(Working document adopted from PHNT)

Plymouth Hospitals NHS Trust and
Livewell Southwest

Transfer of Adult Patients with Mental Health Needs – Joint Guidance

Version No 2.2

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW Intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Modern matron Glenbourne**

Asset Number: **4**

Transfer of Adult Patients with Mental Health Needs – Joint Guidance

Document Status	Up-dated
Version	V2.2 (13.5.16)

Document Change History

Version	DATE	Comments (i.e. Viewed, reviewed amended or approved by person or Committee
V1	May 2011	Reviewed by all operational Matrons Discussed with Director Mental Health Services NHS Plymouth Agreed by Nursing & Midwifery Advisory Board
Revised V2	December 2013 Finalised February 2014	Joint review with PHNT and Livewell Southwest
V2.2	May 2016	Reviewed, Modern Matron Glenbourne

Authors (s)	Karen Grimshaw – Associate Director Nursing/Nurse Consultant Older People (V2) Amended Vicky Clarke Modern Matron
Names & Roles of Contributors	Amanda Williams - Mental Health Act manager - Livewell Southwest Miriam Smith – Emergency Planning & Liaison Manager - Plymouth Hospitals NHS Trust Eva Jakobsen - Matron Glenbourne unit - Livewell Southwest Sue Timmins – Clinical Educator for Orthopaedics Plymouth Hospitals NHS Trust Cyana Anderson – Derriford Liaison Team Mike Hall – Derriford Liaison Team
Relevant to: Staff Groups	Clinical teams acute hospital wards Mental health inpatient units;

	Derriford Liaison team
Document Reference:	CLI/SAF/GUI/526/1
Review date	March 2018
EIA	This guidance promotes appropriate care and communication for people with mental health needs in hospital
Links to other Policies & Procedures	Safeguarding Vulnerable Adults Policy Learning Disabilities Services Standard Operating Procedure Mental Capacity Checklist Best interests Checklist Policy for Consent to examination & treatment. IMCA Involvement checklist Complaints Policy
Distribution	**Specific ☑** **All Clinical Areas**

1. Introduction

1.1 This guidance document sets out the procedures and expected standards for staff from both organisations in managing the care of adult patients (aged 18 and above) who have mental health needs and who have an acute illness/condition requiring treatment at Derriford General Hospital (DGH). The purpose of this guidance is to ensure that such patients have equal access to the appropriate level of medical & nursing care and that the needs of an individual patient with mental health problems are properly assessed and a person-centred care plan developed for their hospital admission. The transfer of patient's between the acute hospital and mental health units and vice versa is important and must also be managed to achieve the best outcome for the patient.

1.2 Whilst this guidance does not formally apply to children and young people the expectation is that the philosophy of equal access to the appropriate level of medical & nursing care, taking account of specific needs, is applied in the same way.

2. Consent and Capacity

2.1 Consent is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to make the particular decision;
- have received sufficient information to make it; and
- Not be acting under duress.

2.2 A detained patient with capacity to refuse physical treatments cannot be "forced" to accept treatment purely because they are detained. A capacitated detained patient has the same right to accept or refuse treatment as any other patient. The treatment of their mental disorder is covered under the MHA

2.3 Where patients have an impaired cognitive function which impacts on their capacity to make decisions for themselves, assessment of mental capacity is needed. The Mental Capacity Act applies to all incapacitated patients, including detained patients. An incapacitated detained patient may be treated under the MCA for any physical treatments they require, providing the five statutory principles of the MCA applied. The five principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2.4 Four key factors need to be established in assessing capacity;

- Whether the patient is able to understand the information.
- Whether the patient is able to retain the information related to the decision to be made.
- Whether the patient is able to use or weigh that information as part of the process of making the decision.
- Whether the patient can communicate the decision by any means available to them.

2.5 Some patients with mental health issues may well lack mental capacity to make decisions regarding their treatment, care or transfer/discharge. Some may require extra support to be able to make a decision or to communicate their decision regarding the care or treatment they are facing.

2.6 The Mental Capacity Act 2005 requires healthcare professionals to assume a person has capacity to make a *specific* decision unless there is evidence to show otherwise. Where a patient is deemed to lack mental capacity, decisions regarding care or treatment must be made using Best Interest decision-making – this must:

- Involve the person and/or their family or other carers as a matter of course unless there is good reason why this should not be so. Reasonable adjustments must be made to support carers to do this effectively.
- Consider the person's past and present wishes and feelings.
- Not be discriminatory on the grounds of age, appearance, disability.
- Involve an advocate if necessary.

2.7 For those patients who are "un-befriended" – i.e. they have nobody who is willing or able to be consulted with or act as an advocate regarding the decision, a referral should be made to the Independent Mental Capacity Advocate services (IMCA).

'Best interests' is a method for making decisions on behalf of others that requires the decision maker to think what the 'best course of action' is for the person concerned. It is not the personal views of the decision-maker, it is a consideration of both the current and future interests of the person who lacks capacity, weighing them up and deciding, on balance, which course of action is best for them. Such decisions must:

- Be clearly recorded in the patient's medical record.
- Include the patient (if possible), relatives **and/or** carers, advocate if necessary, and the relevant healthcare professionals.
- Reflect the requirements of the Mental Capacity Act.

3. Acute hospital transfer admission

3.1 As much information regarding the patient's needs etc. should be gleaned before hospital admission, wherever possible – whether admission is planned or urgent. It is important that any risk assessments, communication needs and plans for on-going mental health treatment are made clear to the clinical team admitting the patient to hospital. The patient's specific needs relating to their mental health should be ascertained and appropriate care planned such as communication forms/aids, emotional well-being/anxiety, cognitive function, behavioural support, medication issues, mental health act status.

3.2 **Out-patient appointments at the Acute Hospital**

- The Mental Health team must liaise with the relevant Out-patient department, prior to the appointment, to discuss care plan and communication channels.
- MHA requirements (status of patient, Section 17 leave) to be shared, including risk assessments
- Appropriate information, regarding needs and risks associated with the patient's mental health must be provided.
- Patient will be escorted by mental health staff if required and deemed necessary according to risk assessments.

3.3 **Elective Admissions**

Pre-assessment – Patient needs and risks should be identified and assessed through the pre-assessment process. It is important that consideration is given to the impact of the planned treatment on the patient's mental health – liaison with mental health and Learning Disability services should be made at the pre-assessment stage. Patient risks should be clearly documented and used to inform the care plan or care pathway for the acute care treatment.

3.4 **Care Pathways** – will normally define the patient care needs according to the condition or treatment provided. However, consideration will need to be taken as to the specific needs of a patient with mental health issues. These should be discussed with the patient and their carer, the patient's Community Psychiatric Nurse, GP and/or Psychiatrist.

3.5 **Emergency Admissions**

- Patients transferred to the Emergency Department from mental health units will be escorted by mental health staff to provide details of patient risks, needs and any specialist requirements such as Mental Health Act status. The staff escort will remain with the patient at all times, until the patient is either returned to the mental health setting, or admitted as an in-patient to Derriford Hospital ward - within the 4 hour standard time.
- Where a patient attends an assessment unit (MAU Thrushel, Tavy or SAU) escorting staff are to remain with patient, until the patient has been transferred for admission to an inpatient bed or discharged back to the mental health unit.

