MENTAL HEALTH SERVICES
Admission, Discharge and Transfer of Care Policy

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Purpose of Agreement	This policy sets out the general principles to be followed in planning and managing patient admissions, transfers, and discharges, which are designed to ensure the safety of the patient and staff
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Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	November 2020	MHS Head of Quality & Professions	Approved at Mental Health Service Line Clinical Governance Meeting, Mental Health Service Line Board, Policy Steering Group and for onward ratification at Clinical Executive Group	New Policy

Executive Summary

This policy document provides overarching quality principles for the Admission, Transfer and Discharge of patients to Solent NHS Trust Mental Health inpatient services. The admission to an in-patient unit takes place when the patient is severely unwell and at their most vulnerable. It is important that the process for admission, transfer and discharge safeguards and promotes patient safety, is person-centred and ensures that communication between patients and their families is effective and timely. All services should put the patient at the centre of plans involving relevant care and provide information in a format the person can access and understand involving family and carers as appropriate. Permission to share and mental capacity must be referred to in all cases.

An admission should be planned. Even in urgent situations a degree of planning will occur, however quickly the admission takes place. The assessment prior to admission should be based on clinical practice decisions utilising all appropriate information and include information from the patient whenever possible.

Admissions to adult mental health (AMH) wards will always be gate-kept by the Crisis Resolution Home Treatment (CRHT) team, to whom patients should be referred (i.e. they should not be referred 'for admission') and alternatives to hospitalisation should be fully considered. Where assessments under the Mental Health Act are made, there is a legal obligation to consider such alternatives and the CRHT should be involved in the process.
Admissions to older persons mental health (OPMH) wards will be agreed by an OPMH consultant.

It is recognised that every patient will be admitted when there is a clearly identified need for admission in order to receive clinical in-patient assessment and treatment. Every admission will be lawful in relation to the patient's needs, wants and wishes and that the admission process takes account of the Equality Act (2010).

Transfer of care can occur within the same unit/hospital or across Trusts. It is also the process of moving patients to their post-inpatient destinations which covers a multitude of Health and Social Care Locations.

Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post discharge support. Consideration should be given to alternatives to inpatient admission whenever possible e.g. Home Treatment services which will help to reduce unnecessary and inappropriate admission; promote early discharge and support recovery.

The principle concern of Solent NHS Trust must be to maintain patient wellbeing via the use of a robust and effective discharge planning process commenced at, prior to or near the point of patient admission. All discharge plans will have involved as necessary, detailed assessment from inpatient and community services, Adult Social Services and the voluntary care sector. Patient's views should be taken into account as far as is reasonably possible whereas the patient's best interest should always be upheld. The view of carers, relatives, advocates and significant others must also be taken into account whenever appropriate and possible.

For patients being discharged from mental health inpatient services, there are specific follow up requirements to consider and book prior to the patient being discharged. See Appendix 3

This document is written for Solent NHS Trust Mental Health services to enable admission, transfer and discharge standards to be consistently applied. The policy is based upon national good practice principles, guidance and CQC standards.

The terms 'patient' and 'service user' are used interchangeably to relate to anyone accessing

mental health services in-patient settings. Whilst this policy outlines the role that Trust clinical staff have in supporting the admission, discharge and transfer of service users, it also recognises that this is often provided in partnership with primary care, social care and third sector services. The overarching principles will apply to all services; the implementation of this policy will be in close co-operation with primary care, secondary care, Ambulance service, the Police and Solent NHS Trust Mental Health services in line with established practice as per the procedures defined within this policy.

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1 Scope

1.1 This policy is inclusive of all Mental Health in-patient services within Solent NHS Trust.

1.2 It is expected that all relevant staff involved in the admission, transfer and discharge of patients within each service will be affected by and will need to comply with this policy.

1.3 Solent NHS Trust will expect other services that utilise and support Mental Health in-patient settings, to apply the principles of this policy as a minimum standard within their services, thus ensuring the provisions of a robust patient admission, discharge and transfer process.

1.4 Patient records may include SystmOne, Rio and/or paper records.

2 Definitions

2.1 Pre-Admission: Is the assessment process used to identify the need for admission to an in- patient setting

2.2 Admission: Admission is the act of transferring care from community or another environment to a Trust in-patient service. Admission begins as soon as the individual arrives on the ward.

Planned:

i. Where the admission has been negotiated with the community team, general practitioner or carer but the process started the day or days previous to the admission.
ii. When the admission is part of a CPA or My Safety & Crisis Plan.
iii. Where the patient had been receiving Home Treatment or Intensive Home Support immediately prior to requiring admission.

2.3 Emergency: Where the admission process was initiated and carried through on the same day from any service.

2.4 Transfer: Transfer is defined as the movement of a patient and their care and treatment needs from one in-patient unit to another (of any in-patient care setting), or a community-based service for continuation of care. This may be because the needs of the patient are best met at another in-patient or care setting.

2.5 Discharge: Discharge is the act of concluding an episode of care within an in-patient setting. This may include handing over responsibility of the care to another service or care provider or discharge to a person's place of choice: These include:

- Community team;
- Crisis Resolution Home Treatment
- Primary care;
- Nursing Home;
- Care Provider;
- Another hospital service e.g. acute hospital care.
- Patients own home

2.6 Follow Up: This may be for the patient to arrange to see their own GP, attend a clinic, see community-based staff. **NB** as a minimum a three day follow up by mental health services is required. An appointment will be made to be seen within a maximum of 72 hours following discharge.

2.7 Delayed Transfer of Care (DTOC): The national definition states that delayed transfer of care occurs when a patient is ready to depart and is delayed. A patient is ready for transfer/discharge when:

a) A clinical decision has been made that the patient is ready for transfer/discharge AND
b) A multi-disciplinary team decision has been made that patient is ready for transfer/discharge

AND

c) The patient is safe to discharge/transfer.

Please refer to the Delayed Transfers of Care flow chart in appendix 6

3 Duties/Responsibilities

3.1 Chief Executive

The Chief Executive has ultimate responsibility for ensuring that safe and effective patient discharges occur from Solent NHS Trust in-patient facilities.

