Northamptonshire Healthcare
NHS Foundation Trust

CLP056 Transfer & Discharge Policy (MH & LD)

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Why we need this Policy

- This policy is to provide all mental health and learning disability practitioners working within the Northamptonshire Health Care NHS Foundation Trust with the standards and responsibilities governing the transfer or discharge of patients from inpatient facilities.
- This policy is supported by the Care Programme Approach Policy.
- Transfer of care between wards and discharge form wards should be a seamless process which does not interrupt the patients care pathway.
- Discharge planning is not an isolated event but a process which may involve a range of inpatient user and community professionals and service depending on the needs of the patients.
- This document sets out the standards that the trust adheres to deliver safe transfer of care.

What the Policy is trying to do

The purpose of the policy is to provide patients, families carers and staff with a framework for enabling timely, safe and appropriate discharge and transfer from in-patients/residential services to an appropriate destination according to the patient's needs. Patients admitted to the Mental Health inpatient wards are admitted from the community via the Urgent Care and Assessment Teams. Admission to hospital is not discharge from the community.

The process of discharge and transfer must be part of a comprehensive risk assessment and risk management plan to enable patients to be supported in gaining independence on the recovery or challenging behaviour care pathway.

The purpose of the handover is to ensure the transfer of high quality clinical information, the effective transfer of information ensures the protection of patients and minimises clinical risk. Continuity of information underpins all aspects of a seamless service providing continuity of patient care and patient safety.

Which stakeholders have been involved in the creation of this Policy

- Inpatient Mental Health Service Managers, Chief Pharmacist
- Directorate Management Team
- Mental Health Clinical Executive
- Trust Policy Board

Any required definitions/explanations

- **Section 117**

  Health and local authorities have a statutory duty under section 117 to provide after-care services for patients who have been detained in hospital under sections 3, 37 (whether or not with restriction under section 41), 47 or 48 of the Mental Health Act 1983, until they are jointly satisfied that this is no longer necessary. The CPA Policy & Practice Guidance clearly outlines Section 117 requirements.

- **Care Programme Approach (CPA)**

  The term CPA is used to describe the approach used in NHFT Mental Health services to assess, plan, review and co-ordinate the range of treatment, care and support needs for people who have complex characteristics

  The main principles of the CPA are:

  - Assessment of a person's health and social needs;
  - Formulation and implementation of a personalized care plan to meet the service user's assessed needs;
  - A named individual responsible for coordinating the care called the CPA care coordinator and who should ensure care is co-produced with the service user and carers;
  - Regular reviews of the personalized care plan;
  - Service user and where appropriate carer coproduction throughout assessment, care planning and interventions;
  - Multi-disciplinary/multi agency working

  All patients admitted to an inpatient mental health ward will be under CPA from the point of admission regardless of their legal status. The admission process requires all inpatients to have an initial CPA meeting as soon as possible following admission and a Discharge CPA meeting as close to discharge as possible from hospital. The Responsbile Clinician will determine at the discharge CPA meeting whether CPA is required following discharge. If not then the CPA episode must be ended at the point of discharge.

- **7 day and 48 hour follow up**

  The national suicide preventon strategy has stated during each publication since 1996 that all service users discharged from inpatient care (including those who discharge against medical advice) will wherever possible have face-to-face contact with a mental health worker (of any discipline) either within forty-eight hours or seven days. If face-to-face contact is not possible then telephone contact will take place.

  Service users who do not require 7-day or 48 hour follow-up are identified within the following categories: -

  - Service users transferred to other mental health inpatient facilities
  - Service users who have been admitted for planned respite care
  - Service users who have been admitted for a short period and for whom it is deemed mental health services are inappropriate
  - Service users who die within 7 days of discharge

- Where legal precedence has forced the removal of a service user from the country

Whilst this is an expectation for all service users post discharge based on best practice guidance, patients subject to CPA post discharge from hospital must have a face to face follow up with a mental health worker within 7 days of discharge. This is a mandatory requirement for mental health trusts set by the regulator NHS Improvement therefore the correct categorisation of patients requiring CPA on discharge is crucial to ensure this target is met. PCART complete all 7 day follow ups.

48 hour discharge follow up is for the those service users deemed to be at higher risk during the inpatient stay. Within the trust, this is specifically for those patients under the care of UCAT upon discharge. It is for those patients for who require additional support on discharge to that which can be provided by PCART. This includes those patients under the care of UCAT where facilitated early discharge by UCAT has taken place.

- **St Matthew's Step down service**
  This is service provided by St Matthew's Healthcare for patients who no longer require an acute inpatient ward to meet their needs and are either awaiting a placement through the individual packages of care team for open rehab or supported accommodation. Patients who are awaiting housing through any of the borough councils are also suitable for transfer.

  The stepdown service is an extension to NHFT's adult acute inpatient service and therefore patients are transferred and not discharged to St Matthew's Healthcare. All referrals made by NHFT for the step down service are assessed by St Matthew's for suitability and transfer arranged accordingly. Patients identified for transfer to the step down service must have a discharge plan that clearly identifies what is required to facilitate discharge from hospital.

  Although once transferred, the responsibility for care and treatment of the patient is that of St Matthew's Healthcare, the bed manager / bed liaison nurse and patient's care co-ordinator will remain involved and continue to have oversight of the patients care and treatment to ensure the discharge plan agreed upon transfer is delivered in a timely way.

- **PCaRT**
  Planned Care and Recovery Team

- **UCAT**
  Urgent Care and Assessment Team

- **Discharge**
  from an inpatient mental health ward includes discharges to Urgent Care and Assesssment Teams, Specialist Services , Planned Care and Recovery Teams and Primary Care, IST/CTPLD(Community Team for People with Learning Disabilities)/private/voluntary provider and other secondary services.

- **Discharge Care Plan**
  For the purpose of this policy, the discharge checklist which is described in national guidance is referred to as the discharge care plan. The discharge care plan is a list of tasks to be completed by the mutli-discilpinary team on the day of discharge.

