Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: Trustwide (TW)
Code: CP1
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Admission, Discharge and Transfer of Care Policy

Lead executive	Medical Director
Authors details	Modern Matrons

Type of document	Policy
Target audience	All clinical staff (excluding LD Respite Services)
Document purpose	To provide clinical staff with the procedure for admission, discharge and transfer of care to and from hospital and within other clinical services.

Approving meeting	Patient Safety and Effectiveness Sub-Committee	Date 1-Oct-17
Implementation date	01-Dec-17	

CWP documents to be read in conjunction with	
CP35	Physical health pathway and policy
CP49	Admission of young people to adult wards
CP19	Advance statement
MP1	Medicines policy
CP28	Smoke free policy
CP24	Cardiopulmonary Resuscitation (CPR) policy
CP25	Therapeutic observation policy and procedure for in-patients
CP30	Do Not Attempt Resuscitation (DNAR) orders
CP3	Health records policy
GR1	Incident reporting and management policy
CP2	Management of risks associated with the identification of patients
CP5	Clinical risk assessment management policy
CP9	The visiting of patients by children on inpatient areas
AM2	Protocol for 7 day follow up – Adult Mental Health
MH9	Section 19 MHA 1983 - Regulations as to the transfer of patients
IM6	Information Sharing (overarching) policy
IM7	Code of Confidentiality Policy

Document change history	
What is different?	Added section 3.1.17 and appendix 9
Appendices / electronic forms	The addition of the revised SBAR Handover Sheet for patient transfers
What is the impact of change?	Low

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Modern Matron, Ward Managers, CMHT Staff,Therapy Staff, Nursing Staff
Corporate services	Head of Compliance, Head of Clinical Governance
External agencies	Therapy Services Manager, Countess of Chester Hospital

Financial resource implications	None

External references
1. Mental Health Act Code of Practice 2. Mental Health Act 1983 3. Disability Discrimination Act 4. Mental Capacity Act 5. Deprivation of Liberty Safeguards 6. Safeguarding Vulnerable Adults Act 7. NICE quality standard 14: Quality standard for service user experience in adult mental health 8. NICE clinical guideline 136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services □

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart 1 – Admission to inpatient areas procedure including information received by services prior to admission

1. Referral Information: The Nurse in Charge facilitating the admission to the inpatient area will obtain relevant information from the care coordinator, patient and carer where applicable. In **Child and Adolescent Mental Health Services** and **Learning Disability Services** this will include a referral letter for planned admissions or verbally for emergency unplanned admissions. This information will include as a minimum reason for admission, presenting problems and a full history of any risk assessments undertaken (as per the policy on management of beds within the adult and older people's services). For **Adult Mental Health Services** a CARSO assessment and HoNOS are completed prior to admission by the care coordinator and immediate contact is made with the doctor and this is recorded in the health records.

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2. Arrange Medical Assessment/Physical examination: The admitting nurse will welcome the patient to the ward and inform the Consultant/SHO (or duty doctor out of hours) that the patient has arrived - this is to arrange a medical assessment and physical examination within 6 hours of admission. If a physical examination is not undertaken within 6 hours of admission by a doctor, the reason must be documented as per the physical health pathway and policy.

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3. Medicines - The nursing staff admitting a patient should ensure that a faxed copy of all medication usually prescribed by the patient's GP is received as soon as possible (on the same day for Mon to Fri 9-5, next working day for nights and weekends) and filed in the prescription section of the patient's notes. This should form the basis of the medicines reconciliation process which must be completed within 24hrs for patients admitted Mon-Fri and within 72hrs for patients admitted Fri 5pm-Sun. In the event this procedure is not completed this will be documented in the patient's records.

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4. Commence the assessment process (including mental health symptoms and signs physical, psychological, social and spiritual / cultural), risks (review of present assessment) and observation requirements. For informal patients a capacity assessment must be undertaken on admission to ascertain the patient's capacity to agree to admission and treatment. These assessments may be undertaken using agreed tools and must be recorded in the health records.

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5. Mental Health Act: For any patients being admitted under a section of the MHA, the Nurse in Charge must ensure that the mental health act papers are received (see policy MH6 receipt and scrutiny of detention papers)and the patient is informed of their rights and this is recorded in the health records. If the patient subject to a Community Treatment Order (CTO) and has been admitted as a result of formal recall, the nurse in charge must ensure that a copy of the recall form **(CTO3**) is placed in the patient's notes (this is the authority to detain the patient) and must complete formal receipt of the recall by completion of CTO4 (see policy MH19 Section 17a-g MHA 1983 - Supervised community treatment including recall to hospital)

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

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

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8. **Primary Nurse** -a primary nurse is allocated to the patient and a care co-ordinator is identified.

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9. Therapeutic Activities: The patient is orientated to the unit and given information about therapeutic activities available.

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10. Care and discharge planning which promotes recovery must begin from admission and have clear outcomes identified with the patient and where agreed, carers.

Quick reference flowchart 2 - Discharge requirements from all inpatient areas procedure including information to be provided and how this is recorded

Discharge is planned as part of the assessment and treatment process via a multidisciplinary review.

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Discharge process is commenced by the care coordinator/named nurse and supported by inpatient team and recorded in the health records

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Date of discharge is discussed with the patient via pre discharge multidisciplinary meeting (include relatives, carers and advocates). If a DoLS authorisation is required following discharge, this should be applied for in advance.

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Documents required for patient on discharge will include a **copy of their care plan**, including information on who to contact in a crisis. Patients discharged on a Community Treatment Order (CTO) must have a copy of the required conditions of the CTO as part of their care plan. Appointments for 7 day follow up are confirmed with the patient as appropriate and on completion of the above actions, recorded in the health records. A HoNOS must be completed.

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Information to be given to the health care professional

Internal	**External**
Professionals will access care plan via the health records	Health care professional are provided with the current care plan as a minimum

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On discharge from CWP ward or unit, patients will be provided with 14 days supply of **medicines** unless following a risk assessment a smaller supply is deemed to be necessary.
A copy of this prescription will be faxed/emailed to the patients GP and Community Mental Health Team (if applicable) within 24 hours of discharge from ward.

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Internal	**External to CWP**
When discharged from inpatient services to a CWP Community Team, a copy of the discharge prescription should be faxed to the Community Team. The electronic discharge summary must include whether or not the reason for admission has been resolved.	Discharge summaries must be received by the GP within 24 hours of the discharge from a ward. Clinic letters must be received within 7 days of the clinic appointment. The electronic discharge summary must include whether or not the reason for admission has been resolved. For discharges to nursing homes/private sector, complete an SBAR handover form.
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A follow up appointment will be arranged within 7 days from discharge date. A decision as to who will undertake the follow up will be made, documented and communicated to the patient.	Within CAMHS a follow up appointment will be negotiated with the appropriate receiving CAMHS.
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	If the patient resides outside CWP footprint, the receiving mental health trust will follow up within 7 working days

***Out of hours discharge process** – It will not be routine to discharge patients out of hours as it is a planned process as detailed above, however, in the event that an unplanned or out of hours discharge occurs the above process will be followed and recorded in the health records.

Quick Reference Flowchart 3 – Transfer of Care, ward to ward within CWP

1. SBAR: A Transfer of Care SBAR – this must be completed and communicated to the service accepting the service user/patient, and this transfer recorded in the care notes.

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2. Documentation

- A copy of the care plan
- Risk assessment reviewed and updated
- A copy of MHA detention papers and consent to treatment forms, if applicable
- Observation levels reviewed and documented in the health records
- Discussion with the patient and carer explaining the transfer will be documented in the health records
- Patient's paper health records will be transferred with the patient i.e. Observation charts, medication charts etc.
- All the above actions, when completed as appropriate, will be recorded in the patient's electronic health record

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3. Transfer Arrangements: The nurse in charge of the transferring ward will inform the bed coordinator within the home treatment team. The nurses in charge of both wards will agree the time for the transfer. If the transfer is to take place to another area within the trust, the HT team in the receiving area must be contacted. The two clinical teams with then discuss transfer arrangements and clinical needs and risks.

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4. Medication: The original prescription chart will be sent to the new unit on the day of transfer. The patient's own medication which is labelled with name and directions will be sent with the patient.

