Northamptonshire Healthcare
NHS Foundation Trust

OPERATIONAL POLICY

Mental Health Services for Older People

Acute In-patient

The Forest Centre
Spinney and Orchard Ward
St Mary's Hospital – Kettering

Brookview and Riverside Wards
Berrywood Hospital - Northampton

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Why we need this Policy

Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides comprehensive mental health services for the 117,400 aged 65+ (2015 JSNA) population in the Northamptonshire region, requiring close partnership working with local health, social care and voluntary/community bodies.

The Older People's Acute Mental Health In-Patient Services based at The Forest Centre, St Marys Hospital, Kettering and Berrywood Hospital, Northampton provide a range of services to people over the age of 65. Flexibility is applied to this age group as admission depends on presenting clinical circumstances (for example those with earlier onset dementia aged under 65 years). The wards provide in-patient assessment and treatment for people experiencing complex and severe mental health difficulties such as emotional disorders, psychosis and living with dementia and where the person's circumstances or care needs cannot be supported at home or in an alternative less restrictive setting.

Within the service there are 48 admission beds across the two sites:

The Forest Centre (Kettering) - Spinney and Orchard Wards provide 24 beds and are a purpose built mental health in-patient facility. The wards provide care and treatment 24 hours a day, 365 days a year to individual service users.

Orchard Ward is an 8 bedded mixed sex admission and treatment ward caring for people predominately over the age of 65 living with dementia. It provides via a multidisciplinary approach a comprehensive assessment, investigations and treatment leading to subsequent appropriate discharge and follow up in the community.

Spinney Ward is a 16 bedded mixed sex admission and treatment ward caring for people predominately over 65 suffering from emotional disorders and psychosis. It has the same multidisciplinary approach to assessment, formulation and treatment as Orchard Ward.

Berrywood Hospital (Northampton) – Riverside and Brookview Wards provide 24 beds and are purpose built mental health in-patient facilities. The Wards provide care and treatment 24 hours a day, 365 days a year to individual service users.

Brookview Ward is an 8 bedded mixed sex admission and treatment ward caring for people predominately over the age of 65 living with dementia. It provides via a multidisciplinary approach comprehensive assessment, investigation and treatment leading to subsequent appropriate discharge and follow up in the community.

Riverside Ward is a 16 bedded mixed sex admission and treatment ward caring for people predominately over 65 suffering from emotional disorders. It has the same multidisciplinary approach to assessment, formulation and treatment as Brookview Ward.

What the Policy is trying to do

The purpose of the policy is to provide operational guidance for the Older People's Mental Health In-patient Admission and Treatment Services based within Northamptonshire Healthcare NHS Foundation Trust (NHFT). The document outlines the core components of the service. This operational guidance is informed and supported by Trust policies, procedures, practice guidance and other general information. We strive to achieve standards of care and direction in response to the following national and local drivers for change.

a. NHS Plans
b. 5 year forward plan – mental health
c. NICE Guidance
d. National Health Service Litigation Authority Risk Assessment Standards
e. AIMS/Quality Network for Older Adults Mental Health Services
f. Forget Me Not Report
g. Mental Health Act 1983
h. Mental Capacity Act 2005
i. National/local Dementia Strategy
j. John's Campaign
k. Trust Policies/Procedures/Guidelines

POLICY DETAIL

1. PHILOSOPHY OF THE INPATIENT SERVICES

The in-patient wards provide a modern, needs led acute mental health service that treats all service users with dignity and respect in an appropriate, safe and supportive environment. It is based on a multi-disciplinary and multi-agency approach to provide a range of services that are appropriate to individual need. The staff aim to work in a non-discriminatory way by working with all service users and understanding their own individual issues. This involves acknowledging the individual service user's culture, life experience and sexual orientation or status.

The service endeavours to work jointly with service users, ensuring partnership in the decision making for their care and treatment. We also strive to include carers in the service user's treatment, recognising their skills and knowledge.

The Trust's mission is "making a difference for you, with you".

2. PRINCIPLES OF CARE

The following principles will underpin the daily activities undertaken by all staff that provides care within the Older People's In-patient Service:

- Professionals are not fixers of problems but instead are facilitators who find solutions by working with service users and carers
- To work with service users and actively encourage them to take an active part in all decisions regarding the care they receive
- Supporting self-management
- Help people to discover and use their own resources and resourcefulness
- Enable people to access the expertise of lived experience not only the expertise of mental health workers
- Recognise the important role of carers and provide support that they need, thus promoting the optimum mental health of both service user and carer
- Ensure effective person-centred recovery planning using the Care Programme Approach (CPA)
- Service users will co-produce their own CPA My Story and in-patient care plans and receive copies of these
- Staff will actively promote the ethos of recovery and living well with dementia through co-production. Where possible service users will direct when and how to begin the recovery process
- Admission to hospital is an opportunity to build on previous recovery plans or review existing recovery plans
- Recovery plans should be portable, accessible and follow the service user between services
- Staff will work collaboratively with service users and carers to plan towards discharge and support in the community at the point of admission. Any teams that are, or will be involved, should commence joint working at the earliest opportunity.
- All staff will ensure that there is an emphasis on early assessment and initial care plans that identify therapeutic activities and interventions required and ensure access to address immediate risks, anxieties and concerns.
- The service will facilitate and promote service users' access to the Patient Advice and Liaison Service

- The service will facilitate and promote interpreting services where English is not the service users first language
- The Trust endorses Independent Advocacy Services and will facilitate and promote access to this.
- Carer's views are sought throughout the inpatient stay. Carers support can be provided by the MDT and in addition all carer's will be offered a Carer's Assessments via Northamptonshire Carers.
- Staff will adhere to the Trust's Carer's Charter

3. ADMISSION PATHWAY

Referrals

Spinney and Riverside Wards

The Urgent Care and Assessment Team (UCAT) will be involved in all admissions to Spinney and Riverside Wards. There are current policies and procedures in place for the referral of service users to Spinney and Riverside Wards by UCAT. The health professionals involved will contact the ward with regard to arranging the admission where home treatment is not thought appropriate. UCAT will be required to inform the ward staff of all relevant details in relation to the service user's history, current presentation and known risks together with a clear rationale for admission to the in-patient service. Staff will ensure that the service user is made aware that they may access an Independent Advocate at any time.

Orchard and Brookview Wards

Admissions to Orchard and Brookview Wards will be managed 09:00-17:00 Monday-Friday via the Ward Matron and when absent via the Ward Matrons for any of the other Older People's Inpatient Wards or the Service Manager. Out of Hours the referrer will contact Orchard or Brookview Ward direct and speak to the Nurse in Charge.

The Older People's Inpatient Services are for service users who are over the age of 65. However, the Service is needs led and this may be reviewed on an individual basis depending on a service users' needs as to where the needs can be best met (Adult or Older People's Services), see appendix 1

Section 136 referrals

Northamptonshire Police may detain people under S136 of the Mental Health Act. People detained under S136 may be brought to the designated place of safety for a mental health assessment. Please refer to the NHFT and Northamptonshire Police joint policy and procedure for S136 referrals.

