Hampshire Partnership NHS
NHS Trust

OLDER PEOPLE'S MENTAL HEALTH DIRECTORATE

POLICY FOR THE ADMISSION, TRANSFER AND DISCHARGE OF CARE OF INPATIENTS

Hampshire Partnership NHS Trust
POLICIES AND PROCEDURES PROFORMA

Subject and Version of Document:	Policy for ADMISSION, TRANSFER AND DISCHARGE OF INPATIENTS IN OPMH DIRECTORATE Version 1
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Date agreed:	November 2008
By whom agreed:	Version 1: DSB
Date of next review/update and by whom:	1st March 2008 and then annually By CIG
Copy obtainable from:	Jane Nicholas, Optimum Admission Programme Lead and OPMH website
Distribution:	All Staff in OPMH
Date document issued:	Version 1: November 2008
Responsibility for dissemination to new staff:	Available on OPMH Website Clinical and non clinical leads Induction and Local Training
Principal Target Audience:	All OPMH staff

Amendments Summary:

Amend. No.	Issued	Page	Comments

1. INTRODUCTION

The Care Programme Approach aims to treat inpatient admissions as part of a continuation of patient care, which usually begins and ends, not in hospital, but in the community with the specialist community mental health team. The Care Co-ordinator retains responsibility for maintaining or initiating the CPA process whilst the service user is in hospital. During the admission, this will be done in collaboration with the Named Nurse on the ward.

It is increasingly evident that effective hospital discharges can only be achieved when there is good joint working between the NHS, local authorities, housing organisations, primary care and the independent and voluntary sectors. Admission and discharge from hospital can be a distressing time for individuals, their families and friends. This policy takes into account the requirements on our staff to liaise with all other agencies.

Discharge planning commences from admission and action is taken to maintain continuity between hospital and community services.

2. AIM OF THE DOCUMENT

To assure the delivery of person-centred care, when service users are admitted or discharged from hospital, or transferred from one service to another by ensuring that:

- Admissions are planned, appropriate and goal directed
- The admission and discharge pathways at **Appendix 1** are followed
- Wards are effectively organised to receive admissions
- There is provision of appropriate information, medication, assessment, treatment, equipment in a timely manner
- *The family/carer will be invited to the first multidisciplinary CPA meeting which will occur within two weeks of admission to review goals for the admission
- There is Involvement of, and consultation with, the service user and as appropriate relatives/carers at all stages of the admission/discharge process
- Service users are discharged from hospital in a timely fashion to a clinically appropriate and safe environment
- There are appropriate health, social care or independent sector care packages in place as required
- Effective communication occurs between health and social care teams at all steps of the admission and discharge pathways

*A CPA meeting is a review of the service user's current and future care needs and treatment plan. It is normally expected that it will be attended by representatives from the nursing, therapy and medical team, the service user's care co-ordinator, the service user and/or their representative, and a social worker where indicated.

3. SCOPE

This policy applies to all clinical services within the older persons' mental health services directorate, and sets out the general principles for planning admissions, transfers and discharge care.

It refers to admissions to inpatient units and to the discharge of care of service users to their own home, to other accommodation in the community, or to the transfer from one hospital unit to another, whether this is within Hampshire Partnership Trust or to another organisation.

4. RESPONSIBILITY

Managers and lead clinicians are responsible for ensuring that all staff involved in the admissions, transfer and discharge processes are familiar with the requirements of this policy and with the associated inpatient documentation. This includes administrative, nursing, community, medical, allied health professionals and managerial staff.

5. TRAINING

Training to familiarise staff with the key principles and standards within the policy and its associated documentation will be provided by lead clinicians, ward managers, office/administration managers, team leaders and/or modern matrons who will keep local training records. This will be a core part of local induction processes.

6. MONITORING

Compliance will be monitored through audit of the inpatient documentation, which sets standards against the pathways. This will be part of the biannual records audit programme by June 2009.

Immediate day-to-day concerns relating to the effective application of the policy will be addressed through the line management system in-hours and OPMH on-call system out of hours.

7. CARE PATHWAYS

Care pathways that describes effective pre-admission, admission and discharge processes are appended to this policy at **Appendix 1**.

The pathways have been developed to inform staff of the various steps and standards required. They are to be displayed in prominent positions to underpin the processes in place on the ward and community teams.

The pathways are reflected in the OPMH inpatient admissions paperwork and the OPMH inpatient discharge planner and provide clinical staff with the assessment tools and prompts to ensure effective ongoing care planning and treatment.

7. STANDARDS FOR ADMISSION TO AN INPATIENT UNIT

7.1 Pre-admission

Referral for admission to an inpatient unit will be made to the appropriate consultant/deputy during working hours or the on-call consultant/deputy outside of working hours.

Bed availability will be confirmed with the senior nurse for the unit at all times.

The ward will be provided with the necessary information including anticipated time of admission prior to the admission. As a minimum, the ward must be advised of the current psychiatric presentation, reason for admission, risk assessment and required levels of observation. Details of any physical health problems and functional needs will be included. A pre-admission form will be used unless the practitioner arranging admission is able to provide information which can be directly entered onto the admissions paperwork.

The service user, and, as appropriate their carer, must be kept informed of the anticipated date and time of admission. Where possible/available, any aids to person-centred care planning e.g. personal history documents will be made available to ward staff. Wherever possible the service user will be encouraged to bring all their medication with them on admission for review. NICE standards regarding medication admissions reconciliation checks (ARC) will apply.

For people who have had previous contact with the CMHT, the most recent care plan, risk assessments and any other relevant documentation will be provided to the ward by the Care Co-ordinator.

In instances when a bed is not available in the locality, the Modern Matron or their designated deputy will ascertain if a bed is available in an alternative inpatient unit within the Trust. In these circumstances it is the responsibility of the admitting consultant/deputy to make contact with the appropriate consultant/deputy in the alternative inpatient unit and agree plans for admission and confirm the ongoing medical responsibility for the duration of the inpatient stay.