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5. Discussion with patient/carer: The nurse in charge of the transferring ward will discuss with the patient, carer/relative as well as the care coordinator and lead professional.

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6. Transport arrangements:
Nursing staff to risk assess and document the patient's needs for transport. The mode of transport and numbers of accompanying staff will be dependent on risk assessment. (In the East locality, follow local protocol for arranging secure transport to PICU). The patient must be accompanied to the admitting ward. All personal belongings must be transferred at the same time as the patient.

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7. Mental Health Act:
If the patient is detained under the MHA, the nurse in charge should inform the MHA team. If transfer occurs out of hours, the nurse in charge must ensure a message is left.

See Appendix 4 for additional requirements for transfer to a psychiatric intensive care unit (PICU)
See Appendix 5 for additional requirements for transfer from 16-19 services to adult services within CWP
See Appendix 6 for additional requirements for transfer from adult to older people's services within CWP.
See Section 5 of this policy for further advice for external transfers of care

1. Introduction

The purpose of this policy is to provide a framework for all clinical staff for the admission, discharge and transfer of patients. The aim is to support the patient's smooth transition into and out of hospital and their transfer of care between services. It seeks to ensure that all CWP staff understand and are working together towards a coordinated service that delivers best practice.

This policy is applicable to all inpatient and community services including Mental Health Services, Drug and Alcohol Services, Child and Adolescent Mental Health Services, Learning Disability Services, Physical Health including Community, Inpatient and Children's Services.

This policy will also relate to the processes into or from the Occupational Therapy, Physiotherapy and Crisis and Re-ablement services provided by CWP physical health teams in inpatient areas owned by external trusts. CWP staff working within these units should be aware of the locally held admission, discharge and transfer of care policies as applicable.

While admission to hospital may be seen as a last resort, every effort will have been made to support the person to remain in the community. Therefore, it is essential that discharge arrangements are commenced / identified prior to admission. Care co-ordination is essential to support this process and will continue throughout the period of admission.

2. Definitions

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

A duty of care is defined as: "We must take reasonable care to avoid any actions or omissions which can be reasonably foreseen and would be likely to injure another individual", (Donoughe vs Stevens (Lord Atkins)). According to the Mental Health Act (1983) once a "duty of care" has commenced a patient may be detained under Section 5(4), 5(2), providing the criteria for detention is met. This implies that the formal admission process is not a pre-requisite.

An **admission** for the purpose of this Policy is where a service user/patient requires an in-patient area and 24 hour care/treatment to meet their needs. *See Section 3*.

A **discharge** for the purpose of this policy is where the service user/ patient no longer requires to be an inpatient to have their needs met. The service user/patient may be discharged to return home or their care transferred to another appropriate level of care. *See Section 4.*

A **transfer** for the purpose of this policy is where the service user/patient has additional physical health or mental health care needs which cannot be met in the current setting/team or when an individual moves out of area. *See Section 5.*

- Internal transfers of care occur between wards and community teams;
- External transfers of care occur from CWP to external inpatient facilities both NHS and non NHS and Community services.

Transfers may be routine and pre-planned, or arranged as an emergency. A transfer of care **SBAR** must be completed and communicated to the service accepting the service user/patient.

3. Admission - key principles to support patients

3.1 Admission to inpatient areas

For admission to inpatient units, all CWP staff working within inpatient areas must follow the procedure as outlined in the quick reference flowchart 1. In recognition that there may be variance in each individual admission, dependent on severity of their illness and risk assessment, quick reference flowchart 1 outlines the minimum requirements but these may be completed at different stages of the admission process i.e. not in the same order.

When a patient is admitted to an inpatient area via a community team, information from the community team must include an entry in the health records which includes reason for admission; presenting problems, expected outcomes of admission, an updated risk assessment and HoNOS

A&E
If the patient being admitted from A&E is unknown to CWP's mental health services, a HONOS or HONOSCA needs to be commenced and a CARSO commenced at the point of admission. See Clinical Risk Assessment Policy.

Mental Health Act Admissions

- See MH6 Receipt and scrutiny of detention papers policy
- See MH3 Admission to Hospital under Part II of the Mental Health Act 1983 - Sections 2, 3 and 4
- Explain rights to the patient and give leaflet "Explanation of Rights" as per section 132 and 130D. MH11 Section 132, 132A, 133 & 130D Information for patients and nearest relatives
- Refer the patient to an Independent Mental Health Advocate (IMHA) if the patient has requested this, or, if the patient lacks capacity and the IMHA / IMCA service may be required. This must be documented in clinical notes.
- Complete "Record of Rights" form and place in case notes

Community Treatment Order is Recalled/Revoked
If the patient has been admitted to hospital because of a recalled/revoked community treatment order (CTO), a copy of the CTO and consent documentation should also be given to the inpatient team for placement in current case notes to ensure compliance with the MHA legislation.

If admitted as a result of formal recall, the nurse in charge must ensure that a copy of the recall form **(CTO3**) is placed in the patient's notes (this is the authority to detain the patient) and must complete formal receipt of the recall by completion of CTO4 see policy MH19 Section 17a-g MHA 1983 - Supervised community treatment including recall to hospital.

The inpatient team should ensure that a copy of the patient's last detention documents (Section 3 or 37 Mental Health Act 1883) issued prior to the patient being placed on the CTO, are placed in the current inpatient case notes.

3.1.1 Risk assessment

Risk assessment and management is pivotal to the safety of the patient and as such, a risk assessment must be conducted at first contact with the Trust and reviewed as part of an ongoing process. Risk assessments must be considered / reviewed at every contact with the patient and changes in therapeutic presentation documented. Where there is no change to risk, it must be documented that the risk has been considered / reviewed and there has been no change. Staff undertaking risk assessments must only use the tools that have been approved for use within the clinical risk assessment policy. For Adult Mental Health Services, a CARSO is completed prior to the admission by the care coordinator or by inpatient staff if the patient does not have a care coordinator. Inpatient staff must review the CARSO and ensure any risk factors identified are incorporated into the care plan. Risk management plans must include consideration of the inpatient environment.

3.1.2 Capacity assessment

Capacity assessment is time and decision specific and must be conducted at first contact with the Trust and reviewed as part of an ongoing process. Prior to admission and as part of the admission process, capacity to consent to admission and treatment should be assessed and documented within the electronic patient record admission clinical entry and headed 'assessment of capacity'. This entry should be completed by the admitting doctor.

3.1.3 Welcome the patient to the ward

The admitting nurse will welcome and orientate the patient to the ward. A primary nurse will be allocated to the patient, and if not previously assigned, a care coordinator will be identified.
Consent will be obtained from the patient to remove medication brought in to the ward and returned to pharmacy for safe disposal and/or follow the Patient's own drug (POD review (MP17) process.

- The patient will be given information about therapeutic activities.

- Specific dietary requirements and support will be discussed including health, spiritual and cultural needs. This will be documented within Care Notes and form part of the care plan as appropriate.
- Smoking cessation and support will be identified in line with the Trust's Nicotine Management Policy.
- Information sharing consent will be agreed and recorded.
- Assess if the patient has capacity to be responsible for looking after their own property - any cash, valuables, or clothes are checked with the patient and recorded and stored appropriately.
- Patients / carers or relatives will be given: information and / or welcome packs; carer support / user groups / carers link information (consent re patient's wish to have nearest relative informed). See MH11 Section 132, 132A, 133 & 130D Information for patients and nearest relatives .
- Information will be also be given re advance statements / decisions and sharing information / agreement.
- Child visiting policy - refers to the visiting of patients by children on inpatient areas policy – form CV1 and completed information regarding children that may visit the patient.

The minimum requirements may be completed at different stages of the admission process i.e. not in the same order and steps maybe interchangeable depending on the health needs of the individual.

3.1.4 Medical, Physical and Nursing assessments, examination and ongoing physical care of the patient

The assessment and ongoing physical care of the patient is a key element to the care of the patient. Details can be found in the physical health pathway and policy.

The admitting nurse will inform the Consultant/SHO (or duty doctor out of hours) that the patient has arrived – this is to arrange a medical assessment and physical examination within 6 hours of admission. If a physical examination is not undertaken within 6 hours by a doctor, the reason must be documented as per the physical health pathway and policy. If physical health issues have been identified prior to the admission, then these should be escalated and a medical review should be completed as soon as possible.

