Leicestershire Partnership NHS Trust

Inpatient Discharge Policy

This policy describes the process for discharging patients or service users from the organisation's inpatient units.

Key Words:	Discharge hospital	
Version:	10	
Adopted by:	Quality Assurance Committee	
Date adopted:	18 June 2019	
Name of Author:	Claire Armitage, Lead Nurse, AMH and LD Services John Devapriam, Consultant Psychiatrist, AMH and LD Services	
Name of responsible committee:	Patient Safety Group	
Date issued for publication:	June 2019	
Review date:	November 2023	
Expiry date:	1 April 2024	
Target audience:	All clinicians engaged in the discharge of service users.	
Type of Policy	Clinical x	Non Clinical
Risk Management Standards if applicable:	Standard 4, Criterion 10: Discharge.	
State Relevant CQC Standards:	Regulation 12	

Contents

Version Control and Summary of Changes…………………………………...4

Equality Statement……………………………………………………………5

Due Regard……………………………………………………………….....5

Definitions and Abbreviations that Apply to this policy....……………………...6

1 Purpose ……………………………………………………….…………..7

2 Summary of Policy...7

3 Introduction 7

4 Duties within the Organisation 8

5 Discharge………………………………………………………………...10

6 Discharge Medication……………………………………………………11

7 Service Users who Refuse Discharge ……………………………………..11

8 Self Discharge ……………………………………………………………...11

9 Delayed Discharge ……………………………………………………...12

10 Training…………………………………………………………………...13

11 Monitoring Compliance and Effectiveness ……………………………...13

12 Links to Standards/Performance Indicators ……………………………......14

13 References and Associated Documentation…………………………..........14

Appendix 1 Discharge process from Adult Mental Health Inpatient Services, CAMHS and Older People's Mental Health Inpatient Services
- Early discharge and the role of the Crisis Team
- Standard operating procedure and flow charts for transfers between wards and to acute hospitals
- Unplanned self-discharge form

Appendix 2 Discharge process from CHS Community Hospitals
- Self-Discharge Checklist and form
- ICE inpatient discharge summary letter - instructions for completion

Appendix 3 Discharge process from Learning Disability Inpatient Services
- Discharge flow chart
- Discharge care plan

- Discharge letter
- Learning Disability Service Discharge Summary
- Discharge Summary from Short Breaks Homes

Appendix 4 MHSOP Delayed Transfer of Care flowchart

Appendix 5 Section 19 Transfer of detained patients flowchart

Appendix 6 Due Regard Assessment

Appendix 7 Policy training requirements

Appendix 8 NHS Constitution checklist

Appendix 9 Stakeholders and consultation

Appendix 10 Procedural Document Checklist

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	March 2012	Harmonisation of LCCHS Transfer and Discharge Policy for Adult Services, LCRCHS Discharge Policy for Adult Service users Leaving Hospital and LPT Inpatient user and Community Discharge and Admission Policy following Transformation of Community Services.
2	April 2014	Updated to incorporate NHSLA feedback and FYPC policy as well as CHS rebranding changes
3	May 2014	Final version
4	September 2015	First version of revised policy following consultation across the Trust. Section 9.2 amended to reflect SitRep and indicator guidance as part of the 2014/15 Quality Account internal audit actions. Addition of the following: • Early discharge from the ward and the role of the Crisis Resolution and Home Treatment Team Standard Operating Procedure for Transfers of Patients from and between Adult Mental Health Wards
5	November 2015	Second version of revised policy following consultation across the Trust. Addition of MHA flowchart – appendix 4
6	November 2015	Addition of: – CHS ICE inpatient discharge summary letter - instructions for completion – Learning Disability Service Discharge Summary – Discharge Summary from Short Breaks Homes
7	December 2015	Amendments made following discussion at the Clinical Effectiveness Group meeting of 10th December 2015
8	February 2016	Review of DTOC section to reflect the new Trust process that was introduced in December 2015 Changes to flow chart in appendix 3 Changes to section 4.5
9	April 2016	Further review of DTOC section
9A	August 2019	New flowchart added app:

For further information contact: The Clinical Lead for your service area.

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

The Trusts commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

This policy recognises that dignity and respect is an essential factor when staff are working within the requirements of the policy.

This is evidenced by various examples highlighted throughout this policy. For example, ensuring information is available to patients, services users, carers etc in an appropriate format such as alternative language, larger print to meet interpretation, translation and accessibility requirements. Other examples include, referral to the IMCA Service under the Mental Capacity Act for vulnerable patients who may lack capacity, referral to an advocate if a service user is feeling threatened, vulnerable or in some way disadvantaged. In addition, when a vulnerable service user wishes to self-discharge, consideration of the risks involved and available alternatives will be made in conjunction with the user, their carers (where appropriate) and their GP.

Unless it is clinically indicated, service users should not be transferred to another area or discharged after 21.00 hrs in order to reduce any impact on vulnerable, older, disabled patients, or impacting on carers availability, quality of life etc.

Definitions and Abbreviations that apply to this Policy

CAMHS	Child & Adolescent Mental Health Unit
CNLD	Community Nurse Learning Disabilities
Community Hospital	For the purpose of this policy the term 'Community Hospital' will include all hospitals and units with inpatient beds.
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CHS	Community Health Service
Discharge	Discharge from hospital is the point at which the patient leaves the hospital and either returns home or is transferred to another facility, such as one for rehabilitation, or to a nursing home.
DoH	Department of Health
GP	General Practitioner
HoNOS	Health of the National Outcome Scoring
IMCA	Independent Mental Capacity Advocate
ICS	Intensive Community Support
Intermediate Care	is generally accepted as services which offer a structured programme of time-limited (typically up to six weeks) rehabilitation to help people to recover as much of their independence as possible and remain living in their own homes. It includes services to prevent hospital admission or ensure timely discharge from hospital. Community Care Act 2003.
LD	Learning Disabilities
LSAB	Local Safeguarding Adults Board
LPT	Leicestershire Partnership Trust
MDT	Multi-disciplinary Team (includes all professional involved in care)
MHP	Mental Health Practitioner
MHSOP	Mental Health Services for Older People
NHSLA	NHS Litigation Authority
PROMs	Patient Reported Outcome Measures
RiO	Mental Health and Learning Disabilities Electronic Patient Record System
SITREP	Situation Report. The SITREP is completed on a weekly basis and details numbers of delayed service user discharges from all occupied beds

1.0 Purpose

1.1 The purpose of the policy is to guide staff so that all discharges are appropriately managed to minimise the risk to service users and to improve outcomes and quality of care.

2.2 This policy applies to all staff employed within LPT and those staff working in a contracted capacity (for example, agency nurses etc.). The contents of this policy apply to all inpatient areas within the Trust.

2.0 Summary of policy

2.1 This discharge policy has been written to provide guidance on good practice to assist the multi-professional team in achieving safe and timely discharge. The policy outlines the principles and steps of effective discharge, the responsibilities of Trust staff and provides guidance on areas such as self-discharge, delayed discharge and advocacy. Discharge processes for Trust inpatient services are provided as appendices to the policy.

2.2 This policy will be updated following relevant audit and evaluation and the introduction of any new policy or legislation relating to discharge planning.

3.0 Introduction

3.1 The need to provide high quality care at the right time, in the right place, delivered by the right people is of paramount importance in reducing pressure on hospital and community services. Equally important is the need to ensure that service users have a good experience whilst in our care and that discharge is safe, timely, coordinated, and well communicated. Leicestershire Partnership NHS Trust (LPT) recognises the contribution that effective discharge care planning makes to high quality service provision, continuity of care and the recovery journey. In most instances, a discharge is not the point of discharge from care, but a transfer in the location of delivery of care. Therefore, there needs to be a robust system in place in order to continue the care and to manage the risk usually with the involvement of service users, carers, and a range of professional groups, other agencies and organisations.

Discharge or Transfer of Care

Discharge from hospital is a process and not an isolated event at the end of a patient's stay.[1] Discharge or Transfer of care is an essential part of care management in hospital settings. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another setting.

The underpinning principles of effective discharge are:

1. Effective **communication**
2. Alignment of services to ensure **continuity of care**
3. **Involvement** of patients / families / carers

---

[1] DH (2003) Discharge from hospital: Pathway, process and practice. DH.

4. Efficient **systems** to support the process
5. Clear **clinical management plans**
6. Early identification of discharge **date**
7. Identified named lead **coordinator**
8. Review and **audit** of practice

The 10 steps of discharge practice are: [2]

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

4.0 Duties within the Organisation

4.1 **The Trust Board has** a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 **The Clinical Effectiveness Group has responsibility for** approval and updating of the policy.

4.3 **Divisional Directors and Heads of Service are responsible for:**

- ensuring that the requirements of this policy are disseminated, implemented, and audited within their area of responsibility.
- ensuring appropriate and effective local procedures are developed in their designated areas within their scope of responsibility.
- ensuring there are appropriate resources provided within their service area to train, implement and adhere to the policy.

4.4 **The Ward Manager /Team Leader/Hospital Matron are responsible for:**

- effective inter-agency and multidisciplinary communication, internal and external to LPT.
- ensuring that staff have access to information and support in the implementation of local and national policy and legislation relating to discharge.

[2] DH (2010) ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care. DH.

- monitoring and overseeing standards of practice for all staff responsible for progressing discharge.
- influencing strategic planning to achieve national and local performance targets.
- ensuring that staff report any examples of non-adherence to the policy through the incident reporting process.
- monitoring discharge progress for all service users and take action to expedite discharge of those who have exceeded the expected discharge date.
- investigating incidents/complaints that occur as a result of discharge.
- ensuring that decisions regarding discharge home, where there are known safeguarding issues with regards to adults and children, are not made without the agreement of the key worker(social worker) and the Trust Safeguarding Named Nurses.
- Ensuring that safeguarding issues are recorded in the notes and staff are aware of all the issues. Staff must follow the LSAB procedures.
- highlighting therapy related issues to the Therapy Team Managers.
- ensuring that the data is collected and submitted to the appropriate person each week for validation prior to sending the SITREP.