- The Emergency Department will keep electronic care plans of those patients with mental health/Learning disability needs who are known to mental health services and who attend ED on a regular basis, so that information regarding the specific needs of these patients can be readily accessed by Emergency Department staff.
- Where a patient who has an identified mental health need is admitted through the Emergency Department or to Hospital wards, staff will contact the Derriford Liaison Team at the earliest opportunity, who will provide liaison with the mental health unit/mental health services or Learning Disability services - to find out information regarding the patient's specialist needs, community care plans or services and advise on any risk assessments or care plans needed.
- The specialist nurses from Derriford Liaison Team will liaise closely with the clinical teams to ensure that there is clear communication and appropriate care planning (include staffing needs) to meet the patient's needs. This will include discussion with the patient and their carer/s, the nursing/medical staff and other relevant agencies.
- All nursing staff within Emergency Services will receive in- service training to ensure that they are confident and competent in caring for patients with mental health/learning disability issues. This may come from the Psychiatric Liaison nurses, staff from mental health units or other bespoke training.
- When the patient is transferred to an appropriate ward the Nurse-in-charge on the transferring ward must inform the Nurse-in-charge on the receiving ward of the patient's specialist needs – including any risk assessments, specific drug interventions, needs for increased supervision, care plans for mental health problems and copies of MHA paperwork.
- The staff at Derriford will assume responsibility immediately for any nursing observations of the patient. The release of staff back to the mental health unit, will be on a needs led basis, consideration being given to current mental health and presenting risks – however, once the initial assessment of the patient has been concluded, it will be expected that escort staff will be released.
- Ongoing communication and support from the mental health team will be maintained – either directly with the ward clinical team or via the Derriford Liaison Team.
- The treatment of patients detained under the Mental Health Act at Derriford, will in most circumstances take place whilst they are on Section 17 leave, as it is likely that they will be returning to their mental health setting.

3.6 **Communications on Transfer of a Patient to Acute Hospital**

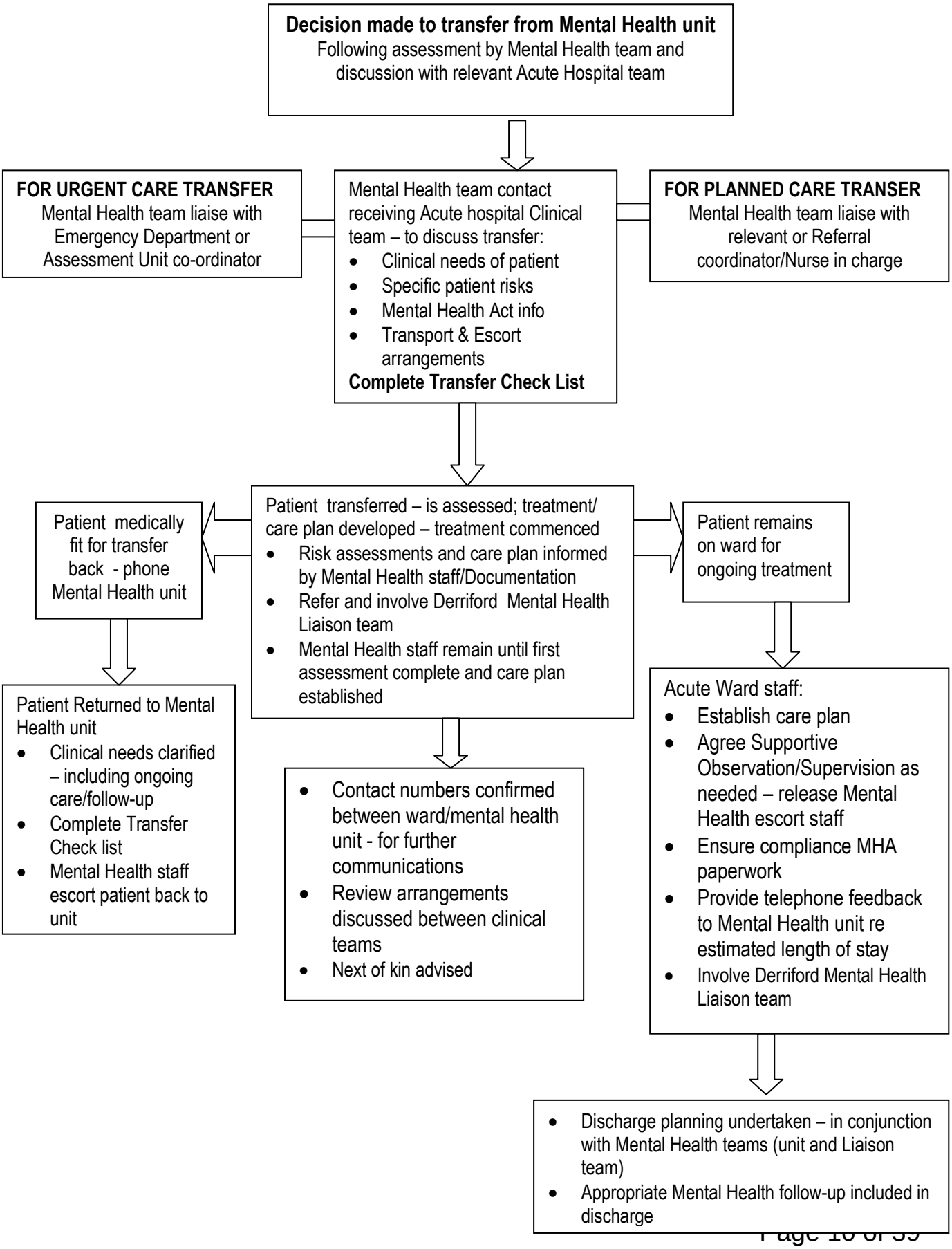
- The two clinical teams must liaise directly before transfer of patient - to discuss patient needs, risks, care plans etc
- Arrangements are to be made by the mental health unit for the appropriate transport to convey the patient to Derriford Hospital.

- Mental Health staff will stay with the patient, whilst patient is being assessed and a decision to admit is made; to offer support/care to patient and provide transfer information to the receiving clinical area.

3.7 **Documentation to accompany patient:**

- Letter from referring medical officer staff – providing relevant medical & psychiatric history.
- Copy of medication chart.
- Copies of Mental Health Act paperwork including consent to treatment, Section 17 leave - Service users who require urgent treatment, are to be taken to Derriford and the Section 17 leave form, completed retrospectively.
- Copy of risk assessments, warning screen and any other relevant information from CPA - including AWOL risks, behaviour patterns, need for close observation
- Psychiatric clinical notes can be obtained on request to the mental health unit.

Flowchart for transfer of patient from Mental Health Units to Derriford Hospital



4. Risk Management and use of Risk Assessments

4.1 Risk assessments should identify any specific or particular needs of a patient with mental health problems on or before admission to hospital. Any subsequent care plan developed in hospital, needs to address the patient's mental health needs including known and potential risks, as well as their physical needs, clinical condition, and social needs. Attention should be given in the care plan to how a hospital admission and the patient's physical condition may impact on a person's mental health needs.

Specific Patient Risks

4.2 As with all patients, assessment of clinical risks is important. This includes clinical risks regarding the patient's physical health and their mental health/behaviours.

4.3 Issues with risks of infection, falls, allergies, tissue viability, malnutrition, immobility, venous thrombosis and others must be clearly documented with the corresponding multi-professional plan of care recorded to manage the identified risk; risks associated with patient behaviour must also be clearly documented such as confusion, mental capacity, medication compliance, wandering behaviours, aggression, self-harm.

