Standard Operating Procedure
Admission and Discharge for Adults of Working Age
Inpatient Service

<table>
<thead>
<tr>
<th>Version Number:</th>
<th>V1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of originator/author:</td>
<td>Consultant Clinical Lead/ Deputy Acute Care Services Manager/ Matron AOWA</td>
</tr>
<tr>
<td>Name of responsible committee:</td>
<td>Clinical Governance Committee</td>
</tr>
<tr>
<td>Name of executive lead:</td>
<td>Chief Nurse and Director of Quality Assurance</td>
</tr>
<tr>
<td>Date V1 issued:</td>
<td>February 2014</td>
</tr>
<tr>
<td>Last Reviewed:</td>
<td>February 2014</td>
</tr>
<tr>
<td>Next Review date:</td>
<td>February 2017</td>
</tr>
<tr>
<td>Scope:</td>
<td>Adults of working age Inpatient service – adult acute wards and PICUs</td>
</tr>
<tr>
<td>MMHSCT Document Code</td>
<td>CL82</td>
</tr>
</tbody>
</table>
## Document Control Sheet

<table>
<thead>
<tr>
<th>Document Title / Ref:</th>
<th>Standard Operating Procedures - Admission and Discharge for Adults of Working Age Inpatient Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Executive Director</td>
<td>Chief Nurse and Director of Quality Assurance</td>
</tr>
<tr>
<td>Author and Contact Number</td>
<td>Consultant Clinical Lead/ Deputy Acute Care Services Manager/Matron AOWA</td>
</tr>
<tr>
<td>Type of Document</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>Broad Category</td>
<td>Clinical</td>
</tr>
<tr>
<td>Document Purpose</td>
<td>This standard operating procedure aims to ensure that all Trust staff involved in the admission and discharge of patients to adult inpatient services [excluding Acacia] understand and are working together towards an effective coordinated service that meets the individual needs of service users, as well as those of their relative/carer(s).</td>
</tr>
<tr>
<td>Scope</td>
<td>Trust wide</td>
</tr>
<tr>
<td>Version number</td>
<td>1</td>
</tr>
<tr>
<td>Consultation</td>
<td>Inpatient management teams, Mental Health Home Treatment Team service, Community, Head of Nursing, Operational Management Team, Clinical Risk Committee, Heads of Professions</td>
</tr>
<tr>
<td>Approving Committee</td>
<td>Clinical Risk Committee</td>
</tr>
<tr>
<td>Approval Date</td>
<td>March 2014</td>
</tr>
<tr>
<td>Ratification and Date</td>
<td>Lead Exec Approval</td>
</tr>
<tr>
<td></td>
<td>March 2014</td>
</tr>
<tr>
<td>V1 Valid from Date</td>
<td>February 2014</td>
</tr>
<tr>
<td>Date of Last Review</td>
<td>New document</td>
</tr>
<tr>
<td>Date of Next Review</td>
<td>February 2017</td>
</tr>
</tbody>
</table>

**Procedural Documents to be read in conjunction with this document:**
- Admission, Discharge and Transfer Policy
- The Guidelines for the Physical Assessment of Service User
- Assessment, Care and Support Planning Policy and Procedure for Care Programme Approach (CPA) and Non CPA.
- Medicines Policy
- Slips, Trips and Falls policy
- Absent Without Leave Policy (including procedure for missing persons)
- Relevant Mental Health Act Policies
- Clinical Handover of Care Policy
- Safeguarding Policy

Current version is valid from approval date
| Training Needs Analysis Impact | Training needs have been identified and are being delivered within the acute care capacity plan 2013/14. Ongoing engagement events held with Inpatient Services. | Financial Resource Impact | There are no Financial or Resource impacts. |

**Document Change History**

*Changes to this document in different versions must be detailed below. Rationale for the change should also be given*

<table>
<thead>
<tr>
<th>Version Number / Name of procedural document this supersedes</th>
<th>Type of Change i.e. Review / Legislation / Claim / Complaint</th>
<th>Date</th>
<th>Details of Change and approving group or Executive Lead (if done outside of the formal revision process)</th>
</tr>
</thead>
</table>

**External references used in the creation of this document:**

If these include monitoring duties upon the Trust for this policy the specific details should be recorded on the *Monitoring and Compliance Requirements sheet*

**Privacy Impact Assessment submitted**

N/a | Any issues? | Choose an item. |

**Fraud Proofing submitted**

N/a | Any issues? | Choose an item. |

If not relevant to this procedural document give rationale:

**Policy authors are asked to consider each of the nine protected characteristics under the Equality Act 2010. We expect you to demonstrate that throughout the policy process you have had regard to the aims of the Equality Duty:**

1. Eliminate unlawful discrimination, harassment and victimisation and any other conduct prohibited by the Act;
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
3. Foster good relations between people who share a protected characteristic and people who do not share it.

Please provide a brief account of how you have done this, further work to be completed and any support you have had in considering the aims and working in compliance with the Equality Duty.
If you are unclear on how to do this or would like further advice and support then you may contact quality.admin@mhsc.nhs.uk.

It is the responsibility of the approving group to ensure this statement reflects the Trust's objectives and position with compliance as set out within the NHS Equality Delivery System.

This standard operating procedure is broad and the scope is Trust Wide so complies with the Trust's Equality Delivery System. This procedure is aligned to the Trust's Admission, Discharge and Transfer Policy and is therefore compliant with Trust's Equality Delivery System.

| In line with the Trust values we may publish this document on our External Website. Is there any reason you would prefer this is not done? | No |

It is the Authors responsibility to ensure all procedural documents comply with the Trust values.

If you are unclear on any of the requirements in the document control sheet then please email quality.admin@mhsc.nhs.uk before proceeding.
## Monitoring and Compliance Requirements Sheet

For audit, Registration and NHSLA purposes all procedural documents must have monitoring requirements or key performance indicators set by the authors, Committees or Lead Directors. This allows the Trust to routinely monitor the effectiveness and impact of their procedural documents on a regular basis.