3.2 Clinical leads/Managers/Supervisors

Clinical leads, managers and supervisors will:

- Ensure that enough priority is given to the successful implementation of the policy in in- patient wards.
- Monitor compliance with current standards by all clinical staff;
- Ensure clinical documentation and records used are in line with Trust policy including where this interfaces with other services e.g. Commissioners, Ministry of Justice;
- Ensure that any change in practice recommendations are notified to all clinical staff;
- Ensure all staff participate in audit and Quality Improvement processes to help identify good practice and identify deficits in order to support improvement and learning.
- Ensure that processes for daily assessment of risk and need for continuing admission, identification of delayed transfer of care (DTOC) and provision are functioning effectively.
- Ensure that social care leads are notified as soon as social care needs are identified and that DTOCs are agreed.
- Senior nursing and managerial staff must ensure that all staff involved in the admission, discharge and transferring of patients are aware and adhere to this policy. They are responsible for ensuring that any deviation or errors arising are reported, dealt with in a correct manner and that risks are identified and acted upon.

3.3 Clinical Staff

The responsibilities of the clinical staff are:

- Registered staff will be accountable as per their Professional Body;
- Maintain clinical competency as per Mental Health competency framework.
- Bring to the attention of appropriate senior staff any deficiencies in knowledge, ability or resources that may mediate against safe admission, discharge and transfer of patients;
- Participate in audit and Quality Improvement programmes related to measuring the quality and safety of admission, discharge and transfer of patients. This would include addressing any improvements required and celebration of good practice
- Ensuring they are familiar with relevant policies and procedures in their area of practice. Specific attention should be given to ensuring staff competence in the care and discharge planning for patients with co-morbidity and that risk assessment processes are consistently applied and recorded across the care pathway.

3.3.1 All Trust clinical and non-clinical staff involved in a patient admission, discharge and transfer process, are responsible for applying the principles contained in this policy. The role of all clinicians/team members will be clearly defined within the admission, discharge and/or transfer process DOH (2002) and the 2015/16 NHS Standard Contract Service Condition 11.6.

3.4 **Multidisciplinary Teams**
All members of the multi-disciplinary team should be aware of individual patients' needs related to admission, discharge and transfer and undertaking their responsibilities to ensure safe admission, discharge and transfer in a timely and appropriate manner according to patient need.

3.5.1 The multi-disciplinary team should ensure that all care and planned support is scheduled and confirmed to commence with specified dates and times. This is to promote seamless care including transfer, discharge and follow up of the patient (DH 2010).

3.5.2 In a situation when a patient refuses discharge from an inpatient setting either on or prior to the confirmed day of discharge, the Modern Matron or Head of service has the responsibility to follow 'NHS choice on discharge policy and guidelines' which should be read in conjunction with this policy to ensure discharge occurs. This could involve implementation of a discharge plan including section 117 arrangements (MHA 1983). In any event the clinical team should seek appropriate advice from senior managers who will be able to access other support including legal advice if appropriate.

4 Minimum requirements for all clinical staff

All patients must have an appropriate holistic assessment of their physical and mental health and social care needs. This assessment must be appropriately documented as per Trust record keeping guidance. Additional content and the procedure for this will vary depending on the person's mental or physical illness, medication, age, initial findings and the involvement of primary care. Issues of sensitivity, gender, ethnicity and preference should also be considered.

4.1 Relevant patient documentation will be obtained from the referring service (for example CRHT, GP, Acute or Community Team, Consultant or Hospital Clinician, Ambulance Crew) including current problems and risks, past medical history, medication history and social circumstances.

5 Main policy content

5.1 In the case of patients accessing AMH inpatient services, referrals will be gate-kept by the Crisis Resolution Home Treatment (CRHT) team and alternatives to hospitalisation should be fully considered. Where assessments under the Mental Health Act are made, there is a legal obligation to consider such alternatives and the CRHT should be involved in the process. Admission will be considered when lesser restrictive options are deemed inappropriate due to risk e.g. Home Treatment.

5.2 In the case of patients accessing OPMH inpatient services the OPMH consultant will gatekeep admissions

5.3 Pre-Admission: Prior to admission the following best practice principles will be adhered to:

5.3.1 The decision for admission will be based upon a comprehensive assessment of risks and needs.

5.3.2 The decision to admit will be made when all other options for assessment and treatment have been considered and deemed inappropriate.

5.3.2 If the service user is admitted under a section of the Mental Health Act all the legal

requirements of detaining a person under the Act will have been met so that the detention is lawful.

5.3.3 The admission is person centred and the decision includes consultation with carers/relatives as where possible/practicable.

5.3.4 The decision to admit to an in-patient unit will form part of an individualised care plan which will include the objectives and likely care outcomes of the admission and the pathway out of hospital/in-patient care. This will be shared with the carer and nearest relative, where appropriate, prior to admission.

5.3.5 The reason for admission, expected outcomes and likely length of stay will be discussed with the patient and carer. The rationale for the admission will be made clear to the patient and their carer. An explanation of the proposed care pathway will be communicated to the patient and carer including the likely length of stay, prior to admission.

5.3.6 The reason for admission, expected outcomes and likely length of stay (proposed discharge date) will be discussed with the in-patient unit.

5.3.7 The information to be communicated should be delivered in a clear and concise manner wherever possible using a recognised and agreed communication tool such as “Situations”, “Background”, “Assessment”, “Recommendation” and “Decision” (SBARD). The SBARD tool is a structured method for communicating important information that requires prompt attention and action. Its purpose is to improve the effectiveness of verbal communication at important events such as at patient admission. It encourages prior preparation for communication and should help to reduce the likelihood of misleading or missed communication.

5.3.8 A full record of the assessment will be provided within the electronic patient record in accordance with Trust record keeping policies. This will include SystmOne, RiO (in the case of patients admitted from Southern Health) and any secondary records, which will be made available to the in-patient unit prior to the admission.

5.3.9 Admission information should include all relevant clinical information pertinent to the needs of the patient e.g. Personal History, Past History, Mental capacity, Capacity assessment if required, Risks, Diagnosis, Infection Risks, Physical health Needs, Mobility and Sensory Impairments, Social Circumstances, i.e. if service user homeless or home is not fit, start housing process immediately, Safeguarding Concerns and, Cultural and Religious beliefs.

5.3.10 The referring clinician/team member, coordinating the admission will contact the ward as soon as admission is identified and ensure that there is an appropriate bed available for the patient. They will communicate to the patient which in-patient unit they are to be admitted to and the expected time of their arrival for admission.

5.3.11 The bed will be needs-based and gender appropriate for the service user.

5.3.12 The referring clinician/team member will ensure that in relation to the risks, resources at the patient’s disposal, and needs of the service user/carer, appropriate transport arrangements are made with the patient for them to arrive at the in-patient unit in a safe and timely manner.

5.3.13 This will be arranged as soon as possible after confirming the need for admission and availability of a suitable bed. Other relevant care agencies will be informed of the admission.