4.4 **Care Programme Approach (CPA)**

This is the framework under which a mental health plan for patients under the care of mental health services is provided. The plan is reviewed regularly by the persons Care Coordinator and in liaison with the patient and others involved in their care. On admission to the acute hospital a person currently open to mental health services should have a current care plan in respect of their mental health needs which should be communicated with the hospital team. There should also be a current risk assessment if the person is open to mental health services. A summary of risks a person may present with and their risk history should be shared with the hospital via the CPA Risk Summary Document, so that everyone involved in the patient's treatment and care, understands the particular risks a person may present. Current care plans should be available to the acute hospital to enable care and treatment continuity to be maintained.

4.5 **Review of Treatment Plan**

In hospital the patient's treatment plan should be developed and reviewed daily – considering their acute care needs and on-going mental health support; arrangements for weekend review will need to be made by the medical team. All reviews of care planned, should include the patient as a partner in care. Even for those patients who lack mental capacity, every effort should be made to include the patient in decision-making and care planning.

5 Supportive Observation

5.1 Some patients with a severe and enduring mental health problem may need more support in hospital than the general patient population. They may need additional support for aspects of care such as behavioural management, anxiety, suicide/self-harm risks, communication, dealing with strangers involved in their care/treatment, pain control, and management of long-term conditions, eating & drinking, continence, mobility, and sleep. The plan of care to meet any specialist needs may require additional resources in terms of carer support and/or equipment – within the acute hospital the Restraining Therapies care plan must be in place for any supportive observation

5.2 The need for additional care/support in hospital needs to be planned in advance wherever possible and in accordance with the levels of risks identified for the individual (see Appendix 7 for Levels of Supportive Observation):

- For elective admissions this should be agreed and communicated prior to admission.
- For emergency admissions this should take place at the earliest opportunity but not longer than 24 hours after admission.
- The appropriate level of support needs to be agreed with the Ward Manager or nurse in charge in order to identify how best to meet the additional needs of the patient with mental health needs.

5.3 **Principles of Supportive Observation:**

The nurse responsible for Supportive observation will normally:

- Be a first level Registered Nurse, a non-registered nurse (Health Care Assistant) or Student Nurse who is deemed to be competent by the Nurse in charge.
- Know the patient, their history, background and risk factors.
- Be familiar with the ward, the ward policy for emergency procedures and the potential risks within the environment.
- Be familiar with the patient's social context and significant events since admission.
- Follow a specific observation care plan, preferably with multi-disciplinary input, written in conjunction with the patient. Issues such as how toileting and personal hygiene activities are to be supervised must be specified.
- Show the patient unconditional positive regard.
- If the patient is uncommunicative, the nurse must convey a willingness to listen and should initiate conversation as appropriate.
- The patient and/or relative must be informed of the reasons for supportive observation.
- Reflect on their own thoughts, feelings and attitudes about supportive observation to ensure that this intervention is supportive and therapeutic.

- The multi-disciplinary team must provide an open and supportive environment, to enable members of staff to discuss their feelings about participating in supportive observation.
- Where disagreement between disciplines exists with regard to the level of observation required by the patient, the higher level of observation will prevail until the resolution of differences takes effect.
- Not be expected to undertake Supportive observation for longer than one hour at a time, except in exceptional circumstances. The management of the nursing team should ensure that Supportive observation is changed on a regular basis so that the same member of staff is not left observing the same patient for long periods.
- The level of observation will be reviewed on a regular basis – at least daily. The registered nurse will request assistance from Derriford Liaison service, where there are concerns that the level of observation is thought to need changing according to patient risks or where the level of observation is thought to be prolonged.
- Security staff may be called upon to assist and support with Supportive Observation (at Bay level or Bed Watch) – where patients are at risk to themselves or others. However, this should not be on a continuous basis, without the use of Restraining Therapies care plan and or specific risk assessment and care plan in place. Use of Security staff must be reviewed by the clinical team on a daily basis and kept to an absolute minimum

5.4 **Likely Scenarios:**

a. Extra staffing to assist the patient undergoing specific treatments or care, on a 1:1 basis (escort, communication, reassurance).

b. Staffing to maintain the patient safety during hospital stay – to include 1:1 supervision support for specific clinical treatments and care, but not continuously.

c. 1:1 support to enable the person's risks of self-harm or challenging behaviour to be managed within an acute hospital setting, whilst undergoing treatment and care.

5.5 **The following Agreement applies**

- Increased supervision is directly related to the level of risk associated with the patient's mental health state.
- Where 1:1 supervision funding is provided in the community for a patient, the carers concerned will continue to provide this level of care whilst the patient is in hospital.
- Where extra provision is required this will be funded by the Hospital either by:

Provision of NHS Professionals staff to support the ward team or Payment to the normal care provider to cover backfill costs of providing their staff to cover.

- Where the extra provision required exceeds 1:1, i.e. 2:1, funding should be agreed with the commissioning authorities via the Matrons and Assistant Directors of Mental Health

NB. Agreement for funding the provision of specialist equipment should be part of the assessment of needs. See Appendix 8

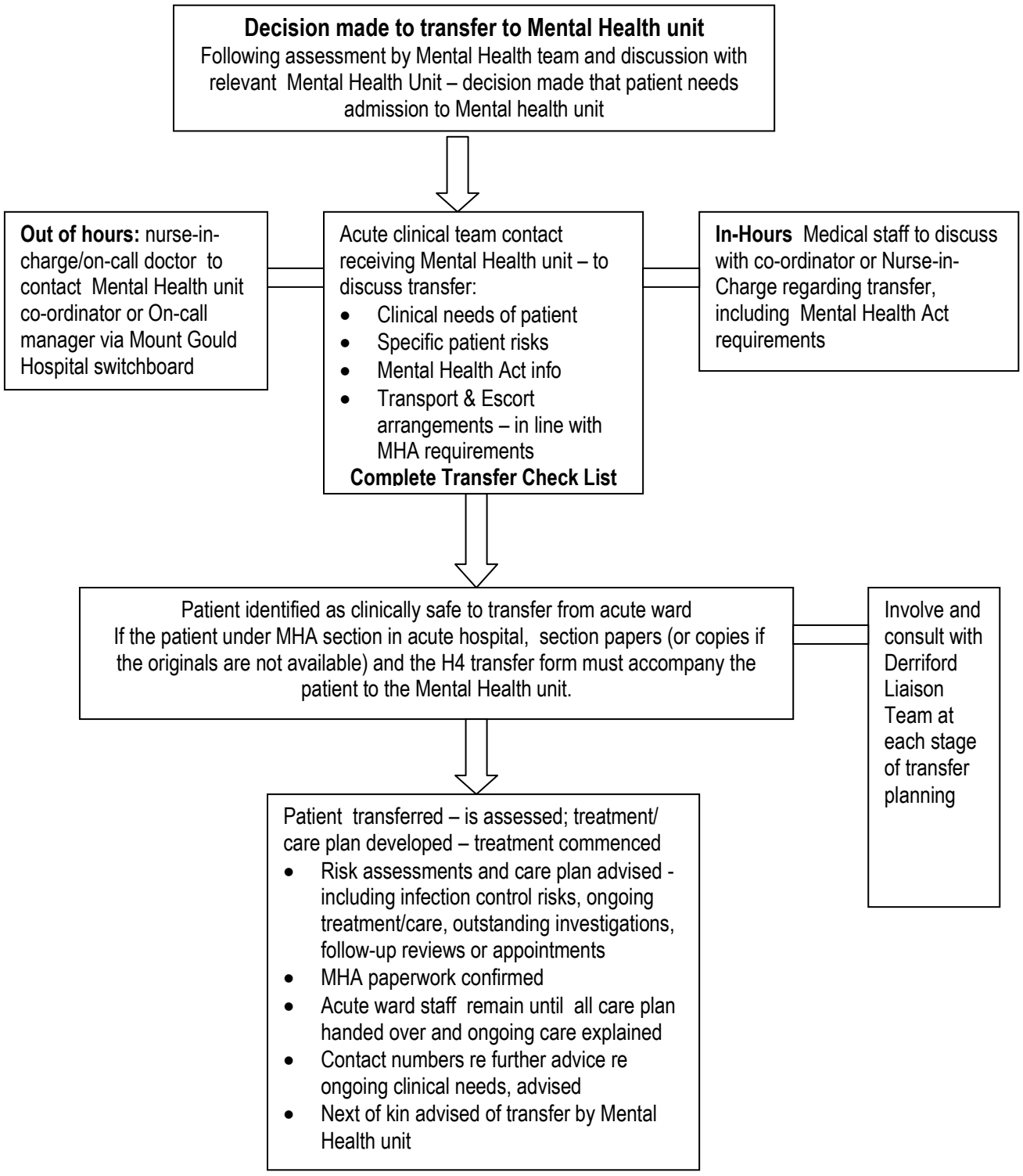
6. Procedure for transfer from Derriford to mental health units