- **Discharge letter**
  is a letter advising of the discharge arrangements that is sent to the GP by the discharging nurse on the day of discharge. A copy of this letter is given to the patient.

- **Discharge Summary**
  is a comprehensive report which consists of a full summary of the patients admission, discharge arrangements, including medication, risks and future appointments posted to the GP by a Psychiatrist within 7 days of discharge.

- **Handover of information**
  refers to the information which is given between shifts on inpatient wards within a 24hour period. However information given may be from any time span if it felt appropriate.

- **IST**
  Intensive Support Team

- **Transfer**
  refers to patients who are transferred between wards within NHFT.

- **NHFT**
  Northamptonshire Healthcare NHS Foundation Trust

Key duties

- **Chief Operating Officer**
  The Chief Operating Officer is responsible for ensuring the implementation of this policy across the clinical areas.

- **Inpatient members of Staff (including Responsible Clinician and Multi-disciplinary Team)**
  All inpatient members of staff have a responsibility for ensuring that they comply with the Inpatient Discharge Policy.

- **Responsbile Clinician**
  The patient's Responsible Clinician (RC) is ultimately responsible for the discharge decision. This can fall to on-call clinicians out of hours.

- **Staff**
  CPA Coordinator, Key Worker, Named Nurse, Responsible Clinician, Multi-Disciplinary Team and UCAT Team/IST case holder/CTPLD nurse

CPA Coordinator/PCART retains their role whilst the patient is an inpatient. Discharge planning should be coordinated by the CPA Coordinator/PCART, Key Worker, Named Nurse, Allocated Staff Nurse (Ward Staff), Responsible Clinician, Multi-Disciplinary Team, and Crisis Resolution Home Treatment Team where appropriate. IST/CTPLD

- **Lead Clinicians, Service Managers/Senior Matrons/Ward Matrons**
  They have the responsibility for dissemination of this policy to local areas under their responsibility, to ensure that staff are aware of and comply with this policy

- **Mental Health Act Administration Team**
  The Mental Health Act Manager will provide reminders to clinical staff and be a source of advice when needed in the discharge planning arrangements for patients subject to detention under the Mental Health Act. This includes patients being discharged under Community Treatment Orders. The Mental Health Act Manager will be notified of transfers of patients detained under the Mental Health Act.

Policy detail

- **Transfer Procedure for inpatient mental health services**

Transfers between wards within inpatient mental health services take place routinely. This is generally to enable the inpatient service manage the beds across the organisation. Specific situations that will require a patient to transfer to another ward will be

- Where a patient is admitted to a bed in the north of the county but lives in the south and vice versa. This is to ensure that patients receive care in the hospital closest to where they live
- Where a patient is admitted to a ward where another member of their family is already receiving treatment
- Where the patient needs separating from another patient(s) due to ongoing concerns about their relationship.
- The patient decides that they wish to receive their inpatient care and treatment on another ward of the same type as that where they are receiving treatment. For example a patient on Cove Ward may decide that they wish to have their treatment on Avocet
- As part of the care pathway, admission to a gender specific acute ward will sometimes lead to transfer to another acute ward which is mixed gender.

For the purposes of clarity, a transfer is a move from one NHFT inpatient ward to another NHFT inpatient ward including wards of a specialist nature. In some cases a transfer will result in the patient's responsible clinician remaining the same, but in other cases the responsible clinician may change depending on where the person is transferring to.

The decision to transfer a patient between the mental health inpatient wards will be made by the nurse in charge of the ward. This will usually be in conjunction with the bed manager / bed liaison nurse and the nurse in charge of the ward receiving the patient. The responsible clinician may also contribute to the discussions around transfer. In the event of any disagreements then the proposed transfer should be escalated to the relevant Head of Service who will make the decision based on all the factors involved.

There is a different process for the transfer of patients between the acute wards and the psychiatric intensive care units. See Shearwater PICU and Marina PICU operational polices for details

Once a transfer has been agreed, the transferring ward will initiate the transfer care plan within the electronic patient record (see appendix 1).

The transfer care plan identifies all of the tasks that require completion for transferring the patient.

The patient must be given prior notice that they are being transferred to another ward. Ideally this should be 2 hours to enable them to prepare themselves and their belongings.

The transferring ward must contact the patient's family and / or carers and advise that the patient is transferring to another ward and advise them of the name of the ward and what time they are expected.

Following consideration of all of the clinical risk factors, escorting staff will be identified by the nursed in charge. The number of escorting staff will be determined by these risk factors. At least 1 of the escorting staff members must be familiar with the patient's history and be able to give details regarding the presentation during the previous 24 hours.

- **Handover Requirements for transferring patients between NHFT wards**

A full handover from the transferring ward will be given to the nurse in charge of the receiving upon following transfer.

The escorting staff will communicate an accurate concise account of information on matters which have arisen from the previous 24 hours.

The escorting staff will ensure that all property items and property logs are handed to receiving ward staff. Items previously kept for safekeeping are handed to receiving ward staff and the nurse in charge of the receiving ward will ensure these items are logged and stored away safely.

- **Transfers to local Acute / General Hospitals**

In the case of patients requiring acute medical intervention at a General Hospital for short term treatment they remain the responsibility of the trust, In these situations, the inpatient mental health ward will provide escorts who will reamin with the patient until the situation changes.

The provision of escorts including the number of staff in all cases of transfer will be determined by the nurse incharge in the absence of the ward manager following discussion with the responsible clinician. The number of escorts must be determined following an assessment of risk including the likelihood of the patient absconding.

There will be cases where a patient is transferred to the local general hospital for treatment where it is identified by the ward manager and responsible clinician that the patients physical health needs outweigh their mental health needs. In these circumstances the patient will be discharged to the local general hospital and the trust would no longer be responsible for

provided an escort. In such cases, inpatient services will continue to liase with mental health services that based at the general hospital to ensure that readmission to inpatient mental health services can occur in a timely way if required.

