Livewell Southwest

Nurse Led Discharge Protocol

Version No 1.3
Review: December 2017

Notice to staff using a paper copy of this guidance

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

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Associated documentation	a) Chatterjee, M. (2004) Nurses to take over simple discharge. Nursing Times; 100: 35, 2 b) Lees, L. (2004) Making nurse-led discharge work to improve patient care. Nursing Times; 100: 37, 30. c) Department of Health (2004) Achieving timely simple discharge from Hospital. A toolkit for the multidisciplinary team. Accessed via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh /@en/documents/digitalasset/dh_4088367.pdf d) Acute Care Declaration – South West Development Centre
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Document review history

Version No.	Type of Change	Date	Originator of Change	Description of Change
0.1	New Protocol	30.03.2010	Harford Ward Manager	
1.0	Ratified	21.10.2010	Policy Ratification Group	Ratified
1.1	Updated	11.10.12	Deputy Modern Matron	Procedure and grammar, updated from PCT to LSW Flow chart updated
1.2	Extended	17.12.14	Deputy Modern Matron	Extended no changes.
1.3	Updated	25.6.15	Modern Matron	Minor changes including epex changed to SystmOne

Nurse Led Discharge Protocol

1. Introduction

1.1 The importance of Nurse Led Discharge (NLD) has been highlighted in Government plans to overhaul the NHS discharge process, and is listed as one of the ten key roles shaping the future of nursing as set out by the chief nursing officer for England in the NHS Plan (DOH,2000) and Making a Difference (DOH,1999). This process of NLD requires the registered nurse to assume responsibility for the proactive planning and co-ordination of the patient's discharge without further recourse to the medical team (Chatterjee, 2004). The Department of Health (DOH 2004) recognised that simple discharges make up approximately 80 percent of discharges, and recognises that nurses are the appropriate health care professionals to undertake the process. It also recommends the involvement of nurses in discharging patients who have more complex needs.

1.2 Appropriate patients for NLD are those who fall into the category of simple discharge for example:

a) Will be discharged to their own home or place of residence, with a clinical or existing support package in place eg. Home Treatment Team.

b) Have ongoing care needs that can be facilitated and implemented prior to discharge.

c) No longer require acute care / intervention.

d) Have a predicted length of stay eg. commencement of medication regime.

2. Purpose

2.1 The following Protocol applies to all members of the Multi Disciplinary Team within all Mental Health Services of Plymouth Community Healthcare, who undertake or are involved in discharge planning for Plymouth patients.

2.2 Discharge planning includes the formal authority for registered Mental Health Nurses to discharge patients from a ward / unit who meet locally agreed criteria for Nurse Led Discharge without further recourse to the medical team. Locally agreed criteria will be identified and authorised and reviewed by Multi Disciplinary Teams.

3. Definitions

AMH	Adult Mental Health
AOS	Assertive Outreach Service
DoH	Department of Health
EDD	Estimated Date of Discharge
HTT	Home Treatment Team
LD	Learning Disabilities
MDT	Multi Disciplinary Team
NLD	Nurse Led Discharge
OPMHS	Older People's Mental Health Service
PCLS	Primary Care Liaison Service

4. Duties and Responsibilities

4.1 Service Managers / Line Managers for each area must take responsibility to disseminate this protocol to all members of their team.

4.2 Service Managers / Line Managers will ensure that all staff are working to the protocol.

5. Discharge Toolkit

5.1 The Department of Health has launched a toolkit that will contribute to more effective discharge as part of a total approach to improving bed management. This ten step guide can be used to ensure the essential steps are covered to improve hospital discharge processes (DOH, 2004). The steps are:

1) The Multi Disciplinary Team (MDT) should take a pro active approach to discharge
2) Ensure executive-level support
3) Agree a range of patient groups with which to start
4) Clarify the roles and responsibilities of members of the MDT
5) Review and revise the systems and processes you use to manage the discharge decisions
6) Identify the skills needed by team members
7) Gain acceptance and prove that the revised discharge process is effective
8) Develop a policy framework that encompasses the whole hospital.
9) Refine policy and guidelines
10) Capture, monitor and audit the impact

5.2 NLD is not a new concept - nurses have always been involved in planning patient discharge. The recommendations from the DoH are a further development in the discharge planning process (Lees 2004).