Patients transferred from Derriford hospital to mental health inpatient units may need ongoing physical care for clinical conditions such as tissue viability, continence, blood monitoring etc. Referral to the local Community Nursing team should be made by the Derriford ward, to arrange for follow-up of the patient in the mental health unit.

A Patient Needs on Transfer letter should be completed and sent with the patient, to communicate the specific care needed from the Community Nursing team.

Transfer to Mental Health units must be thoroughly planned and well communicated – discussions with the Mental Health team (medical and nursing) must take place prior to transfer; involvement of Derriford Liaison team should be regular in planning transfer.

Flowchart for transfer of patient from Derriford Hospital to Mental health units



7. Information Sharing

7.1. Multi-agency working is important for the safe and appropriate transfer of care between acute/general hospital and mental health units. To ensure patient safety and continuity of care during transfers between acute/general and mental health units, appropriate information sharing is important. Information sharing between organisations should be specific to patient need and risks and on a need to know basis. Information shared should be accurate and timely in respect of individual cases to ensure appropriate risk management and care planning.

7.2 In general patient consent to information sharing should be sought and discussed with the patient. However, if the patient will not consent to information sharing, this needs to be recorded in the clinical record. For patients who lack capacity to give consent to share information, this should be recorded and information sharing should be undertaken only in the patient's Best Interest.

7.3 There is an information sharing protocol, signed by the chief executive of partner organisations, working within the procedures for Safeguarding Vulnerable adults, the principles of which should be followed when dealing with vulnerable adults requiring liaison between acute and mental health services.

7.4 Confidentiality should never be confused with secrecy, and any information to be shared should be on a 'need to know' basis only. Any decisions made in terms of withholding or sharing information must be recorded and always discussed with a senior manager and/or Legal Services Advisor.

7.5 In all cases clear and concise records must be kept. Consistent and accurate record keeping as an integral part of professional practice is critical to the success of this process. It is not separate from the process and not an optional extra to be fitted in if time and circumstances allow.

8. Role of Derriford Liaison Team (DLT) and The Learning Disability Liaison service in the acute hospital

8.1. Derriford Liaison Team includes mental health nurses working within and with clinical teams in the acute hospital to provide assessment of people presenting with mental health needs. This includes:

- Bio-psychosocial assessment.
- Risk assessment/management advice.
- Triage / signposting/care pathway.
- Sharing of information across agencies.
- Patient centred approaches.
- Consultation/liaison.
- Education of patient and clinical teams.
- Advice on referrals for psychiatric opinion and co-ordination of response from mental health service.

8.2. A crucial role of the Derriford Liaison Teams is to provide advice and signposting, liaising with acute and community mental health services, to share information

across clinical teams in order to manage known patient risks and ensure continuity of care.

The team will actively seek out and explore all alternatives to mental health hospital admission and liaise/involve all relevant parties in the decision making process. Mental health assessments will not usually be carried out until the patient is medically/clinically stable and fit for assessment or discharge. However advice and support can be given to the clinical team in terms of managing the patient's mental health and behaviours. The Liaison team will gather and contribute relevant information from mental health services to inform the clinical team.

Patients will not be assessed whilst under the influence of alcohol or drugs.

8.3 **Contacts**

Through one central telephone number for all referrals and advice:

37499 (internal) / 01752 437499 (external)

- Adult Psychiatric Liaison Nurses - Pager 89883
    - 0900-2100hrs Daily (including weekends/bank holidays)
- Older Adult Psychiatric Liaison Nurses – Pager 89575
    - 0830-1900hrs Monday – Friday (excluding bank holidays)

Outside of working hours the duty SHO psychiatry should be contacted for advice and urgent assessment via Switchboard.

8.4 Learning disability Liaison Team

The roles of the LD liaison team are to facilitate the meeting of individual healthcare needs for people with LD with complex needs and support clinical teams to best meet the needs of individuals. This involves liaising with the community learning disability teams, community providers, families and acute hospital clinical services and co-ordinating support, planning and treatment delivery for referrals of people with Learning Disabilities, who may require help to access acute services. The functions of the LD Liaison team include:

- Facilitate and co-ordinate of patient care – focusing on needs of the individuals and incorporating Hospital Passport information and ensuring that reasonable adjustments are made to take into consideration the individual's complex needs.
- Ensure appropriate reasonable adjustment risks assessments and information are made available to inform the patient care plan.
- Provide support that legal requirements are met re clinical decision making, under Mental Capacity Act.
- Develop effective working relationships – between clinical teams, relatives, providers/carers involved with the individual, community services.
- Ensure good governance is maintained and national standards are met - with respect of care planned and delivered, communications, patient information and involvement.
- Promote staff awareness, education and training re need of people with Learning Disabilities.
- Provide leadership in the developments and approach to care for people with LD.

9. Transport of Patients with Mental Health Needs

9.1 The transportation for a patient between the acute hospital and mental health units should be assessed on the individual's need and risks. The guidelines detailed below are for non-urgent transfer of patients. When booking transport, the transport provider must be informed of mental health status e.g. informal or detained.

9.2 Patients transferring a short distance to another unit (e.g. Derriford Hospital to Glenbourne Unit) may walk, providing they are escorted by a trained nurse, the patient is well-known to staff and are safe to transfer on foot. A full assessment of risks of walking transfer must be undertaken and recorded in the patient's clinical record.

If walking is not an option, the appropriate form of transport should be arranged. Patients being transferred by car or taxi will require a nurse escort. If an ambulance is required due to medical need and the patient is of low risk, there is no requirement for a nurse escort.