Standards for admission

- For Spinney/Riverside Ward the person will have been assessed by UCAT and it will have been determined that the person is unsuitable for home treatment.
- There is a clear purpose (aim) for the admission/assessment.
- All persons must have had a mental health and risk assessment prior to admission.
- The service will not admit persons who are assessed when intoxicated.
- Admitting staff will ask if the person has a completed advance statement/directive.
- All persons have a risk profile, identified through assessment that can be safely managed within an Older People's Inpatient setting. This decision should be negotiated between the referrer and older people's In-patient staff.
- All individuals will be assessed as medically fit.

Admission Criteria and Definition of the Service User Group

The person needs to be medically fit (no immediate life endangering conditions) to be admitted to the Older People's In-patient Service and where possible will have had baseline observations completed, including bloods and urine tests to rule out any acute infection/illness.

Single sex accommodation

As per CQC guidance in relation to the assessment same sex accommodation it sets the following criteria by which services will be measured. On mixed wards it is essential that service users and their families and friends are given a clear explanation of how the bedrooms and other facilities are organised to ensure privacy and dignity.

Our In-patient Older Peoples Wards adheres to the following CQC criteria:

• Sleeping accommodation is in single rooms within mixed wards, with toilet and washing facilities en-suite or very close by; these facilities are clearly designated either male or female ***or***

• No one should have to pass through rooms occupied by the opposite sex to reach their toilet and washing facilities near to their bedrooms and bed bays. The exception is toilet facilities used while in day areas where service users are fully dressed. If there are limited facilities for disabled people which need to be used by both men and women, people who may be vulnerable could be escorted by a member of staff ***and***

• On mixed wards good practice requires a day lounge for use by women only (mandatory for services provided in facilities built or refurbished since 2000) as well as spaces where men and women can socialise and take part in therapeutic activities together

• Every effort is made to ensure the availability of staff who is the same sex as the users they are caring for, especially for intimate care.

If a breach of single sex corridors occurs in exceptional circumstances, all service users will be risk assessed, appropriate care plans put in place and a Datix completed. All service users will be transferred back to the appropriate sex corridor as soon as practical.

Privacy and dignity
Service users that are under our care should feel that they are treated with respect dignity and in an environment that is safe and free from any kind of physical, psychological, emotional, financial and sexual abuse.

A fundamental culture of respect and dignity is based in staff attitudes and behaviours. Staff must be courteous at all times, especially at times when they are working under pressure. Service users must feel that they matter to staff and do not experience negativity, or offensive attitudes, language or behaviour from staff, this links with the Trusts PRIDE Values, Leadership Behaviours and Mission statement.

Mental Health Act
Most of the time, service users will be admitted informally. However, in some cases it may be necessary to admit the person under a section of the Mental Health Act (1983). In every circumstance the requirements identified within the Act will be adhered to at all times, with particular reference to the code of practice.

Mental Capacity Act
The Mental Capacity Act 2005 provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity provided that:

- Staff have followed the principles of the Mental Capacity Act
- Staff have completed an assessment of capacity and reasonably believes that the person lacks capacity in relation to the matter in question
- Staff reasonably believe that the action they are taking is in the best interests of the person

A person may be admitted to the service without capacity to consent to the admission. If the Mental Health Act 1983 does not apply the admission will be taken as being in their best interests. The Deprivation of Liberty Safeguards (DoLS) provide safeguards for people who lack capacity to consent to the arrangements made for their care, and are receiving care and treatment in circumstances that may amount to a deprivation of their liberty.

The DoLS Code of Practice indicates that a number of factors will be relevant when trying to identify if deprivation is occurring and this will depend on the individual person, circumstances and the degree and intensity of the restrictions placed on them.

All staff should refer to Mental Capacity Act Policy including Deprivation of Liberty Safeguards. The relevant documentation should be completed.

Criteria for admission

The In-patient service will provide a Service for people in Northamptonshire who are:

- Usually over the age of 65 years;
- Experiencing an acute mental health problem/crisis with clear evidence of the failure of community packages of care;
- Experiencing psychosis to a degree that impedes upon functions of daily living, inability of community packages of care
- Experiencing severe depression/mania/agitated depression
- A danger to self or others caused by a mental disorder
- Dual diagnosis and presenting in crisis
- Experiencing crisis within unstable personality disorders
- Experiencing psychological or behavioural complications associated with dementia – including Alzheimer's Disease, vascular Dementia, Frontal-temporal dementia, Lewy Body Dementia etc.

Where possible, all necessary investigations will have been carried out by the referrer before admission to ensure it is appropriate;

- Service Users with physical problems should be screened prior to admission. When the need for physical nursing care outweighs the presenting mental health issue, referral should be made to an acute general hospital until the physical illness is stabilised and no longer outweighs the service user's mental health needs.
- Re-admission from a general hospital should occur following re-assessment via the Liaison Psychiatry Service for Older People (LPOP) or in consultation with the Consultant Psychiatrist

- Transfer of service users from another ward area within the Trust will be via the appropriate Consultant Psychiatrist.
- The service does not offer de-toxification to service users unless there is clear evidence of a dual mental health diagnosis
- Access to the service for people with learning disabilities will be based on assessment and discussion of the person's needs and a clinical judgement should be made as to which service is in the best position to meet the needs of the individual.

All decisions to admit should be based upon a thorough assessment of needs and available community and domestic support. There must be an articulated statement of the reasons why the individual requires the level of support only an Older People's In-patient Unit can provide, and a clear statement of the purpose of admission.

Admission Process

Once admission has been agreed, the service user's GP will be advised of the admission and a GP summary will be requested. It is desirable that this is undertaken before the service user arrives via the patient electronic record system (SystemOne).

Upon admission, the service user will be met and greeted by a member of nursing staff. They will be shown around the ward and the ward admission process such as the storage of property, visiting times and smoking policy will be explained to them. It is important that all service users are greeted professionally and warmly.

NHFT is a non-smoking Trust. Staff, service users, visitors, and contractors are not permitted to smoke on Trust sites or in Trust grounds. For more information refer to the Smoke Free Environment Policy and the Nicotine Management Policy.

Nursing staff will discuss with the service user details of their family or carers and seek the service user's permission for them to be advised of the admission and consent to the sharing of information. Where applicable Mental Capacity Act/Best Interests principles are used.

A member of medical staff will be contacted and advised of the admission. They will attend the ward and complete a mental health assessment and a physical examination, including a VTE Assessment. This is a standard admission form and is situated within the electronic patient record. A member of nursing staff will be present throughout this process. It is known within the service as "clerking in".

As part of the clerking in process the admitting doctor must complete a Medication Reconciliation Form also found within electronic patient record. This is to ensure that existing physical conditions and treatments can be clarified and also so that the medication prior to admission has been validated. The GP summary will be required for this form to be completed.