5.3 The process of NLD requires the registered nurse to assume responsibility for the proactive planning and co-ordination of the patient's discharge. Discharge planning will include the formal authority to discharge patients from a mental health setting without further recourse to the medical team. Locally agreed criteria will be identified and authorised by multi professional teams. The rationale for this is that delegating authority to suitably competent nursing staff will enable the whole discharge practice to be formally completed by nurses, advancing current discharge practice and contributing to optimising bed capacity.

6. Aim

6.1 The aim of NLD is to enhance the patient's admission and discharge experience by streamlining the processes. It will also empower nurses to work in partnership with their patients, so that they can aid the patient to:

6.2 Take ownership in their own recovery and set goals which can be clarified, discussed and agreed in advance. This can help to minimise the length of stay on an acute ward therefore optimising the amount of time needed to facilitate recovery.

6.3 To work towards the standards set out in the Acute Care Declaration 2010. "We will work together for the provision of high quality acute care by developing simple and timely access into and discharge out of in-patient services if care can not be best delivered at home."

7. Statement of Protocol

7.1 The aim of this protocol is to:

a) Facilitate timely discharge planning for patients between care environments.

b) Provide a generic framework to facilitate discharge for all Plymouth patients.

c) Promote the involvement of all relevant members of the MDT.

d) Provide information for all members of the multidisciplinary team regarding different types of discharge process ie. NLD, inter Hospital transfers and self discharge patients.

e) Promote the involvement of patients and their carers at all stages of the discharge planning process.

f) Encourage staff to proactively facilitate patient flow.

8. Implementation of Protocol

8.1 Service managers / line mangers for each area must take responsibility to disseminate this protocol to all members of their team.

8.2 Service managers / line managers will ensure that all staff taking the lead in NLD are working to the protocol and meet required competencies.

8.3 The key to successful NLD is to ensure that nurses have the pre requisite knowledge and skills.

9. Education, Training and Supervision

9.1 Registered nurses new to the organisation undertaking this role will have to:

a) Work within their code of conduct

b) Be aware of the protocol.

c) Have finished their preceptorship

d) Worked within a Mental Health setting for six months and met specified NLD competencies

10. Competencies for Nurse Led Discharge

10.1 Team working communication skills are needed to liaise with all members of the MDT to set discharge date.

10.2 The nurse should demonstrate an understanding of the criteria for discharge and recognition of variance. For instance if the patient's social circumstances have changed preventing a smooth transition into the community, or a significant event impacting on risk to the patient or others has been raised.

10.3 Documentation should include clear timing, sequence and who is responsible to aid the patient in their recovery. This must be identified in the care plan.

10.4 Clinical practice should be evidence based and use rating tools to add to patient assessments such as the Becks depression inventory and HAD etc.

10.5 The nurse must have undertaken suicide prevention training such as STORM.

10.6 Awareness of how to raise concerns regarding vulnerable adults and domestic abuse issues.

10.7 The nurse may need to take on a mentorship role with junior members of the team or less confident members to help them with discharge processes.

10.8 Competent in following an Integrated Care Pathway eg. Admission ICP and Schizophrenia ICP.

10.9 It is the responsibility of the band 6 and above nurses to facilitate the process of education / training and supervision requirements, to ensure competence of practice and retain records of completion of training. See Appendix F.

10.10 The registered nurse is responsible for updating and completing his / her Personal Development Plan in conjunction with performance development and review process, building this role into Personal Development Plan objectives.

10.11 Staff must complete an observed assessment of a patient's needs which is carried out by Home Treatment Team staff. [Alternative arrangements for judging this competency will be made within OPMHS]. This can be repeated as many times as necessary for the staff member to feel confident and / or the HTT staff to judge as competent before undertaking the Nurse Led Discharge for the Wards.