<table>
<thead>
<tr>
<th>Procedural Document Title:</th>
<th>Standard Operating Procedure for Admission and Discharge for Adults of Working Age Inpatient Service – <em>an Appendix to the Trust’s Admission, Discharge and Transfer Policy.</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this procedural document offer support or evidence for the Trusts registered activities and outcomes?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is this an NHSLA Document?</td>
<td>Yes</td>
</tr>
<tr>
<td>If other Monitoring requirements are necessary i.e. Health &amp; Safety Act and you should include them here and record them in the External References section</td>
<td></td>
</tr>
</tbody>
</table>
| Specify where the requirement originates | Care Quality Commission (2010), *Essential Standards of Quality and Safety*, CQC, London  
National Confidential Inquiry Into Suicide and Homicide by people with Mental Illness, Safer Mental Health Services: a toolkit (November 2012)  
Care Services Improvement Partnership (2007), *A Positive Outlook: A good practice toolkit to improve discharge from* | | Additional Details i.e. Section number, Code of Practice |
<table>
<thead>
<tr>
<th>Minimum Requirement / Standard / Indicator to be monitored &amp; Section of document it appears</th>
<th>Process for monitoring</th>
<th>Responsible Individual / Group</th>
<th>Frequency of Monitoring</th>
<th>Responsible Group for review of results / action plan approval / implementation</th>
<th>Comments</th>
</tr>
</thead>
</table>
| **Level 1**
  a. The documented process to include admission and discharge requirements for all patients. | Review | Deputy Acute Care Services Manager and Head of Nursing | 3 yearly | Clinical Governance Committee | |
| b. The documented process to include roles and responsibilities of all receiving healthcare professionals. | Review | Deputy Acute Care Services Manager and Head of Nursing | 3 Yearly | Clinical Governance Committee | |
| c. The documented process to include information to be given to the patient during their inpatient stay. | Review | Deputy Acute Care Services Manager and Head of Nursing | 3 Yearly | Clinical Governance Committee | |
| d. The documented process to include how a patient's medicines are managed. | Review | Deputy Acute Care Services Manager and Head of Nursing | 3 Yearly | Clinical Governance Committee | |
| e. The documented process to include how the organisation records the information given in minimum requirements b) and c) | Review | Matrons and Deputy Acute Care Services Manager | 3 Yearly | Clinical Governance Committee | |

**NB:** If you have selected audit you should complete the required audit registration form and standards document and submit these with your expected timescales for completing the audit to quality.admin@mhsc.nhs.uk as soon as possible and no later than 4 weeks prior to the audit commencing.

The Group / Committee should also ensure the monitoring work is added to their yearly schedule of monitoring and action logs as appropriate.
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Specific Tasks and Related Guidance Notes</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Roles and Responsibilities Within 24 Hours</td>
<td>10</td>
</tr>
<tr>
<td>3.1</td>
<td>Responsible Clinician</td>
<td>10</td>
</tr>
<tr>
<td>3.1.1</td>
<td>Review Safe and Supportive Observation Levels</td>
<td>10</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Review Risk Assessment and Management Plan</td>
<td>10</td>
</tr>
<tr>
<td>3.1.3</td>
<td>Agree Purpose of Admission and Devise Admission Plan</td>
<td>10</td>
</tr>
<tr>
<td>3.2</td>
<td>Junior Doctor (FT/CT/ST)</td>
<td>11</td>
</tr>
<tr>
<td>3.2.1</td>
<td>Check Risk Assessment completed</td>
<td>11</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Prescription of Medication including PRN</td>
<td>11</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Complete Risk Follow Up and Review Risk Scores</td>
<td>11</td>
</tr>
<tr>
<td>3.2.4</td>
<td>Physical Health Examination Pro Forma completed within 6 hours</td>
<td>11</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Complete Summary and Abnormalities from Physical Health Examination completed on Amigos within 6 hours</td>
<td>11</td>
</tr>
<tr>
<td>3.2.6</td>
<td>VTE Assessment</td>
<td>11</td>
</tr>
<tr>
<td>3.2.7</td>
<td>Discuss and Agree Observation Levels with Nursing Staff</td>
<td>11</td>
</tr>
<tr>
<td>3.2.8</td>
<td>Complete Admission Bloods (FBC, U+Es, LFTs, TFTs, BGlu, Lipids, Prolactin)</td>
<td>11</td>
</tr>
<tr>
<td>3.3</td>
<td>Nursing Team</td>
<td>11</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Allocate Named Nurse</td>
<td>11</td>
</tr>
<tr>
<td>3.3.2</td>
<td>Update Patient Information</td>
<td>11</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Patient Property</td>
<td>11</td>
</tr>
<tr>
<td>3.3.4</td>
<td>Admission CPA</td>
<td>12</td>
</tr>
<tr>
<td>3.3.5</td>
<td>Contact Duty Doctor</td>
<td>12</td>
</tr>
<tr>
<td>3.3.6</td>
<td>Inform Bleep holder and Bed Management</td>
<td>12</td>
</tr>
<tr>
<td>3.3.7</td>
<td>Inform RC</td>
<td>12</td>
</tr>
<tr>
<td>3.3.8</td>
<td>HONOS and Cluster</td>
<td>12</td>
</tr>
<tr>
<td>3.3.9</td>
<td>First NEWS Assessment</td>
<td>12</td>
</tr>
<tr>
<td>3.3.10</td>
<td>Urine Drug Screen (UDS)</td>
<td>12</td>
</tr>
<tr>
<td>3.3.11</td>
<td>Risk Follow Up and Review Risk Scores</td>
<td>12</td>
</tr>
<tr>
<td>3.3.12</td>
<td>Admission Care Plans</td>
<td>12</td>
</tr>
<tr>
<td>3.3.13</td>
<td>Assign Safe and Supportive Observation Levels</td>
<td>12</td>
</tr>
<tr>
<td>3.3.14</td>
<td>Ensure MHA Paperwork Received if Detained</td>
<td>12</td>
</tr>
<tr>
<td>3.3.15</td>
<td>MHA Rights Given and Advocacy Referral Offered and Recorded</td>
<td>12</td>
</tr>
<tr>
<td>3.3.16</td>
<td>Welcome Pack</td>
<td>12</td>
</tr>
<tr>
<td>3.3.17</td>
<td>Confidentiality Form</td>
<td>13</td>
</tr>
<tr>
<td>3.3.18</td>
<td>Contact Carer and Offer Appointment with Professionals</td>
<td>13</td>
</tr>
<tr>
<td>3.3.19</td>
<td>Dependents including Pets</td>
<td>13</td>
</tr>
<tr>
<td>3.3.20</td>
<td>Refer to Housing Advisor if Homeless on Admission</td>
<td>13</td>
</tr>
<tr>
<td>3.3.21</td>
<td>Other Assessments as Required for eg Falls Assessment and MUSTS</td>
<td>13</td>
</tr>
<tr>
<td>3.3.22</td>
<td>Check Advance Directives</td>
<td>13</td>
</tr>
<tr>
<td>3.3.23</td>
<td>Alcohol Screening (Audit)</td>
<td>13</td>
</tr>
<tr>
<td>3.3.24</td>
<td>Healthcare Associated Infections - HCAIS</td>
<td>13</td>
</tr>
<tr>
<td>3.3.25</td>
<td>Close any Previous Inpatient Care Plans</td>
<td>13</td>
</tr>
<tr>
<td>3.4</td>
<td>Ward Clerks</td>
<td>13</td>
</tr>
<tr>
<td>3.4.1</td>
<td>Obtain Current and Previous Notes</td>
<td>13</td>
</tr>
<tr>
<td>3.4.2</td>
<td>FAX GP Pro Forma</td>
<td>13</td>
</tr>
<tr>
<td>3.4.3</td>
<td>AMIGOS System</td>
<td>13</td>
</tr>
<tr>
<td>3.4.4</td>
<td>Patient Demographics and Minimum Data Set on AMIGOS</td>
<td>13</td>
</tr>
<tr>
<td>3.4.5</td>
<td>Statutory Sick Note</td>
<td>13</td>
</tr>
<tr>
<td>3.5</td>
<td>Care Co-ordinator</td>
<td>14</td>
</tr>
<tr>
<td>3.5.1</td>
<td>Notify Community Consultant</td>
<td>14</td>
</tr>
<tr>
<td>3.5.2</td>
<td>Agree Purpose of Admission with MDT</td>
<td>14</td>
</tr>
</tbody>
</table>
### 3.6 Occupational Therapy