- Nursing staff will commence their assessment process including mental health signs and symptoms, physical, psychological, social and spiritual / cultural), including as a minimum, assessment of capacity, risks (review of present assessment), and observation requirement.
- On the admission of an informal patient a capacity assessment must be completed regarding admission and treatment and documented within clinical notes. If a patient lacks capacity to consent to admission consideration should be given to the use of the Mental Health Act or Mental Capacity Act (DoLS). See Appendix 8 Guidance on Deprivation of Liberty Standards, and MCA intranet page
- These assessments should be recorded in the health records.
- Any actions and referrals required from the assessments must be incorporated in the care plan.
- The joint assessments must be completed within 24hrs by nursing staff and 6hrs by medical staff using the electronic patient record assist workflow.
- If the assessments are not completed within these time frames the reason must be documented in the relevant electronic patient record assist document e.g. the patient refuses to be examined.

See also physical health policy and pathway and physical observations assessment and the management of altered levels of consciousness (including MEWS, AVPU (Alert, Voice, Pain, and Unresponsive) and GCS).

3.1.5 Identification of treatment post assessment

- Review risk and decide observation levels.
- Document the rationale for the observation level.
- Formulate a care plan that will be developed and documented in care notes.
- Address mental and physical health needs.
- Promote strengths and support recovery.
- Record any condition which may increase the risk of injury or collapse e.g. cardio-pulmonary function, muscle or joint impairments, falls, self-harm, management of violence and aggression, with the appropriate treatment or management plan.
- Regular review of capacity to consent to admission and treatment if there is evidence of impaired or fluctuating capacity.

3.1.6 Consent to treatment

General Principles of Consent

"Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on an adequate knowledge of the purpose, nature, likely effects and risks of the treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not 'consent'" *(Code of Practice for the Mental Capacity Act, Chapter 23.31)*.

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

- For consent to be valid it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
- If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.
- Consent should be sought for each aspect of the person's care and treatment.

For guidance on the Consent to Treatment under the MHA, see trust policy MH13 Consent to Treatment.

Principles of good practice regarding chaperones
All patients should have the right, if they wish, to have a chaperone present during an examination, procedure, treatment or any care. A chaperone provided by CWP can be a professionally qualified member of staff or the patient may choose to have a relative or friend present with them during any examination or procedure. A Chaperone poster for display is available as Appendix 9.

3.1.7 Spiritual / cultural needs
On admission spiritual / cultural needs need to be explored with the patient and referral to the appropriate faith / spiritual service will take place and will be reviewed regularly. Staff can access support via the CWP Chaplains.

3.1.8 Activities within inpatient areas
It is essential to have activities which promote recovery and maintain well being (e.g. physical activities or occupational therapy). At the point of admission, these needs will be assessed and agreed with the patient.

3.1.9 Gender specific needs
On admission, any gender needs will be discussed with the patient. This will include the requirement to have available chaperones for intimate procedures and gender specific facilities available with Single Sex Accommodation.

3.1.10 Admission of children and young people
Decisions about admission to hospital need to be considered separately to decisions about treatment in hospital as different criteria apply. The law on consent for admission is also different for children under 16 and young people aged 16 and 17.

See also Admission to CWP Tier 4 CAMHS beds: guidance for staff.

Children under 16

Gillick Competency identifies children aged under 16 who have the legal capacity to consent to medical examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks and alternative courses of actions. If a child under 16 lacks competence, the consent of the person with parental responsibility will be required

- Consent for admission of a child under 16 who is Gillick competent to decide can be provided by the child themselves.
- For a child under 16, who lacks Gillick competence, it may be possible for a person with parental responsibility to consent on their behalf, to informal admission.
- For a child who is Gillick competent and refuses admission, the Mental Health Act Code of Practice advises against relying on the consent of a parent with parental responsibility to override the child's

decision. In such cases consideration should be given to the Mental Health Act or a court authorisation.

Young people aged 16 and 17

For a 16 or 17 year old who lacks capacity, admission must be authorised using the Mental Health Act or Mental Capacity Act. Section 131 of the Mental Health Act provides that a young person's refusal of their admission to hospital cannot be overridden by those with parental responsibility.

- Consent for admission of a young person with capacity to decide can be provided by the young person themselves.
- If a young person with capacity does not consent to admission, a person with parental responsibility cannot consent on their behalf. If admission is thought to be necessary, then in such cases consideration should be given to the Mental Health Act or a court authorisation.

- The admission of a young person who lacks capacity may be authorised by:
  - the person with parental responsibility consenting to admission,
  - the Mental Capacity Act if treatment is in the young person's best interest.
  - If the person with parental responsibility does not agree to admission, consideration should be given to the use of the Mental Health Act or court authorisation. This needs careful consideration, particularly if the admission involves a deprivation of liberty.

- For guidance on the admission of children and young people under 18 and the role of parents in decisions about admission and the Zone of Parental Control please refer to Chapter 19 of the Code of Practice 2015 and consent to treatment by children and young people.

3.1.11 Medications

- Nursing staff admitting a patient should obtain a faxed / emailed copy of medication currently prescribed and a summary including allergies from their GP on the same day for admissions occurring Monday to Friday 9am - 5pm; the next working day for nights and weekends. This should be filed in the prescription section of the patient's health record.
- All patients must be asked about medicines allergies on admission. This must be documented on the patient's medicine chart.
- If the GP highlights any clinical alerts, this should also be documented in the patient's health record.
- This should form the basis of the medicines reconciliation process which must be completed within 24hrs for patients admitted Mon-Fri and within 72hrs for patients admitted Fri 5pm – Sun. If this is not completed it will be documented in the patient's health record.
- The Pharmacy team will complete the medicines reconciliation.

3.1.12 Infection prevention and control issues

All staff must ensure that any patient admitted to an inpatient bed who is known to have an infection, infestation, and or virus, or who is on an antibiotic or decolonising treatment for MRSA, has their status documented and that an immediate referral to the Infection Prevention and Control Team (IPCT) is made. Where indicated, an IPC assessment is carried out within 24 hours.

Any patient known to be infectious, who is being discharged to another healthcare facility, must have their status documented, so that the receiving staff are informed. In line with the Department of Health's requirements, patients from acute trusts and nursing homes must be swabbed for MRSA and assessed for C. Difficile in line with the infection prevention and control policies.

When discharging to another healthcare facility, including nursing homes, Health Care Associated Infections (HCAI's) status including investigations and treatment undertaken, including a 'completion' date will be included in the care plan / discharge summary on discharge. The patient's immediate area i.e. bed and locker, must be cleaned prior to the next admission. Please refer to the infection prevention and control policies.

3.1.13 Safeguarding

On admission consideration must be given to the patient's vulnerability and staff will make the appropriate referral in line with the safeguarding adults' policy or the safeguarding children's policy.

3.1.14 Children visiting

Refer to the visiting of patients by children on inpatient areas policy.

3.1.15 Smoking cessation

On admission to the services a patient's needs in relation to smoking and NRT will be assessed and a care plan will be developed in line with CP28 Nicotine Management Policy

3.1.16 Identification of patients

It is essential that the correct recording of the identification of patients is completed to ensure their safety and support clinical care, see CP2 management of risks associated with the identification of patients.

3.1.17 Care and Treatment Reviews (CTRs)

CTRs have been developed to reduce admissions and unnecessarily lengthy stays in hospital of people with a learning disability or autism. They relate to people of all ages with learning disabilities or autism who are at risk of admission or who are currently in receipt of specialist learning disability or mental health inpatient services. The policy also applies to those subject to Ministry of Justice restrictions. See appendix 9 for further information and guidance.

3.2 Admission to Therapies Services - Ellesmere Port Hospital (EPH) and Tarporley War Memorial Hospital (TWMH)

- Duty of care will commence at the point of acceptance of the referral by the relevant service i.e. Occupational Therapy and Physiotherapy.
- If EPH's or TWMH's therapists speak to the previous facility's therapy staff, an SBAR tool is to be used to record contemporaneous patient information and evidence of that conversation and handover is to be documented within the patient's record SBAR (Situation-Background-Assessment-Recommendation Handover / Communication Tool
- If patients are transferred from COCH, their episode of care will be documented on Meditech which is available to EPH staff
- Commence Therapies assessment

3.3 Admission: Crisis and Reablement Service (Respite and Rehabilitation)

Respite Admissions to Sutton Beeches and Curzon House

Respite is accessed via a Social Worker, who does a full assessment of the patient and collates relevant information.