5.3.14 Infection, Prevention & Control measures: Patients with an infection can expect relevant information about it to be shared between providers when they are admitted, transferred to, or discharged from a hospital to ensure seamless care. The risk assessment undertaken on admission will include risks associated with health care acquired infections where appropriate.

5.3.15 The IP&C procedure for documenting and sharing information about infections and their treatment will be followed. This includes evidence of information sharing to manage and support patients with an infection on an ongoing basis (including transfer and isolation arrangements for them) during admission, transfer and discharge.

6 Admission

6.1 It is the admitting nurse's responsibility to ensure that the patient is met and greeted and orientated appropriately to the ward on arrival. The time and date of arrival will be recorded in the patient care record.

6.2 The admission pathway will be completed in full and within the timeframes stated in the pathway. See Appendix 1

6.3 An initial risk assessment, risk management plan and Inpatient plan of care (IPoC) will be undertaken immediately on arrival appropriate to the patient needs by a registered nurse. This will take into account the immediate and potential risks relating to the safety of that patient within the clinical setting e.g. pain management, risk of self-harm, falling, patient going missing from the ward etc. in order to establish appropriate intervention and level of observation.

6.4 Patients will be asked if they have brought in their medicines from home or have other medication in their possession such as cream or inhalers and any over the counter medication. Permission from the patient should be obtained to use the Patients own Drugs (PODs) or destroy them where appropriate. The PODs should be stored and kept securely. During working hours these PODS will be checked by a Medicines Management Technician. If they are suitable for reuse the prescription chart will be initialled, dated and the strength and number of tablets noted on the chart. If a patient has brought in a controlled drug these must be entered into the section of the Controlled Drug Register and maintained solely for the use of that patient.

6.5 Patients will have their medicines reconciled by pharmacy team members as soon as possible after admission, and no later than 2 working days after admission. A minimum of two sources of information should be used to obtain a list of the medicines being taken by the patient prior to admission (single sources are rarely complete and accurate). The sources of information used should be recorded in the medicines reconciliation note See Medicines Reconciliation Policy) within the case notes/electronic record.

6.6 Throughout the admission provide families/carers accessible information as appropriate along with information about support services available to them.

6.7 The patient will be provided with a ward information leaflet and a Welcome Pack and their personal information/contact details checked and accurately recorded.

6.8 Alerts including drugs, allergies, foodstuff sensitivities and reactions will be recorded in line with Trust Policy on record keeping, if not previously noted. This information will be recorded on the prescription chart and on the electronic record. 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.

6.9 Resuscitation status will be confirmed on the inpatient admissions record as will any advance directive or lasting power of attorney. Any subsequent change to any of these must be recorded in the patient's care records.

6.10 The patient will be asked to sign an information sharing consent pro forma and will be provided with an appropriate information sharing leaflet. If the service user declines to grant consent, the

reasons will be recorded in records and on the pro forma.

6.11 With the patient's 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 and recorded in the appropriate healthcare records.

6.12 The following will be clearly recorded on the patient record:

- The reasons for the admission;
- The patient's understanding of the reasons for admission;
- The goals/objectives for admission from both the professional and service user perspective
- Discharge plans

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 patient and the admitting nurse will undertake receipt and scrutiny procedures. For people detained on a section of the Mental Health Act (1983), the policies relating to rights, information and Independent Mental Health Advocacy (IMHA) provision in accordance with additional policy and protocols related to admitting any patient subject to conditions of the Mental Health Act (1983).

6.13 Physical assessment will be completed as soon as practical following admission, but within 24 hours following NEWS2. Where physical assessment does not happen immediately, discussion of existing medical conditions with the on-call junior doctor, will take place.

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

6.15 The decision regarding discharge should involve the patient, relatives and carers (as appropriate) and should be made following an assessment at pre-admission or on admission. It should also take account multiple pathology/multiple needs. All those involved in the patient's care should be aware of the estimated date of discharge and discharge plans.

6.16 The date for the initial Care Programming Approach (CPA) review will be established (which may involve face-to-face or teleconference contact). Where the patient already has an identified Care Co-ordinator in the community, communication will be maintained between the Care Co-ordinator and the Named Nurse regarding progress and steps towards discharge, including attendance at relevant formulation or review meetings as per the CPA Policy.

7 During an inpatient stay

7.1 During the inpatient stay SOLENT NHS TRUST will do everything possible to assist in the patient recovery ensuring that the patient recovers as quickly as possible.

7.2 Patients will be reviewed by the MDT as per ward protocol and Standard Operating Procedures (SOP)

7.3 The IPoC will be reviewed and updated as risks or care needs change and will include discharge plans.

7.4 As an integrated health and social care partnership we must carry out an assessment under the Care Act (2014) of anyone who appears to require care and support, regardless of their likely

eligibility for state funded care. The assessment will focus on the persons needs and how they impact on their wellbeing and the outcomes that they want to achieve.

7.5 Social Care needs will be assessed at the first opportunity after admission and a discharge plan will be formulated. This assessment will be arranged by the Discharge and Liaison Coordinator and carried out by the ward discharge and liaison social workers or the care coordinator, whomever is deemed the most appropriate.

7.6 Where a person's eligible needs indicate a state funded care package in order to return home or the need for a more secure funded placement, a plan will be agreed and actioned prior to the discharge meeting. In order to secure funding, the assessor will liaise as required with the Adult Social Care funding panel or the Social Care Lead if a decision outside of panel is required.

Ward Managers and the discharge coordinator will monitor the time it takes for clinical and social care staff to complete assessments and ensure this function receives prompt attention.

8 Transfer

8.1 Transfer of care can occur within the same unit/hospital or across Trusts.

8.2 Prior and during the process of transfer of care, the following best practice principles will be adhered to. This includes transfer between wards within the same unit e.g. Intensive care ward to Acute ward or transfer between wards and community teams. The following 'Transfer Principles' will be applied:

8.3 A decision to transfer a patient to another ward or community service will be based on assessment of risk and needs. It will be in the best interests of the safety and clinical management of the patient.

8.4 The multidisciplinary team will update the IPoC or CPoC having conducted a full and thorough assessment of risk and health which will be specific to the needs of the patient and will have identified that their clinical care needs are best meet in a different setting.

8.5 The reason for the transfer, expected outcomes, likely length of stay and discharge plans will be fully discussed with the patient and their carer and recorded in the patient record.