3.6.1 Screen New Admissions

### 4 Roles and Responsibilities Within 72 Hours

#### 4.1 Responsible Clinician

4.1.1 Discuss at First Daily Service User Review (DSUR)

4.1.2 Chair Admission CPA Meeting

4.1.3 Prescribe Sec 17 LOA if appropriate

4.1.4 Review CTO Recall Patients for Revoke

4.1.5 Agree Medication Requirements

4.1.6 Set Estimated Discharge Date

#### 4.2 Junior Doctors (FT/CT/ST) Either Team Doctors of On Call Doctor

4.2.1 Review Results of UDS

4.2.2 Review History and Treatment (Medication and Psychological Therapies)

4.2.3 Complete or Request ECG

#### 4.3 Nursing Team

4.3.1 Smoking Cessation

4.3.2 MUST Screen

4.3.3 Falls Screening

4.3.4 Meeting with Carer

4.3.5 Complete Admission CPA Meeting

4.3.6 Welfare Rights

4.3.7 Referral to Specialists eg Dietetics and Dual Diagnosis

4.3.8 Risk Follow Up Review 48 hours

4.3.9 Risk Follow Up Review 72 hours

4.3.10 Refer to CMHT

#### 4.4 Crisis Resolution Home Treatment (CRHT)

4.4.1 Attend Daily Service User Review

#### 4.5 Pharmacist

4.5.1 Medicines Reconciliation

4.5.2 Pharmaceutical Care Plan

4.5.3 Attendance at DSUR and Admission CPA as required

#### 4.6 Care Co-ordinator

4.6.1 Attend Admission CPA

4.6.2 Agree Level of Contact

4.6.3 Update MANCAS

#### 4.7 Occupational Therapist

4.7.1 Prioritise Service Users for OT

4.7.2 Attend Admission CPA

#### 4.8 Housing Advisor

4.8.1 Screen all Referrals and Collate Housing History

4.8.2 Attend Admission CPA for those Referred at Admission

### 5 Roles and Responsibilities Within 7 Days

#### 5.1 Junior Doctors (FY/CT/ST)

5.1.1 Complete Admission Summary

5.1.2 Review of Mental State

5.1.3 Follow Up and Monitor Physical Health

#### 5.2 Nursing Team

5.2.1 Entry Questionnaire

5.2.2 RETHINK PHC

5.2.3 LUNSERS

5.2.4 CPA Care Plan Updated

### 6 Roles and Responsibilities Pre Discharge

#### 6.1 Team Doctor (RC/FY/CT/ST)

6.1.1 Attend Discharge CPA

6.1.2 Request AMHP Assistance for CTO Allowing Sufficient Time for Completion

6.1.3 Liaise with Community RC

6.1.4 Complete Discharge Prescription and GP Notification

6.1.5 Review Cluster

#### 6.2 Nursing Team
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.1</td>
<td>Attend Discharge CPA</td>
<td>17</td>
</tr>
<tr>
<td>6.2.2</td>
<td>Speak to Principle Carer</td>
<td>18</td>
</tr>
<tr>
<td>6.2.3</td>
<td>Exit Questionnaire</td>
<td>18</td>
</tr>
<tr>
<td><strong>6.3 Pharmacist</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>6.3.1</td>
<td>Discharge Medication</td>
<td>18</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Identify Source of Supply of Medication</td>
<td>18</td>
</tr>
<tr>
<td>6.3.3</td>
<td>Medication Follow Up Requirements</td>
<td>18</td>
</tr>
<tr>
<td><strong>6.4 Care Co-ordinator</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>6.4.1</td>
<td>Attend Discharge CPA</td>
<td>18</td>
</tr>
<tr>
<td><strong>6.5 Occupational Therapist</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>6.5.1</td>
<td>Report Findings, Progress and Recommendations</td>
<td>18</td>
</tr>
<tr>
<td>6.5.2</td>
<td>Attend Discharge CPA</td>
<td>18</td>
</tr>
<tr>
<td><strong>6.6 Housing Advisor</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>6.6.1</td>
<td>Attend Discharge CPA</td>
<td>18</td>
</tr>
<tr>
<td>6.6.2</td>
<td>Liaise with the Care Co-ordinator after the IB is Secured</td>
<td>18</td>
</tr>
<tr>
<td>6.6.3</td>
<td>Ensure Furniture Packages, Repairs, Change of Address Forms, Utility Budgets are Carried Out</td>
<td>18</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7 Roles and Responsibilities On Discharge</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td><strong>7.1 Team Doctors (RC/FY/CT/ST)</strong></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>7.1.1</td>
<td>Discharge Patient from Section if Detained</td>
<td>18</td>
</tr>
<tr>
<td>7.1.2</td>
<td>Transfer RC Responsibility if Starting CTO</td>
<td>19</td>
</tr>
<tr>
<td>7.1.3</td>
<td>Complete CTO Paperwork</td>
<td>19</td>
</tr>
<tr>
<td>7.1.4</td>
<td>Agree Diagnosis for Recording on Discharge Summary</td>
<td>19</td>
</tr>
<tr>
<td>7.1.5</td>
<td>Discharge Medication</td>
<td>19</td>
</tr>
<tr>
<td>7.1.6</td>
<td>Discharge Summary within 10 days</td>
<td>19</td>
</tr>
<tr>
<td><strong>7.2 Nursing Team</strong></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>7.2.1</td>
<td>Confirm with Principle Carer and Patient that they are Aware of Discharge Plans</td>
<td>19</td>
</tr>
<tr>
<td>7.2.2</td>
<td>Risk Follow Up Risk Summary Update</td>
<td>19</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Review Property Log and Check Safe</td>
<td>19</td>
</tr>
<tr>
<td>7.2.4</td>
<td>Provide with TTO’s</td>
<td>19</td>
</tr>
<tr>
<td>7.2.5</td>
<td>Inform Bed Management</td>
<td>19</td>
</tr>
<tr>
<td>7.2.6</td>
<td>Close Inpatient Care Plans</td>
<td>19</td>
</tr>
<tr>
<td>7.2.7</td>
<td>Plan for and Undertake 7 Follow Up</td>
<td>19</td>
</tr>
<tr>
<td><strong>7.3 Ward Clerk</strong></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>7.3.1</td>
<td>Ensure Discharge Address and Contact Details of Patient and Principle Carer are Correct on AMIGOS</td>
<td>19</td>
</tr>
<tr>
<td>7.3.2</td>
<td>Discharge from AMIGOS</td>
<td>20</td>
</tr>
<tr>
<td>7.3.3</td>
<td>FAX GP (South Only)</td>
<td>20</td>
</tr>
<tr>
<td>7.3.4</td>
<td>File all Paperwork and Return Files</td>
<td>20</td>
</tr>
<tr>
<td><strong>7.4 Pharmacist</strong></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>7.4.1</td>
<td>Transfer of Discharge Information</td>
<td>20</td>
</tr>
<tr>
<td>7.4.2</td>
<td>Transfer of Pharmaceutical Care Plan</td>
<td>20</td>
</tr>
<tr>
<td><strong>7.5 Care Coordinator/ CRHT</strong></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>8.4.1</td>
<td>7 Day Follow Up</td>
<td>20</td>
</tr>
</tbody>
</table>

| Appx 1 | MTD Admission Checklist | 21 |
| Appx 2 | MTD Discharge Checklist | 23 |
| Appx 3 | Process and Principles for Daily Service Review Meetings | 24 |
| Appx 4 | Guidance on Expected Discharge Dates | 26 |
1 Introduction

