South Eastern Health and Social Care Trust

Policy Code: MH/PW/P08

Title:	**Admission & Discharge Policy**			
Author(s)	William Delaney Clinical Manager Mental Health Services			
Ownership:	South Eastern Trust Mental Health Programme			
Approval by:	Director of Adult services		**Approval date:**	22 March 2017
Operational Date:	22 March 2017		**Next Review:**	22 March 2019
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Key words:	Admission/Discharge			
Links to other policies	MH/PW/P15 Good Practice Guidance on the Assessment & Management of Risk Regional Bed Management Protocol for Acute Psychiatric Beds MH/PW/P04 Observation and Engagement Policy and Procedure MH/PW/P03 The Management of Inpatient Absconding Policy and Procedure MH/PW/P07 Leave Policy and Procedure MH/PW/P01 Entry and Exit Policy for Acute for Acute Inpatient Units MH/PW/P16 Protocol for the admission and management of children and adolescents in the South Eastern Trust's psychiatric units Children Visiting MH/PW/P14 Policy for the seven day follow-up of patients discharged from hospital with a continuing care plan. MH/PW/P16 Bed Management Policy for Acute Psychiatric Beds Procedure for the management, use and checks of the alarm system and walkie talkies used within mental health hospital services MH/PW/31 Transfer of patients with Mental ill Health			

1.0 Introduction

The admission and discharge process to hospital should always be respectful of the individual's Human rights and the patient's involvement if appropriate should always be requested in decision making about their care and treatment. The vast majority of admissions to adult mental health services are admitted as voluntary patients however there are some who

are admitted compulsorily under the legislation of the Mental Health Order (Northern Ireland) 1986.

This policy aims to ensure that the experience of patients and their families during the admission and discharge processes is one that is participative, positive, helpful and beneficial. It is important that admission to, and discharge from in-patient facilities is viewed as a single process that enables staff to provide structured and continuous care within this framework. It is also important that discharge planning should commence at the point of admission and continue throughout the patient's period of hospitalisation.

2.0 Definitions/Scope of the Policy & Procedure

This policy and procedure applies to all mental health patients admitted to and discharged from psychiatric inpatient care within South Eastern H&SC Trust.

3.0 Roles/Responsibilities

This policy and procedure sets out the standards mental health staff are required to comply with in respect of the admission and discharge process. It is the responsibility of line managers and team leaders to ensure this policy is brought to the attention of all staff. Relevant staff must familiarise themselves with the policy and adhere to its contents.

4.0 Key Principles

4.1 A single point of entry is operated for admissions to adult mental health services. There are a number of exceptions to the provision:

- The patient is referred out of Trust.
- The patient (South Eastern H&SC Trust) is referred directly as a detained admission;
- The patient is over 65 years of age (POA).
- The patient is aged under 18 years of age

4.2 All patients within the South Eastern H&SC Trust area referred for voluntary admission should first be referred to the appropriate Home Treatment Service for assessment to determine if admission is appropriate or if the patient can safely be managed alternatively. Referrals outside the operational hours of the Home Treatment Services should be made to the Mental Health at Night services.

4.3 Such alternatives include intensive support involving frequent contact and on-going risk and needs assessment, medication management, specific psychosocial interventions and support to maintain and improve social networks, practical assistance with accessing services

such as benefits, housing and childcare, education on maintaining good mental health and relapse prevention.

4.4 Where admission is indicated staff should follow MH/PW/P18 Bed Management Policy for Acute Psychiatric Beds.

5.0 Criteria for Admission

- Adult mental health service provision is for those individuals with a mental illness aged 18 years and over and includes Psychiatry of Old Age (POA) inpatient services.
- Patients under the age of 18 years are ordinarily not admitted to an acute psychiatric ward unless in an emergency and in accordance with MH/PW/P16 Protocol for the admission and management of children and adolescents in the South Eastern H&SC Trust's psychiatric units.

6.0 Mental Health Order (Northern Ireland) 1986

For individuals who are admitted compulsorily under the legislation of the Mental Health Order (Northern Ireland) 1986:

6.1 Applicants must be made on the appropriate prescribed forms and care must be taken to ensure that these are completed correctly by the referring GP and Family member or Approved Social Worker (ASW).

6.2 The responsibility for receiving the patient and checking the application must be assumed by a First Level Nurse (Part 1 Mental Health).

6.3 The Nurse should check the application form for any inaccuracies that may invalidate the authority to admit.

6.4 The Nurse should refer between office hours to the authorised administrative officer (Medical Records & Information Department Manager) in any case where there is doubt about the validity of the documents.

6.5 Outside of office hours, the nurse should refer to the Senior Manager/Consultant Psychiatrist on call in any case where there is doubt about the validity of the documents.

6.6 Certain errors may be corrected in accordance with Article 11 of the Mental Health Order (Northern Ireland) 1986.

6.7 Part II of the Mental Health Order (Northern Ireland) 1986 applies equally to children and young persons under the age of 18 years. Specific reference should be made to MH/PW/P16 Protocol for the admission and management of

children/adolescents in the South Eastern H&SC Trust's psychiatric units.

7.0 Preparation before Arrival

7.1 Where an admission is planned between office hours, the nurse in charge should arrange for any previous health records the patient may have to be made available prior to admission. Where this is not possible, the nurse in charge should arrange for information on previous care planning and intervention to be sourced within 1 working day. There is a responsibility upon referring team/agent to notify the ward of an impending admission to enable the ward to adequately prepare. This will include the provision of:

- The most up to date comprehensive assessment
- Updated clinical risk assessment
- ECP documentation if applicable
- Care pathways for Lithium/Clozapine if applicable

8.0 Exchanging Information

8.1 On admission it is important that all available information is obtained and exchanged between those involved in the admission, including accompanying relatives/carers, police, ambulance staff and/or other mental health professionals. This will include any documentation from professionals pertaining to the patient's mental health and risk assessments. Any information exchanged must comply with public protection and the Data Protection Act 1998.

8.2 The patient should be involved in decisions (wherever possible) about when, where and with whom information about them is going to be shared and used. Reference should be made to MH/PW/P17 Involving Families/Carers in the Assessment, Care Planning, Review & Discharge Processes.

8.3 The receiving nurse has the responsibility for requesting relevant information that will inform the patient's assessment.

8.4 The receiving nurse should review all relevant information and ascertain if the patient has any caring responsibilities (young children, care dependents, pets etc.) that require attention. Issues identified should be raised as a matter of urgency to enable appropriate interim measures to be put in place where this is practical and reasonable and this information communicated to the relevant personnel.