Prior to, or following the clerking in process, a member of staff will collate and complete admission forms within the electronic patient record, which consists of:

- NHFT Registration Form and Consent Form
- Accommodation, Employment, SDS and Smoking Information
- Service User Property Disclaimer
- Admission Care Plan
- Risk Assessment
- HONOs (Health of the nation outcome scales
- HCAI Risk Assessment (Infection Control Assessment Form)
- Patient Manual Handling Risk Assessment
- Falls Risk Assessment
- Waterlow
- MUST
- Section 132 and S132a (For those detained under the Mental Health Act.)
- Informal rights information given
- Welcome packs will be given to service users/carers
- Individual care plans for needs already identified.

The service user will be asked to assist with the completion of these documents and will be asked to sign them, where applicable. The service user will be advised of their key worker, Consultant Psychiatrist and it will be explained to them the time of their ward round.

Following admission, all service users will have an ECG and urine analysis completed together with routine blood investigations which are acted upon. The philosophy within the service is that physical healthcare needs are assessed on an on-going basis. Support in the management of these conditions is available locally through liaison with provider services that are part of NHFT.

The allocation of a Keyworker

The decision to allocate a key- worker will be made by the nurse in charge of the ward at the time the service user is admitted. The allocation will be made based upon the availability of staff over the 72 hour period following admission. The decision to allocate a key- worker will be strongly influenced by a team member's current workload.

The responsibilities of a Keyworker

The key-worker will introduce themselves to their allocated service user as soon as possible following admission. It is essential that a therapeutic relationship is developed quickly through demonstrating skills of the 6 C's in nursing care and an understanding attitude. The keyworker will ensure that the following documentation is completed as part of the admission process.

- Working With Risk 1
- Co-produced individual care plans specific to the needs identified as part of the initial assessment process using the 3 changes checklist
- Health of the Nation Outcome Scale (HoNOS)

The Keyworker must also make sure that contact is made with the service user's family or any individual who cares for the service user in the community. A carers' information pack, should be given. The purpose of this contact is to ensure that carers are asked if they require an assessment of their needs as a carer. If this is the case then the Keyworker will give the carer the contact details for Northamptonshire Carers or refer the carer for a Carer's Assessment.

The Keyworker on Spinney/Riverside Wards will meet with their allocated service users at least twice weekly. The purpose of this 1:1 time is to build and maintain the therapeutic relationship. These 1:1 sessions will be the forum for the Keyworker to re-assess and prioritise needs in co-production with the service user and evaluate care plans. They will also be used to update and evaluate risk assessments.

On Orchard/Brookview Wards where possible (depending on the service user's clinical presentation) Keyworkers will meet with their allocated service users at least once weekly. The purpose of this 1:1 time is to build and maintain the therapeutic relationship. These 1:1 sessions will be the forum for the Keyworker to re assess and prioritise needs in co-production with the service user and evaluate care plans. They will also be used to update and evaluate risk assessments.

All wards will have identified Daily Protected Therapeutic Engagement Time to promote uninterrupted staff engagement with service users.

4. ASSESSMENT OF NEED, CARE-PLANNING AND TREATMENT

The Care Programme Approach (CPA) provides the corner stone of current Mental Health policy. It denotes a co-produced structured assessment, care

planning, service delivery, evaluation and review, which provides for individualised, integrated care for each service user.

A Comprehensive Multidisciplinary Team (MDT) assessment of care needs will be undertaken within the first 72 hours of admission, which will identify needs and strengths in relation to:

- Relevant history
- Factors leading to admission
- Risk
- Current mental state
- Psychosocial situation
- Functional performance

A fundamental part of this initial assessment is identifying risk factors, which will lead to development of individual care plans. On-going evaluation of risk assessment is paramount to quality care, and is reviewed by the MDT during the stay, as change occurs and as part of discharge planning.

Close liaison is essential with carers/family when devising care-plans, particularly when input is limited from the service user, due to the state of their mental health; however staff are mindful of confidentiality commitments

A pre-discharge meeting (CPA Care Programme Approach Meeting) is arranged for all service users, with all relevant professionals and family members/carers, to discuss assessment and address future care needs.

Informed consent to treatment is sought at all times and recorded. However, where this is not feasible, the Mental Capacity Act 2005 and the Mental Health Act (1983) is consulted.

The following treatments are available within specific unit areas:

- Reality Orientation - used where appropriate on an individual or group basis and can be over a 24 hour period
- Validation Therapy - Used to reinforce historical events that have become irreversibly entwined or lost in a confused thought process
- Reminiscence Therapy
- Relaxation Therapy
- Counselling, schema-based cognitive-behavioural therapy, eye-movement desensitisation and reprocessing (EMDR) therapy,
- Functional analysis and positive behavioural support,
- Family support
- Neuropsychological assessment of cognitive function

- Anxiety Management
- Electro Convulsive Therapy
- Ketamine Infusions
- Repetitive Transcranial Magnetic Stimulation
- Medication Management is used therapeutically to treat both physical and psychiatric conditions. Consideration is given to the recommendations from the National Institute of Clinical excellence
- Recovery skills (sleep management, problem solving, mindfulness)
- Cognitive Stimulation Therapy (CST)
- Exercise Groups (Move it or lose it – strength and balance)

5. PRINCIPLES OF CARE DELIVERY

During any stay within the Older People's In-patient Service the following principles of care delivery will apply:

- Health Professionals include psychiatrists, psychologists, occupational therapists, physiotherapist, pharmacists, nurses and other relevant specialist services.
- Others involved are healthcare assistants, independent advocacy, service user's representatives, volunteers, chaplaincy and PALS.
- Welcome Pack information will be supplied on each ward giving information about the team, contact numbers and other useful information on admission to the service. These packs are updated as necessary.
- The Older people's In-patient service aims to provide a safe environment for service users, visitors and staff. Staff aim to support positive risk taking to promote recovery.
- Staffs from all disciplines are committed to maintaining and developing a person centred therapeutic environment.
- The multi-disciplinary team will engage service users, families and their carers, collaboratively in the therapeutic process to promote recovery.
- The Older people's In-patient staff aim to deliver care in a non-discriminatory manner respecting each individual's needs and beliefs.
- Each service user will be offered individual time with their named Keyworker.
- Each ward will have Daily Protected Therapeutic Engagement Time to promote uninterrupted staff engagement with service users. Other health professionals and independent agencies will be able to visit the wards during these times if the purpose of the visit is direct service user engagement.

- Each service user will have access to a range of evidence-based interventions and there will be a flexible range of therapeutic, social and recreational activities available.
- Each service user will be offered the opportunity to engage in a programme of activity for each day of their stay that reflects their personal treatment goals. The treatment plans will involve choice where possible and not reflect professional assumptions about what service users want to do or are capable of doing.

6. CONTROLLED ACCESS TO THE WARD

The Older people's In-patient service operates a controlled access system to all entrance and exit doors within the open ward areas. This is one of the measures the service takes to minimise risk to service users, staff and visitors in providing a safe environment.

Controlled access allows ward staff to ascertain who is attempting to gain entry or exit the ward and also make an assessment as to whether or not they should be permitted into the ward area. All visitors to the ward are met and greeted by a member of the ward team. Controlled access is not to try and keep service users detained against their will.