The following Standard Operating Procedure (SOP) relates to the admission and discharge processes specific to Adults of Working Age Inpatient Services. This SOP has been developed to provide a clear process for each discipline within the Trusts AOWA inpatient services. It outlines the expectations that are referenced within the policies mentioned above, relevant to AOWA inpatient. This should be read in conjunction with these policies as it provides key highlights within expected timeframes as part of the Inpatient care Pathway.

Several elements are as a result of learning from incidents and SIRI’s. The SOP aims to ensure that there is consistent practice within these services and that staff have clear guidance, located in one place.

Consultants and their Ward Management Teams are responsible for the implementation and monitoring of the following standard operating procedure.

2 Specific Tasks and Related Guidance Notes

Tasks on the admission and discharge checklist and detailed below, largely refer to one off essential activity however, several actions are repeated during the rest of the admission period.

The full multi-disciplinary admission and discharge checklists reflect the care pathway and associated timescales as noted within Appendix A.

It is acknowledged that the current working hours of some professional groups will impact on the specific times for key activity. This will be taken into account in terms of the monitoring of actions against standards.

3 Roles and Responsibilities within 24 hours

3.1 Responsible Clinician

3.1.1 Review Safe and Supportive Observation Levels - Any levels of increased safe and supportive observation levels above general are to be reviewed as part of the Daily Service User Review (see Trust Policy for Safe and Supportive Observations and SOP for Daily Service User Review). Outcomes of the review are to be recorded in the patient’s clinical record and conveyed to the patient.

3.1.2 Review Risk Assessment and Management Plan - The Risk Assessment Tool (RAT) completed during admission is reviewed and discussed during the first ward round/admission CPA.

3.1.3 Agree Purpose of Admission and Devise Admission Plan - The precise purpose for admission is to clearly stated and recorded and will inform all assessments and the outcome measures for the patient.
3.2 Junior Doctors (FY/CT/ST)

3.2.1 **Check Risk Assessment Completed** – if not complete Trust RAT completed on Amigos plus CHORES as appropriate, if Amigos is not available, complete as 12 page booklet.

3.2.2 **Prescription of Medication including PRN** - Attempts to perform a physical examination and ECG (where indicated) must be undertaken before prescribing medication. (See Trust Rapid Tranquilisation Policy). Document review of medication reconciliation and physical examination.

3.2.3 **Complete Risk Follow Up and Review Risk Scores** – A Mental State Examination must be completed by the trainee psychiatrist following admission to the ward. This must include a differential diagnosis and treatment plan. The treatment must include details of the observation level required. The aim is to complete a risk follow up of each patient at least once per week.

3.2.4 **Physical Health Examination Pro Forma completed within 6 hours** - Completed as per Trust guidelines on physical examinations.

3.2.5 **Summary and Abnormalities from Physical Health Examination completed on Amigos within 6 hours** - As the pro forma is on paper format currently it is essential that a summary of the physical health examination is entered on to the AMIGOS system as part of the admission process.

3.2.6 **VTE Assessment** - Refer to Trust Policy for specific guidance.

3.2.7 **Discuss and Agree Observation Levels with Nursing Staff** - Refer to Trust Policy for Safe and supportive observations levels.

3.2.8 **Complete Admission Bloods (FBC, U+Es, LFTs, TFTs, BGluc, Lipids, Prolactin)** – Take full bloods on admission if clinically indicated, if not possible complete request card for bloods to be completed as soon as possible. Ideally BGluc and Lipids completed after fasting.

3.3 Nursing Team

3.3.1 **Allocate Named Nurse** - The Named Nurse should also be clearly identified and patient informed of same. A named and associate nurse will be allocated, by the admitting nurse, taking into account any issues that might affect engagement including patients view, gender and ethnicity. Support Workers will be allocated the role of co-worker.

3.3.2 **Update Patient Information** - The patient will be added to the daily service user review board (white board) and fields completed where the information is available.

3.3.3 **Patient Property** - The admission process should include: the checking and logging of patients belongings and timed in accordance with the patients well being. Risk items such as medication, sharp objects and other contraband items such as illicit drugs, alcohol and lighters must be removed. Provide information to patients regarding storage of property in the lockable cupboards and drawers. The admitting nurse must complete the property checklist and disclaimer. For full guidance staff should refer to the SOP for Property log, Policy for management use of disclaimer. The outcomes of all of these areas will be recorded on the patients’ property record.
3.3.4 **Admission CPA** - It is expected that the admission CPA is scheduled to occur after 72hrs of admission. Contact the Care Coordinator by phone and/or email at the earliest convenience after admission. Refer to Trust CPA Policy for additional information.

3.3.5 **Contact Duty Doctor** - At the earliest opportunity a Registered Nurse will advise the medical staff on an admission and agree any immediate actions in lieu of attendance based on initial clear information provided by the Registered Nurse.

3.3.6 **Inform Bleep holder and Bed Management** – to advise of admission and use of bed.

3.3.7 **Inform RC** - The RC will be advised of the admission of any new patients. This may initially be by email in the case of out of hours.

3.3.8 **HONOS and Cluster** – Discuss and document on AMIGOS

3.3.9 **First NEWS Assessment** - The NEWS will be undertaken by a Registered Nurse and results discussed with medical team.

3.3.10 **URINE Drug Screen** - A urine drug screen is to be requested in a sensitive manner at the earliest opportunity. Results from UDS will be recorded on AMIGOS. Refer to Policy for substance misuse and Policy for care of the consciously impaired patient.

3.3.11 **Risk Follow Up and Review Risk Scores** - Mental state and risk assessment are expected to be undertaken on the first three consecutive days after admission, ideally by 3 different Registered Nurses. Following the initial risk assessment if the scores are felt to be accurate they can remain in place and the review noted on the RFU.

3.3.12 **Admission Care Plans** - At the point of admission, it is expected that the admitting Nurse completes an admission/assessment care plan. The care plan will outline purpose of admission, the anticipated assessment pathway and immediate management plan over the first 72 hours. The care plan will highlight that the patient will be assessed in the following areas as a minimum Psychological Health, Physical Health, Discharge Risk, Mental Health Status and Activity. Where possible the patient views and opinions must be included in completion of the plan and documented accordingly.