8.5 It is particularly important that staff obtain all relevant details from police when they are involved in an admission because of a patient's aggression or violence, including previous instances of aggression or violence.

8.6 This information should be recorded on the clinical records and indicate the time of admission/transfer. In addition this information must be brought to the attention of the nursing team at ward level and the admitting First on Call Doctor.

8.7 The admitting First On Call Doctor should record any relevant information obtained directly from the referral agent and communicate this to the appropriate personnel where indicated

8.8 Community staff should be actively involved in the admission process where practicable and they are aware of the admission.

8.9 Admitting nurse to check Maxims to ascertain if patient is known to CMHT/CAT staff and notify them via email. If the key worker is not available then the respective team leader to be emailed. Admitting nurse to also email the generic email address for the local assessment centre to advise of individual's admission

8.10 Admitting nurse to evidence sent email on appropriate email tab on Maxims

8.11 Receipt of this email should act as a reminder to CMHT/CAT staff to provide a written report to hospital staff within one working day of being advised of the admission.

9. Procedures on admission

9.1 On acceptance of the admission nursing staff are required to

- Conduct a search of available information on Maxims to include the electronic risk assessment
- To comply with the procedures detailed in MH/PW/F01 Admission/Discharge Care Pathway (Appendix 1).

9.2 The admitting doctor should conduct a search of letters of involvement on Maxims and with consent if appropriate from the patient conduct a search of the Northern Ireland Electronic Care Record to obtain any further relevant clinical information on the patient. This will include:

- Allergies status
- Previous and current medications
- Previous medical history

10. Guidance to be followed when a planned admission fails to attend for admission

When a planned admission to an acute MH Inpatient Unit does not happen, i.e. the patient fails to arrive within two hours of the agreed time, the nurse in charge should:

- Contact the source of the request for admission
- Attempt to contact patient, nearest relative (issues in respect of confidentiality should be considered) and GP to ascertain the reason for delay and if there is any cause for concern.
- Discuss the delay with the first on call doctor and seek guidance. The first on call doctor may need to discuss with second on call doctor or Consultant Psychiatrist on call.
- Record advice/action plan provided in the patients clinical records
- Consider alternative community follow-up in consultation with consultant.
- Discuss with Clinical Manager/ Senior Manager on call

11. Staff safety

The safety of the staff is paramount and medical and nursing staff must give consideration in advance of interview to any risk the patient may present before conducting the assessment. This will include information from relevant sources, including Maxims/Clinical Risk Assessment/NIECR if the patient is a re-referral. Each member of staff has responsibility for ensuring that interviews are conducted in a safe environment. This rule equally applies to any interview with the patient throughout their period of care.

11.1 All staff should carry their personal alarms.

11.2 As part of local orientation and induction, all staff must be familiar with the procedure for activating and rapidly responding to an activated alarm.

11.3 The Ward Sister/Charge Nurse has responsibility for ensuring all his/her designated staff participates in local orientation and induction programmes.

11.4 Interviews should only take place in rooms that have a readily accessible emergency call system or where the personal alarm system can be activated.

11.5 The furniture in the interview room should be arranged in a manner that does not impede escape.

11.6 In the rare occasions where a joint assessment is not being undertaken, the admitting doctor/nurse should arrange for other staff to be aware of their presence and staff should only see the patient on their own after an assessment of risk suggests that it is reasonably safe to do so.

11.7 When conducting a physical examination, medical staff should request that a member of nursing staff be present to act as a chaperone. A member of staff of the same sex as the patient should ordinarily act as a chaperone.

12. Clinical Risk Assessment

All patients on admission will have their clinical risk assessment reviewed and updated. Reference should be made to MH/PW/15 Good Practice Guidance on the Assessment and Management of Risk.

- The assessment of risk should be dynamic and continue throughout the patient's period of hospitalisation, with the full involvement of the patient and their carer (if the patient gives consent).

13. Medicines reconciliation on admission (MOA)

In December 2007, the National Institute for Health and Clinical Excellence (NICE) in collaboration with the National Patient Safety Agency (NPSA) issued guidance to the NHS on how to improve the process of medicines reconciliation for adults on admission to hospital. Medicines Reconciliation on Admission seeks to ensure that any medicines patients are taking prior to admission to hospital are properly documented on admission.

13.1 As part of the admission process all patients should have their prescribed medicines on admission reconciled on admission through a review of the NIECR. The responsibility for this reconciliation lies with the admitting doctor.

14. Continuity of care

14.1 It is important that Community Mental Health staff remain actively involved after the patient's admission to hospital and is involved in the discharge planning process for individuals back into the community.

14.2 Relevant community mental health staff (or their representative) where possible, should attend a multidisciplinary team assessment meeting within two weeks of admission in order to ensure information is available to inform the assessment process and development of the care plan.

14.3 Where the patient's length of stay extends beyond twenty eight days, the keyworker must attend a further Team Assessment Meeting prior to the discharge.

15. Discharge planning:

15.1 Discharge planning should commence at the point of admission.

15.2 Effective discharge planning requires co-ordination and the dedicated time of all disciplines/services involved to enable the patient's timely and effective transition from inpatient care to the community.

15.3 A care plan which takes account of requirements to enable a safe and timely discharge from hospital should be developed in consultation with

the patient and their carer (with the patient's consent) and agreed by the multidisciplinary team.

15.4 In planning and implementing discharge, staff will follow procedures and guidance detailed in MH/PW/P15 Good Practice Guidance on the Assessment & Management of Risk.

15.5 Under current Priorities for Action Targets (Target 4(a)) all patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge. Reference should be made to MH/PW/P14 Procedure for the Seven Day Follow-up of Patients Discharged from Hospital with a Continuing Care Plan.

16. Leave

Leave of absence from the ward or unit is often used as an adjunct to the discharge process. Given that the patient is not yet ready for discharge it must be assumed that the service user still has needs which cannot be met fully in the community. It follows then that all periods of leave involving overnight stays must be planned. Specific reference is made to MH/PW/P07 Policy and Procedure for a Patient Going on Leave.

17. Admissions and Discharges out of area

17.1 Patients are occasionally admitted from outside the Trust on an emergency basis. Arrangements should be made for the return of these patients to their respective Trust as soon as practicably possible through consultation with the Mental Health Clinical Manager or nominated deputy.

17.2 Staff should ensure that all relevant information is obtained where available on admission, or make arrangements to obtain this information as soon as possible after admission.

