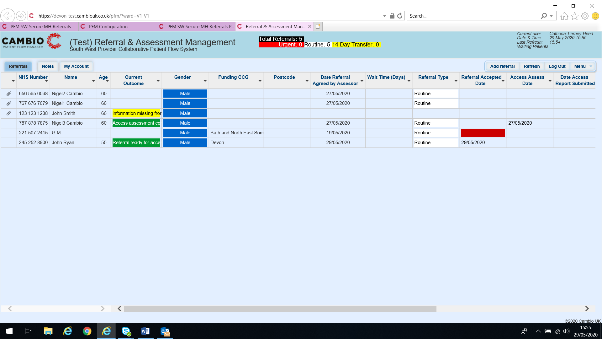


The outcome details following access assessment panel



The access assessment itself which will be uploaded as a file attachment on this tab.

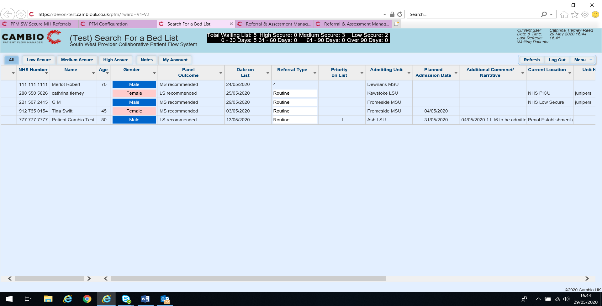


You will also be able to see “grid” view below which is a summary page illustrating the overall status of all referrals. Please note you will only be able to view you own patient on the gird. 

This grid view will be used on the weekly regional calls with secure service providers to

* Look at the current outcome status to establish if there is a delay in the referral process and if so where this might be happening eg. Is there missing information in the referral
* Review any delays on completing the access assessments against the specified timescales. There is a summary at the top of the page to show how many referrals are in and the overall status. There is also time monitor against each referral that indicates the number of days the assessment is overdue.

Once the access assessment panel have agreed to the recommendation for admission the patient is removed from the “grid” and appears on the “searching for a bed list” again you will only be able to view your own patients on this list. This page will also be discussed on the weekly referral call to reach agreement on which unit and when the patient will be admitted.



Once agreement has been reached that the patient is to be admitted they are removed from this list and added to the ward where they will go. You will then be contacted by the secure services provider to advise you that there is a bed available and arrangements need to be progressed for admission.