8.6 Rationale and an explanation of the care pathway through to discharge will be made clear with the patient.

8.7 Coordination of the transfer of care process will be delivered through effective leadership and handover responsibilities at ward level and no transfer will take place until all transfer arrangements are fully agreed by both the discharging ward and the receiving ward or community service.

8.8 The clinical team are responsible and accountable for communicating all necessary information to the receiving transfer ward/team and ensuring that the care transfer process is safe, effective, timely and maintains continuity of care for the patient.

8.9 All clinical information will be updated fully prior to the transfer; this will include comprehensive assessment, risk history and assessment, social care/social circumstances, clinical management plan, current IPoC/CPoC and current prescribing plan. Any communication should be described and noted in the patient record including where a specific communication aid such as SBARD, has been used.

8.10 The nurse in charge of the ward at the agreed date and time of the transfer is responsible for

leading the transfer process. They will ensure that the receiving ward or community service has all necessary medicines and medical equipment that may be required to meet specific care plan needs to ensure continuity of care and safety through the transfer process.

8.11 Prior to transfer to another ward or community service, where appropriate, a detailed risk assessment will be carried out by a designated clinician to determine the mode of transport and level of escort required (including chaperone arrangements if required).

8.12 Transfer of a patient detained under the Mental Health Act will follow the procedures related to the transfer and admission of a patient subject to the MHA.

9 Discharge

Discharge is a process and not an isolated event that happens at the end of a patient's stay.

The NHS Standard Contract 2016/17 mandates the use of AoMRC (Association of Medical Royal Colleges) headings for sending eDischarge summaries from 1st December 2016.

The following section details the underpinning principles and organisational standards that apply to clinical services to ensure that this DoH expectation is achieved. Discharge from Hospital should be a managed process with a designated person in the role of discharge coordinator (DOH 2002; DH 2010). There are 10 key steps outlined by the document (DH 2010):

1. Start planning for discharge or transfer before or on admission.
2. Develop a clinical management plan for every patient within 24 hours of admission.
3. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
4. Discuss with the patient or carer an expected likely length of admission or date of discharge or transfer within 24–48 hours of admission.
5. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
6. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence. This includes seeking permission from the patient or their family to assess needs for discharge. Please refer the choice on discharge policy and guidance.
7. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
8. Use a discharge checklist 24–48 hours prior to transfer. Appendix 3.
9. Make decisions to discharge and transfer patients each day.

9.1 Planning for discharge will be detailed in the IPoC which will be agreed with the patient and reviewed and updated on a regular basis and at a minimum at each multi- professional ward meeting including CPA reviews

9.2 A discharge CPA must happen prior to discharge from the acute care pathway either via the ward or Home Treatment Team (HTT). A CPA review will be arranged at a time as close as possible to the point of the patient being expected to be ready to leave hospital but should not delay discharge.

9.3 The patient will be identified as ready for discharge when:

1. The patient is deemed medically fit and ready for discharge by the multi-disciplinary team, and
2. Management of their psychiatric condition and risks to self or others can occur in the community, and

3. Support and resources including social care are identified and available within an alternative setting to meet their care needs effectively
.
4. The discharge pathway will be completed in full for every patient who is discharged in any circumstances. Appendix 3

9.4 The outcomes of this discharge CPA meeting/review will be discussed and agreed with the patient and where appropriate their carer/representative and clearly recorded in the patient record.

9.5 Wherever possible, the aim will be for the patient to be discharged home first and to be enabled to return to their own home or usual care setting.

9.6 Patients 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).

9.7 Where patients 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 patient.

9.8 All discussions with the patient and/or their representative(s) will be recorded in the patient record in line with record keeping policy.

9.9 As soon as a decision to discharge is agreed the multidisciplinary team will ensure that adequate preparation for discharge is made.

9.10 The care arrangements following discharge will be clearly identified and recorded on the IPoC/CPoC to ensure that all patients leaving hospital will either return home with any necessary support in place or have other appropriate care arranged.

9.11 The multi-professional team will ensure that patient/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.

9.12 The Named Nurse Worker will liaise with other professionals involved to ensure the availability of and supervision arrangements for all necessary equipment, dietary supplements etc. where required.

9.13 The Named Nurse working closely with other professionals will advise community services colleagues in writing and verbally if necessary, of the discharge and follow up care required.

9.14 All patients will have appropriate arrangements for follow up after discharge. This may be for them to arrange to see their own GP, attend a clinic and as a minimum will have a three day follow up appointment undertaken by CRHT, following discharge. If community services have been involved in the discharge planning, they will be aware of the current risk and treatment plans and are therefore best placed to complete the follow up. Best practice recommends that the follow up appointment is booked with the patient prior to discharge.

9.15 If a patient chooses to self-discharge ideally, they will talk to the nurse in charge and medic responsible for their care. The medic in charge must be made aware and the incident recorded in records. Immediate plans for medication and safe follow up must be made as soon as possible.

9.16 In the event that the patient/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 and is competent to do so. Staff will document the content of conversations fully within the patient care record.

9.17 If a patient is currently clinical stable and Medical Fit for Discharge (MFFD) and safe to transfer and there is a delay in their discharge, the patient should be identified recorded as 'DTOC delayed' and the process followed Appendix 5

10 Discharge Correspondence

10.1 All SOLENT NHS TRUST in patient units are required to send electronic discharge summaries to GP Practices within 24 hours of discharge

11 Medicines

11.1 Patients should have their medicines reviewed and reconciled prior to completing the immediate discharge prescription/letter. This includes any withheld during their stay.

11.2 Discharge medicines supporting treatment will be prescribed as clinically indicated.

11.3 The discharge medicine pro forma will record all medicines being taken at the time of discharge with their dosage and frequency. Non-specific directions e.g. od (daily) or PRN must not be used.

11.4 Discharge medication (TTOs) will be ordered and checked. A copy of the medication summary will be emailed to the current GP.

12 Managing Complex Discharge

12.1 Complex discharge is a specialist area requiring core skills and competencies in planning and expediting complex discharge in order to support timely transfer of care. This will support effective patient flow through acute and community hospital beds. In support of this it is vital that secondary and community healthcare providers harmonise their approach in order to ensure there is no confusion or conflict around the implementation of patient choice by standardising the way this is managed across hospital systems.

12.2 Patients and families can find it difficult to make decisions and/or make the practical arrangements for a range of reasons, such as:

- A lack of knowledge about the options and how services and systems work;
- Concerns about either the quality or the cost of care;
- Feeling that they have insufficient information and support;
- There is uncertainty or conflict about who will cover costs of care;
- Concerns about moving into interim accommodation and then moving again at a later stage;
- The choices available do not meet the patient's preferences;
- Concerns that their existing home is unsuitable, cold or needs work done to ensure a safe environment for discharge;
- Worry about expectations of what family and carers can and will do to support them.