17.3 The responsibility for a patient discharged 'out of area' should be retained until the patient is formally transferred to the local clinical services to which the patient has moved.

17.4 Where possible the accepting multidisciplinary team should be involved in planning aftercare and as a minimum standard, receive all relevant information at the time of discharge.

17.5 Aftercare planning should ensure clear and open communication between voluntary and statutory agencies.

17.6 Staff should make specific reference to MH/PW/31 Transfer of Patients with Mental ill Health

18. Patients detained under Mental Health (NI) Order 1986.

18.1 Patients detained under the Mental Health Order may only be transferred on completion of Forms 1, or 2, 3 and 7. Under no circumstances can patients be transferred on a Form 5.

18.2 Patients detained under the Mental Health (NI) Order 1986 are deemed to be in legal custody (Article 13.1{1}). Should the patient abscond while being conveyed to another hospital, s/he may be retaken and returned to the admitting hospital.

18.3 A PSNI escort should be requested if it is deemed necessary. This will be agreed by the professionals involved in the treatment and transfer of the patient.

19. Unplanned Discharge

Individual voluntary patients on occasions may indicate that they wish to discharge themselves prematurely and against medical advice.

19.1 If by discharging him/herself the patient could potentially be at risk then staff should endeavour to persuade the patient to stay.

19.2 The nurses in charge should engage and assess the patient and establish the reasons why the patient has decided to discharge themselves against advice.

19.3 The nurse in charge should be familiar with any risk(s) pertaining to the patient as detailed in the most recent risk assessment and care plan.

19.4 The risk of self-discharge before it is recommended by medical staff must be explained to the patient.

19.5 If the patient is insistent that they are going to proceed with their self-discharge, then the relevant First on Call Doctor should be contacted by nursing staff and informed of the situation, any identified risk(s) and be requested to attend the ward and assess the patient.

19.6 The First on Call Doctor should, assess the patient and explain the potential detrimental effect of proceeding against medical advice.

19.7 If the patient is assessed as representing a significant risk to themselves or others, consideration should be given to the application of the Nurses Holding Power (Form 6, if a doctor is not immediately or imminently available), or where the doctor is available to the application of Form 5 for the detention of a voluntary patient already in hospital.

19.8 In situations where staff are unable to detain a patient who has been deemed to be at serious risk of physical harm to themselves or others, then a follow up care plan should be agreed at the earliest opportunity

in retrospect by the responsible multidisciplinary team. The care plan should detail what to do in a crisis and on-going plans for review. It is noted that patients who discharge themselves against medical advice may still require and accept aftercare. Proactive attempts should be made to engage the patient in these situations.

19.9 If the patient proceeds with their discharge against medical advice they will be asked to sign the discharge against medical advice form and the First on Call Doctor should record the outcome in the clinical records.

19.10 The nurse in charge should discuss the case with the First on Call Doctor and/or responsible Consultant to agree any follow-up arrangements required for the patient's continuing care and treatment in the community and advise the patient of these arrangements. This should include any additional arrangements arising if the patient discharges themselves outside the routine working hours of services.

19.11 The nurse in charge will be responsible for making any necessary arrangements for follow-up, including information to the GP, CMHT, etc. Reference is made to MH/PW/F01 Admission/Discharge Care Pathway. The patient's discharge destination must be confirmed to assist this process.

19.12 The patient's next of kin/carer (consider issues of confidentiality) should be informed of the discharge by the nurse in charge and advised of any relevant elements of the discharge care plan that apply to them, including elements of the contingency plan.

19.13 A detailed account of proceedings, including the advice provided to the patient and carers should be recorded in the patient's clinical records.

19.14 The decision to discharge a patient prematurely as a consequence of inappropriate behaviour will be taken by the relevant consultant/deputy following an assessment and/or discussion with the senior nurse on duty.

19.15 The consultant should agree in discussion with members of the MDT any follow-up arrangements required and the timeframe within which these should be delivered (if a difference of opinion occurs around the response time, the final decision will be made by the Consultant Psychiatrist) and procedures detailed in Paragraphs 18.9 - 18.12 above followed.

20. Discharge from Absconding

On occasions, a decision may be taken to discharge a voluntary patient who has absconded.

20.1 In the first instance, a comprehensive MDT review and updating of the risk assessment and the individual's circumstances should be

completed. A request for an emergency referral made to Home Treatment Services should be considered.

20.2 The Home Treatment Services will ascertain the patient's current wellbeing (home visit), update the risk assessment and discuss their presentation with responsible Consultant Psychiatrist.

20.3 Where it is clear that the patient is unwilling to return, and where concerns exist, the Home Treatment Services should discuss these concerns with the responsible Consultant Psychiatrist and agree the appropriate course of action, which may include requesting assessment for detention by the patient's GP.

20.4 The decision to discharge ultimately rests with the responsible Consultant Psychiatrist. If no grounds exist for detaining the patient for assessment under the Mental Health Order (Northern Ireland) 1986, the responsible Consultant Psychiatrist will consider a decision to discharge based on the presenting risk, any continuing care needs the patient may have and discussion with the Home Treatment Service and the patient's GP.

20.5 The Consultant Psychiatrist should confirm any follow-up support that may be required and me within which these should be provided. If a difference of opinion occurs around the response time, the final decision will be made by the Consultant Psychiatrist. This should be formally communicated to the Home Treatment Service, the patient, and the patient's GP.

20.6 In situations whereby Home Treatment Services are unable to establish contact with the patient (and their carer/family) despite multiple attempts, or the patient has absolutely refused to engage with services; the decision to discharge should only be taken following consideration of 19.3

21 Mental Health review tribunals

Patients detained under the Mental Health (Northern Ireland) Order 1986 have the right to have their detention reviewed, at specified intervals, by a Mental Health Review Tribunal. The Tribunal must discharge the patient if the statutory criteria specified in Article 77 of the Order are met, and has discretion to the discharge patients in other cases. If the patient is subject to a restriction order the tribunal may direct that he or she is discharged subject to any conditions which the Tribunal may specify.

- Where a patient is to appear before a Tribunal, the possibility of discharge must be recognised and an assessment and care management process put in place so that arrangements for the patient's community care can be effected without delay.

22. Follow up after discharge

22.1 The arrangements for the follow-up after discharge are detailed in MH/PW/F01 Admission/Discharge Care Pathway.

22.2 A discharge summary letter should be completed by the relevant medical staff as soon as practicable after the individuals discharge

22.3 Consideration should be given to the carer involvement and a relapse prevention plan should be drawn up with the carer's involvement.