Entering the Ward Area

To enter the older people's In-patient ward areas between the hours of 09:00 – 17:00, the ward has a manned reception. When signing in the receptionist will then escort visitors on to the ward. If reception is not manned a bell is situated on the outside of each ward area/entrance, this activates a bell in the ward dining room and ward staff will then attend as soon as possible to meet whoever has rang the bell. This will be completed in a friendly and welcoming manner.

Staff on the wards will check, with the Service User, all items of property returned to the ward following any periods of leave. All wards clearly display a list of items that are not permitted within the ward as well as the Trust disclaimer notice.

The Older People's In-patient wards encourages all service users to limit the amount of property that is brought into the ward areas and will at every opportunity encourage items to be returned home. Service users take full responsibility for their property whilst in hospital unless this is handed to ward staff for safe keeping. In such cases a receipt will be issued.

Exiting the ward

To exit the ward, all service users will approach nursing staff to ask for the door to be opened. Ward staff will then accompany the service user to the door. This also applies to visitors on the ward wishing to leave.

The Older People's In-patient service will ensure at all times that the rights of informal service users are not compromised and will undertake regular audits to ensure that these rights are maintained.

All ward exits have a sign clearly explaining the rights of informal service users should they wish to leave the ward.

7. MANAGEMENT OF PROPERTY WITHIN THE SERVICE

The management of property on the wards is undertaken through individual risk assessment. Plastic bags are not allowed in any of the ward areas apart the individual ward kitchens and clinic rooms. Sharps items such as razors are not allowed to be stored in communal areas and will be kept by the ward for safekeeping. Razors will be handed to service users upon request and providing it is safe to do so however, they will be handed back to ward staff after being used for safe storage.

The NHFT property disclaimer is clearly displayed on each ward entrance and within the day areas of the ward. The service will not take responsibility for any item of property that is not handed in to the ward for safekeeping. A list of property will be taken upon admission for every service user and retained with the clinical record. This list clearly determines those item retained by the service user and those items handed in for safe keeping. Each ward maintains a record of items kept by the ward for reference.

8. DAILY WARD ROUTINE

Handover

The daily routine on all wards starts with a handover between night staff and those working the early shift (07.30hrs – 08.00 hrs). Further handovers take place between 13.45hrs - 14.30hrs and 20.15hrs - 20.45hrs.

The purpose of handover is to pass information about service users and the ward from the outgoing shift to those staff coming on duty. The format used within the service is that each service user is discussed in turn, with the essential components of the report being their name, legal status, leave status, physical/mental health, feedback of the nursing observations of the service user's presentation from the previous shift (focusing on risks, care plans and

strengths) and any tasks that are needed to be completed by the incoming shift.

Although the handover is primarily to handover the care delivery of service users, it also provides peer support for team members that are present. The handover allows nursing staff to express their feelings concerning service users and situations, including emotional events and sometimes may function as a de-briefing session. It may provide an opportunity for safe individual and team reflection.

Ward Round / Multi-disciplinary Team Meetings

The clinical team for the Older People's In-patient service is led by a Consultant Psychiatrist who will see all the service users with the rest of the MDT on a weekly basis. Relatives can request to attend Ward Round and an appointment time will be given.

Care Programme Approach (CPA) and pre-discharge meetings will be arranged regularly to discuss the service user's progress and will provide an opportunity for open, honest and informal communication between the service user, family, carer and the MDT.

Meal times

Meal times are protected to ensure that service users are allowed to eat their meals without unnecessary interruption and to focus on providing assistance to those service users unable to eat independently. However variation to this arrangement can be made directly with Ward Matrons if families/carers wish to assist those service users who need assistance or if visiting times are difficult for families/carers due to other commitments.

Visiting Times

Visiting times are open and flexible. However we need to be mindful as part of in-patient care we deliver daily therapy programmes (taking place during the morning and afternoon), these are an essential part of recovery and we encourage all service users to participate. We therefore ask that all visitors consider this when visiting. See appendix 2 for further information and visiting in relation to children and unwanted visitors.

John's Campaign is promoted within the Service. It focuses on people with dementia but also those who are frail or who have particular needs that would benefit from the nurture of a family member or trusted friend when they are in hospital. The campaign supports the rights of willing family carers to continue to support a service user through a hospital admission as they would have prior to admission.

Use of interpreters
Where English is not the first language, arrangements will be made to access interpreting services (AA Global), the race, gender and culture of the interpreter should be appropriate to need and acceptable to the service user.

Access to Occupational Therapy, Physiotherapy and Clinical Psychology
Occupational Therapy (OT) and Physiotherapy is automatically accessible to all individuals requiring mental health in-patient services.

Occupational Therapy provides a specialist service with a unique occupational focus using activities to both assess and treat needs within a person's everyday life (personal care, activities daily living, work ability, social ability and leisure). Service user participation in occupational therapy treatment is an essential part of the overall therapeutic care provided within the units, alongside medical and nursing care. Occupational therapists assess and continually evaluate individuals' levels of functioning, contributing to the overall MDT care planning process and discharge planning.

Occupational therapy treatment is based around graded activities which meets the needs of the individual and facilitates a sequential development in occupational performance. The activity prescribed will take a variety of forms – this may be on a 1:1 basis; in a small group; on the ward or within a community environment and may include home visits to identify and address specific areas of concern prior to discharge.

Ongoing assessment of functioning and participation within treatments ensures timely identification of changes (positive or negative) and adjustment of treatment accordingly.

Every service user will have an initial Physiotherapy assessment and a plan of care will be devised in order to maintain individual service user's safety and promote their independence. A number of enjoyable exercise programs tailored to the individuals' needs are available which will help to build their mental and physical wellbeing.

Any service user referred to the in-patient Clinical Psychology service will be offered assessment, formulation and intervention dependent on space in the clinician's caseload. Liaison and planning with the OPCMHT as regards any on-going psychological needs following discharge to the community will be done by the ward psychologist.

Use of mobile telephone and devices

The Trust's aim is to safeguard and promote the welfare of all service users and recognises that promoting communication between relatives, friends and carers can benefit the service user, while at the same time it is aware that mobile camera/video phones and personal computing devices pose a potential risk to the welfare and the confidentiality of other service users. In addition the Trust is aware that mobile phones and personal computing devices have the potential to:

- cause a nuisance and be annoying to service users and staff
- breach the principles of privacy, dignity and confidentiality of all Trust users including service users, carers, visitors and staff in the event they are fitted with cameras.

In Older People's inpatient settings we endeavour to establish an appropriate balance regarding the use of mobile telephones and personal computing devices, whilst ensuring privacy and without causing inconvenience to service users. It is trying to balance the right of service users and visitors to use their mobile phones and personal computing devices with the rights of service users and staff in respect of privacy and dignity. Please see Appendix 3

Ward Equipment Safety Checks

There are daily checks in the clinic that ensure that the following equipment is in working order.

