	Pre-Admission	Admission – First 48 hours	First 7 Days	First 6 Weeks	Discharge Planning
Mental Health	Access Assessment Form reviewed to assess suitability for admission: • During working hours, review by a senior member of the MDT • Out of hours reviewed by the NIC and discussed with consultant on call if necessary • If necessary, request additional relevant background information to inform decision re suitability Timescales from referral to decision / admission should adhere to those stipulated in NHSE Service Specs for GAU/PICU/LSU (see Appendix 1) For LSU referrals the national pre-admission process should be followed including face to face assessment	All young people must have an initial assessment and initial Keeping safe care plan completed within 24 hours. Review by a consultant psychiatrist on first working day after admission Background Information (Past Medical History / Medication) to be requested from GP / CAMHS team by first working day A Competency / Capacity Assessment is completed on admission An information sharing agreement is developed with the young person which will inform the Keeping Connected care plan MHA /MCA – referral to advocate, IMHA and IMCA (as appropriate) Admission HoNOSCA and clinician rated CGAS to be completed.	Preliminary formulation and initial working diagnosis are developed Initial Goals for Admission agreed with young person, family and locality professionals within 5 working days Initial multidisciplinary treatment plan agreed including attendance at an MDT meeting within 7 days Discussion around medication plan and patient given information (PILs) Development of Keeping Healthy, Keeping Well, Keeping Safe and Keeping Connected care plans. Assessment of sensory needs	A collaborative formulation should be developed within 4 weeks and a Working Diagnosis established and communicated Care plans and treatment plans reviewed within 4 weeks as part of MDT meetings An initial CPA review meeting will take place within 6 weeks (GAU/PICU) A Welcome Meeting with parents / carers and professionals will take place within 4 weeks (LSU)	Early consideration given to discharge destination and pathway (e.g. home, community placement or adult inpatient service) Relapse Prevention Plan developed collaboratively between MDT, young person, family and professionals A Section 117 discharge planning meeting should take place prior to discharge for Section 3 patients Consideration of benefits of legal framework on discharge (e.g. CTO) The Discharge Checklist (Form 11A) should be completed on the day of discharge. Discharge HoNOSCA and clinician rated CGAS to be completed.
Physical Health	Where a patient is being admitted from an acute medical ward, check that they are medically fit for transfer Where there are significant pre-existing medical conditions (e.g. Diabetes, Epilepsy) ensure the ward is prepared to manage this from the point of admission (e.g. medication, training)	A physical assessment should take place within 24 hours including a physical examination. Bloods/ECG should take place on the next working day. Smoking cessation support as required. Completion of the physical health care plan if physical health concerns have been identified.	Feedback results of initial physical investigations to patient Encourage engagement in appropriate levels of physical activity (e.g.exercise groups / gym) according to physical health needs / weight. Monitor for re-feeding syndrome in patients who have been restricting diet	Regular physical health monitoring as per Keeping Healthy care plan Physical observations will be measured once a day as a minimum *(Priory policy?)* Weight will be measured weekly as a minimum according to clinical need Physical monitoring for patients on psychotropic medication takes place as per policy *(H100 Monitoring Physical Health in Inpatients)* Where possible 150 minutes of exercise per week.	Send information on physical health / investigations to GP via discharge summary
Safety	Ensure that an up-to-date Risk Assessment has been reviewed prior to admission	Initial Risk Assessment completed within 4 hours of admission *(Priory policy?)* Keeping Safe Care Plans written within 24 hours Observation level prescribed on admission	Completion of MDT Risk Formulation and Risk Assessment including risk factors and background risk history	Ongoing review of Risk Formulation, Assessment and Management Ongoing reviews of Observations Ongoing review of leave off the unit	Updated Risk Assessment and Crisis Management Plan to be shared with young person, family and professionals

		Immediate safeguarding issues are incorporated into initial plan of care. For LAC contact lists and arrangements are clarified with social care			
Therapeutic Activity		A leave prescription is written for initial leave off the ward as appropriate A Welcome Pack should be provided to a young person on admission Orientation to the ward should take place (layout, timetable, staffing, visits, leave, banned and restricted items) Mutual Expectations should be clarified Any religious, cultural, dietary, disability and communication needs are identified if not already known	Young people should be issued with an individual therapeutic timetable within 2 working days of admission A first keyworker session with a named nurse should take place within 7 days An initial psychology session should take place within 7 days The OT should meet the young person within 7 days An Individual Education Plan should be commenced within 7 days including liaison with young person's school/college Dietitian input to be considered for young people with Disordered Eating in 7 days Young person should be invited to attend a Community Meeting within 7 days	Ongoing review of engagement in the therapeutic programme including: • Weekly Named Nurse sessions • OT assessments and interventions • Individual psychological therapy focusing on stabilisation that is formulation driven and evidence based • Weekly skills based psychological therapy groups • Educational activities • Compliance with medication Reflective Practice Groups should be taking place for staff on the ward at least monthly to support therapeutic approaches to care giving and insights into ward dynamics	We need to reference transition here. Team should support the young person to manage endings of relationships with peers and staff and transition to new service Therapeutic work to focus on independence, life skills, relapse prevention, social inclusion and future goals Planning process takes place between Unit Education team and local education provision to ensure appropriate service on discharge and assist with transition
Outcomes			Complete clinician-rated and self-rated HoNOS-CA and CGAS within 7 days at first MDT meeting (and EDQ for ED services)	Complete clinician-rated and self-rated HoNOS-CA and CGAS prior to each CPA review meeting (and EDQ for ED services)	Complete clinician-rated and self-rated HoNOS-CA and CGAS at discharge (and EDQ for ED services) Patient Satisfaction Survey completed *(Name?)*
Family & Carers	Where possible, a clinician should speak to the family / carer prior to admission and/or send them a parent / carer pack For LSU referrals, parents / carers should be involved in pre-admission assessment	If not previously sent, a parent / carer pack should be provided to families An initial contact made by NIC with parents / carers to orientate to the unit and provide information about contact and visiting arrangements, banned and restricted items. Important background information gathered.	Parents / Carers should be invited to attend Initial Planning Meeting (where appropriate) Agreement reached re frequency and method of communication with family which contributes to Keeping Connected care plan Parents / Carers invited to attend the unit Parents and Carers Group	Ongoing regular contact with parents and carers as per Keeping Connected care plan Consideration given to suitability of Family Therapy and sessions offered Parents / carers invited to contribute their views to MDT and CPA meetings	Support / advice provided to families as part of discharge planning process Parents / carers should be included in discharge planning meetings and plans for future care Parent / Carer Survey completed

				Encourage parents / carers to attend Parents and Carers Group meetings	
Community MH Team	Check that 'blue light' CETR has taken place prior to admission of a patient with ASC/LD	Notify locality CAMHS team and Case Manager of admission and identify details of locality professionals involved with the young person Invites to IPM should be sent on first working day after admission (GAU/PICU)	For GAU and PICU services an Initial Planning Meeting will be convened with external professionals and family within 5 working days	Ensure that a community care coordinator is identified, attends regular CPA review meetings and is part of discharge planning	A handover discussion should take place between the ward team and the receiving service on the day of discharge An outpatient appointment should be offered within 5 working days of discharge A written communication should be sent to GP / CAMHS re risk and discharge medication on day of discharge. A full Discharge Summary to GP/CAMHS to be completed within 7 days of discharge