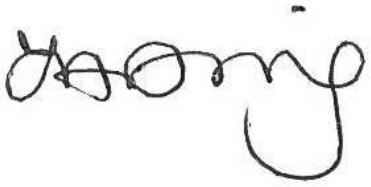
Cambridgeshire and Peterborough NHS Foundation Trust

ADMISSION, TRANSFER AND DISCHARGE POLICY FOR INPATIENT SERVICES

Author:	Quality & Clinical Effectiveness Manager Policy Review Group
Sponsor/Executive:	Director of Nursing and Quality
Responsible committee:	Clinical Effectiveness, Audit & Research Group – May 2019
Ratified by:	Quality and Compliance Executive
Consultation & Approval: (Committee/Groups which signed off the policy, including date)	Developed by working group with representatives form directorates and other interested parties
This document replaces:	Version 5
Date ratified:	26 June 2019
Date issued:	4 July 2019
Review date:	31 May 2022
Version:	Version 5.1
Policy Number:	CL03
Purpose of the Policy:	To support the process of admission, transfer and discharge for inpatient services
If developed in partnership with another agency, ratification details of the relevant agency	N/A
Policy in-line with national guidelines:	



Signed on behalf of the Trust: ……..

Tracy Dowling, Chief Executive

Elizabeth House, Fulbourn Hospital, Fulbourn, Cambs, CB21 5EF Phone: 01223 726789

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Version	Date	Author(s)	Comments
1.0	January 2008	Wendy Llaneza Ann Hiles	Discharge Guidance initially developed by Ann Hiles, later expanded into Admission, Discharge & Transfer Policy in line with NHSLA standards. Policy ratified by Quality & Healthcare Governance Committee
2.0	May 2010	Wendy Llaneza	Policy updated to reflect new CQC and NHSLA standards, national guidance and Trust governance structures, and SUI recommendations, in particular: • list of definitions (section 3) • duties and responsibilities (section 5) • list of information required in accordance with the CQC standards on transfer/discharge (section 7.3) • documentation completed on discharge (section 12.1, 12.2 and 12.4) • guidance related to lost contacts/DNAs (section 14.1 and 14.2) • guidance regarding 7-day follow-up (section 16) • monitoring arrangements (section 25) • revised Discharge Notification Form v2 (Appendix 4)
2.1	May 2011	Wendy Llaneza Mick Simpson	Reviewed. Minor amendments made to sections 5.7, 7.3, 12.1, 14.1 and 16.2.
3.0	March 2015	Wendy Llaneza Policy Review Group	Full review of the policy. Key changes include: • new Trust governance structure • the new clinical/operational structures • simplifying and clarifying standards of practice, processes and procedures, being mindful of evidence-based good practice standards • definitions and criteria on key performance indicators – CRHT gatekeeping, 7 day follow up and Delayed Transfers of Care • revised checklists – admission, standards of admission documentation for doctors, discharge, discharge notification form

Version	Date	Author(s)	Comments
4.0	April 2018	Neil Winstone, Associate Director and policy review group	Full review of policy, key changes include: • Updated to reflect OPAC physical health wards • Inclusion of Care of pregnant women plus a check list • Strengthening of the suicide prevention section with reference to the Trust's Zero Suicide strategy • Updating of mental health act guidance • Updating of the Think family approach to child and family welfare and safeguarding • Alignment the involving of carers including sharing information with the carers Policy so that there is consistent message across relevant policies
5.0	May 2019	Anna Tuke (Associate director of Involvement and Partnerships	Review of policy to ensure consistency with the Confidentiality policy Review of section 22 with Orna Clarke
5.1	September 2019	Neil Winstone	6. Additional text regarding supervision of CPFT learners added. Agreed with Trust Executive, governance committees, Directorates and Learning and Development

Policy Circulation Information

Notification of policy release: All recipients; Staff Notice Board; Intranet;	
Key words to be used in DtGP search.	

CQC Standards	

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APPENDICES

OVERARCHING POLICY STATEMENT

1 Introduction

Cambridgeshire & Peterborough NHS Foundation Trust (hereafter referred to as 'CPFT' or 'the Trust') is committed to providing safe and effective services that reflect the needs of the people it serves and meets the national standards of quality and safety.

The admission, transfer and discharge of patients are significant stages of the care process, and an integral component of the Care Programme Approach (CPA). The Trust recognises that an effective admission, discharge and transfer process enables patients to move forward towards greater independence in the communities in which they live, in line with the philosophy of recovery.

2 Purpose

This policy sets out the key steps that must be taken to ensure that the admission, transfer and discharge process is carried out in a safe and effective manner.

This policy aims to ensure that all Trust staff involved in the provision of health and social care are working together towards an effective coordinated service that meets the individual needs of patients, as well as those of their relative/carer(s).

This policy must be used in conjunction with other relevant Trust policies and guidance listed in Section 9.

3 Scope

This policy applies to all patients who come under our care and all staff in the following inpatient services:

- Adult & Specialist Directorate
- Older People and Adult Community Directorate
- Children, Young people and Families Directorate

4 Definitions

A **Patient** is a person who receives services provided by the Trust. For the remainder of this document, the term '**patient**' will be used to refer to people who use our services.

The **Care Programme Approach** (CPA) is the process used by providers of mental health care to coordinate the care, treatment and support for people who have mental health needs (CQC 2010).

Care Planning describes, in an easy accessible way, the services', care and support being provided to the patient and where appropriate the carer/family. It should be discussed and negotiated with the patient to ensure they are in agreement with all proposed plans of care.

A **Care Coordinator** is a health or social care practitioner who is responsible for coordinating the care of a patient.

A **Key worker/Primary nurse/allocated nurse** is a nurse who is responsible for the planning, implementation, and evaluation of the nursing care of one or more patients for the duration of an inpatient stay.

The Carers Trust definition of a carer is as follows. '*You are a carer if you provide help and support, unpaid to a family member, friend or neighbour who would otherwise not be able to manage without this support.*

The person you care for may have physical or learning disability, dementia or mental health problems or they may misuse drugs or alcohol. What ever their illness they are dependent on your care.

The person may live with you or elsewhere, they may be an adult or a child, but if they rely on you for support, then you are entitled to support as a carer.

Anybody can be a carer. Carers come from all walks of life, all cultures, and can be any age. You may be a mother, father, wife, husband, parent, partner, friend, uncle, niece, colleague or neighbour. No matter what your relationship, if the person you care for can not manage without your support then you are a carer.'

Advance Decisions – Advance Decisions are governed by the Mental Capacity Act (MCA) 2005 and relate to refusals of specified treatment, if specific circumstances arise in the future at a time when the person no longer has mental capacity. Advance Decisions are sometimes also known as 'advance directive', 'advance refusal' or 'living will'. However, the statutory term is "Advance Decision". A valid Advance Decision, which is applicable to the circumstances which arise, is legally binding in the same way as a contemporaneous refusal by a person with capacity, with the exception of treatment of mental disorder in people who are detained under the MHA 1983. Professionals may be legally liable if they administer treatment that a service user has refused in a valid and applicable advance decision.

Advance Statement – is a general statement of a person's wishes and views. People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of mental capacity. It can reflect their religious beliefs or other beliefs that they have and allows the person to state how they would like to be treated should they not be able to communicate their wishes in the future.

Admission refers to the formal acceptance of a patient into a service. Within the context of this document, this refers to the admission of a patient into an inpatient unit.

Transfer refers to the movement of patients between care settings and care providers, both internally (i.e. between Trust services) and externally (i.e. between a Trust service and another agency).

Discharge is the point at which a patient's inpatient stay comes to an end.

5 Over-arching Principles of Good Practice

This policy should be implemented in conjunction with the Care Planning Policy, Clinical Risk Assessment Policy, and the Trust Access Policy.

All staff should work within a framework of integrated multidisciplinary and multi-agency team working to effectively manage all aspects of the process.

The engagement and active participation of the patient and their relative/carer(s) as equal partners in the process are central to the delivery of care.

A robust and comprehensive assessment and management of risks covering all relevant aspects of the patient's care and treatment should be made, repeated at regular intervals where necessary, particularly during the patient's discharge planning process, and recorded clearly and accurately in a timely manner. In the absence of patient consent the views of carers, relatives can and should be sort to ensure potential crucial information contributes to the over all assessment.

The patient and their relative/carer(s)/friends etc. with the patient's consent, are given relevant, appropriate and adequate information at every stage of their journey through the care pathway. This is essential to ensure that carers' needs are met so that they can give the best possible support to their relative or friend. If consent hasn't been given it is essential to communicate this to carers reassuring them that this doesn't prevent them discussing with clinical staff their concerns about their relative or friend. Regular communication with carers is essential regardless whether consent has or hasn't been given.

6 Duties and Responsibilities

Chief Executive and Trust Board

Responsibility for compliance with this policy is vested in the Trust Board, delegated to the Chief Executive and in turn delegated to relevant staff across the Trust, to ensure that there are appropriate systems and processes in place to facilitate an effective discharge.

Executive Directors

The Director of Nursing and Quality, the Medical Director and the Chief Operating Officer have joint overarching responsibility for the implementation of this policy and for ensuring that appropriate processes are in place for the admission, transfer and discharge of patients within the Trust. This responsibility is delegated to Clinical Directors and managers within the Clinical Directorates.

Quality, Safety and Governance Committee (QS&G)

The Quality, Safety and Governance Committee (QS&G) is responsible for the ratification of this policy.

The Quality and Compliance Executive (formally the Clinical Governance and Patient Safety Group, CGPSG), which reports to QS&G, has overarching responsibility for the development, approval, monitoring and review of this policy. Other relevant subgroups and working groups within the Trust will form part of the consultation process as appropriate in line with the Trust's governance framework.

Directorate Managers
This includes the Clinical Directors, Associate Directors of Operations, General Managers, Directorate Heads of Nursing, Ward Managers and Modern Matrons within the clinical services who are responsible for the correct and consistent implementation and monitoring compliance with this policy within their respective service areas.