11. Training Implications

11.1 This is covered in Sections 9 and 10.

12. Monitoring Compliance and Effectiveness

12.1 The Ward Manager and Modern Matron will take the lead in the initial review of all patients subject to NLD, including variance monitoring and outcomes which will be fed back to the individual Consultant and discussed within Teams as appropriate.

12.2 Delayed Discharges will be monitored / audited more effectively at Whole Service Care Pathway meetings.

12.3 Results will be reviewed quarterly.

12.4 Success of the NLD will be monitored annually by the Patient satisfaction survey.

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.

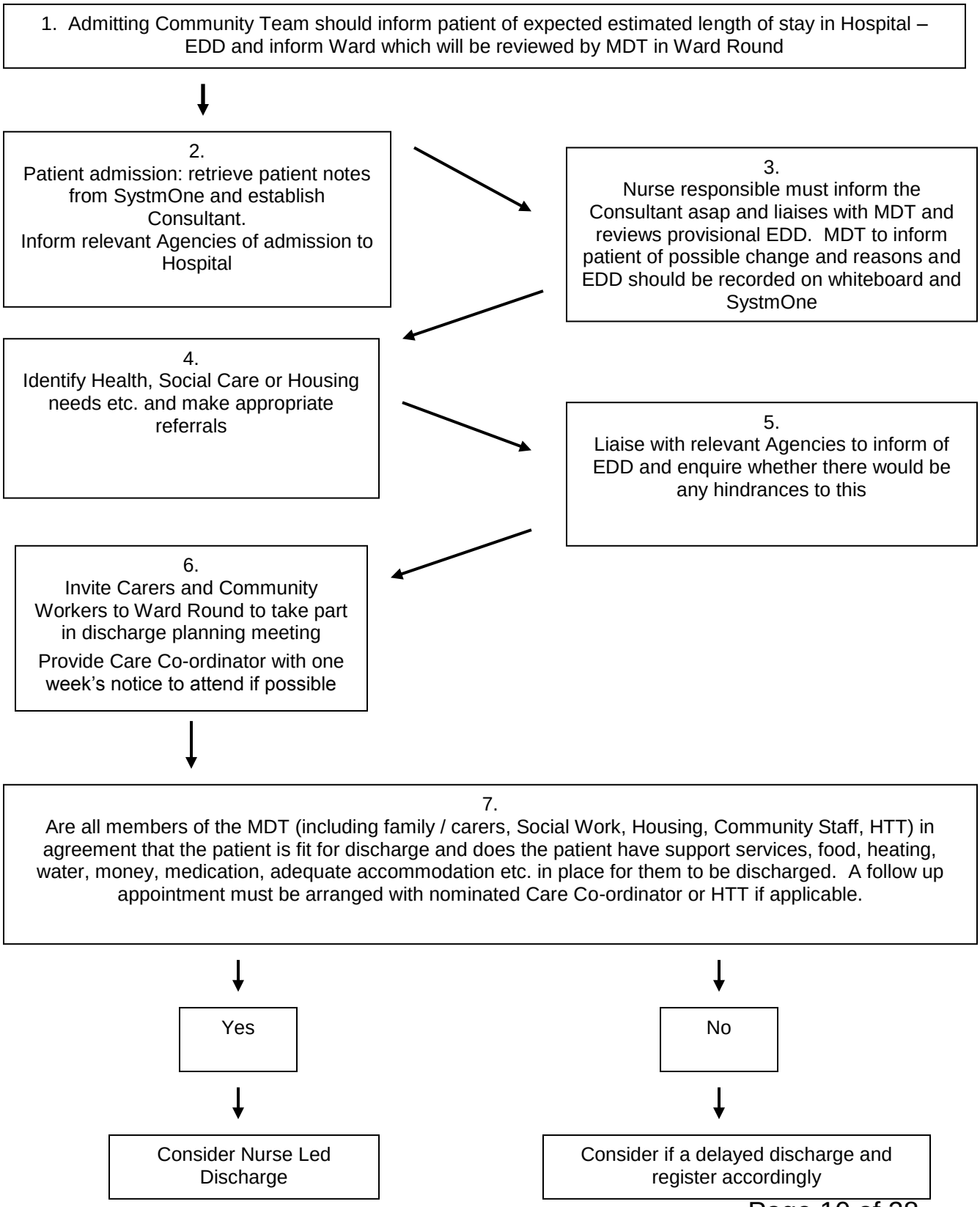
The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 3rd December 2015

Appendix A

The Patient Journey



Appendix B

The Patient Journey Flow Chart - Guidance Notes

The Patient Journey will normally follow 3 stages; the timing of each of these stages will vary depending on the needs of the patient and flow through the clinical area and hospital. Each of the following sections describes the steps in the patient journey flow chart.

