MENTAL HEALTH PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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SUMMARY	This document aims to provide a clear guide for all clinicians who are involved in the admission and discharge/transfer of care of consumers to and from Acute Mental Health Inpatient Units, which includes Psychiatric Emergency Care Units and Older Person's Mental Health Units.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-MentalHealth-PoliciesandDocuments@health.nsw.gov.au

Admission and Discharge/Transfer of Care Processes for Acute Mental Health Inpatient Units (including Direct Admissions for Consumers linked with Community Mental Health)

SESLHDPR/735

1. POLICY STATEMENT

This procedure is necessary to ensure:

- That all consumers being considered for admission to an Acute Inpatient Mental Health Unit (MHU) have been thoroughly assessed prior to admission.
- Consumers have had all requirements for a collaborative and comprehensive discharge/transfer of care completed to support a safe and appropriate transition of care.
- That family and carers are involved at all stages of admission, transfer and discharge and their right to information and collaborative care planning is upheld.

2. BACKGROUND

This procedure applies to all clinicians involved in the assessment, admission and discharge of consumers to and from Acute Mental Health Inpatient Units of the South Eastern Sydney Local Heath District (SESLHD), including Psychiatric Emergency Care Centres (PECCs), Acute Mental Health Inpatient Units and Older Persons Mental Health Inpatient Units.

NOTE: There is a separate admission pathway for the Mental Health Intensive Care Unit as per SESLHDBR/017 Referral to SESLHD Mental Health Intensive Care Unit (MHICU), and the Mental Health Rehabilitation Unit, however discharge processes for these Units remain the same as for all the MH Acute Units.

This procedure should be used:

- When it is decided, following a Mental Health (MH) current assessment, that admission to an Acute Inpatient Unit is the least restrictive method of care for a consumer
- For consumers actively linked with the community, directly admitted to a MHU (therefore bypassing the Emergency Department (ED)):
  - During the initial assessment phase
  - In determining the appropriateness of an admission
  - During the admission process itself.
- For Consumers during the Discharge/Transfer of Care Process from a MHU

3. RESPONSIBILITIES

3.1 Employees will:

Follow the procedure.

3.2 Line Managers will:

Ensure clinical staff members are familiar with the procedure, circulate the procedure document and enable local implementation. Ensure non-clinical staff members are also aware of the procedure.

3.3 Service Managers will:

Distribute the procedure within their relevant service. Ensure that line managers are familiar with the procedure and ensure staff adhere to the procedure.

3.4 Service Directors will:

Monitor the compliance and review of the procedure at the local Clinical Governance Committee, and report to the SESLHD Mental Health Service (MHS) Clinical Governance Committee.

4. PROCEDURE

4.1 ADMISSION PROCESSES

a) Assessment and Decision to Admit

All consumers presenting for admission must have a formal identification process completed as per SESLHDPR/288 Identification of Patients within Inpatient Mental Health Care Settings. Consumer and carer contact details must be checked and updated, if required, in iSOFT Patient Management (iPM) for the new episode of care.

All consumers presenting for admission must receive a comprehensive mental health current assessment **and**, if presenting through the ED, be declared “fit for discharge from ED”, which includes consideration of all available treatment options.

Consumers and family/carers are partners in care and have a right to be involved at all stages of care and discharge planning. It is the responsibility of the treating team to ensure Designated Carers and/or Principal Care Providers are identified at the initial assessment. It is the responsibility of the treating team to ensure continued involvement of family, carers and/or principal care providers throughout the consumer’s admission and at discharge.

Family and carers can provide valuable information and input into care planning (unless there are exceptional circumstances such as suspected or confirmed domestic violence, or elder abuse). Even where consent has not been granted by the consumer, clinicians can receive information from carers to inform care planning. Clinicians are to exercise care to uphold consumer privacy, however *receiving* and *requesting* information without *sharing* any information is not a breach of confidentiality.

A physical assessment to ensure a consumer is “fit for discharge from ED” **should be completed**. This includes a baseline electrocardiogram (ECG), routine blood tests with blood borne virus (BBV) screening as per SESLHDPD/330 Blood Borne Virus Testing. Screen for delirium for those clinically indicated, are over 65 years, or are over 45 years for those who identify as Aboriginal and/or Torres Strait islander peoples, and those with an intellectual disability.

If it is not possible to complete the full physical assessment in the ED, the consumer should be physically assessed to ensure they are fit to be transferred to a MHU, and all required core components of physical assessment are to be completed within 24 hours of admission to a MHU, as per NSW Health PD2017_033 Physical Health Care within Mental Health Services. This physical assessment must be documented within the Physical Health Examination documentation module in eMR.

It is the responsibility of the admitting medical officer (AMO) to ascertain if the consumer has an active 'advanced care directive' (ACD). In order to accept an advance care planning document into the medical record it must be reviewed and assessed, in consultation with the consumer or person responsible and the AMO (Consultant). If there is an ACD for the consumer the following process must be followed; SESLHDPR/643 - Upload of Advance Care Planning Documents into the Patient Electronic Medical Record (eMR).

The following factors should be considered in assessing appropriateness for admission, either from ED or as a direct admission from the Community:

- The nature and acuity of the presenting clinical syndrome.
- The view of family and/or carers.
- The age of the consumer and appropriateness of admission to an adult Acute Mental Health Inpatient Unit.
- Functional impact of the current condition.
- Availability of community services and family supports.
- Clinical risk assessment and formulation.
- The Acute Mental Health Inpatient Unit's ability to safely manage the clinical presentation.
- Potential treatment responsiveness.
- Possible exclusions.