4.5 **Medical Staff and Advanced Nurse Practitioners are responsible for:**

- issuing discharge from hospital certificates and statement of fitness to work (Form Med 3), as appropriate, for a period consistent with the anticipated incapacity Department of Work and Pensions).
- assessing that the service user is fit to be discharged on the discharge day (where areas have 7 day medical support).
- writing a discharge letter to the GP
- writing a discharge letter to the District Nurse/CPN/MHP CNLD confirming details of the prescribed medication where a service user requires medication prescribed via injection or an infusion pump. This may also include authorisation for administration of medication and care delivery, e.g. dressings etc., and referral to other services for ongoing care, e.g. incontinence services, diabetic nurses.
- carrying out a medical review if the service user has become medically unstable. This must be recorded within the medical records section of the multi-disciplinary notes by the appropriate clinician and the service
- ensuring that a service user is not discharged until a full medical review has been untaken and they have been assessed as fit for discharge (with the exception of the learning disability short breaks homes, where patients need not be under the care of an LPT consultant). If the patient is assessed to be unwell, he or she will not be fit for discharge.
- Completion of ICE inpatient discharge summary letter (see appendix 2 for instructions on completion)
- Undertake any additional discussions with relevant professionals, such as GPs, in the event of complicated discharges
- Order medication for discharge in a timely manner

4.6 **Out of Hours Medical Staff are responsible for:**

- reviewing the service user if the nurse deems the service user’s condition has deteriorated prior to discharge or becomes medically unstable.
- If the service user cannot be managed within the community hospital or inpatient unit, Out of Hours medical staff must arrange a suitable transfer.

4.7 Independent Mental Capacity Advocate (IMCA)

The IMCA Service has been established under the Mental Capacity Act 2005 to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no one else (other than paid staff) to support or represent them or be consulted (Mental Capacity Act 2005 Code of Practice). Staff should refer to their local arrangements for access to Advocacy and IMCA.

4.8 In Mental Health Areas including CAMHS and Learning Disabilities Named Nurse/Care Co-ordinator/Lead Professional

For service users who have an existing CPA Care Co-ordinator, the coordinator will be responsible for close liaison between themselves and the allocated named nurse on the ward. The CPA Care Co-ordinator of the service user in the community will retain his/her role if the service user becomes an inpatient. When there is not a CPA care coordinator identified, a member of the ward staff must take on the role temporarily and commence the discharge process. For further information please refer to the Care Programme Approach (CPA) Policy which can be found on the Trust intranet.

4.9 Service User's Advocate

The services of an advocate are of particular importance if a service user is feeling threatened, vulnerable or in some way disadvantaged. They will provide an independent view to facilitate the service user's needs being met and opinions heard. Independent Mental Capacity Advocates can be used for those who lack capacity to agree to their care and treatment and have no family / friends to support them.

5. Discharge

5.1 This policy covers the discharge from the following inpatient units:

- CAMHS, Adult and Older Persons inpatient mental health services
- Community hospitals within Community Health Services
- Inpatient learning disability services (i.e. the Agnes Unit and Short Breaks Homes)

Further local guidance for each is given in the appendices to this policy.

Where there is a known or suspected infection, discharge arrangements must adhere to the relevant infection control policy.

5.2 Decisions regarding discharge home where there are known safeguarding children or adult protection issues should not be taken without the involvement and agreement of the Trust Safeguarding Named Nurses (0116 2957261). Safeguarding is the term used to describe child protection, adult protection (especially vulnerable adults), and domestic violence, and the Trust works to uphold the right for all to live their lives free from abuse.

The dedicated safeguarding children and adults teams provide expert advice and guidance to staff on safeguarding matters, working closely with partner agencies (such as the local Safeguarding Children's Board, Adult Protection Board, NHS Domestic Violence Group, police and social care) to support society's most vulnerable groups from abuse and neglect.

Staff must ensure that safeguarding issues are recorded in the patient record and dealt with in accordance with local safeguarding procedures. Staff are directed towards various supporting policies, such as the Adult Safeguarding Policy, Children's Safeguarding Policy, Domestic Violence Policy and Guidance, Deprivation of Liberty Policy, Mental Capacity Act, MAPPA Policy and Prevent Policy.

A number of Trust Safeguarding groups monitor performance, and identify any actions required to ensure our practice adheres to government standards.

5.3 Discharge or transfer of patients under the Mental Health Act (MHA) should follow the relevant MHA policy. The Trust produces an overarching Mental Health Act Policy and a number of related procedures and guidance documents.

6. Discharge Medication (TTOs)

6.1 Refer to the Medicines Management Policy for information regarding discharge medication which can be found on the LPT intranet.

7. Service Users who Refuse Discharge

7.1 If a service user refuses to be discharged and is not eligible for a Health Authority review of their case under the Continuing Health Care criteria, consideration must be given to each individual case, as the service user does not have the right to occupy an NHS bed indefinitely.

7.2 The Service Manager/Matron/Operational Lead must be informed and a multi-disciplinary review held to agree an appropriate strategy for discharge. Social care colleagues will be involved in the review as appropriate.

8. Self-Discharge

8.1 Where a service user expresses a wish to leave the hospital prior to completing tests and treatment and against medical advice, then staff must follow the appropriate local procedure for self-discharge.

8.2 If a mental health service user wishes to be discharged from a specific service, consideration must be made to the risks involved and if appropriate, the Care Co-ordinator/Lead Professional must explore available alternatives with the service user, their carers or parents (where appropriate) and their GP. The outcome of this must be documented and clearly communicated to all parties involved and to the GP. Risk can be to self or others thus necessitating a mental health assessment. In the inpatient setting consideration may need to be given to the use of the MHA sections 5.2 or 5.4.

9. Delayed Discharge

9.1 The Community Care Act 2003 states that a service user cannot be recorded as a delayed discharge unless a discharge date has been set and that this is recorded in the service user's records.

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

A patient is ready for transfer when:

- A clinical decision has been made that patient is ready for transfer **AND**
- A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
- The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

9.2 The following DTOC process has been designed in accordance with the Monthly Delayed Discharge Situation Reports Definition and Guidance, NHS England, 2015.

Cases are reviewed by clinicians as part of the ward-based MDT process, which then determines when a service user is fit for discharge and therefore, when they have become a delayed discharge.

Cases may also be identified by the multi-disciplinary, weekly Length of Stay (LoS) Meeting – these cases are then confirmed with the full care team on the ward as outlined above.

The responsibility for reviewing DTOC recording on a daily basis has remained with individual wards and clinicians. This should occur at service user level, being updated each time the service user discharge plan is reviewed (usually as part of an MDT meeting, daily review or ward round).

Additionally, the DTOC recording will be overseen by the LoS Meeting and the Bed Management Team.

DTOCs must be discussed as part of the meeting, and the Bed Manager must ensure that any DTOC changes required are recorded electronically on the RiO system (or alternative electronic or paper-based system as appropriate). The Bed Manager will also cross-check the information from the LoS Meeting with the existing DTOC information recorded on the RiO system (or alternative), and ensure that any conflicts are resolved.

Please note: this is an additional back up process and does not replace or alter the individual ward/ clinician responsibility for ensuring that DTOCs are accurately recorded.

Commissioners will receive an anonymised monthly DTOC report, detailing the reasons for delays. This will be produced by the Bed Management Team, using information from the weekly LoS meetings.

Monitoring of delayed transfers of care will take place by weekly census at midnight on Thursday for submission to DoH UNIFY 2.0 performance reporting. The information should be accurate and it is the responsibility of each ward to report all delayed transfers of care on the SITREP.

9.3 The Hospital Matron/Community Bed Manager must support the clinical teams with regard to delays in the provision of equipment by escalating issues via the incident reporting process.

9.4 Recording a DTOC on RiO:

- The DTOC must be recorded in the 'Progress notes' section of the clinical record.
- A heading stating 'Delayed Transfer of Care' should be recorded in bold.
- The start date of the DTOC, people present at the meeting when the decision was made and the rationale for DTOC status being applied must be recorded
- A patient must only by counted in one category of delay each day, and this category should be the one most appropriately describing the reason for delay.
- Actions being taken to resolve the delay in discharge along with a review date must be recorded
- An account of the conversation with the patient and their carer, along with any concerns the patient or carer raises, must also be recorded

A note must be made if a DTOC status is removed, for example, if a patient's health status deteriorates making the person unfit for discharge. The process for agreeing a DTOC must be revisited when the person becomes fit for discharge.

A DTOC form must be completed. When a change to the DTOC status occurs (for instance, a change in the SitRep delay reason or discharge) the form will need to be updated (See RiO DTOC guidance).

10. Training

10.1 There is no training requirement identified within this policy, although clinical staff will receive instructions on local discharge processes as part of their induction programme.

11. Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
9.2	Monitoring of delayed transfers of care weekly	Weekly reports from wards	SITREP	Operational management groups	Weekly
9.1	Quality Account Quality Priority to reduce the number of mental health patients	Panel minutes	Multi-agency length of stay panel	Trust Board	

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	delayed in hospital				
4.5	Medical staff to send discharge summary to GPs	Retrospective audit	GP Discharge summary letter audit	Clinical Effectiveness Group	Annual – trust wide
	Bradgate Unit annual audit	Retrospective audit	Suicide prevention audit	Patient Safety Group	Quarterly
	All inpatient units	Bed management data	Bed management	Operational management groups	Ongoing

12. Links to Standards/Performance Indicators

Target/Standards	Key Performance Indicator
This policy meets the requirements of the NHSLA Risk Management Standards 2012-13	Standard 4, Criterion 10: Discharge
This policy also supports the CQC Essential Standards of Quality and Safety:	Outcome 1-Respecting and involving people who use services. Outcome 2-Consent to care and treatment. Outcome 4-Care and welfare of people who use services. Outcome 6-Cooperating with other providers.