If a patient chooses to self discharge, please refer to the Discharge against Medical Advice pro forma.

Patient Journey - Stage 1

1. Community Team should set EDD date if possible

2. Patient admission – source patients notes- establish place of residence, and consultants.

All patients in contact with Plymouth mental health services will have records held on SystmOne since 2001. Prior records will need to be sourced through Medical Records at Hatfield House.

Locate GP and advise of admission clarify medication and inform Consultant and Primary care service of admission.

3. Nurse responsible liaises with Multi-Disciplinary Team (MDT) and reviews Estimated Date of Discharge (EDD)

Estimated Date of Discharge (EDD)

This is an estimate of the length of time the patient will need acute hospital care:

1. It is good practice to review the estimated date with the MDT as soon as possible following admission to agree that it is realistic; this then becomes the expected discharge date. This should be recorded on the whiteboard and on SystmOne.

2. It provides a useful focus for the MDT to work towards in Planning transfer / discharge.

Patient Journey - Stage 2

4. Identify health, social care or housing needs etc, and make appropriate referrals

If the patient's circumstances have changed since admission to hospital, it may be relevant to raise a new referral to Health, Social Care or Housing providers. Patients who are homeless or in vulnerable housing may experience particular problems during a period of inpatient admission.

5. Liaise with relevant agencies to inform of EDD and enquire whether there would be any hindrances to this.

Communication with relevant service providers in Health, Social ~Care and Voluntary Services is essential.

Patient Journey - Stage 3

6. Invite Carers and Community Workers to Ward Round to take part in discharge planning meeting

The responsible nurse should liaise with the MDT and discuss who should be involved in planning the patients discharge. All involved in the patients care should be invited to ward round where possible and given advance notice to be able to attend. If this is not possible the ward should make every attempt to contact those involved to seek out their opinion of the impending discharge and recording in notes.

7. Are all members of the MDT (including family / carers social work housing, community staff, HTT) in agreement that the patient is fit for discharge and does the patient have support services, food, heating, water, money, medication, adequate accommodation, etc. in place for them to be discharged.

If all members of the team are happy with the discharge plans and all referrals have been made and the criteria laid down by the consultant has been met then NLD can take place.

The Registered Nurse will then need to fill in the pro forma example on the next page and place in the patient's notes.

Nurse Led Discharge

NHS Number: ……
Name: ……

Expected Date of Discharge: ……..……
Actual Date of Discharge: ……..……

Part 1
To be completed by Consultant / Registrar / SHO
I agree that this patient is appropriate to be discharged by Nursing Staff providing the following criteria are met within …… days.
1.
2.
3.

Signed:……
Date: ……

Part 1A
Has preparation for discharge ie. Patient Checklist been commenced ? Yes / No

Part 2
To be completed by Nursing Staff prior to discharge
Have the above criteria been met ?
Yes = Discharge No = Refer to Medical Staff

Have Risks changed since Ward Round or completing preparation for discharge ?
Yes / No
If yes then seek advice from Medical Staff

Variance [Reasons why NLD did not happen on this occasion as planned]

⇩

Where is patient being discharged to: ……
……
Date of follow up appointment: ……
Appointment with: ……
Location: ……
Amount of meds: ……...
……
Care Co-ordinator: ……

Signed: ……
Designation: ……
Date / Time: ……
PRINT Name: ……

If the patient can not be discharged at this point then they should be registered as a delayed discharge on the status board and the Ward Manager should be made aware.