All patients whether detained or informal must be risk assessed, to identify the level of support needed whilst the patient is conveyed to the alternative unit. Important factors to consider when transferring patients to a mental health unit/ward are listed below:

- The distance which is to be travelled. (Not all detained patients will be transferred to local units).
- Any risks to the health and safety of the patient and any need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be, used.
- The nature of the patient's mental disorder and their current state of mind. Where transfer to Mental health unit is deemed urgent - consideration will be given re use of urgent transport or emergency ambulance when necessary.
- The likelihood of the patient behaving in a violent or dangerous manner.
- The health and safety of the people conveying the patient and anyone else accompanying them.
- The likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen.

9.3 Patients who have been sedated before being conveyed must always be accompanied by a health professional that is knowledgeable in the care of such patients, is able to identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so.

9.4 The appropriate transport provider should be booked dependent upon the patient's needs and associated risks (see Tables 1 and 2):

	ERS Medical	**SWAST**
Service	Non-Emergency Patient Transport Service	Urgent Ambulance

Ambulance Crew	Ambulance Care Assistants	Paramedics
Risk	Low Medium	High
Monday- Friday 0900-1900hrs	Derriford Transport Team Ext 31954 or 01752 431954	0845 6020455
Out-of-Hours	PHNT Bed Manager Bleep 779 0856	0845 6020455

Table 1

9.5 Table 2 provides guidance on how the patient is to be accompanied, dependent on the outcome of the risk assessment.

Risk	Background	Outcome
Low	Patient assessed as not likely to pose a physical threat through reasons of infirmity or the nature of their illness. It is accepted that there may be some risks.	Ambulance crew only required.
Medium	Patients who are: • Reluctant, or agitated, but have no relevant history of violence. • Require only very minimal restraint and do not post a physical risk to themselves or others. • No known history or someone who has become mentally disturbed for the first time.	Ambulance crew plus one other escort. This should be a relative or friend or other trained nurse, able to travel in the vehicle.
High	• Relevant history of violence and/or pose a threat of physical injury to themselves or others • Patients who need more than minimal physical restraint.	Ambulance crew plus police officer to travel in the ambulance/vehicle as an escort. (This will be in exception circumstances when there is likely to be a breach of the peace.)

Table 2

Based on an Extract from D&C Peninsula Section 136 Protocol

10. Links to other policies

Joint Learning Disabilities Protocol (PHNT/Livewell Southwest)

Safeguarding Vulnerable Adults (PHNT/Livewell Southwest)

Restraining Therapies within the Acute Hospital Setting for Adults (PHNT)

Practical Guidance for Managing Patients Detained Under the MHA (PHNT)

On-call manager's guidance (PHNT)

Care Programme Approach Policy (Livewell Southwest)

System One policy (Livewell Southwest)

Information Sharing Protocols (PHNT/Livewell Southwest)

Supportive Observation policy (Livewell Southwest)

Rapid Tranquilisation (NICE Guidance)

11. Reference Documents

Code of Practice Mental Health Act 1983, Department of Health 2008

Code of Practice Mental Capacity Act 2005, Department of Health 2007

12. Appendices

Appendix 1. Transfer checklist

Appendix 2 Useful Addresses and Contacts

Appendix 3 Care Programme Approach (CPA) Risk Assessment

Appendix 4 Details of Plymouth Mental Health services

Appendix 5 Guidance on the Mental Health Act 1983

Appendix 6 Guidance on the Mental Capacity Act 2007

Appendix 7 Levels of Supportive Observation

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 5th September 2016

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here

Appendix 1

TRANSFER CHECKLIST

Referral Made by Dr _____ **Accepted by Dr** _____

Transferring Ward _____ **Tel** _____

Receiving Ward _____ **Tel** _____

PART A – to be completed by Transferring Ward

	Referring Ward	✓ or N/A
1	Current risk assessment and care plan, to include details of any current supportive observation being undertaken	
2	General medical and mental health notes	
3	Infection Control position	
4	Copy of Prescription chart/TTA summary	
5	Copy of MHA Section Papers and Section 17 leave form	
6	Next of kin informed	
7	Derriford Liaison Team notified	
8	Patient specific medication and equipment with patient	
9	Appointments/clinic referrals details included	
10	Transport arrangements booked and confirmed	
11	Escort arrangements booked and confirmed	
12	Discharge from iPM/system one	
	Signature of Registered nurse arranging transfer	Date

Name of nurse arranging transfer of patient _____

PART B – to be completed by Receiving Ward

	Referring Ward	✓
1	Confirm receipt of: ❑ risk assessment ❑ medical and mental health notes ❑ Prescription Chart and TTA summary ❑ medication ❑ MHA Section paperwork – if applicable If elements missing ➔ contact Transferring Ward	
2	Next of kin informed - if not already notified	
3	Admit onto iPM/system one	
	Signature of Registered nurse receiving transfer information	Date

Time Patient Arrived : hours **Time Escort Released** : hours

Name of nurse receiving patient _____

Appendix 2

USEFUL ADDRESSES AND CONTACTS

Hospital/unit name, organisation and address must be used in full on all paperwork if a patient is being formally admitted or transferred.

PLYMOUTH HOSPITALS NHS TRUST

Derriford Hospital Plymouth Hospitals NHS Trust
Derriford
Plymouth PL6 8DH

☎ 39062 or Bp 89363 for Miriam Smith, Emergency Planning & Liaison Manager

☎ 0 or 0845 1558155 for On-call Manager, Duty Senior Nurse or Acute Care Team Co-ordinator (out-of-hours)

Livewell Southwest

Transfer papers should be made out to '*Livewell Southwest*.

Glenbourne Unit Morlaix Drive Derriford, Plymouth PL6 5AF Tel: 01752 (4)35434 Fax: 01752 763133 Harford Ward**:** 01752 763124 or 53124 Bridford Ward**:** 01752 763109 or 53109	**Syrena House** 284 Dean Cross Road Plymstock Plymouth PL9 7AZ Tel 01752 314491: Fax 01752 337645
Lee Mill Unit Beech Road Lee Mill Ivybridge Plymouth PL21 9HL Tel 01752 314800 : Fax 01752 314804	**Edgcumbe Unit** Mount Gould Hospital Mount Gould Road Plymouth Tel 01752 435399
Other Useful Numbers Glenbourne Unit Reception ☎ 53103 Amanda Williams MHA Manager for NHS Plymouth, Glenbourne Unit ☎ 53143 Helen Link, Deputy MHA Manager for NHS Plymouth, Glenbourne Unit ☎ 57609 Glenbourne On-call Manager - via Mount Gould Switchboard ☎ 0 or 268011	

Patient Transport Providers

☎ 31954 - ERS Medical booked through Derriford Transport Team
Bleep 779 0856 - out-of-hours via PHNT Bed Manager

☎0845 6020455 - SWAST Urgent Ambulance with paramedic crew

Care Programme Approach (CPA) Risk Assessment **Appendix 3**

Livewell Southwest	**CPA RISK SUMMARY**	***SS Case No:***
		NHS No:
		Hosp No:

Patient/Client details		
Name:	DOB:	Mental Health Status:

Care Co-ordinator details		
Care Co-coordinator/Named Worker Name:	Unit / Service:	
Completed by Name:	Completed by Signature & Designation: (On behalf of the team)	Date:

Risk History
Suicide:
Neglect:
Aggression/Violence:
Mood State:
Other:
Forensic information:

Appendix 4

Details of Plymouth Adult Mental Health Services

1) **The Glenbourne Unit - Acute Adult Mental Health – 01752 763103 or Ext 53103**

The Glenbourne Unit is the Adult Mental Health Unit for the City of Plymouth. It has 46 beds and provides inpatient care for people with acute mental health problems. Patients may be detained under the Mental Health Act or informal.