- **Discharge from Inpatient Mental Health Services**

The Department of Health (DoH) Document "Discharge from Hospital: Pathway Process & Practice 2003 confirmed that discharge is a process and not an isolated event that happens at the end of a patients stay. 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 DH (2010):

1. Start planning for discharge or transfer before or on admission.

2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in the decision

3 Develop a clinical management plan for every patient within 24 hours of admission.

4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Discuss with the patient or carer an expected likely length of admission or date of discharge or transfer within 24–48 hours of admission.

6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.

7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.

8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.

9. Use a discharge checklist 24–48 hours prior to transfer. The discharge checklist will be contained within the local procedure or SOP.

10. Make decisions to discharge and transfer patients each day.

Planning for discharge will commence at the point of admission (or earlier where admissions are planned) DOH (2002); DOH (2003); DH (2010)

On admission the Named Nurse/ Key Worker will discuss the reasons and the goals for the admission with the patient and where appropriate with their carers. As part of this process the Named Nurse/ Key Worker will outline to the patient the anticipated length of stay.

All patients will have an Estimated Date of Discharge (EDD) determined as part of the admission process. This date must be entered within the electronic patient record no later than the first ward round / admission CPA meeting.

Planning for discharge will be detailed in a discharge care plan 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 within Mental Health and Learning Disability settings.

Comprehensive, ongoing assessment and review will inform the discharge process and discharge destination.

During multi-disciplinary meetings, which could include ward rounds, progress against the goals for admission will be reviewed and revised as appropriate in agreement with the patient. If not identified earlier the estimated discharge date will be agreed at the first ward round with the patient and clearly recorded in the electronic patient record.

In all admissions, the relevant community mental health workers (including community LD services) must be informed and involved in discharge planning at the earliest opportunity to minimise the risk of delayed discharge.

All relevant issues must be considered at the initial and subsequent multi disciplinary review meetings e.g. is a continuing health care assessment indicated etc.

Ongoing review of the discharge care plans will take place weekly as a minimum. Th estimated discharge date and expected destination will be reviewed and amended as required by the team together with the patient

Referrals to Northamptonshire Adult Social Services (NASS) if a financial assessment is required will take place in a timely manner as soon as the need is indicated. This will be recorded in the care plan

Where it is expected that a move to a care home or an individualised care package will be required, and the discharge cannot be arranged until the funding source has been identified and agreed, the process to do this will begin as soon as the need is indicated. This should be prior to the discharge meeting. The service will liaise as required with the IPC Team and the relevant NASS worker.

Ward Managers or other Senior Nurses will monitor the time it takes for clinical staff to complete assessments and ensure this function receives prompt attention.

A discharge CPA / multi-disciplinary review meeting will be arranged at a time as close as possible to the point of the patient being expected to be ready to leave hospital.

The date of this discharge CPA/multi disciplinary case meeting will be recorded within the electronic patient record.

The Named Nurse/ Key Worker will ensure outcomes are communicated to the team and the patient to ensure timely follow-up. In some instances, the initial meeting will fulfil this function e.g. short admission and the patient will be deemed to be ready for discharge at a ward round.

The patient will be identified as ready for discharge when

1. The patient is deemed medically fit and ready for discharge by the multidisciplinary team, and
2. Their psychiatric condition cannot be further improved by remaining in hospital, and
3. Support and resources are identified and available within an alternative setting to meet their care needs effectively.

If the discharge cannot proceed, the patient would be classified as a delayed discharge, refer to the CLPr023 - Delayed Discharge and Transfers of Care Procedure.

The outcomes of this discharge / multi-disciplinary review meeting will be discussed and agreed with the patient and where appropriate their carer / representative and clearly recorded in the discharge care plan of the electronic patient record.

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

Wherever possible, the aim will be for the patient to be enabled to return to their own home or usual care setting

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).

The responsible clinician will ensure that a decision is made and recorded at the discharge mutlidiscplinary review as to whether the patient needs the support of the Care Programme Approach following discharge. If not, then the CPA episode intiated upon admission must be ended upon discharge.

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.

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

As soon as a decision to discharge is agreed the multi disciplinary team will ensure that adequate preparation for discharge is made. Preparation includes ensuring arrangments are in place to ensure medication can be prescribed and administered. See page 14 section named Arrangements for Medication Post Discharge

If the preferred of accommodation/residential/nursing home is not available, discharge must still take place to alternative accommodation that meets the patient's needs. The patient can negotiate a preferred choice once in the alternative setting. In exceptional circumstances, when there is a delay between the patient being ready for discharge and appropriate accommodation being available, funding of alternative accommodation may be considered for a period no longer than 1 week. This includes the use of bed and breakfast / hotel accommodation. Any decision to do this should prompt completion of a risk assessment for example Working with Risk 3 - please refer to CLP021 - Working with Risk Policy.

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

The multi disciplinary 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. Assessment of concordance with medication will take place, and will be recorded in their discharge plan.

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

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

All patients will have appropriate arrangements for follow up after discharge. See section below Procedure for Following up Service Users After Discharge 7 day / 48 hour follow up

- **Discharge Against Medical Advice (DAMA)**

If a patient makes a request to take their own discharge against medical advice, the nurse in charge of the ward/unit will assess whether the patient is liable to be detained under the Mental Health Act (1983).If already detained – refer to CLP020 - The Mental Health Act 1983 (As amended by the 2007 Act)

In the event that the patient is not detainable, the nurse in charge of the ward/unit will discuss the reasons why discharge has been requested and notify the Duty Medical Officer to attend the ward to review the patient at the earliest opportunity. In this event, the nurse in charge of the ward will encourage the patient to remain on the ward/unit until such time as they have been reviewed by the Duty Medical Officer. Should the patient insist upon leaving the ward before review by the Duty Medical Officer can take place, the nurse in charge of the ward will request that the patient signs the Trust's discharge against medical advice disclaimer forms. (Appendix 5)

Where a patient leaves hospital before a review can be arranged (i.e. discharge against medical advice) the nurse in charge is responsible for informing the relevant service that will be providing follow up care and passing on the CPA my story or support plan that has been agreed so far. This should be done as soon as possible after discharge as 7 day /48 hour follow up still applies and will have to be arranged by the team providing follow up.