13 Training Requirements

13.1 All clinical staff involved in the admission, discharge and transfer of patients should receive training through their local induction processes on commencing work and should include accurate recording of DTOC to ensure Care Act 2014 compliance**;**

14 Monitoring Compliance

This policy will be reviewed through the governance process and regularly monitored by senior

nurses/matrons e.g. regular monitoring will include:

- Completion of Admission Pathway
- Completion of Discharge pathway
- Discharge summaries
- Inpatient Plan of Care, to include risk assessment and safety plans

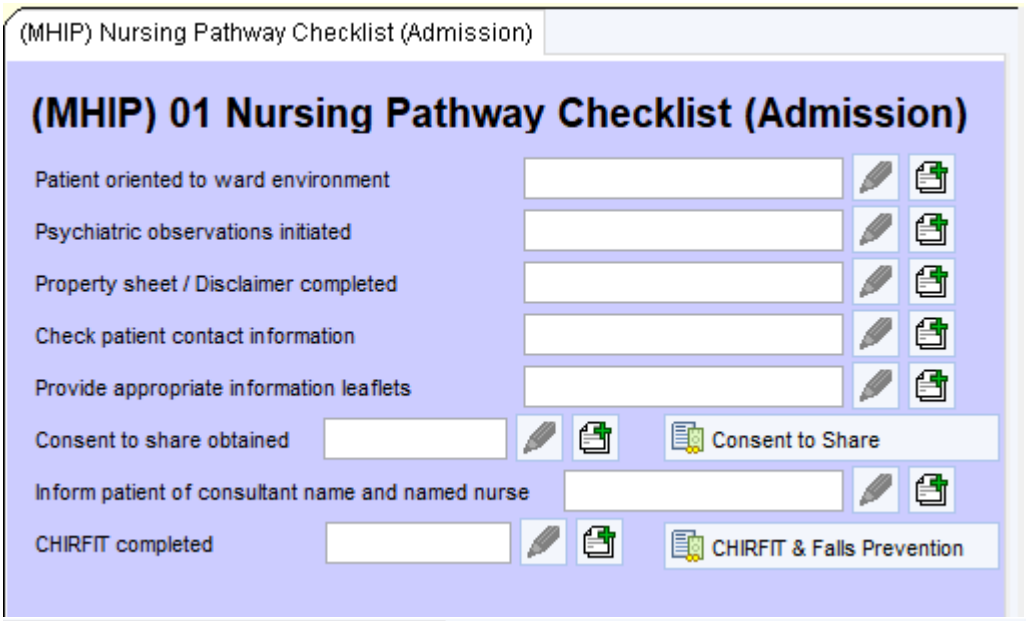
15 Policy Review

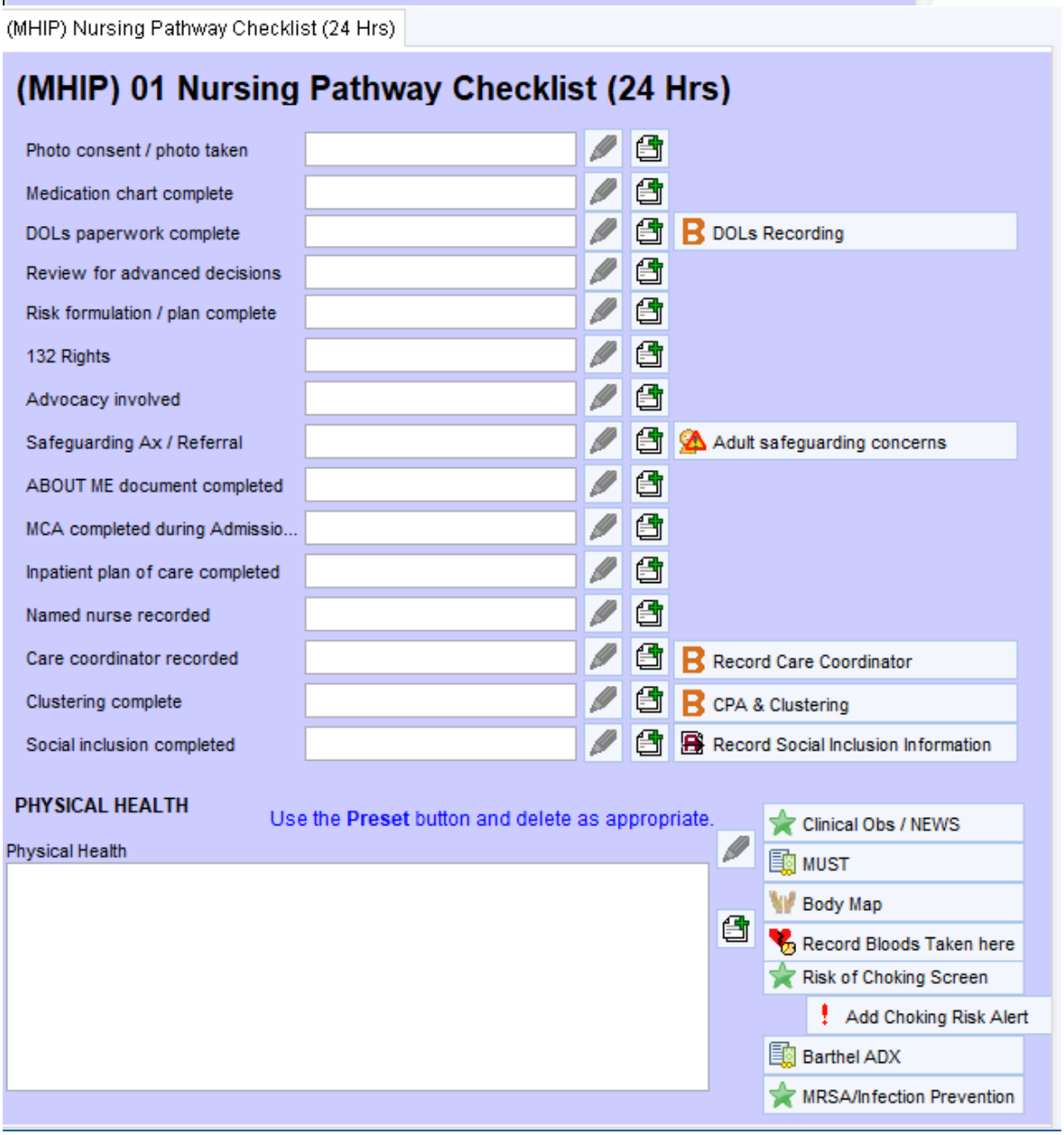
15.1 This policy will be reviewed in 3 years or sooner if national guidance or legislation require.