3.3.13 **Assign Safe and Supportive Observation Levels** - Nursing staff are to immediately assign a level of nursing observations in accordance with the assessed need and risk. Please refer to the Trust Policy for Safe and Supportive observations.

3.3.14 **Ensure MHA Paperwork received if detained** - A Nurse of Band 6 or above may receive MHA papers on behalf of Hospital Managers having ensured that the documentation has been completed as per legal requirements. MHA papers are then delivered to the MHA office during working hours or posted in the MHA office post box out of hours.

3.3.15 **MHA Rights Given and Advocacy Referral Offered and Recorded** - Any detained patient is to be given their rights in accordance with the Act and the outcome recorded under the appropriate legal tab on AMIGOS. Detained patients are to be advised of and offered the advocacy service and the record and outcome of this recorded on AMIGOS under the legal tab.

3.3.16 **Welcome Pack** - All patients will be provided with and talked through a ward welcome pack.
3.3.17 Confidentiality Form - All patients need to be asked who they wish to have information about their care shared with in terms of family and carers. This information is to be recorded on the confidentiality form and documented on AMIGOS.

3.3.18 Contact Carer and Offer Appointment with Professionals - invite to admission CPA. Contact the patients’ next of kin, advise of the admission (consider patients consent).

3.3.19 Dependents, including Pets - Admitting nurse are to discuss arrangements made with patient regarding dependents. Any further actions need to be discussed with Care Co-ordinator. Outcomes will be recorded within the clinical notes.

3.3.20 Refer to Housing Advisor if Homeless on Admission - If patients are known to be homeless at the point of admission, a referral to the Housing Officer is to be made via email. The Housing Officer will attend the Daily service user review and the admission CPA meeting to establish plans.

3.3.21 Other Assessments as Required, for example Falls Assessment and MUSTS - Full information is found in the associated Trust Policies.

3.3.22 Check Advance Directives - Named Nurse will liaise with the patient, carer and Care Coordinator to ascertain if there are any existing advance directives that would inform the planned care.

3.3.23 Alcohol Screening (AUDIT) - Using the ‘AUDIT’ tool, services are required.

3.3.24 Healthcare Associated Infections (HCAIS) - During physical examination each service user is to be asked if they have had any current or recent infections and if they have been taking antibiotics or any other medications due to an infection (e.g. TB, HIV medications. This should be raised with the IPC team for advice if required (e.g. if patients have significant infections i.e. MRSA, TB, diarrhoea of infectious origin). This follows the principles of the Health Act 2008 Code of Practice on the prevention and control of infections.

3.3.25 Close Any Previous Inpatient Care Plans - Any previous inpatient care plans should be closed at the point of the admission.

3.4 Ward Clerk

3.4.1 Obtain Current and Previous Notes - The patients’ current and previous medical records will be requested and stored securely on the ward throughout the admission

3.4.2 FAX GP Pro-forma - It is essential the GP is aware of the admission and information help plan future care is requested. A request, using the Trust approved proforma will be sent, requesting the past 12 months of medical history and current prescribed medications. The request must be noted as having been completed using the physical health entry on AMIGOS.

3.4.3 AMIGOS system - All key patient information is to be added to the AMIGOS record

3.4.4 Patient Demographics and Minimum Data Set on AMIGOS - Check patient demographics on AMIGOS and input any missing data.

3.4.5 Statuary Sick Note - it is essential that issues of the required sick note are addressed as early as possible in accordance with the patient’s entitlement.
3.5 Care Coordinator

3.5.1 Notify Community Consultant - On being notified of the admission, the Care Coordinator will ensure the Community Consultant is informed. This can be via email or phone contact in the first instance with a record of the contact being made in the patients' clinical record.

3.5.2 Agree Purpose of Admission with MDT – Please refer to guidance above regarding Admission CPA.

3.6 Occupational Therapist

3.6.1 Screen New Admissions – Using the Principles of the Model of Human Occupation Screening Tool. Service users will be defined as active or waiting for occupational therapy.

4 Roles and Responsibilities within 72 hours

4.1 Responsible Clinician

4.1.1 Discuss at First Daily Service User Review (DSUR) - The Registered Nurse (usually Band 6 or above) who will be chairing the DSUR will highlight new admissions for discussion.

4.1.2 Chair Admission CPA Meeting – Lead planning for continuing assessment and any potential barriers to discharge.

4.1.3 Prescribe Sec 17 LOA if appropriate - After risk plan is reviewed and leave is agreed section 17 leave form for detained patients will be completed.

4.1.4 Review CTO Recall Patients for Revoke - Completed by community RC with duty AMHP or RC responsibility transferred to inpatient RC. For revoke complete form CTO5. If revoked complete CTT process - Complete form 62 plus SOAD referral or T2.

4.1.5 Agree Medication Requirements - PRN medication reviewed/prescribed and document on medication card. Longer term medication should be agreed after medicines reconciliation and review of previous treatment – staged medication plan then documented on Amigos.

4.1.6 Set Estimated Discharge Date - The estimated date of discharge will be discussed and provisionally agreed. Any barriers to discharge will be acknowledged and action instigated to ensure they do not affect the date of discharge.

4.2 Junior Doctors (FY/CT/ST) Either Team Doctors or On Call Doctor

4.2.1 Review Results of UDS - Assess results and record in patient's clinical record. Consider use of routine and/or intermittent UDS for ongoing monitoring.

4.2.2 Review History and Treatment (Medication and Psychological Therapies) - Ensure current or historical medication and psychological therapies are taken into account when planning the care.

4.2.3 Complete or Request ECG - As clinically indicated and as required under rapid tranquilisation policy.
4.3 Nursing Team

4.3.1 Smoking Cessation - All patients will be advised regarding the availability of smoking cessation services.

4.3.2 MUST Screen - A baseline MUST screen will be undertake within 7 days of admission (within 48 hours if over 50 years old). Outcomes will be recorded on AMIGOS under the appropriate tab and results will inform care in the area of nutrition.

4.3.3 Falls Screening – Complete if patient is over 50 years old or presents with risks that may lead to unexpected falls.

4.3.4 Meeting with Carer - The Named Nurse will make contact with the patients’ main carer/next of kin where the patient has consented for this. Invites to ongoing CPAs will be discussed. The Named Nurse will offer and provide 1:1 time to offer support and information and ongoing contact arrangements will be agreed.

4.3.5 Complete Admission CPA Meeting - All Patients will have an Admission CPA planned and carried out within 72hrs of admission. This is to ensure that the service user and full care team have a clear understanding of the plan for the admission and areas of responsibility. Full guidance for conducting CPA's can be found in the CPA policy.

4.3.6 Welfare Rights - Where the patient has benefit entitlements, Named Nurse to refer to Welfare Rights Officer for completion of relevant forms.