22.4 Where a patient's mental health illness may impact on the care of the children or other dependents (e.g. older people), staff need to consider interface between mental health, child care services and other specific teams, to ensure effective communication and the co-working of cases.

23. Seven day follow-up of patients discharged from hospital with a continuing care plan.

Patients who are discharged with a continuing care plan should be followed up within seven days of discharge as per MH/PW/P12 Policy for the Seven Day Follow-up of Patients Discharged from Hospital with a Continuing Care Plan.

See also section 19.0 Discharge and Absconding

24. Monitoring

The effectiveness of this procedure will be monitored through policy review arrangements.

25. Evidence Base / References

1. The Mental Health (Northern Ireland) Order 1986.
2. The Code of Practice (Mental Health Order (Northern Ireland) 1986.
3. DHSSPSNI 2004 Guidelines 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could represent a Risk of Serious Physical Harm to Themselves or Others'.
4. Acute in-patient psychiatric care for young people with severe mental illness (Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists) Council Report CR106 June 2003 Royal College of Psychiatrists.
5. The Human Rights Act 1998.
6. The Northern Ireland Act 1998 (Section 75 Equality Considerations).
7. Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability. Revised May 2010.
8. Mental Health Hospital and Community Interface Good Practice Standards 2012.

26. Consultation Process

This procedure has been reviewed with input from multidisciplinary staff input.

27. Appendices / Attachments

Acute Psychiatry- Admission > Discharge Nursing Care pathway

28. Equality Statement

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact	☐
Minor impact	☑
No impact	☐

Signatories)
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director)

B. Mongan

Bria Mongan
Director of Mental Health & Prison Services

Date: 11/4/17

D. Brannigan

Damien Brannigan
Mental Health Acute Services Manager
(Lead Nurse)

Date: 20/4/17

W Delaney

William Delaney
Mental Health Clinical Manager

Date: 20/4/17

ALLERGY STATUS:

Name:	DOB:	
Date of arrival: Time: Dr..... informed @		VARIANCE – If an intervention is not completed or late – record reason, action taken & outcome. DATE & SIGN ALL INTERVENTIONS.
Within 1 hour of admission		
2. Patient escorted to ward by: Carer □ Relative □ Friend □ Nurse □ Police □ Ambulance □ ASW □ Other □ _____		
3. Information Exchanged on admission	Y/N	
4. Greet on arrival, show to appropriate area & offer hospitality to patient & carer	Y/N	
5. Communication needs assessed Confirm adequate literacy skills Comment..... Interpreter required	Y/N Y/N Y/N	
6. Ward induction/orientation and patients responsibilities explained.(if patient well enough)	Y/N	
7a. Discuss: Patient's responsibilities, rights & expectations of admission	P □ C□	
7b. Client Experience Standards	P □ C□	
7c SET Mental Health & Support Services	P □ C□	
7d. Compliments & Complaints Leaflet	P □ C□	
7e. Explain level of observations. General and enhanced observations.	P □ C□	
7f. Explain plastic bags policy within mental health wards	P □ C□	
7g Explain Confidentiality and sharing of information with other voluntary and statutory services	P □ C□	
7h Explain the misuse of alcohol and illicit/unprescribed drugs policy	P □ C□	
7i. Request individual consent to access NIECR	P □	
7j. Explain rationale of 30 Minute checks	P □ C□	
8. If patient detained – ensure they are informed of their requirement of period of assessment under MHO 1986	P □	

9. Explain the need to potentially have to search property and seek consent from patient/carer if appropriate	P □ C□	
10. Valuables: with patient □ placed in safe □ recorded in property book □ sent home with relative □		
11. Medications on admission in accordance with Trust Policy: Returned to relative □ Consent for Disposal □		
12. Interventions √ = completed. Smart Board □ Patients name on Fire List □ Maxims completed □ Half hour check list □ Property Safety Check □ Fire plan (individual/generic) □		
Within 6 hours of admission		
13.Complete Risk Assessments : Body Chart □ Braden Scale □ Nutrition/MUST Assessment □ Consider: Infection control, moving & handling, falls □ Anti-absconding Discussion/ Risk □ AWOL Score on admission □ Consider urine drug screening □		
14. Jointly complete and update PQC risk assessment and management plan with medical staff. Consider the potential dangers of previously known used ligatures □ Consider other episodes of self-harm with razors or other instruments □ Consider phone chargers/headphones as ligatures, consider removing if necessary with consent □ Is the individual on a profiling bed □ Does the individual require a profiling bed □		
Within 24 hours of admission		
15. Complete identified needs, care plan(s) on Maxims in conjunction with patient		
16. Provide patients with a copy if requested.		
17 Ensure discussions on anti-absconding initiated to include the rationale for the sign in/out process.		

18. For detained patients only, verbal and written explanation of rights to appeal provided □ (Ensure confirmation sheet signed)	
19. Advocacy services explained □	
20. Patient wishes to see Chaplin Yes/No	
3 Monthly Re-assessments completed	
..../...../.....	..../...../.....

Nursing - Discharge from Hospital

	VARIANCE – If an intervention is not completed or late – record reason, action taken & outcome. **DATE & SIGN ALL INTERVENTIONS.**
1.Nurse informed patient of their discharge date	
2. Confirm & record discharge address for patient (SAI recommendation)	
3 Confirm next of kin details	
4 Inform NOK of discharge. (Record name and date of notification)	
5. Transport arranged	
5. Discharged/Transferred to other hospital - CREST form & Nursing transfer documentation completed	
6. Medication √=yes Discharge Advice Summary Ordered □ Medication given to patient/carer □ Medication explained to patient/carer □ Kardex filed in notes □ Blue copy in patients file □ White copy to GP □	
7. Nursing document √ = yes Nursing notes & Care plan completed □ Removed from Fire List □ Removed from Smart board □ Patients property returned / Appendix 1	

completed ☐ Discharge details, referral & follow up section on Maxims completed ☐ Please record weight on discharge ☐ Computer spell closed ☐	

DISCHARGE	Informed of discharge **Record By Phone/E-mail** – Name & Contact number	Name (print) , signature, date & time
GP		
CPN		
Care Co-ordinator		
Social Worker:		
Home treatment		
Day Hospital		
Family & Child Care		
Addictions		
Voluntary Sector **Probation Service** **Psychology** **Nursing home** **Other (specify)**		