All planned admissions will be within Monday to Friday 0900 – 1700h.

7.2 Within two hours of admission:

It is the admitting nurse's responsibility to ensure that the service user is met and greeted and orientated appropriately to the ward on arrival.

The time and date of arrival will be recorded on the OPMH inpatient admission paperwork.

An initial risk assessment and management plan will be undertaken immediately on arrival of the service user to the ward by a qualified nurse or mental health practitioner. This will take into account the immediate and potential risks relating to the safety of that service user e.g. risk of self harm, falling, patient going missing from the ward etc in order to establish appropriate intervention and level of observation.

Medication brought into hospital including any drugs purchased over the counter will be recorded (quantitatively), retained by the staff and kept securely in the ward for appropriate use in accordance with the patient's own drugs (PODs) procedures.

Permission will be obtained from the patient/relative/carer to record details of drugs brought in. Any controlled drugs **must** be entered in the register in line with Medicines Control Administration Prescribing Policy (MCAPP).

The service user will be provided with a ward information leaflet and a Welcome Pack and their personal information/contact details checked.

Alerts including drugs, allergies, foodstuff sensitivities and reactions will be recorded on the front of the healthcare record, if not previously noted. This information will also be recorded on the prescription chart and on the OPMH inpatient admissions paperwork. The person entering this information will sign the front of the prescription chart. Important allergies and the expected response(s) e.g. anaphylaxis will also be recorded on the prescription chart.

Resuscitation status will be confirmed on the OPMH inpatient admissions paperwork as will any advance directive or lasting power of attorney. Any subsequent change to any of these must be recorded in the front sheet of the healthcare record.

If this has not happened previously the patient will be asked to sign an Information Sharing consent proforma and will be provided with the OPMH information sharing leaflet. If the service user declines to grant consent, the reasons will be recorded. A sticker indicating their wish for their information not to be shared with other organisations will be displayed on the front of the healthcare record.

Subject to agreement, the ward will contact the next of kin to advise them of the admission if they are not already aware. Emergency contact information will be confirmed.

The service user's GP will be informed and the current prescription requested

If the service user is detained under the Mental Health Act, the relevant paperwork will be completed and the Mental Health Act Administrator will be informed and the appropriate information given to the service user.

The following will be clearly recorded on the OPMH inpatient admission paperwork:

- The reasons for the admission
- The service user's understanding of the reasons for admission
- The goals for admission from both the professional and service user perspective.

Information about the admission will be recorded in the admission book/electronic patient administration system.

7.3 Within 6 hours of admission:

The following will be undertaken/recorded:

- Presenting psychiatric and medical history
- Patient description
- Distinguishing features/injuries
- *Physical health assessment including baseline observations – temperature, pulse, respiration, blood pressure, urine dip, and glucose if relevant

- Current sleep pattern
- Smoking history – and note if this needs revisiting
- Alcohol consumption
- Mental health assessment – to include, mood, cognition, judgement, behaviour, communication, perception, orientation, concentration, risks to self and others

*Generally a physical examination is expected soon after the admission. However there may be exceptions e.g. admission occurs at the weekend to meet service user/carer need when there is no medical cover on the ward. In this case the physical examination will be undertaken prior to the admission. All physical examinations occurring outside of the expected timescale will be clearly documented in the healthcare record.

Patients' property will be checked and recorded on arrival using the ward property form; valuables should also be recorded and, with the service user's agreement, taken into safekeeping. If service users refuse safe keeping of valuables this should be recorded in the health care records and the service user's signature obtained if possible.

7.4 Within 24 hours of admission:

A named nurse will be allocated to the service user.

Assessment of the service user's social networks including pets, hobbies, occupation, normal routines, personal preferences, cultural needs and beliefs and sexual orientation will be undertaken. Ethnicity and language will be confirmed.

Any special needs will be identified and documented accordingly e.g. diet, or religious requirements. Compliance issues identified will be recorded to be taken into consideration in the ongoing care plan.

Detail of any existing community care package/support will be noted.

Appropriate support will be provided to carers if required, e.g. help with arranging transport to get home, explanation of service user's needs.

Within the admission assessment, the following will be completed where indicated:

- Patient handling profile
- Falls
- Body mass index and nutritional status
- Swallowing
- Diabetes
- Pressure area risk assessment
- Hygiene
- Elimination

An estimated date of discharge will be noted by the admitting/named nurse, in collaboration with the admitting practitioner, on the inpatient discharge paperwork.

The date for the initial CPA meeting (standard is within two weeks of admission) will be established. It is expected that an estimated/potential discharge date will be set

at the first CPA meeting, and recorded in the admissions paperwork, if this is not achieved within the first 24 hours of admission.

The initial care plan, drawn up within the first 6 hours, will be reviewed to ensure it meets the service user's needs. It will be reviewed again after 72 hours.

8. ONGOING ASSESSMENT AND TREATMENT

The admission assessments will highlight the need for referral to other services e.g. psychology, occupational therapy, physiotherapy, adult services. These should be noted on the OPMH inpatient admission paperwork to ensure follow-up and action. However referrals can be made at any time during the admission.

Ongoing risk management assessment by the multi-disciplinary team will take place throughout the admission, and will be clearly documented within the health care records providing clear evidence of the assessment and the actions proposed to meet the service user's care needs. Wards will use risk assessment tools e.g. Mental health, Falls, Waterlow, MUST, as required. These will be available separately from the OPMH Inpatient Admission paperwork. The required actions will be captured in person-centred care plans.

Care plans will have a clearly defined goals and review dates, according to individual need. They must be reviewed at least weekly in conjunction with the service user/carer wherever possible. Service users will be asked to confirm they are in agreement with revised care plans by signing and dating them. Copies of care plans will be made available to service users and carers as applicable. The outcome of each review will be communicated to all relevant professionals and agencies involved.

Assessments will inform the discharge planning process and any applications for on-going packages of care.