13. References and Associated Documentation

This policy was drafted with reference to the following:

- BMA Patient Liaison Group (2014), Hospital discharge: the patient, carer and doctor perspective
- Community Care (Delayed Discharges) Act, 2003
- CQC Fundamental Standards on safe care and treatment (2014)
- CSIP/NIMHE (2007), A Positive Outlook: a good practice guide to improve discharge from in-service user health care
- Department of Health (1991), National Service Framework for Older People
- Department of Health (2003), Discharge from Hospital: pathway process and practice
- Department of Health (2010) Ready to go? Planning the discharge and the transfer of patients form hospital and intermediate care
- Leicestershire Together (2014), Leicestershire Information Sharing Protocol

- LPT Infection Control Policies
- LPT (2013), Care Programme Approach Policy
- LPT (2013) Medicines Management Policy
- LPT (2014/15) Quality Account
- LPT (2014/15) Quality Schedule
- LPT (2014) Record Keeping and the Management of the Quality of Health Records Policy
- LPT (2014) Mental Health Act Overarching Policy
- LPT (2014) Clinical Risk Assessment Policy
- LPT (2015) Policy for Consent to examination or treatment
- LPT (2015) Data Protection, Caldicott and Confidentiality Policy
- Mental Capacity Act, 2005
- NHSLA Risk Management standards, 2012-13
- Nursing Times (2013) The key principles of effective discharge planning
- NIMHE (2003), Preventing Suicide: a toolkit for Mental Health Services
- Royal College of Psychiatrists (2014), Accreditation for Acute Inpatient Services for Working Age Adults

Appendix 1:

Discharge process from Adult Mental Health Inpatient Services, Older People's Mental Health Inpatient Services and CAMHS, including unplanned self- discharge

Discharging Mental Health service users with severe mental illness from inpatient Mental Health Services will be carefully considered in consultation with all professionals involved and undertaken in consultation with the service user and (where relevant) their carers or parents. Any such decisions must be clearly communicated to the GP, the referrer and all parties involved in the service user's care and the service user themselves.

Service users must have a date of discharge agreed at the first multidisciplinary team meeting or a provisional discharge date is set at 4 weeks pending the weekly review by the team. The date must be recorded in the service user record and reviewed accordingly.

When patients are admitted to Mental Health Services for Older People (MHSOP) inpatient settings, discharge is discussed but a date is not normally agreed at this point.

As an exception, patients in the Adult Eating Disorders service will attain specific outcomes prior to discharge, usually related to weight and eating. Discharge will not be time specific.

A CPA review meeting must be held which for service users detained under the Mental Health Act will constitute a Section 117 after-care meeting. The named nurse must seek the views of those not attending and provide the subsequent providers with feedback, including the discharge date. The CPA Care Coordinator must be involved in the discharge planning process.

Documentation and information must be given, (where appropriate and relevant), to the service user and/or their carers/relatives (with the service user's consent).

Where early discharge may result in difficulty in arranging a formal CPA review, it will be acceptable to undertake a brief and functional pre-discharge meeting providing that requirements for post-discharge follow-up are met for those on CPA and a full CPA review is arranged post-discharge.

Clinical risk issues will be discussed at the pre-discharge meeting. This must be documented and communicated to all relevant parties prior to discharge. If there is an identified risk of harm to self or others, this information must be passed onto all professionals involved in the service user's care with the agreement of the Service User. Where consent has been withdrawn, a service user's decision can be overridden when there is a concern or a risk of serious harm to either the service user or any other person. The pre-discharge meeting must use the RiO Risk Assessment Tool which is normally completed on admission.

Planned discharge can only be facilitated if a member of the medical team has reviewed the service user. If the discharge meeting cannot be organised, this must be clearly documented in the medical notes (such as discharge against medical advice).

Where possible, all service users must be involved in their own discharge planning.

Consideration must be made when planning discharge for those service users with

culminating disabilities and those who have communication difficulties. This includes responsibilities under the Mental Health Act. Consideration must be given to any appropriate support that could be offered.

Support may include:

Advocacy or IMCA
Translation services
Carer, family member or friend

The service user must be given enough time to consider and prepare thoughts prior to the meeting.

Carers (where possible) must be fully involved in the discharge planning process. The Trust recognises the support offered by carers as essential to a successful discharge. The needs of carers must be addressed if the Trust is to support carers in their crucial role. Therefore, carers providing regular and substantive care must be offered their own assessment of need and care plans that are reviewed under CPA. The CPA Policy provides additional information regarding carers.

All service users under CPA will have a nominated CPA Care Co-ordinator who must be involved with pre-discharge planning. The CPA Policy (Section 6) provides more information regarding the role of the CPA Care Coordinator.

Where a service user is discharged and not on CPA, the rationale for this decision must be recorded. Those not on CPA will have a Lead Professional identified. (Unless the service user is discharged from the services).

National CPA guidance states that all service users discharged from inpatient services should remain under CPA at least until the first post discharge review.

Where the service user lacks capacity, the clinical team may consider providing the carer/Lasting Power of Attorney a copy of the service user discharge care plan in his/her 'best interests' in accordance with the Mental Capacity Act 2005. The service user discharge care plan can be withheld from a service user if the clinical team feels that providing such information could be clinically harmful to him/her.

All members involved in the service user's care must receive relevant information including the discharge care plan. A copy must be sent to the carer with consent from the service user (where possible). It should be faxed to the GP within 24 hours of the service user's discharge. The discharge plan must be used by the care coordinator to update the general CPA care plan.

Service users must be contacted within seven days of discharge if they are on CPA. It is the responsibility of the named nurse to ensure that the accepting team are made aware of the discharge date.

Within 24 hours of the service user's discharge, the doctor must complete the detailed e-discharge letter which is stored within the electronic records system within RiO. This must be sent through to the GP via the ICE electronic system (for surgeries where ICE Is not available, the discharge letter must be sent via either secure email or fax). The service user / carer must be offered a copy. It should contain the following information as a minimum:

- Initial reason for admission
- Investigations carried out and all available results
- Clinical summary of treatment
- Clear statement of definitive primary diagnosis where confirmed or reason for not being available
- Medication commenced and to be continued, including duration
- Medication changed or stopped, and reason
- Management Plan/Crisis Plan if problems (i.e. who to contact)
- Follow up arrangements and referral to other agencies
- Information provided to the service user
- Infection Prevention and Control status
- Functional ability on discharge

For any unplanned discharge, a review should take place urgently and within 7 days of discharge.

Wherever possible, suitable accommodation must be secured prior to a service user being discharged. However, should this not be possible for any reason, the service user must be directed to either:

- Housing Options, (Leicester City service users); or
- Local Housing Department (Leicestershire County and Rutland)

The majority of inpatients within MHSOP services are transferred into a care setting on discharge. The points above are all applicable to enable the care to continue. Further guidance can be found in the Clinical handover policy as these patients are not discharged from all MHSOP services.

Service Users who move out of Leicestershire.
Refer to the CPA Policy on the Trust intranet

Mental Health service users requesting discharge at short notice
It is acknowledged that there are occasions where service users who are informal and have capacity, may wish to leave at short notice and/or refuse further service involvement, which will affect the service's ability to make effective discharge arrangements. In this circumstance, the nurse in charge of the ward must:

- Complete the 'Unplanned Self-Discharge' form.
- Ask the service user to remain on the ward until seen by a member of their medical team.
- If possible, request the service user's consultant psychiatrist to review the service user prior to them leaving the ward.
- If the consultant psychiatrist is not available, contact the junior doctor and request they review the service user prior to them leaving the ward.
- For service users whose mental state presents significant risks (for example, of harm to self or others), an assessment must be made for possible detention under the Mental Health Act 1983 (amended by the Mental Health Act 2007). If medical staff are not immediately available, nursing staff may need to make use of the nurses holding powers under section 5(4) where they feel it would be unsafe to allow the service user to leave the ward.

- Any unplanned discharge should be accompanied by an urgent multidisciplinary review, ideally before the individual leaves, or if not, within 7 days afterwards. This should include a review of the risks presented, who needs to be informed and any other action to be taken. The review must be recorded in the case notes.

Early discharge from the ward and the role of the Crisis Resolution and Home Treatment Team

The Royal College of Psychiatrists Home Treatment Accreditation Services standards (2015) state that if hospitalisation is required, regular formal joint reviews take place between acute inpatient and home treatment team staff, with the involvement of carers, to ensure that the person is transferred into the least restrictive environment as early as clinically possible.

The Crisis Resolution and Home Treatment (CRHT) team is able to facilitate early discharge from adult inpatient wards by offering home treatment when the risk presented by an inpatient are assessed to be manageable in the community with intensive support.

Home treatment is an alternative to hospital admission, and the referral criteria for early discharge remains the same as for a referral to the team through the triage system, i.e. the patient is currently experiencing a mental health crisis and, without the crisis team input, would remain in hospital.

Early discharge should be considered as soon as possible after the point of admission, in order to treat the patient in the least restrictive environment. As soon as the ward team feels the risk is manageable, the CRHT can assess for home treatment.

The CRHT will review all patients admitted to the ward on a regular basis throughout the admission.

Standard Operating Procedure

Transfers of Patients from, and between, Adult Mental Health Wards within Leicestershire Partnership NHS Trust

Purpose

The Standard Operating Procedure (SOP) is developed as a result of incidents related to patient safety that have occurred within Acute Rehabilitation and Forensic Secure services within the Adult mental Health and Learning Disability Division of Leicestershire Partnership Trust (LPT). This SOP aims to provide a protocol to guide clinicians and operational staff in the transfer of patients, with the overarching aim of patient safety.