	VARIANCE – If an intervention is not completed or late – record reason, action taken & outcome. **DATE & SIGN ALL INTERVENTIONS**
MAXIMS search for involvement with other healthcare professionals/ECP involvement	
Confirm Current Demographic Details including: **- Details of Next of Kin & significant others --** **Patients telephone phone number**	
Patient escorted to ward by nurse, police or ambulance, exchange contact details and information	
Security of the patient's home, whereabouts of children & animals – admitting nurse to check with referring agent re above – record in free text area in admission. **Consider UNOCINI/VULNERABLE ADULTS ISSUES**	
Family composition (under family history)	

Baseline observations & colour of hair, eyes, weight, height, distinguishing marks, build Admission Bloods □ Urinalysis/MSSU □ Drug Screen □	
Family history – obtain collateral history from immediate family or significant others, effect on family prior to admission. Family needs.	
Initial assessment – on Maxims Personal History Personality Past Psychiatry history–currently open case - yes/no Past Medical history Nutrition (under physical) Smoking (under drugs/alcohol) Appearance & behaviour Affect & Mood Perception Thought form and Content Cognitive function Gender needs Anti-absconding discussion/rationale of signing in and out	
Initial assessment – The patient is able to involve the people they rely on for support in their assessment. Record on Maxims if carer/friend/relative involved in assessment	
Admission Summary –complete on MAXIMS	

Community teams involved in the patients care should be informed of their admission to hospital. The key worker should be invited to attend the first Team Assessment meeting.
E-mail Mental Health Assessment Centres to inform them of patients admission Yes/ No /NA
E-Mail Community Mental Health Teams to inform them of patient's admission –Yes/ No / NA
(VERBALLY AND IN WRITING)

Insert name and Contact details of individuals contacted.	**Informed of admission - Yes, No, N/A**	**Name (print) , signature, date & time**
Consultant Psychiatrist :		
Next of Kin:(with patients consent) & provide with contact details of ward :		

GP :		
CPN :		
Care Co-ordinator :		
Social Worker:		
Home Treatment :		
Day Hospital:		
Day Centre:		
Family & Child Care:		
Voluntary Sector: **Probation Service:** **Psychology:** **Nursing home:** **Other (specify):**		
Addictions		

Health and Social Care

Documentation for Mental Health Hospital Services (South Eastern HSC Trust)

Complete on admission and monthly as per MUST Protocol:

Name:	**Date of Birth:** _ _/_ _/_ _ _ _		**Health and Care Number:**					
Height (m):	**Please Tick:**	**Actual**		**Recalled**		**Ulna Length (cm)**		
DATE:		/ /	/ /	/ /	/ /	/ /	/ /	/ /
WEIGHT (kg):								
BMI (kg/m^2):								
STEP 1 BODY MASS INDEX – BMI (use step 1 BMI score)		**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
• Over 20kg		0	0	0	0	0	0	0
• 18.5kg to 20kg		1	1	1	1	1	1	1
• Less than 18.5kg		2	2	2	2	2	2	2
STEP 2 UNPLANNED WEIGHT LOSS IN LAST 3-6 MONTHS (use step 2 weight loss score)								
• Less than 5 %		0	0	0	0	0	0	0
• Between 5-10 %		1	1	1	1	1	1	1
• More than 10 %		2	2	2	2	2	2	2
STEP 3 ACUTE DISEASE • If patient is acutely ill AND there has been OR is likely to be no nutritional intake for more than 5 days		2	2	2	2	2	2	2
TOTAL MUST SCORE:								
SIGNATURE: **DESIGNATION:**								

SCORE 0 = LOW RISK	SCORE 1 = MEDIUM RISK	SCORE 2 OR MORE = HIGH RISK

HSC Health and Social Care

Name: _____ Date of Birth: __/__/____ Health and Care Number: _____

Malnutrition Universal Screening Tool (MUST)
NUTRITIONAL CARE PLAN
for MEDIUM RISK (MUST Score 1) and HIGH RISK (MUST Score ≥2)

Please Action as Appropriate for the individual Client	Tick/ N/A	Comments	Date	Print Name and Sign
• Put patient on High Protein / Energy Diet • Offer High Energy / High Protein Snacks • Ensure foods are fortified • Offer Nourishing Drinks				
Assist patient with eating and drinking as appropriate				
Identify reasons for weight loss e.g. pain/constipation/ dentition/infection/dysphagia/altered eating/poly-pharmacy/mood /psychological or social factors				
Record food and fluid intake for 3 days (using Food Record Chart) To identify pattern of eating and highlight potential areas of concern e.g. insufficient food taken, preferred eating time/meal				
Weigh monthly (record in Kg)				
Repeat MUST at least monthly If improving continue until 'low risk'. If deteriorating consider treating as 'high risk'				
Inform and involve family with nutrition care plan				
Refer to Dietitian if high risk/MUST score ≥2 (or follow local policy)				
Other actions to meet the client's individual needs:				