Where a patient has been discharged against medical advice but requires the support of the CPA framework and a CPA care co-coordinator/PCART involvement has not been allocated, the professional completing the 7 day follow up will formulate a plan to support the individual until a care coordinator can be allocated.

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. Staff will document the content of conversations fully within the electronic patient record.

- **Discharge Letter and Discharge Summary**

  On the day of discharge, a discharge letter will be completed by the nursing team, using information from within the electronic patient record that has been completed by the teams junior doctor on behalf of the multi-disciplinary team. The letter should contain the following information

  Date of discharge
  Management Plan following discharge
  Diagnosis
  Details of medication upon discharge including when next dose is due
  Date, time and location of 7 day follow up

  A copy of the letter must be given to the patient before they leave the ward.

  Within 7 days of discharge, a Discharge Summary must be completed. This should include information about why the person was admitted and how their condition has changed during the hospital stay and details of the care plan that was agreed at the point of discharge. (NICE NG53)

- **Discharge Care Plan**

  The process to be followed on the day of discharge is detailed within a Discharge Care Plan Template on Systm1. A copy of the tasks requiring completion is shown in **Appendix 3.** Nursing staff must ensure that all of the tasks are completed.

  The procedure for a patient to be discharged to back to the community should always be followed as set out in **Appendix 2**

  Ensure contact details are correct by checking with the patient and updating S1 accordingly

  Ensure that the patient has a copy of their CPA My Story.

Procedure for Following up Service Users After Discharge 7 day / 48 hour follow up

- **7 Day follow Up**

  The follow up process will be arranged by the inpatient nurse completing the discharge process and the relevant PCART. PCART will complete all of the 7 days follow ups from inpatient services.

  In all cases of arranging the 7 day follow up PCART and the inpatient team should aim to arrange the appointment for within 3 days working days of the discharge date. This is to ensure that further attempts to complete the follow up can be arranged in the event of the patient not attending.

- **CPA**

Wherever possible, care co-ordinators should be present at the meeting where discharge is decided. Where this is the case, the 7 day follow up appointment will be arranged directly between the care co-ordinator and the patient for a mutually conveneient time within the 7 day period.

If this is not possible then the request for 7 day follow up will be made to the PCART team directly and an appointment made in the same way as stated below for No CPA.

- **No CPA**

For those patients not subject to CPA post discharge, or those that are awaiting allocation, the ward nurse completing the discharge process will contact PCART and a follow up appointment will be booked into the the team diary. Where availability exists for the teams junior doctor to complete the follow up appointment then this will be arranged as the teams junior doctor will have been involved with the patient whilst an inpatient.

Where this is not available an appointment will be made for the follow to be completed by the worker(s) covering the team facilitator duties.

- **CATSS**

The completion of the discharge process within the electronic patient record automatically notifies the Crisis and Telephone Support Service (CATSS) that a patient has been discharged. CATSS will attempt to ensure that all patients discharged from hospital receive a follow up telephone call within 24 hours of discharge. The purpose of this call is to ascertain their well being and reaffirm the time, date and location of the follow up appointment. The CATSS service will ensure this contact is recorded within the electronic patient record.

- **St Matthew's Step down Service**

Patients transferred to St Matthew's Healthcare for step down as described on page 4 of this policy do not require 7 day follow up as they are transferring to another inpatient facility.

However, 7 day follow up is required upon discharge from St Matthew's and this will be arranged in the same way that it is arranged from Berrywood or St Mary's Hospital with staff from St Matthew's ensuring that an appointment has been made with the patients care co-ordinator within 7 days of discharge.

- **Action for Staff should the patient not attend for follow up**

If the service user does not attend the appointment the CPA care co-ordinator or nominated professional tasked with completing the follow up will telephone the service user.

If telephone contact cannot be made a home visit should take place to ascertain the welfare of the service user, unless a risk assessment indicates that a visit to the service user's home should not take place.

After a further period of 24 hours without contact being established by the care co-ordinator, the nominated professional or CATSS then a police welfare check must be requested. Once contact has

If a face to face or telephone contact has not been made by either the CPA care co-ordinator, nominated professional or CATSS then a police welfare check will be requested by the CPA care co-ordinator or lead professional. When contact has been established an appointment should be made for the service user to see the CPA care co-ordinator or nominated professional within the 7 days from discharge date.

If a face to face contact is still not possible then a telephone call to the service user should be made by the CPA care co-ordinator or nominated professional.

- **48 hour follow up**

NICE guidance (NG53) advises that those patients where a risk of suicide has been identified should by followed up within 48 hours of discharge. The requirement for 48 hour follow up will be determined by the inpatient consultant.

Following a period of inpatient treatment it is expected that the risk of suicide has reduced for patients however in some cases this risk will not be eradicted entirely. 48 hour follow up is used in circumstances where patient is supported by UCAT for early discharge.

Early discharge is the process in which inpatients who are still displaying symptoms of the acute disorder which resulted in their admission are referred to UCAT to enable them to be discharged from the wards earlier than would otherwise occur. UCAT then manages the patient in community settings until their condition has improved and they can be transferred to an alternative service or discharged to primary care. Early discharge is appropriate when an inpatient's presentation has subsided to a degree where it poses little or no risk to the individual or to others, but acute symptoms are still present.

Within the trust, 48 hour follow up is therefore used specifically for patients under the care of UCAT as part of the early discharge process and the follow appointment is completed by the UCAT team.

Arrangements for Medication Post Discharge

All patients who require treatment with medication to continue post discharge should be given a supply before they leave hospital. This supply may take the form of discharge medication supplied by the Trust against a TTO prescription or the return of supplies of patient's own medicines brought into hospital on admission or a combination of the two in accordance with MMP001 Control of Medicines Policy.