Appendix C

Roles and Responsibilities of the MDT

Nursing Staff

1. To take on named nurse role and key co-ordinator role in integrated discharge planning and effective timely discharge from hospital.
2. Assume responsibility and accountability for his / her decisions and actions relating to discharge planning.
3. Liaise and co-ordinate with the MDT and Social Care staff.
4. Establish and record EDD on the patients care plan, patient whiteboard and on SystmOne.
5. Complete discharge plan to be recorded on the care plan.
6. Ensure that patients and carers are involved in decision making relating to discharge, kept informed of the discharge plan from day to admission or where possible pre admission and provide verbal updates. Record and review any concerns the patient / carer / relative may have and seek to resolve these.
7. Ensure accurate and full documentation of the discharge process.
8. Ensure that all instructions regards post-discharge care / advice are given to the patient and / or carer with a full and comprehensive explanation.
9. Ensure that all take home medications are ordered in advance of the discharge date.
10. Arrange appropriate transport for the patients, ensuring that where possible the patients have a morning / early afternoon discharge.

Ensure the patient has adequate clothing for discharge and that house key / access to home is available. If the patient is homeless or in a vulnerable housing situation please refer to the Housing Officer.

1. In addition the nurse will obtain medical authorisation to discharge the patient using the discharge checklist or discharge plan in the care plan.
2. Complete the discharge criteria checklist ensuring the patient meets the discharge criteria before proceeding to discharge.
3. Check that the patients contact numbers and discharge address is correct and entered into the notes.
4. Ensure that a referral to the Home treatment team has been completed on SystmOne within Adult Services and talk to a member of the home treatment team and arrange follow up care and appointment times.

5. Inform the patient of appointment times and contact numbers to call if needed.
6. Discuss / inform with the consultant any patient no longer meeting the criteria for nurse led discharge.

Role of the senior nurse (band 6 and above)

1. To maintain a record of staff training and competence.
2. Monitor quality of discharge planning and devise action plans to address quality issues.
3. Support adverse incident management reporting and de-brief / analysis where the discharge has been unsuccessful.

Role of the Nurse

1. If patient being discharged to care of GP, the Nurse must contact the GP Surgery and arrange an appointment / contact within seven days as per policy.
2. The Nurse also needs to fax the discharge to the GP Practice and ensure that prescriptions are re-instated.
3. If patient has an ongoing Safeguarding Alert – please contact Managers involved and ensure discharge planning is linked to adult protection plan.
4. See Appendix F

Roles and Responsibilities of the Medical Professionals

1. Confirm when patients are medically fit for discharge.
2. Support implementation of an expected date of discharge for all patients with a predictable length of stay admitted under their care.
3. Complete immediate discharge letter.

Roles of the Consultant

1. The Consultant will agree discharge criteria and parameters of clinical / mental stability and will be responsible for setting and reviewing EDD date with MDT.
2. Agree condition specific criteria for discharge.
3. Sign nurse-led discharge checklist or authorise NLD in care plan in patient notes thereby delegating formal authority to the registered nurse to proceed to discharge if patient meets agreed criteria.

Roles of the Occupational Therapist

1. Assess functional abilities and suitability for discharge or transfer to appropriate destination.
2. Provide specialist assessment as necessary eg. sensory, perception, cognition, physical and behavioural.
3. Enable patients to achieve their optimum level of functioning prior to discharge.
4. To liaise with and refer to other agencies that will potentially support discharge eg. social work OT service.
5. Ensure the provision of equipment for discharge
6. Liaise with relatives / carers as permitted by the patient e.g. regarding ongoing support required on discharge.
7. Carry out home visit as necessary in conjunction with the MDT plan.

Role of the Pharmacy Team

1. Identify the pharmaceutical needs of the patient and work with the MDT to ensure those that need to be are addressed prior to discharge.
2. Ensure safe effective and appropriate use of medicines by patients / carers through explanation and education
3. Ensure discharge medication is available for the EDD.
4. Assess patient for suitability of monitored dosage system or other compliance aid if this is requested by another member of the MDT.
5. Confirm arrangements for further supplies of medication as determined by the patient's need and the service to which they are discharged.