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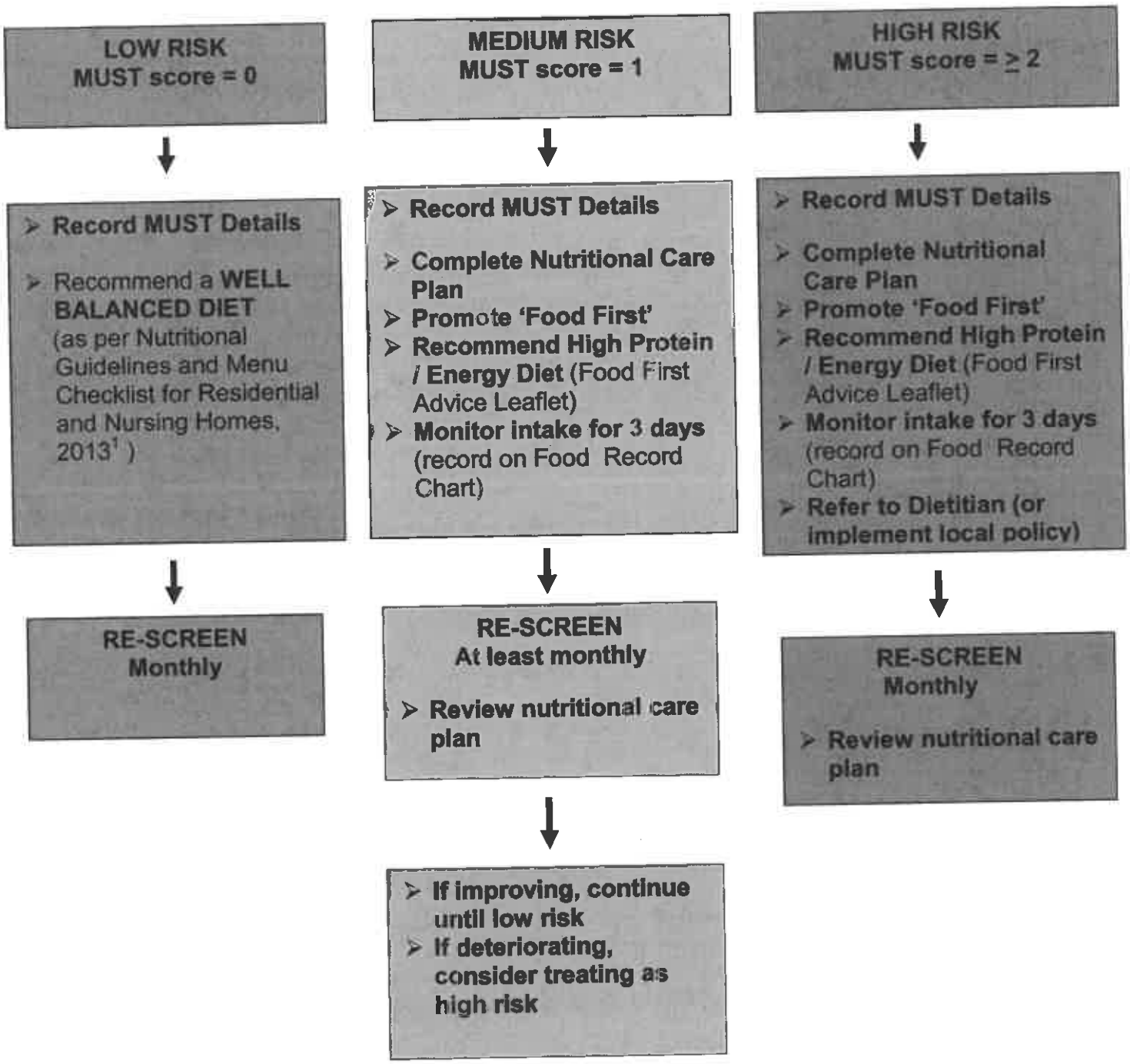
Malnutrition Universal Screening Tool (MUST)

***Documentation for** Mental Health Hospital Services (South Eastern HSC Trust)*



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Admission Alcohol Care Pathway Mental Health

Patient consent Yes □ No □ Un-fit □

Do you drink Yes □ No □

Complete AUDIT Questionnaire Score =

AUDIT score 0-7 Education on units of Alcohol

AUDIT score 8-15 suggests "Harmful drinking"-simple brief advice e.g. Education on units, harmful drinking leaflet.

AUDIT score 16-19 suggests "Hazardous drinking"-simple advice + brief counselling e.g. Alcohol + You booklet, Drink diary, self-monitoring period, educate on physical effects of long term drinking.

AUDIT score 20 -40 suggests need for specialist advice/referral and inform G.P (see page 2)

For further information and advice you can refer to:

HELP available via-Interactive website with self-help material @ www.alcoholandyouni.com
Alcohol clinics; counselling clinic; Family intervention service;
Help and support is only a phone call or click away; 02892604422

ALCOHOL HISTORY:

Recent Alcohol consumption: YES NO

Binge drinking: for how many days , type of alcohol beer, spirits, cider,

Regular or x-strong

Total units daily: date and time of last drink:

Continuous drinking (no recent break) , type of alcohol beer, spirits, cider, regular or strong

Total units daily date and time of last drink:

Consider completing CIWA, consider Pabrinex therapy, and liaise with SHO Refer to Trust guidelines for management of Alcohol withdrawal.

List prescribed medications:

List use of non-prescribed medications:

List illicit drug use:
List method of use oral □ sniffing □ injecting □ patches □

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MEDICAL OFFICER TO ASSESS DUAL MANAGEMENT OF ALCOHOL + DRUGS WITHDRAWAL

It is essential to request a history of PREVIOUS management of WITHDRAWAL SYMPTOMS:

Has the patient been detoxed in the past? YES □ NO □

Does the patient have a history of withdrawal seizures YES □ NO □

AMBULATORY detox (did not require bed rest or have previously completed detox at home) □

MEDICAL detox (required hospital admission in past for detox) YES □ NO □

If yes to seizures or medical detox consider admission to General Hospital for management of
withdrawal symptoms liaise with Consultant /SHO.

AUDIT score-20-40 the following interventions should be carried out with the patients consent.
Consent yes □ no □

1. Complete Alcohol dependence questionnaire. Date :
   score :
2. Educate on recognising withdrawal symptoms. Date:
3. Assess physical health Date:
4. Educate re physical effects of long term heavy alcohol use. Date:
5. Educate re association of current health problems (both mental health + physical) to alcohol consumption. Date:

The outcome of this assessment has been explained to me.

Patient's signature: Date:

Nurse's signature: Date:

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FALLS PREVENTION MANAGEMENT PLAN

Falls Prevention Management Plan must be completed <u>within 6 hours of admission.</u>

DOES THE PATIENT HAVE A HISTORY OF FALLING **YES /NO**
DOES THE PATIENT HAVE A FEAR OF FALLING? **YES/NO**

Part A: The following actions must be carried out for all patients

(record if actions are completed ✓ or NA)

Risk Factor	Actions to be considered & actioned	Interventions initiated (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA
	Date					
Environment	Ensure call bell is in reach					
	Ensure personal items are in reach and observe area for slips, trips and falls hazards					
Mobility	Consider referral for a walking aid					
	Ensure suitable footwear is worn					
Communication	Communicate falls risk using visual cues at bedside, room door, whiteboard / safety brief					

Part B

Part B must be completed on all inpatients over 65 years and also on patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition (patients with a sensory impairment or dementia, and patients admitted to hospital with a fall, stroke, syncope, delirium or gait disturbances)

Risk Factor	Actions	Interventions initiated (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA	Interventions reviewed (✓) or NA
Maintaining a safe environment	Measure lying and standing Blood Pressure					
	Complete a urinalysis					
Signature of Accessing Nurse: Designation						
Date						
Review Date						

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South Eastern Health and Social Care Trust

PRESSURE ULCER RISK ASSESSMENT/PREVENTION & MANAGEMENT CARE PLAN

Patient's Name:
_____

Hospital/ Health & Care No.:
_____

Date of admission/ onto caseload:
_____

REMEMBER

Check all of the patient's pressure risk sites on admission/ first visit

You are responsible for acting on your findings – instigate and document preventative care as appropriate

Re-evaluate the patient's risk status each time their condition changes. If their risk status does not change record the fact weekly in acute care, monthly in long term care settings and quarterly in primary care.