The Consultant Psychiatrist / Consultant Geriatrician or other medical lead
The responsibility for the overall treatment plan of a patient lies with the Consultant Psychiatrist, working with the multidisciplinary team (see 6.6). As part of this responsibility, the Consultant Psychiatrist must ensure that:

- the correct admission and discharge medication is prescribed the Discharge Notification Form (DNF) is completed and sent to the GP within 24 hours of discharge, and a copy given to the patient and/or their cares/family
- the Discharge Summary is completed and a copy sent to the GP within 7 days
- the patient's ICD10 diagnosis is made, recorded in the appropriate documentation and coded in a timely manner

Multidisciplinary team (MDT)
The multidisciplinary team consists of professionals, practitioners and all staff involved in the provision of treatment and care to the patient, and as such is responsible for ensuring that:

- a comprehensive assessment of the patient's strengths, needs, and relevant risks is carried out
- the patient and/or relative/carer(s) are given every opportunity to actively participate in the admission, transfer and discharge process
- the patient and/or their relative/carer(s)/other significant people with the consent of the patient are given relevant, appropriate and adequate information and explanations where required
- an agreed plan of care is in place prior to the planned discharge of the patient from Trust inpatient services
- good and effective communication is maintained with all members of the multidisciplinary team, and in particular liaising closely with the care coordinator as required
- all interventions and assessments are undertaken, including pre-discharge assessments, in a timely manner as required, and reporting the outcomes in the appropriate format
- an effective formulation of the care and treatment plan is in place, including the discharge plan
- ensure good communication with other services involved
- all information relevant to the patient's care is recorded in accordance with the Clinical Record Keeping Policy

The Care Coordinator (Mental Health services only)
The care coordinator has the overall responsibility for coordinating all aspects of the care and treatment of the patient at all stages of their journey through the care pathway (for services that are not covered by the CPA, these responsibilities are synonymous with the responsibilities of the named nurse). This includes:

- ensuring that all relevant information are available and easily accessible by other members of the multidisciplinary team in a timely manner
- where known, alert relevant other services and practitioners about any issues related to safeguarding adults/children or MAPPA, particularly those that may impact on safe and effective discharge planning
- ensuring that any identified relative/carer(s) are well informed with regards to issues related to the admission, transfer and discharge process, including treatment and care options and including interim or intermediate placements.
- ensuring that all practitioners and agencies, including non-statutory or and voluntary agencies, involved in the planning and preparation of the patient's transfer/discharge are aware of the plan of care and transfer/discharge arrangements.
- ensuring that appropriate follow up arrangements are made within the required timescales in line with this policy.

The Named / Primary Nurse/ Ward Manager or deputy
The named / primary nurse / or allocated nurse on shift is responsible for coordinating the patient's care within the inpatient setting. In some instances, the named / primary nurse may also be the care coordinator whilst the patient remains in hospital. Other key responsibilities include:

- working closely with the community care coordinator, where applicable, in relation to all aspects of the patient's care.
- ensuring the correct and timely completion of the necessary agreed documentation, including checklists, and Discharge Notification Form, and that all relevant individuals are provided with copies thereof.
- coordinating all necessary arrangements, including time and date of transfer/discharge, transport, accommodation, property and valuables, etc., and ensuring that these are communicated to all relevant individuals involved in the patient's discharge plan.
- medication concordance issues

The Pharmacy team
As part of the healthcare team, the pharmacist and pharmacy technicians are key players in medication management both as a source of medicines information and practical guidance for staff, patients and their relative/carer(s) in the preparation for discharge. In addition the pharmacy team will

- advise on ongoing medication issues including the need for compliance aids
- dispense any required medicines
- check the discharge medication prescription chart for accuracy and appropriateness, amending if necessary

Supervisors and Assessors of learners
CPFT provides training to learners from a range of disciplines. Regulatory bodies (such as the NMC or HCPC), and the Trust require that registered staff who undertake the supervision and assessment of student learners have the proficiency, skill and knowledge to facilitate the education for learners. They will, within the scope of their responsibilities, ensure that learners have completed agreed relevant placement training and are able to demonstrate the understanding of the theory prior to the practicing of the skill.

7 Staff development

Relevant training in the form of induction and team based coaching will be provided in conjunction with training around the Care Planning Policy, Clinical Record Keeping Policy and clinical risk assessment and management procedures. In addition, service managers will provide the necessary guidance and support for the correct and consistent application of this policy.

8 National Key Performance Indicators (KPIs)

The processes set out in this policy include three mandatory national KPIs that the Trust submits to NHSi[1]. This policy sets out the definitions and exemptions from the perspective of clinical practice and operational procedures. More detailed definitions and exemptions that support the collation and analysis of data are set out in the KPI handbook which can be accessed via this link: http://nww.intranet.cpft.nhs.uk/Corporate/BusinessInformation/glossary/Pages/default.aspx.

The relevant KPIs are:

- CRHT gate keeping
- CPA 7-day follow up
- Delayed transfers of care

9 Monitoring Compliance

The main responsibility for monitoring the implementation of this policy lies with the senior managers through team/care review meetings and supervision.

Monitoring of key aspects of the care process, including the assessment, risk assessment, care planning, review and discharge process is done through the Quality & safety assurance tool (QSAT) review process and record keeping audits.

[1] NHSi is an executive non-departmental public body of the Department of Health. Its main purpose is to protect and promote the interests of patients by ensuring the whole sector works for their benefit. It has a specific role on monitoring the performance of NHS Foundation Trusts, by ensuring that:

- independent NHS foundation Trusts are well-led so that they can provide quality care on a sustainable basis
- essential services are maintained if a provider gets into serious difficulties
- the NHS payment system promotes quality and efficiency
- procurement, choice and competition operate in the best interests of patients

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Specific monitoring requirements to meet the risk management standards (NHS Litigation Authority) for the discharge process are set out in Section 46 of this policy.

Additional monitoring arrangements will be agreed on a risk-based approach and may include formal Trust audits or service evaluations.

There are also specific Key Performance Indicators (KPIs) related to the implementation of this policy which will be reported upon as part of the Trust's integrated quality and performance dashboard.

10 Other Associated Trust Polices

The following are key policies and guidelines that should be considered in conjunction with this policy. Please see the policy site on the Trust intranet to check that the current policies are being referred to.

- The Care Planning Policy
- Carer Policy
- Child Visiting Policy
- Choice Policy
- Clinical Risk Assessment Policy
- Clinical Record Keeping Policy
- Confidentiality Policy
- RiO Consent to Share Information SOP
- Consent Policy
- Medicines Policy and associated MM SOPs
- RiO SOP for Discharge
- Service Access Policy
- Admission of a Young Person to an Acute Ward 2018
- Transfer of Patients between Adult Mental Health (AMH) & Older People Mental Health (OPMH) Services Criteria
- Falls Prevention and Management Policy
- Infection Control Policy
- Serious Incident (SI) Policy and Procedure
- Safeguarding Children Policy
- Eliminating Mixed Sex Accommodation Policy
- Protocol for Driving and Psychiatric Disorders
- Relevant Mental Health Act Policies
- CPFT Zero Suicide Strategy
- Physical Assessment of Inpatients Policy
- Leave of Absence from Hospital (AWOL) Policy
- Transfer: CAMHS to Adult Mental Health Services Protocol
- General Protocol for Protecting and Using Personal Information within Cambridgeshire and Peterborough

ADMISSION INTO INPATIENT SERVICES

11 Context

Being admitted to hospital is a significant and often stressful event for the patient and their family/carer(s). It is therefore important to remember that first impressions are often those that the patient or family/carer remembers the most. With this in mind, it is essential that staff are friendly, confident and professional; and offer reassurance, explanation and information as appropriate.

Every effort will have been made to support the person to remain in the community. The needs of the patient and their family will be central to the admission process.

It is essential that as appropriate, discharge arrangements are commenced/identified prior to admission. Care co-ordination is essential to support this process and will continue throughout the period of admission.

12 General Principles

Admissions into inpatient services should be based on the following principles:

- People will be admitted to an appropriate environment consistent with their mental health, physical health and safety needs.
- The person and/or their family/carer(s) are fully involved in the process and are given adequate, appropriate and timely information.
- Where other agencies or professionals are involved in the person's care, their involvement is sought as appropriate
- The professional who has primary responsibility of the person's care is responsible for ensuring that all information required is handed over to the receiving team prior to admission.
- People are treated in the least restrictive environment which is consistent with their clinical and safety needs.

13 Accessing Inpatient Services

Each individual service will have their own criteria and process for accessing their services. Refer to the relevant service operational policies, protocols and procedures and the Trust Access Policy for further guidance.

First Response Service
The First Response Service provides urgent 24-hour access, seven days a week, 365 days a year, to mental health care, advice, support and treatment for people experiencing a mental health crisis. This includes access to the "sanctuary" which is an out of hours "safe place" for those in crisis and referral to other primary and secondary services. It is available to anyone who lives in Cambridgeshire who feel they need urgent mental health care. This includes service users, carers, family and friends. Anyone can refer to FRS via 111 Option 2.

Psychiatric Liaison (psychiatric liaison for acute medical services)
This pathway provides specialist mental health assessment advice and intervention to people in acute hospitals.

14 Gatekeeping by CRHT (Adult & Specialist and OPMH wards)

The Department of Health (DH) requires that all admissions into adult acute psychiatric inpatient wards for patients aged 16-65 are gate kept by the Crisis Resolution and Home Treatment (CRHT). An admission is deemed to have been gate kept if the CRHT team has assessed the person before admission and they were involved in the decision-making process that resulted in admission (DH, 2011)[2].

Exceptions to the CRHT gatekeeping requirement are listed below:

- Patients transferred from another NHS hospital for psychiatric treatment
- Internal transfers between wards in the Trust for psychiatric treatment
- Patients on leave under Section 17a of the Mental Health Act (MHA)
- Patients who are planned admissions to a Detox bed
- Patients under a Ministry of Defence (MoD) contract
- Planned admissions for psychiatric care from specialist units such as eating disorder units

For patients who are brought in under the MHA, including Section 136 (Place of Safety) and CTO recall or revocation, the CRHT must be involved in the decision to admit them into a ward.

In situations where a patient from another area presents locally and requires emergency admission, the home area should be contacted and ask to find a bed in their area, this include sourcing a private bed if no NHS one is available. Where the home area has exhausted all options and no bed is available then, in the best interest of the patient which should be paramount, a local CPFT bed (if available) should be used. A clear plan of transfer back to the home trust should be agreed with the expectation that the patient will be returned to their home area within 48 hours of admission. All information regarding the patient and admission should be recorded on RiO

15 Admission of Pregnant Women

Although relatively unusual pregnant woman admitted because of their mental health needs are at greater than those of the average population due to their increased physical health needs, and for some limitations in the use of medication to manage their mental health condition. There is also a clear need for the involvement of outside agencies to manage the pregnancy using a multi disciplinary approach **Appendix 8** provides a check list to be used when a pregnant woman is admitted

[2] This official definition and exceptions are taken from the *Technical Guidance for the 2012/13 Operating Framework* published by the Department of Health on 22 December 2011.

16 Admission of a Young Person to an Acute Ward

As a principle young people aged 16 years old and under will NOT be admitted into an adult acute ward. If it is not possible to identify an appropriate adolescent unit then if necessary, a young person of 16 or 17 years old may be admitted on to an adult psychiatric ward.

When considering the possible admission of a young person to an adult inpatient ward the decision must be reached to ensure the safety and wellbeing of the young person and that the risks associated with such admission are identified and managed with the appropriate safeguards in place to promote the safety and welfare of the young person.