Role of the Support Time and Recovery Worker [where applicable]

1. To aid the named nurse and occupational therapist in assessing the patients needs.
2. To support the patient in understanding dietary needs, exercise and reasons for non-concordance with the patient regarding medication.
3. To work with the patient around significant relapse indicators and person centred care plans to help the patient recognise when they will require further support upon discharge to the community.
4. To help the patient access community groups and support that will aid in their re-integration into the community.
5. To help liaise with HTT and PCLS or non statutory and voluntary services around

further support on discharge.

Role of the Housing Officer [where applicable]

1. When receiving a referral the housing officer should promptly attend the ward and liaise with the nursing staff and patient / carers about the housing needs.
2. Wherever possible the patient will be fully involved in the process of exploring and securing suitable accommodation.
3. Liaise directly with the landlord or council etc if needed on behalf of the patient.
4. Document all conversations and plans in the patient notes and be party to a discussion in ward round about housing accommodation plans and lengths of time that these plans may be put into place.

Role of the Welfare Rights Officer / Debt Advisor [where applicable]

1. Patients who need to access the service need to be referred as soon as possible.
2. All referral forms should be completed with patient involvement and copy put in notes.
3. Nearing the time of discharge or when discharge is being planned, staff will need to contact the service to see if the patient's referral has been acted on and sorted. There may be the need for further referrals to outside agencies.
4. Note that staff will need to contact the service as soon as planning discharge to allow enough time to carry out the necessary work. Communication will need to be made available with Outreach teams like Home Treatment, Assertive Outreach Service etc. If the Occupational Therapy Service, Pages or any other service make referrals, it must be noted in the patient's notes.
5. Ensure on discharge that Welfare Rights Officer and Debt Advisor are made aware so that benefits can be re-instated.

Role of the Primary Care Liaison Service

1. When a PCLS service user is admitted to Hospital the admitting team will try when possible to give the service user an EDD. At the first ward MDT, a team discussion will be held and EDD reviewed / set.
2. If admission through HTT, care co-ordinator to be informed.
3. When patient admitted to the ward and has no care co-ordinator early identification of need and referral initiated to appropriate PCLS for allocation.
4. Allocation of care co-ordinator will be discussed at referral team meeting.
5. Care co-ordinator or team representative will attend each ward round to participate in ongoing care plan and discharge planning.

6. Care co-ordinator to maintain contact with service user during admission or if new allocation to meet service user before discharge if possible to establish relationship to facilitate a seamless transfer of care between services.
7. Care co-ordinator to attend discharge planning meeting with HTT [Adult Mental Health] and Care co-ordinator to continue with identifying the needs of service user and ensure implementation of ongoing care plan post discharge, collaborative with HTT.

Role of Home Treatment Team [Adult Mental Health]

1. If admission through Home Treatment Team / Gateway and EDD needs to be set.
2. Home Treatment will attend each ward, currently this will be at each ward round, but this should increase to daily contact with the ward.
3. Home Treatment will meet with the service user and identify their individual needs, a care plan will be formulated, and an appointment made for initial contact following discharge.
4. A decision by the MDT regarding safety of medication will be made prior to leaving the ward. Home Treatment will then monitor and or supply medication depending on level of risk identified.
5. Home treatment will offer carers assessments, if not already completed whilst an in-patient.
6. Finances will also be reviewed if a need is identified.
7. The Home Treatment team will plan to work with the service user for up to six weeks, a discharge date will be identified in the early stages of care, and referrals to the appropriate follow on service will be made.

Role of Assertive Outreach Service [Adult Mental Health]

1. When an AOS service user is admitted to hospital the admitting team will try when possible to give the service user an EDD. At the first ward MDT, a team discussion will be held and EDD reviewed / set.
2. The Care Co-ordinator will meet with the service user at least weekly whilst an in patient to review their care and treatment and plans for discharge.
3. The Care Co-ordinator will document their visit in the ward notes and update the ward staff of progress.
4. If housing is an issue the Care Co-ordinator will liaise with the housing officer at the earliest opportunity to discuss housing needs and complete referral forms.
5. The Care Co-ordinator will liaise with family and the service users social support systems and offer carer assessments and referral to family intervention or family therapy if indicated.