- Oxygen Cylinder and Masks (Recording amount of oxygen)
- Suction Machine
- Contents of Resuscitation Trolley and expiry dates of contents
- Contents of the top of the Resuscitation Trolley which includes Defibrillator, Gloves, Ligature Cutters and Suction Machine.
- Temperature of fridges in line with Cold Chain Policy

There are other daily checks that include kitchen fridge / freezer temperature. Staff also should check their personal alarms and pager are working and operational. Twice daily all external doors and bathrooms are checked by the incoming and outgoing nurse in charge. These checks are to ensure that items that may cause harm to others such as razors, paper clips, glass etc are not left undetected. Checks are also completed on internal doors that should be locked including, laundry, kitchen, clinic, disposal, linen rooms and storage cupboards.

Every week a Controlled Drug audit is completed to ensure that the stock is correct and has been signed for correctly. The clinic stocks including medication and medical devices are checked every weekend and out of date items disposed of accordingly. The clinic area is deep cleaned every weekend.

Ward Night Routine
Service users are encouraged to develop and maintain a healthy sleep pattern as part of their treatment plan. Supper is provided at 21.00hrs and night medication is dispensed from 20.00hrs. Service users should be aware that observations remain throughout the night, either enhanced, 15 minute or on an hourly basis. Staff continue to be available for therapeutic interventions during the night when needed.

Discharge and follow up care
The decision to discharge is based on multidisciplinary discussion but is ultimately the responsibility of the Consultant Psychiatrist in charge of the individual service user. Planning for discharge and aftercare will be part of the on-going process of care commencing at the initial assessment of the service user. As soon as appropriate, the multi-disciplinary team will prepare a discharge and after-care plan in accordance with agreed policies and procedures. The person responsible for the co-ordination and dissemination of information regarding the discharge and after-care plan will be clearly identified and recorded in the service user's notes.

On discharge, clear information regarding any special instructions and follow-up arrangements will be passed on to the service user and their carers/relative.

Where there is a delayed discharge, liaison is maintained between care-management and carers. For the recording and reporting of Delayed Discharges see the Delayed Transfers of Care Policy.

Prior to discharge a clear identified plan involving the service user and other relevant persons will be put in place. On discharge, service users will be given the date and time of their follow up appointment and will receive a copy of their discharge summary. This will also be sent to the service users GP and also the service that is undertaking the follow up arrangements post discharge from hospital.

Up to 4 sessions post-discharge may be offered by the ward psychologist to help with the transition back to the community for service users who have engaged in psychological therapy during their admission.

Discharges Against Medical Advice
Service Users may decide to discharge themselves from the hospital against clinical advice. If a service user wishes to self-discharge:

- Staff must advise the service user why it is in their best interest to remain in hospital
- All information regarding potential risks of self-discharge and the benefits of continuing with their hospital care must be explained to the service user to allow them to make an informed decision
- The service user is encouraged to sign the disclaimer that is kept on the ward
- The doctor on duty / on call must be informed in order to carry out an assessment of the service user's mental health
- The doctor on duty must inform their Consultant as soon as possible (if relevant)
- All reasonable steps must be taken to ensure that the service user receives their medication
- Relatives and Social Services must be contacted, if relevant: if the self-discharge occurs during out of hours, this must be done as soon as the relevant agencies open the following morning or after the weekend/bank holiday
- The GP must be contacted at the time the service user leaves the hospital: a discharge letter must be sent to the GP within 48 hours of the service user leaving hospital
- All discussions with the service user must be documented accurately in the service users records
- Ensure all appropriate members of the multi-disciplinary team involved in the service user's care are informed as soon as possible

Admission to an Acute Hospital

In case of any physical deterioration, Doctor's will assess and liaise with medical teams prior to transfer if appropriate, however in an medical emergency the service user may require immediate transfer to an Acute Hospital.

In both circumstances a covering letter or transfer documentation from system one will be provided which will include medical assessment, up to date care plans, information on treatment outcomes, on-going care requirements, diagnosis and prognosis, medication prescription, allergies, any advance directives, body maps of wounds or injuries explaining how they occurred if applicable, infections if applicable and risk assessments. The service user will be escorted by a ward nurse to Accident and Emergency (A & E) from the transferring ward. The nurse escorting will ensure that a full handover is given to staff at the Acute Hospital. See Appendix 4

9. DUTIES

Management of Services

The Chief Operating Officer (COO) and the Deputy Director of Mental Health have strategic responsibility for the countywide in-patient mental health service through the Head of Hospitals, North and South. The Head of Hospitals North has overall responsibility for the Older People's Mental Health Services Countywide. The operational responsibility for the Older People's Mental Health Services Countywide is through the Service Manager. The Service Manager is supported by a Ward Matron based on each ward and Operational Managers for the Community Services.

Staffing Levels

The minimum staffing levels for each ward are:

Riverside and Spinney
Early shift – 5 staff (3 qualified nurse & 2 HCA's)
Late Shift – 5 staff (2 qualified nurse & 3 HCA's)
Night shift – 3 staff (1 qualified nurse & 2 HCA's)

Orchard and Brookview
Early shift – 4 staff (2 qualified nurse & 2 HCA's)
Late Shift – 4 staff (2 qualified nurse & 2 HCA's)
Night shift – 3 staff (1 qualified nurse & 2 HCA's)
This is as per safer staffing requirements. Staffing levels can be increased at the discretion of the Ward Matron depending on clinical need.

The role of the nurse-in-charge

The nurse in charge is a designated role on each ward that is undertaken by the most senior member of ward staff on duty. The nurse in charge role assumes delegated responsibility for the running of the ward for the shift from the Ward Matron.

10. MANAGEMENT OF BED CAPACITY

The responsibility of managing bed capacity for Older People's In-patient services is assumed by the Ward Matrons during the hours of 09:00 - 17:00 Monday - Friday. Outside of these hours they will be managed by the nurse in charge of each respective ward.

11. THE USE OF EMERGENCY ALARMS AND PAGERS

Alarms and Pagers:

The roles of the Nurse in Charge should be clearly displayed in each ward office. To enable monitoring and an audit trail, all wards will ensure that it is recorded on the shift plan who has undertaken this role on each shift. The pager/alarms system currently shows three different alerts. These are CALL, ALARM and ATTACK.

CALL is displayed when one of the assistance alarms in the bathrooms on the wards are activated. Only staff from these areas will respond to this display.

ALARM is displayed when the red button is pressed on the personal alarm. This button should only be used when additional local support is required and, therefore, staff response to this will be from the immediate area only. All staff on duty in the immediate area will respond to this display

ATTACK is displayed when a staff member requires immediate assistance and is activated by pulling the personal alarm downwards to activate the system. All nominated response nurses across the wards/hospital site will respond to this display immediately. In the event of a response nurse not being able to attend, they will ensure that a colleague responds on their behalf.

12. SERVICE DEVELOPMENT AND EVALUATION

There will be an on-going process of both clinical and quality audit and evaluation in relation to the quality of service delivered, the results of which feed into the Trust's governance structures and strategic planning. This will involve the production of demographic data, service user feedback, carer and staff feedback and admission/treatment/discharge data.