The Unit comprises of 2 wards Bridford and Harford and each ward is demographically aligned to an area of Plymouth and the GP surgeries within that area.

Bridford Ward Accommodates the outer city patients but also the inpatient facility for the citywide Assertive Outreach Service.

Harford Ward Accommodates the inner city patient population and also provides 4 beds for Devon Partnership Trust acute inpatient needs.

The Glenbourne Unit comprises of:

- Patient services for those with severe depression, manic phases of an illness or distressing psychotic symptoms
- ECT Suite providing treatment twice a week to our own inpatients, older person services and the community.
- Place of Safety (136 Suite).
- Occupational Therapy Department which provides a 7 day service to the inpatients within the Unit and using local services.
- Mental Health Act Office.

Recovery In-patient Units

2) **Lee Mill Low Secure Unit (Nr Ivybridge) -**

A 12 bedded Low Secure Unit which provides in-patient care for men. A multi-disciplinary team provide care and treatment in a safe and secure environment for service users who present with serious, complex and enduring mental disorders.

Lee Mill provides security arrangements that impede (rather than completely prevent) those who wish to either escape or abscond. Lee Mill security provision has a greater reliance on staff observation and support rather than physical security arrangements.
Average length of stay can range from 6 months to 2 years. Lee Mill in-patients are often well known to mental health services and may well have spent very lengthy periods of time as an in-patient in psychiatric units or hospitals. This may include a step down from medium security.

All services users will be detained under the Mental Health Act, mostly Section 3, Section 37 or Section 37/41. Most of the service users have significant risk histories and often substance misuse problems.

3) **Syrena House (Plymstock)**
Syrena House is a 9 bedded male in-patient recovery service, for service users with a severe and persistent mental disorder (e.g. Schizophrenia, major affective disorders) associated with a high level of disability. Emphasis is placed on a recovery approach, where service users are treated in a safe and supportive setting. Following discharge Syrena staff continue to support patients whilst they are in the community until their support is no longer required.

4) Edgcumbe Unit (Mount Gould Hospital) – Tel 01752 436399
The Edgcumbe Unit is an inpatient facility based at Mount Gould Hospital for people predominantly aged over 65, who are suffering from dementia or cognitive impairment and are in the most acute and vulnerable stages of their illness.

5) **Cotehele Unit (Mount Gould Hospital) – Tel 01752 436388**
The Cotehele Unit is an inpatient facility for people predominantly over the age of 65, who are suffering from functional mental health issues and are in the most acute and vulnerable stages of their illness.

6) **Greenfields (Mount Gould Hospital) – Tel 01752 434145**
Greenfields is a specialised 9-bedded inpatient unit that can be accessed by women, which aims to provide individualised care, treatment and recovery for women with severe and enduring mental health problems.

Community Services

7) **Assertive Outreach Service – 01752 435050**
This specialised service engages and works alongside adults who have long and enduring mental health issues, primarily schizophrenia who find it difficult to engage with other teams and services

The Assertive Outreach Service can support clients with a multitude of issues that include difficulties around medication compliance, drug and alcohol issues, symptom management and education, relapse indicator education management.

8) **Home Treatment Team – Tel 01752 314033**
The Home Treatment Team is a multi-agency team which works with individuals in an acute psychiatric crisis. The team provides an alternative to hospital admission or enables individuals to be discharged earlier from hospital. Home treatment provides, 7 days per week and 24hr support to individuals on caseload.

The service provides an emergency on-call service overnight for individuals on the Home Treatment Caseload. Referrals can be made overnight, with assessments taking place during the night when required.

Individuals will usually be supported by the Home Treatment Team for up to 6 weeks. Referrals will be made to longer term support teams, primary care liaison teams, Routeways, Harbour, Insight and Icebreak for example. Some individuals will have an acute-relapse plan formulated, which will enable a rapid referral and immediate response; other individuals may have a “respite access” care plan with

Home Treatment, which will identify boundaries and structures to support the individual.

Individuals receiving HTT input may be on a Community Treatment Order or managed on Section 17 Leave.

9) **Community Mental Health Teams (Adult)**

Community Mental Health Teams are separated into 5 teams depending on which area of the city the patient's GP is located in. The teams offer specialist assessment and where appropriate treatment for a range of mental health conditions and comprise of Mental Health Nurses, Occupational Therapists, Consultant Psychiatrists and Mental Health Support Workers.

10) **Beauchamp Centre (Mount Gould Hospital) – Mon-Fri 0900-1700hrs**

Complex Care Dementia Team – Tel 01752 435365
Assists those in the later stages of their illness, where behavioural and psychological symptoms may become challenging.

Memory Service – Tel 01752 435363/4
Offers multi-disciplinary assessment and diagnosis for people who are referred with a primary presentation of memory difficulties.

Complex Care Functional Team – Tel 01752 435365
This service will accept referrals for anyone 65 and over with a functional memory health condition e.g. anxiety, depression, bipolar disorder or schizophrenia, that cannot be managed in primary care alone.

Appendix 5

Care for a patient under the Mental Health Act 1983

INTRODUCTION

1.1 The purpose of the following information is to provide guidance, to ensure that patients are lawfully detained and receive the best possible care when being transferred under the MHA between Livewell Southwest (LSW) and Plymouth Hospitals NHS Trust. This guidance will also assist practitioners to care and treat individuals who are not detained but are known to the mental health services appropriately, taking into consideration legislation, best practice and in a "joint up" approach.

1.2 Further guidance relating to the Mental Health Act may also be obtained from:

PHT On-call Manager – via Switchboard - Miriam Smith, Emergency Planning & Liaison Officer Tel 39062 or Bp 89363

LSW MHA Manager at Glenbourne Unit, Tel 53143 or MHA Deputy Tel 57609

1.3 The Responsible Clinician for any patient detained at Derriford hospital will be the Consultant Psychiatrist who would have been in charge of the patient's care had they been detained to the LSW.

CARE OF A PATIENT DETAINED UNDER THE MENTAL HEALTH ACT 1983

2.1 The Mental Health Act 1983 (MHA) Section 1(1) states, "The provisions of this Act shall have effect, with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters." According to the Court of Appeal, "The policy and objectives of this Act are to regulate the circumstances in which the liberty of persons who are mentally disorder may be restricted and where there is conflict, to balance their interests against those of public policy."[1]

2.2 Only about 20 per cent[2] of people receiving treatment in psychiatric units are compulsorily detained under a section of the MHA. These patients may be referred to as detained, sectioned or formal patients. Patients who are not detained under the MHA but receive treatment in psychiatric units are often referred to as informal or voluntary patients.

2.3 The MHA sets out the legal requirements which need to be complied with, before a person can by detained against their will or treated without their consent. If followed correctly, the MHA provisions ensure that professionals treating detained patients are compliant with the European Convention Human Rights and are free from civil or criminal liability for the actions they take when using the legislative powers to detain or forcibly treat. The MHA provides specific professionals with responsibilities and uses terminology which is only applicable to person's detained under the Act.