Any admission of an under 18 into an adult acute ward is requires an IMR Serious Incident (SI) and will be reported in accordance with the Trust's incident reporting procedures. Refer to the Serious Incident (SI) Policy and Procedure for guidance.

Please refer to the Trust policy 'Admission of a Young Person to an Acute Ward 2018' for further guidance.

17 Admission of a Child or Parent of a Child Subject to a Child Protection Plan

Promoting children's well-being and safeguarding them from harm crucially depends upon effective information sharing, collaboration and understanding between agencies and professionals There must therefore be effective channels of communication between all agencies including care coordinators, GPs, Health Visitors, School Nurses, Children's Social Care and any other relevant agencies of any planned or unplanned attendance, admission and discharge of a child or parent of a child who is subject to a Child Protection Plan.

Further advice and guidance around this issue can be obtained from the Safeguarding Children Team within the Trust. Please also refer to the Safeguarding Children Policy and the Guidance document for effective joint working for Safeguarding Children who have a Parent or Carer with Mental Health Problems for further guidance.

18 Infection Control

Patients with acute diarrhoea and/or vomiting should not be admitted to the Trust. Please inform and take advice from the Infection Prevention and Control (IPaC) Modern Matron if you are asked to accept a patient with these symptoms.

Patients admitted to OPAC Physical health wards from acute Trust or other institution must be isolated in a side room until a negative MRSA screen is obtained, (unless a negative screen has been obtained within the last 7 days).

19 Information Requirements for Admission and Transfers of Care

Good clinical practice requires specific information to be available to the receiving service to ensure that the needs of the person are met safely and that there is no delay to the assessment of needs.
Effective communication between the community team and inpatient unit is essential. This will include and up-to-date assessment, care plan, and risk assessment.

20 Care Coordination, Primary Nursing and role of ward manager on physical health wards

A primary nurse who will be responsible for the coordination of the patient's care and treatment whilst in hospital will be identified within 24 hours of admission.

It is good practice to consider the individual needs of the patient (e.g., age, gender and ethnicity) when allocating a primary nurse.

When patients are admitted into a ward from a Trust community team, contact should continue by that team during their period of admission. Where applicable communication will be maintained between the care coordinator and the primary nurse regarding progress and steps towards discharge, including attendance at relevant review meetings, to ensure continuity of care.

21 Admission Process

The standard Admission Checklist (**Appendix 1**) sets out the necessary steps and procedures that need to be carried out during the admission process.

The Minimum Standards for Admission Assessment Documentation by Medical Staff is set out in **Appendix 2**.

22 Consent to admission care and treatment

Psychiatric inpatient wards – Following the 'Cheshire West' supreme court ruling (2014), patients who lack capacity to consent to their admission, care and treatment cannot be admitted to psychiatric wards as informal patients. Staff must assess [1]all inpatients capacity to consent to the admission care and treatment within 24 hours and record the outcome on the dedicated RiO form (IP capacity to consent to care & treatment form, under the 'Consent' tab). Patients who lack capacity and who are not already detained under the MHA are deprived of their liberty (acid test – see MCA/DoLS policy and procedures). An urgent Deprivation of Liberty safeguards (DoLS) authorisation and a standard DoLS application must be put in place. Patients who lack capacity to consent to their admission care & treatment and object - do not meet the DoLS criteria. In those cases, consideration for a MHA Assessment should be given.(See MCA/DoLS policy and procedures).

Physical Health wards – a valid consent should be obtained from patient at the point of admission (see Consent to Examination and Treatment policy). As part of the discussion, if the nurse suspects that the patient may lack capacity to consent to their

admission, care and treatment, a full capacity assessment should be carried out and recorded on the Trust capacity assessment form. A copy of the capacity assessment must be filed in the patient's manual health records. If the patient lacks capacity a best interest assessment should follow. For patients who are subject to a regime which amounts to a deprivation of their liberty (see acid test – see DoLS policy) an urgent Deprivation of Liberty safeguards (DoLS) authorisation and a standard DoLS application must be in place. (See MCA/DoLS policy and procedures).

A person's capacity to consent can change and should be regularly reviewed when circumstances change, or as part of the care planning reviews.

A physical health assessment must be carried out within 24 hours of admission, or sooner if deemed necessary. When declined by the patient, a note of this must be made in the electronic clinical record. Please refer to the Physical Assessment of Inpatients Policy for further guidance.

The risk assessment must be reviewed and updated within 24 hours of admission to ascertain whether this is still relevant and accurate within the context of the inpatient setting, and an initial plan of care developed.

Medicines reconciliation must be carried out in accordance with the requirements and timescales set out in the Medicines Policy.

23 'Think Family' and the Safeguarding of Children

On admission the ward need to establish whether the service user/patient has carer responsibilities (either part time or full time), or is living with children under age of 18 years. If this is the case, staff need to explain that as a Trust we promote a 'Think Family' approach. The purpose of this is to provide support and an assessment of what the family needs might be, and that arrangements are in place ready for discharge

As a minimum the ward need to obtain details of the children including

- DOB
- Address
- Nature of relationship of parental responsibility
- Whether they are already receiving support through Early Help Assessment or Children's Social Care.
    - If so then the ward should liaise with those professionals with consent.
    - If no services are currently in place, assessment around the level of need for the child/ young person should be completed by staff

There are a number of tools available to assist with that assessment including the Keeping Children Safe risk assessment tool. Staff using RiO need to complete the electronic form. Staff using other systems need to complete the template and attach in the patient record (**Appendix 9).** It is essential for staff to ensure that a responsible adult is identified to care for children whilst their parent/ carer is in hospital.
It is important for staff to reassure service users that in the majority of circumstances, information will only shared with their consent This includes accessing services to support parents and carers whose health needs may mean they need extra help for a time.

However, in rare circumstances if staff are made aware that any child/young person is at risk of significant harm, the law requires staff to share information with other agencies in order to keep children safe, even if the parent doesn't consent. In those cases staff would generally explain to the service user what information is being shared and the reasons for this decision.

Support and advice and further guidance around record keeping when safeguarding children, should be accessed via

- the safeguarding children team 01733 777961, or
- cpm-tr.CPFTsafeguardingchildren@nhs.net
- the NHS app
- the CPFT safeguarding children's satchel on PC desktops
- or the Safeguarding children 'User Guide' (attached)

Links to other policies

- Safeguarding children policy
- Child Visiting Policy

On admission the carer record should be completed

24 Information to Patients and/or Family/Carers

As part of the admission process, an assessment must be made of the person's capacity, or competence in the case of children or young people, to understand, retain information and make informed decisions about their care. Refer to the Consent Policy for further guidance.

The clinician must use their judgement to determine how much information to give and at what stage of the admission this is given.

Patients and families should be provided with relevant verbal and written/electronic information (leaflets etc.). Ward teams will need to record what has been provided and what more needs to be given.

As a minimum, the patient and/or their family/carer(s), with the patient's consent, should be given information about the ward through a ward information leaflet if available, and an accompanying explanation of significant points if required.

Patients admitted under the Mental Health Act (MHA) or Mental Capacity Act must be given information about their rights under the Act. Please refer to the relevant Mental Health Act policies for further guidance.

Draw up Implement and an individualised care plan within 24 hours.

It is important that staff understand that even where consent has not been given, they should still attempt to gather information from families and friends, especially in regard to risk information. Confidentiality is not broken by listening, and does not stop staff gathering information.

25 Information Sharing and Confidentiality

Staff need to take into account the principles and procedures around information sharing must be explained to the patient or their family/carer(s). They also need to take into account the principle and policies around working with carers and families. Whilst this is normally straight forward, staff can face complex dilemmas. In such cases they should seek guidance from senior staff including the Team 'Carers lead'. Refer to the Confidentiality Policy and RiO Consent to Share Information Standard Operating Procedure (SOP) for further guidance.

Information about the admission will be shared with other relevant practitioners and agencies, subject to consent from the patient in accordance with the policies and standards around information sharing as defined in the relevant Trust and multi-agency policies to ensure that appropriate and relevant information is shared in an appropriate and timely manner.

26 Record Keeping

All admission documentation must be completed in accordance with the relevant Trust policies and procedures.

Refer to the Clinical Record Keeping Policy for further guidance.

27 Child Visiting

Patients who come into hospital have the right to maintain contact with and be visited by anyone they wish to see, subject to carefully limited exceptions. This applies equally to all patients, including those who are formally detained under the Mental Health Act.

The child's interests must remain paramount and take precedence over the interests of the adults involved when decisions are made about whether visits are appropriate.

Refer to the Child Visiting Policy for further guidance.

28 Single Sex Accommodation/Privacy and Dignity

The patient's safety, privacy and dignity will be paramount throughout their stay in the least restrictive environment. Refer to the Trust's Eliminating Mixed Sex Accommodation Policy for further guidance

TRANSFERS

29 Transfers between Trust Services

It is important to ensure that when assessing the need and appropriateness of a transfer to another service, the views of all members of the multidisciplinary team, those of the patient and their relative/carer(s) and any other individuals involved in their care are fully considered and documented.,

Where a transfer to another ward or another service within the Trust is necessary, the transferring team must

- Provide a comprehensive verbal and written handover. Identify the clinician who will be responsible for the patient's plan of care in the new/receiving team.
- Agree the patient's plan of care with the receiving team prior to the transfer, including responsibility for identified interventions/actions.
- The receiving ward team must review the care plan including risk plan and level of observations to check that they are appropriate to their ward.

The patient and/or their relative/carer(s) will be given information about the reason for referral, the team/service they have been referred to, their plan of care and such other relevant information as required. This will be recorded in the patient's progress notes.

An inventory must be made of any valuables handed in for safekeeping or properties brought in by the patient prior to the transfer, signed by a member of staff from the transferring and receiving service and the patient or family/carer.

Patients will be escorted where appropriate when being transferred to another service. The nature of the escort will depend on clinical need and identified risks.

For patients detained under the Mental Health Act, staff must comply with the MHA legal requirements as outlined in the Transfer under the Mental Health Act SOP.

The transferring team is responsible for ensuring that the transfer is documented in the patient's records in accordance with the Trust's record keeping procedures.

The receiving ward is responsible for updating care plans and other documentation to reflect the change of environment and team

30 Transfers into CPFT from another Hospital

Transfers from an acute Trust must have a consultant to consultant (or nominated medical/nursing representatives) dialogue and agreement before a transfer takes place, which is recorded in the case notes. This is to ensure the patient is medically fit and any ongoing physical health care needs are able to be met by the receiving ward.

A transfer will be treated as a new admission and the same procedures apply.

The transfer of patients detained under the MHA to CPFT from another hospital manager's jurisdiction must be done in compliance with the MHA legal requirements as outlined in the Transfer under the Mental Health Act SOP.