Remember the Braden scale is an aid to clinical judgement, it cannot replace

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Braden Scale Pressure Ulcer Risk Assessment Tool

Sensory Perception Ability to respond meaningfully to pressure related discomfort.	1. Completely Limited Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	2. Very Limited Responds only to painful stimuli. Cannot communicate except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture.	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry; linen only requires changing at regular intervals.
Activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	3. Walks Occasionally Walks occasionally during the day, but for very short distances, with or without assistance. Spends a majority of each shift in bed or chair.	4. Walks Frequently Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	1. Completely immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern [1]NPO: Nothing by mouth [2]IV: Intravenously [3]TPN: Total parenteral nutrition	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about ½ of any foods offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meats, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on tube feeding or TPN[3] regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

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Friction and Shear	**1. Problem** **Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.**	**2. Potential Problem** **Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.**	**3. No Apparent Problem** **Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.**	

Source: Barbara Braden and Nancy Bergstrom. Copyright 1988. Reprinted with permission.

Admission to Ward/ Caseload / Transfer/ Re-assessment

SECTION A – **Complete Braden Scale Assessment and Document Below**
On Admission

Date:							
Time:							
Total Braden Score:							
Skin Condition Checked:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Pressure Damage present? If yes, use diagrams to indicate sites.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Signature:							

Braden Score Low Risk = 19 – 23 At Risk = 18 or less

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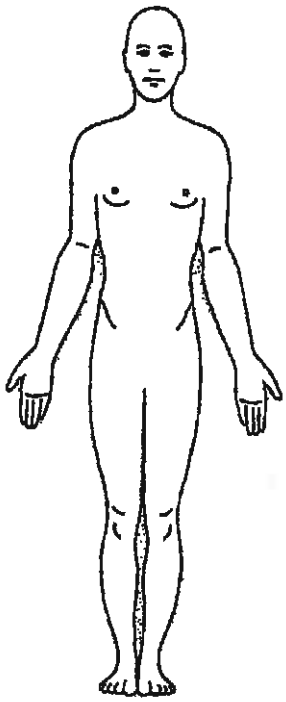
Document Grades of Pressure Ulcers below & indicate on body chart. Re-evaluate & record any deterioration

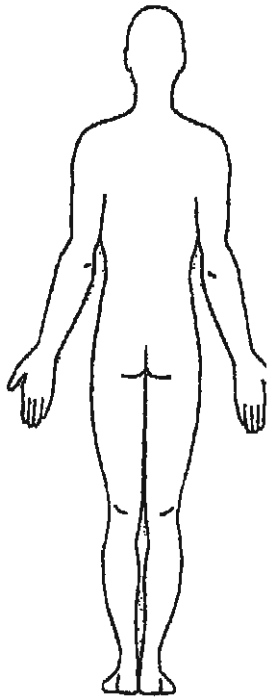
Ulcer 1 - Grade _____ Date: _____

Ulcer 2 - Grade _____ Date: _____

Ulcer 3 - Grade _____ Date: _____

Ulcer 4 - Grade _____ Date: _____





Definitions of Pressure Ulcer Grades – EPUAP/ NPUAP

Grade 1
Non-blanchable redness of intact Skin.

Grade 2
A shallow open ulcer with a red pink wound bed, without slough or an intact/ ruptured serous/ **serosanguinous** filled blister.

Grade 3
Full thickness tissue loss, but bone, tendon or muscle are NOT exposed

Grade 4
Full thickness tissue loss WITH exposed bone, tendon or muscle visible or directly palpable.

Ungradeable
Unable to determine base of wound due to the presence of slough or eschar or blood **treat as grade 4**

Action required:

Grade 2 - 4 pressure damage - Wound observation chart commenced

YES ☐ NO ☐ N/A ☐ Date: _____

Grade 2 - 4 Facility acquired pressure damage - IR1/ clinical incident completed

YES ☐ NO ☐ N/A ☐ Date: _____

Grade 3 - 4 pressure damage - Tissue viability nurse Referral

YES ☐ NO ☐ N/A ☐ Date: _____

If you have answered NO to any of the above, explain variance_____

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Complete Section B for all patients

SECTION B PREVENTION/ MANAGEMENT CARE PLAN

Interventions	Pressure Ulcer Prevention (Circle appropriate response)	Date & Sign each section
Educational Needs Patients should be advised of their 'AT RISK' status and the actions that they can take to prevent pressure damage.	Verbal advice on pressure relief given YES / NO /N/A If NO state reason ..... Written advice on pressure relief given YES / NO /N/A	
Repositioning Needs If a patient cannot reposition themselves a repositioning schedule must be initiated. Consider whether Sitting time should be restricted to less than 2 hours per session.	Patient is able to reposition self YES / NO If NO, Reposition Schedule implemented / advised YES / NO Repositioning schedule discussed with carers YES/ NO / NA	
Moving and Handling Needs If you are unsure about moving and handling needs contact the Ergonomics Team.	Patient moves independently YES / NO If NO, Sliding sheet required YES / NO Hoist required YES / NO Other.....	
Therapy Bedding Needs Use Therapy Bed Flow Chart for acute/ primary care as appropriate, to choose appropriate support surface.	Pressure Reducing Foam Mattress supplied YES / NO OR Dynamic Mattress ordered YES / NO Model ordered.....Date: ..... Model supplied.....Date: ..... Up /downgraded.....Date:	
Therapy Cushion Needs Use therapy Flow Chart to choose appropriate cushion. Contact Occupational Therapist for wheel-chair users.	**Recommended** length of time to sit up..... Pressure Reducing Cushion required YES / NO If NO, state reason..... Model ordered .....Date: ..... Date cushion supplied.....	
Nutritional Needs Use the Braden Scale or a Nutritional Assessment Tool to help you assess whether a dietetic referral is needed. Consider referring patients with grade 3 and 4 pressure ulcer.	Patient has special nutritional needs YES / NO Patient referred to the dietician YES / NO	
Special Skin Care Needs e.g., if patient has very dry skin or is incontinent.	pH 5.5 soap alternatives required YES / NO Barrier Cream required YES / NO AND/OR Emollient required YES / NO Other.....	