Where medication post discharge is to be administered by a community mental health service preparation and communication must to take place prior to discharge. The inpatient consultant must liaise with the community responsible clinician to ensure a prescription chart is completed. This will require clear written documentation of the drug dose and duration including when next administration is required. The 24hr discharge summary should also contain this information. When arranging a 7 day follow up with PCART, the inpatient team must also request that the patient is booked into the depot clinic on the appropriate date or an appoinment made with the team to administer this.

Patients who discharge themselves against medical advice but who require medicines post discharge should be provided with a supply of discharge medication obtained in the usual

manner through pharmacy against a TTO prescription. If the patient is wishing to leave the ward immediately it will not be possible to provide the supply prior to their departure and arrangements must be made with the patient or their carers to collect the medication from the ward at an agreed time following delivery from pharmacy.

If discharge occurs out of hours (i.e. when pharmacy is closed) arrangements should be made to provide a supply at the earliest opportunity. The ward team should follow the local practice relevant to their supplying pharmacy (KGH/NGH). TTOs may not be available until the next working day. The emergency duty pharmacist may be contacted for advice and to discuss when a TTO supply will be available. Once this information is known arrangements should be made for the patient or carer to return to collect the medication at an agreed time.

When a patient is discharged information about their discharge medication must be forwarded to the GP as part of the discharge summary.

Management of medicines on handover between care settings.

When patients are transferred between the care of NHFT and another hospital setting e.g. one of the acute hospitals, details of their current medication must be transferred with them. This may be in the form of a copy of their current prescription chart or detailed within any letters of referral to the receiving organisation. A record of what information has been transferred with the patient should be made within the patient's notes. Medication issued to an individual patient should not routinely be transferred with the patient unless it is labelled with instructions for use i.e. dispensed as discharge medication.

A record of any verbal communication about the patient's medication at the point of handover of care to another organisation must also be documented in the patients' record.

It is expected that when patients are admitted into the care of NHFT from another organisation that details of their current medication will be provided.

Training requirements associated with this Policy

- **Mandatory Training**
  Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Statutory and Mandatory Training Policy'

- **Specific Training not covered by Mandatory Training**
  The completion and recording of the transfer care plan, discharge care plan, 7 day follow up, discharge letter and discharge summary all require access to the electronic patient record (SystmOne). Specific training regarding the completion of these tasks is available using the SystmOne Helpsheets which can be found on the trust intranet.

How this Policy will be monitored for compliance and effectiveness

The table below outlines the Trusts' monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual responsible for the monitoring	Monitoring frequency	Group or committee who receive the findings or report	Group or committee or individual responsible for completing any actions
Duties	To be addressed by the monitoring activities below.				
7 Day follow up post discharge for all patients discharged from mental health ward	Performance report / KPI	Senior Matron	Monthly	Directorate Management Team	Mental Health Clinical Executive
The effectiveness of the Discharge Transfer policy in relation to all patients receiving a CPA review prior to discharge which includes representation from both community mental hleath services and /or family carers	Audit of 10 randomised records of patients discharged	Senior Matron	Annually	Head of Service	Mental Health Clinical Executive
Staff have completed training associated with this policy in line with the TNA	Training will be monitored in line with the Statutory and Mandatory Training Policy.				
Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.					

For further information

Please contact the Head of Mental Health Services North and South

Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Policy. The trust will ensure that individual's with a sensory , mental or physical or physical disability have appropriate care plans and risk assessments will be available in a format as required by the patient (easy read). Staff will be expected to work in a way that is culturally sensitive and competent way. Work is underway with the Moving Ahead Project – Delivering Equality in Mental Health Services for BME to support any adverse impacts identified for BME Service User Groups. Patients whose first language is not English will be supported through the use of translation services. Consideration must be given to a person's age with awareness regarding the frailty for older service users however every precaution is taken to ensure individual health and safety. Service users will be treated as the gender they identify at the time and the trust will ensure they receive care and treatment within a same sex ward or an area of a ward which is designated for the gender they identify. Individual religious beliefs and activities will be respected, where they do not pose a further threat to others or themselves. The trust will ensure that women who are pregnant or have recently given birth have access to maternal mental health services including if necessary transfer to a specialist ward. For women who have recently given birth, all efforts will be made to ensure contact with the new born is safely maintained through an assessment of risk.

Reference Guide

NICE guideline NG53 (2016) Transition between inpatient mental health settings and community or care home settings

Document control details

Author:	Head of Mental Health Services South, Ward Matron, Harbour Ward
Approved by and date:	TPB 13.3.18
Responsible Committee:	Clinical Exec. approved January 2018
Any other linked Policies:	CLP010 - CPA Policy

	CLP016 - Policy for Delayed Discharges CLP020 - The Mental Health Act 1983 (As amended by the 2007 Act) CLP028 - AWOL Policy CLP031 - Policy for Identifying an Inpatient Bed CLP052 - Policy 7 Day/48 hour Follow-up CLP056b - Discharge and Transfer Policy for Community Healthcare and Community Hospitals CRM001 - Risk Management Policy CRM002 - Incident Policy IGP107 - Health Records Management Policy IGP108 - Policy for Producing Patient Information IGP021 - Recording and Administration Procedure for Inpatient Discharge MMP001 – Control of Medicines Policy
Policy number:	CLP056
Version control:	9

Version No.	Date Ratified/ Amended	Date of Implementation	Next Review Date	Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)
9	13/03/2018	13/03/2018	13/03/2021	Changes to how Discharge Letter is created within S1 S1 help sheets created to demonstrate change in process for training Changes to timeframes regarding completion of discharge letter and discharge summary to comply with NICE NG53 Updated transfer care plan in S1 Creation of Discharge Care Plan / Checklist in S1 Step down service provided by ST Matthew's included

