Tees, Esk and Wear Valleys
NHS Foundation Trust

Admission, Transfer and Discharge Policy

CLIN-0012-v7.5

Status: Ratified
Document type: Policy

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1 Why we need this document

The admission, transfer and discharge framework is a critical function of the Trust in delivering a person-centred approach to care.

It is also a critical period in the life of the service user for whom it may be the only time they will have contact with our services.

We recognise and emphasise the importance of effective multi-disciplinary and inter-agency collaboration in the admission, transition and discharge processes. We aim for effective communication and involvement through the development of sustainable partnerships and collaboration between Trust staff and our service users, their families, carers, significant others and other involved professionals.

We are embedding the recovery approach and person-centred approaches to caring which are essential to supporting a positive service user experience and outcome. This aims to support and smooth transitions from hospital and residential settings to the community and vice versa, promoting seamless care and helping people to live as independently as possible.

1.1 Purpose

The purpose of this document is to:

- Describe the minimum standards of practice to be followed to support service users through their admission to hospital or residential unit, any transitions/transfers between hospital services, and subsequent discharge to and from the inpatient or residential unit;
- Ensure that it is the agreed needs of the service user which determine the service most appropriate to coordinate their care, and **not** age or diagnosis.
- Set out the overarching principles and standards to support local protocols

The detailed implementation of the principles and standards within this framework must be incorporated in each ward or team's local clinical operational policy.

1.2 Objectives

The objective of this document is to provide a framework that:

- Directly informs practice described in a ward or team's operational policies
- Supports the delivery of meaningful admission to a person-centred service within a complete system of care, including the wellbeing and social inclusion of the service users and their carers/family;
- Supports the provision of accessible information to service users and/or their carers/families
- Begins planning for successful discharge at the point of admission
- Ensures that users of the service are:
    - Admitted to the service in a respectful, professional and courteous manner.
    - Given appropriate information about their treatment and the care they will receive from the service
    - Fully involved in the process and able to make informed choices about their care, wherever possible

- Treated fairly, equally and have their diversity respected and their needs met throughout their care
- Discharged from the service with support as deemed appropriate, and within mandatory and statutory frameworks, such as Care Programme Approach and Section 117 of the Mental Health Act 1983.

