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Consultation	Embedding Gold Standard SOPs Project
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Related Trust documents (to be read in conjunction with)
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Version	Author	Summary of amendments	Issue date:
1.0	Tendai Ruwona - Associate Director for Urgent Care and Inpatient Services (Mid & South)	New document Development of eSOP to aid staff based on XXX - XXX	Date

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1 Introduction

This Checklist describes the process for admitting a patient onto a ward that uses Mobius as their EPR system. The steps are divided into those that need to be done upon admission, within 2 hours, within 4 hours, within 6 hours, at 48 hours and at 72 hours.

All the forms that are completed manually need to be sent to the scanning team/ward clerk to be uploaded to Mobius. Please find the scanning procedure available on the Intranet and follow your local procedure to handle scanning. If you are unsure about the procedure, please contact your manager.

Acronyms used;

- DOB – date of birth
- RN - registered nurse
- HIE - Health Information Exchange system
- OOH - out of hours
- AMHP - allied mental health practitioner
- CPA - care program approach
- MHA - Mental Health Act
- NOK - next of kin
- NEWS2 - National Early Warning Score
- GTA - Guide to Action

2 SOP

Pre-Admission

1. **Ensure the patient has an NHS number and a Mobius record has been created with the correct details (Qualified member of staff)**
 - Open Mobius using windows log-in details
 - On the homepage, type the DOB or name under "search for patient" in the search bar
 - Alternatively, search for the inpatient list by clicking on the hospital icon, which is situated on the right side of the screen (3rd icon from the left)
 - Select your ward to access the patient list
 - Select the correct patient from list
 - If the patient details are not there, create new record on Mobius
 - Complete New Patient Form on Intranet
 - Go back into Mobius to see the new patient record (follow local Mobius Guide on the Intranet)

Note: to access forms, locate E-form library on right side of window opposite the patient's name, search by form name or number and press start to open it

2. Check HIE for any information – if patient is transferred from North to South (RN)

- Locate HIE portal on Intranet
 - On the right side of the screen, click on “tools”
 - In the drop down, click on “clinical systems”
 - Select “HIE portal” from the pink square options
- Enter the patients NHS number in the search bar and their details will appear.
 - If you do not have the NHS number, click on “advanced”
 - Type the patients first and last name or DOB
 - Click on “apply”

3. Request history from referrer and locate case notes in Patient’s record (RN)

- Locate history and case notes
 - If the patient is known to the service, find information on Mobius or HIE
 - If patient is not known to the service, please find paper copies with patient
- Locate the Handover Form and Section papers on Mobius or HIE
- Have pharmacy technician complete medication reconciliation, and share with the doctor on the ward
 - **If OOH, pharmacy tech will complete on shift**
- If the case notes (incl. Medicine Chart, Section Papers, Physical Health Obsv) were not transported with the patient, contact Bed Management or if OOH, site officer
 - Via email using epunft.bed.management@nhs.net or
 - Via phone using the following extensions (within the Trust)
 - North: 22449
 - South: 22445
 - If needed, use SwitchBoard

4. Identify care coordinator and liaise with all other professionals involved (RN)

- Find care coordinator’s name
 - If the patient is known to the community service, locate information on Mobius and HIE
 - If patient is not known to community service, patient won’t haven’t been allocated a care-coordinator
 - Have admin forward the name and information of the patient to the local community team and ask them to allocate the patient a care-coordinator
- Inform care coordinator of admission & invite them to ward review

5. Check that CPA Initial Assessment inc. Risk/AMHP are completed (RN)

- Under Doc Type 2, find Initial Assessment Form (2.1-00) inc. Risk
 - If the form has already been completed prior to admission to the ward, update and submit form on Mobius
 - Amend the date on the form to the date of admission