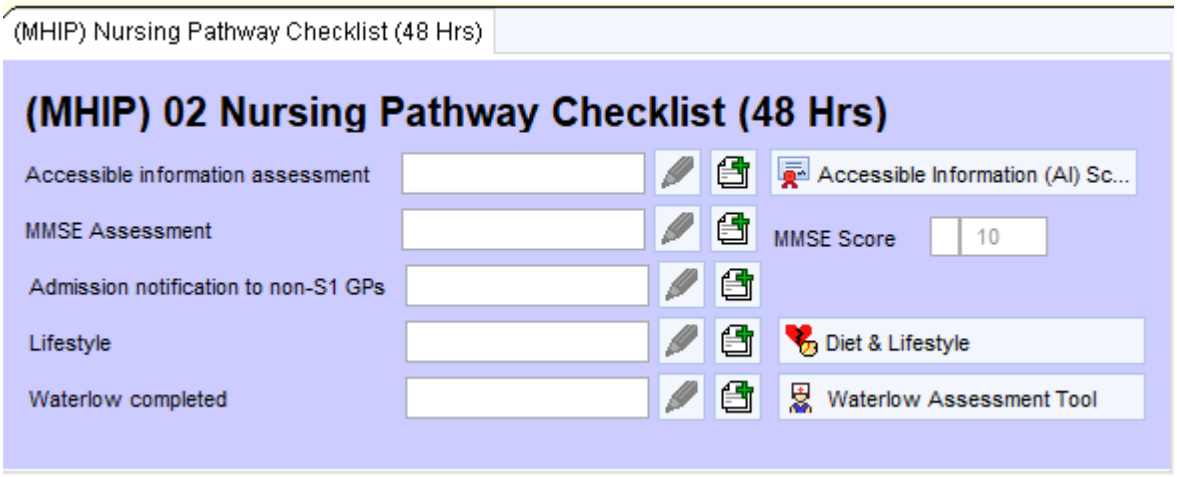
16 Supporting References

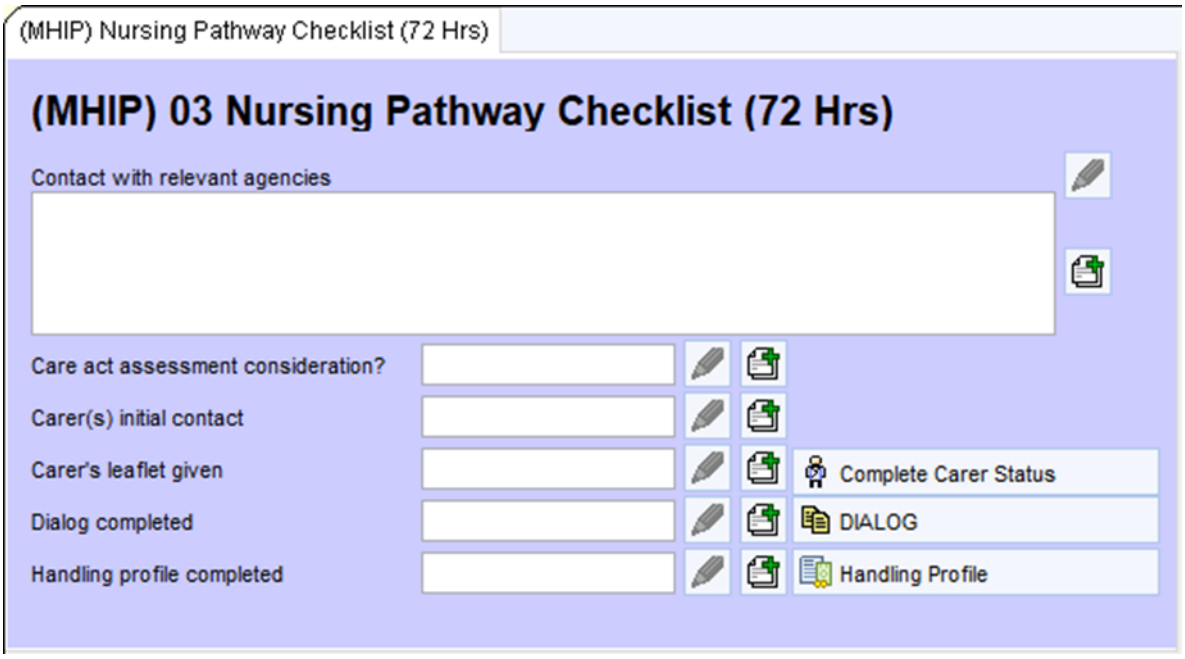
- Care Act 2014
- Mental Capacity Act, 2005
- Mental Health Act, 1983
- Department of Health (2003) Discharge from hospital: pathway, process and practice
- Department of Health (2004) Achieving timely 'simple' discharge from hospital: A toolkit for the multidisciplinary team
- CSIP/DH/NIMHE March (2007) Improving discharge from Inpatient mental health care – A good practice Toolkit
- Department of Health (2010) Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care
- NPSA (2010) Rapid Response Report NPSA/2010/RRR009: Reducing harm from omitted and delayed medicines in hospital.
- Dodds L.J. Unintended discrepancies between pre-admission and admission prescriptions: results of a collaborative service evaluation across East and SE England. IJPP 18 (Supp 2) September 2011 pp9-10.
- NICE 2011: Prevention and control of healthcare-associated infections: Quality improvement guide Issued: November 2011. NICE public health guidance 36 guidance.nice.org.uk/ph36
- Association of Medical Royal Colleges-Electronic Discharge Summaries

Appendix 1: Admission Pathway on SystmOne






(MHIP) Nursing Pathway Checklist (48 Hrs)
(MHIP) 02 Nursing Pathway Checklist (48 Hrs)
Accessible information assessment
Accessible Information (AI) Sc...
MMSE Assessment
MMSE Score
10
Admission notification to non-S1 GPs
Lifestyle
Diet & Lifestyle
Waterlow completed
Waterlow Assessment Tool


(MHIP) Nursing Pathway Checklist (72 Hrs)
(MHIP) 03 Nursing Pathway Checklist (72 Hrs)
Contact with relevant agencies
Care act assessment consideration?
Carer(s) initial contact
Carer's leaflet given
Complete Carer Status
Dialog completed
DIALOG
Handling profile completed
Handling Profile