2 Scope

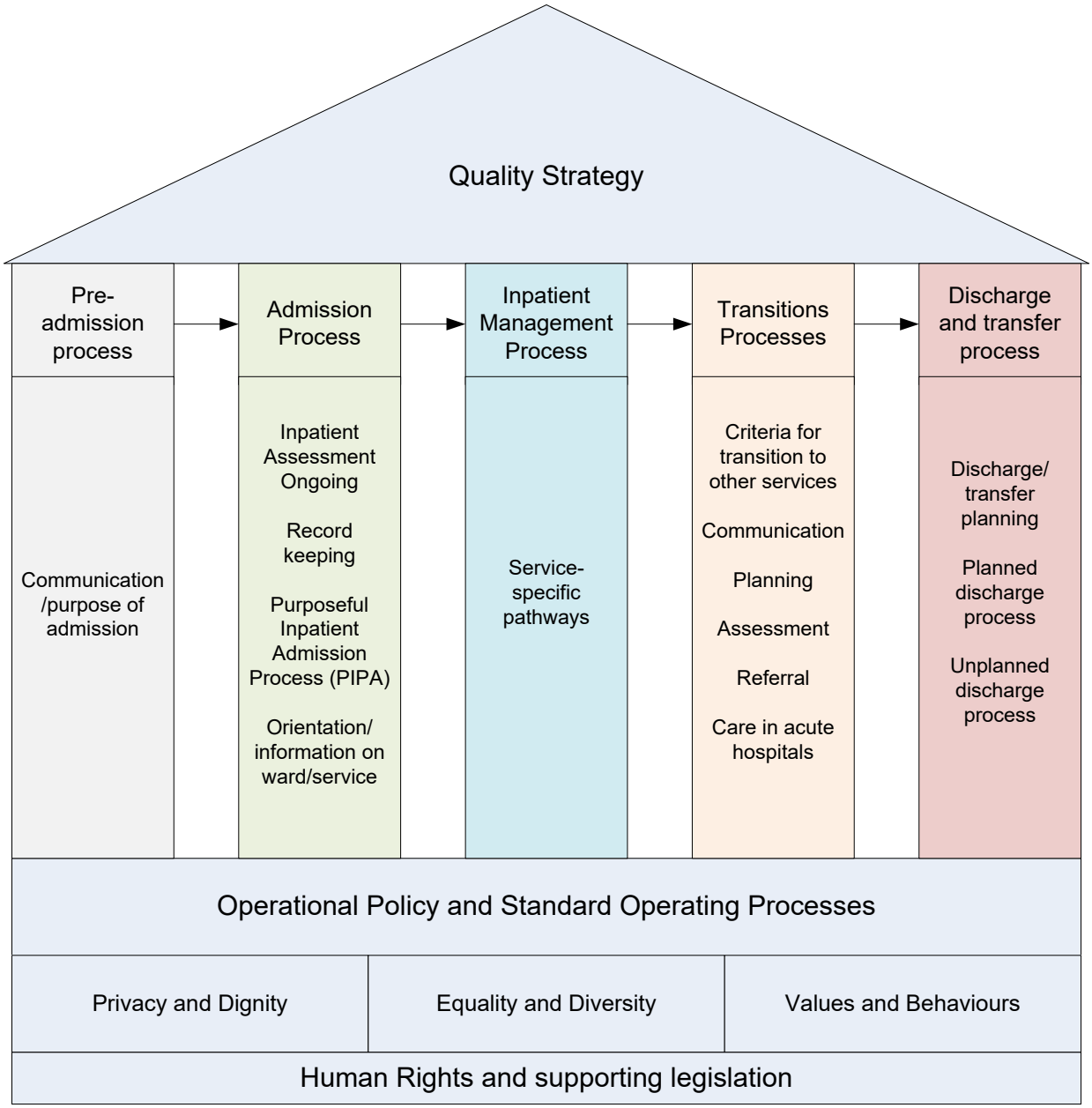
2.1 Who this document applies to

- All employees of the Trust, including temporary and bank staff, locums, contractors and volunteers.

2.2 Roles and responsibilities

Role	Responsibility
Care Co-ordinator (see also CPA Policy)	**On admission to hospital, the Care Co-ordinator maintains the lead role.** • Leads on discharge planning. • Ensures that all required care documents are completed • Continuously reviews the service user's cluster throughout their journey to reflect any change in their presentation or care package and to adjust any clustering as required. Where the service user remains in hospital for a protracted spell it may be appropriate for a member of the inpatient team to take on the Care Co-ordinator role. The team must agree this transfer of responsibility in line with local commissioning arrangements. If the Care Co-ordinator is not available any point in this process, the appropriate duty worker must take over the duties of the care coordinator until they return
Ward team	Ensure the Care Co-ordinator, family/carer and other staff members currently open as associated people are aware of the admission Ensure all necessary admission procedures are completed Ensure the Care Co-ordinator is invited to all review meetings
Consultant or RC or their nominated deputy	Must be involved in all stages of the inpatient episode from formulation meeting to discharge.

2.3 The Admission, Transitions and Discharge 'House'



- The concept of the admission, transitions and discharge house has foundations that are based on the Trust's commitment to Human Rights, ethical and legal practices e.g. privacy and dignity, equality and diversity, safeguarding, patient safety, information governance, mental health act, mental capacity act and deprivation of liberty safeguards and the Trust's values and behaviours.
- These foundations underpin the operational policies in place across the various services which, amongst other things, specify criteria for admission, transition and discharge.
- Services have in place standard work and processes to manage the process flow from pre-admission through to discharge/transfer.
- These processes all sit under the roof of Quality Strategy which sets the vision and direction for the development and improvement of the quality care delivered by the Trust.

3 Admission

At the point of admission to our hospital or residential unit, many service users will experience the Trust and in some cases mental health services for the first time.

Positive first impressions can make a real difference. Service users must feel that they are entering a compassionate, safe and respectful environment and we must always respect the human rights, diversity and the needs of service users throughout their care.

You must take into account that a service user may not fully understand information that is given to them. You must check that they understand, and, if they agree, you must also involve family, carers, advocates, or anyone else the service user wishes to be informed in line with relevant legislation.

Within our hospital inpatient areas, we have adopted the principles of 'Purposeful Inpatient Admission Process' (PIPA). Please see Appendix 2 for detail.

All service users admitted to hospital will be supported by CPA and will require an identified care coordinator if one does not already exist. Please refer to the Trust's CPA policy.

3.1 Pre-admission

All admissions should follow national and local operational policies that meet this framework and consider capacity, consent and appropriateness of the admission.

When considering the most appropriate setting according to the needs of the service user, the least restrictive care option must always be considered first.

When planned admissions take place ward information should be provided to service users before the point of admission. Easy read information must be available for those service users who require this.

3.1.1 Adult admissions

Crisis or Community Access teams will assess all adult admissions to acute inpatient facilities (with defined exceptions – see below).

Admissions must not be made to Adult services without a Crisis Team gatekeeping assessment.

Exceptions to the above are:

- planned admissions for psychiatric care from specialist units
- internal transfers of service users between wards in a trust and transfers from other trusts
- service users recalled on Community Treatment Orders or
- service users on leave under Section 17 of the Mental Health Act 1983.

(Ref: Monitor Risk Assessment Framework 2015)

Before admission, the Crisis Team or CMHT must, in the role of Initial Assessor, make sure that the service user understands the conditions of admission as far as possible. If you have any doubts as to their understanding, refer to appropriate legislation.

3.1.2 CAMHS admissions

A multi-disciplinary team pre-admission assessment and appointment will be offered to the young person and family, taking into account the urgency of the referral. This will usually be one appointment; however occasionally, a second session may be helpful.

⚠ The least restrictive option must always be considered first. This might include more intensive support from CAMHS service or input from Local Authority in the form of a Child in Need assessment

3.1.3 MHSOP admissions and age appropriate services

All services should be available to people on the basis of need, not age. Please refer to Appendix 3: Managing age discrimination for guidance.

3.1.4 Admission of people with a Learning Disability

All services should be available on the basis of need, not intellectual ability.

3.1.5 Forensic admissions

Referrals usually come through NHS England case management arrangements, Prison and consultants within adult acute mental health services.

A multi-disciplinary team, pre-admission assessment will be arranged within 5 days for emergencies and 21 days for routine. This will act as a gate-keeping assessment to determine level of security ensuring least restrictive practice and suitability for service. This will usually be one appointment; decision for access depending on urgency will usually be within 5 working days.