On Admission

6. Complete Bed Management Lite Form (Qualified member of staff)

- Find Bed Management Lite Form (17.4) on Mobius

- Complete form to start the hospital admission and for the patient to be created within Oxevision devices (will be created within 20 minutes)
- 7. For patient admitted under informal admission – read Informal Rights (RN)**
- Search for Section 131 Rights Form (7.2-01) on Mobius
 - Read the patient their rights and complete form
 - Give patient Rights Leaflet
- 8. For patient admitted under MHA - scrutinise Mental Health Act papers on ward, complete H3 and read Section Rights (RN)**
- Check the Section paperwork, Transport form, and forms on Mobius
 - Complete MH Scrutiny Checklist
 - Have admin scan the checklist in and email it to the **MH Act Office who will upload paperwork to Mobius**
 - If anything is wrong in paperwork, talk to AMHP
 - If anything is wrong in the Drs paperwork, MHA Office will notify ward to rectify (refer to local procedure)
 - Complete H3 Form (Record of Detention in Hospital) to accept the patient
 - Search for Section 132 Rights Form (7.2-00) on Mobius
 - Read the patient their rights and complete form
- 9. Attach MHA paperwork to bed state for collection and email/ communicate with MHA team (if patient detained under MHA) (RN)**
- Provide paper copy to the ward admin/scanning team so they can post it to the MHA Office on the next working day after admission
 - If OOH, follow local procedure to place paperwork in e.g., MHA Office Paperwork Folder, the Office Safe, etc.
 - Scan the Section papers and email MHA Office at epunft.mhaoffice@nhs.net
 - In the body of the email, write down the patient name, NHS number and ward
- 10. Ensure Initial assessment inc. risk assessment/screening is completed / updated and risk management plan recorded (RN)**
- Click on 'Assessments' on top of screen
 - Click on 'Risk assessment' in left hand side menu
 - Check the latest Risk Assessment Form (2.1 - from within 4 hours of admission) is completed
 - Check risk levels, risk plan, etc. and amend where needed
- 11. Record patient's consent to information sharing (RN)**
- Under Doc Type 1-Admission, open Consent to Share Information Form (1.5-00)
 - Check Mobius to identify if the form has been completed for this admission
 - If the form has not been completed, complete the form

- If needed, print the form to obtain patient signature and scan/upload form to the system

12. Determine the observational level based on presenting risk and record in patient record (RN)

- Based on initial assessment/ screening and risk assessment, determine the appropriate level (see Appendix A – Observation and Engagement Levels for further guidance)
 - Level 1 - General observation
 - Level 2 – Intermittent observation (4-6 times in 60 minutes) – refer to local procedure
 - Level 3 - Continuous within eyesight
 - Level 4 – Continuous within arm’s length
 - If patient is at level 2, 3 or 4, complete Engagement and Supportive Observation Record Form (4.2-00) for the 15/30 mins observation
 - Print form and complete over 24 hour period
 - Have admin scan form onto Mobius
- Complete Engagement and Formal Observation Care Plan Form (5.3-00) on Mobius

13. Search and record patient belonging inventory (RN)

- Under doc type 1, open Patient Belonging Inventory Form (1.7)
- Read through the form to check if personal item section is completed for this admission
 - If not yet completed, complete the form
 - Save on Mobius

14. Complete COVID-19 risk assessment (RN)

- Complete COVID-19 swab
- Complete COVID Risk Assessment Form on paper (form is found on shared drive)
- Have admin/scanning team scan form onto Mobius
 - If the patient has COVID, isolate the patient
 - Complete Continuation and Progress Outcome Sheet (4.1)
 - Call or email the Infection Prevention Control Team to inform them

15. Complete Medicine Reconciliation Form (Dr or pharmacy technician)

- Under Tab 3 ‘Physical Health’, search for Medicine Reconciliation Form (3.32) on Mobius
 - If you are Dr, complete within 6 hours (level 1)
 - If you are pharmacist, complete within 24-72 hours (level 2)
 - Save on Mobius
 - If completed on paper, have admin scan onto Mobius

16. Complete Inpatient Admission Assessment including Physical Health (Doctor)

- Search for Admissions Assessment/Physical Examination Form (16.2-00-CP) on Mobius
 - Refer to shared care record
- Complete Inpatient Admission Assessment and record findings
- Complete additional assessments and record findings, including;
 - Mental State Examination
 - Physical health
 - ECG assessment
 - Record under Doc Type 3 'Physical Health' tab, save ECG result in Physical Health Form (3.22)
 - Routine bloods (if not already done)
 - Complete paper Blood Form
 - Send bloods to hospital for testing
 - Drug allergies – check information from Admission Handover, Reconciliation Form, Med Chart, etc.)
 - Record on PMAC
 - Baseline Single Parameter Track and Trigger Physical Observations
 - Use NEWS2 chart
 - Record under Doc Type 3 'Physical Health' tab, complete Physical Observation Form (3.1-00)