The results of audits will be disseminated to staff and management of the unit including service user groups and appropriate senior managers. Policies, protocols standards etc. will be amended based on information and evidence from audits.

Evaluation feedback and further service development will also be obtained from and fed back to the following forums:

- Service User Views via 'I Want Great Care'
- Older Peoples Operational Management Team Meeting (OMT) (Monthly)
- Weekly OMT
- Community meetings
- Team meetings
- STAR days
- Clinical Audit Effectiveness Committee
- Therapy specific feedback

13. EDUCATION, TRAINING, STAFF DEVELOPMENT AND SUPERVISION

Skills development and continuing practice development is a joint responsibility between all staff and their managers. Staff must ensure that mandatory training is up to date. Managers will ensure that other training is cascaded and integrated into everyday practice.

Through Appraisal, Individual Performance and Development Review (IPDR) individual learning needs will be identified and a personal development plan formulated and reviewed. Team-based training and case formulation sessions will occur within the STAR days with the focus being determined by the team and also national guidance.

Clinical supervision, in line with the Trust's commitment to clinical governance agenda, forms a crucial part of the development and maintenance of good clinical practice. All staff will be encouraged to have supervision, 1:1 and group on a regular basis; this is to encourage self- reflection, development and the maintenance of skills.

Management supervision allows a person in a supervisory position to manage, direct and oversee the performance and operation of another member of staff, enabling the individual to achieve a satisfactory level of competence and promote their potential within the organisation. All staff employed within the trust will receive regular management supervision in line with the Trust's agreed standards and procedures.

14. STAFF INDUCTION

All new staff will attend a Trust induction and will also receive a local induction programme individual to their respective area. This will include orientation to the ward, unit and also an individual programme relevant to the role.

15. STUDENTS, TRAINEES AND LEARNERS

All students on placement will be provided with an induction, an assigned assessor/mentor and on-going experiential learning, including time with other disciplines. Students will be closely monitored and supported. Each ward completes a profile of learning opportunities available to student nurses. Following their placement, feedback will be sought to ensure that the placements have been positive experiences. Service users have the right to decline student involvement in their care.

16. SERVICE USER AND FAMILY/CARER INVOLVEMENT PRINCIPLES

It is recognised that service users are best placed to help staff understand their needs. Staff will promote service user and carer involvement/co-production in all decision making processes and the planning of their care. Service user involvement will be facilitated through:

- One-to-one sessions with their allocated workers
- Ward rounds
- Co-production care planning
- Independent advocacy
- Community ward meetings
- Advance statement/directive
- Discussion with family/carers with permission of service user
- Membership of the Trust, opportunity to be elected as Governor
- Opportunity for membership to Patient Experience Group (PEG) and local Older People's Service User Involvement Group

All of the wards have an identified Carers' lead. This identified person works in collaboration with a Carers' Governor and Northamptonshire Carers to ensure that the wards are engaging effectively with carers, to act as a ward resource for carers and clinical staff regarding available support. The carers' lead is responsible to ensure the carers' information contained within ward areas is up to date and relevant.

Each ward has carers' information held within the entrance area. Ward staff will also distribute Carers Cards to both service users and carers advising of the ward visiting times, ward telephone number and the name of both the key worker and Consultant Psychiatrist.

17. I WANT GREAT CARE (IWGC)

IWGC is the easy way for our service users and carers to feedback and rate our inpatient service. It is simple and safe way to provide ratings and reviews. The comments received help the teams and other service users and carers by highlighting what we could do better. It is also a good way of thanking us for great care.

18. PATIENT ADVICE AND LIAISON SERVICE

There is a patient advice and liaison service (PALS) in the Trust. PALS focuses on improving services to service users. It aims to provide "on the spot" resolution of concerns, advice, information and support for service users, their families and carers.

19. COMPLAINTS

Information on how to complaint is available within the ward information. Service users and carers must be reassured that their care will not be affected if they wish to make a complaint.

20. INDEPENDENT ADVOCACY

All service users have the right to access independent advocacy. Total Voice Northamptonshire provide advocacy Services to our inpatient areas. Service users can choose to use alternative advocacy services if they wish to do so.

Total Voice Northamptonshire provides advocacy for the service users, which is free, independent and confidential. The service offers:

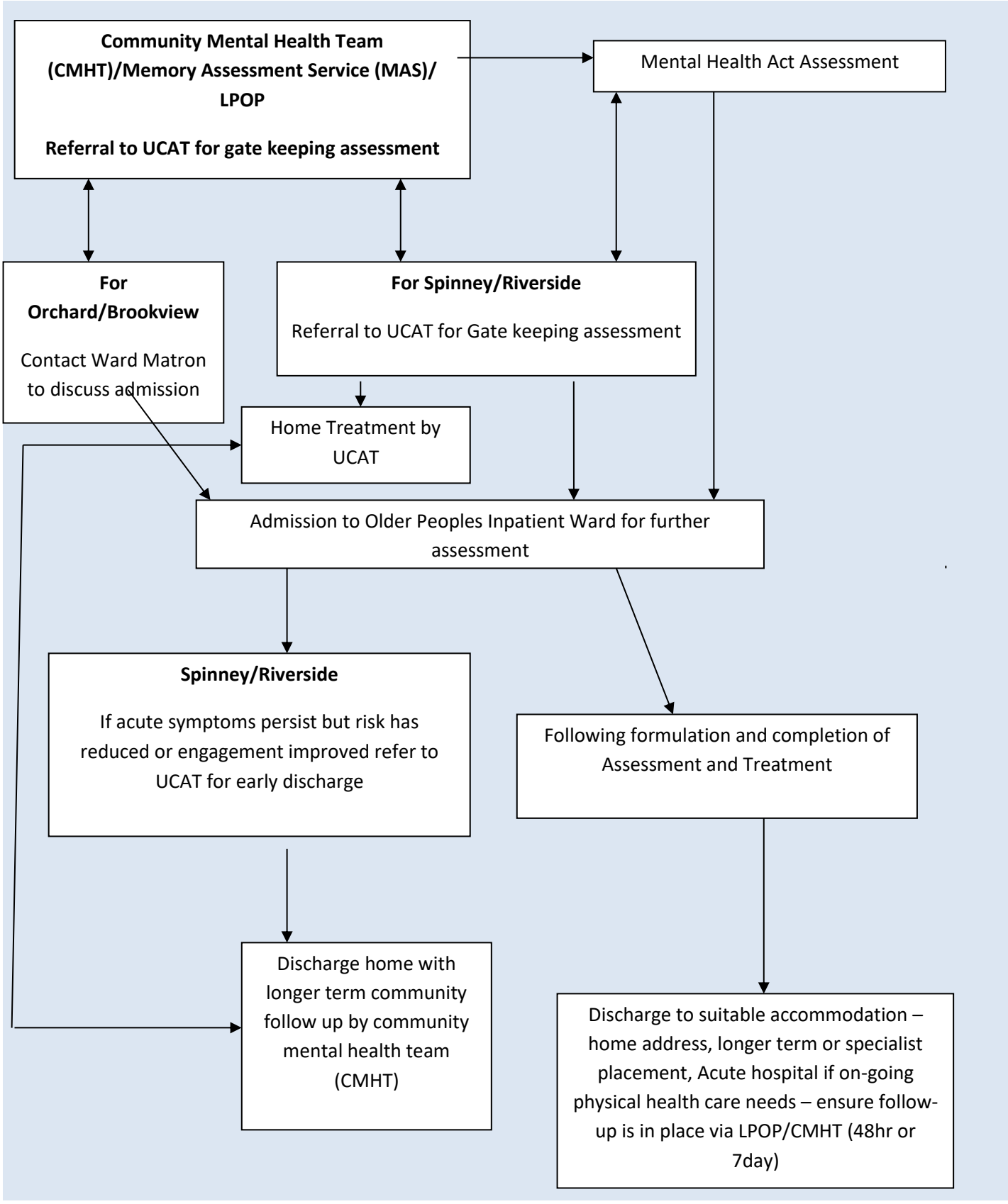
- Support at clinical reviews, CPA reviews, tribunals and meetings
- Help and support service users in making and resolving complaints
- Information on service user rights within the Mental Health system
- Signposting service users to local services, self-help groups and user groups
- Helping people to voice ideas and opinions about the service they are using
- Support in talking with professionals