Categories

Transfers fall into three categories:

1. Transfers within same service (inter ward)
2. Transfers within same organisation (may be to a different service or category of bed) – this includes Rehabilitation wards, low secure and PICU
3. Transfers between organisation (between MH or between MH and Acute hospitals) – this includes UHL transfers and transfers to Out of Area MH Beds.

Key issues

The key issues that emerge from transfer of patients are:

1. Disruption of continuity of care
2. Inadequate risk transfer, sharing and management
3. Poor patient experience (based on how much of shared decision making on transfers happens)

Reasons for a transfer

1. *Clinical reasons*: there may be situations where for clinical reasons, a patient would be moved to another bed. This may be related directly to the illness and symptoms that a patient may suffer from or may be related to patient mix on a particluar ward. There also may be issues related to safeguarding or vulnerability. This also includes patients who are moved to an acute hospital for treatment of their co-morbid physical health conditions.
2. *Patient choice:* there may be situations where a patient may exercise their choice of ward or bed and this should be taken into consideration as part of person centred care. The key is to make shared decisions between patient, their families and professionals.
3. *Service need*: This may arise out of service related issues like lack of availability of beds, same sex acciomodation issues etc whereby a patient has to be moved.

Principles

There is no nationally available guidance specifically on transfers and therefore the SOP has been developed by extrapolating from some associated guidance[3] on this issue and is based

[3] 1. NICE CG 136 (service user experience in Mental Health)

2. OP79 doing the right thing: how to judge a good ward (RCPsych paper)

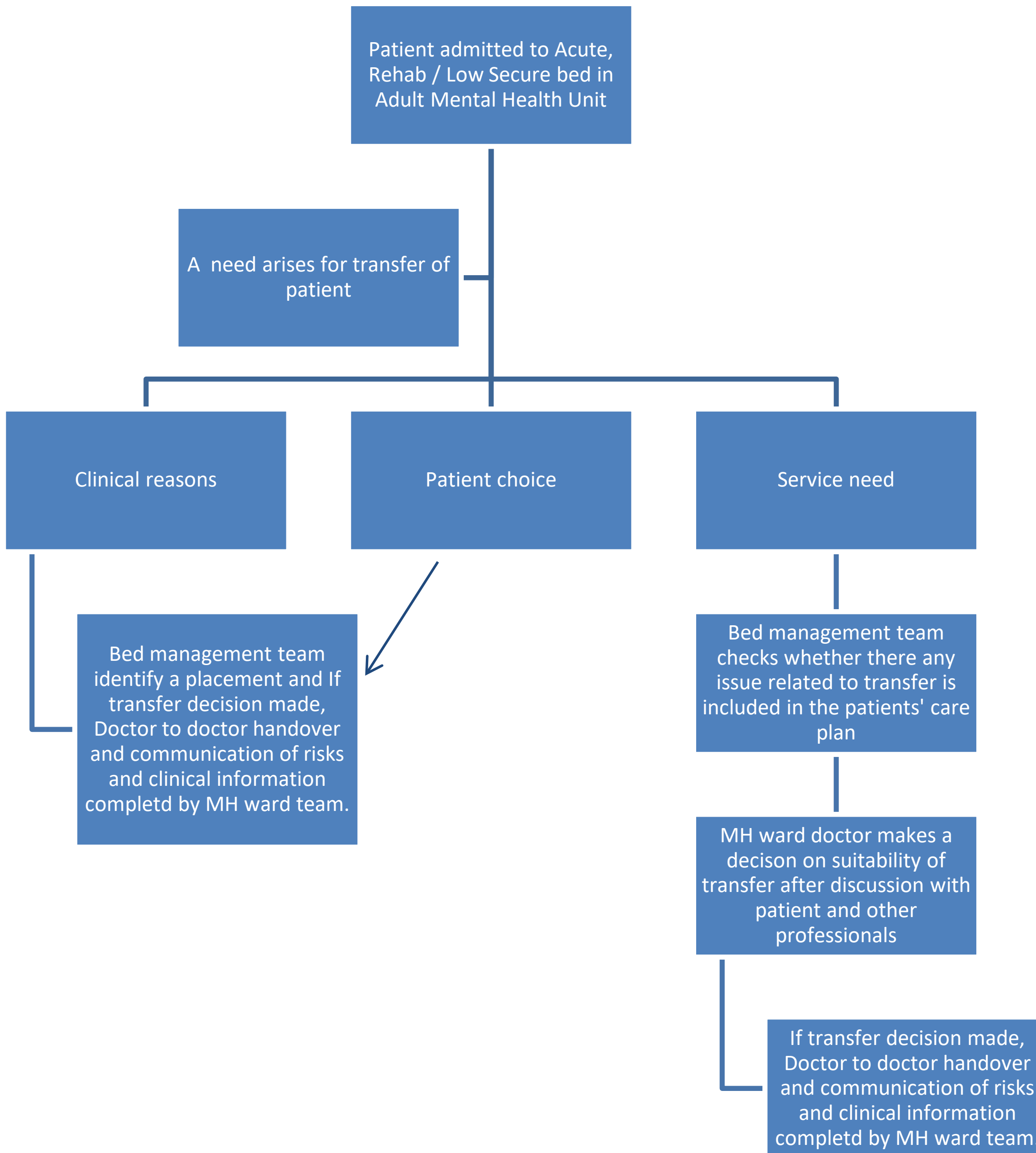
on the following principles

1. Clinical decision making takes primary position in the decision about transfers. The primary decision maker is the psychiatrist who should arrive at a decision after consultation with the members of the multi-disciplinary team
2. Patient (and family/carer where appropriate) involvement in the decision making is essential,
3. The team/ ward professionals from where the patient is transferred take primary responsibility to ensure communication (legal, clinical & risk) related to safe transfer to the receiving team is completed. There should be a psychiatrist to psychiatrist/doctor handover.
4. The above principles equally apply when receiving patients.

---

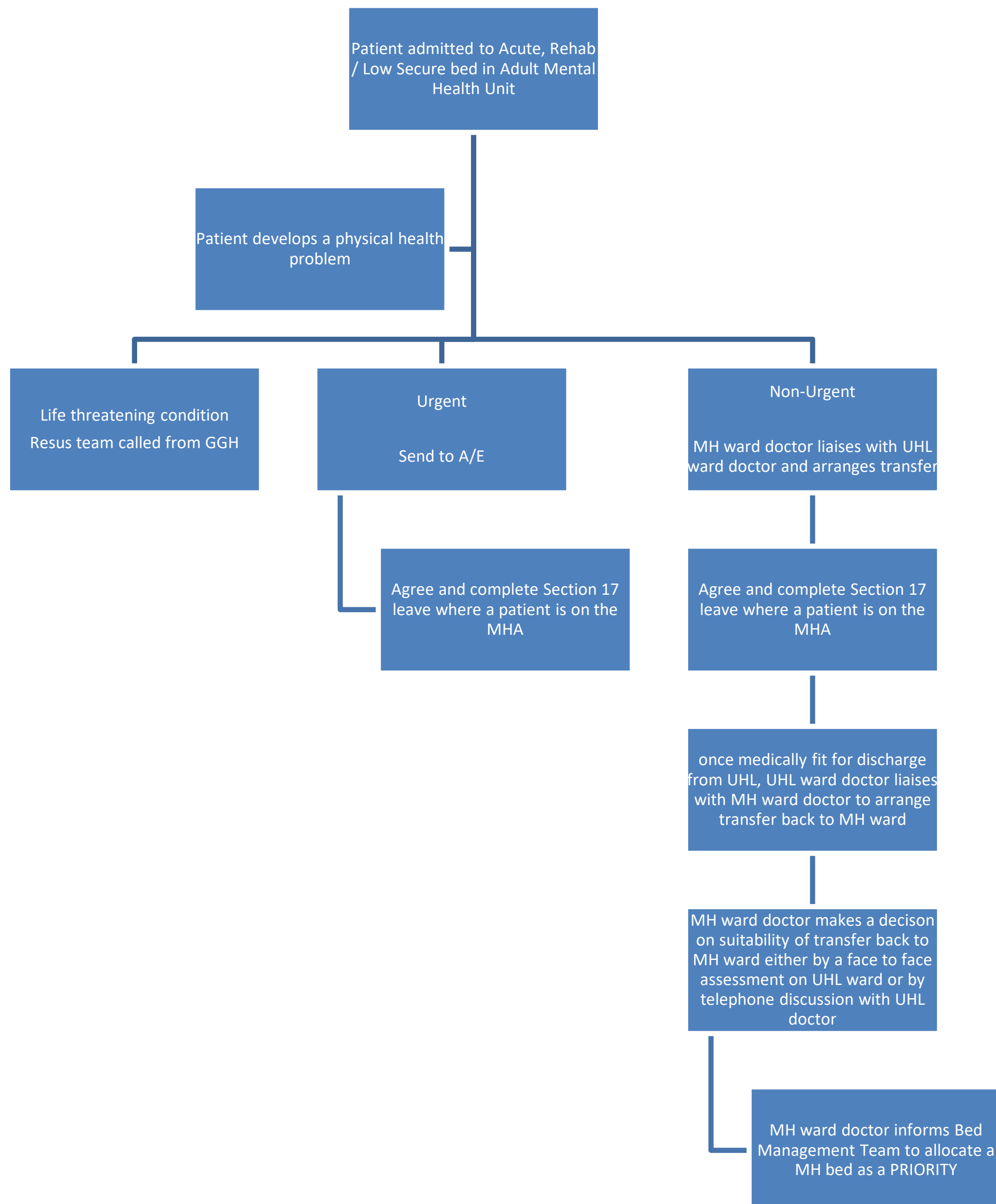
3. The commission to review the provision of Acute IP psychiatric care for adults

Flow Chart 1: Transfers between Adult Mental Health Beds



Conditions and protocols associated with the respective legislative frameworks i.e. Mental Health Act, Section 17 Leave, Mental Capacity Act etc. must still be adhered to.