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SECTION C	**Pressure Ulcer Prevention** (Circle appropriate response)	**Date & Sign**
Preparation for Discharge Community Staff need at least 3-4 days' notice to organise therapy bedding. Try to give as much notice as possible.	Risk assessment score on discharge: ..... Equipment required on discharge/transfer YES / NO If YES, Community/Other informed on..... By..... Person contacted.....	
This booklet should be photocopied and sent with the patient if they are discharged or transferred to another facility e.g. hospital, primary care or nursing Home		

If interventions need to be re-assessed, please use single copy of Section B

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South Eastern Health & Social Care Trust - Recommended Repositioning

Patient Name:_____ H&C No. /PIL:_____ (Patient Identification Number/LABEL)	Reposition:_____ (State recommended frequency) when in BED Reposition:_____ (State recommended frequency) when up to SIT Special Considerations:_____ (e.g.: Patient can only lie on back, etc.)

Action to relieve pressure may include repositioning using a 30° tilt, standing or mobilising patient. Inspect and document the condition of all pressure areas <u>at least</u> twice daily. The condition of the patient's skin should be recorded each time the patient is repositioned and any deterioration in skin condition reported to Key Worker/Line Manager (where appropriate).

TIME & DATE	State current skin condition/and area(s) affected	Action taken to relieve pressure	Report Changes, if deterioration contact Key Worker/Line Manager (where appropriate) and state name of person informed	PRINT NAME

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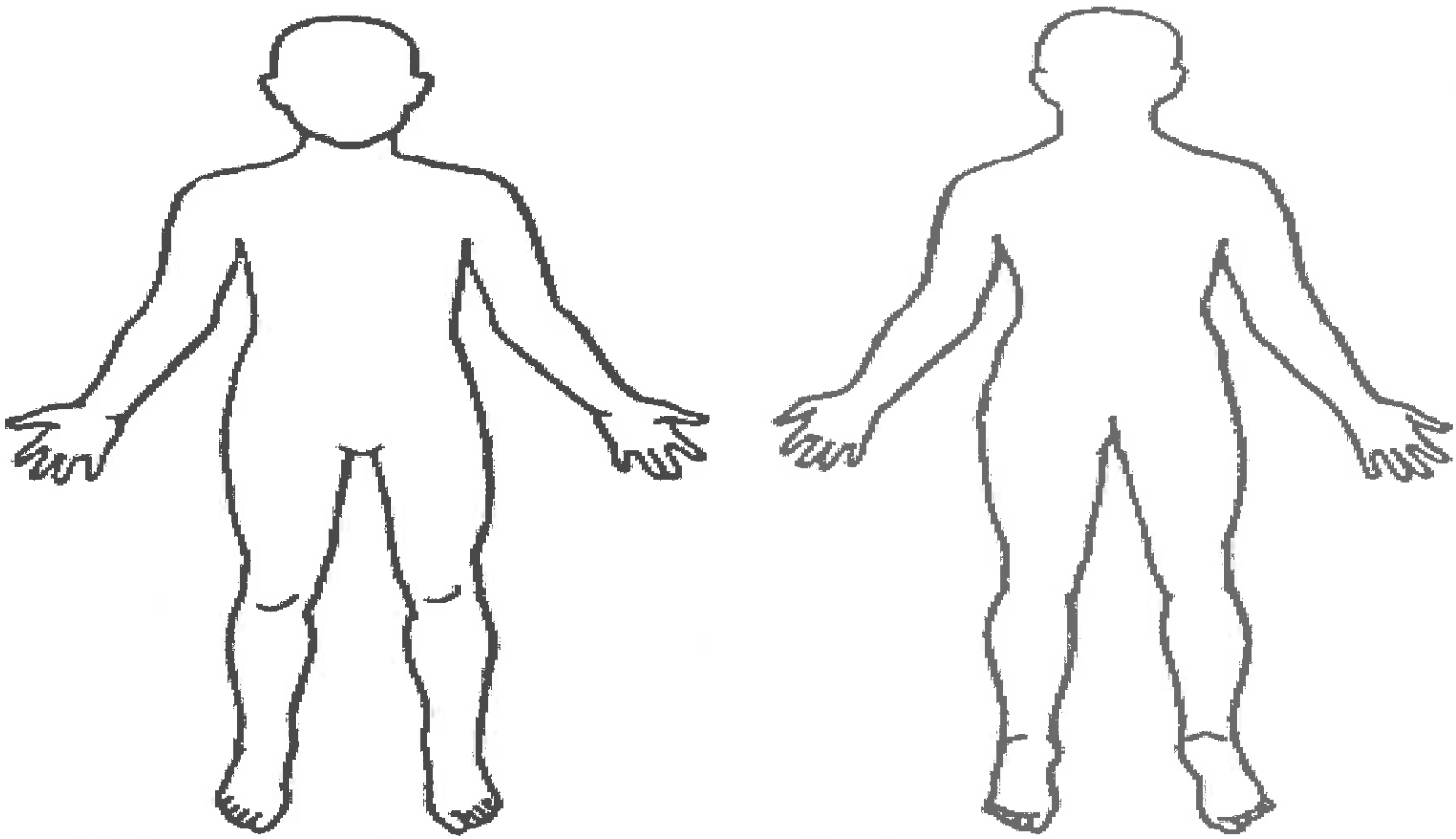

Please circle the area concerned on body chart and number. Describe nature of bruise/injury			
Date	**No**	**Description (including size and colour)**	**Signature**

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Assessment on Smoking Status

Do you Smoke	Yes	No
Number of cigarettes smoked per day	.....	
How long has person smoking?	..... years	
Brief Smoking Cessation advice given:	Yes	No
Smoking Policy explained	Yes	No
Interested in stopping:	Yes	No
Referred to Smoking Cessation Service:	Yes	No
Additional Information:		
Has need been identified:	Yes	No
If yes, link to Plan of Care.		

Additional information

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Discharge Plan

Name.....

Following discharge your first appointment is with

.....

On.....

At.....

Other services which have been arranged for you are as follows

.....

.....

.....

.....

Relapse Prevention Plan

What helps me when I'm unwell

*

*

What activities can help to distract me from a relapse

*

*

Should you feel unwell on weekdays you should contact your key worker, if you have one

Your key worker is.....

Telephone Number

.....

If you do not have a key worker, then you should contact your GP on

.....

If you feel unwell at night or at the weekends you should contact the GP on call or attend your local A&E