[1] R. v Secretary of State for the Home Department Ex p. K [1990] 3 All E.R.
[2] http://www.mind.org.uk/help/rights_and_legislation/mental_health_act_1983_an_outline_guide

2.4 The MHA has a Code of Practice which provides guidance to registered medical practitioners ("doctors"), approved clinicians, managers and staff of hospitals, and approved mental health professionals (AMHP) on how they should proceed when undertaking duties under the Act. *The Code of Practice can be accessed at Mental Health Act Code of Practice.*

2.5 "While the Act does not impose a legal duty to comply with the Code, the people listed above to whom the Code is addressed, must have regard to the Code. The reasons for any departure from the Code should be recorded. Departures from the Code could give rise to legal challenge, and a court in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure that there is sufficiently convincing justification in the circumstances." *(Code of Practice Introduction).*

2.6 A set of guiding principles underpin the MHA, these must be used at all times to inform decision making when using the MHA. The principles do not determine decisions. The principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision. The principles to consider are:

- Purpose.
- Least restrictive alternative.
- Respect.
- Participation.
- Effectiveness, efficiency and equity. [3]

SECTION 17 LEAVE

3.1 Section 17 of the MHA allows for detained patients to be granted Leave of Absence from the hospital in which they are detained, to another hospital in order that they may receive treatment. In most instances detained patients will be moved from LSW to Derriford under Section 17 Leave, in order that they may receive medical treatment as an inpatient. They will then return to the detaining hospital or unit once medical treatment is complete. Detained patients may also attend for out-patient appointments whilst they are inpatients of LSW or on Section 17 Leave to the Community.

3.2 To ensure that the PHT are fully aware of the legal and risk implications whilst caring for detained patients, it is expected that the following documents are provided by LSW when the patient is admitted:

- Copy of Section 17 Leave form.
- Risk Assessment (e.g. print-out from SystmOne).
- Copy of Section papers, including consent to treatment forms – originals are not required.

3.3 Copies of all papers should be placed in the patient's medical records, with a complete copy left in the Emergency Planning & Liaison Officer's office. If the patient is in need of urgent care and treatment out of hours, the documents can be

[3] Code of Practice Mental Health Act 1983, Department of Health 2008 – Chapter 1

provided at the next working day. In no instance must the patient's treatment be delayed due to lack of documentation.

3.4 The above documents are not required for out-patient appointments.

3.5 Whilst on Section 17 Leave to Derriford, in-patients will not be granted further leave into the community by PHT staff. Leave can only be granted by the Responsible Clinician (patient's Consultant Psychiatrist).

3.6 If a detained patient is admitted to Derriford from the community whilst they are on Section 17 Leave, the LSW ward in which they were an in-patient prior to their leave is to be notified. The appropriate professionals will then become involved in assisting PHT in managing the patient's discharge from hospital, whether that be admission to a mental health ward or discharge to the community.

TRANSFERS ON THE MENTAL HEALTH ACT

4.1 Patients detained under the MHA can be transferred to/from another hospital under Section 19. (Form H4 – Authority for transfer from one hospital to another under different managers).

4.2 **Patients detained to local mental health units will attend Derriford hospital on Section 17 Leave only and must not be transferred. PHT On-call Managers MUST NOT accept patients on a Form H4 from these establishments – see above paragraphs.**

4.3 All patients transferred under Section 19 from an out-of-area hospital must arrive with Form H4 with Part 1 completed. The On-call Manager must be notified whenever a Section 19 Transfer occurs. Part 2 of the form can then be completed.

4.4 Patients originally detained at Derriford Hospital who require further treatment for their mental disorder will be transferred to a mental health unit under Section19, once their physical medical treatment is complete. The On Call Manager is to complete Part 1 of the H4 and send a copy to the Emergency Planning & Liaison Officer. The original Form H4 and the original section papers held in the Emergency Planning & Liaison Officer's office will accompany the patient to the new ward hospital/unit.

4.5 Out-of-hours, the photocopied Section papers should be copied and along with the completed H4 transfer with the patient. A photocopied set of papers and the original H4 will be sufficient authority to transfer the individual. The Emergency Planning & Liaison Officer will then arrange for the originals to be sent to the receiving hospital the next working day.

4.6 Patients who are detained under Section 5(2) (doctors holding powers) cannot be transferred to another hospital. The 72 hour holding power is sufficient time to allow for a full Mental Health Act Assessment to take place. Once the MHA assessment is completed the patient may be:

- Patients may be transferred to a mental health unit (using Form H4) at a later date if detained to Derriford hospital or admitted to the new hospital if the detention papers are made out to that hospital

or

- be discharged after the MHA assessment has concluded that the patient no longer requires further detention in a hospital.

TREATMENT FOR A MENTAL DISORDER OF A DETAINED PATIENT

5.1 The treatment of metal disorder for detained patients is covered by Part IV of the MHA. Any treatment required for an individual's mental disorder whilst they are in Derriford will continue to remain the responsibility of their Responsible Clinician (Consultant Psychiatrist). It is of utmost importance that when a detained patient is admitted to Derriford, nursing staff are made aware of any medication the patient receives, whether they are capable of consenting to that medication and also whether they consent or refuse the medication. The patient's care plan must identify the correct way for managing a refusal of medication as discussed between the LSW ward manager or named nurse and the PHT ward manager or named nurse.

5.2 Patients who have capacity to consent to treatment for their mental disorder and who refuse their treatment can be treated under the MHA, providing Part IV of the MHA is complied with. Part IV permits for the treatment of incapable or refusing detained patients for no more than 3 months. Thereafter a Form T2 must be completed by the patient's Responsible Clinician if the patient has capacity and consents, or a Form T3 must be completed if the patient is incapable or refusing treatment. A Second Opinion Appointed Doctor (SOAD) from the Care Quality Commission will complete a T3. A copy of either the T2 or T3 must be provided with the copied section papers if the patient has been detained for longer than 3 months. It is advisable that either the MHA Manager of LSW or the Emergency Planning Officer are contacted to check that the correct paperwork has been provided.

5.3 Rules around ECT differ. Guidance relating to the provision of ECT can be obtained from the MHA Office, Ext 57609 or 53143.

5.4 Supervised Community Treatment (Section 17A) allows for certain detained patients to be discharged from detention in hospital by means of a Community Treatment Order (CTO). The CTO powers, allow for the Responsible Clinician to recall the patient to hospital if there are concerns about their compliance with the conditions attached to the CTO. A CTO allows the RC to recall the patient to hospital if the patient needs to receive treatment for their mental disorder in hospital and there is a risk of harm to the patient's health and safety or to other people if they were not recalled.

5.5 If a CTO patient is admitted to Derriford as an in-patient the MHA office in the Glenbourne Unit (Tel 57609, or 53143) must be notified. They will be able to advise of the Responsible Clinician and the patient's care co-ordinator. The status of the CTO patient will be the same as an informal patient whilst they are in the general hospital unless the RC formally recalls them to hospital. The MHA office will be able to advise of the recall procedures and MHA considerations should a recall occur. The status of a CTO patient is not affected by attendance at an out-patient appointment.

DEATH OF A PATIENT DETAINED UNDER THE MENTAL HEALTH ACT

6.1 In the event of a patient dying whilst detained under the MHA, the following people must be notified as soon as possible:

PHT Miriam Smith, Emergency Planning & Liaison Manager Tel 39062 / Bp 89363
Out-of-hours On-call Manager or Acute Care Team Co-ordinator – via Switchboard 0 or 0845 1558155

LSW MHA Manager at Glenbourne Unit, Tel 53143 or MHA Deputy Tel 57609

They will then advise of the appropriate paperwork which would need to be completed

TREATMENT OF AN INFORMAL PATIENT'S MENTAL DISORDER

7.1 An informal patient with capacity has the right to consent or refuse treatment for their mental disorder and their physical condition. If it is considered that the patient may have a mental disorder which requires further assessment or treatment in hospital and they are stating that they wish to leave Derriford Hospital the On Call Manager must be contacted and consideration given to the use of Section 5(2). Only the patient's registered medical practitioner in charge of the patient's care or his nominated deputy can place a patient on a Section 5(2). The nominated deputy will be the Consultant's Specialist Registrar and must not be a junior doctor.