Flow Chart 2: Transfers between Adult Mental Health Beds and Acute Hospitals



Key Points:

1. There is no involvement of liaison psychiatry team in this protocol
2. This protocol applies irrespective of whether patient has been transferred or discharged from electronic systems
3. Conditions and protocols associated with the respective legislative frameworks i.e. Mental Health Act, Section 17 Leave, Mental Capacity Act etc. must still be adhered to.

Adult Mental Health Inpatient Services, Older People's Mental Health Inpatient Services and CAMHS Unplanned self-discharge form

Patient Name:	Ward:	Date:	Time:
Is there a current risk assessment?	Is the patient willing to wait until they are assessed by the duty doctor?		
Does the patient have the capacity to decide to discharge themselves?		Is there a temporary loss of capacity due to intoxication?	
Does it appear that the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient's health or safety or for the protection of other people (criteria for section 5 (4)?			
Are there any carers or professionals who need to be urgently informed?		If the patient has already left – do the police need to be informed?	
Have you considered CPA and 7 day follow up?		Is it more appropriate for the person to be put 'On Leave'?	
Have you documented the events and your justification for the above opinions in the case notes?			
Name of person completing form: Signed:			
Are you a qualified nurse or doctor?			

Appendix 2:

Discharge process from Community Health Services Community Hospitals

Patients must have a date of discharge agreed at the first ward round or multidisciplinary team meeting or within 48 hours of admission. The date must be recorded in the patient's healthcare record and added to the ward patient status white board.

Patients/relatives/carers, especially those with complicated discharge needs, must be encouraged to attend a multidisciplinary team meeting to identify problematic areas and to instigate a date of discharge.

Patients/relatives/carers must provide informed consent to referral to other agencies during the discharge planning process and, wherever possible, to information being shared with relatives/carers. Agreement must be documented in the discharge planning tool or the patient record.

The discharge medication prescription must be completed on the electronic discharge summary in a timely manner so that the order of medication from the pharmacy can be requested prior to discharge.

Arrangements must be made with the district nursing team for any syringe drivers and medication requirements in place when the patient is discharged to be returned to the hospital.

A patient must not be discharged or transferred to another area after 21.00 hrs except for a medical emergency or interventional management. An incident form must be completed if a patient is transferred from another area to a CHS ward after 21.00 hrs. Transfers may take place after 21.00 hrs if acute hospitals are declaring a stage 3 alert.

A medical summary of treatment / medical management plan for on-going care needs for patient transferred to other community hospital, care home or social care facility or home must be completed using the electronic discharge summary.

The discharge summary must be received by the medical practice within 24 hours of discharge. This is stored electronically and is printed and filed in the patient's medical notes. A copy must be given to the patient with the instruction to show this to the practice if required. It should contain the following information as a minimum:

- Initial reason for admission
- Investigations carried out and all available results
- Clinical summary of treatment
- Clearly state definitive primary diagnosis where confirmed or reason for not being available
- Medication commenced and to be continued including duration
- Medication changed or stopped and reason
- Medication and reason
- Follow up arrangements
- Information provided to the patient

- Infection and Prevention status
- Functional ability on discharge

All necessary information for discharge must be gathered, recorded, communicated and used in the patient’s best interest. Patients and carers must be provided with information both verbal and written on what to expect following discharge including planning and arrangement of reviews and follow up appointments.

Appropriate referrals must be made to the relevant agencies (e.g. District Nursing, Home Enteral Nutrition Service, Community Mental Health Team, Community Therapy Team) for further assessment or on-going intervention using the appropriate referral criteria.

Continuing health care assessments for all patients with ongoing health care needs must be considered, using the continuing care check list.

All patients who are referred to social services will be screened for Continuous Health Care needs before a section 2 form is sent.

The individual patient’s multidisciplinary assessment must be thorough, comprehensive and all possible options including intermediate care, intensive community support and rehabilitative opportunities considered.

All equipment essential for discharge must be in place prior to discharge. If a patient who lives outside of the Leicestershire county boundary discharged, the Community Hospital/Inpatient Unit must have a method of contacting, referring and completing the necessary assessments in order to plan an effective and timely discharge. This must include information on how to access equipment essential for discharge, making referrals to Social Services for community support and the processes required in the patients local area to access care home and continuing health care provision.

Homeless patient must be identified on admission and their pending discharge notified to relevant Primary Health Care Services and homeless providers.

Ward staff must be involved to support patients with mental health or learning disability issues whilst planning discharge.

Staff must ensure procedures are clearly defined for patients who do not have the capacity to represent themselves.

The patient/relative must be aware of the planned discharge date at all times during their stay in hospital. Any changes will be agreed following communication and agreement with the patient/relatives. Red, amber and green communication sheets must be given to patients at appropriate times during their stay.

All members of the multidisciplinary team must record the outcome of assessments in the discharge planning tool or the patient record on completion of the assessment.

All staff involved in the ordering of equipment will highlight any delays in provision to their immediate line manager and report this via the patient census.

The healthcare professional responsible for the patients will ensure that all paper and electronic records are complete on discharge.

Transport services must be given as much notice as possible for planned discharge. Arrangements should be made to ensure the patient is collected before 12 noon.

Out of Leicestershire transport must be requested at least 48hours prior to discharge. The transport booking office must be notified of any special requirements for patient at the time of booking.

All staff discharging a patient from a Community Hospital/Inpatient Unit to an external organisation will complete the appropriate transfer form electronically.

Patients must have a medical review on the day of discharge if there has been any change in their condition since their last review.

CHS Community Hospitals: Form to be completed when patient takes own discharge

Address of hospital:

……………………………………………………………………………………...….

………………………………………………………………………………………

TO BE COMPLETED BY PATIENT TAKING OWN DISCHARGE

I ……………………………………………………………………………… of

……………………………………………………………………………… hereby

declare that I am leaving (or taking ……………………………………………

……………………………………………away from) the ………………………

…………………………………………… Hospital at my own desire and

contrary to the advice of the Medical Staff.

I have had the risks of doing so explained to me and I accept full responsibility for my action.

Signature ……………………………………………………………………..

Date ………………………………….

Witness ……………………………..

CHS Community Hospitals Self Discharge Checklist

	Signature	Comments
Patient communicates that they wish to take their own discharge		
Staff to talk to patient to see if the issue can be resolved		
MDT and GP to be involved in discussion if appropriate		
Inform relatives/carer of the patients' intention (with patient consent)		
If the patient still insists on taking their own discharge, inform them that it is against medical advice		
Ask patient to sign the Self Discharge form		
Return any of their own medication to the patient		
Ask patient how they are getting home and assist (if needed) to arrange transport		
Inform patient's GP of discharge		
Inform District Nurses, Social Services and/or ICS		
Inform Safeguarding team if there is doubt about patient's mental capacity.		
Document fully in patient's medical notes		
File Self Discharge form in medical notes		

ICE inpatient discharge summary letter - instructions for completion

JOE BLOGGS **NHS number: 123 456 7890**

Inpatient Discharge Summary v3

THIS LETTER IS ALSO SENT ELECTRONICALLY TO ENABLED PRACTICES

Patient Identification

JOE BLOGGS	**Admission / Clinic Date**	**01/01/2014 00:00**
22 THE GREEN	**Discharge Date**	**14/01/2014 00:00**
ANYTOWN	**Sex**	**Male**
MIDSHIRE	**Date of Birth**	**25/12/1925**
MM45 6AA	**Marital Status**	**Unknown**
	NHS Number	**123 456 7890**

Hospital Information
Hospital Ward, Community Hospital, Hospital Way, Anytown, Midshire, MM45 8BT

Admission Information – Admitted from Midshire University Hospitals

Discharge Destination & Contact Telephone Number – Home address

Expected Discharge Date – 14/01/2014

> **WARD CLERK RESPONSIBILITY**
> This section is completed By the Ward Clerk, Scan to ensure your details are correct.

Advanced Nurse Practitioner Responsible for Patient Care
Advanced Nurse Practitioner
Simon Smith
01234 000 112

> **PLEASE NOTE**
> A contact telephone number should be entered. This must be the ward contact number and NOT your mobile number.

Reviewed by Consultant?
Dr C Geriatrician
Consultant Geriatrician
01234 000 112

CLINICAL SUMMARY OF TREATMENT

> **DOCTOR / ADVANCED NURSE PRACTITIONER (ANP) RESPONSIBILITIES**
> Populate the following sections ideally up to 48 hours before discharge using patient friendly terminology where possible

Action Required by own G.P.
Utilise suggestions in Drop down box

Please Review - *advise for when patient is to be reviewed, detailing rationale and timescale for this request, i.e. within 1/52 to review U/E's please.*

Synchronisation of medication against repeat prescription - *Record where relevant which medication is to be: re-initiated, stopped, titrated up / down, or if its effectiveness is to be reviewed with rationale for request and offer a suggested timescale for this to take place.*
Identify which of their normal medication has been stopped and which medication has been started since last GP summary
Follow up treatment plans or commencement of other treatments e.g. refer to Falls Programme, check Hb
Additionally note as appropriate:

Refer to anticoagulation section. *Add INR Due date. Note - The Registered Nurse may enter the INR due date in the TTO section*
Record DNAR-CPR status if evident. Note the review date if relevant, or record if 'Not for Review', also as appropriate note if the patient / significant others are aware of DNAR-CPR status.