The named nurse will work with the care co-ordinator and service user to co-ordinate inpatient care within the CPA process. Care co-ordinators/lead professionals will maintain contact with inpatients and the named nurse. This includes attending CPA meetings on the ward. Each contact will be documented in the service user's health care records in line with record keeping policy.

Care and support will be person-centred and respect individuals, recognise and value diversity, preserve dignity and promote recovery and social inclusion. Service users' strengths and abilities will be acknowledged.

9. PLANNING FOR THE EFFECTIVE DISCHARGE OR TRANSFER

Planning for discharge will commence at the point of admission. At admission, in conjunction with the multi-professional team, the care co-ordinator/named nurse should discuss the reasons and the goals for the admission with the service user and their carers. These will be recorded in the OPMH Inpatient Admission paperwork.

Assessments and reviews during the inpatient admission will be used to inform the planning process for the discharge.

Service users and/or their relative/carer/other representative (who may be an Independent Mental Capacity Advocate) will be involved with and should if possible agree with the discharge destination and future intervention decision(s).

Where service users are unable to participate in the process, decisions will be made in the best interests of the individual, as defined within the Mental Capacity Act 2005. The opinion of representatives will be sought, ensuring, where possible, their interests and wishes do not conflict with those of the service user.

The discharge date and destination will be set and agreed through the CPA review process.

All options for discharge will be explained to the service user and/or their representative(s) as early in the admission process as possible. The cost consequences of all options will be communicated in understandable and explicit terms. Referrals to Adult Services if a financial assessment is required will take place in a timely manner as soon as the need is indicated.

Comprehensive, ongoing assessment will inform the decision with regard to destination on discharge. Whenever possible, service users will be enabled to return to their own home or usual care setting. If a discharge is effected to a residential home (because the service user is not able to return home), this will not preclude future assessments where this becomes feasible.

All discussions with the service user and/or their representative(s) will be recorded in the healthcare records in line with record keeping policy.

9.1 The discharge procedure

It is expected that the estimated discharge date will be agreed and noted on the OPMH in-patient discharge planner on the day of admission or, at the latest, at the first CPA meeting.

The multi-professional team will discuss the estimated discharge date and destination with the service user and their carer/s at the earliest suitable opportunity.

The expectation that discharge to a residential placement if required will take place within 4 weeks of the fit-for-discharge date will be made clear.

9.2 Initial CPA meeting

An initial CPA meeting will be arranged within two weeks of admission. The care co-ordinator will be invited to chair this meeting. If, rarely, the care co-ordinator is unable to attend, the named nurse will ensure outcomes are communicated to them to ensure follow-up. The date of the initial CPA meeting will be recorded on the OPMH Inpatient Discharge Planner.

It is a requirement of the initial CPA meeting that the estimated discharge date will be discussed and entered onto the OPMH inpatient discharge planner if not achieved on admission (n.b. the estimated discharge date is to provide a focus for planning).

The following sections in the OPMH discharge planner will be considered and completion will begin at the initial CPA meeting:

- ❖ The *Carers Intervention* section: This will inform communication with the service user/carer during the admission. Consideration will be given to whether the service user is also a carer, and the needs of their carer if they have one.

- ❖ The *Complex Discharge Needs* section: This will guide timely assessments required for discharge planning up to and until the discharge CPA meeting. It will inform applications for continuing health care funding, care funded by adult services, or care funded by health and/or adult services and/or privately.

The following will be documented as appropriate during the admission:

- Whether the service user requires an Independent Mental Capacity Advocate
- Whether a continuing health care assessment is indicated
- Date of completion of continuing healthcare checklist
- Date of referral to adult services
- Completion of adult services financial assessment process
- Assessments required by either the PCT or adult services, to include social worker/care manager, occupational therapy, nursing, medical, physiotherapy, psychology, other
- Date of multidisciplinary completion of full adult services assessment
- Date the case will be considered by the adult services Panel if required
- The outcome from the Panel
- The name of the person responsible for processing/progressing the case and informing the service user/carer of the outcome
- Date of completion of the continuing healthcare decision support tool
- Date the case will be considered by the PCT Panel if required
- The outcome from the Panel
- The name of the person responsible for processing/progressing the case and informing the user/carer of the outcome

- ❖ The *Further Considerations* section will enable consideration to be given to e.g. Section 117 aftercare, guardianship.

Note that as soon as discharge to a care home is indicated, *the information sheets attached at* ***Appendix 2 and 3*** *will be given to the service user/nearest relative/primary carer. This can occur at any time during the admission. The information sheets allow for a different destination following discharge to be proposed, should the situation alter.*

The information sheets explain the process to follow and that a suitable placement should be found within four weeks of confirmation of the decision that a person requires on going care or support within a nursing or residential care home. The information sheets outline that it may be necessary for the service user to consider an alternative interim placement to the home of their choice in the first instance and until a place there becomes available. This applies to placements funded either privately or by health or by social services, or any combination.

9.3 Ongoing review of discharge planning

The estimated discharge date/expected destination will be reviewed and amended as required by the team together with the service user each week when the care plans are reviewed. Care plans will be signed by and copied to the service user/carer as he/she wishes.

The OPMH inpatient discharge planner will be used throughout the admission and prior to the CPA discharge meeting to inform decisions, referrals and actions. It will be brought to each ward round.

Where it is expected that a move to a care home or a care package will be required, and the discharge cannot be arranged until the funding source has been identified and agreed, the process to do this will begin *as soon as the need is indicated.* This can be prior to the CPA discharge meeting. The service will liaise as required with Adult/Social Services and the relevant Primary Care Trust. Ward Managers/Modern Matrons will monitor the time it takes for clinical staff to complete assessments and ensure this function receives prompt attention.