7.2 Whilst a patient is detained on a Section 5(2) the provision of treatment under Part IV of the MHA does not apply, therefore the patient can only be given treatment for their mental disorder with their consent, or if they lack capacity, under the Mental Capacity Act after due consideration is given to the Principles of the MCA.

Appendix 6

Care of patients under the Mental Capacity Act

THE MENTAL CAPACITY ACT (MCA)

1.1 The Mental Capacity Act Code of Practice[4] Chapter 13 provides guidance between the relationship of the Mental Health Act and the Mental Capacity Act.

1.2 A detained patient with capacity to refuse physical treatments cannot be "forced" to accept treatment purely because they are detained. A capacitated detained patient has the same right to accept or refuse treatment as any other patient. The treatment of their mental disorder is covered under the MHA, see paragraphs 4.1 and 4.2 above.

1.3 The Mental Capacity Act applies to all incapacitated patients, including detained patients. An incapacitated detained patient may be treated under the MCA for any physical treatments they require, providing the five statutory principles of the MCA applied. The five principles are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

1.4 There must be no assumption of a patient's capacity to make decisions based on their contacts with mental health services. Decisions relating to capacity and consent are specific to the decision which needs to be made and the timing of that decision.

1.5 There may be times when guidance relating to the assessment of a patient's capacity may be required from a mental health professional, however it is important to remember that the decision maker i.e. the person responsible for the provision of

[4] **http://www.publicguardian.gov.uk/mca/code-of-practice.htm**

the particular treatment has the final responsibility to ensure that the capacity of the individual is assessed and the outcome recorded.

RESTRAINT UNDER THE MENTAL CAPACITY ACT

2.1 Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- The person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm.

2.2 In addition to the requirements of the MCA, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty.

2.3 Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible. For patients in the acute hospital, there is guidance on “Restraining Therapies for use within the Acute Hospital for Adult Patients” which must be followed (access via StaffNet)

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

3.1 Although section 5 of the MCA permits the use of restraint where it is necessary under the above conditions, there is no protection under the Act for actions that result in someone being deprived of their liberty (as defined by Article 5(1) of the European Convention on Human Rights). Some people may be detained in hospital under the Mental Health Act 1983 – but this only applies to people who require hospital treatment for a mental disorder (see chapter 13 MCA Code of Practice). Detention of a patient, who lacks mental capacity, must only be applied with a formal DOLS authorisation.

3.2 The difference between restriction, restraint and deprivation of liberty is down to degree or intensity of the restraint; this can relate to:

- The type of care being provided.
- How long the situation lasts.
- Its effects, or the way in which a particular situation came about.

3.3 Whether someone is deprived of their liberty is not a decision that can be made by the patient’s clinical team. There are 6 formal assessments which need to take place before an authorisation can be granted or before it can be decided that a

patient is not deprived of their liberty. Concerns about or arrangements for authorisation of DOLS should be brought to the attention of the Trust's lead for Safeguarding Adults. Application for DOLS is via the Health & Social Care DOLS office.

Levels of Supportive Observation **Appendix 7**

1 General Supportive Observation

1.1 General supportive observation is the minimum acceptable level of observation for all in-patients. It is good practice to be aware of the locations of patients at all times however, this may vary within each unit. The frequency of general observation must be agreed by the clinical team.

1.2 The location of all patients should be known to staff, but all patients need not be kept within sight. On an hourly basis the nurse in charge of patients on Supportive Observation must observe and record in the clinical record the patient's whereabouts.

2 Intermittent Supportive Observation

2.1 This level of observation is appropriate when patients are potentially, but not immediately, at risk of seriously harming themselves or others. Observation must be carried out and recorded on an hourly basis, even when the patient is asleep in bed.

2.2 Patients on intermittent observation must have a specific care plan that clearly indicates:

- The intervals at which the observation should be carried out
- The nature of the therapeutic activity planned
- The need for a mental state assessment on each shift
- A record of any untoward incident

2.3 A summary of the patient's behaviour and mental state must be entered in the multidisciplinary records at the end of each shift and all staff on the shift who may or may not have been responsible for the intermittent observation are consulted prior to the completion of the multidisciplinary records and handover to the new shift.

3 Continuous Supportive Observation (within eyesight)

3.1 Continuous (within eyesight) observation is required when the patient could attempt suicide or attempt to seriously harm themselves or others. The patient will be kept within sight of and be accessible to observing staff at all times, by day and by night. An hourly summary of the patient's condition, care and treatment must be entered into the multidisciplinary record.

3.2 An entry must also be made in the multi–disciplinary team (MDT) notes at the end of every shift (as a minimum) This must include details of changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. All staff on the shift should be consulted prior to the completion of this summary to ensure accurate and complete information is documented.

4 Continuous Close Supportive Observation (Close proximity / arms length)

4.1 Continuous close observation will be applied when a patient is considered to be in need of the very highest level of observation i.e. the patient is considered to be at a high risk of suicide / seriously harming themselves or others, and thus may need to be nursed in close proximity, with due regard to safety, privacy, dignity, gender and

environmental dangers. An hourly summary of the patient's condition, care and treatment must be entered in to the multidisciplinary record.

4.2 An entry must be made in the daily records section of the MDT notes at the end of each shift (as a minimum); including details of changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events.

Appendix 8

Inpatient Unit One to One request

This form must be completed for all patients on a 1:1, 2:1 or for supported eating

The form must be filled out at the beginning and again at the end of each occurrence

Patient Name	
Date of Birth	
NHS Number	
Address	

Reason for 1:1 • Safeguarding • Risk to others/self • Personal Care – give details of complexity • Preventing out of area admission	
Ward	
Start date	
Start time	
Finish date	
Finish time	
Review date(s)	

Budget number	
Type of Staff	Agency / NHSP / Overtime / CST
Staff Grade	

Please e-mail this form at the beginning of the 1:1 and at the end of every 1:1 to:

1	IPP Requests	Devon Clinical Commissioning Group	D-CCG.IPP-Requests@nhs.net
2	Dave McAuley	Deputy Director of Operations	david.mcauley@nhs.net
3	Tracy Clasby	Locality Manager – City Wide Services	tracy.clasby@nhs.net
4	Mike Howe	Management Accountant - Finance	michael.howe@nhs.net
5	Lisa Gimingham	Deputy Locality Manager	lisa.gimingham@nhs.net
6	Helen O'Toole	Deputy Locality Manager	hotoole@nhs.net
7	Vicky Clarke	Modern Matron – Glenbourne Unit	vclarke4@nhs.net
8	Karen Full	Administrator – Glenbourne Unit	karen.full@nhs.net
9	Sophie Rowntree	Finance	sophierowntree@nhs.net
10	Lauren Griffiths	Referral Co-ordinator	laurengriffiths@nhs.net
11	Jess Austen	Referral Co-ordinator	jausten@nhs.net