6. Care Co-ordinator to arrange a II7 meeting if the individual has been detained to plan for discharge.
7. Care plan and risk assessments will be updated by AOS if the service user is on long term leave.
8. CPA Review to be arranged by AOS Care Coordinator prior to discharge.

Address Label

Appendix D

Patient Checklist – Leaving Ward

	Date and Time	Signature	Variance ✓ / X
Trained Staff			
Care Plan including all information for Patient			
Discharge leave sheet			
Medication chart in patient notes – consent to treatment (T2 and T3)			
Nurse documented in notes that the patient has left and discharge label attached to daily records sheet			
How they left:			
When they left:			
Medication – how much does the patient have with them ?			
When or who is seeing them after discharge and does the patient know ? (Ensure seven day follow up) If not, HTT or PCLT book appointment with GP and ensure prescription is re-instated – document. Fax discharge summary to GP.			
Risk assessment			
Care plan			
Honos			
CPA review			
Photocopy medication chart and ensure discharge summary is accurate (if notes taken by HTT)			
Discharge sticker completed			
Discharge address and phone numbers are correct (actually check phone number before the patient leaves)			
Ensure PCLS referrals are complete If not, ensure HTT are aware			
Has the STR Worker checked that the patient have any money, appropriate clothing, access to property, gas / electric, food, transport ? **If no, what action have you taken ?**			

Nursing Assistant / STR Worker / Assistant Practitioner			
Patient locker is checked and cleared out and all property is returned			
Ward storage checked and cleared out			
Patient wardrobe and drawers checked and cleared out			
Mattress and bed space checked			
Drawer in ward reception area checked for cigarettes, phone chargers etc.			
Fridge checked and patient items removed			
Laundry checked and patient items removed			
Finances			
Patient financial items collected – and check benefits have been re-instated			
With patient:			
Sent on to:			
Reception			
Check safe for patient keys			
With patient:			
Sent on to:			
Inform			
Contact all relevant parties: (if out of hours ensure written in the Ward diary)			
Family			
GP			
Consultant			
PCLS / Home Treatment Team			
Welfare Rights			
Debt Advisor			
Carer Support			
Psychology			

Appendix E

Inclusion Criteria for Nurse Led Discharge

This is a discharge with mutual agreement between patient, family / carers and the multidisciplinary team. Ward staff to liaise directly with the CPN / HTT [Adult Mental Health] for the patient to return to their previous environment.

Patients who are no longer able to return to their pre-admission package eg. care coordinator or supported housing. Ward staff should refer to the identified service for assessment and provision of package. Discharge meeting would be required to facilitate an agreed plan for discharge.

Exclusion Criteria

Patients who have broken their care plans or who have been intoxicated on the ward or under the influence of illicit drugs or violent, should still be assessed as previously and it would not be appropriate in this situation for the patient to be subject to NLD unless the consultant has specifically agreed this and documented it clearly in the notes.

Patients wishing to take their own discharge should be reviewed by the Medical Team with Nursing support and if necessary make reference to the Discharge Against Medical Advice procedure. (See Appendix G) Capacity issues need to be taken into consideration.

Patient is no longer an informal patient, or mental health has deteriorated since previous EDD arranged.

Escalation Processes

Staff need to be aware to inform their line manager and the patients consultant of potentially problematic discharges.

Although the NLD may be carried out by the named nurse or responsible nurse on the day, the process is a team approach and there would have been consultation with members of the MDT. Therefore the nurse does not take full responsibility if the process has not been successful and the positive risk taking involved with any discharge is held by the team.