3.2 Out of locality admissions and managing local beds

⚠ Every effort must be made for the service user to remain in their chosen locality. It is the responsibility of joint locality bed management to meet the needs of service users in the most appropriate way.

3.2.1 Admitting Trust service users within Trust but out of locality

Sometimes a service user has to be admitted to an out of locality bed. Wards **do not** have the right to refuse to take an out of locality admission **unless** it is the last bed available in your locality, **and** there are other beds available in the Trust that are nearer or more appropriate for the service user.

3.2.2 Admitting service users from outside the Trust

Empty beds on the Psychiatric Intensive Care Units (PICU) should not be included when determining whether an admission can be made.

Admission	Hospital	Conditions
AMH Male or Female "Out of Trust" admission	Harrogate Northallerton Scarborough Sandwell Park Lanchester Road	There must be 2 free gender-specific beds within that unit (excluding leave beds) and at least 1 other free gender specific bed within the same locality (not including PICU)
AMH Male or Female "Out	Roseberry Park Hospital	There must be at least 3 empty gender specific beds available within the AMH units (not including

of Trust" admission		PICU)
AMH beds are not gender specific	West Park Hospital	There must be at least 3 empty beds before an out of Trust service user is admitted These beds must not include PICU or MoD beds

⚠ A service user from outside the Trust's area who is being seen by a Trust clinician in one of our Acute hospitals **can** be treated as a Trust area patient **if** they require urgent admission **and** it is not possible to secure them a bed in their home area in a timely manner.

3.2.3 Admitting service users outside the Trust

Service users should only be admitted to hospitals outside the Trust as a very last resort and the decision to admit is subject to Director's agreement.

3.3 At the point of admission

Service users and their carers/families are at their most vulnerable upon admission to hospital and it is essential that they feel confident in our abilities to care for them or their loved ones.

We should always endeavour to provide compassionate, safe, attentive and personalised service to service users and their carers/families from the moment they arrive in our care. The Trust expects all staff, including bank staff, agency workers, students and volunteers to demonstrate the same level of respect you would want for yourself or someone you love and care for.

At the point of admission, all service users must be allocated an identified member of staff to lead on care who makes themselves known to the inpatient and carer/family.

⚠ Each service must provide the service user with appropriate verbal and written information explaining what they can expect during their stay. Services should contact the Communications Department for advice on standard patient information. Easy read information must be available for service users who require this.

⚠ Each service should have its own admission checklist within its operational policy based on the PIPA principles.

⚠ If the service user is not known to the CMHT, ward nurse must allocate self as Care Coordinator **until CMHT has allocated one**. They should contact the relevant team manager for attendance at formulation meeting or allocation.

- On admission, the care coordinator must communicate to the ward:
- The reason for admission
- Any anticipated risks
- Expected outcome
- Expected length of stay
- Capacity (this should also be recorded in the care documents)
- Any other pertinent information about the admission or service user.

The Care Coordinator must also contact the service user's GP practice to advise of admission as soon as it practicable. If the service user does not have a current Care Coordinator ward staff should take on this responsibility.

Any paper records must be transferred to the ward and/or retrieved from archive in a timely manner

The Care Coordinator should also identify any carers and establish whether the service user wishes them to be notified of the admission.

3.4 After admission

Every inpatient must have an identified member of staff to lead on care **at all times** who makes themselves known to the service user and carer/family.

It is important to ensure that the service user is orientated to their new environment and assessed as soon as possible after admission, and that planning begins to work towards a successful discharge. You should consider initiating discharge documents at this point.

⚠ A 72 hour CPA Review / Formulation meeting must be arranged immediately following the 24 report out on admission (this does not apply to rehabilitation and currently some Learning Disability inpatient areas).

Principles

- Service users must be orientated to the ward environment and introduced to their named nurse (if needed) and care staff on duty
- The service user must be given a copy of the privacy notice and we should explain to them how we use their personal information. A case note entry must be made to reflect the fact that the conversation has taken place and any refusal to share information with specific individuals or organisations must be noted. Easy read information must be available for those service users who require this.
- The ward staff must maintain communication with the Care Co-ordinator about progress and steps towards discharge, including attendance at relevant formulation or review meetings as per the CPA Policy. Review electronic and paper care record (known patients)
- Comprehensive nursing assessments must be completed, including updating of clinical risk assessment, intervention plan, ensuring prescribed medication is available (especially for admissions out of hours) and relevant care documents in line with local operational policy.
- Any other relevant agencies or disciplines must be notified of the admission.
- Work should begin with care co-ordinator and MDT to consider discharge planning and aftercare arrangements as soon as possible.
- Consider facilitating referral to advocacy service if appropriate

Duty /Ward doctor

Service users must be assessed and physical examination must be completed within 24 hours. This assessment includes allergy status and prescribing of medication. Information about medication prescribed by the GP can be accessed via the Summary Care Record.

Pharmacist

Medicines reconciliation must be completed at the earliest opportunity following admission – (usually within 48 hours, but dependent on pharmacy service available). Advice from the on-call pharmacist can be sought out of hours

⚠ Ask whether the service user is a veteran, and if so, subject to their permission, notify the British Legion.

3.5 Patients detained under the Mental Health Act (1983)

All service users detained under the Mental Health Act 1983 are entitled to an Independent Mental Health Advocate (IMHA).