4.3.7 Referral to Specialists e.g. Dietetics and Dual Diagnosis - Named Nurse will establish any current involvement with specialists and ensure the contacts continue uninterrupted during the admission period. Alternatively, in the event of assessed need, the Named Nurse will make referrals to the appropriate Professional Lead.

4.3.8 Risk Follow Up and Summary Review 48 hours - Risk follow up is expected to be repeated within 48 hours and any significant changes communicated to the MDT.

4.3.9 Risk Follow Up and Summary Review 72 hours - Risk follow up is expected to be repeated again within 72 hours and any significant changes communicated to the MDT.

4.3.10 Refer to CMHT - To be completed on admission. For patients who are homeless, referrals are to be sent to the Rehab and Recovery Managers who hold a rota for such allocations.

4.4 Crisis Resolution Home Treatment (CRHT)

4.4.1 Attend Daily Service User Review - Attendance at DSUR by CRHT will occur as often as is practicable in order to consult and advise wards in terms of the appropriateness of referral to CRHT for early supported discharge. Attempts will be made by CRHT to attend on request to discuss particular patient or patients wherever possible.

4.5 Pharmacist

4.5.1 Medicines Reconciliation - Compare at least 2 separate sources of information relating to the service users current medication with the current prescription chart on the ward. This will be documented on the front of the prescription chart and on Amigos. Please see Trust Medicines Reconciliation procedure for further guidance.
4.5.2 **Pharmaceutical Care Plan** - Pharmaceutical needs will be assessed and a pharmaceutical care plan will be developed and care will be allocated to the appropriate member of the medicines management team.

4.5.3 **Attendance at DSUR and Admission CPA as required** - Attend daily reviews or CPAs where appropriate to ensure updates are provided re pharmaceutical information and advice.

4.6 **Care Coordinator**

4.6.1 **Attend Admission CPA** - It is expected that the Care Coordinator attends the admission CPA during which key activities and actions will be agreed.

4.6.2 **Agree Level of Contact** - As part of the initial discussions around purpose of admission and the admission CPA, the Care Coordinator will agree and confirm with the patient and the Named Nurse the arrangements for contact during the admission period. Contact at the patients’ place of residents during any period of leave will also be agreed.

4.6.3 **Update MANCAS** - Although the admitting Nurse will update the initial MANCAS the ongoing ownership and responsibility of the MANCAS will remain with the Care Coordinator who will closely collaborate with the Named Nurse in terms of content.

4.7 **Occupational Therapist**

4.7.1 **Prioritise Service Users for OT** - Service users on the waiting list and plans for those identified as active are to be discussed with named nurse. On completion of screening, results will be shared with the MDT.

4.7.2 **Attend Admission CPA** - On completing of each stage of assessment /treatment Occupational Therapy will provide a report to the MDT and relevant stakeholders.

4.8 **Housing Advisor**

4.8.1 **Screen All Referrals and Collate Housing History** - It is essential that the team have clear understanding of the housing history for service users who are homeless at the point of admission within the first CPA meeting.

4.8.2 **Attend Admission CPA for those Referred at Admission** - They will gain written consent from the service user wherever possible. When written consent is not possible due to severity of illness, information can be gathered from external agencies.

5 **Roles and Responsibilities within 7 Days**

5.1 **Team Doctors (RC/FY/CT/ST)**

5.1.1 **Complete Admission Summary** - This should include relevant details of circumstances of admission and past history.

5.1.2 **Review of Mental State** – This is to be completed in preparation for the ward round;

5.1.3 **Follow up and Monitor Physical Health** - Patients should have regular physical health reviews during their admission by the doctor on the unit and a detailed physical health management plan.
5.2 Nursing Team

5.2.1 Entry Questionnaire - The entry questionnaire will be given to the patient early in the admission period i.e. within 1 week to allow the patient sufficient exposure to the ward and processes to make reasonable comment on their experience.

5.2.2 RETHINK PHC - The first RETHINK PHC is to be completed within 2 weeks of admission and recorded on AMIGOS. It is essential that all areas are completed including the smoking cessation section. Thereafter, the RETHINK will be repeated every 6 months.

5.2.3 LUNSERS - A LUNSERS assessment will be administered at the point of prescription of neuroleptic medication or in the event of the report of side effects.

5.2.4 CPA Care Plan Updated - Nurse will respond to latest information obtained as part of the MANCAS in order to ensure that the patient’s current needs are addressed and communicated to the MDT appropriately.

6 Roles and Responsibilities Pre Discharge

6.1 Team Doctors (RC/FY/CT/ST)

6.1.1 Attend Discharge CPA - The Discharge CPA should be conducted prior to the date of discharge to ensure that all plans can be put in place before the service user is discharged and so that they receive a copy on discharge. The CPA document should be circulated to all involved in the care of the service user including the GP.

6.1.2 Request AMHP Assistance for CTO Allowing Sufficient Time for Completion - MDT to discuss use of CTO at least two weeks in advance of final discharge planning. Inpatient RC will need to discuss the CTO with the community consultant and gain agreement, then inpatient RC will need to notify AMHP CTO co-ordinator by email.

6.1.3 Liaise with Community RC - Inpatient consultant and community consultant to liaise by email, phone or in person to agree joint plans for admission, discharge and longer term plans for medication and support.

6.1.4 Complete Discharge Prescription and GP Notification - Discharge prescription completed by junior doctors before date of discharge so that medication is ready on the ward at the point of discharge. Ward staff will fax a letter/form giving the GP information about discharge medication and basic care plan information on the day of the discharge, form will be completed by junior doctor staff.

6.1.5 Review Cluster - Review cluster at discharge CPA to reflect overall care package requirements, to be recorded on Amigos by care co-ordinator.

6.2 Nursing Team

6.2.1 Attend Discharge CPA – The Named Nurse is expected to attend the discharge CPA in order to present the case history and to agree the discharge parameters with the MDT.
6.2.2 Speak to Principle Carer - To ensure discharge plans are understood and agreed. Carers will be signposted to support and crisis plans as appropriate. Carers are expected to be given reasonable and appropriate notice of planned discharge especially when the patient resides with the principle carer.

6.2.3 Exit Questionnaire - As part of the CQUIN standards and to ensure good service, Manchester Mental Health and Social Care Trust need to ensure services are meeting their needs. We are therefore asking service users to complete this brief questionnaire to help us to learn about their experiences.

6.3 Pharmacist

6.3.1 Discharge Medication - Support timely prescribing of discharge medications and clinically check the discharge prescription as per Trust clinical pharmacy standards

6.3.2 Identify Source of Supply of Medication - This may include issue of service users own medicines from ward and dispensing from on-site pharmacy.

6.3.3 Medication Follow Up Requirements - Ensure requirements in place for post discharge

6.4 Care Coordinator

6.4.1 Attend Discharge CPA - It is expected that the Care Coordinator attends the discharge CPA in order to ensure agreement and understanding of the discharge plans and after care arrangements.

6.5 Occupational Therapist

6.5.1 Report Findings, Progress and Recommendations - All decisions will be reviewed weekly, communicated to the primary nurse and documented on AMIGOS using the screening tab.