Rehabilitation Admissions at Sutton Beeches

Admission is arranged through Single Point of access (SPA). All information should be faxed to SPA who will triage information regarding suitability of placement and discuss with Sutton Beeches Senior Care Co-coordinator.

4. Discharge requirements for all patients

For discharge from all inpatient areas, all inpatient staff must follow the procedure as outlined in Flowchart 2. Documentation that should accompany the patient is also described. There are information requirements for patients which are outlined within Flowchart 2 and discharge guidance which provides staff with an aid memoire (appendix 2). See also AM2 Protocol for 7 day follow up visits following discharge from acute mental health in-patient care.

The MHA team should be informed of discharge from hospital of patients subject to the MHA or DoLS. A DoLS authorisation cannot be transferred; therefore, if a patient is transferred to a residential or nursing home, and will potentially be deprived of their liberty, a new authorisation must be applied for by the home, ideally prior to discharge.

Discharge summaries must be received by the GP within 24 hours of the discharge from a ward. Clinic letters must be received within 7 days of the clinic appointment.

4.1 Discharge from hospital against advice

Discharge against advice arises when the patient makes a decision to leave the hospital despite advice from medical and nursing staff to the contrary. The patient is free to do this unless detained under the Mental Health Act 1983, or, in the case of young people, being treated under parental authority.

When a patient makes a decision to discharge themselves against advice the following guidelines should be considered:

- All risk factors including self-harm and harm to others and vulnerability should be assessed. Consideration should be given to detention under Section 5(2) Mental Health Act 1983 or in the absence of a registered medical practitioner, who is the approved clinician in charge of the patient's care or nominated deputy, Section 5(4) Mental Health Act 1983;
- In the case of young people, consideration should be given to using parental authority and where appropriate, involvement of Social Services. However, the decision of competent young people aged 16 and 17 cannot be overridden by those with parental responsibility and powers under the Mental Health Act need to be considered;
- The patient will be asked to wait to see a member of the medical team;
- The capacity to understand the implications of discharge;
- The training grade doctor needs to consider contacting the covering consultant;
- In hours (0900-1700hrs) medication should be given as prescribed. Out of hours the patient should be asked to return to the hospital the next day for their medication or attend their GP for further supplies. Arrangements should be made for them to attend their GP for a continuing supply of medication;
- The responsible community team should be informed at the earliest practicable opportunity;
- All patients who discharge against medical advice should be discussed at the relevant community mental health team (CMHT) meeting;
- The GP will be notified by fax/email;
- A care plan and contact details of how to contact services for support will be printed and given to the patient;
- In these circumstances the named nurse or another nurse nominated by the person in charge of the ward should attempt to give the person a plan based on the latest provisional discharge plan and will attempt to inform all named parties including carers unless it specifically states otherwise. There may be circumstances related to public safety issues which may override this. The plan and whether or not the user accepted it should be entered into the health record at the same time as noting that the user left against advice before all processes could be completed;
- The nurse in charge asks the patient to sign a discharge against advice form appendix 3 and filed in notes, if the patient declines to sign it this is detailed on the form and filed in the notes.

4.2 Out of hours discharge process

It will not be routine to discharge patients out of hours as it is a planned process, however, in the event that an unplanned or out of hours discharge occurs the process outlined in Flowchart 2 will be followed and recorded in the health records.

4.3. Information and documentation to be prepared

4.3.1 Information to be given to the receiving healthcare professional and how this is recorded

The requirement for information regarding patient care on discharge is outlined in Flowchart 2.
An SBAR handover form should be completed for discharge to a Nursing home/private sector.

4.3.2 Information to be given to the patient when they are discharged and how this is recorded

The requirement for information regarding patient care on discharge is outlined in Flowchart 2.

4.4 How patient's medicines are managed on discharge

The requirement for information regarding patient medication on discharge is outlined in Flowchart 2.

4.5 Discharge from Physical Health Services

4.5.1 Discharge from Therapy Services

- Package of care arranged / reinstated, if required, by Social worker or care manager
- Liaise with family / carer as appropriate
- SBAR transfer of care tool to be completed. SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool. (See appendix 7)
- SBAR to contain contemporaneous patient information and handed over to any further services providing follow up. Evidence of that conversation and handover is to be documented within the patient's record

4.5.2 Discharge Home from Rehabilitation at Sutton Beeches

- Inform patient's GP & provide medical update
- Package of care arranged/reinstated, if required, by Social worker or care manager
- Family liaison
- Transport
- Medication
- Continence informed for delivery of products if required
- Transfer of care letter to District nurses if ongoing treatment required
- SBAR transfer of care tool to be completed. SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool. (See appendix 7)
- SBAR to contain contemporaneous patient information and handed over to any further services providing follow up.

4.5.3 Discharge from Respite at Curzon House

All discharges are arranged by the Care Manager (Social Worker or Social Care Assessor). This information varies according to reason for admission e.g. Emergency Respite i.e. may need new package of care arranging; Equipment provision; Referral to other agencies such as Hot Meals Service. If the respite is part of a planned routine, they may just return to their existing package of care.

5. Transfer of Care

5.1 Introduction

It is sometimes necessary to handover / transfer patients within Trust services or to non CWP services and staff must be aware of the protocols outlined in this document.

5.2 Handover requirements between all care settings, to include both giving and receiving of information

5.2.1 Internal ward to ward handover / transfer of care

Documentation required to transfer patients internally, including out of hours are:

- A Transfer of Care SBAR- this must be completed and communicated to the service accepting the service user/patient, and this transfer recorded in the patient's electronic health record. SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool. This is in addition to any Discharge Report requirements.
- A copy of the care plan;
- Risk assessments reviewed and updated;
- Observation levels reviewed and documented in the health records;
- Discussion with the patient and carer explaining handover / transfer will be documented in the health records;
- The current prescription chart will be sent to the new unit on the day of transfer; Patient's own medication which is labelled with name and directions will be sent with the patient;
- Patient's paper health records will be transferred with the patient.

All the above actions, when completed as appropriate, will be recorded in the patient's electronic health record.

- When patients are transferred from one ward to another the nurses in charge of both wards will agree the time for the transfer. The nurse in charge of the transferring ward will inform the bed co-ordinator within the Home Treatment Team (HTT) team. If the transfer is to take place to another area within the trust, the HT team in the receiving area must be contacted. The two clinical teams will then need to discuss transfer arrangements and clinical needs and risks. The nurse in charge of the transferring ward will discuss with the patient, carer / relative as well as care coordinator / lead professional;
- Nursing staff to risk assess and document the patient's needs for transport and complete the Safe to Transport Risk Assessment. The patient must be accompanied to the admitting ward. The mode of transport and numbers of accompanying staff will be dependent upon risk assessment;
- All personal belongings must be transferred at the same time with the patient;
- If the patient is detained under the Mental Health Act, copies of all detention papers and consent to treatment authority forms must be sent with the patient. The nurse in charge should inform the MHA team (out of hours to leave a message);

- Medication chart and patient's own medication which is labelled with name and directions will be sent with the patient;
- Risk assessment for patient's needs for transport.

5.2.2 Transfer from ward to Psychiatric Intensive Care Unit (PICU)

- For transfer from ward to PICU see appendix 4 for additional requirements.

5.2.3 Transfer from 16-19 to adult services

- For transfer from 16-19 to adult services appendix 5 for additional requirements.

5.2.4 Transfer from adult to older peoples' services

- For transfer from adult to older people services appendix 6 for additional requirements.

5.2.5 Transfer between CMHTs and from ward to CMHT

All ward to community transfers, and transfers between community teams should be through the CPA process. The careplan and risk assessment should be updated and provided in addition to the CPA review.

5.3 External handover / transfer of care documentation / information requirements

Documentation required when transferring patients externally:

- A Transfer of Care SBAR- this must be completed and communicated to the service accepting the service user/patient, and this transfer recorded in the patient's electronic health record. SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool. This is in addition to any Discharge Report requirements.
- Copies of the care plan (patient's needs and risks);
- Mental Health Act documentation (section 19 paperwork if detained under MHA 1983);
- Verbal handover / documented handover in the health records.