- For people detained on a section of the Mental Health Act 1983, this will include the relevant rights leaflet, and information about the local IMHA provision. A formal entry must be made in the service user's clinical notes including the level of comprehension when their rights were given. This is in order that the process can be repeated if the service user had not been capable of understanding when the first notification was made. (Click here to access the Trust's S132 procedure)
- If the service user has been transferred from another hospital outside the Trust, then the escort should not be allowed to leave until all the Mental Health Act 1983 documentation has been certified in order and the formal Section 19 transfer has been completed.
- If the service user is to be admitted under a Section of the Mental Health Act (1983), the MHA office must be informed of the pending arrival. The process for this must be detailed in the ward's operational policy.

3.6 Unplanned Admission of Children

There must be effective channels of communication to inform care co-ordinators and General Practitioners of any unplanned attendance, admission and discharge of a child who has a Child Protection Plan, including Trust safeguarding children staff. Please refer to Trust Safeguarding Children Policy.

For emergency CAMHS admissions at weekends, acute adult beds are available for service users aged 16-18; please refer to the Policy on Young People admitted to Adult Inpatient Wards for details of approved beds.

4 During the episode of care

Inpatient stays must reflect the principles of Purposeful InPatient Admission (PIPA) processes please see Appendix 2) including regular MDT review, communication between all involved staff, purposeful intervention plans to support recovery and the ultimate aim of a successful discharge from inpatient services.

Regular MDT review meetings should be maintained with everyone involved in the service user's care including the Care Coordinator. These meetings should focus on

- Purposeful intervention plans to support recovery in a person centred manner
- Ensuring continued appropriateness of cluster
- Treatments required including medication review and referral to additional services
- Discharge planning

Medicines should be reviewed regularly by the Trust pharmacists.

4.1 Privacy and dignity

Privacy and dignity includes personal space, modesty and privacy in personal care. It includes confidentiality and the treatment of medical and personal information relating to an individual. Please refer to the Trust's Privacy and Dignity policy for detail.

The Trust expects that every person is given individualised care with the least restrictive interventions that meet their needs and enable our service users to maintain the maximum possible level of dignity, independence choice and control.

The Trust has zero tolerance against all forms of abuse including invasion of privacy.

4.1.1 Transgender

Information on meeting the needs of trans service users can be found in section 4.4 of the Privacy and Dignity Policy.

5 Child Visiting Policy

The Mental Health Act Code of Practice (2008) requires all hospitals that provide psychiatric care to develop detailed child visiting policies in consultation with local Social Services authorities. Please see the Trust's Child Visiting Policy for further details.

6 Transfer to other hospital services

The standard Trust GP discharge document can also be used as a summary for transfer outside the Trust.

- In response to the needs of individual service users and the service, the transfer process will be initiated following discussion and care plan review with the multi-disciplinary team members, service user and carers
- It is the responsibility of the care co-ordinator or lead professional to co-ordinate this and planning should involve all relevant members of the multi-disciplinary team and other services or providers of support.
- Any referral made to an external or internal service should clearly indicate the level of urgency.
- All transfers must take into consideration the medicines management needs of a patient.
- All transfers both within the Trust and externally will be in line with the CPA policy
- If transfer is to an acute hospital or vice versa, the Physical Health and Wellbeing Policy (Appendix 1) provides a physical healthcare assessment template that should be completed prior to a patient returning to our services. Consideration needs to be given to availability of specialist medication for Mental Health needs (e.g. clozapine). When patients return from an acute Trust the medicines reconciliation process must be undertaken to review / rewrite the prescription and administration Chart.
- Local Protocols will be adopted for each service area in accordance with operational policies. Appropriate departments, including Medical Records, the CPA department and the Mental Health Act Office must be notified as required.
- Consider providing appropriate information to GPs and involved agencies about a service user's transfer – the detail and method will need to be determined on a case by case basis
- If the service user is transferring to another TEWV service, their paper file must be transferred to that same team.
- Community based Care Coordinators and Lead Professionals must be made aware of all transfers to enable them to contribute to the process.

7 Transfer Summary - within the Trust

The following process does not apply within Forensic services

It is recognised that there may be times when a service user has to transfer from one ward to another. Good communication and documentation underpins effective transfer processes. A service user should only be transferred in response to their individual needs and the transfer process will be initiated following discussion and review with the multi-disciplinary team members, service user and carers

All transfers will be in line with the CPA policy. The transferring nurse will open a casenote and record a summary under each of the following headings. The accepting ward will review on arrival so they have a formal handover of PIPA. This summary does not replace the verbal the handover of the patient. ~~The standard Trust GP discharge document can also be used as a summary for transfer outside the Trust.~~

- Patient Name:
- Date and time of transfer:
- Named Nurse:
- Responsible Clinician:
- Reason for Transfer:
- MHA Status:
- MHA office informed (who informed and when if applicable):
- Agreed Purpose of Admission:
- Progress:
- Safeguarding issues or risks:
- Significant Physical Health Needs:
- Plan from Formulation (admission meeting in MHSOP):
- Medication on transfer and items issued to transferring ward:
- Medication transfer book process complete as per Appendix 3a/3b **Medicines Ordering storage security transporting and disposal.pdf**
- Family/carers informed:
- Patient property transfer (valuables):
- Suggestions and Outstanding Tasks:

A copy of the current visual control board should also be sent to the accepting ward highlighting completed and outstanding tasks.