6.5.2 Attend Discharge CPA – to present findings and recommendations of any assessments or reports.

6.6 Housing Advisor

6.6.1 Attend Discharge CPA - Allocate tasks for discharge and liaise with relevant agencies regarding roles and responsibilities to enable the discharge to occur without delay.

6.6.2 Liaise with the Care Co-ordinator after the IB is Secured - To assist in identifying placement in line with the budget awarded.

6.6.3 Ensure Furniture Packages, Repairs, Change of Address Forms, Utility Budgets are Carried Out - To ensure the entire above are in place prior to discharge and advise wards and the CC and/or Team Managers of any anticipated delays.

7.0 Roles and Responsibilities on Discharge

7.1 Team Doctors (RC/FY/CT/ST)

7.1.1 Discharge Patient from Section if Detained - Inpatient RC to complete discharge from section (form related to section 23) if patient still detained and CTO not being used.
7.1.2 Transfer RC Responsibility if Starting CTO - See CTO policy, complete form, to be faxed to community RC and on return send to MHA office.

7.1.3 Complete CTO Paperwork - Consultant to complete CTO letter 1 to set out conditions of CTO, sent to patient on discharge. Consultant to discuss medication with patient and complete CTO 12 or refer to SOAD.

7.1.4 Agree Diagnosis for Recording on Discharge Summary - Agree ICD code 10 diagnosis at discharge CPA.

7.1.5 Discharge Medication – Ensure that this is prescribed

7.1.6 Discharge Summary (within 10 days) - Include diagnosis and latest risk assessment. Notes sent to medical secretary, junior doctor dictates discharge summary, Summary put on Amigos and sent to GP, community consultant and CMHT.

7.2 Nursing Team

7.2.1 Confirm with Principle Carer and Patient that they are Aware of Discharge Plans - Where consent allows, principle carers and family will be contacted by the Named Nurse in advance of the discharge to ensure that all are clear of the plans for discharge including medication arrangements, crisis support and/or follow up appointments.

7.2.2 Risk Follow Up Risk Summary Update - To be completed 3 days prior to planned discharge date to ensure accurate detail.

7.2.3 Review Property Log and Check Safe - Ensure the property log is reviewed with the patient and all property is packed and removed from the ward in advance of the discharge. Refer to Trust Policy regarding patient property.

7.2.4 Provide with TTO's - Provide the service users with their discharge medication (TTO’s) that have been dispensed by pharmacy. The nurse providing these should check that all medications that are currently prescribed have been provided and that the service user is clear on when they should take them. The nurse should check that the service user is clear on where they will get there next prescription from to ensure that they do not run out of medications following discharge. The nurse should record that they have been provided these within their discharge entry on AMIGOS.

7.2.5 Inform Bed Management - The nurse in charge of discharge is expected to confirm with bed management at the earliest opportunity that the patient has an expected and planned discharge. This should be following the daily service review meeting and to inform he daily bed status report.

7.2.6 Close Inpatient Care Plans - Once the patient has been discharged, the Named Nurse will ensure the patients electronic care record is updated including that any care plans active during the inpatient period are formally closed down.

7.2.7 Plan For and Undertake 7 Follow Up - For patient without CRHT or CMHT involvement the ward will undertake the 7 day follow up.

7.3 Ward Clerk

7.3.1 Ensure Discharge Address and Contact Details of Patient and Principle Carer are Correct on AMIGOS - To be clarified and updated as appropriate in order to
ensure that 7 day follow up can be completed and ongoing communication with patient and carers can be maintained.

7.3.2 Discharge from AMIGOS - The patient will discharged from AMIGOS once it is confirmed that the discharge is complete.

7.3.3 FAX GP - It is expected that the patients GP is advised of the patients discharge via FAX. It should be ensured that the receiving FAX is a safe haven facility to ensure confidentiality.

7.3.4 File all Paperwork and Return Files - Any files or paperwork relating to the inpatient period will be collated, filed and returned for safe storage to the appropriate department with the appropriate tracking system being used for assurance.

7.4 Pharmacist

7.4.1 Transfer of Discharge Information - Ensure that discharge information relating to medication has been transferred to G.P and other services, e.g., CMHT, CRHT, Treatment suite. Provide patient information and education around their medicines and reinforce their use. Ensure patient information leaflets / booklets have been given and completed along with documentation on Amigos to this effect.

7.4.2 Transfer of Pharmaceutical Care Plan - Send to appropriate services, e.g. local pharmacy, drug services. To pilot a 7 day follow up service to help ensure effective communication of medication needs, continued supply and appropriate care.(for review)

7.5 Care Co-ordinator/CRHT

7.5.1 7 Day Follow Up - Patients discharged with CMHT or CRHT follow up will be seen by their allocated worker or a nominated deputy up in accordance with the plan agreed for this with the patient in advance of discharge.
### Appendix 1: Adults of Working Age Inpatient Wards – MDT Admission Checklist

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Time of Admission</th>
<th>Service user</th>
<th>District Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Within 24hrs**

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Sig</th>
<th>Date / Time</th>
<th>Sig</th>
<th>Date / Time</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Responsible Clinician**

- Review safe and supportive observation level
- Review risk assessment and management plan
- Agree purpose of admission & devise admission plan.

**Team Doctors/ On call Doctors (FY/CT/ST)**

- Check that Risk Assessment completed, if not complete
- Physical Health exam pro forma completed (6hours)
- Discuss and agree observation levels with nursing staff
- Prescription of appropriate medication including PRN
- Summary and abnormalities of physical health exam completed on Amigos within 6 hours.
- Complete Admission Bloods

**Complete Risk Follow Up & Review Risk Scores**

- VTE assessment

**Nursing Team**

- Allocate Named Nurse
- Initial NEWS
- Confidentiality Form
- Update service user information on white board
- UDS
- Contact Carer and Offer appointment with professional
- Patient property
- Risk Follow Up & Review Risk Scores
- Issues relating dependent including pets addressed
- Plan admission CPA
- Admission Care plan
- Refer to Housing Advisor if homeless at time of admission
- Contact Duty Dr
- Assign safe and supportive obs level
- Other Assessments as required e.g. falls and Musts
- Inform bleep/bed management
- Ensure MHA paperwork received if detained
- Check advanced directives
- Inform RC (email)
- MHA rights given and advocacy referral offered and recorded
- Alcohol Screening (AUDIT)
- HCAIS
- HONOS and Cluster
- Welcome Pack provided
- Close any previous Inpatient care plans

**Ward Clerk**

- Obtain current and previous notes
- Admit to AMIGOS
- Check Minimum Data Set all up to date
- FAX GP pro-forma
- Check Pt demographics on AMIGOS
- Provide Sick note

**Care Coordinator**

- Notify Community Consultant
- Agree Purpose of admission with MDT

**Occupational Therapy**

- Screen for OT requirements

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Sig</th>
<th>Date / Time</th>
<th>Sig</th>
<th>Date / Time</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Within 72hrs**

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Sig</th>
<th>Date / Time</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Responsible Clinician**

- Discuss at first Daily service user review
- Review CTO recall patients for revoke (community RC unless transfer responsibility)
- Agree medication requirements
The original of this record must be kept with the service users medical records.