5.3.1 Transfer from CWP to another mental health trust (out of area, high secure or specialist unit)

- The nurse in charge will inform the bed coordinator within the Home Treatment Team (HTT).
- It will not be routine to transfer patients out of hours. Transfers should be part of a planned process. However, in the event that an unplanned or out of hours transfer occurs, the above process will be followed and recorded in the health records.
- When patients are transferred from one Trust to another Trust, the nurse in charge of the ward will agree an appropriate time for the transfer to take place. The nurse in charge of the transferring ward will inform the patient and their carers / relatives as well as the care coordinator, of the arrangements and document in the health records;
- Escort arrangements will be dependent upon risk assessment. The receiving Trust may arrange the transfer, (which may include staff to accompany the patient). This will be negotiated by both Trusts;
- All personal belongings must be transferred at the same time;
- The transfer of patients subject to detention under the Mental Health Act 1983 requires specific procedures and completion of statutory forms prior to transfer (refer to Section 19 MHA 1983 - Regulations as to the transfer of patients. The MHA team must be informed as soon as possible so that wherever possible the original detention papers can be sent with the patient (NB some mental health trusts will not accept a transfer unless the original paperwork accompanies the patient);
- A copy of the current prescription chart will be sent to the new unit on the day of transfer. Patient's own medication which is labelled with name and correct directions will be sent with the patient.

5.3.2 Transfers from CWP to a local acute trust

A&E

- In an emergency medical situation, it is vital that contemporaneous patient information is provided to A&E staff, therefore a Transfer of Care SBAR – must be completed and communicated to A&E staff.
- As this situation is urgent, initially the SBAR may be communicated verbally over the phone, but must be faxed to A&E as soon as possible following the patient's transfer of care
- Details of the person receiving the SBAR communication must be recorded in the Care notes
- CWP's clinical team will review the risk assessment and care plan in conjunction with the acute hospital

- For patients detained under the Mental Health Act, transfer to an acute trust for medical treatment is authorised by the Responsible Clinician under Section 17 leave. See also section 5.8 of this policy.
- In a medical emergency, paperwork can be completed after the patient's clinical needs are met
- A copy of the physical and / or mental health assessment documents and care plan will accompany the patient to the acute hospital
- For patients detained under the Mental Health Act the nurse in charge of the ward / or their deputy should decide how many staff and of which grade will be required to escort the patient. This decision shall be based on the risk assessment and documented in the health records
- For patient's detained under the Mental Health Act but transferred to a local acute hospital, a leave bed will be held for them
- CWP have responsibility for ensuring that appropriate transfer arrangements are in place to enable the patient to be transferred to an acute hospital. These arrangements will be documented in the health records
- The observation level required to ensure that the patient's mental health / learning disability care needs are supported and should be identified as part of the transfer process. This plan should be shared with and agreed with by the acute hospital care team.
- The details regarding the level of observation required to support the patient should be included in the transfer documentation and in the care plan
- The care coordinator / lead professional should be informed of the transfer

Inpatients

- An informal patient admitted to an acute hospital ward will be discharged from the mental health or learning disability ward
- The care coordinator / lead professional should be informed of the transfer of care
- The observation level required to ensure that the patient's mental health / learning disability care needs are supported, should be identified as part of the transfer process, included in the transfer SBAR and in the care plan.
- For patients detained under the Mental Health Act, transfer to an acute trust for medical treatment is authorised by the Responsible Clinician under Section 17 leave. Refer to Section 19 MHA 1983 - Regulations as to the transfer of patients

- For Patients detained under the Mental Health Act, the nurse in charge of the ward / or their deputy should decide how many staff and of which grade will be required to escort the patient. This decision shall be based on the risk assessment and documented in the health records
- This plan should be shared and agreed with by the acute hospital care team.
- CWP's clinical team will review the risk assessment and care plan in conjunction with the acute hospital. A copy of the physical and / or mental health assessment documents and care plan will accompany the patient to the acute hospital.
- A copy of the current prescription chart will be sent to the new unit on the day of transfer
- Patient's own medication which is labelled with name and correct administration instructions will be sent with the patient
- When possible the transfer is to be planned, this should occur between the hours of 0900 – 1700hrs Monday to Friday.

Outpatients

If the patient is required to attend the acute hospital for a scheduled outpatient clinic appointment or to undertake a specific procedure, the patient be accompanied by a member of staff and will have a copy of the patient's care plan and medication chart.

For patients detained under the Mental Health Act, attendance at an outpatient department in an acute trust will require Section 17 leave authorisation from the Responsible Clinician.

5.4. Community patients moving out of the area

Community patients who receive care under the Care Programme Approach or Standard Care may inform their care co-ordinator that they are planning to move out of the area. Even if moving only temporarily, it is important that information should be shared between mental health professionals and their counterparts out of area. If, and when, the patient returns, information should be sought by the care coordinator from counterparts out of area to ensure that they have as detailed picture as possible of how the service user had presented recently in relation to their mental health.

Care coordinators should initiate communication and sharing information regarding issues of risk, dependent on individual circumstances, with other relevant professionals. These issues of risk will be identified and discussed with the patient, and the care coordinator will inform the patient that contact will be made with the local mental health services for the relevant catchment area. This will be completed within a timeframe of 28 days but may have to be expedited if there are concerns about the person's risk profile and mental health. The referral will go to the single point of access service of the relevant receiving trust.

To facilitate the relevant teams out of area having sufficient information regarding issues of risk that is in the interests of service users and others, the following information will be shared in line with data protection and associated legislation:

- the current detailed care plan,
- current risk assessment,
- current medication and current treatment plan,

If the patient moving out of area is subject to a Community Treatment Order, written acceptance from the receiving Community Team must be obtained prior to transfer of care. The care coordinator must inform the MHA team as soon as possible of the pending transfer to ensure all statutory forms are completed and documentation sent to the new trust. Refer to policy MH19 – Supervised Community Treatment including recall to hospital.

Care co-ordination will be maintained by CWP unless, subsequent to this, a transfer of care provision is indicated.

For further advice, see Code of Confidentiality Policy (IM7) and Information Sharing (overarching) Policy (IM6), or consult the Trust's Record Manager or Caldicott Guardian.

5.5 Escorts for patients not detained under the Mental Health Act

- If a patient requires an escort, they should be accompanied by a member of CWP staff with the skills to support the individual. Where a risk assessment indicates that more than one staff member is required, then the appropriate number of staff will accompany the patient. Where practicable, staff undertaking escort duties will be known to the patient;
- The escort should ensure that the patient's health care needs are communicated during the transfer procedure. The escort will take responsibility for transferring relevant clinical information, including a copy of the current medication list (any labelled medication will also be transferred e.g. Clozapine);
- Where it is clinically appropriate the patient may be accompanied by a relative or carer. In these circumstances the responsibility for ensuring effective communication with the acute hospital department remains with the trust clinical team.
- Escorts will ensure a comprehensive handover is given to the acute hospital care team ensuring continuity of care.

Escorts for patients detained under the Mental Health Act

- The CWP nurse in charge of the ward / or their deputy should decide how many staff and of which grade will be required to escort the patient. This decision shall be based on the risk assessment and documented in the health records. See MH17 Conveying of mentally disordered persons policy

5.6 Observation levels for patients being treated in acute trusts

The observation level required to ensure that the patient's mental health and learning disability care needs are supported and should be identified as part of the transfer process. This plan should be shared (via and SBAR) and agreed with by the acute hospital care team. The details regarding the level of observation required to support the patient should be included in the transfer documentation and in the care plan.

5.7 Section 17 leave

Section 17 leave is required for patients detained under the Mental Health Act prior to being transferred to an acute hospital **except** in emergency situations. In such cases the Responsible Clinician (RC) should authorise leave at the earliest opportunity. Section 17 leave can only be authorised by the Responsible Clinician (RC) after discussion with the patient and nursing team.

A leave bed on the mental health and / or learning disability ward will be held for the patient during their stay in the acute hospital.

CWP's clinical team will retain responsibility for ensuring that the specialist mental health or learning disability care needs of the patient can be managed on the acute ward whilst they remain under a section of the Mental Health Act.

These arrangements should be communicated to the nurse in charge of the acute ward and documented in the care plan. **Copies** of the patient's section papers **must** be sent with the patient.