Care Plan for ONE-TESTPATIENT, Testpatient

Transfer to an internal ward

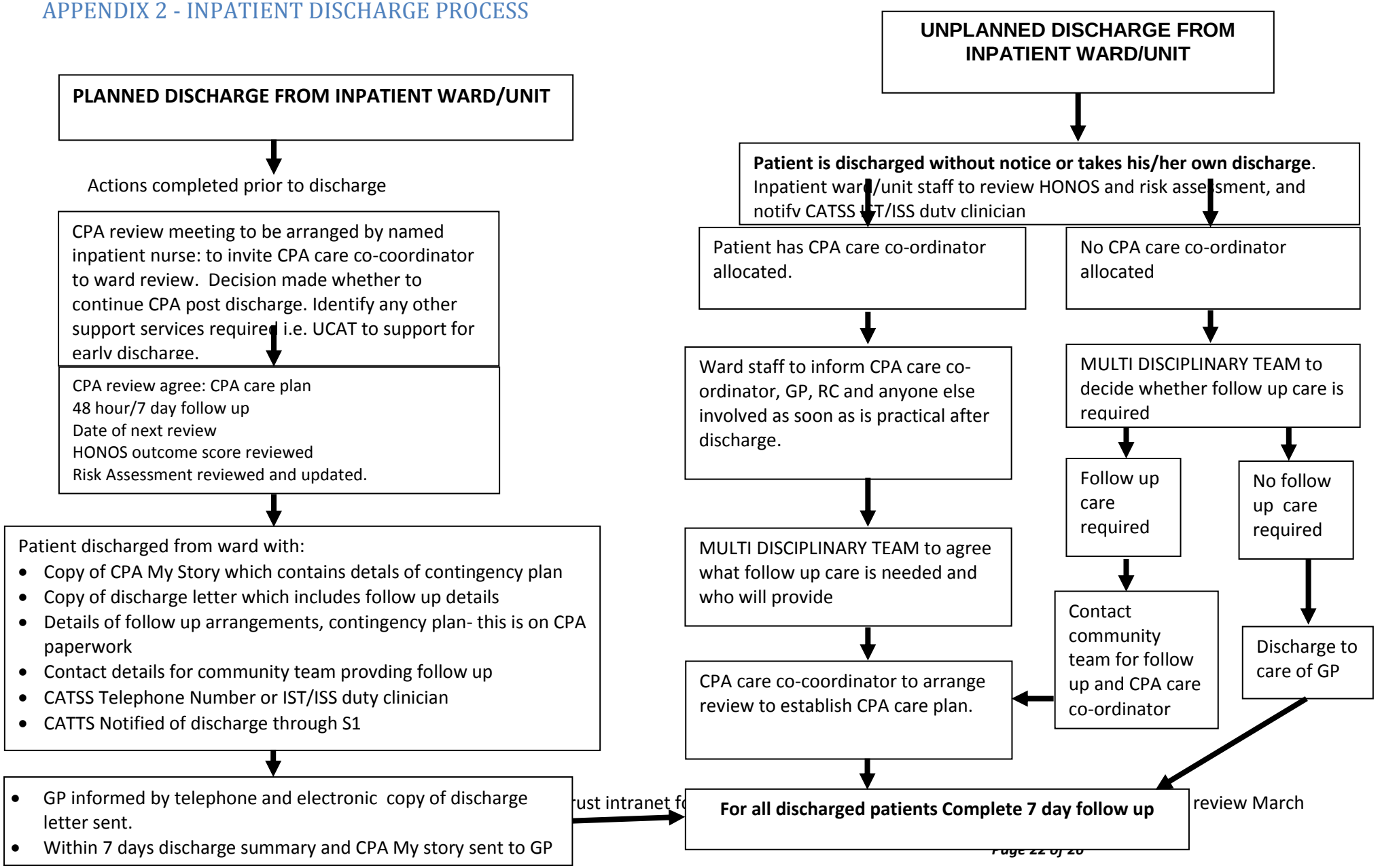
NHS Number:
Date of Birth:
Contact Details:

Date Printed:
Implementation Date:
Review Required:
Care Needed: Transfer to an internal ward
Goal: Aim : To ensure smooth transition across care settings and promote continuity of patient care

Instruction	Responsibility	Date Performed	Performed By	Signature
Informed verbal consent for assessment and treatment, including student contribution are gained from the patient	Nurse			
Ensure the patient is involved in the development of their care plan	Nurse			
Ensure the patient understands the purpose of the proposed interventions and is aware of all the risks of not engaging in interventions	Nurse			
There is no reason to doubt this patient's capacity to make an informed decision relating to this treatment at this time	Nurse			
If there is reason to believe the patient may lack capacity to give informed consent please complete a formal Mental Capacity Assessment within the patient record. Link to capacity assessment template Use Mental Capacity Assessment template	Nurse			
The patient has been offered/ provided with a copy of the care plan	Nurse			
Discuss the need for transfer with patient and carers	Nurse			
Inform receiving ward of impending transfer	Nurse			
Ensure a verbal handover takes place using current care plans (Mental Health and Physical Health), assessments, Risk Screening Tool and Advanced Decisions; ensure that safeguarding concerns are clearly communicated; ensure that forthcoming appointments are communicated. If the Admission Care Plan is not completed, then this is clearly communicated to staff on receiving ward	Nurse			
Ensure patient_s current leave status is clearly communicated to receiving ward	Nurse			
In the case of detained patients, inform the Mental Health Act Administration of transfer	Nurse			
Inform CPA Care Co-ordinator of transfer	Nurse			
Complete Mental Health Clustering Tool prior to transfer	Nurse			