8 Discharge from hospital

The discharge planning process will allow sufficient time for those involved to ensure that a smooth, safe and efficient transition from hospital to community or another facility is implemented.

The CPA Care Plan must be reviewed prior to discharge from hospital. Only in exceptional circumstances will a service user be discharged from hospital on Standard Care.

To complete	When	☑
Relevant referral forms	as soon as possible	
Pre-discharge risk assessment	Before discharge	
GP discharge letter	Before discharge	
Review clustering tool	Before discharge	
Follow up care plans	Within 7 days of discharge	
Care plan implementation review	Within 1 month of discharge	
Copy of GP letter shared with GP, patient and/or carer	On discharge Within 24 hours of discharge	
Follow up care plan for those requiring additional support	Within 48 hours	

Key findings from the 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report include:

- The first 3 months after discharge remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks.
- Suicide in the first 2 weeks post-discharge has been linked to admissions lasting less than 7 days and to adverse life events

Careful planning is always required whenever anyone is discharged from hospital. It is important to identify those who may require additional support in the first 48 hours of discharge from in-patient care to ensure that this is reviewed. Everyone should be seen within 7 days of discharge from hospital.

No service user should be discharged without the authority of the consultant psychiatrist, RC for detained patients responsible for that patient or his/her nominated deputy.

Community based staff including primary care should be involved in hospital discharge planning from an early stage, and be kept informed of progress. Care planning should be timetabled around the needs of the service user and their carer with the right of advocacy.

If a service user is clinically fit to be discharged but cannot due to other factors as per the Delayed Transfers of Care guidance; please refer to the guidance for further action.

8.1 Planned Discharge

Planning for discharge should commence at the earliest opportunity. Evidence shows that planned discharge is safest, and the preferred method is a collaborative approach between the service, the service user and the wider community.

The following is a list of principles for a successful planned discharge, but this is not exhaustive and wards/units should ensure these are incorporated into local protocol.

8.1.1 Pre discharge

Principles
• Facilitates discharge process in collaboration with the care co-ordinator and the MDT and relevant others. • The discharge process for the service will be followed together with the Care Programme Approach.
• A care plan review should be held before discharge at which the service user, relatives, carers, relevant others and multi-disciplinary team members will discuss and review the discharge needs. • Medicines management needs post discharge must be considered, this will include ongoing supply of medication e.g. arrangements for 'red' hospital only medicines e.g. clozapine and re-instating or arranging supply of controlled drugs for substance misuse – please refer to Prescribing and initiation of treatment document - supporting adherence e.g. compliance aids and managing risk by reducing supply of medication at discharge from Trust standard of 7 days. Some areas of the Trust are currently working to a 14 day standard. • A discharge plan will be formulated which includes an assessment of risk and risk management plan including consideration of positive and therapeutic risk taking to support recovery. • Service users' medication information needs on discharge should be considered. • Carers' needs will be taken into account and carers' assessment will be offered and the outcome documented.
• Ensure safe transfer of care by providing comprehensive information to services in the community, including GPs. • The discharge letter care document should be completed at this point according to the Trust's guidance.

8.1.2 On discharge

Principles
• Care plans must be reviewed on discharge from hospital; the written agreed care plan will identify the care co-ordinator and set out the care and ongoing recovery interventions to be provided including identifying potential relapse triggers to reduce the possibility of readmission and any physical healthcare needs. • Service users, carers and relevant others will be informed of a named contact including a telephone number as appropriate, in the event of experiencing any difficulties following discharge.

• Give the service user a written copy of their agreed after care plan:
  ○ setting out the care and ongoing recovery interventions to be provided,
  ○ identifying the Care Co-ordinator, and

○ specifying what actions are to be taken in a crisis. ○ Easy read information must be available for those service users who require this.
• Ensure the service user receives all the medication required at discharge and knows the arrangements in place for getting further supplies. If they are to be looking after their medication themselves, make sure service user/carer/family knows how to take the medication safely.
• GP discharge letter must be sent within 24 hours of discharge from inpatient services to the service user's GP and other involved agencies. A copy should be given to the service user and to their carer(s) where appropriate.
• The service user's paper notes must follow them to their new team (if within TEWV)
• Ensure continuity of therapeutic interventions begun in the inpatient environment if appropriate

8.1.3 Follow-up

What
All service users who have had a period of TEWV inpatient admission, excepting respite care, must include follow up within 7 days (best practice is within 3 days) of hospital discharge by the person identified on the care plan.– please refer to CPA policy .
It is important to continue therapeutic interventions, learning from admissions to prevent relapse as far as possible.

8.2 Unplanned Discharge / Discharge against Medical Advice

If an informal patient requests discharge against medical advice, the consultant psychiatrist or their deputy will assess the patient.

- Discuss the request with the patient and review their risk documents. Consider using Mental Health Act powers if appropriate.
- Consider facilitating early discharge with Crisis Team
- Following discussion with the Multi-disciplinary team, the consultant psychiatrist may decide to implement the discharge planning process if possible, considering the availability of resources at short notice. This must be fully documented in the PARIS clinical record.
- Advise the service user's relatives/carer and relevant others of the decision to leave, where appropriate, as soon as possible
- Complete GP discharge documents within 24 hours of discharge and inform the service user's General Practitioner and Care Coordinator of the service user's decision to leave against medical advice as soon as possible
- The appropriate Care Co-ordinator/ professionals / carers / agencies involved will be informed as above and a CPA Care Plan implemented as necessary and as soon as possible in the absence of the service user/carer.