31 Transfers from CPFT to another Hospital

Where a transfer is necessary, the named nurse or nominated deputy should discuss the reasons with the patient and/or their relative/carer(s) in terms that they understand.

Where a transfer to a ward outside the Trust (i.e. acute Trust) is necessary, a comprehensive handover must take place verbally and in writing along with a transfer letter and other applicable documents.

The transfer of patients detained under the MHA from CPFT to another hospital manager's jurisdiction must be done in compliance with the MHA legal requirements as outlined in the Transfer under the Mental Health Act SoP.

32 Out of Hours Transfer Arrangements

Where possible, transfer of patients should happen during normal office hours. However, transfer of patients out of hours is sometimes necessary. Any out of hours transfer should pay special consideration of safe escort arrangements, prior risk assessment and adequate documentation to accompany the transfer.

DISCHARGE FROM AN INPATIENT SERVICE

33 General Principles

All discharge and aftercare arrangements must be made in a manner which ensures a safe and smooth transition from an inpatient stay in hospital to returning home or to a community-based treatment/care including residential or nursing care home

Planning for discharge should commence as soon as possible following admission. This should be done with the full involvement of the patient and/or their family/carer(s), where appropriate and in collaboration with all professionals and other agencies involved in their care.

Patients on mental health wards will not be discharged without the agreement of the Consultant Psychiatrist, and for detained patients the Responsible Clinician (RC) having responsibility for that patient, or his/her deputy.

Patients on OPAC physical health wards will be deemed fit for discharge by a doctor. Thereafter actual discharge will be agreed by the MDT lead

Patients and/or carer must be given an estimated date of discharge.

The procedure for discharge will be facilitated by the named nurse/practitioner, in collaboration with the community mental health care coordinator or for physical health patient with the District Nurse/speciality team.

Carers' needs will be taken into account throughout the discharge process and will be involved whenever possible.

The Discharge Checklist (**Appendix 3**) must be completed, dated and signed off by a designated member of the care team.

The Discharge Notification Form (**Appendix 4**) or relevant documentation on physical health wards, must be completed and sent to the GP (General Practitioner) and the

community team within 24 hours, with a copy given to the patient. The Discharge Summary must be completed and sent to the GP within 7 days of discharge.

CPFT is contracted to supply 7 days of medication at discharge. Patients at risk of taking an overdose may be prescribed less than 7 days, the exact amount to be decided by risk assessment. In these situations, it is good practice for the ward to speak to the GP about the appropriate quantities to be prescribed for future prescriptions in primary care. In some circumstances, it may be appropriate to supply more than 7 days supply on discharge. This must be decided on an individual basis or, in the case of adult acute assessment units, between 7 and 14 days may be supplied in line with their local procedure.

34 Discharge Planning

Every patient will have a meeting where discharge is discussed prior to a planned discharge. They should be invited to attend whenever possible and appropriate, and be given advance notice verbally.
The patient should be informed that a relative/carer and/or an advocate may accompany them, and the relevant individuals invited with the consent of the patient. The named nurse and the community care coordinator should attend or where appropriate be appropriately represented. When not in attendance, communication between the inpatient unit and the care coordinator will take place prior to discharge.

If the discharge involves arrangements for a social care funded package of care, then the package should be discussed at the earliest opportunity with the relevant Social Care Lead. Specific procedures will vary across Cambridgeshire and Peterborough services, and between different client groups. This policy should be used in conjunction with the relevant local procedures.

As far as possible suitable days, dates and time for discharge should be discussed and agreed with all concerned.

Arrangements for the follow up should be agreed in the meeting discussion/agreeing discharge plans, including who/which team is responsible for the follow up.

Service users entitled to statutory after-care under s117 must have their needs assessed and clarified as part of the Care Programme Approach (CPA) process. After-care planning should start as soon as possible after admission and should be service user focused. As part of the discharge planning, a S117 must be organised and aftercare arrangement agrees with the patient their carer and relevant professionals. For additional information, see s117 policy and procedure.

35 Discharge against Medical Advice

There may be occasions when informal patients wish to discharge themselves against medical advice.

Staff should make every effort to elicit the reason why the patient is wishing to leave the hospital, or in the carer's case for wishing to remove the patient from hospital. The patient should be requested to speak with a doctor and nurse in charge or deputy before they leave.

If the patient refuses to speak to a doctor, the immediate risks must be assessed and consideration given to the use of Section 5.4 or Section 5.2 of the MHA. Refer to the relevant MHA policy for guidance.

Where the patient has an identified care coordinator in the community, they should be contacted as soon as possible and informed of the developments.

The carers/family should be informed of the patient's decision to leave hospital, with the patient's consent.
The patient should be requested to wait for their discharge medication. If they refuse to wait, they should be advised to see their GP.

The patient should be asked to sign the Discharge from Inpatient Care Against Medical Advice form (**Appendix 5**). An entry should be made in the patient's clinical records that the departure is against medical advice. If the patient declines to sign the form, then the entry should reflect that.

36 Transport

Transport arrangements should be considered during the discharge planning process.

The Trust will only provide transport if there is a clinical need to do so.

The patient should be asked to make their own arrangements wherever possible. This should be determined when discharge plans are first discussed with the patient.

37 Communication and Information Requirements

It is the responsibility of the key worker/primary nurse/named nurse to maintain effective communication with the patient and their relative(s)/carer(s) and other relevant professionals/agencies involved in their care in a timely manner.

The patient and/or their relative(s)/carer(s), with the patient's consent,

- should be kept informed of the discharge date and any changes that occur
- will be given a copy of their care plan, and where appropriate safety plan (Safe Plan) , and details of how to contact the service for support including emergency contacts . In these circumstances the named nurse or another nurse nominated by the person in charge of the ward should attempt to give the person a plan based on the latest provisional discharge plan.
- will be provided with other relevant information as required, including information about other agencies and sources of support in the community.

In the event of consent not being given, but where the carers involvement post discharge is required/likely, staff need to ensure that enough information is provided to enable the carers to carry out the support safely and effectively. Additional guidance from senior staff should be obtained to assist with developing plans.

For discharges from under the MHA refer to the relevant MHA policy.

The General Practitioner (GP) will be given a copy of the, Discharge Notification Form and the Discharge Summary in accordance with the required timeframes. This must include information about:

- mental health diagnoses, with ICD10 code
- physical health diagnoses/conditions
- medication (psychotropic and others)
- monitoring requirements of the above

Other professionals and agencies will be given relevant information on a need to know basis, with the patient's consent (refer to section 35.7), to ensure safety and continuity of care.

The information provided on discharge must include, as a minimum:

- an up to date care plan, which includes crisis and contingency arrangements
- the most recent and up to date clinical risk assessment
- Mental Health Act (MHA) requirements, where applicable
- any infection and physical health conditions that needs to be managed
- any other relevant verbal or written information, including social, financial and psychological factors affecting the patient's ongoing care

38 Medication on Discharge

The Medicines Policy and RiO Standard Operating Procedure for Discharge must be followed when prescribing and obtaining medication for discharge.

For physical health wards the medicines policy and agreed local medicines discharge documentation must be followed and completed fully.

If possible, discharge medication should be obtained from pharmacy in advance of the time of discharge to avoid unnecessary delays for the patient.

The nurse responsible for the discharge must check that the medication chart and the Discharge Notification Form correspond to the dispensed medicines.

The nurse in charge must ensure the patient and/or their relative(s)/carer(s) understand the medication regime and any possible side effects prior to handing discharge medication to the service user.

Consideration about any risks on driving ability must be made and the necessary action(s) taken. Refer to the Protocol for Driving and Psychiatric Disorders for further guidance. https://www.gov.uk/guidance/psychiatric-disorders-assessing-fitness-to-drive

39 Infection Control Considerations

Prior to transferring, discharging or accepting patients into inpatient or residential areas, the named nurse or nominated deputy must be mindful of issues relating to healthcare

acquired infection (HCAI) and refer to the Infection Control Manual for guidance, where required.

It is essential that this information is considered both when transferring a patient with a known infection to other healthcare settings such as hospitals/wards, nursing/residential homes and also when a patient is going back to their home and receiving either district nursing input or other community support services to ensure that appropriate precautions and care can be put in place. Further information and guidance may be obtained from the Infection Prevention and Control (IPaC) Modern Matron.

For patients with a MRSA (colonisation or infection) or any other active infection or CDiff during their stay, follow the following procedures:

If the patient has diarrhoea and/or vomiting and is being discharged to another institution, please inform that institution prior to transfer. Do not transfer until 48 hours post symptoms without discussing with IPaC Modern Matron.
Complete an Infection Control Transfer Form

40 Follow Up Arrangements for patients on inpatient wards

All patients discharged from psychiatric inpatient care with ongoing mental health issues, including those who have discharged themselves against medical advice, will receive follow up from specialist mental health services.

Additionally, the Department of Health (DH) requires that all patients under adult mental illness specialties on CPA discharged to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge the timing of this dependant on the needs of the patient. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.[3]

Exemptions to this rule are set out below:

- Where legal precedence has forced the removal of a patient from the country.
- Patients transferred to NHS psychiatric inpatient ward
- CAMHS (child and adolescent mental health services) are not included
- readmitted within 7 days
- discharged to Drug and/or Alcohol Services/Community Drug Team
- discharged to Out of Area
- discharged having been admitted under the Ministry of Defence contract or as a planned admission to a Detox bed
- transferred to other wards (patients transferred to NHS psychiatric inpatient ward)
- admitted for whom it is deemed mental health services are inappropriate and are referred back to their GP

Additional partial exemptions agreed by the Trust are:

[3] This official definition and exceptions are taken from the *Technical Guidance for the 2012/13*

where patients are discharged to other hospitals (e.g. acute general hospitals), a telephone discussion 'by proxy' with the clinical team caring for that patient will count as a 7-day follow up to take account of the physical condition of the patient. for patients discharged to prisons, a discussion with the relevant prison in-reach team 'by proxy' will count as a 7-day follow up.

The 7 day period should be measured in days not hours and should start on the day after the discharge. In all cases, follow up must take place within seven calendar days of discharge, day one being the day after the date of discharge.

For services that are not covered by the Department of Health requirement above, such as children and learning disability services, good practice would dictate a follow up within 7 days of discharge.

The follow-up must be in person. Non face-to-face follow up can only be made on agreement by the MDT based on clinical judgement, with a clear rationale documented in the patient's clinical records.
The arrangement for the follow up must be clearly documented in the discharge plan, Discharge Notification Form and Discharge Summary.

The follow up must be recorded in the patient's clinical records.

If the follow up does not take place, the reason must be recorded, including attempts made to contact the patient.