Appendix F

Competencies

		Date	Signature
1)	Registered Nurse – who has completed Preceptorship		
2)	Already qualified Nurses new to the organisation should have worked within a Mental Health setting for six months		
3)	The following Mandatory training is in date:		
	• Vulnerable Adults		
	• Child Protection		
	• Domestic Abuse		
	• STORM		
	• CPA, Record Keeping and SystmOne		
4)	MDT working and signposting		
	• Completed 4 Ward Rounds		
	• Followed and successfully discharged patients from Ward Round		
	• Assessed conducting a patient assessment to a competent standard [eg. by the HTT]		
	• Aware of HTT referral process where applicable		
	• To regularly set / review EDD within Ward Round		
5)	Use of Clinical assessment tools eg. BECK		
6)	How to raise Safeguarding concerns		
7)	Aware of Section 117 responsibilities in discharge planning		
8)	To receive regular Line Management		
9)	PDP / IPR up to date and have NLD identified on it		
10)	Working towards or have completed Care Co-ordinator workbooks		
11)	Able to follow Integrated Care Pathway		
	• Aware of variance tracking		
	• Have a working knowledge of ICPs eg. Admission ICP		

Appendix G

Protocol for Patients wishing to discharge Against Medical Advice (AMA)

Patient's Name:	
Hospital No:	
Consultant:	
Named Nurse:	
Date of Birth:	
Date:	

	Signature	Designation
Nurse in charge nominates qualified Nurse to speak to Patient wishing to self discharge.		
Allocated Nurse should spend one to one time assessing the Patient this should include reason why they wish to leave, risk factors, what has changed since admission, evidence of mental illness, plans for when they get home / follow up.		
Allocated Nurse to look with Patient at alternatives to discharge they will consider, eg. overnight leave, review following day.		
If Patient is detainable, at sufficient risk and refuses to wait then to use section 5(4) of 1983 MHA. F2 doctor (between 9 - 1pm, Monday - Friday) or Duty SHO (all other times) to be contacted immediately to request Section 5(2) assessment. Complete 5(4) paperwork and forward to MHA Office.		
Patient to be assessed by Duty SHO and if possible Doctor to discuss with RMO / Care Co-ordinator.		
If detainable then to use section 5(2) of 1983 MHA with suitable emergency management plan put in place.		
If not detainable then HTT Care Co-ordinator to be informed of discharge and follow up plan formulated immediately including details of visit within 72 hours.		
If Patient is not detainable and unwilling to stay in Hospital, AMA form to be signed (overleaf). If Patient refuses to sign form, wait for medication etc. - to be clearly documented in notes.		
If Patient has no care coordinator then GP to be informed a soon as possible.		

	Signature	Designation
Allocated Nurse and SHO to consider what medication and amount to be given to the Patient including PRN. This to be communicated to HTT / PCLT / GP as appropriate and amount given documented in notes clearly. Amount given is dependent on joint risk assessment and follow up arrangements. An FP10 could also be used.		
Allocated Nurse to ensure follow – up arrangements are communicated to Patient and Care Co-ordinator / HTT.		
To ensure Patient has transport home, food, milk, door key, gas / electricity etc.		
Ask Patient if they wish a carer / nominated friend to be informed of discharge and follow – up arrangements.		
Complete risk assessment, document clearly in notes, complete discharge paperwork, SystmOne.		

Discharge Against Medical Advice

Patient's Name:	
Hospital No:	
Consultant:	
Named Nurse:	
Date of Birth:	
Date:	

This is to confirm I am leaving this Hospital at my own request, at my own risk and on my own responsibility and against the advice of the Clinical Team.

Signed: (Patient)	
Address:	
Date:	

Signed: (Staff Member)	
Designation:	
Date:	

To be filed in Medical notes

Copy sent to:	

Appendix H

Nurse Led Discharge –Older People's Mental Health Services

Cotehele Unit

Cotehele Unit deals predominantly with those people aged 65 and over, who have a functional mental health problem.

In most cases, discharge will be back to their home address.

Edgcumbe Unit

The Edgcumbe Unit deals predominantly with those people aged 65 and over, who have a cognitive impairment / dementia.

In most cases, discharge will be back to a residential or nursing home. This may be back to the care setting from which they were admitted or to a new accommodation, due to a change in their care needs.

On both units, Nurse Led Discharge will follow the same process as set within the protocol for Adult Mental Health.

As OPMHS does not have access to a Home Treatment Service or Assertive Outreach Service, the Care Coordinator will follow up care and be the point of contact in most cases.

The flow chart for OPMHS reflects the slightly different needs of older people.

Nurse Led Discharge – OPMHS