In the event of a service user being absent without leave, procedures will be followed as stipulated in the Missing Persons Procedure.

8.3 Delayed Discharge from TEWV inpatient services

Ref: Delayed transfers of care in the non-acute and mental health sector protocol.

If a case continues to be complex and progress towards discharge is unsatisfactory, you should initiate the "Stop the Line" process to get consensus on a way forward.

9 Record keeping

All events will be fully documented and recorded in PARIS.

10 Continuous improvement

This policy will be regularly reviewed to ensure that learning is incorporated from SUI action plans as appropriate. Local protocols and processes should also be regularly reviewed to take into account lessons learned and shared throughout the Trust.

11 How this document will be implemented

- Directors, General Managers and Heads of Service / Service Managers are responsible for ensuring that this policy is effectively implemented.
- This policy will be available on the Trust's intranet and website.
- Routine training or guidance on this policy will be provided to relevant staff during local induction and preceptorship and included in CPA update training.

12 How this document will be audited

Routine audit/monitoring of compliance with this policy will be part of normal operational management responsibilities. Compliance with the discharge element of this policy will be monitored by the annual Care Coordination / CPA audit and via the routine Service User Hospital Discharge Survey.

13 References

This policy should be read in conjunction with the following Trust policies and procedures:

- Care Programme Approach policy
- Missing Persons procedure
- Child Visiting policy
- The Purposeful Inpatient Admission Process (PIPA)
- Delayed transfers of care guidance
- Local operational policies and standard operating procedures
- Guidance notes for Patient monies and property
- Medicines Overarching Framework

14 Definitions

Term	Definition
CPA	Care Programme Approach
PIPA	Purposeful InPatient Admission – this is a process to be followed to ensure that all inpatient admissions incorporate purposeful intervention plans to support recovery and ultimately a successful discharge from IP
MDT	Multi-disciplinary team
24 hour report out	A meeting which must take place every 24 hours to discuss patient progress. 10 minutes are allocated for new admissions to agree initial assessment and plans for treatment and discharge. Attendees must include Community representative, Ward nurse, specialist nurse, Admin practitioner, Psychology, OT, Pharmacy, SHO and consultant
72 hour CPA Review/ Formulation meeting	A meeting which must take place within 72 hours of a service user's admission to agree Formulation / CPA documentation and outcome plans. Attendees must include Care coordinator, Ward nurse, specialist nurse practitioner, OT, psychologist, Crisis or community team, SHO and consultant
Hospital	Any TEWV setting where service users can stay overnight. This includes inpatient and residential units.
Transfer	The movement of a service user between hospital services
Admission	The arrival of a service user into a hospital unit
Discharge	The point where a service user leaves hospital services.
Carer/Family	Includes significant others and nominated people who have responsibility for the welfare of a service user
Ward team	The multidisciplinary team delivering the inpatient care in that ward or unit.

15 Appendices

15.1 Appendix 1 – FREDA Human Rights principles

Fairness is…
To keep an open mind, not make decisions or offer choices without considering everyone's point of view.

Respect is…
To be polite
To listen
To value yourself and other people.

Equality is…
Not treating someone worse or making them feel less important or less valuable because of their disability or the colour of their skin, who they love, what they believe in or how old they are etc.

Dignity is…
To respect someone's privacy and to be clean and comfortable
To listen to someone about how they would like to be treated.

Autonomy is…
To respect people's wishes and choices, whenever possible
To allow people to make choices on their own or with support if they need it
To help people to be independent, to live full healthy lives within their community by providing services that help them to recover or to manage their illness.

15.2 Appendix 2 – PIPA Principles

The Tees Esk and Wear valleys NHS Trust (TEWV) is committed to development of a model of inpatient provision that provides an effective, safe and therapeutic user-focused inpatient service.
The components of PIPA (Purposeful InPatient Admission) are:

A reason for admission
A development of a clear formulation
A clear plan as to goals to be achieved to facilitate discharge when clinically appropriate

Formulation meeting plays a pivotal role in purposeful inpatient admission. Formulations attempt to make sense of the persons experience and problems within a psychological framework and can be carried out at different levels, from a complex cognitive formulation, to a simplistic Thoughts–Feelings-Behavioural understanding. A plan of treatment based on formulation is discussed with the patient, their carer and referrer with the patients' permission and will be recorded on PARIS.

15.3 Appendix 3: Managing age discrimination

15.3.1 Meeting the needs of Older Adults with Mental Health Problems

The Royal College of Psychiatrists position paper on age discrimination, endorsed by the Royal College of GPs, the RCN, the British Geriatrics Society, Age UK and Help the Aged suggest a list of needs that should be the basis for access to specialist older people's services (Royal College of Psychiatrists, 2009a p.4):