Advocates do not make decisions for their clients or try to tell people what they should do; they will listen and offer support in whatever way is appropriate. Advocates endeavour to provide information in order to empower service users to make informed decisions.

21. VOLUNTEERS AND EXTERNAL WORKERS

The Older People's inpatient wards are committed to improving the service user experience through recognised initiatives. An important component of this is 'bringing the outside in' and broadening the opportunities offered in hospital which serves to facilitate recovery opportunities post-discharge. Volunteers from the local community provide supervised and supported input to the units in a variety of roles to assist in the provision of low key activities and general engagement. External sessional workers also provide input to complement care provided within the units such as Tai Chi, Reflexology, PAT Dog, Shia'tsu and others depending on need and resource availability. Volunteers and sessional workers are fully DBS checked and receive induction and support to ensure safety of practice.

Admission Pathway



Training requirements associated with this Policy

Mandatory training is not a requirement of this policy.

How this Policy will be monitored for compliance and effectiveness

The Operational Policy is a working guide for all ward team members. It also serves to inform primary care services, local statutory and voluntary services, service users and carers about the OPCMHT.

This Operational Policy will be reviewed three yearly to reflect major changes in national policy and practice and feedback from local stakeholders and service user experience.

The updated version of the policy will be available on the Trust Intranet and brought to all staff's attention through the staff room.

In addition the Ward Matron's will bring the policy and any revised additions to the attention of all staff with in the ward teams.

Equality considerations

Equality Statement

The Trust aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Action 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

In carrying out its functions, the Trust must have due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the Trust is responsible, including policy development, review and implementation.

Due Regard

This policy has been reviewed in relation to having due regard to the Public Sector Equality Duty (PSED) of the Equality Act 2010 to eliminate discrimination, harassment, victimisation; to advance equality of opportunity; and foster good relations. Due regard comprise two linked elements: proportionality and relevance. The weight given to equality should therefore be

proportionate to its relevance to a particular function. It should also be noted that there will policies/proposals that have no impact and little relevance to equality. This policy is specific to a target group defined in the eligibility criteria namely those people who are over the age of 65 who require mental health services. The potential of any negative impact on those outside of the age criteria is limited as services are provided for those Service users through other pathways such as Adults of a Working Age Teams. The target group for individuals who do not have English as their first language will be supported through interpreter services. The ward teams additionally promotes and encourages service user and carer involvement co-production and feedback as this informs better outcomes of care. This policy also states that the Trust will promote effective liaison and collaborative working partnerships with local voluntary and non-statutory agencies that will be of benefit to service users. The team will liaise with and as necessary refer to other specialist teams e.g. Community Brain Injury team, Learning Disability Teams, MS nurses, Parkinson 's Disease Nurses, Mentally Disordered Offenders Services, Personality Disorders Hub and services to meet the physical needs of Service users (such as District Nurses, Fall Service and ICT).

The Trust works in accordance with its Equality, Inclusion and Human rights policy and its Equality, Inclusion and Human rights strategy.

Appendix 1

Guidance for transfer of care between Adult Mental Health Services and Mental Health Services for Older People Inpatient Care

This guidance outlines the Northamptonshire Healthcare NHS Foundation Trust Mental Health's (NHFT) approach to transfer of care from Adult Mental Health Services (AMH) to Mental Health Service for Older People (MHSOP).

NHFT is committed to providing the highest possible quality of care to the people who use its services and believe that service users should receive support from the service that is best suited to meet their needs. NHFT recognises that it is particularly important to be mindful of the impact that transfer of care can have on service users and will therefore ensure that when transfer of care is deemed appropriate, disruption to the service user will be minimised and it will not impact on the quality or extent of the care that they receive.

NHFT works within the framework of CPA. All service users who are transferred to MHSOP from AMH will therefore remain on CPA and the transfer will take place according to the CPA guidance - see policy CLP010.

Within NHFT MHSOP we provide assessment, treatment and support for service users aged over 65. However, subject to this guidance, flexibility exists for accepting referrals for, or requests for transfer of, service users who are aged under 65 and who have:

- Early onset dementia
- Physical frailty to the extent that their needs would best be met by MHSOP

MHSOP will only accept referrals for service users aged under 65 when it is demonstrable that their needs would best be met by MHSOP. Whether or not a service user's needs would best be met by MHSOP will be according to the judgement of MHSOP professionals.

All requests for transfer of care to MHSOP should be made to the appropriate Consultant Psychiatrist and Ward Matron. Prior to accepting any request for transfer of care, it may sometimes be necessary for an MHSOP professional to undertake an assessment.

Service users who at their 65th birthday are receiving treatment or support from AMH will continue to receive support from AMH unless or until their needs have

changed. Service users who turn 65 should not therefore be automatically referred to MHSOP.

Service users aged over 65 who have previously had contact with AMH but who have not been seen for twelve months or more will be regarded as new service users and will be the responsibility of MHSOP.

Service users must be informed of the request for transfer prior to its being made and, in ideal circumstances, be in agreement with it.

Transfer care plan will be completed if the service user is currently an inpatient on an AMH Ward.

Appendix 2

Guidance on the use of Mobile Telephones and Personal Computing Devices within Older People's Inpatient Wards

Management of the use of mobile telephones and personal computing devices is recommended by the Department of Health however we are required to protect service user safety and uphold the principles of privacy, dignity and confidentiality of all Trust users including service users, carers, visitors and staff.

This guidance applies to service users and visitors. Older People's Inpatient Wards promote the welfare of all service users and recognises that promoting communication between relatives, friends and carers can benefit the service user, while at the same time it is aware that mobile camera/video telephones and personal computing devices pose a potential risk to the welfare and the confidentiality of others. In addition we are aware that mobile telephones and personal computing devices have the potential to:

- cause a nuisance and be annoying to others
- breach the principles of privacy, dignity and confidentiality of all Trust users including service users, carers, visitors and staff in the event they are fitted with cameras.