Appendix 2: Transfer of care Flowchart

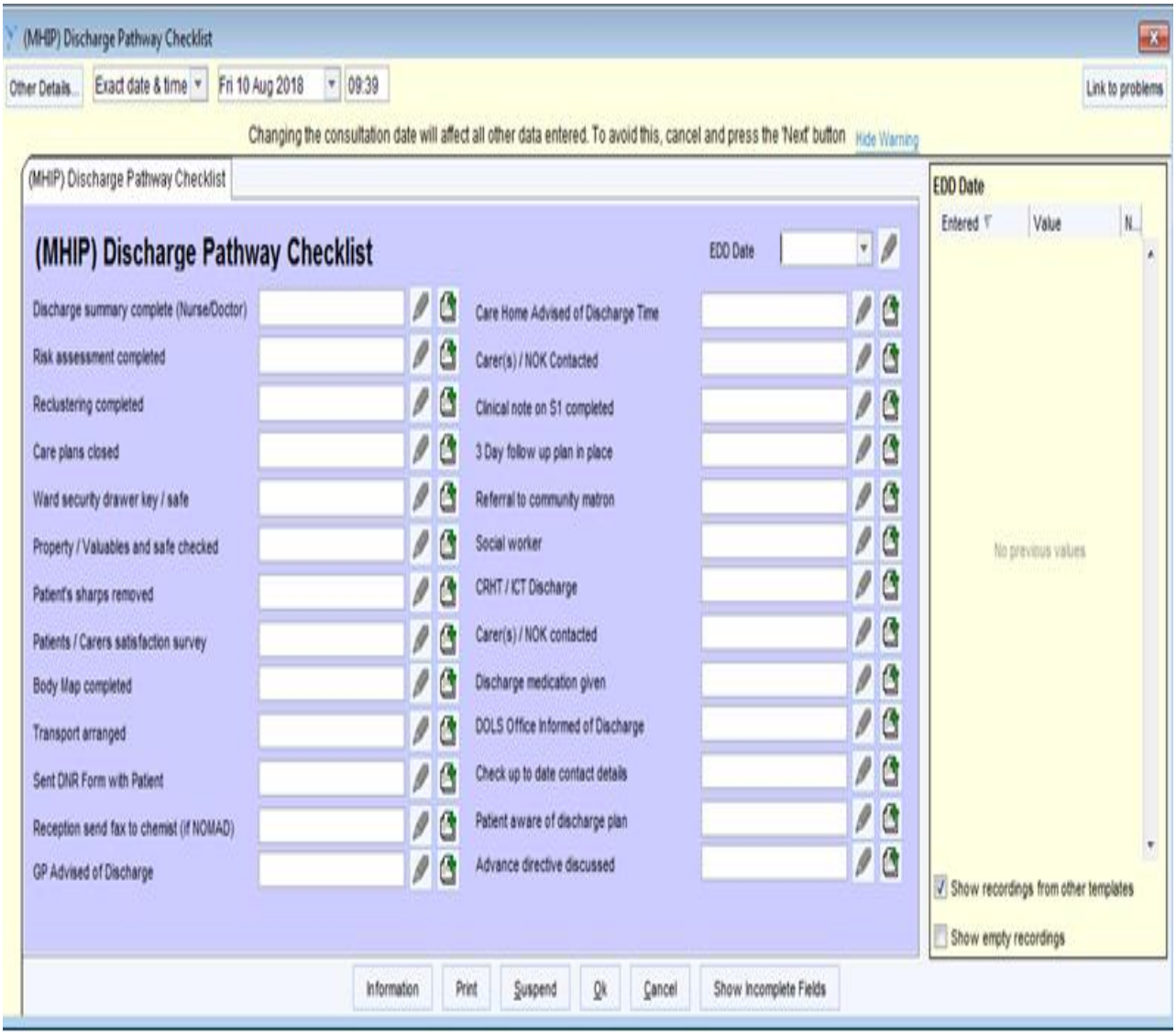
PRIOR TO TRANSFER

- Assess Risks, Mental State and Health needs, social care needs.
- Update risk assessment, safety plan (crisis and contingency) and Plan of Care
- Discuss with the patient and where appropriate their carer, the reason for the transfer, expected outcomes, likely length of stay and discharge plans.
- Record discussion with patient and carer
- Coordinate transfer ie care needs, date, time etc with receiving ward/team and document