9.4 The discharge CPA meeting

The discharge CPA meeting will be arranged at a time as close as possible to the point of the service user being expected to be ready to leave hospital. The care co-ordinator will be invited to chair this meeting. If the care co-ordinator is unable to attend, the named nurse will ensure outcomes are communicated to them to ensure follow-up. In some instances, the initial CPA meeting will fulfil this function e.g. short admission and the service user will be deemed to be ready for discharge at a ward round.

Service users are ready for discharge when:

- The service user is deemed medically fit and ready for discharge by the multi-disciplinary team, and
- Their psychiatric condition cannot be further improved by remaining in hospital, and
- Referral to the relevant adult services department or PCT has been made where appropriate.

The date of the CPA discharge planning meeting or ward round will be recorded, together with the outcomes of the meeting, on the OPMH inpatient discharge planner.

Up-to-date risk assessments will be considered at the CPA discharge meeting or ward round, in order to identify/confirm ongoing needs and inform decision-making. Ideally these assessments will be available immediately for applications for funding so that unnecessary delay does not occur.

The clinical team will discuss the decision with/inform the service user/their representative(s) both verbally and in writing that the assessment process has confirmed the level of care and support required. The outcome of the multidisciplinary CPA review will be provided to the service user/their representative(s) if placement is to occur together with the letter at **Appendix 4**. The purpose of the letter is reflect what by now will be a shared expectation i.e. that discharge will occur within 28 working days; it is to be provided to reinforce earlier discussions started at the initial CPA meeting

Copies of the outcome of the CPA discharge review meeting will be circulated to all other involved parties e.g. GP, care manager, nursing home.

The confirmed 'fit for discharge date' will be recorded on the OPMH discharge planner in the healthcare record, as will a contingency plan in the event of an

unsuccessful discharge. The proposed date for the discharge will be recorded on the OPMH discharge planner.

The multi-professional team will advise other relevant professionals of the proposed date of discharge and requirement for follow-up care.

9.5 Preparing for the discharge

Service users will receive copies of all relevant documentation relating to their post discharge care plan, which includes follow up appointments where possible and the location of their community pharmacy.

The multi-professional team will ensure that service users/carers/representatives receive appropriate advice and education relating to all aspects of their ongoing care needs, e.g. medication, compliance aids, moving and handling, correct use of equipment, physical health needs. Assessment of concordance with medication will take place, and will be recorded in the healthcare record.

Transfer of care arrangements will be made to ensure that all service users leaving hospital will either return home with any necessary support in place or have other appropriate care arranged. The named nurse working with the care co-ordinator will liaise with other professionals involved to ensure the availability of and supervision arrangements for all necessary equipment, dietary supplements etc.

The named nurse working closely with the care co-ordinator will advise community nursing colleagues in writing and verbally if necessary, of the discharge and follow up care required. Follow up will take place within a maximum of 7 days.

The named nurse working closely with the care co-ordinator will confirm with the service users psychiatric consultant that the patient is medically fit for discharge and with community health and social services colleagues that planned discharge arrangements are in place; this will be documented in the patient's health care records.

Where discharge is delayed due to the service user being unwell, the identified professional will inform the patients' relatives and any other relevant persons/agencies involved.

In the event that the service user/representative(s) decline to accept the care arrangements proposed, staff will ensure that the service user fully understands the implications of that decision and the acceptance of responsibility. Staff will document the content of conversations fully within the health care records.

9.6 Medication

The doctor will write up the prescription for drugs required on discharge on an approved Hampshire Partnership Trust prescription and sign all relevant documentation.

Discharge medicines supporting treatment will be prescribed for 28 days. Short term treatment should be indicated by writing "'X' days only and then stop". Service users for whom there is a risk of self harm identified should be written up for whatever quantity of medicines is considered appropriate by the prescriber and stated "x days only". Any risk should be assessed and written in the service user's notes.

The discharge medicine proforma will record all medicines being taken at the time of discharge with their dosage and frequency. Non-specific directions eg od (daily) or prn must not be used. If service users have sufficient supply of their own medicines (a minimum of 7 days) the quantity should be endorsed by writing "POD" (patient's own drugs). This is usually done by pharmacy staff e.g. medicines management technician. This proforma is then the formal record of their medicines at discharge.

9.7 Concordance issues

Issues relating to the ability/intent of the service user to take medication as prescribed will be considered as part of the ongoing risk assessment described throughout this policy. All efforts will be made to provide information and education aimed a facilitating compliance to service users in formats they find comprehendible.

Where a service user is assessed as lacking capacity to make an informed decision, the Mental Capacity Act provisions will apply.

10. DISCHARGE FROM HOSPITAL

The *discharge checklist* in the OPMH inpatient discharge planner will be completed from this point to ensure an effective well-managed, timely discharge following the patient being declared fit for discharge.

The discharging nurse will complete the discharge checklist and ensure that the discharge care plan has been discussed and agreed with the service user and their representative(s) and they understand it fully. If not already done, the discharge plan will be recorded in the healthcare record.

The discharge address will be confirmed and all professionals involved in ongoing care informed of the discharge date.

Discharge medication (TTOs) will be ordered and checked. A copy of the medication summary will be faxed to the current GP. Risk assessment of suicide/self harm in relation to PODs/TTOs will be undertaken and the outcome recorded in the healthcare record.

If a discharge has been delayed for any reason whilst waiting for care home placement, a medical assessment of the service user will be undertaken within the 24 hours prior to leaving the ward.

The service user will be provided with:

- All necessary written information regarding discharge advice
- Details of telephone help lines and contact telephone numbers of the care co-ordinator and other professionals involved in their care
- Details of actions to be taken out of hours
- Equipment and adequate supplies of medication, dressings, dietary supplements
- Training/advice in relation to equipment, medication, dietary supplements
- Their personal belongings including valuables and PODs. PODs are the property of the service user and must be returned, even if the directions have changed. It is the responsibility of the patient/carer to take non-required medicines to the community chemist for disposal

- Appropriate Patient Information Leaflets (PILs)
- Information regarding follow-up arrangements (including within 7 day/48 hour standard) and community pharmacist
- The patient discharge satisfaction questionnaire
- The hospital discharge letter
- The blue copy of the prescription sheet where utilised.