The Older People's Inpatient Wards endeavour to establish an appropriate balance regarding the use of mobile telephones and personal computing devices, whilst ensuring privacy and without causing inconvenience to. It is trying to balance the right of service users and visitors to use their mobile phones and personal computing devices with the rights of service users and staff in respect of privacy and dignity.

All service users will be risk assessed and appropriate care plans put in place if risks are identified.

Definitions

- A "Mobile Telephone" is defined as a telephone that is connected to an external mobile telephone/data network via a radio signal to provide voice and text capabilities.

- Smart Phone technology (e.g. iPhone ©, Android phone, etc.) is a full-featured "Mobile Telephone" with additional functionality such as access to email, Internet Web browser, camera and video messaging etc.

- "Personal Computing Device" includes Laptop/Tablet/Palmtop Computers.

- Laptop/Notebook/Tablet/Palmtop Computers are defined as portable computing devices; such devices can connect to an external mobile telephone/data network via a radio signal to provide functionality such as access to email, Internet Web browser, webcam etc (e.g. Ipad ®).

The use of mobile phones and personal computing devices in the following areas is permitted;

- Hospital reception and entrance areas
- Specially designated rooms/areas
- Public corridors
- On wards e.g. dayroom and non-clinical areas where direct clinical care is not delivered, bedroom areas
- There are no restrictions on the use of offline Kindle ® or similar E-book Digital Readers in any areas.

(Note: In all areas, as a precautionary measure, the use of mobile communication devices should be prohibited within two metres of any service user connected to a medical device).

However, it may be that it is not always appropriate for mobile telephones and personal computing devices to be used even in the areas listed. Users of these devices must never use them to take photographs/videos of service users or other service users without their consent.

Mobile telephones or personal computing devices should not be used without the permission of the nurse in charge.

Mobile telephones or personal computing devices must always be used with consideration for others.

The following criteria must be applied where mobile telephones and personal computing devices are being used as identified:

- Must not be used to record / video any aspects of care delivery including communication without the explicit permission of all those involved.

Infection Control – studies have found high bacterial contamination, including MRSA, on mobile telephones. To minimise the risk to service uses, people who use their telephones are advised to wash their hands before they come into direct contact with the service users.

Appendix 3

Visiting guidance to Mental Health Services for Older People (MSHOP) Inpatient Wards

The value of visits from family and friends to service users receiving treatment and care on these wards is recognised as a key element in a service user's care, treatment and recovery. Paragraph 11.4 in the revised Mental Health Act 1983: Code of Practice (2015) states 'All service users have the right to maintain contact with, and be visited by, anyone they wish to see, subject to carefully limited exceptions'. Article 8 of the European Convention on Human Rights (ECHR) protects the right to a family life. However visiting arrangements have to balance the needs of the service user to be able to maintain family links with safety privacy and dignity issues for themselves, for other service user's and visitors.

The purpose of this guidance is to set out the process by which the MHSOP will seek to facilitate visits to service users whilst in Hospital. By providing this guidance NHFT staff will ensure that visits to service users are made as comfortable and easy as possible for the visitor and the service user. It will provide clear guidance to staff on the process and actions required when unwanted visitors attend the ward (those who pose a threat to service users or staff)

Visiting times are open and as flexible as possible on the wards however it is accepted that there are important activities that occur on all ward environments that are most effectively delivered when dedicated, uninterrupted time is available for staff to provide assessment, treatment and care. Examples of such activities are:

- Protected meal times (this should not be implemented as a blanked restriction as individual care plans may indicate visits should be encouraged at meal times)
- Therapy Sessions
- Multi – Disciplinary Team Reviews / Meetings, although family members may attend
- Providing personal care at key times throughout day
- Visits after 20.00 hours to ensure good sleep hygiene

Where visitors have difficulty in managing to undertake visits during preferred times, due to their personal circumstances such as work commitments or travel arrangements then their requirements should be accommodated where it is reasonably possible and does not compromise the safety or privacy and dignity of service users and this can be arranged with ward staff.

Service users should be able to see their visitors in private. Visits should preferably take place in dedicated visiting areas and such areas should be welcoming (lounges, dining room or garden areas).

Children visiting are also important to enable service to maintain their role as grandparent etc. Visitors are asked to ring in advance if children are part of the visiting party. A private room will be made available for the visiting party. Any safeguarding or risk issues should already be assessed and care planned, including the actions required during visits e.g. staff may be required to sit in the room during visits. It is recognised that this may feel intrusive and staff will only sit in the room during the visit where there are safety concerns.

Unwanted visitors, in circumstances that there may be unwanted visitors or visitors posing a risk to the safety of service users and staff, the nurse in charge is to follow the following steps:

- Request the visitor to leave the ward (if safe to do so)
- If the visitor refuses to leave the ward advise them that you will be contacting the police
- Contact the police for assistance
- Complete a Datix

Appendix 4

Guidance for transferring service users from MHSOP Inpatient Wards to Northampton and Kettering General Hospitals.

This guidance has been drawn up to support staff when service users are being transferred to the Acute Hospitals (AH) and when it is appropriate to transfer service users back to any of the MHSOP Inpatient Wards following a period of admission to the AH's.

In case of any physical deterioration, Ward Doctor's or Duty Doctor's will assess and liaise with the AH's medical team prior to transfer (unless nursing staff have made a 999 call) A covering letter will be written and sent with the service user which will include medical assessment, up to date care plan, information on treatment outcomes, on-going care requirement, diagnosis and prognosis, medication prescription, allergies, any advance directives, body maps of wounds or injuries explaining how they occurred if applicable, infections if applicable

The service user has to be escorted to accident and emergency department (A & E) by a nurse from the transferring ward and the escort will remain with the service user until they are admitted to a ward within the AH

Nurse escort to ensure that there is a proper handover to A & E Staff, / Medical ward as applicable

A copy of the covering letter will be uploaded onto System 1

Risks will be highlighted and management plan's explained to the AH's

LPOP will be notified by email/telephone when service users are transferred from MHSOP Inpatient Wards to AH's if follow-up mental health reviews are required

Whilst the service user is at the AH, staff will get an update via telephone at least once a day

If the service user still requires further investigation/treatment at the AH after five days then the Consultant Psychiatrist will discharge the service user to the AH and LPOP will be requested to complete a 48hr/7day mental health follow-up on the service user whilst at the AH

The AH will make contact with the MHSOP Inpatient Wards Ward Doctors, Ward Matron or the Nurse in Charge responsible for the service user to discuss

transfer back to the MHSOP Inpatient Wards when the service user is deemed medically fit to transfer back

On transfer back to the MHSOP Inpatient Wards all service users should return with a clear document discharge summary and if a service user still requires active medical treatment this should be clearly recorded e.g. Service users requiring oral antibiotics following a course of IV antibiotics

Document control details

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