Clinical judgement must be used to determine the number of the attempts made to contact the patient, supported by an assessment of the risks involved. This must be discussed with the MDT. Decisions made and actions subsequently taken must be documented in the patient's clinical records.

41 Suicide Prevention

The Trust has adopted a Zero Suicide strategy to help reduce the number of suicides of service users. Central to this is good risk assessment and risk plan formulation. Subject to information sharing consent this should routinely include involving carers, friends and families in gathering information to help inform the assessment and plans. Where the patient has been identified as a suicide risk prior to or during the period of admission:

- the risk management plan including level of observation needs to take into account the specific ward environment the patient is admitted to. The risk plan should be reviewed on transfer to another ward as appropriate
- the discharge care plan should take into account the heightened risk of suicide in the first three months after discharge and make specific reference to the first week
- Follow up from a professional practitioner of the mental health service should be made within 7 days, the timing of this dependant on patients need. Patients in followed up by CRHT will normally be seen is 48 hours of discharge. This will be recorded in the patient's clinical records

42 Carer Needs

This section is taken directly form the Trust's Carers Policy. It is replicated here so that there is consistency across relevant policies regarding the involvement of carers, and so that staff can be clear about expectations and supported to work with what sometimes can be, complex situations.

CPFT recognises the significant role often taken by carers in the care, treatment and support of service users and should be proactive in developing constructive and supportive relationships. Clarity and honesty about issues of information sharing between staff, service users and carers are a vital part of developing such relationships. The sharing of information with carers is crucial in order to provide the safest and best clinical care possible to service users.

The issue of confidentiality should be discussed with the service user as early as possible and discussion, and any agreements, should be recorded. Professionals should explain to the service user the benefits of sharing appropriate information with the carer.

The issue of confidentiality should also be raised as soon as possible with carers. It should be explained that there is a limit to the information we can share with them if the service user does not consent, or withdraws consent, and any current restrictions that are relevant to them should be discussed. However, an assurance should also be given that, in any case, staff will continue to support them as far as possible in their caring role, to ensure that their needs are met.

In all cases staff should aim to reach a position where families can be fully involved in the care and support of the cared for person to maximise the chances of a good outcome for their family member. Once staff are able to involve families fully they should make sure they do so.

Carers also should be able to expect that the information they provide will be held in confidence by the professional care team if they request this..

Circumstances in which information should be disclosed when consent is given
It is imperative to remember that the prime use of patient information is for the delivery of personal care and treatment.

- If a service user has consented to sharing of information with their family and carers this information should be clearly recorded. If consent has been given

it is essential that this information is shared with family and carers and that this is sharing is clearly recorded.

- Patients who have the capacity to consent but are unable to read, write or require an interpreter, must receive appropriate support

Circumstances in which information must be disclosed without the consent of the patient

There are some specific circumstances permitted by law where patients' wishes in relation to information being kept from their carer and relatives can and should be overridden through clinical decision making: These are listed below.

- For the protection of the public or another individual such as a carer, service user or staff member
- If a service user is considered to be at significant risk of suicide or serious harm to themselves. Carers should be informed of this risk as soon as possible and provided with appropriate support
- There may be a statutory duty to breach confidentiality where children at risk are identified. Child protection (Children's Act 1989)
- There is a specific duty to involve the nearest relative of patients who are detained under the Mental Health Act (note: the term "nearest relative" has a precise definition within the Mental Health Act). Mental health action 1983, section 11.

Wherever possible decisions about sharing information without consent should not be made alone. Staff should consult their line manager or wider team treating the patient and should follow trust policy in relation to the process of sharing information without consent.

In the exceptional cases where clinical information is shared without the patient's consent, staff should if at all possible discuss beforehand with their line manager or team. Where this is not possible – for example a mental health crisis where a patient's family are at risk from the patient – staff should inform their line manager immediately afterwards.

For circumstances where there is no immediate clinical risk it is important to discuss the appropriateness of breaching the service users confidentiality with your line manager, team or Caldecott guardian if required.

Where issues arise that cannot be resolved or are complex the trust's Caldecott guardian is available to support staff. The Trusts' Information governance manager is there to provide guidance around ensuring that decisions are made within the legal framework.

Where we do breach confidentiality a breaching confidentiality form should be completed and submitted to the information governance team.

The organisation must be able to justify any exceptional decisions to pass on information.
The reasoning for this must be documented within the notes, as well as signed and dated.

Circumstances in which it must not be disclosed.
There may be times when in spite of continued efforts to encourage service users to involve carers and relatives in their care consent to share information is still refused. If there is no indication of the circumstances where it should be disclosed the service users would be deemed to have a valid reason for refusing consent and their request for confidentiality must be respect.

Where a patient has expressed a wish that information be withheld the consequences of this must be explained to the service user and the patient's wishes must be communicated to other staff who need to know. An example would be where non- disclosure will affect the Trust's ability to work with another agency such as Adult Social Care.

Carer Engagement
Lack of consent from a service user must not preclude sensitive discussion and appropriate and helpful sharing of general information. Every effort should be made by staff to support carers in their caring role, and they should be supported and encouraged to discuss and resolve any concerns or difficulties.

If the service user withholds consent, there should be discussion about whether this applies to all information or specific details, and the outcomes of this discussion recorded (For example, a service user may be willing to share information about their care and treatment but reluctant to make carers aware of issues of sexuality and relationships).

Where consent to share information is refused, the service user's decision should be shared sensitively with the Carer (alongside an offer to support them as far as possible).

Refusal of consent should be reviewed regularly with the service user. They should be made aware at the earliest opportunity that refusing consent will not mean staff cannot provide support to the carer for their own needs. Staff should encourage the use of advance decisions to confirm whether carers can be contacted in the event of an admission or emergency.

The provision of general information about mental illness, emotional and practical support for carers does not breach confidentiality. Neither does discussion about matters that the carer is already aware of (for example, information discussed at a meeting where the carer was present).

Receiving information from carers is not a breach of confidentiality. Carers will have information about the service user and this information should be considered in the forming of the care planning process.

It may well be helpful to support Carers to access information about a condition or potential side effects of medication as long as this does not involve disclosure of information
(such as a diagnosis) that the carer was not already aware of.

The provision of information about carer organisations and other sources of support
(for example local groups) may be particularly helpful where staff are precluded from sharing particular information.

Staff should encourage the use of advance decisions to confirm whether carers can be contacted in the event of an admission or emergency.

Further information about Confidentiality Issues including useful case studies can be found at: www.rcpsych.ac.uk/campaigns/partnersincare/carersandconfidentiality.aspx

Top Tips for Best Practice

- Aim for full involvement of the carer so that you can work together with them
- Ensure that confidentiality is clearly understood / agreed between all parties.
- When meeting a carer for an assessment, ensure that you have any appropriate information leaflets. This will vary according to individual needs, and may need to be focused to avoid an overload of information.
- Check that any referrals made have been picked up and action has been taken.
- Ensure that the Carer has a clear contact within the service in case the situation needs to be reviewed.
- Ensure that the Carer is aware of support groups outside the statutory services.
- Ensure that health, cultural, religious and spiritual needs of the Carer have been addressed.

43 Carers' Assessment

The CPFT Carer Charter (2015) defines a carer as:

"Someone who is providing help and support, unpaid, to a family member, friend or neighbour who would otherwise not be able to manage without this support."

In comparison the legal definition contained within the Care Act 2014 states:

"A carer is someone who helps another person, usually a relative or friend, in their day-today life. This is not the same as someone who provides care professionally, or through a voluntary organisation."

In the context of CPFT, a carer is also:

Anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Thus the legal definition of a carer is now very broad. The statutory role for inpatient units is to identify carers and record this appropriately on the electronic patient record.

Once identified, carers should be offered an assessment of their own needs. See the Carers Policy for next steps.

The Care Act relates mostly to adult carers – people aged 18 and over who are caring for another adult. However, regulations under the Act also sets out how assessments of adults must be carried out to ensure the needs of the whole family are considered, including the needs of young carers[4].

If both the carer and the person they care for agree, a combined assessment of both their needs can be undertaken. Consideration must be given to the capacity of the patient and issues around confidentiality in regard to undertaking carers' assessments.

Young carers (aged under 18) and adults who care for disabled children are assessed and supported under The Children and Families Act. This gives young carers (and parent carers) similar rights to assessment as other carers under the Care Act.

44 Mental Health Legislation and Legal Requirements

Refer to the relevant MHA policy and procedures, or to the Mental Health Legislation Manager/Locality Mental Health Act Administrator for guidance on the following:

Scheme of Delegation under the MHA
Receipt and Scrutiny of Detention Papers Policy
Section 132/132a Reading of Rights Policy
Working with Independent Mental Health Advocates (IMHA) Policy
Section 26 The role of the Nearest Relative Policy
Section 5(2)/5(4) Doctor/Nurse Holding Powers
Section 58 Consent to Treatment Policy
Mental Health Act Hearings Policy
First Tier Mental Health Tribunal Hearings Policy
Detained patients in Acute Hospital Policy
Section 117 aftercare
Supervised Community Treatment (Section 17A-G)

Guardianship (Sections 7 and 37)
Mental Capacity Act Multi Agency Policy
Deprivation of Liberty Safeguards (DoLS) Policy and Procedures
Consent to examination and treatment policy

45 Delayed Transfers of Care (DTOC)

A delayed transfer of care (delayed discharge) occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for discharge when:

A clinical decision has been made that patient is ready for discharge **and**

[4] This includes assessing what an adult needs to enable them to fulfil their parental responsibilities towards their children, or to ensure that young people do not undertake inappropriate caring responsibilities.

A multi-disciplinary team decision has been made that patient is ready for discharge
and
The patient is safe to discharge.

The point at which all of the above criteria are met and there is thought to be social carer requirements, the relevant team need to liaise with Social Care colleagues following agreed processes. This also needs to be clearly recorded in the patient's records.

46 Monitoring Compliance

In addition to the responsibilities in relation to monitoring compliance with this policy set out in Section 6 and 9, there are specific risk management standards that apply to discharges which is outlines below.

Area to be monitored	Arrangements for monitoring	Frequency
Discharge requirements for all patients	Discharge checklist – audit to be determined on a risk based approach	As agreed
Information to be given to the receiving healthcare professional	Section - audit to be determined on a risk based approach Management and clinical supervision	As agreed
Information to be given to the patient when they are discharged	Section - audit to be determined on a risk based approach Management and clinical supervision	As agreed
How a patient's medicines are managed on discharge	Section Review of DNF by Pharmacy staff Audit to be determined on a risk based approach	On-going As agreed
Out of hours discharge process	Section 32 Audit to be determined on a risk based approach	As agreed

Compliance with specific standards around discharge is also monitored through clinical audit using a risk-based approach as agreed in accordance with the Clinical and Practice Audit Policy.