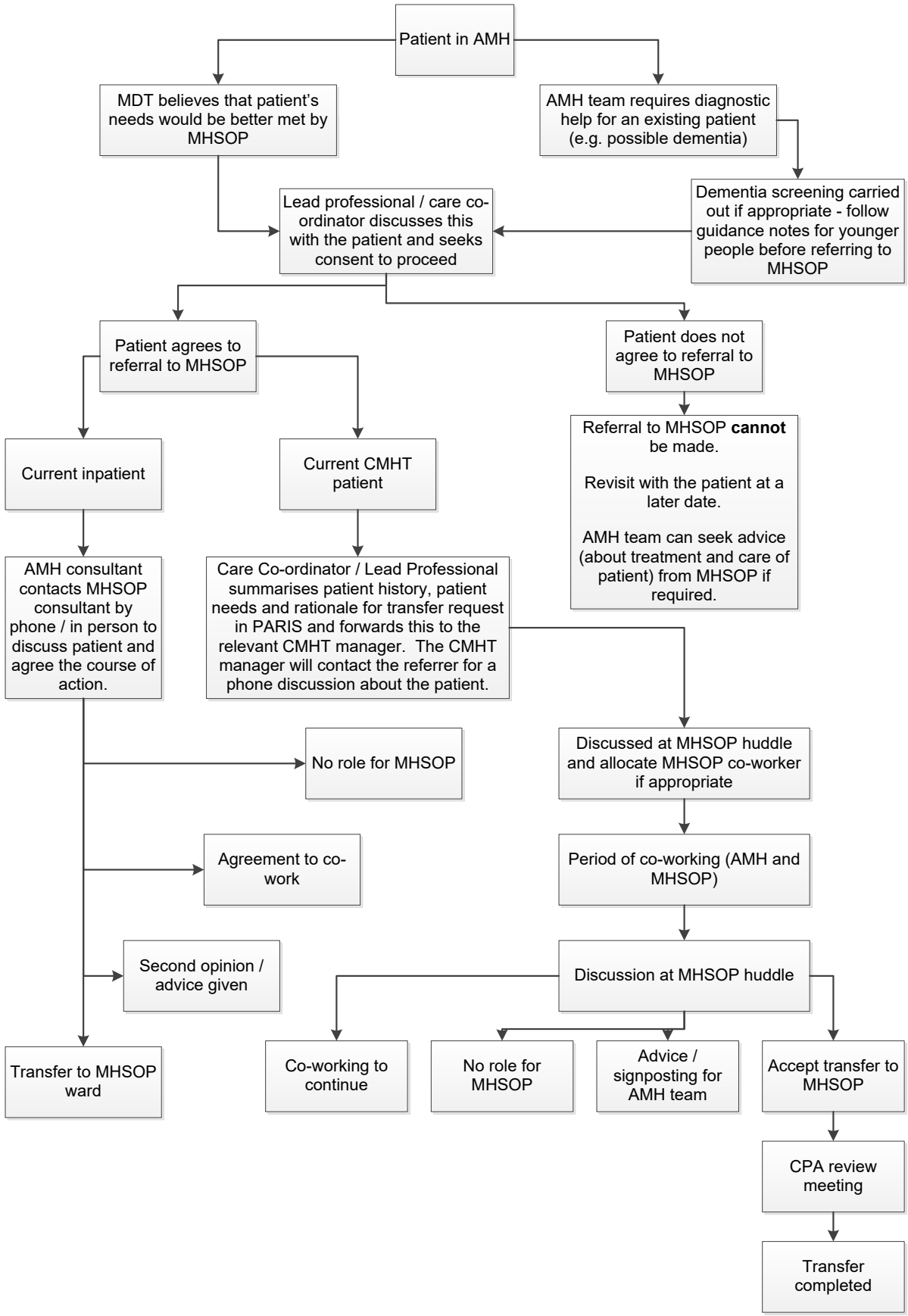
- Mental health problems developing in later life, as these are often of a different nature and require a different approach to treatment than those occurring earlier in life; this applies to a range of conditions including cognitive disorders, mood disorders and psychoses
- Multi-morbidity of both physical and mental health conditions
- Dementia
- Problems related to being at a later point in the life cycle, which include psychological and social difficulties and lifestyle
- Frailty
- Where other services required are more directed to the needs of older people, for example, particular types of social care needs or care homes

15.3.2 Conflict resolution

It is expected that appropriate transfer between specialist services is agreed based on clinical need at multi-disciplinary team level and with informed consent of the patient and/or carer and that effective communication and CPA processes will resolve any areas of conflict.

1. If **local resolution fails at team level**, the appropriate Locality Manager/ Modern Matron and ACD's will review the case.
2. If **locality resolution fails at this level** the appropriate Heads of Service and CDs/Senior CDs will review the case.
3. Patients and/or their carer have access to the Trust PALS and complaints procedures.
4. All outcomes should be based on good practice and the involvement of the patient and/or their carer.

15.4 Appendix 4 - Transfer guidelines from Adult Mental Health Services to MHSOP



15.5 Appendix 5 - Assessment of younger patients with cognitive symptoms – guidance notes

Updated August 2017

Please note ages mentioned are for guidance and are in keeping with commissioning arrangements. Also they reflect likelihood of having dementia diagnosis and are not intended to discriminate, but instead to point towards the most appropriate initial assessment for the patient.

The majority of those younger people referred, whether from primary or secondary care, do not have a dementia but a significant proportion have a functional illness. It potentially disadvantages those patients if seen by memory team first as those services have not been designed to manage large numbers of functionally ill younger patients.

If there is evidence of other symptoms (that potentially could cause cognitive symptoms) such as depression or anxiety then the initial assessment should be undertaken by Adult Mental Health Services.