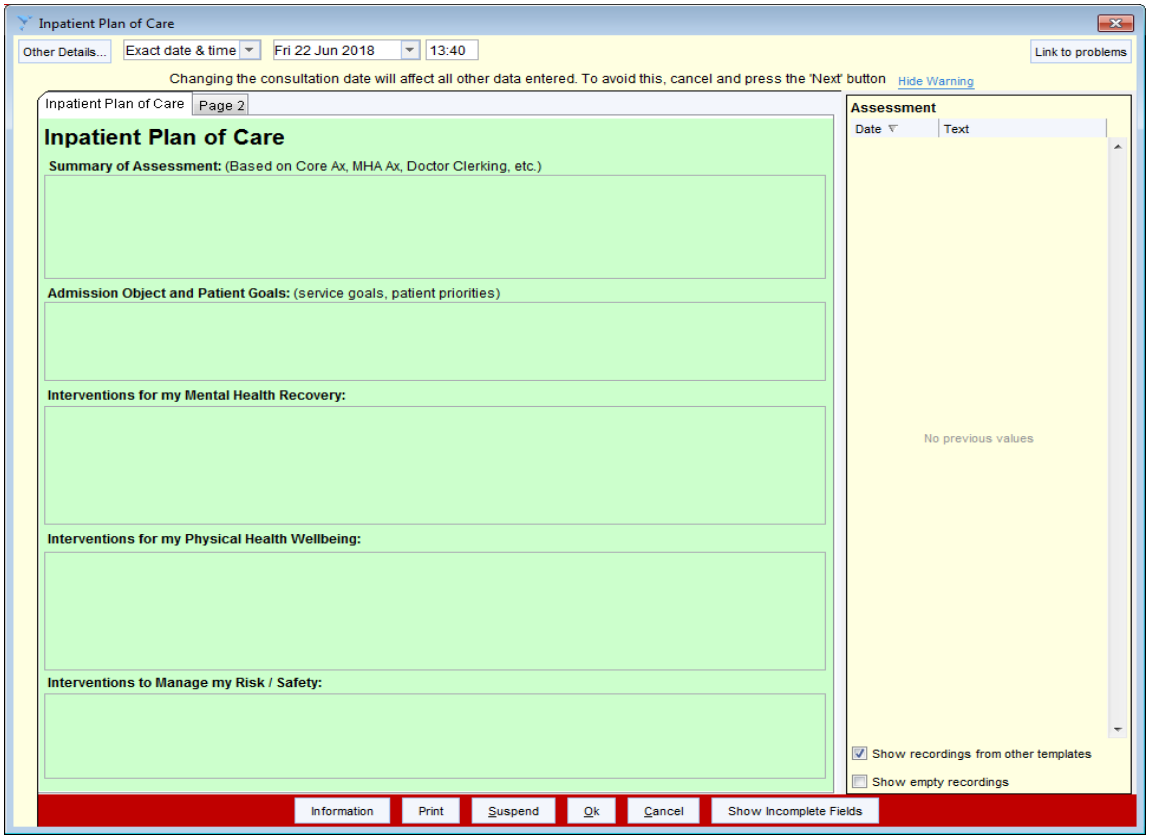
INFORMATION HANDOVER

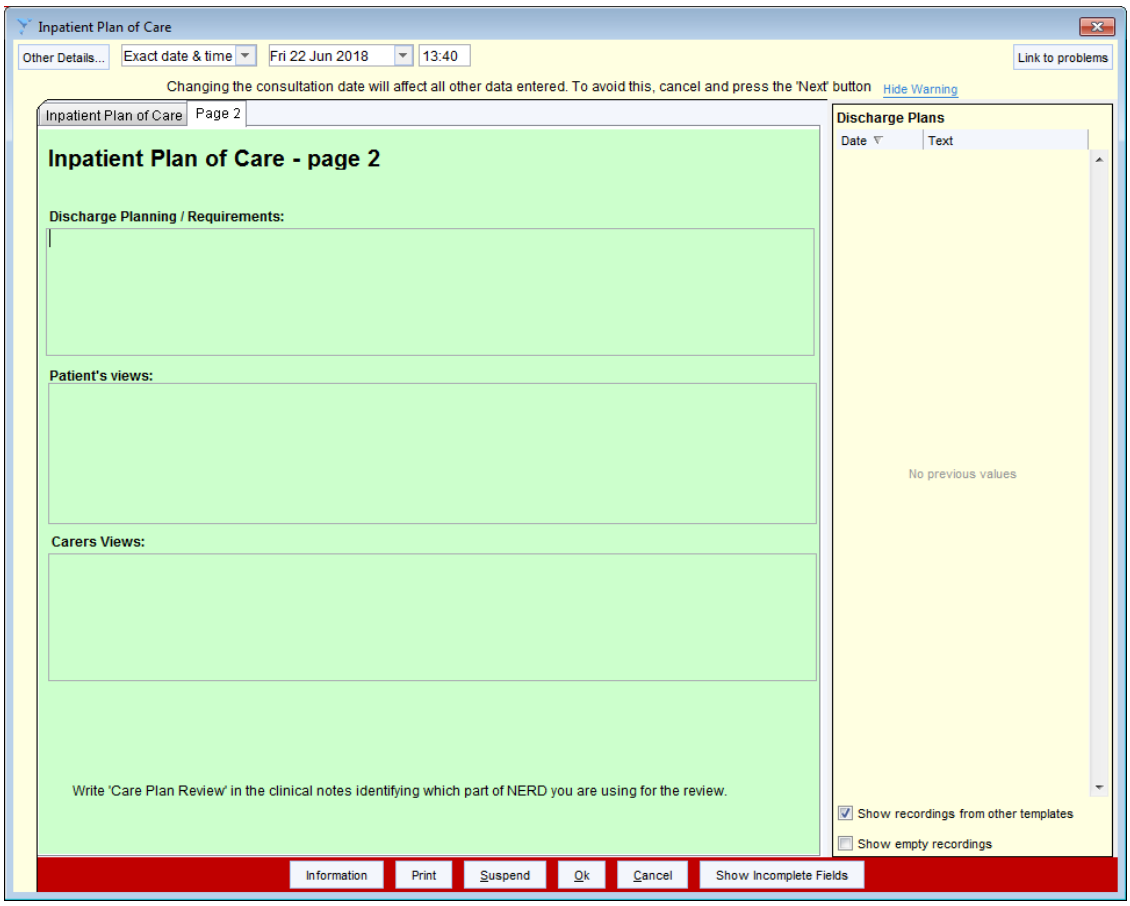
- All patient information to be handed over following the SBARD format
- Ensure all risk assessment and management plans (including physical heath) are handed over to receiving team/service
- Ensure Significant and current Mental Health and physical health concerns are handed over to receiving team/service

Appendix 3: Discharge Pathway on SystmOne



Appendix 4: Inpatient Plan of Care (IPOC)





Appendix 5: Process for Reporting DTOC

Delayed Transfer of Care Guidance (DToC)

What is DToC?	A delayed transfer of care occurs when a patient is ready to depart from our wards and is still occupying a bed.
When is someone DToC?	NHS England states that a patient is ready for transfer when: a. A clinical decision has been made that patient is ready for transfer **AND** b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND** c. The patient is safe to discharge/transfer.
What does this mean in practice for Brooker, Oakdene, Hawthorns and Maples?	All appropriate assessments and interventions must be completed prior to a person being formally declared DToC. This will include a care act assessment where appropriate. The treating MDT must then agree that the person is in fact DToC. This may include Medical staff, Social Worker, Nursing Team, Occupational Therapist etc where appropriate. A single professional **cannot** declare someone as DToC, this **must always be an MDT decision.** In cases where the MDT cannot agree, the majority decision should be considered, alternatively a professionals meeting could arranged to agree what criteria would need to be met.

Appendix 6

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims		
Service Line / Department	Mental Health Service	
Title of Change:	Admission, Transfer and Discharge Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Implementation of new policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	Yes	There were no external stakeholder consultations for this policy. Consultations have taken place via the MHS Clinical Governance Group. Admission, Transfer and Discharge is determined by the needs of the individual, to show parity between different groups and fairness to all inpatients. Inpatients can share views on their experience and to help service improvements in the future.
Have you taken into consideration any regulations, professional standards?	Yes	This policy makes reference to relevant legislative frameworks, such as the Mental Health Act and Equality Act.

Step 3: Review, Risk and Action Plans			
How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Ben Martin-Lihou*	*Date:*	*08/02/2021*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team