Use HoNOS / MHCT template				
Review Risk Screening Tool prior to transfer Use Risk Screening Tool template	Nurse			
Check that all the patients belongings together with items from the safe are collected prior to transfer	Nurse			
Ensure the patient_s medication chart is transferred together with any non-stock medication which is prescribed; staff to ensure that the patient has a photograph on their medication chart together with the completed consent form	Nurse			
Ask patient to complete _I Want Great Care_ prior to transfer	Nurse			
Transfer patient on SystmOne to new ward	Nurse			
Receiving ward to ensure patient is orientated to the ward and that they have a Welcome Pack in their room.	Nurse			
Receiving ward to ensure patient_s belongings are searched and that the patient is offered to store valuable items and contraband items in room box; a Property Form is completed and the patient is made aware of the Property Disclaimer	Nurse			
Receiving ward to ensure that the correct Consultant Psychiatrist is allocated on SystmOne	Nurse			
Receiving ward to assess level of observation which is required and ensure this is recorded on observation chart	Nurse			
Receiving ward to ensure that relatives and carers are given the contact details for the ward	Nurse			
Receiving ward to ensure that a keyworker and co-worker is allocated. Complete Named Nurse on SystmOne	Nurse			
In the case of detained patients, Section 132 rights to be re-read by receiving ward; informal patients to be made aware of their rights	Nurse			

APPENDIX 2 - INPATIENT DISCHARGE PROCESS



Care Plan for

_____

Discharge Acute inpatient to community setting

NHS Number:
Date of Birth:
Contact Details:
Date Printed:
Implementation Date:
Review Required:
Care Needed: Discharge Acute inpatient to community setting
Goal: Aim : To ensure smooth transition across care settings and promote continuity of patient care

	Responsibility	Date Performed	Performed By	Signature
Ensure the patient is involved in the development of their discharge care plan	Nurse			
The patient has been offered/ provided with a copy of the discharge care plan	Nurse			
Discuss the discharge rationale with patient and carers.	Nurse			
Order TTO medication from pharmacy and arrange collection	Nurse			
Inform Care Co-ordinator of discharge, ensuring a verbal handover takes place either in person or by telephone to community and ensure that forthcoming appointments are communicated.	Nurse			
Ensure the patient has a 7 day follow up with PCART and inform the patient of the agreed date and time. (Document on S1) unless patient requires 48 hour follow up this will be completed by UCAT as per early discharge process Use eReferral dashboard template	Nurse			
Give patient crisis and telephone support service (CATSS) telephone number	Nurse			
In the case of detained patients, inform the Mental Health Act Administration of discharge	Nurse			
Complete Mental Health Clustering Tool prior to discharge Use HoNOS / MHCT template	Nurse			
Review Risk Screening Tool prior to discharge Use Risk Screening Tool template	Nurse			
Check that patient's belongings together with items from the safe are collected prior to discharge along with property disclaimer.	Nurse			
Complete discharge letter which must include details of Diagnosis, TTO medication and date, time and location of follow up appointment. Print copy and give to the patient. Send	Nurse			

electronically to GP. Use Discharge Letter to GP template				
Ensure patient has paper copy of CPA My story Use Discharge Letter to GP template	Nurse			
Inform patients GP by telephone of discharge and advise that written discharge summary to follow	Nurse			
Ask patient to complete I Want Great Care prior to discharge	Nurse			
Where patient requires depot medication post discharge, ensure patient is booked into depot clinic or appointment made with relevant community team to ensure this is facilitated.	Nurse			

APPENDIX 4 – FORM OF DISCHARGE

FORM OF DISCHARGE

AT PATIENT'S OWN REQUEST

Ward / Department :_____

I,……

discharge myself from the care of Northamptonshire Healthcare Foundation Trust contrary to the advice given to me by the medical staff and in doing so accept full responsibility for my action

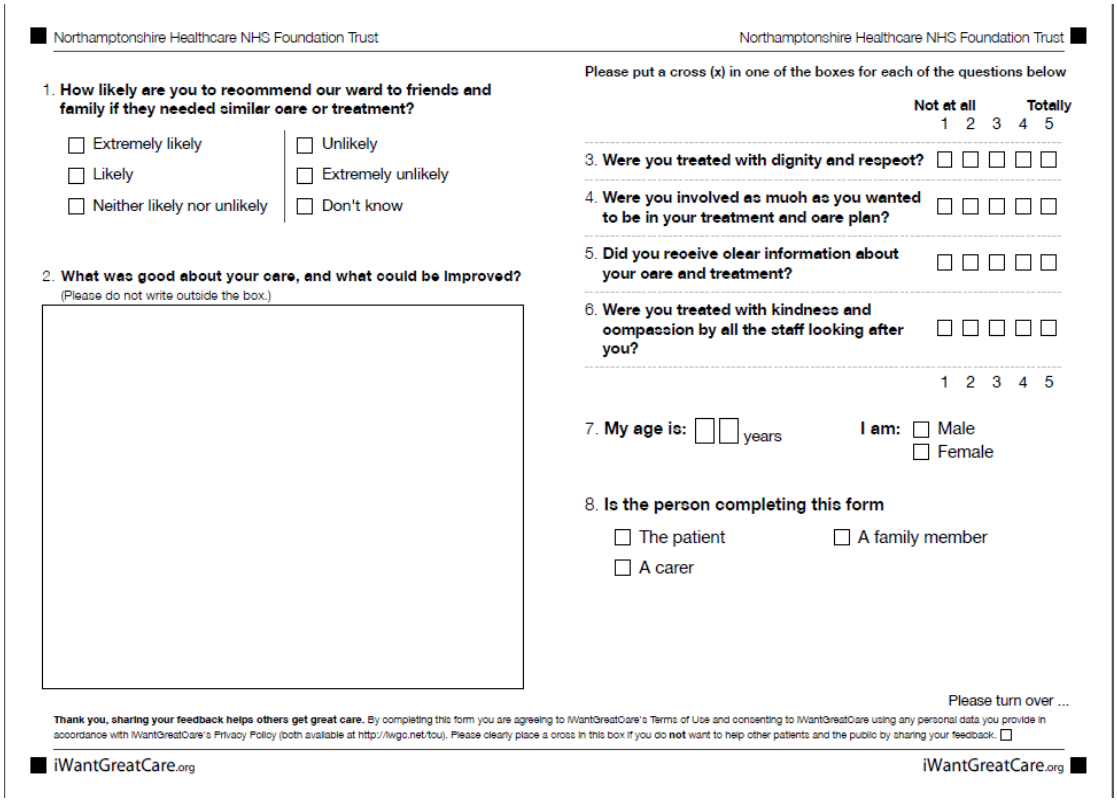
Signature…….