Reason for Admission – Rehabilitation post fractured right neck of femur.
Utilise the drop down box or add diagnosis at the time of admission and detail aim of this admission e.g. Rehabilitation post fractured right neck of femur

Main Diagnosis at Discharge
Fall
Head Injury post fall
Diabetes Mellitus – Type 2
Hypertension
Insert Past Medical History
Utilise suggestions in Drop down box
Include co-morbidities, risk factors and relevant past medical history
Add current health status, e.g. Resolving / Resolved

Medical Summary of Treatment (Narrative)
Narrative summary of treatment.

Summarise the patients' journey whilst an inpatient in the community hospital, detailing any significant events, i.e. falls, syncopal episodes etc. and detailing the actions that were taken and the outcome from each event's. If Blood transfusion given

Record if the inpatient stay has been uneventful.

Note any issues pertaining to safeguarding or onward referrals to other agencies with name and contact details of contact if known, e.g., Referred to Community Matron (name if known), on what date and record reason for referral.

Add current health status, i.e. 'Resolving / Resolved Urinary Tract infection, record if on any current treatments or if these are completed, i.e. Resolved Urinary Tract Infection following completion of 3/7 course of Trimethoprim'.

Record any medical management plans for the patient with detailed information, e.g. patient has COPD and has specific self- treatment OR anticipatory medications with relevant GP review date.

Record DNAR-CPR status if evident, note the review date if relevant, or record if 'Not for Review', also as appropriate note if the patient / significant others are aware of DNAR-CPR status. This information will need to be recorded on the discharge letter on a patient by patient basis, whilst not common some patients may have a DNAR that they or their family are unaware of. The letter should sensitively reflect patient preference wherever possible. However, DNAR-CPR status must be communicated to the GP/ relevant health care professionals and may require an additional letter from the service to the GP to reflect this issue.

Relevant Investigations and Results
Utilise suggestions in drop down box
Detail any blood tests taken and the date when they were taken (if not resolved on discharge, i.e. improving Haemoglobin levels post operatively). Record any X-rays, Scans, and any other relevant laboratory investigations and their results that have occurred whilst an inpatient.

Outpatient Arrangements
Detail any follow up arrangements with date, name of Service, Consultant. Also note any OPA's that may have been arranged whilst and inpatient in the acute setting with dates as known.

Is a Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) order in place ?
(optional, leave blank to hide on letter)
This is a drop down menu of Yes or No. State where and when the form was originated this could be the acute \trust or the GP. State the reasons why the form was completed and by who. State that the original form will be with the patient and the patient and family, where applicable are aware of the order.

Is the DNA CPR Order for Review? *(optional, leave blank to hide on letter)*
State if the form is for review and when the review date is. State if the form is not for review

Clinical Summary of Treatment Completed By
Advanced Nurse Practitioner
Simon Smith
01234 123100

DOCTOR / ADVANCED NURSE PRACTITIONER (ANP) RESPONSIBILITIES

Is the Patient an Infection Risk? –
Please ensure carrier status is included if relevant

REGISTERED NURSE RESPONSIBILITY
Scan to ensure details are correct.

Patient exposed to other with infection (e.g. D & V)? *(optional, leave blank to hide on letter)*

If the patient has diarrhoeal illness please indicate bowel history for last week *(optional, leave blank to hide on letter)*
Is the diarrhoea thought to be of an infectious nature? *(optional, leave blank to hide on letter)*

Relevant specimen results *(including admission screens - MRSA, glycopeptide-resistant enterococcus SPP, C. Difficile, multi-resistant Acinetbacter SPP and treatment information) including antimicrobial therapy: (optional, leave blank to hide on letter)*

Treatment Information: *(optional, leave blank to hide on letter)*

Is the patient aware of their diagnosis / risk of infection? *(optional, leave blank to hide on letter)*

Does the patient require isolation? *(optional, leave blank to hide on letter)*

Infection Control Nurse informed of Discharge? *(optional, leave blank to hide on letter)*
Other information: (optional, leave blank to hide on letter)

EMAS informed of transfer? *(optional, leave blank to hide on letter)*

MULTI-DISCIPLINARY TEAM SUMMARY

Nursing - Ward *(optional, leave blank to hide on letter)*

Nursing - Other *(optional, leave blank to hide on letter)*

OT *(optional, leave blank to hide on letter)*

Physio *(optional, leave blank to hide on letter)*

Dietician *(optional, leave blank to hide on letter)*

SALT *(optional, leave blank to hide on letter)*

Other *(optional, leave blank to hide on letter)*

Home Arrangements and information given to patient

Reviewed and signed off by *this will be completed by the RN completing the form*

TTO SECTION

DOCTOR / ADVANCED NURSE PRACTITIONER (ANP) RESPONSIBILITIES
Populate the following sections ideally up to 48 hours before discharge using patient friendly terminology where possible:

ANTIOCOAGULATION SECTION

Anticoagulation
Utilise suggestions in drop down box
Yes / No.
The drop down menu options is:
No

Yes – Apixaban	*Yes – Clopidogrel*	*Yes – Dabigatran*
Yes – Rivaroxaban	*Yes – Ticagrelor*	*Yes – Warfarin*
Yes - Aspirin		

State the reason for prescribed medication; add current dosage, when started if recent and the date if this requires titrating, with advised onward dosing regime.

Add the reason for initiation, latest INR result with date taken pre- discharge, current dosage regime and when next due, with note of date when referred to anticoagulation service. E.G.´Current INR is… Dosing regime is…..

(as per yellow booklet), Referred by nursing staff on.... to anticoagulation service for home testing, next test due on......How long treatment course required for e.g. 6 months or life long '

Patient has a Yellow OAT Booklet (optional, leave blank to hide on letter)
Document as Issued. The drop down menu choice are Yes or No

Appointment for INR follow up (optional, leave blank to hide on letter)
Document here if referred

Dementia Screen on Admission (All patients admitted over 75yrs)
The options here are :
AMT Score
MMSE Score, if completed
MOCA Score, if completed

Scores and the dates of the testing should be entered and details of any follow up needed.

Allergy Status: -
Utilise suggestions in drop down box
No known allergies
Record allergies with reaction if known.
If no allergies Record 'No known allergies'.

Medication aids required:- (optional, leave blank to hide on letter)

Weight on Discharge: -

FOR PHARMACY USE ONLY –

PC –

Dispensed by – sign and date

Checked by – sign and date

ANY PAGES CONTAINING DRUGS WILL NEED TO BE SIGNED BY THE PRESCRIBER

Drug and Dose Changes Made Whilst in Community Hospital –
Note any drug changes with rationale for change and date with outcome if known e.g. 'Pregablin titrated from ... to... with improved pain control'.

Ensure current prescription reflects TTO medication.

JAC TTO's

TTO Drug	Dose	Frequency	Route	Duration	GP To Continue	Verified By
PARACETAMOL 500 mg Tablets	1000mg	FOUR TIMES DAILY PRN QDS - PAIN	Oral	14 days	Yes	Pharmacist name
WARFARIN (AS PER CHART) Reminder	1 Dose	EVENING	Oral	14 days	Yes	Pharmacist name

AB SMITH
The Surgery
200 High Street
Anytown
Midshire
MM45 7LL
01234 456 778

Consultant: Dr C GERIATRICIAN
Ward / Clinic: Hospital Ward
Speciality: Not Specified
Letter Ref: 99989/9
Date Signed / Typed: 01/01/2014 16:57
Typed by: Jean Smith [IP Ward Clerk/Admin]
John Blue [IP Therapist]
Susan Green [IP Therapist]
Amanda Clarke [IP Nurse Prescriber]
Simon Smith [IP Nurse Prescriber]

Appendix 3:

Discharge process from Learning Disabilities Inpatient Services

In line with recommendations from the Winterbourne View investigation, a discharge plan and date must be identified on admission.

Prior to discharge the patient should be involved in discharge planning. They should be supported to understand the process and have choices offered around any new accommodation found.

Those who lack the capacity to make choices around change of accommodation and have no family or friends to support them should have the services of an IMCA.

All patients who are discharged from a learning disabilities inpatient area (i.e. the Agnes Unit) will be on CPA . All patients who are discharged from a learning disabilities short breaks home will remain on CPA if this is the arrangement within the community setting. Those on CPA will have a CPA care coordinator identified and involved in the process.

For patients eligible for SECTION 117 aftercare, Community Treatment Order, Guardianship or Deprivation of Liberty implications for future placement, the implications of this will be discussed in the discharge meeting.

Provide information in an accessible format according to assessed individual needs. i.e. Care plans.

The inpatient pathway should be followed throughout the inpatient stay and links maintained with any other learning disability pathways the patient may be on.

On discharge the relevant learning disability pathways will be used according to assessed need.

The discharge meeting will finalise details of:

- Accommodation
- Funding agreements
- The care package
- CPA care coordinator
- Community team involvement
- Agree the discharge care plan
- Provide discharge pack
- PROMS
- Complete Net Promoter score
- Update the RiO risk assessment
- Agree how 7 day follow up will be completed
- Agree first post discharge CPA meeting date
- Agree first post discharge outpatient clinic appointment with psychiatrist
- Complete E discharge
- Complete discharge letters

All relevant agencies, professionals, family/carers and the patient should be invited to attend the discharge meeting. Those professionals unable to attend should provide a report when appropriate.

Criteria for Discharge – LD Core pathway describes the discharge process for the service.

A client/patient is ready for discharge when the following has been agreed:

- A clinical decision has been made that the client/patient is ready for discharge as they have met the goals/outcomes agreed.
- The client/patient is safe to discharge

This has been discussed with the multidisciplinary team (MDT) where MDT involved and agreement made that the client/patient is ready for discharge.

Process for Discharge

Where possible, patients and their relatives and/or carers must be encouraged to work in partnership with the MDT on discharge planning.