Within 2 hours

17. Allocate a Named Nurse (RN/nursing home/ward/unit manager or deputy)

- Allocate a named nurse to the patient based on availability/capacity - no more than 5 patients per worker.
- Record Named Nurse-within the Care Plan - Refer to CG10 Named Nurse clinical guidelines for further guidance
- Record within the Bed State

18. Record patient's consent to admission and assessment (RN)

- Gain patient's consent to admission
 - If patient is under informal admission, complete Patient Consent Form 7.1-00
 - Under Doc Type 7.2, complete Admission Contract (131) and have patient sign
 - If patient is detained under MHA, complete Patient Consent Form 7.2-00
- Have admin scan form onto Mobius

19. Complete cash and valuables register (Qualified member of staff)

- Search patient belongings (e.g., clothes, bag, cash, valuables, etc.)
 - If large sums of cash, discuss with family (with consent) about them taking it home or placing it in welfare
- Record the patients valuable in paper form

- Be as specific as possible with the description (e.g., mention colours, labels, etc.)
- Have admin scan form onto Mobius

20. Ensure patient is oriented to ward and given welcome pack (Qualified member of staff)

- Give patient the Welcome Pack (including info about mealtimes, visiting times, contact details, My Care, My Recovery form, Rights leaflet, sexual safety leaflet, Oxehealth fact sheet, Advocacy etc.)
 - If patient is not well enough, give Welcome Pack to the next of kin
- Show patient around the ward (their room, the canteen, common areas, etc.)
- Have patient fill My Care My Recovery out (or you/family to help them fill it out) so that they can input on how they want to receive care
- Have admin/scanning team scan form onto Mobius under Tab 5 'Care and Treatment Plans'

21. Discuss Oxevision use with patient and/or relatives - (*Implied consent as per SOP*) (clinical team)

- Print the Oxevision form from the shared drive
- Give the form to the patient to sign and give consent to Oxevision
 - If patient doesn't have capacity and/or doesn't consent, discuss in MDT
 - Consider speaking to next of kin/relatives etc.
- Document needs and/or outcome in care plan on Mobius
- Have admin scan Form onto Mobius/or shared drive in some wards

Within 4 hours

22. Complete care plan (RN)

- Under Doc Type 5, start completing the Care Treatment Plan Form (5.1) on Mobius
 - Complete care plan summary and refer to My Care My Recovery
 - Select relevant care plan in the dropdown (mental health needs, physical health, crisis/contingency/safety plan)
 - Identify needs and risk, action intervention agreed by patient, who, due date, outcome, day care plan agreed, time, care plan agreed by (complete this for every care plan)
 - Check to ensure that care plan has been discussed with the patient and carer
 - Ensure that the care plan has been written with the patient's involvement
- Save form on Mobius

23. Identify and inform next of kin on admission (RN)

- Under Doc Type 1, find Demographics Form (1.2)
- Find next of kin (NOK) details
 - If the patient does not have a NOK listed, check with patient (or family) who next of kin is
- Call next of kin and update them on the patient's admission

24. Enter bed state and daily report, update white board (ward clerk)

- Update daily bed state with patient name, obs level, Section update, etc.
- Send updated bed state daily to management team
- Send admission notification to GP
- Ensure nursing team updates white board & admission book

25. Complete MRSA screening tool (RN)

- Complete assessment, if needed
- complete MRSA swab and send to lab for testing (see local procedure for guidance and appropriate service)
- On Infection Control Transfer and Admission Form (1.6) on Mobius, complete Page 3 with findings and interventions
- Save form

26. Complete NEWS2 – Baseline Vital signs (RN)

- Use NEWS2 chart to take baseline vitals
- Under Doc Type 3, complete The Baseline Physical Assessment Form (3.1)
- Save form

27. Complete VTE Assessment (Doctor)

- Complete assessment
- Under Doc Type 3, complete VTE Assessment Form (3.16)
- Save form