47 Links to Other Documents

In addition to the documents listed in Section 10, the following should also be referred to for further guidance

Cambridgeshire and Peterborough Patient Discharge and Transfer protocol and performance Monitoring

Information Sharing protocol to prevent Homelessness (multi-agency protocol for patients discharged from Mulberry 1, 2 and 3)

48 References

Care Quality Commission (2008), The Health and Social Care Act 2008 (Regulated Activities 2009)
Department of Health (2011), Technical Guidance for the 2012/14 Operating Framework
Preventing Suicide: A toolkit for mental health services (2009), NPSA
NHS England (Oct 2014), Specialised Mental Health Services Operating Manual
Protocol: Referral and access assessment procedures for children & young people into inpatient services.
(http://nww.intranet.cpft.nhs.uk/Childrens/ChildrensBusinessUnit/Pages/howtogetabed.aspx)

49 Acknowledgements

A policy review group was established to support the effective review of this policy. The author would like to acknowledge the contribution from key members of staff from across the Trust's services, as follows:

Neil Winstone, Associate Director of Performance & Service Delivery
Eddi Paul, Adult & Specialist Directorate Interim Head of Nursing
Joe Lynch, OPAC Directorate Head of Nursing (mental health)
Nicky Bidwell, OPAC Practice Development Lead
Orna Clark, Patient Information & MHA Legislation Manager
Rob Bode, Modern Matron – The Croft, The Darwin Centre and The Phoenix Centre. Interim Service Manager for the Intensive Support Team.
Dr Julia Deakin, Consultant Psychiatrist and Trust Physical Health/mental health lead
Clare Mundell, Chief Pharmacist

Mental Health Wards
ADMISSION CHECKLIST
For use in preparation for and during patient admission

Name of patient: **Hospital Number:**

Ward: **Date of Admission:**

Core tasks

Individual wards may add tasks or additional explanatory notes or guidance to this list.

No.	Action	Tick if completed Or N/A	Signature of admitting Nurse
1	Complete Eliminating Mixed Sex Accommodation form (for AAU only)		
2	Enter patient details on Bed Map/Board and on Named Nurse List/Allocate Named Nurse.		
3	Access patient's historical notes/records.		
4	Ensure bedroom is clean and ready.		
5	Inform doctor of admission.		
6	Contact care coordinator to ensure they are aware of admission and request attendance at ward for review and discharge planning.		
7	Ensure completed pre-admission paperwork is received, to include: • up to date Core Assessment • most recent and up to date risk assessment. • up to date and current care plan (**Note:** see s18.2 of Admission, Discharge & Transfer Policy for full list of information/documentation) Discuss discharge date with referring team.		
8	On arrival, • welcome patient and/or relatives, introduce self, show them to a quiet room and offer a drink. • give Welcome/Information Pack (patient & carers) • Inform/confirm reason for admission • outline plan of care, including discharge plan • orientate to ward area, outline ward routine and other specific ward policies and procedures inform of Controlled Access procedures		
9	Assess patient consent to admission care and treatment and record outcome on the "Inpatient capacity to consent to admission care & treatment" RiO form. (**If the patient lacks capacity** to consent to the above, give consideration for the patient status under the appropriate legal framework – i.e. DoLS, MHA, Court of Protection order)		
10	Give the **Consent to Share Information leaflet** to the patient and discuss with the patient their rights around sharing information. Record outcome of discussion on **RiO consent to share information Form**. Identify exceptions.		
11	Inquire about arrangements for any domestic issues (e.g. pets, home security, caring responsibilities)		
12	• Identify carers • Offer Carer's Assessment, where applicable		
13	<u>Medications</u> • contact GP to request Medication Summary • ask patient to hand in any medications and consent to use own medicines • In working hours – phone pharmacy to inform them of admission (they will come to check and order any if required) • Out of working ours – registered nurse can check patient's own medicines for re-use, and if not appropriate, can obtain stock via out of hours procedure		

No.	Action	Tick if completed Or N/A	Signature of admitting Nurse
14	If required and only with patient's consent, inform relatives of admission and give information.		
15	Complete other relevant consent forms and **upload in RiO.**		
16	Screens & risk assessments: Complete and **upload in RiO** • MRSA screening (if necessary) • Falls screen / risk assessment • VTE screen • MUST • People Handling Risk Assessment Form • Keeping Children Safe Risk Assessment Form		
17	Check/search belongings with patient/relatives. • drugs or alcohol should be removed • weapons/sharp objects should be handed to staff for safe-keeping. • any electrical items need to be PAT tested. • if patient has valuables, ascertain whether they wish these to be taken home by relatives or handed over for safe keeping. Log patient property handed over for safe keeping.		
18	Have **Disclaimers** signed for: • Non-prescription Drugs/alcohol • Valuables		
19	Give patient a bedroom key card/door fob		
20	Enter patient details on • fire safety board • Bed state • Task Board		
21	If detained under the MHA: • Receive section papers, check the forms by following the **Nurse Receipt and Scrutiny check list**, complete **H4A form** and scan/upload all detention papers onto RiO. • Send original detention papers, AMHP's SOC 323 form and signed scrutiny list to the locality Mental Health Act Administrator. • Read rights within 24 hour of admission. **Upload successful rights form onto RiO**.		
22	Undertake joint assessment interview with the doctor. Complete/update jointly with admitting doctor: • Core Assessment v2 • Risk Assessment (including driving risks) • Identify any safeguarding issues/needs Obtain/update **all** patient demographic details. Agree the appropriate level of observation and communicate to patient and all staff		
23	Undertake Physical health examination • Physical Health Check Part B completed **Note:** Different versions for adults and CAMHS		
24	For doctors: Complete - See minimum documentation standards • RiO Capacity assessment to consent to treatment for all inpatients. • Medication Chart • Physical Health Check Part A completed • VTE assessment FOR PHARMACISTS • Medicines Reconciliation process and form		

24	<u>Doctors and nurses</u> • Physical observations • Summarise admission with appropriate entry in RiO patient's progress notes. • Develop initial plan of care (48//72 hr care plan)		

APPENDIX 2

Minimum Standards for Admission Assessment Documentation by Medical Staff

Background

These are the minimum standards of documentation for admission assessment carried out by medical staff. Clinical records that document the assessment of service users must comply with the Record Keeping standards set out in this policy

The CPA is the core assessment tool that will contain current and historic service user information.

Interview

Standard: an interview/consultation must take place

Exception: A clearly recorded reason why this did not happen (e. g. service user refused to talk, mute, violent) must be recorded. If this exception applies, the following subsections of interview will also be excepted apart from the observable elements of mental state examination. Service users who refuse interview may accept physical examination and/or blood tests, so it must be recorded which elements of admission have been omitted. Information previously obtained can be included provided it is actually available (i.e "see notes – with location of relevant document" is ok if notes available and have the information)

Demographic data

Name, age, ethnicity

Reason for admission/history of presenting complaint

Some description of events/symptoms leading to presentation

Past psychiatric history

Include information about previous admissions
Include information about previous psychiatric medications and treatment response
Reference to past problems or none

Past medical history/ medication: ***

Significant past illnesses or none
Current medication prescribed and taken
Any allergies/adverse reactions

Family and personal history ***

Report on family history of mental or physical illness
List of key family members. Include full names and dates of birth of any children in the home
Some mention of developmental milestones
Reference to schooling and educational attainments
Employment and relationship history
List of substance use or "none" ***

Current circumstances
Employment or lack of it (or other activities)
Living alone/who with (or other support)
Financial situation (claiming benefits and which ones, debts, savings)

Forensic history/risks ***
Any criminal/delinquent behaviour, convictions
Risk of self-harm (may be in mental state examination), harm to others, self-Neglect (include reference to past behaviours)

Mental state examination
Appearance & Behaviour: some description
Observed [these must be recorded even in service users who cannot be interviewed]
Speech: some description
Mood Subjective: some description
Mood Objective: Some description
Thought content/delusions: some description, must include suicidal thoughts or not
Perceptual abnormalities: some description
Cognitive: orientation in time and place

Capacity to consent to admission, care and treatment

Service user strengths, needs and expectations

Carer views and needs (include unpaid and informal carers)

Physical examination
Complete the Trust Physical Health Check form Part A

Investigations*
- FBC, U&E, LFT, HBA1c, CRP, TSH, CRP, non fasting lipid screen (consider further tests such as Lithium, BFT, Urea, GGT, B12/Folate , CK, ESR, First Presentation Psychosis and Clotting Screen as appropriate).

Summary
A statement including key demographics e.g. name, age, relationship, employment and accommodation status. E.g. John Smith is a single 25 year old cleaner who lives with his 13 year old son in rented accommodation.
Diagnosis (may be provisional or query) with supporting evidence
Risk assessment (may be above)
Statement of capacity/consent – if capacity/consent is lacking, what action is being taken (e.g. Mental Health Act, Independent Mental Capacity Advocate)

Initial plan
Admit/not; if admitted, voluntary or not
Medication
Goal of admission – what is required for discharge to be acceptable?

* Exception is recorded refusal or other reason (e.g. risk of provoking violence)
**Exception is recorded lack of necessary equipment
*** May be split into more than one section/recorded under different headings

Note about recording data in a Core Assessment

With the electronic records it becomes very helpful to be able to reuse information for example in the Core Assessment and the Risk Assessment.

Your entries are much more helpful if you can use absolute time frames (e.g. “When he was 20 years old” or “in 2012”) rather than relative ones (“last week” or Five years ago”)

It can be helpful to capture the patients own words, but with small additions you can avoid confusing people later.

Bad: “He reports that he took an overdose five years ago”
Good: “He reports that he took an overdose five years ago (~2012)”
Good: “He reports that he took an overdose five years ago, when he was around 18 years old.”
Good: “Update 9 Sep 2017: Mr X reports that last week Y happened...”

Bad “He agreed to a home visit next Tuesday at 10am”
Good “He agreed to a home visit next Tuesday (30/1/2018) at 10am”

Dr David Dodwell (July 2005, reviewed Feb 2015, Dr Deakin reviewed 2018)

WARD ADMISSION CHECKLIST : DUTIES OF THE ADMITTING DOCTOR

This standard operating procedure is for the admitting ward or on call doctor working on the inpatient wards across CPFT. Please note it runs in conjunction with the ward admission checklist which details the nursing roles and duties for each admission. The following duties should be completed within 24 hours from the time the patient is admitted to the ward, unless otherwise specified. The reason for any deviation from this should be documented in the progress notes.

Before admission

- The **referring clinician** should complete the full **Core Assessment V2** and separate **Risk Assessment Form** ensuring the reason for referral, history of presenting complaint, medications, past medical history, past psychiatric history, drugs and alcohol and other background history are complete and up to date. It is important that they document whether they feel the patient has **capacity to accept informal admission** and if not what framework they are expecting the ward team to adopt to treat the patient under once admitted. It is important that they highlight any potential risks in the full risk assessment.
- Exceptions currently include Ministry of Defence, Detox and Mental Health Act Assessment admissions for which the core assessment responsibility currently lies with the admitting ward or on call doctor.