Patients should be informed of the planned discharge and a copy of the discharge care plan should be given to them. Information should also be given on what to expect following discharge to include any arrangements for reviews and follow-up appointments by others. All this information should be given verbally and followed by an appropriate written format.

A HoNOS, PROMs and a Net Promoter should be completed with the patient. A discharge summary should be sent within 14 days of the patient receiving the information in point 3. A copy of this is filed in the patient's notes.

This should be sent to:

- Patient
- Original referrer (after considering the relevance of this)
- Registered GP where GP was not the referrer.

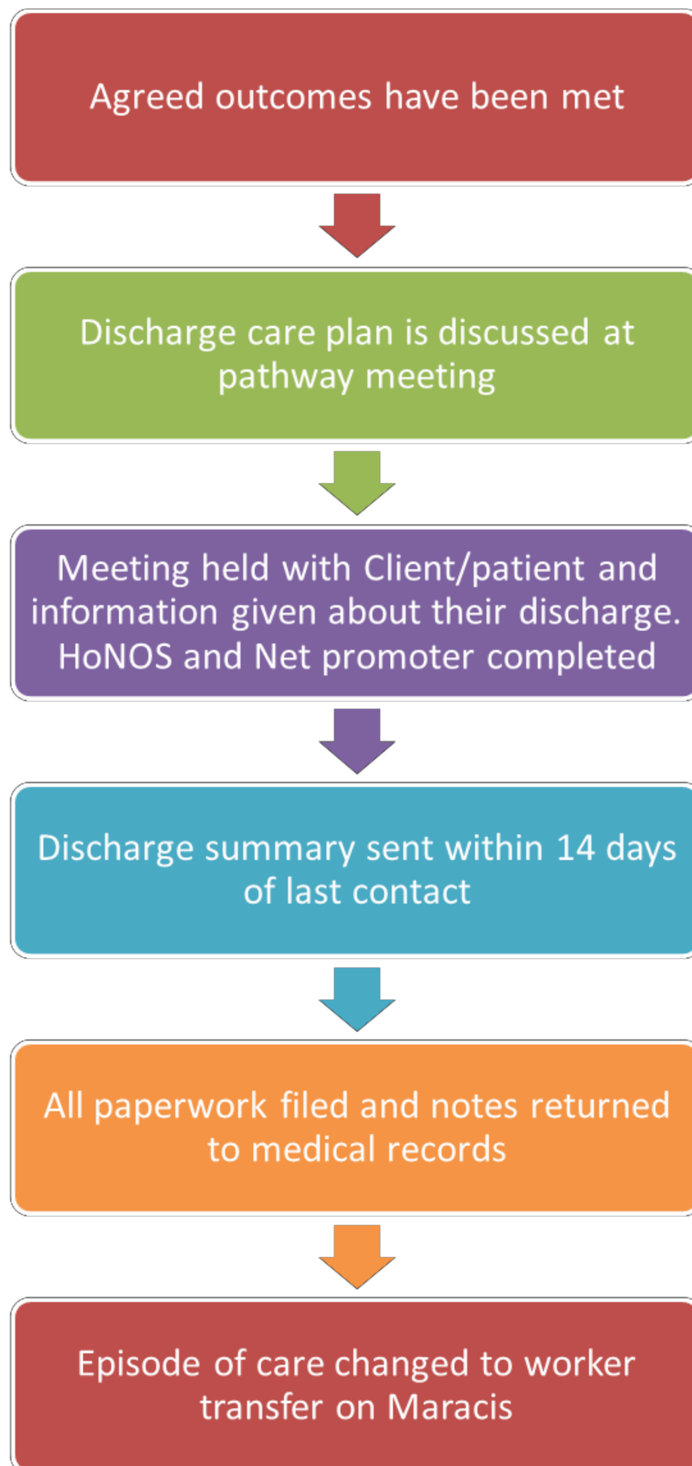
The summary should contain the following information where applicable:

- Initial reason for referral
- Investigations carried out and all available results
- Clinical summary of treatment
- Definitive primary diagnosis where confirmed or reason for it not being available
- List of medication commenced and to be continued including duration Medication changed or stopped and the reasons (for all inpatients and where relevant for community patients)
- Management plan
- Should give recommendations for on-going management or monitoring.
- Relapse indicators
- Plan for crisis management
- Point of contact for crisis support
- Follow up arrangements by other professionals within the service
- Preventive measures or pro-active steps that could be taken should there be problems in future.

- Management plan/crisis plan – who to contact
- What information has been provided to the patient on the condition and the management.
- Is the person on CPA
- Does the person require an IMCA

RiO must be updated and all information relating to the referral should be filed and returned to CVS.

Learning Disabilities Discharge Flowchart



Discharge Care Plan

Name: DOB:

NHS No: ICD10 Code:

Current Care Pathway(s)	
Care Co-ordinator:	
Name	
Address	
Postcode:	Tel:

	Date		
Agreed outcome	agreed	achieved	agreed with MDT

Learning Disabilities Discharge Letter

Name
Address
Date
(specific discipline) **Discharge Report**

Name:
NHS No:
DOB:
ICD10 Code:

Please include:
Initial reason for referral
Investigations carried out and all available results
Clinical summary of treatment
List of medication commenced and to be continued including duration
Medication changed or stopped and the reasons
Management plan/crisis plan – who to contact
Follow up arrangements
Information provided to the patient
Infection and prevention status

Yours sincerely

C/c

Learning Disability Service Discharge Summary

Name:

Address:

Date on Birth:

NHS Number:

Referral Date:

Reason for original referral:

[Insert Text]

Aim for intervention:

[Insert Text]

Outcome(s) of intervention:

[Insert Text]

Recommendations and summary:

[Insert Text]

How and where to re-refer:

[Insert Text]

Report Completed By:

Signature: ___________________________

Role:

Date:

Copies Sent To:

Discharge Summary for Short Breaks Homes

23rd November 2015

Dear,

Please see below a summary of how _______ stay with us [INSERT SHORT BREAK HOME NAME HERE] has been.

We hope this information will be of use to you. Should you wish to discuss anything regarding this stay, please do not hesitate to contact us.

Eating

Drinking

Sleeping

Medication

Physical

Epilepsy

Continence

Mood/Behaviour

Social

Accidents/Incidents

General

We are returning £[INSERT TEXT] unused cash this stay.

We look forward to seeing _________________ on their next stay which is currently booked for [INSERT DATE].

Yours Sincerely,

[INSERT SENDER DETAILS]

Appendix 4 MHSOP Delayed Transfer of Care (DToC) flowchart v3 start date 16 April 2019 baileyc

START
2 weeks to EFFD

Send # S2 form -referral for Social Worker Assessment 48 hrs to allocate

No Social Worker needed

MDT agree patient Fit for Discharge / optimised

YES

Inform S/S (if applicable)

Send FFD email notice to S/S City/County/Rutland (if applicable)

Agree DToC code with social worker (if applicable)

YES

2 w/day

Stage 1
Set DTOC

Unable to confirm DToC with S/S manager. Attempt to contact named s/w to set code. – if no response set DToC after 24 hrs and email details of change.

Physically unwell, causing a delay to discharge

PAUSE DToC

(By the period unwell)

Mentally no longer fit for discharge

DToC END

DTOC restart date to be discussed case by case **New S2 form may be needed when fit again.**

ON LEAVE or **DISCHARGED**

YES

END Successful

DToC END

Failed leave / discharge - Placement not appropriate:

Re-admitted or returned

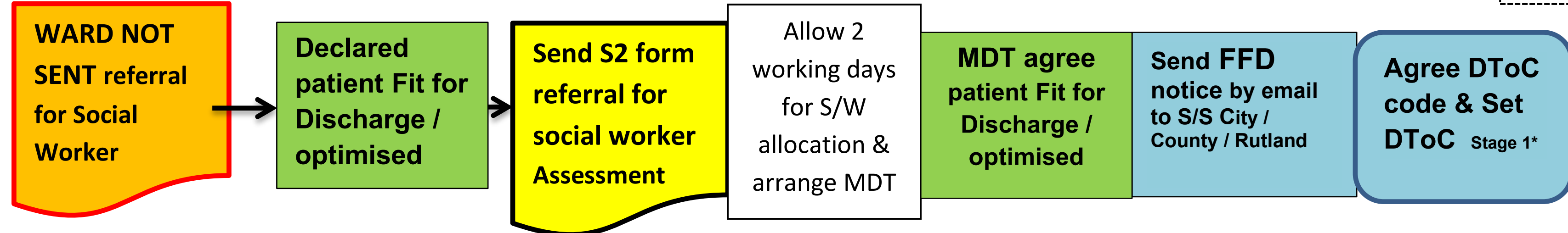
IF remains FIT for discharge - discuss with s/w before re-starting DToC