28. Complete essence of care assessment (RN)

- On Mobius, click on 'Essence of Care assessment' in left hand side menu
- Add new assessment and take patient through all the domains (health promotion, safety, privacy and dignity, self-care, etc.)
- Save form

Within 6 hours

29. Complete cardio metabolic form (Doctor)

- Under Doc Type 3.2, complete Cardiometabolic Monitoring Form (3.2-01)
- Save form

30. Complete drug screen and urinalysis and record results in Patient Record (RN)

- Conduct drug screen (not on older adult unless required)
- Conduct urine analysis (not always but if suspected UTI infection)
- Conduct pregnancy tests on people who menstruate
- Complete Baseline Physical Observations Form (3.1-00) and record findings
- Save form

31. Complete medicine chart and prescribe medicine (Doctor)

- Review Medicines Reconciliation Form & Medicine Chart from pharmacy tech
- Complete medicine chart on paper
- Prescribe medication

32. Scrutinise medication chart (RN)

- Check for accuracy on medication chart if prescriptions are legal or legible
 - If anything does not seem accurate, have the Dr review the medication chart
 - Make sure it's prescribed
 - Make sure it's signed for & dated accurately

33. Complete Waterlow Assessment (if required) (RN)

- Complete the Waterlow Assessment (check for skin damage – high risk of e.g., dehydration)
- Under Doc Type 3 'Physical Health', complete Waterlow Assessment Form (3.33-06)
- Save form
- Discuss in MDT

34. Complete Falls Risk Assessment and record on Mobius (RN)

- Under Tab 2 'Assessment/Risk', complete GTA Risk Assessment Tool (FRAT) (2.25-06)
- Save form

35. Complete manual handling needs and record on Mobius (RN)

- Under Doc Type 3 Physical Health, complete Manual Handling Risk Assessment and Care Plan (3.16-02)
- Save form

36. Request consent for patient photograph to be taken and take photograph (Qualified member of staff)

- Discuss consent with patient and complete form on paper
- Give the Consent for Patient ID Photograph (paper) form to the patient to have them consent to their photograph being taken
 - If the patient refuses to having their photograph taken, they should write so on the form

- If patient consented to photograph, take photograph of the patient (registered nurse)
- Have admin upload the form under Tab 1 'Admission' (1.12) within 24 hours (except for weekends and bank holidays)
 - Refer to electronic record CPG9d Scanning Procedure

37. Complete MUST Assessment tool in the Patient record (Qualified member of staff)

- Under Tab 3 'Physical Health', find the MUST Form (3.5-00)
- Print form and barcode
- Conduct assessment and complete form on paper
- Have admin scan form onto Mobius
- Make arrangements with canteen to accommodate patient and refer to dietician, based on the MUST result;
 - a. 0 – green: no concern
 - b. 1 – amber: monitor weight and patient to be on food and fluid chart to monitor eating
 - c. 2 – red (high risk): refer to dietician
 - d. 3 – red (very high risk): refer to dietician
- Discuss in MDT

38. Complete Food and Fluid Monitoring Form (RN)

- Under Tab 3 'Physical Health', find the Food and Fluid Monitoring Form (3.33-02)
- Print form and barcode
- Conduct assessment and complete form on paper
- Have admin scan form onto Mobius

39. Complete body mapping form (RN)

- Under Tab 3 'Physical Health', find the Body Mapping Form (3.3-00)
- Print form and barcode
- Conduct mapping and complete form on paper
- Have admin scan form onto Mobius

At 48 hours

40. Complete Incontinence Assessment (RN)

- Conduct assessment
- Under Tab 3 'Physical Health', complete Incontinence Assessment Form (3.33-09) on Mobius
- Save form

41. Refer for care coordinator if not already allocated (RN)

- Discuss patient case and discharge with discharge coordinator

- On Mobius, go onto the inpatient referral patient is on right now
- Submit referral for care coordinator

42. Complete PBR Clustering Form (RN)

- Open PBR Form (2.16) on Mobius
- Complete the form and save to the record

43. Complete Care Plan (RN)

- Ensure all physical and mental health assessments are included in Care Plan
- Complete Crisis/Contingency/Safety Plan