On arrival to the ward

- Ask the ward nursing team chase the core assessment and risk assessment from the referring team if this is still outstanding.
- Review the patients notes and receive a handover from ward staff. This will alert you to the patients clinical needs and also any potential risks.

Patient review

- Interview the patient focusing on current mental state, risk assessment, and perform a physical examination. A full history is ideal.
- You may have an opportunity to clarify any missing information.
- Review the patient's current medications and allergies, reconciling this with what is already documented on RIO.

Investigations

- After reviewing the patient, decide if there is an urgent clinical need for further investigations, such as blood tests and ECGs.
- If the patient is physically well and it is out of hours baseline bloods can wait until the next day to be completed.
- ECGs should ideally be performed on admission especially if there is a likelyhood of antipsychotic prescribing or rapid tranquilisation.
- Consider a urine screen for infection and drug use.
- *Bloods and ECGs can be performed by any member of trained staff.*

Liaising with the ward team

- Hold a discussion with the nurse in charge, to devise a plan together for the patient's admission. This may include ways to mitigate risk such as observation levels or repeat physical observations, and it should include any tasks that still need to be completed, identifying who is best placed to do this.

Paper documentation

- Write a drug chart, including as required medications (e.g. medications for sleep and agitation).
- Complete the blood test request form and leave it in the agreed place on the ward for phlebotomy completion. Routine admission bloods include FBC, U&E, LFT, HBA1c, CRP, TSH, non fasting lipid screen (consider further tests such as Lithium, BFT, Urea, GGT, B12/Folate , CK, ESR, First Presentation Psychosis and Clotting Screen as appropriate).
- If routine bloods have been performed within the last two weeks only repeat if indicated and document previous results in progress notes.

RIO documentation

- Update the mental state examination, formulation and plan in the Core Assessment V2 and Risk Assessment on RIO, **creating a new form with the time that you saw the patient**. If not already clear on the core assessment, state which ward the patient has been admitted, whether this is informally or under section, and the date of admission in the referral section, ensure the medication list is current, and any allergies and physical health concerns are documented. Update any missing information in the core assessment as appropriate. Your assessment is ideally in the progress notes as well as copied into the subsections of the Core Assessment.
- Complete the **inpatient assessment of capacity and consent to treatment form** in the consent section of RIO.
- Create a new **physical health part A form and VTE (venous thromboembolism) risk assessment form.**
- Finally, write a **summary** of the admission in the progress notes. Copying your formulation and plan from the core assessment.
  - *Please note: if the patient refuses physical examination, or is asleep, the doctor should complete the physical examination refusal form and document the reason in the progress notes. Please create a new form for each refusal.*
  - *A formulation should include a summary of the patient including key demographic, diagnostic, social and risk factors in a concise sentence to provide clarity to the case notes and your overall impression of the patients presentation*

APPENDIX 3

Mental Health Wards
DISCHARGE CHECKLIST
(For planned & unplanned discharges)

Name of patient: **Hospital Number:**

Ward: **Date of Discharge:**

No.	Discharge Requirements	Y/N or N/A	Date Completed	Signature and Designation	Comments or further actions required
1	MDT review/pre-discharge meeting with • Consultant Psychiatrist • community Care Coordinator • Carer/relative(s) with patient's consent				
2	For doctors: Complete Discharge Notification Form. This must include: • mental health ICD10 diagnosis • any known physical health diagnosis/ conditions • discharge medication • monitoring requirements of the above				
3	Review and update risk assessment				
4	Risk to driving ability • identify any risk(s) to driving ability • inform patient and/or relative/carers of any risk(s) from medication or diagnosis • inform DVLA if required				
5	Care planning • Update care plan to reflect discharge plans. Ensure any monitoring requirements are explicitly stated. • Complete contingency/crisis plan.				
6	Identify and inform community Care Coordinator/ CRHTT of discharge.				
7	Follow up arrangements: Identify who will follow up, where and when. • mandatory **7-day** follow up • **48 hrs** follow up for **high risk/suicide prevention** (good practice)				
8	Carers/relatives • Carer/relatives informed of discharge plans, with patient's consent • Carer care plan completed, where applicable				
9	Medication • One copy of Discharge Notification form printed and sent to Pharmacy with patient's medication • TTO medication received on ward and given to patient • Medication leaflets given to patient/carer				

No.	Discharge Requirements	Y/N or N/A	Date Completed	Signature and Designation	Comments or further actions required
10	Other relevant information documents completed: • Observation charts • Fire Safety Board • Bed state • All CPA paperwork • Others, as required				
11	• Mental Health Act 1983 • Discharge from Section paperwork completed • Section 117 paperwork completed (MH Law Office notified)				
12	Mental Capacity Act/DoLS assessments for patient who lack capacity - actions completed (MH Law Office notified)				
13	Where applicable, inform <u>other agencies</u> of discharge plan, with consent from patient (E.g. police, social services, voluntary agencies, MAPPA, etc.)				
14	<u>Social care</u> • Continuing Care Criteria met? Date applied for_____ • Benefits/Direct payments • Caring arrangements • financial and social care issues				
15	Personal belongings and valuables returned to patient				
16	**Where applicable**, patients have their walking aids to take home with them				
17	<u>Information given to patients</u> • Copy of care plan and crisis card • Copy of Discharge Notification Form • Sources of support in community				
18	Room/door card/fob returned to ward				
19	Final Discharge Notification Form printed and • faxed to GP and • copy sent to Care Coordinator				
20	Date discharge letter sent to GP (must be within 7 days of discharge)				
21	Last entry in notes including time of dis-charge & who accompanied Service User				
22	Discharge recorded in relevant electronic patient record system (RiO)				
<u>Comments/Notes</u>					

APPENDIX 4

Mental Health Wards
DISCHARGE FROM INPATIENT CARE NOTIFICATION FORM

Client: **Date/time:** **Assessment Referral:**	
Ward: **Ward Event Number:** **Date of Birth:** **Date of Admission** **MHA / MCA status on Admission:** **S117 Aftercare Status:** **Normal Place of Residence:** **Discharge Address: If discharge address is the same as normal place of residence (Tick box)** ☐	**NHS / Hospital no.:** **Date of Discharge:** **Inpatient Consultant:** **Care coordinator/key worker at time of discharge:**

Discharge Address: if not the same as the normal place of residence

GP Details: **Name of Initial Community team Contact:** **ICD10 Working Diagnosis:** **ICD10 primary Diagnosis:** **ICD10 Secondary Diagnosis:**

Community Team (if applicable)

Medications at Discharge

Allergies or Adverse Reactions

Discharge Medication

Medicine Name	Medicine Form (e.g. tabs)	Dose	Route	Time / Day	No. days	Additional Instructions	Amount Supplied (Pharmacy)

Please include any changes during admission with reason why, and instructions for the GP

Medication Recommendation and Changes during Admission

I have considered the overdose risk when prescribing medications ☐ Yes ☐ No

Doctor's signature: **Doctor's Designation:**

Doctor's Name: **Date:**

Pharmacist's Name (Pharmacy Use Only):

Date:

Plan at Discharge

Please make sure that the patient plan at discharge includes follow up within 7 days, by GP, by CPFT, Risk Management, Crisis Plan, Other Agencies, / services involvement and any additional Information are provided below.

Day Follow up Required? (Yes, No, NA)

Is there a risk to the patient's driving ability (Yes, No, NA)

If Yes, I confirm that I have advised the patient of the risk(s) of impaired driving ability associated with their medication or diagnosis, and of their responsibility to inform DVLA of this risk(s). ☐

Doctor's signature: **Doctor's Designation:**

Doctor's Name: **Date:**

Please print one copy and sign and send to pharmacy. When notified by pharmacy, please print final version from RiO and give a copy to patient/carer and send a copy to the GP and care coordinator.

Has the discharge plan been discussed with the patient? ☐ Yes ☐ No

APPENDIX 5

DISCHARGE FROM INPATIENT CARE AGAINST MEDICAL ADVICE

I……..am discharging myself from hospital in-patient care against medical advice. I have had an opportunity to see a doctor to discuss my situation.

Signed…….. Date……..

Name in Capitals ……..

Name of nurse in charge…….

Signature of nurse in charge…….……..

IF THE PATIENT REFUSES TO SIGN

The patient…… has refused to sign the Discharge from Inpatient Care Against Medical Advice Form.

Name of nurse in charge…….

Signature of nurse in charge…….. Date……

Witness Name……..

Signature of witness……. Date……

This form must be filed in the patient's medical records

APPENDIX 6

OPAC – Physical Health Wards
ADMISSION CHECKLIST

For use in preparation for and during patient admission

Individual wards may add tasks as additional explanatory notes of guidance to this list.

NO.	Action	Tick of completed or N/A	Signature of admitting Nurse
1	Enter patient details on white board		
2	Access patient's historical notes/ records.		
3	Ensure bedroom is clean and ready.		
4	Inform doctor of admission		
5	Contact social services to ensure they are aware of admission and request attendance at ward for review and discharge planning		
6	Ensure completed paperwork is received to include • Up to date referral • Northwick Park assessment		
7	On arrival, • Welcome patient and/or relatives, introduce self, show them to their room and offer them a drink. • Discuss reason for admission • Give welcome/ information pack (patient and carers) • Discuss plan of care, including discharge plan • Seek and the patient (valid) consent to admission care and treatment. If you are concern about the patient capacity to consent, carry out a capacity assessment and record it on the appropriate form. • Orientate to ward area, outline ward routine and specific ward policies and procedures • Inform of Controlled Access Procedures		
8	Give Consent to Share Information Leaflet to the patient and discuss their rights around sharing information. Record outcome of discussion in paper notes.		
9	Inquire about arrangements for any domestic issues (e.g. pets, home security, caring responsibilities)		
10	• Identify carers • Offer Carers Assessment where applicable		

NO.	Action	Tick of completed or N/A	Signature of admitting Nurse
11	**Medications** Nurse to complete first reconciliation • Contact GP to request Medication Summary (if applicable) • Ask patient to hand in any medications and consent to use own medicines • Out of working hours – registered nurse can check patient's own medicines for re-use, and if not appropriate, can obtain stock via out of hours procedures.		
12	If required and only with patient's consent, inform relatives of admission and give information.		
13	Complete other relevant consent forms and upload in S1		
14	**Screens & Risk Assessments** MRSA Screen Falls Screen VTE Screen MUST Bedrail Alcohol/ Smoking SSKIN Waterlow People Handling risk assessment		
15	Check/ search belongings with patient/relatives (if appropriate) • Any electrical items should be PAT tested • If patient has valuables, ascertain whether they wish these to be take home by a relative or handed over for safe keeping • Log patient property handed over for safe keeping		
16	Have **Disclaimers** signed for: • Non-prescription Drugs/alcohol • valuables		
17	Give patient a bedroom key card/door fob (if applicable)		
18	Enter patient details on • White board • System one		
19	For doctors: complete • Medication chart • Overview assessment. • Complete VTE • Review DNR status		
20	Therapists and nurses : Complete Observations Develop initial plan of care		
21	If the patient lacks capacity to consent to their admission care and treatment and are under constant supervision and control and are not free to leave the ward (Cheshire West supreme court ruling "Acid Test") consider applying the Deprivation of Liberty Safeguards (DoLS)		

APPENDIX 7

OPAC Physical Health Wards
Discharge Checklist

For use in preparation for and during patient admission
Individual wards may add tasks as additional explanatory notes of guidance to this list.