The named nurse working closely with the care co-ordinator will ensure that the service user is given all relevant written communication required by other professionals for their continuing care in the community or transfer to another care setting. Subject to agreement, the nursing summary and person centred information will be sent to care homes upon placement.

All professionals will ensure that professional standards relating to discharge documentation are adhered to when transferring service users out of their care.

Administrative staff will ensure prompt and timely completion of administrative/electronic records relating to service users discharge.

11. LEAVE FROM HOSPITAL

The named nurse and care co-ordinator will liaise in preparation for any leave to ensure clear responsibility is documented for monitoring the leave period. This will include updating the care plan and CPA risk assessment for the agreed leave period. The service user will be provided with a copy of the care plan including strategies to cope with trigger factors and arrangements for returning to the ward unit at the end of the leave or in the event of a crisis. Service users at risk from self harm returning from leave will be risk assessed in relation to belongings being brought onto the ward and searched if applicable.

12. DISCHARGE FROM HOSPITAL AGAINST PROFESSIONAL ADVICE

In the event of a patient wanting to take their own discharge against the advice of health professionals, all relevant facts surrounding the situation should be recorded in the patient health care records.

Risks will be taken into account in relation to use of the Mental Health Act.

Where the situation allows, the risks will be identified to the service user. If he/she still wishes to leave hospital, an opportunity will be given to discuss the situation with relevant members of the multi-professional team and where possible, the signature of the patient obtained to indicate that they understand the risks involved.

The professional team will ensure that the service user/carer is given relevant contact telephone numbers and advice regarding contact with community and support services.

The named nurse working closely with the care co-ordinator will ensure that there is a clear follow-up plan in place for the patient following their self-discharge.

The psychiatric consultant will inform the patients' GP that the service user has taken their own discharge against medical advice and what follow up care and treatment is in place.

It is important to ensure that a written summary of decisions is recorded in the health records.

Patients will be informed that self discharge does not prejudice them from obtaining health care treatment in the future.

13. TRANSFERS TO OTHER HOSPITALS OR NURSING/RESIDENTIAL CARE HOMES

For service users being transferred to other hospitals or nursing/residential care homes, the named nurse working closely with the care co-ordinator will liaise with the receiving unit to notify them of the needs of the service user. This will include co-ordination with pharmacy. It is the responsibility of the named nurse to ensure that the care co-ordinator is informed of the transfer in order to ensure continuity of mental health follow-up and intervention.

The transfer documentation will be completed and copies of up to date risk assessments and care plans included in the transfer information. Person centred information e.g. information captured in life diaries or the Alzheimer's Society Care and Companionship Guide should accompany the service user.

If a detained service user requires treatment in a general hospital they must be placed on section 17 leave. The appropriate proforma should be correctly completed by the Responsible Clinican (RC) and a bed on the ward reserved for them. Information about their detention and any risk will be given to the receiving ward.

The responsibility of the mental health care needs of the detained service user remains the responsibility of the Older People's Mental Health service.

14. CARE HOME PLACEMENTS

Service users requiring a care home placement are covered in Section 4 of the OPMH inpatient discharge planner.

This section requires the nursing team/social worker to ensure service users/carers are provided with information to assist them in choosing a care home. The date that this information is given will be recorded on the OPMH inpatient discharge planner. A record of the conversation will be entered the healthcare record.

Users/cares will be advised at CPA meetings and verbally, in addition to the information sheets described above, that a suitable placement should be found within 4 weeks of **confirmation** that a care home placement is required. This event will be recorded in the healthcare record and the date noted on the OPMH inpatient discharge planner. Confirmation will follow the discharge CPA meeting.

~~The date that a care home is identified/chosen by the user/carer, and the name of the~~ care home and its address will be recorded on the OPMH inpatient discharge planner.

The following will be recorded:

- The date the care home completed its assessment
- The date the care home accepted the patient
- The date that the date and time of discharge is agreed
- The date and time the transfer information is completed
- The date when a new GP has been identified if required

Discharge arrangements will be made as above.

14.1 Home of choice not available/refusal to go

If a care home has not been identified within 4 weeks of confirmation to the user/carer that a care home placement is required, the named nurse/ward manager/modern matron will inform the Locality Manager. The date the Locality Manager is informed will be recorded on the OPMH inpatient discharge planner.

The Locality Manager will be responsible for informing adult services and will arrange a meeting with the user/carer(s) and adult services as soon as possible. The meeting should take place no later than the sixth week following confirmation that a care home placement is required.

If resolution is not achieved within the next two weeks, the Locality Manager will call a second meeting.

The next stage is for the Locality Manager to raise the issue with the Director of Operations (OPMH) and seek legal advice. It is essential that the full described process is followed prior to seeking legal advice.

15. QUALITY MONITORING

The OPMH Directorate will ensure that monitoring arrangements are in place via the biannual records audit to ensure that there is compliance with this policy.

Bibliography

Department of Health (2003); Health and Social Care Joint Unit and Change Agent Team. Discharge from hospital pathways, process and practice.

Department of Health (2004) Achieving timely simple discharge from a hospital. A toolkit for the MDT.