A copy must be taken at the end of the first week and held on the ward for audit purposes.
## Appendix 2: Adults of Working Age Inpatient Wards – MDT Discharge Checklist

<table>
<thead>
<tr>
<th>Date of Discharge</th>
<th>Time of Discharge</th>
<th>Service user</th>
<th>District Number</th>
</tr>
</thead>
</table>

### Pre Discharge

#### Responsible Clinician
- Attend Discharge CPA
- Request AMHP assistance for CTO (2 weeks Prior)
  - Complete discharge prescription & GP notification

#### Nursing Team
- Attend discharge CPA
  - Speak to principle carer to ensure discharge plans understood and agreed

#### Pharmacist
- Discharge Medications
  - Identification of source of supply

#### Care Coordinator
- Attend Discharge CPA

#### Occupational Therapy
- Report findings, progress and recommendations.
  - Attend Discharge CPA

#### Housing Advisor
- Attend Discharge CPA
  - Liaise with the care coordinator after the I.B.is secured

### On discharge

#### Team Doctors (FY/CT/ST)
- Discharge service user from section if detained
  - Complete CTO paperwork
- Transfer RC responsibility if starting CTO
  - Agree diagnosis for recording on discharge summary

#### Nursing Team
- Confirm with Principle carer and service user they are aware of discharge plans
  - Review Property Documentation and return items from safe
- Risk Follow up
  - Risk summary Update
  - Provide with TTOs
- Close inpatient Care Plans

#### Ward Clerk
- Ensure Discharge address correct on AMIGOS
  - Fax GP notification to GP – TTO script
- Discharge From AMIGOS
  - File all Paperwork and return notes

#### Care Coordinator / CRHT
- Complete 7 day follow up as agreed at discharge CPA

#### Pharmacist
- Ensure discharge information relating to medication transferred to other services
  - Transfer of pharmaceutical care plan to appropriate services
- Pilot a 7 day follow up service
Appendix 3

PROCESS AND PRINCIPLES FOR DAILY SERVICE REVIEW MEETINGS

- Review all admissions in the previous 24hrs and to monitor the relevant activity
- Identify potential service users for early supported discharge.
- Review planned discharge date for each service user and ensure all processes are in place to support the planned discharge
- Identify any potential barriers to planned discharge and agree the level for escalation required
- To confirm communication with carers.
- Early application for individual budgets/panel applications are to be considered and arranged as required.

ATTENDANCE

<table>
<thead>
<tr>
<th>EXPECTATIONS OF DAILY ATTENDANCE</th>
<th>MINIMUM EXPECTATIONS OF ATTENDANCE FROM THE MDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Manager, Deputy Ward Manager or CPL</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td></td>
</tr>
<tr>
<td>Housing Advisor - weekly</td>
<td></td>
</tr>
<tr>
<td>CRHT - weekly</td>
<td></td>
</tr>
<tr>
<td>OT - weekly</td>
<td></td>
</tr>
</tbody>
</table>

QUORUM

<table>
<thead>
<tr>
<th>Mon - Fri</th>
<th>Sat - Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RC or nominated deputy</td>
<td></td>
</tr>
</tbody>
</table>

Attendance will be recorded on the ward action notes and monitored for compliance. In the absence of the RC, the Daily Service User Review (DSUR) will continue with any decisions being ratified outside of the meeting with the RC at the earliest opportunity.

MAINTENANCE OF THE BOARD INFORMATION

Service User details are to be added to the board as part of the admission process. In the event of a transfer, pt information from the board is to be given to the receiving ward. The board will be updated ‘live’ during the daily round where ever possible. Wards will instigate systems for updating the board outside of daily rounds in the event of changes occurring in the interim e.g. care plan updates, giving of rights etc.

MINIMUM DATA SET FOR MEETINGS

At the commencement of the daily round, there will be a specific slot to discuss service users discharged since the last daily round to ensure that activity on the discharge checklist have been completed. The Registered Nurse will lead discussions by reviewing each service user and highlighting any gaps in information or providing new information. The round will focus purely on task completion and activity affecting length of stay. Discussion of wider issues will be directed to the ward round.
MEETING MANAGEMENT AND ADMINISTRATION
A member of the daily round team will record any new actions on the appropriate sheet and feedback on actions from the previous day. Significant actions and feedback for any service user is expected to be captured within the service users AMIGOS records.
Tasks from the daily round are to be allocated following review. Action notes are to be retained for one month as a record of attendance and actions after which they can be disposed of as per the process for confidential documents. The daily round is expected to commence at the same time every day to allow for attending professionals to plan and embed the activity as part of their routine.
The Daily round will commence with whoever is in the room at the appointed time – see escalation for management of late or no attendance of individuals. All daily rounds are expected to have been completed by 11 a.m. in order to provide time for ward round to commence and for tasks to be completed.

ESCALATION OF ATTENDANCE ISSUES
Repeated non attendance by any particular member of the MDT will be addressed by the Ward Manager directly with the member of staff in the first instance and escalated to line management if no improvements achieved.

ESCALATION OF LENGTH OF STAY ISSUES
- Level 1 issues – Can be resolved at ward level, Responsible Lead: Ward Manager
- Level 2 issues – requires LOS Review Panel, escalation. These issues will be presented to the weekly LOS review panel meeting held each Monday afternoon. Lead: Deputy Acute Care Services Manager
- Level 3 issues – requires General Manager escalation. These issues will be first discussed through the LOS review panel and escalated as appropriate.

CONFIDENTIALITY
The board and/or the room are expected to be locked when not in use.
Appendix to Adults of Working Age Admission and Discharge Standard Operating Procedures

1.0 Guidance on setting Expected Discharge Dates

1.1 The expected discharge date is the date the inpatient team expect the service user to be fit for discharge from inpatient care and/or transfer from PICU.

1.1.1 Any stay in hospital after this date is either due to a change in clinical need (i.e. the patient is no longer fit for discharge) or they are a delayed discharged (as per the delayed transfer of care guidance).

1.2 The expected discharge date will be set within 72 hours of admission by the consultant and ward team informed by all information received for the multidisciplinary team.

1.3 The expected discharge date will be recorded on AMIGOS

1.4 The expected discharge date can be changed for any/all of the reasons noted below. The reason must be recorded according to the following definitions:

- Non response to treatment
- Absent without leave
- Non compliance with treatment
- Substance misuse
- Change in diagnosis
- Transfer in/out of PICU
- Additional information received from care coordinator

1.5 Reasons for change to the expected discharge date will be reported on a monthly basis and information shared with senior operational and clinical leads.

1.6 The expected discharge date is a metric reported on the inpatient dashboard and includes % of patients with an expected discharge date set within 72 hours and % of expected discharge dates met on discharge.

1.7 Exception reporting will be done in those instances where an expected discharge date has not been met.