NO.	Action	Tick if *completed* or N/A	Signature of admitting Nurse
1	MDT review/ pre-discharge meeting with • Consultant/ GP • Social worker • Carer/ relative (s) with patient consent		
2	For doctors: Complete discharge summary This must include • Any known physical/ mental health diagnosis/conditions • Discharge medication • Monitoring requirements of the above.		
3	<u>Risk to driving ability</u> • Identify any risk (s) to driving ability • Inform patient and/or relative/carers of any risk(s) from medication of diagnosis		
4	Pressure areas checked on discharge and documented		
5	<u>Care planning</u> • Update relevant care plan to reflect discharge plans • Update relevant care plans to reflect care needs		
6	Ensure section 5 on social services form is completed if relevant.		
7	Ensure ongoing referrals are completed.		
8	<u>Carers/relatives</u> • Carer/relatives informed of discharge plans, with patient consent. • Keys available • Food available		
9	<u>Medication</u> • TTO medication received on ward and given to patient • Medication leaflets given to patient/carer		
10	Mental Capacity Act/ DoLS assessments for patient who lack capacity – actions completed This would read better as: If patient subject to MCA and DoLs update team re patients discharge (Inform MH Law Office)		

NO.	Action	Tick if *completed* or N/A	Signature of admitting Nurse
11	Personal belongings and valuables returned to patient		
12	Date discharge letter sent to GP (must be within 7 days of discharge)		
13	Last entry made in notes inclusive of time of discharge		
14	Discharge recorded in relevant electronic patient record system (S1 or hand held document.)		
15	If this patient is known to SALT- SALT advice on ward sent home with patient If known to SALT- inform SALT of discharge		

APPENDIX 8

Community midwife:
On-call midwife:

No baby movement?
Vaginal bleeding?

On-call midwife!

Care of the pregnant patient

On admission:

☐ Ensure pregnancy is confirmed (midwife or blood test).
☐ Has patient felt baby move in last 24 hours? – If not call on call midwife.
☐ Ensure patient has a community midwifery team and referral to obstetric consultant led care.
☐ Read electronic pregnancy notes and document particulars in care plan and notes.
☐ Record specific risks identified by community midwifery team in notes.
☐ Urinalysis; group bloods and regular admission bloods.
☐ Choose room carefully – consider dignity, close to nurses etc..
☐ Consider level of observations and document rationale; start MEOWS chart.
☐ Request previous pregnancy summaries from the obstetric service if applicable.
☐ Contact PMVA team to inform a physical intervention management plan and document clearly.
☐ Record nature and dates of all upcoming appointments/investigations in notes and ward diary.

<u>At 27 weeks gestation:</u>

☐ Devise a *management plan* (patient preferences, transport arrangements). Have an *emergency plan*, and a plan if *on leave* (also inform community and on-call midwife when patient is on leave).

<u>At 30 weeks gestation:</u>

Consider transfer to perinatal mother and baby unit. Referral is usually consultant to consultant.

People to inform (ensure patient is aware of information sharing with these professionals):

☐ Trust perinatal consultant
……
☐ Community midwifery team/obstetric consultant
……
☐ Health visitor (from 20 weeks)
……
☐ Mental health midwife at maternity hospital
……
☐ Named midwife for safeguarding
……
☐ Trust perinatal nurse
……
☐ Social care and safeguarding team
……
☐ Pharmacy (to inform prescribing)
……

Once all professionals have been involved, consider inviting relevant parties to a <u>care planning meeting</u>

‘Think Family’ Keeping Children Safe Assessment Tool

a) Does the service user live in a household where there are children? Check Records

☐ Yes ☐ No if no go to question b)

Please specify relationship :

Where there are children in the household please specify their age if known:

Name of Child	Date of Birth	Gender

b) Does the Service User have contact with children (not living in the same household) from previous relationships?

Yes ☐ No ☐ if no go to question c)

If yes, please specify:

If no and there are children from a previous relationship, is it likely that the contact will be resumed;

c) Does the service user have significant contact with other children? For example, children within extended family circumstances or children outside the family relationship?

Yes ☐ No ☐

If yes please specify;

If no to all the above questions then no further action is needed with the form. Save copy in patient notes

Family and Environmental Factors

Does the Service User experience any family and environmental difficulties that could impact on their ability to care for children? Yes ☐ No ☐

Please use this space to support your assessment outcome. Possible factors: Family Functioning, Wider Family and Relationships, Housing, Employment, Income/Financial Difficulties, Social Integration, Access to Community Resources

Parenting Capacity

Consider the outcomes of the Adult Assessment. Can the Service User demonstrate their ability to care for Children or do they require any additional support with parenting?

Yes ☐ No ☐

Please use this space to support your assessment outcome. Indicators: Dependency of Child upon Adult (consider age factors), Ability to provide Basic Care, Ensuring the Safety, Emotional Warmth, Stimulation, Guidance and Boundaries and Stability

Child Developmental Needs

Does the information gathered so far suggest that there could be identified difficulties with the child's developmental needs? Yes ☐ No ☐

Please use this space to support your assessment outcome. Indicators: Potential Poor Health Outcomes, Lack of Education, Emotional and Behavioural Development, Identity, Family and Social Relationships, Social Presentation, Self Care Skills

Domestic Abuse

Are there any factors of domestic abuse impacting on any known children? Yes ☐ No ☐

Please use this space to support your assessment outcome. Document what you know.

Substance Misuse

Have any concerns been identified in relation to substance misuse? For example, drug and alcohol use that may impact on daily functioning, offending behaviour, the care and wellbeing of children. Is the drug use by the parent: Experimental? Recreational? Chaotic? Dependent?

Yes ☐ No ☐

Please use this space to support your assessment outcome. Indicators: Impact on social, physiological, psychological, and economical factors such as poor mental and physical health, domestic abuse, criminal activity and associated peers

Mental Health, Delusional Ideations and Suicide Planning

Does the risk assessment profile indicate delusional beliefs involving children?

Yes ☐ No ☐

Does the risk assessment profile (or any additional risk assessment tools used) indicate suicidal ideation and or a suicide plan involving children?

Yes ☐ No ☐

Are there any other mental health concerns which may impact on the service user's ability to care for children?

Yes ☐ No ☐

Please use this space to support your assessment outcome, taking into account what you know from other risk assessments.

Current Risk/Need Status score =

Analysis =

Action =

The outcomes of the Keeping Children Safe Assessment will help you to summarise and inform your decision as to whether additional support and services is required. It should also clearly explain the identified risks. The recommendations and actions of the professional completing the Keeping Children Safe Assessment Tool should be determined against the risk/need ratings below[5]. This will assist in identifying the most appropriate referral pathway. In developing this guidance the following outcomes have been determined to identify risks/need:

Current Risk/Need Status

0 = No Apparent Risk/need. No history or warning signs indicative of risk to children and no apparent additional needs.

Outcome: No Further Action Required

1 = Low Apparent Risk/need. No current behaviour indicative of risk to children but person's history and/or warning signs indicate the possible presence of risk and additional needs for the children. Necessary levels of screening/vigilance covered by standard current adult support/care plan and ongoing review arrangements. Advice can be sought from the trust Safeguarding Children Team, and where addition needs are apparent a referral may be appropriate.

[5] The numeric score is a simple indicator e.g. Zero (0) is a very low or nil concern, whereas a greater number is an indication of a higher level of concern.

Outcome: Support within Adult Services with relevant monitoring and identification of additional needs with appropriate information sharing with consent and referral if required to Early Help Assessment.

2 = Significant risk/needs. Person's history and current presentation indicate the potential of risk to children or the need for additional support and this is considered to be a significant issue. Additional Support should be explored to minimise any risks.

Where **Significant Risk/need** a telephone conversation with Children's Social Care should take place to determine appropriate interventions and course of action to prevent risk escalating and meet additional needs through team around the family. A copy of the Keeping Children Safe assessment Tool should be shared.

Outcome: Advice should be sought from the Safeguarding Children Team or via Children's Social Care to determine appropriate course of action. Consider discussion with CPFT safeguarding children team 01733 777961

3 = Serious Apparent Risk. Circumstances are such that potential risks to children are apparent and referral to Children's Social Care is required.

Where **Serious Apparent Risk** is determined an initial telephone consultation with Children's Social Care should take place and any referral documentation should be completed. The Keeping Children Safe Assessment tool should be shared with the team and the appropriate course of action determined

Outcome: Contact Children's Social Care and if appropriate support referral with the Keeping Children Safe Assessment.

4 = Serious and imminent risk. The person's history and presentation indicate high need for child protection and the organisations child protection procedures should be implemented. This will result in a referral to children's social care – as a 'child in need' or 'child protection'.

Where **Serious Imminent Risk** is determined. **Immediate action required.**

An initial telephone consultation with the Children's Social Care should take place and any referral documentation should be completed requiring services to follow their own child protection and child in need procedures. The Keeping Children Safe Assessment tool should be shared with the team to support referral and the appropriate course of action determined.

Outcome: Contact Referral and Assessment Team as high priority and support referral with this Keeping Children Safe Assessment.

MAKING A REFERRAL

IF YOU THINK THAT A CHILD OR YOUNG PERSON IS AT IMMEDIATE RISK OF SERIOUS HARM CALL THE POLICE (999) OR

CAMBRIDGESHIRE
Multi-Agency Safeguarding Hub
Professionals Number: **0345 045 1362** (Mon – Thurs) 8am – 5:30pm; (Friday) 8am – 4:30pm
Emergency Duty Team (Out of Hours) **01733 234724.**
MASH.C&F@cambridgeshire.gcsx.gov.uk

PETERBOROUGH
Telephone**: 01733 864170** (Mon – Fri 9am to 5pm).
Emergency Duty Team (Out of Hours) **01733 234724.**
PDCSC@peterborough.gcsx.gov.uk