Discharge from Hospital – a good practice checklist. (Dept of Health)

Hampshire Partnership Trust Observation Policy

Hampshire Partnership Trust Medicines Controls, Administration and Prescribing Policy

Mental Capacity Act 2005

Mental Health Act 2007

NICE (Medicine Reconciliation Checking) 2007

The Community Care (Delayed Discharges etc.) Act 2003

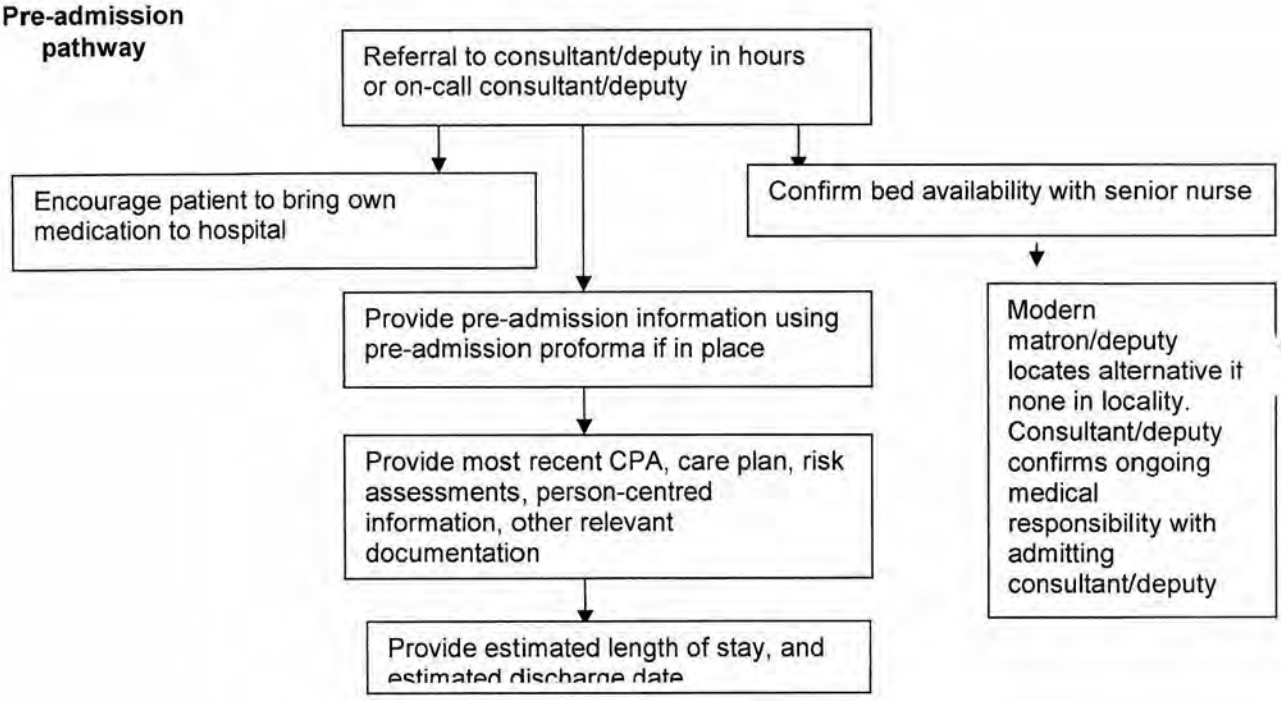
The Annual Health Check 2008/9

Appendix 1

Hampshire Partnership NHS
NHS Trust

OPMH Inpatient Care Pathway

Pre-admission pathway



Admission Pathway, as reflected in *OPMH Inpatient Admissions paperwork*

Admitting nurse meets and greets patient/carer(s)

Time and date of admission recorded OPMH inpatient admission paperwork

Initial risk assessment, assessment by qualified nurse or mental health practitioner and Care Plan

All medication brought into hospital quantitatively recorded with permission and stored on the ward. CDs entered in the register

Alerts if not previously noted are recorded on the front of healthcare record, on drugs chart and admission paperwork

Resuscitation status confirmed on admission paperwork

Consent to share confirmed/signed or reasons recorded

Next of kin advised of admission if not aware and emergency contact information confirmed

GP informed and current prescription requested

Paperwork completed for service users detained under Mental Health Act, MHA administrator informed, information given to service user

Clearly record on admissions paperwork:

- **The reasons for the admission**
- **The patient's understanding of the reasons for the admission**
- **The goals for the admission**

Standard: Within 2 hours of admission

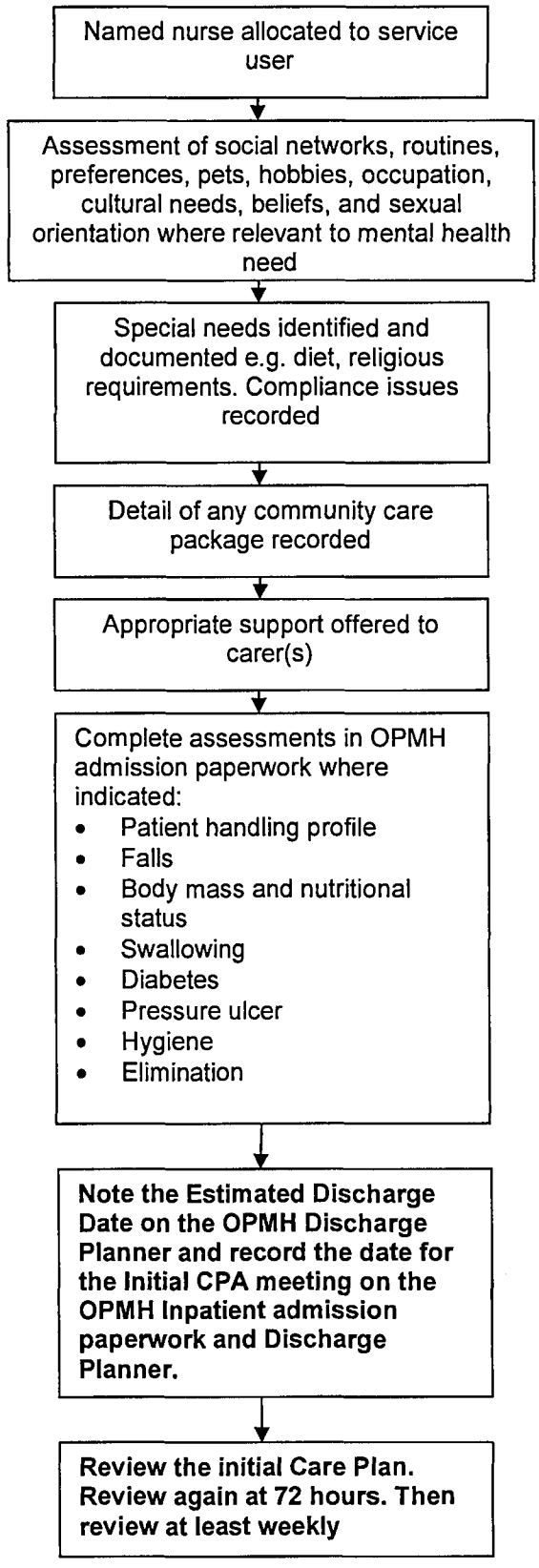
Undertake/record:

