DISCHARGE / LEAVING THE SERVICE

1. INTRODUCTION

This policy intends to ensure arrangements for discharge of patients / residents from a PiC service are appropriate and clear.

2. SCOPE

This policy provides guidelines as to the discharging of patients to the following areas:

- To a community placement
- To another hospital / unit
- To prison
- Discharge to a placement across borders

This policy should be read in conjunction with:

- PiC Operational Policy – *Patient / Residents Property Policy*
- PiC Operational Policy – *Assessment and Management of Clinical Risk*
- PiC Operational Policy – *Multi-Agency Public Protection Arrangements (MAPPA)*
- Mental Health Act 1983 – Code of Practice (Revised 2015)

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

3. PROCESS AND PLANNING

Section 117 Requirements

The Mental Health Act 1983 – Code of Practice (Revised 2015) Para 33.2 states:

Section 117 of the Act requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. This includes patients granted leave of absence under section 17 and patients going on community treatment orders (CTOs). It applies to people of all ages, including children and young people.

CPA administration procedure provides guidelines for implementation and should be referred to when considering a discharge. The Mental Health Act 1983 – Code of Practice (Revised 2015) Para 33.13 states:

Before deciding to discharge or grant more than very short-term leave of absence to a patient or to place a patient onto a CTO, the responsible clinician should ensure that the patient's needs for after-care have been fully assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan. If the patient is being given leave for only a short period, a less comprehensive review may be sufficient, but the arrangements for the patient's care should still be properly recorded.

When patients are discharged from medium secure units, the discharge documents include a full risk assessment which contains a description of identified indicators of relapse and the suggested steps to be considered in the event of a relapse.

A copy of CPA documentation and either Section 117 discharge planning meeting minutes or pre-transfer meeting minutes (whichever is appropriate) and Risk Assessments will be made available to the receiving unit (for transfers) and in the case of discharges to the community to all those directly involved in providing care in the community.

A member of the multi-disciplinary team is nominated to co-ordinate the discharge arrangements. The team will ensure that the patient has the opportunity to complete the Patient Discharge Survey.

Please see ***Appendix A*** for an **example agenda for a S117 meeting** to be used when a patient is discharged into the community.

Section 17A Requirements

Supervised Community Treatment (SCT) provides a legal framework through a Community Treatment Order (CTO) for supervising the aftercare in the community of certain patients who have been detained under the Mental Health Act 1983.

The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.

SCT provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

Refer to Mental Health Act 1983 – Code of Practice (Revised 2015) Chapter 29.

4. CO-ORDINATION OF DISCHARGE

Please see ***Appendix B*** for an **example agenda for a Discharge / Transfer Planning Meeting** to be used when a patient is being discharged or transferred to another hospital.

A member of the multi-disciplinary team will be allocated responsibility for co-ordinating the discharge.

They should:

- Make arrangements for the patient to visit the new placement prior to discharge where clinically indicated and practicable
- Provide the patient / resident with as many relevant details as possible about the new placement and environment
- Liaise with the receiving placement and confirm details of the discharge
- Inform the Next of Kin / Nearest Relative of the discharge arrangements, if the patient / resident is in agreement
- Make suitable escort/s arrangements ensuring that they have an adequate knowledge of the patient / resident and discharge details
- Arrange transport for the patient / resident and their belongings
- Liaise with the Mental Health Act Administration Department and ensure that all related discharge documentation has been completed and that copies are available, if required, to send with the patient / resident and escort
- Ensure that the patients / residents clothing and belongings are packed and listed and that all valuables and monies are accounted for. Refer to PiC Operational Policy – *Patient / Residents Property Policy.*
- If the patient / resident has an appointee ensure this is relinquished on discharge to allow benefits to be claimed
- Collate all necessary documentation, which may include:
  - Consent for transfer to another placement
  - Correspondence from the accepting placement
  - Consent to treatment status form (Forms T2/T3, three-month rule, S61, S62 and informal)
  - Nursing and CPA care plan
  - Minutes of Section 117 meeting or transfer meeting minutes as appropriate
  - Risk assessment
  - Discharge summary
  - Discharge checklist (***see Appendix C***) to be completed by the discharging nurse
  - List of medication prescribed
- Ensure that any prescribed medication that may not be held as a stock drug e.g. inhalers, etc. is to be taken with the patient / resident to the placement at the time of discharge
- Provide an appropriate supply of medication to the patient / resident for community placements
- Patients being discharged into the community should be registered with a General Practitioner prior to discharge and the GP is supplied with relevant information
- Ensure any follow up appointments are recorded in the discharge summary
- Inform the hospital / unit pharmacy and Mental Health Act Administration Department of the patient / resident discharge
- Document the discharge in the ward / house report and all details of the discharge in the clinical / care record
- Where appropriate liaise with the Ministry of Justice and/or MAPPA