If aetiology thought to be alcohol related, Adult Mental Health Services should undertake the initial assessment. Patients with a history of excess alcohol use may have multitude potential aetiologies (delirium, intoxication, sub-dural haematomae, Wernicke's encephalopathy (a medical emergency), Korsakoff's psychosis (which is a static injury). For alcohol related dementia the key to management is achieving abstinence and managing risk via supportive measures such as a care package.

In the very young (under 45 years of age), consideration should be given to making a neurology referral in the first instance. This is because very young patients are more likely to require other investigations such as lumbar puncture.

Younger people with static (non-progressive) cognitive impairment are not usually appropriate for transfer to MHSOP. This would include people with

- Korsakoff's, traumatic brain injury, static damage due to e.g. brain infection, hypoxia or neurotoxin.
- Acute onset large vessel stroke or brain haemorrhage.

Referrals from AMH to MHSOP should follow the flow chart. MHSOP consultants are also available to have case-based discussions with AMH colleagues prior to consideration of transfer.

Prior to referral of a younger person with suspected dementia it is expected that the following will usually have been completed:

- A PARIS entry detailing the nature of the symptoms and a description of their onset and progression
- MRI (or CT) head scan, (most younger patients will require MRI)
- bloods, (fbc, U&Es, LFTs, bone, B12, folate, thyroid, ESR, glucose, lipid profile and consider if thought to be at risk HIV and syphilis)
- EEG if relevant
- ACE-III (AMH have psychologists who are competent to do this)
- OT assessment
- ECG if there are cardiac symptoms or history
- If a patient's usual mental disorder is unstable, they should have treatment and symptoms optimised prior to referral (many will have improvement in their cognition).
- If referral is considered urgent, then consultant to consultant discussion (phone or in person) is necessary.

For both inpatients and outpatients, the patient should remain open to adult services up until such a time as determined appropriate by MHSOP team to take over as very few of these referrals conclude with a dementia diagnosis.

Dr Sarah Pearce
Consultant Old Age Psychiatrist

16 Document control

Date of approval:	28 August 2019	
Next review date:	31 October 2021	
This document replaces:	CLIN-0012-v7.4 Admission Transfer and Discharge Policy	
Lead:	Name	Title
	Simon Lancashire	Head of Service – Forensic Mental Health
Members of working party:	Name	Title
	Gillian Boycott	Project lead – KPO clinical pathways
	Alison Bullock	Trust Wide Professional Head of Occupational Therapy and Art Therapy
	Natalie Chung	Community LD Nurse
	Tracey Loynes	Equality and Diversity Officer
	Jane Leigh	GP Strategic Advisor
	Mick Norman	Advanced Nurse Practitioner (AMH)
	Ros Prior	Clinical Pharmacy Services Manager
	Mark Spencer	Modern Matron (AMH)
	Kevin Stubbings	Modern Matron (MHSOP)
	Donna Sweet	Service Development Manager (CAMHS)
	Sharon Tufnell	Service Development Manager (MHSOP)
	Stuart Tweddle	Ward manager (AMH and Sub. Misuse)
This document has been agreed and accepted by: (Director)	Name	Title
	Brent Kilmurray	Chief Operating Officer (up to v7.4)
	Ruth Hill	Chief Operating Officer (v7.5)
This document was approved by:	Name of committee/group	Date
	EMT	02 November 2016 (up to v7.4)
	SDG or AMH	16 May 2019
	SDG for MHSOP	May 2019
	SDG for LD	20 June 2019
This document was ratified by:	Name of committee/group	Date
	Executive Management team	28 August 2019 (v7.5)
An equality analysis was completed on this document on:	20 July 2015	

Version	Date	Amendment details	Status
6.1	March 2016	Section 4.1.1 added re the privacy and dignity of transgender service users Section 7 Discharge process amended to reflect key findings from the 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report	Withdrawn
7	November 2016	Section 3.1 Guidance added regarding planned admissions. Section 3.1.4 Pre admission time frame for none urgent cases corrected to 28 days. Sections 3.1, 3.3, 3.4 and 7.1.2 Requirement for easy read information to be given to those who require it identified. Section 3. Care Coordinator to advise GP practice of admission as soon as practicable and ward staff to take on this responsibility if no Care Coordinator allocated Section 6. Need for all Community Care Coordinators and Lead Professionals to be made aware of transfers to other hospital services identified. Section 7.1.1 Need for consideration of service users' medication information needs on discharge identified. Section 7.1.1 Principle added regarding ensuring safe transfer of care by providing comprehensive information to community services, including GPs.	Withdrawn
7.1	October 2017	Appendices 1 and 2 added	Withdrawn
7.2	March 2018	Minor amendment to wording in section 6	Withdrawn
7.3	June 2018	Appendix 4 – approved for Trust-wide use (no longer restricted to Durham and Darlington locality)	Withdrawn
7.4	September 2018	Title amended from Admission, Transfer and Discharge of service users within hospital and residential settings Footer amended from Admission, Transfer and Discharge Policy	Withdrawn
7.5	July 2019	Amended section 6 'Transfer to other hospital services' and added section 7 'Transfer Summary - within the Trust'	Published
7.5	Jan 2020	Review date extended from 02 Nov 2019 to 30 Apr 2020	Published
7.5	15 Apr 2020	Review date extended from 30 April 2020 to 30 October 2020	Published

7.5	22 Sept 2020	Review date extended by six months	Published
7.5	May 2021	Review date extended to 31 July 2021	Published
7.5	July 2021	Review date extended to 31 October 2021	Published