Acute Inpatient Admission and Discharge Arrangements

Prior to or on admission
If known to NTW services - Referring person ensures Core Assessment Risk Profile (FACE) and Care plan and Risk Management Plan are up to date on electronic care record
OR section papers and AMHP assessment provided to ward if compulsorily admitted.
OR other organisations assessment risk assessment and care plan provided to ward if not previously known to NTW services
If service user is informal referrer and ward completes MC1

Admitting nurse, SHO, referrer, service user and carer (where appropriate), collectively update the core assessment, including physical health checks, and risk profile (including keeping children safe assessment if appropriate) and use as a basis to develop the initial in-patient Risk Management Plan, incorporating:
- Planned or agreed leave
- Observation levels
- Action to be taken in the event of increased clinical risk e.g. abscondion risk
- Any medication patient requires
- Details of risk history
Plan should cover patient care up to first MDT / CPA meeting. Copy available to community professionals via RiO or paper copy of plan provided to Non-RiO users by Ward Staff.

Is the referrer the lead professional / care co-ordinator?
No

Admitting ward / clerk checks via RIO whether there is an existing care co-ordinator.

Yes

No care co-ordinator
First working day after admission

Ward Nursing Staff take care co-ordination responsibility. Ensure registration of service user including completion of CPA management screen

If IMCA / IMHA (or general advocate) or health and welfare LPA in place

Inform relevant Community Team / Single point of access of admission and referral for allocation

Within 7 working days of the receipt of the referral

Community based Care co-ordinator in place

Ward Manager or Rep. advises of admission (FAX/email). Invited to first MDT

Attends / contributes to

First in-patient Multi-disciplinary Team Meeting with service user and carer involvement = formal Care Co-ordination
Review completes a full review of the patient’s care needs for the duration of their in-patient admission and formulates care plan.
Care co-ordination documentation completed by appropriate member of in-patient MDT. Accessible via RiO or paper copy sent to Care Co-ordinator.

Community based Lead professional / Care co-ordinator in place

MDT add to risk history as appropriate

Yes

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Appendix 7 – Flowcharts – V04-Iss2 – Dec 17 - Part of CC-CPA-PGN-03 – LD Services within Community IP Forensic D IP Services Care Groups and Autism Services within Specialist Group (NTW(C)20 – CC/CPA Policy)
Each in patient admission, regardless of time elapsed, is a separate episode and will have a full assessment including risk assessment completed at all times.

**No Community based Care co-ordinator in place**
- Within 7 working days
  - New Community based Care co-ordinator allocated.
  - Next working day
  - Contact with the ward manager to inform them of allocation and agree timing of hand over of responsibilities (prior to discharge). CPA management screen updated If no allocation
  - Ward Manager to inform Service Manager

**First in-patient Multi-disciplinary Team Meeting**
- Within 7 working days
  - = formal Care Co-ordination Review with service user and carer involvement. Meeting completes a full review of the patient’s care needs for the duration of their in-patient admission. Review form completed by inpatient team and copy sent to Care Co-ordinator and other agreed stakeholders

**Care plan, including observation, leave and risk management plans (where appropriate)**
- Updated / developed by in-patient team. Liaison arrangements between ward and Community professionals, agreed and documented in care plan.
- Care plan copied to care co-ordinator if no access to RiO and other agreed stakeholders

**In-patient review meeting**

**Discharge Planning**

**Community based Care co-ordinator in place**
- Attends / contributes to
  - If IMCA / IMHA general advocate / health and welfare LPA in place
  - Within 7 working days

**Inpatient Consultant - Admission summary**
- Copied to community based Consultant, Care Co-ordinator, GP

**No Community based Care co-ordinator in place**
- Within 7 working days

**If IMCA / IMHA general advocate / health and welfare LPA in place**
- Attends / contributes to

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Appropriate members of the in-patient MDT. This must include a consultant psychiatrist (or associate specialist) for all service users who express delusional beliefs involving children or might harm a child as part of a suicide plan.

In-patient review meeting(s) focusing on discharge planning = a formal Care Co-ordination Review. FACE risk profile (and keeping children safe assessment if appropriate) relating to plans for discharge completed.

Discharge Care plan formulated - identifying the patient’s care needs for their immediate discharge and successful reintegration into the community, with particular reference to immediate needs, support in the first week of discharge including 7 day follow up arrangements and the subsequent 3 months. If needed Care co-ordination change of circumstances registration form completed to formalise hand over of care co-ordination responsibility. Care plan to identify section 117 services if S3 and any required locality 117 forms completed.

If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services, the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made.

If a service user expresses delusional beliefs involving children or might harm a child as part of a suicide plan discharge planning should include multi-agency planning via the safeguarding process. Care plan documented by designated member of care team. All discharge planning documentation circulated to care team at least one working day prior to the patient being discharged.

As agreed at discharge planning. Can be undertaken by Care co-ordinator, Community Consultant or In-patient consultant.

7 day follow up

No later than 6 weeks after discharge

Care Co-ordination review

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Inpatient – Transfer Between Wards

The service user’s previous unified health records, previous and current RiO support file should always transfer with the service user.

Admitting nurse and doctor check all Care Co-ordination documents completed on RiO and current

- No action required
- Complete if client has capacity. If client does not have capacity then discuss at MDT

Registration / Demographics - are there any change in

- No
- RiO record does not reflect service users current situation / wishes

Consent to share information

- Yes
- Admitting Doctor and Nurse complete relevant assessment screens

Assessment updating

- Yes
- Admitting Doctor and Nurse Update on Transfer

Recent Risk assessment i.e. completed FACE risk profile

- Yes
- Does RiO need updating to reflect current risk?
  - No
  - Does Care plan need updating?
    - Yes
      - Update on Transfer
    - No
      - Agree at first MDT and record on MDT review Staff to discuss & record all changes Re Care Co-ordination

To be completed by Admitting Doctor and Nurse on transfer

Complete on transfer

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