Medical history	Patient description	Distinguishing features/injuries
Phys assessment/ baseline observations	Smoking history	Current sleep pattern
Initial Care Plan	Alcohol consumption	Mental health assessment

Standard: Within 6 hours of admission

Patient's property checked and recorded using property recording proforma, valuables recorded and, with consent, stored safely. If patient declines storage, record in healthcare record with signature if possible

Admission Pathway Continued

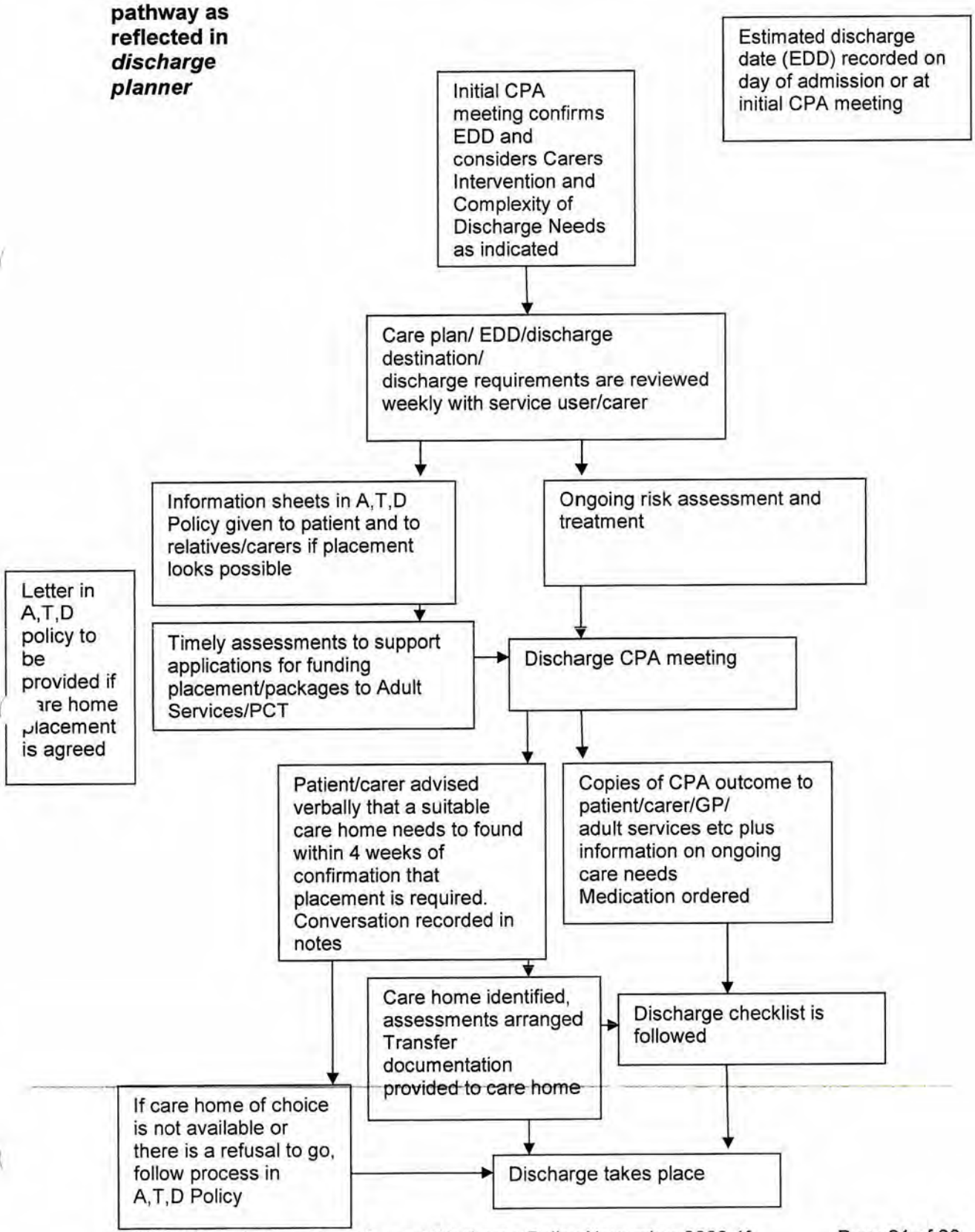


Standard: Within 24 hours of admission

Hampshire Partnership NHS
NHS Trust

OPMH Inpatient Care Pathway

Discharge pathway as reflected in *discharge planner*



Appendix 2

OLDER PERSONS MENTAL HEALTH DIRECTORATE

Information Sheet for Patients - Future Care and Support Needs

Our clinical team believe that you are likely to need significant care and support when you leave hospital.

This information sheet outlines how the team will continue to assess your needs and what should happen next.

What happens now?

The team will discuss your needs further with you. Those staff involved will include either your consultant or GP, the nurses, and someone from Adult Services. Other staff may also be involved such as physiotherapists, occupational therapists or both. Someone from the Adult Services department or hospital team will contact you soon to explain more about this assessment process.

If you agree and would like it, your nearest relative or primary carer will be involved in addition

Once the assessment has been completed the team will use this information to work with you in deciding about any care that you need.

The clinical team will inform you both verbally and in writing of the outcome of the assessment and what is then expected.

If you do not need care in a nursing or residential care home

You will be discharged home, or into your relative's care.