Escorts will ensure a comprehensive handover is given to the acute hospital care team, ensuring continuity of care.

Transfer documentation (SBAR) should include information necessary to ensure medication required to meet specialist mental health and learning disability needs can be administered within the acute hospital ward. The care plan should indicate which staff will undertake responsibility for administering the medication implemented and provide details of review arrangements to be put in place.

The acute trust care team may contact the relevant consultant or clinical team for advice and guidance. In the absence of the relevant consultant or team or in an emergency, liaison psychiatry may be contacted for advice.

5.8 Transfer / returning patient to CWP following admission to acute trust

Documentation to be requested from the acute trust:

- A copy of the care plan;
- Results of any investigations;
- Patients medication, labelled with name and correct administration instructions to be sent with the patient;
- Verbal handover to CWP staff and recorded in the health records.
- Copy of their SBAR form.

5.8.1 CWP inpatient unit

When the patient is ready to transfer back to the CWP inpatient unit, then the acute hospital care team, or other organisation, will contact the CWP inpatient care team.

The CWP inpatient care team will then inform the Home Treatment Team (HTT) who will:

- Amend the bed status report / identify the bed;
- Decide alongside the inpatient care team whether there is a continuing need for inpatient care.

If the patient requires inpatient mental health and / or learning disability care and their physical health needs can also be safely met, then arrangements for transfer will be made.

Transfer arrangements will be organised by the acute hospital care team in conjunction with CWP staff, ensuring the needs of the patient can be safely met. Transfer should not take place until the receiving clinical team have confirmed that they are satisfied with the care arrangements that have been proposed. A copy of the acute trust's care plan will be requested to accompany the patient, including the results of any investigations. The patient's medication labelled and with dispensing instructions, will be sent with the patient.

An SBAR format should be used to receive a verbal handover and recorded in the health records.

5.9 Transfer of Care from Therapy Services

- SBAR tool to be completed See SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool.
- SBAR to contain contemporaneous patient information and handed over to the acute hospital's therapy staff / other / external / internal agencies as appropriate.
- Evidence of that conversation and handover is to be documented within the patient's record

5.10 Transfer of Care from Sutton Beeches/Curzon House to Hospital

- GP liaises with SPA regarding medical reason for admission of Sutton Beeches Rehab patients.
- Send a copy of medication administration record (MAR Sheet) with the patient
- Send a GP letter where possible
- Send Next of Kin information and any relevant patient details
- Sutton Beeches Senior Care Co-coordinator to inform patients' next of kin of hospital admission
- If the patient is admitted to an acute hospital (usually as an emergency) information accompanies the patient detailing Name; address; DOB; Reason for admission to Sutton Beeches / Curzon House; Next of Kin details; Copy of medicine administration chart
- If the patient has Dementia this is highlighted on the paperwork.
- Staffing levels prevent sending an escort, but staff contact next of kin and request that they meet the patient at A&E is possible.
- If patient is being transferred to another place of care this is directed by the Care Manager (Social Worker or Social care Assessor).

5.11 Out of hours transfer / handover of care

Transfer of care will not normally happen out of hours, unless urgent/emergency care with the A&E department, admission to an acute hospital ward or PICU is required; otherwise transfer of care should form part of a planned process. However, in the event that an unplanned of out of hours transfer occurs, the transfer processes described previously, will be followed as appropriate to the situation and recorded in the health records.

5.12 Handover from one shift of staff to another

A handover from one shift of staff to another is a type of transfer of care. Is a vital process to ensure important contemporaneous information is disseminated between the nursing team. An **SBAR** tool SBAR (Situation-Background-Assessment-Recommendation) Handover/Communication Tool (appendix 7) must be used to facilitate the handover.

- Information must be accurate and factual
- Effective handover ensures continuity of care
- Handover is a time for clinical discussion and to plan care approaches
- Handover is to occur at the commencement of a shift
- All staff are to receive handover at the earliest suitable time
- Patients must not be left unattended during handover
- It is the responsibility of the nurse in charge to ensure that handover is completed and that all staff attend
- All staff are responsible for ensuring their awareness of, and conversance with, care plan contents
- Handover is of particular importance to new staff or staff returning to duty following an absence
- Handover is predominantly related to the client's health care, but could include:

    - Current or planned events that have been observed or identified and reported verbally, electronically or in writing
    - Sharing clinical information from the Multi-Disciplinary Team (MDT)
    - Operational issues affecting the care of the client, eg observational levels
    - Untoward occurrences
    - Activities i.e. social events / visitors
    - Risk assessments
    - Remaining tasks requiring completion
    - Any Safeguarding issues

5.13 Effective Communication

Communication is central to: successful caring relationships; effective team working and positive outcomes for our service users / patients. Teamwork often involves hurried interactions between human beings, with varying styles of communication. Poor or ineffective communication processes can increase risk and affect outcomes for service users/patients, causing distress for them and their families/carers. It is therefore essential for staff to communicate effectively when our service users/patients are being admitted, discharged or transferred, internally *or* externally to the Trust.

The facility accepting our service user/patient must be given accurate, relevant, contemporaneous information about them as part of the handover process. An **SBAR** tool SBAR (Situation-Background-

Assessment-Recommendation) Handover/Communication Tool (appendix 7) must be used to minimize the likelihood of: inaccuracy; untoward variance in practice; or development of customs and practices that do not reflect the Trust's policies or standards. It can be used to communicate information effectively and is a standardised tool for concise factual communications among staff.

S = Situation (a concise statement of the problem)
B = Background (pertinent and brief information related to the situation)
A = Assessment (analysis and consideration of options – what you found / think)
R = Recommendation (action requested / recommended – what you want

In Completing the SBAR tool it should detail information held within:

- CARSO / risk assessment (as appropriate);
- Care plan;
- Medicine card etc.

Appendix 1 – Admission checklist (aide memoire)

Patient Name/DOB ……..

✓	**Action**
☐	Inform Duty Medical Officer
☐	Inform all contacts as per contact sheet
☐	Request or collect previous case notes, if notes on another site faxed summary
☐	Action – Ensure physical exam completed within 6 hours for Doctors, 24 hours for nurses
☐	Action – Obtain faxed copy of patient summary including allergies and current medication from GP
☐	Action – Medication card
☐	Action – Review risk and document and agree observation levels
☐	Action – Blood forms, ECG request form (and chest x-ray where clinically indicated)
☐	Prepare interview / assessment room if necessary / prepare nursing profile / admission pack
☐	Prepare bed space / room
☐	Input details – All details as required in the health records
☐	Input details – Admission / discharge records
☐	Input details – Daily returns
☐	Input details – Statement of particulars
☐	Input details – Inpatient / fire list / observation rota
☐	Benefits – Obtain / request sick note from ward clerk if appropriate
☐	Advanced directives – Action as necessary if available
☐	Diary relevant clinical assessments that are required within certain timelines eg MUST
☐	DoLS – capacity of informal patient to be assessed regarding consent to admission
	Property – action
☐	Assess if has capacity to be responsible for looking after own property
☐	Obtain consent from patient to remove medication brought in to ward and return to pharmacy for safe disposal and / or follow POMs process
☐	Record any property which is in for safe keeping or valuable kept by patient
☐	Allocate a locker and provide keys if applicable/manage pts monies
	Inform patient / carer – action
☐	Orientate to ward / unit and give information / welcome pack
☐	Information sharing agreed and recorded
☐	Introduce to Primary Nurse and team
☐	Carer support / user groups / carers link information (consent re patient's wish to have nearest relative informed)
☐	Child visiting policy – form CV1 and completed information regarding children
☐	Specific dietary requirements and support discussed including health and cultural needs
	Documentation - action
☐	Review CARSO Risk Assessment (or other agreed / approved LD risk assessment)
☐	HoNOS or HoNOSCA where not known to community services
☐	Admission / 72 hour assess intervention plan
☐	Copies of care plan given to patient:

If admission under MHA 1983/MCA

✓	**MHA 1983 - action**
☐	1) Accept section papers (on behalf of Hospital Managers) using the attached checklist for assistance. Complete Form H3 (receipt of section papers)– **this must be done**
☐	2) Copy section papers and fax to the MHA Team. Place copy of papers in case notes and ensure original papers are placed on the designated ward for medical scrutiny to be undertaken – **THIS MUST BE DONE**
☐	3) Explain rights to the patient and give leaflet "Explanation of Rights" as per section 132 and 130D. Refer the patient to an Independent Mental Health Advocate (IMHA) if the patient has requested this, or, if the patient lacks capacity and IMHA / IMC service may be required, document into clinical notes.
☐	4) Complete "Record of Rights" form and place in case notes