Witness……

Date…….

This form must be carefully preserved in the patient's clinical record

APPENDIX 5 - DISCHARGE QUESTIONNAIRE 'I WANT GREAT CARE'



Northamptonshire Healthcare NHS Foundation Trust

Northamptonshire Healthcare NHS Foundation Trust

1. **How likely are you to recommend our ward to friends and family if they needed similar care or treatment?**

- ☐ Extremely likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Extremely unlikely
- ☐ Don't know

2. **What was good about your care, and what could be improved?**
(Please do not write outside the box.)

Please put a cross (x) in one of the boxes for each of the questions below

	Not at all 1	2	3	4	Totally 5
3. **Were you treated with dignity and respect?**	☐	☐	☐	☐	☐
4. **Were you involved as much as you wanted to be in your treatment and care plan?**	☐	☐	☐	☐	☐
5. **Did you receive clear information about your care and treatment?**	☐	☐	☐	☐	☐
6. **Were you treated with kindness and compassion by all the staff looking after you?**	☐	☐	☐	☐	☐
	1	2	3	4	5

7. **My age is:** ☐☐ years **I am:** ☐ Male ☐ Female

8. **Is the person completing this form**

- ☐ The patient
- ☐ A family member
- ☐ A carer

Please turn over ...

Thank you, sharing your feedback helps others get great care. By completing this form you are agreeing to iWantGreatCare's Terms of Use and consenting to iWantGreatCare using any personal data you provide in accordance with iWantGreatCare's Privacy Policy (both available at http://iwgc.net/tou). Please clearly place a cross in this box if you do **not** want to help other patients and the public by sharing your feedback: ☐

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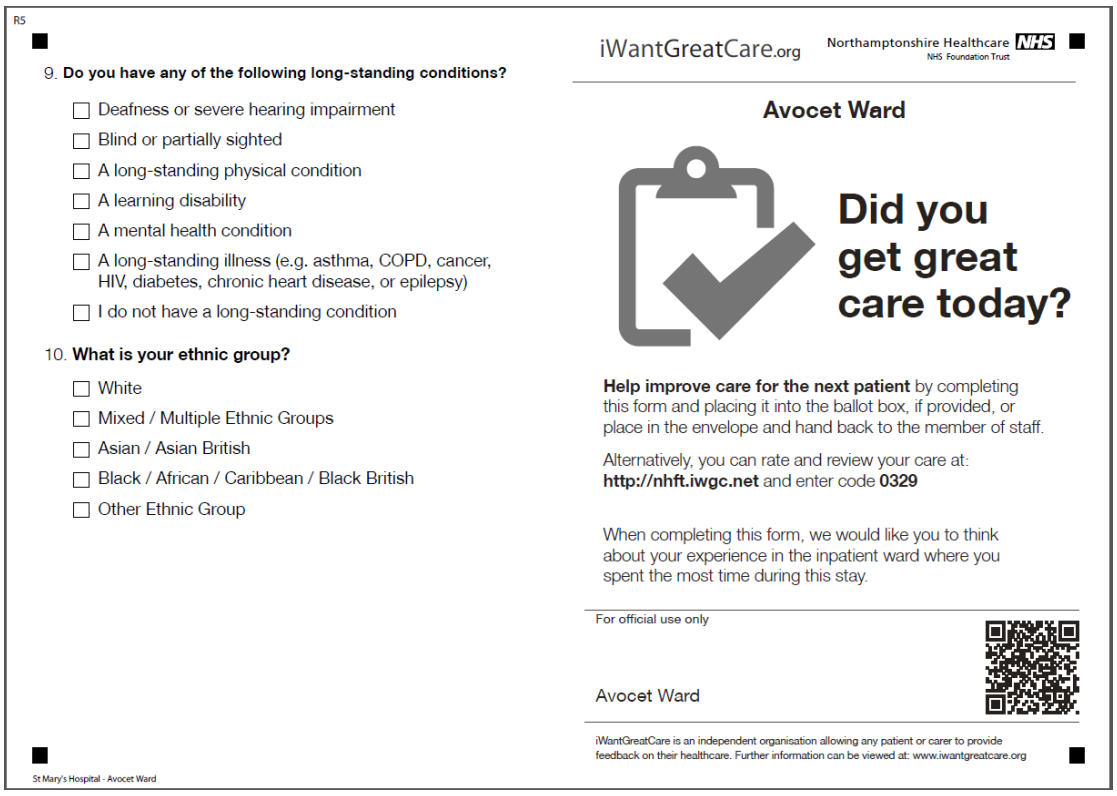

R5

9. **Do you have any of the following long-standing conditions?**

- ☐ Deafness or severe hearing impairment
- ☐ Blind or partially sighted
- ☐ A long-standing physical condition
- ☐ A learning disability
- ☐ A mental health condition
- ☐ A long-standing illness (e.g. asthma, COPD, cancer, HIV, diabetes, chronic heart disease, or epilepsy)
- ☐ I do not have a long-standing condition

10. **What is your ethnic group?**

- ☐ White
- ☐ Mixed / Multiple Ethnic Groups
- ☐ Asian / Asian British
- ☐ Black / African / Caribbean / Black British
- ☐ Other Ethnic Group

St Mary's Hospital - Avocet Ward

iWantGreatCare.org Northamptonshire Healthcare NHS Foundation Trust

Avocet Ward

Did you get great care today?

Help improve care for the next patient by completing this form and placing it into the ballot box, if provided, or place in the envelope and hand back to the member of staff.

Alternatively, you can rate and review your care at: **http://nhft.iwgc.net** and enter code **0329**

When completing this form, we would like you to think about your experience in the inpatient ward where you spent the most time during this stay.

For official use only

Avocet Ward

iWantGreatCare is an independent organisation allowing any patient or carer to provide feedback on their healthcare. Further information can be viewed at: www.iwantgreatcare.org