The ward team will help to plan the discharge arrangements with you and ensure that, if necessary, an appropriate package of care and support is available to meet your needs, and that financial implications have been fully explored and explained.

If you need care in a nursing or residential care home

You will need to choose a home that can meet your care needs and, if the Council is paying for your place, it should be within the Council's cost limits.

Once you have been assessed as ready to leave hospital, it is very important that your discharge is not delayed. This is because there may be other people who need admission to the ward.

There are often shortages of vacancies in care homes in this area, so you will need to consider several homes in order to ensure a suitable home with a vacancy can be found within a limited time frame.

If a place within your preferred choice home is not available within four weeks, you will be asked to consider being discharged to another home with a vacancy which could offer you a temporary place whilst you are waiting for your preferred choice home to become available.

A member of our team will keep in touch with you and your relative/primary carer during this period to ensure that you are making progress in finding a suitable home and can offer help if needed.

Adult Services staff have a lot of knowledge and experience in this area and they can help and advise you and discuss whether you can visit homes before making your choice. They can also advise on the financial implications.

What if my condition changes?

Staff will review your condition regularly while you are in hospital and revise your discharge plans if your condition or other circumstances change.

You will not be discharged until your doctor and other team members are satisfied that your health care needs can be met outside this hospital.

Getting answers to your questions and concerns

If you have any questions, please talk to your named nurse, consultant/doctor, Adult Services care manager or any staff member.

The Patient Advice & Liaison Service (PALS) can also provide advice and support at this stage.

Contact details are listed below.

Useful names and telephone numbers

NAME	**TELEPHONE NUMBER**
Ward	
Consultant.....	
Named Nurse.....	
Adult Services.....	
Care co-ordinator.....	
Patient Advice & Liaison Service, (PALS).....	023 80475265
www.PALS@hantspt.nhs.uk	

Appendix 3

OLDER PERSONS MENTAL HEALTH DIRECTORATE

Information Sheet for Relatives and Carers
Future Care and Support Needs

Our clinical team believe that your relative is likely to need significant care and support when he/she leaves hospital.

This information sheet outlines how the team will continue to assess your relative's needs and what should happen next.

What happens now?

The team will discuss your relative's needs with them and you. Those staff involved will include the consultant or GP, nurses, and someone from Adult Services. Other staff such as occupational therapists or physiotherapists or both could be involved in addition. Someone from the Adult Services department or hospital team will contact you soon to explain more about this assessment process.

As nearest relative or primary carer you will also be involved, subject to your relative's agreement.

Once the assessment has been completed the team will use this information to work with you and your relative in deciding about any care that your relative needs.

The clinical team will inform you both verbally and in writing of this decision and what is then expected.

If your relative does not need care in a nursing or residential care home

Your relative will be discharged home, or into your care.

The ward team will help to plan the discharge arrangements with you and your relative to ensure that, if necessary, an appropriate package of care and support is available to meet their needs, and that any financial implications have been fully explored and explained.

If your relative needs care in a nursing or residential care home

You and your relative will need to choose a home that meets his/her care needs and, if the Council is paying for the place, is within the Council's cost limits.

Once your relative has been assessed as ready to leave hospital, it is very important that discharge is not delayed. This is because there may be other people who need admission to the ward.

There are often shortages of vacancies in care homes in this area, so your relative will need to consider several homes in order to ensure a suitable home with a vacancy can be found.

If a place within the preferred choice home is not available within four weeks, your relative will be asked to consider discharge to another home with a vacancy which could offer them an interim-placement whilst awaiting a vacancy in their preferred home to become available.

A member of our team will keep in touch with you and your relative during this period to ensure that your relative is making progress in finding a suitable home and can offer help if needed. Adult Services staff have a lot of knowledge and experience in this area and they can not only help, advise and discuss whether your relative can visit homes before making a choice, but also advise on financial implications.

What if your relative's condition changes?

Staff will review your relative's condition regularly during their hospital admission and revise the discharge plans if any circumstances or your relative's condition changes.

Your relative will not be discharged until the doctor and other team members are satisfied that health care needs can be met outside this hospital.

Getting answers to your questions and concerns

If you have any questions, please talk to the named nurse, consultant/doctor, Adult Services care manager or any staff member caring for your relative.

The Patient Advice & Liaison Service (PALS) can also provide advice and support at this stage.

Contact details are listed below.

Useful names and telephone numbers

NAME **TELEPHONE NUMBER**

Ward .....

Consultant.....

Named Nurse.....

Adult Services.....

Care co-ordinator.....

Patient Advice & Liaison Service, (PALS).....023 80475265
www.PALS@hantspt.nhs.uk

Appendix 3

Proforma to be inserted under the unit's usual letter heading

Letter Confirming the Need for a Nursing Home or Residential

Care Home Placement

Date:

To: Patient and/or Relative/Carer/Advocate

Dear

I am writing to confirm that, following completion of (patient's name)'s multidisciplinary assessments by the clinical team and Adult Services care manager, we consider that (you/patient's name) will require discharge to a Nursing Home/Residential Care Home.

As highlighted in the care placement information leaflet that you should have already received from the ward staff, you will now need to find a suitable home of your choice with a vacancy.

If your preferred choice home cannot offer you a place within 4 weeks, please discuss this with the clinical team within the hospital or your care manager who will advise you on other suitable homes with vacancies to ensure that your discharge is not delayed. It may be necessary to consider being discharged to another home with a vacancy which could offer you a place for an interim period.

We recognise that this decision is a major one and that you will require support and advice to guide you through the process of finding a suitable Nursing Home/Residential Care Home. To help you with this process, regular contact will be maintained by a member of the ward staff and/or your Care Manager.

If you have any queries or concerns, please do not hesitate to contact us.

Yours sincerely

(insert name and designation of professional sending letter e.g. consultant/modern matron)
Older Peoples Mental Health Directorate
Hampshire Partnership NHS Trust