Appendix 2 - Discharge checklist (aide memoire)

Patient Name/DOB ……

✓	**Applicable to ALL discharges - Action**
☐	Care plan formulated with discharge details
☐	Discharge details documented in the health records
☐	Risk assessment reviewed
☐	Check if DoLS has been considered for post discharge
☐	Care Coordinator / CMHT / CAMHS informed
☐	Have the other following people been notified of discharge as per contact sheet
☐	7 Day follow up arranged
☐	Fax/email to GP and other appropriate professional
☐	Fax/email copy of discharge prescription to GP and CMHT
☐	Entry in the health records
	Property - action
☐	Collect money from bank / ward safe
☐	Collect valuables from general office
☐	Check locker for all other belongings
	Inform patient /carer – action
☐	Discuss with patient discharge arrangements
☐	Ensure discharge arrangements and follow up are in the care plan and the patient has a copy of this
☐	Check that patient has contact details of Emergency Duty Team and CRHTT/CAMHS service
☐	Have relevant carers' / relatives been informed of discharge
☐	Ensure patient has all information (if required) on housing, benefits, employment , education and physical health e.g. smoking cessation (if relevant)
☐	Ensure, if relevant, that consideration has been given to care of children
☐	Ensure inpatient discharge questionnaire is offered/ completed by patient
	Action - medication
☐	Ensure medication is ordered well in advance of discharge
	Complete this part if Section 117 Applicable - Action
☐	Has section 3, 37, 45A, 47, or 48 of the MHA ever applied to this patient?
☐	Has the patient had a formal aftercare meeting
	Complete this section if this is an unplanned discharge - Action
☐	Has the patient been offered any aftercare arrangements
☐	Has this been correctly documented in the health records
☐	Have the relevant referrals been sent to aftercare agencies
☐	Have the relevant people been informed – see contact sheet
	Complete this section if there is 'no fixed abode' - Action
☐	Ensure that contact address is known
☐	Ensure that we have mobile phone number

Appendix 3 - Discharge against advice form

Discharge against advice (patient copy)

I _____ of _____

wish to take my discharge from _____ ward. I understand this is against the

advice and wishes of the Team and it has been explained to me by:

Dr _____ *(signed)* and RN _____ *(signed)*

RN _____ *(signed)* (when patient refuses to wait for doctor)

I acknowledge that I have been informed of the risks of taking my own discharge and accept full responsibility for my actions and consequences arising there from.

Date		Signed	*(patient)*

If you require medication, this can only be given to you between the hours of 9.00am and 4.30pm. If you leave hospital outside of these hours and you require medication, you will be requested to return the next day or attend your GP for further supplies.

Ward Copy (file in notes)

Discharge against advice

I _____ of _____

wish to take my discharge from _____ ward. I appreciate this is against the

advice and wishes of the Team and it has been explained to me by:

Dr _____ *(signed)* and RN _____ *(signed)*

RN _____ *(signed)* (when patient refuses to wait for doctor)

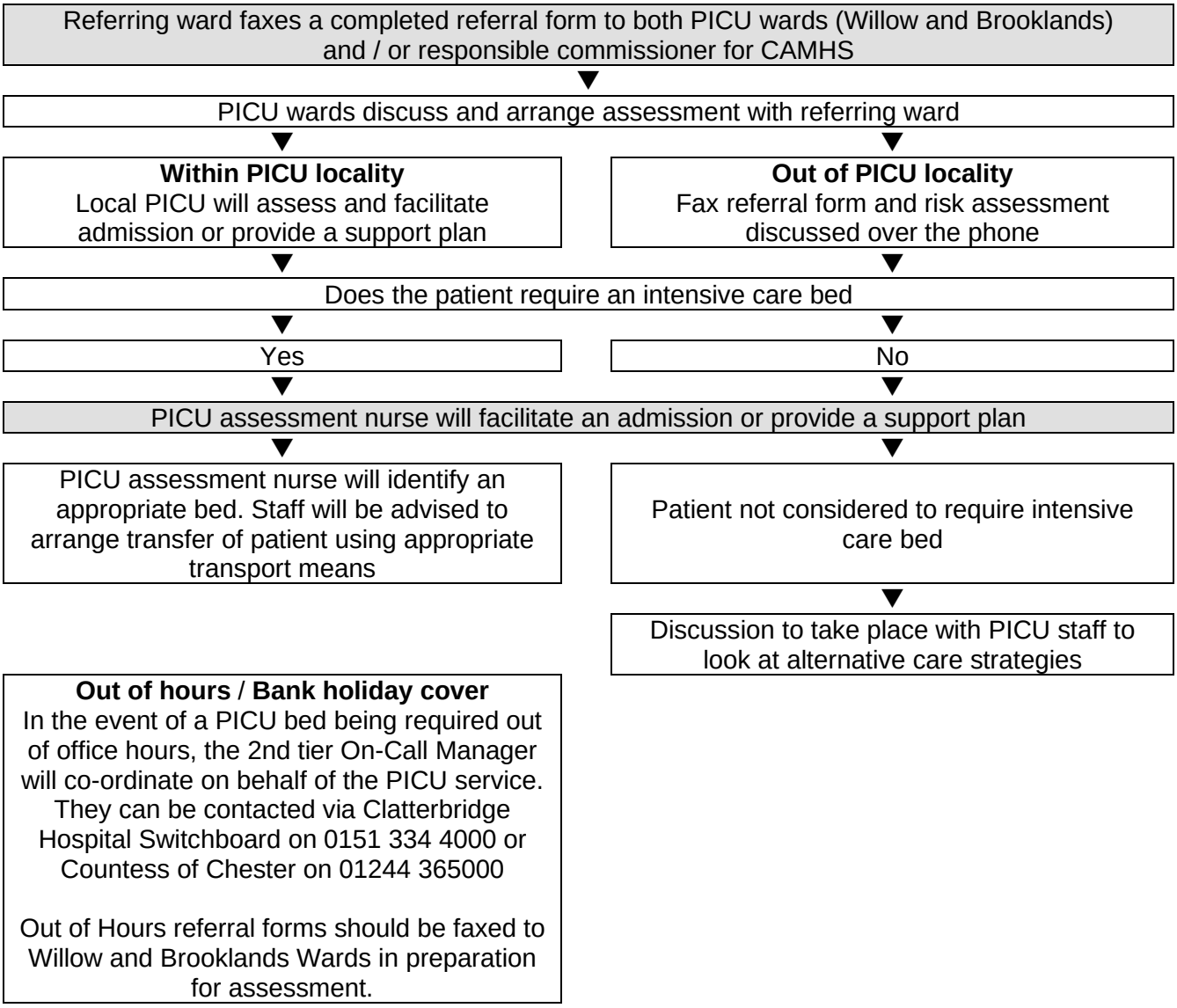
I acknowledge that I have been informed of the risks of taking my own discharge and accept full responsibility for my actions and consequences arising there from.

Date		Signed	*(patient)*

If you require medication, this can only be given to you between the hours of 9.00am and 4.30pm. If you leave hospital outside of these hours and you require medication, you will be requested to return the next day or attend your GP for further supplies.

Notes

Appendix 4 - Transfer to a psychiatric intensive care unit (PICU)



A Transfer of Care SBAR must be completed an communicated to the service accepting the service user/patient, and this handover recorded in the care notes. This is in addition to any Discharge Report requirements

Appendix 5 - Transfer from 16-19 services to adult services within CWP

Principles of transfer:

- To provide a clear seamless pathway enhancing continuity of care;
- Transfer is based upon a decision involving patient, carers (where appropriate) and clinicians regarding need, age and diagnosis / formulation;
- Diagnostic uncertainty is not an exclusion criteria for continuity of care;
- Services will be provided by those with the greatest expertise of assessment, treatment and care to meet the needs of any given patient;
- Continuity of care is paramount and may require flexibility in transition processes (e.g. joint working between 16-19 service and adult services);
- Care coordination guidelines are adhered to;
- Patients should be stable in terms of diagnosis and circumstances for transfer to be planned wherever possible.