DToC (Stage 1) *

IF NOT FIT Discuss with s/w – **New S2 form may be needed when fit again.**

Return to START

DECLARED FIT BUT S/S HAD NOT INVOLVED IN PROCESS TO DISCHARGE

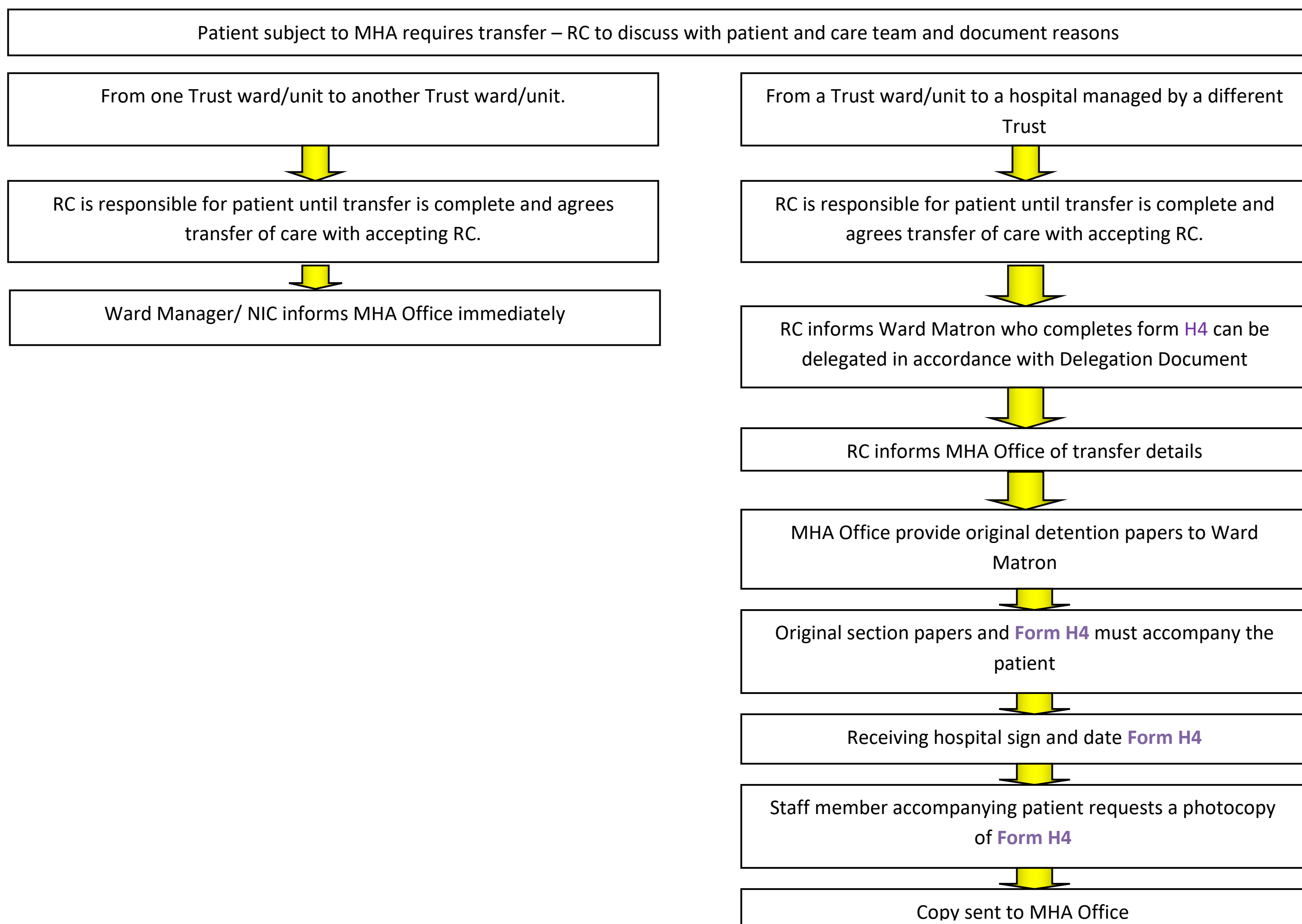


Key: # S2 form = '**Assessment Notice**' – notification of potential need for assessment by Social Services Department

NOTE : A PATIENT ON MHA SECTION 3 or DOLS CAN STILL BE A DTOC

Sometimes someone can be fit for discharge, but because a suitable placement or package of care is still needed to be found, a legal framework is needed to keep them on the ward. S3 will be more appropriate than ending the section and applying for DOLS if the patient is not compliant with care, or poses a risk to others from their behaviour. (See example below)

Appendix 5 - Section 19 Transfer of detained patients flowchart



The responsibility for CTO patients can be transferred to another Trust/Independent Hospital by completion of **Form CTO10** whilst the patient remains in the community or by completion of **Form CTO6** during the 72 hours of recall.

Where patient is transferred to the Trust from another Trust/Local Authority the individual accepting the transfer must ensure that the original section papers are received (including **Form H3**) and checked as well as the relevant transfer documentation (see above) before accepting responsibility or signing transfer documentation. In exceptional circumstances photocopies may be accepted by the admitting nurse. For transfer into the Trust of section 2 or section 3 patients the admitting nurse should follow the procedure described in 7.3.3 or7.3.5 respectively. All paperwork should be sent to the MHA admin team ASAP (within 1 working day).

Appendix 6

Due Regard Equality Analysis

Initial Screening Template

Section 1	
Name of activity/proposal	Discharge of inpatients
Date Screening commenced	June 2015
Directorate / Service carrying out the assessment	Adult Mental Health and Learning Disability Division
Name and role of person undertaking this Due Regard (Equality Analysis)	Claire Armitage, Lead Nurse
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of the inpatient discharge policy is to provide staff within the Leicestershire Partnership NHS Trust with a clear process so that all discharges are appropriately managed to minimise the risk to service users and to improve outcomes and quality of care. The policy applies to all inpatient areas within the Trust.	
OBJECTIVES: The need to provide high quality care at the right time, in the right place, delivered by the right people is of paramount importance in reducing pressure on hospital and community services. Equally important is the need to ensure that service users have a good experience whilst in our care and that discharge is safe, timely, coordinated, and well communicated. This discharge policy has been written to provide guidance on good practice to assist the multi-professional team in achieving a safe and timely discharge.	
PURPOSE: To provide clear guidelines and standards for staff to work within.	

Section 2		
Protected Characteristic	**Could the proposal have a positive impact Yes or No (give details)**	**Could the proposal have a negative impact Yes or No (give details)**
Age	Measures in place throughout this policy ensure that respect for the dignity of patients, carers and service users is maintained during the application of this policy, and that patients are fully involved in the discharge process and offered advocates to support this process wherever appropriate (see sections 3.1, 4.7 and 4.9)	
Disability		
Gender reassignment		
Marriage & Civil Partnership		
Pregnancy & Maternity		
Race		
Religion and Belief		
Sex		
Sexual Orientation		
Other equality groups?		

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.			
Yes		**No ✓**	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4
It this proposal is low risk please give evidence or justification for how you reached this decision:
Throughout the development of this policy, careful consideration has been given to ensure that respect for the dignity of patients, carers and service users is maintained. See for example sections 3.1, 4.7 and 4.9.

Sign off that this proposal is low risk and does not require a full Equality Analysis:

Head of Service Signed:
Date:

Appendix 7

Policy Training Requirements

Training Required	YES	NO ✓
Training topic:		
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development	
Division(s) to which the training is applicable:	☐ Adult Mental Health & Learning Disability Services ☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children ☐ Hosted Services	
Staff groups who require the training:	*Please specify…*	
Regularity of Update requirement:		
Who is responsible for delivery of this training?		
Have resources been identified?		
Has a training plan been agreed?		
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)	
How is this training going to be monitored?		

Appendix 8

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Principle	Tick
Shape its services around the needs and preferences of individual patients, their families and their carers	☑
Respond to different needs of different sectors of the population	☑
Work continuously to improve quality services and to minimise errors	☑
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☑
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☑

Appendix 9

Stakeholders and Consultation

Key individuals involved in the 2016 document revision

Name	Designation
Claire Armitage	Lead Nurse, AMH and LD Services
John Devapriam	Consultant Psychiatrist, AMH and LD Services
Laura Hughes	Head of Information

Key individuals involved in developing the 2014 document

Name	Designation
Caroline Towers	Governance Manager, CHS
Linda Bull	Community Hospital Matron, CHS

Circulated to the following individuals for comments

Name	Designation
Linda Bull	Hospital Matron, CHS
Sarah Clements	Hospital Matron, CHS
Mandy Gamble	Hospital Matron, CHS
Zayad Saumtally	Hospital Matron, CHS
Janet McNally	Hospital Matron, CHS
Mandy Allinson	Hospital Matron, CHS
Maria Ward	Project Lead
Jane Capes	Senior Matron, Acute Inpatient Services, AMH
Liz Compton	Senior Matron, Acute Inpatient Services, AMH
Tracey Finnamore	Practice Development Nurse, LD Services
Lynne Moore	Practice Development Nurse, LD Services
Francisco Guerra	Team Manager, CAMHS
Paul Williams	Team Manager, Eating Disorders Service
Bal Johal	Head of Quality and Professional Practice
Jude Smith	Head of Nursing, CHS
Emma Wallis	Lead Nurse, CHS
Victoria Peach	Lead Nurse, CHS
Kathy Feltham	Lead Nurse, CHS
Neil Hemstock	Lead Nurse, FYPC
Noel O’Kelly	Clinical Director, CHS
Helen Burchnall	Clinical Director, FYPC
Mohammed Al-Uzri	Clinical Director, AMH/LD
Satheesh Kumar	Medical Director
Jacquie Burden	Clinical Governance Lead, AMH/LD
Heather Darlow	Clinical Governance Lead, CHS
Vicki Spencer	Clinical Governance Lead, FYPC
Teresa Smith	Divisional Director, AMH/LD
Helen Thompson	Divisional Director, FYPC
Rachel Bilsborough	Divisional Director, CHS
Michelle Churchard	Head of Nursing, AMH/LD
Mat Williams	Senior Matron, CRHT
Daniel Kinnair	Consultant Psychiatrist, AMH and LD Services
Caroline Barclay	Nurse Consultant, Advanced Practice
Jane Martin	Service Manager, LD Services

Example: patient with aggressive and challenging behaviour that we have not been able to resolve completely with medication and interventions on the ward. In this case he does not require further treatment in hospital, but until a suitable placement is found to meet his needs, he would still need to be under the Mental Health Act to allow us to legally detain him on the ward. A nursing home placement is likely to then apply for DOLS, but ultimately end up with an application to the Court of Protection to authorise his placement (presuming he lacks capacity) if he continues to be a risk to others with his behaviour.