5. TRANSFERRING A DETAINED PATIENT INTO THE CARE OF ANOTHER HOSPITAL

Please see ***Appendix B*** for an **example agenda for a Discharge / Transfer Planning Meeting** to be used when a patient is being discharged or transferred to another hospital.

Regulations under section 19 of the Mental Health Act 1983 (amended 2007) require that when a patient is transferred to another hospital under different hospital managers, an official transfer form must completed.

Original detention papers and all Forms H5 and former Form 24, must accompany the patient to the new hospital. The receiving hospital may require copies of these forms prior to the patient's arrival. This form transfers the legal powers to detain and treat the patient and is valid for 28 days. After this time, if the patient has not been transferred, a new form is needed.

A photocopy of a minimum of the last 2 weeks clinical notes will be sent to the receiving hospital at the time of discharge.

6. DISCHARGING A PATIENT / RESIDENT INTO THE COMMUNITY

Please see ***Appendix A*** for an **example agenda for a S117 meeting** to be used when a patient is discharged into the community.

Where applicable:

- Ensure there is a copy of the CPA / Care Plan, minutes of the Section 117 meeting or transfer meeting minutes as appropriate and the patient's risk assessment
- The Care Co-ordinator or another individual nominated by the clinical team should liaise with the newly allocated Care Co-ordinator or another individual nominated by the receiving clinical team to ensure a smooth transfer and communicate all discharge information, including CPA / Care Plan, Section 117 meeting minutes and risk assessment documentation
- The Responsible Clinician should ensure that a copy of this documentation is sent to the new psychiatrist
- The Social Worker should liaise with local services to ensure that utilities are available and working in the new placement and there is an initial supply of food
- The GP service should be informed of the discharge as well as the name and address of the patient's new GP
- A discharge summary is sent to the patient's GP within one week of discharge

7. DISCHARGE TO PRISON OR HIGHER LEVEL OF SECURITY

In addition to the routine discharge procedures, staff will need to carefully consider transport and staffing arrangements when preparing for a discharge back to prison, or alternatively to a higher level of security e.g. High Security Hospital.

Nursing staff should liaise with the receiving facility to discuss specific details, such as the most appropriate day and time for discharging patients to them.

For patients being returned to prison medical staff should liaise with the Prison In-reach Team to ensure the relevant information has been transferred. In the case of patients being transferred to higher levels of security medical staff should communicate directly with the receiving Responsible Clinician and ensure that the relevant documentation is sent to that person. At a minimum these should include a discharge summary together with a risk assessment.

8. DISCHARGING DETAINED PATIENTS ACROSS BORDERS

The Mental Health Act 1983 (amended 2007) refers to patients in England and Wales. When patients are to be transferred or discharged across borders e.g. Scotland, Isle of Man, Channel Islands and Northern Ireland, medical records departments will deal with the legal issues and provide the necessary paperwork.

9. TRANSITIONAL FUNDING

Where transitional funding is required this should be agreed in advance of the discharge and this may cover items such as:

- Retaining a bed at the discharging hospital / unit
- Providing ongoing supervision
- Providing ongoing therapy

Any delay in transitional funding must not affect the prompt discharge of the patient.