Criteria for transfer from 16-19 yrs mental health service to adult mental health services

Core criteria		Recommended practice
Patient is in service with 16-19 mental health services and has ongoing need.	▶	Registered with a GP in Cheshire or Wirral. Care coordinator / key worker has responsibility to ensure understanding by young person / carers about transfer arrangements and need for consent.
Key worker / care coordinator liaises with adult service team leader to coordinate transition	▶	Should always include joint care planning. May involve joint working practices up to date of transfer. Good practice for referring clinician to invite adult service colleague to attend referral / allocation meeting to discuss transition.
Written referral to adult team is made and care coordination, documentation completed (for patients subject to CPA)	▶	Referral must include relevant history and work undertaken, professional's involved and family history in accordance with Climbie Inquiry.
Acceptance of referral by adult service confirmed in writing	▶	Should be copied to relevant professionals, young person and carers.
Clinical responsibility remains with 16-19 service until formal discharge and acceptance by adult services. Health records to follow client and signed to verify receipt	▶	Transfer of care should be with patient / carers consent and documents in the health records.

A Transfer of Care SBAR must be completed an communicated to the service accepting the service user/patient, and this handover recorded in the care notes. This is in addition to any Discharge Report requirements.

Appendix 6 - Transfer from adult to older peoples services within CWP

Principles of transfer:

- Transfer is never automatic but based on a decision involving patients and carers regarding need and diagnosis;
- Services will be provided by those with the greatest expertise to meet the needs of any given patient;
- Continuity of care is paramount and may require flexibility in transition processes (e.g. allowing attendance at adult day centres);
- Care coordination guidelines must be followed.

Minimum criteria for transition from adult to older people's mental health services

Core criteria		Recommended practice
Discussion takes place and is recorded in the health records, on transfer arrangements with patient, carer and care coordinator	▶	CPA review or out-patient review. Good practice to include OPMH representative at this stage. Moving patients from CPA to standard at the point of transfer should be avoided apart from for the occasional patient who might have moved into full time care or similar circumstances.
Transfer request is made to Older Peoples CMHT	▶	Referral may be by letter, direct to the consultant or to team. If the patient does not want to be transferred and there is no clinical reason to do so, they should stay with adult until circumstances change.
Older Peoples services to be aware of needs / risks	▶	To include any risk assessment, needs assessment etc
At first appointment with older people's service, transfer is confirmed and recorded and plan of care agreed with patient.	▶	This may be a CPA review or out-patient appointment. GP must be informed at this stage. Referral is only complete at this stage.

A Transfer of Care SBAR must be completed an communicated to the service accepting the service user/patient, and this handover recorded in the care notes. This is in addition to any Discharge Report requirements.

Appendix 7 - SBAR handover sheet for CWP patient transfers

One handover sheet per patient transfer, this is to be completed by ward transferring the patient and ensure this is filed in to patients nursing notes on arrival to ward/department

<table>
<tr><th colspan="2">SITUATION</th></tr>
<tr><td>Date & Time:</td><td>Copy of medication card included: Yes/No</td></tr>
<tr><td>Patients Name :</td><td>Age/ DOB :</td></tr>
<tr><td>NHS Number :</td><td>Mental Health Act status:</td></tr>
<tr><td>CCO Name:</td><td>Hospital Number :</td></tr>
<tr><td>Is the patient subject to DoLS? Yes/No</td><td>CPA status:</td></tr>
<tr><td>Current or provisional diagnosis:</td><td>Nearest relative notified: Yes/No</td></tr>
<tr><td>Transferring from :</td><td>Transferring to :</td></tr>
<tr><td>Nurse giving handover :</td><td>Receiving Nurse :</td></tr>
<tr><th>BACKGROUND</th><th>ASSESSMENT</th></tr>
<tr><td>[Specific health/incident details including times & any medication and diets last taken]</td><td rowspan="2">Physical Observations
BP……Pulse……..Respirations…….
MEWS score & time last taken: ……
GCS score & time last taken: ……
Smoker…….Yes/No Substance misuse …….Yes/No
Diet (time last taken)…….
Fluids (time last taken)…….
Assistance required with feeding Yes/No
Please specify (inc type of diet)……

Infection Risk? Yes / No
If yes state why ……
Invasive devices:
IV Cannula Yes / No
Urinary Catheter Yes / No
Other please state:
……..
Waterlow Score: ……

Skin integrity (if has pressure ulcer location and grade)……
Falls Risk? Yes / No
Mobility issues? ……
Known allergies……..
Current DNAR in place? Yes/No

Safeguarding issues? Yes/No
Please specify……..</td></tr>
<tr><td>KNOWN RISKS [Harm to self or others, physical health issues i.e. epilepsy, learning disabilities, diabetes, self-injurious behaviours, nursing observation levels</td></tr>
<tr><td colspan="2">RECOMMENDATIONS [plan of care including pending investigations]</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Signature:</td></tr>
</table>

Appendix 8 - Guidance on Deprivation of Liberty Standards (DoLS)

- On admission of an informal patient ensure capacity assessment regarding admission and treatment is done;
- If the patient has capacity then the fact that they consent to the admission should be recorded and they should be provided with information as to what being an informal patient means;
- If the patient lacks capacity to consent to the admission then they are likely to be deprived of their liberty, applying the acid test from the Supreme Court decision in *P v Cheshire West*:

A deprivation of liberty occurs when:

  - the person is under continuous supervision *and* control; **and**
  - is not free to leave; **and**
  - the person lacks capacity to consent to these arrangements.

- If you identify that a person lacks capacity and is deprived of their liberty then you need to obtain legal authority for their detention.

This can be done by:

  - Detention under the Mental Health Act 1983 (MHA);
  - Obtaining authorisation under DOLS;
  - Obtaining an order from the Court of Protection.

- If the person is objecting to being in hospital or their care/treatment for mental disorder then assessment under the MHA should be arranged. Use Section 5(4) and 5(2) if the assessment cannot be done immediately.
- If the person is not objecting then there may be a choice between the MHA or DOLS. Where possible, consult with the Consultant in charge of the patient's care. If the Consultant advises detention under the MHA then use Section 5(4) and (2) to detain the patient whilst assessment is conducted.
- If DOLS is thought to be appropriate then you will need to put an Urgent DOLS in place initially and make an application for a standard authorisation.
- If you are unsure which is appropriate then put an Urgent DOLS in place and make an application for a standard authorisation. The DOLS eligibility assessor will advise if they think the patient should be detained under the MHA. If at any point CWP feels the patient should be detained under the MHA rather than DOLS then that process should be followed, regardless of the fact that a DOLS assessment may be underway.
- If you are unsure then seek advice from the consultant in charge of the patient's care.
- The capacity of a patient to consent to admission should be kept under regular review.

Appendix 9 - Care and Treatment Reviews (CTRs)

CTRs have been developed as part of NHS England's aim to reduce admissions and unnecessarily lengthy stays in hospital of people with a learning disability or autism. The Winterbourne View Concordat and Transforming Care policies set a national target around people with LD residing inappropriately in specialist LD or MH inpatient settings. CTRs were implemented nationally in November 2015, and responsibility for implementing the CTR process rests with the Care Commissioning Groups (CCG).

CTRs relate to people of all ages with learning disabilities or autism who are at risk of admission or who are currently in receipt of specialist learning disability or mental health inpatient services and are the commissioning responsibility of NHS England or the CCGs. The policy also applies to those subject to Ministry of Justice restrictions.

The CTR process is triggered at the point when a person is identified as 'at risk' of being admitted to a specialist learning disability or mental health inpatient setting, and is supported by the development of 'At risk of Admission Registers' by the CCG. The CTR process facilitates a process of seeking alternatives to admission if possible, and if not, follows them through any subsequent admission, period of assessment/treatment and towards discharge.

The full guidance from NHS England can be accessed via this link:
https://www.england.nhs.uk/learningdisabilities/ctr/

Appendix 10 – Chaperone poster

CHAPERONES

There are occasions when patients need to be assessed by a healthcare professional which might involve intimate examinations.

CWP is committed to putting patients at ease whenever possible, and if you wish a chaperone to be present during your examination please do not hesitate to ask a member of staff.