Acute mental health inpatient admission is generally reserved for consumers with a mental health diagnosis which is: severe, acute or associated with significant risk and/or disability. An inpatient admission should be considered if it is the least restrictive option to treat symptoms and reduce impairment.

Where treatment as an outpatient or by community services is appropriate and available this should be implemented, in preference to admission to hospital, as the least restrictive option.

NOTE:

- All consumers should be considered for a voluntary admission when clinically appropriate, and any consumers admitted involuntarily should be reviewed regularly during their admission regarding their legal status.

- Where consumers are voluntary and have private health insurance, admission to a private mental health facility within their local area should be explored, where appropriate
- If a determination has been made that the consumer requires admission, and there are no beds available in the MHU, the assessing/admitting clinician must refer to the SESLHD MHS Short Term Escalation Plan (S.T.E.P.) Matrix.

If a consumer has Private Health Insurance and elects to use this while in the Public Hospital MHU, a process of informed financial consent is completed, as per NSW Health PD2021_046 Admitted Patients Election Policy.

b) Prior to Arrival at the Mental Health Unit

The mental health assessment – including a risk assessment and management plan, together with the "fit for discharge from ED" assessment – should be reviewed by the site Position Responsible for Patient Flow (PFC). The consumer should not be admitted into a MHU until the current MH assessment document has been completed.

NOTE: If the consumer is a direct admission from the Community Mental Health Service (CMHS) to a MHU: a Physical Health Examination must be completed by the treating Mental Health Team within 24 hours of admission to the MHU and be documented within the Physical Health Examination documentation module in eMR. This must include a baseline ECG, routine blood tests with BBV screening.

The admitting Mental Health clinician **must** ensure that a Consultant Psychiatrist has accepted care of the consumer, authorised the admission, and this must be document.

Discussion in consultation with the PFC/Nurse In Charge of Shift (NIC) and Consultant Psychiatrist should cover the following requirements:

- Bed availability and suitability (taking into account other consumers in the unit).
- The admission is suitable and mental health-related; screening and excluding Delirium and/or cognitive impairment.
- The consumer is aware of the plan to admit and the indication for admission.
- Whether the consumer has identified or excluded Designated Carers, or people of importance to be involved in their care and whether a Principal Care Provider has been nominated by the Psychiatrist or whether the Psychiatrist deems the consumer lacks capacity at this point to nominate or exclude Designated Carers
- Completion of the MH current assessment (including a risk assessment, risk formulation and management plan). Agreement on a plan for identified risks, leave type and observation level.
- Documentation of all areas of risk, leave arrangements (with specifications), the care level and legal status, in the free text area in the eMR Mental Health Current Assessment Module.
- Completion of a medication chart with suitable regular and pro re nata (PRN) medications that cover oral and intra-muscular injection (IMI) options charted within eMEDs.

- Whether the consumer has received medication prior to transfer to the Unit.
- Results of the physical assessment which led to "fit for discharge from ED" status, and any pre-existing medical conditions, ECG interpretation and routine blood test and BBV screening findings, including the need for further review by medical officer.
- Completion and documentation of any NSW Mental Health Act (2007) requirements.
- Whether the consumer is/was in possession of contraband, and whether a search has been conducted as per SESLHDBR/080 Search to Maintain Safety in SESLHD Mental Health Inpatient facilities.
- Whether the consumer has access to dangerous objects (eg, firearms). **NOTE:** As detailed in SESLHDPR/318 Firearms and/or Prohibited Weapons: Notification to Police of Consumers Suspected of having Access to a Firearm and/or Prohibited Weapon NSW Police must be notified so they can safely remove firearms from the consumer and their premises, if required, by completing the NSW Police Force – Firearms Registry Disclosure of Information by Health Professionals form.
- Whether the consumer has a companion animal, please refer to SESLHDBR/089 Companion Animals in SESLHD Inpatient Mental Health Facilities.

c) Allocation of Acute Mental Health Inpatient Unit

Allocation of the MHU is determined by consultation between the admitting clinician, the NIC of the MHU at the time of the admission, and the Consultant Psychiatrist who has accepted care of the consumer.

When determining allocation of a consumer to either PECCs, Acute Mental Health Inpatient Units or Older Persons Mental Health Inpatient Units, the following factors should be considered:

- Age of consumer
- Estimated Length of Stay
- Sexual safety
- Absconding
- Suicide or homicide risk factors
- Self-harm
- Aggression
- Harm to reputation and/or exploitation
- Changeability
- Assessment confidence
- Whether this is the consumer's first episode of illness or first presentation.
- Complex physical health co-morbidities
- CALD including NESB
- Aboriginal and/or Torres Strait Island background
- Medical and physical needs
- Psychosocial risk factors

NOTE: Allocation of a bed within any MHU must be commensurate with the clinical and risk assessment.

In formulating the consumer's risk in order to provide care staff must consult SESLHDGL/082 Clinical Risk Assessment and Management – Mental Health and NSW Health PD2022_043 Clinical care of people who may be suicidal.

If the consumer being admitted requires a bed in an Observation MHU and the only bed available is in a General Mental Health Inpatient Unit, the admitting Consultant Psychiatrist (in consultation with the NIC and Psychiatric Registrar) must determine which of the existing Observation Unit consumers can be moved to the General MHU.

d) NSW Mental Health Act (2007)

If a consumer is being admitted under the NSW Mental Health Act (2007), staff must ensure that original copies of the necessary legal forms are included in the relevant paperwork. These include:

- The initial Schedule 1 (s19) Form or alternative (s20, s22, s23, s24, s25 or s26).
- The first Form 1 (s27), which must be completed by an authorised Medical Officer within 12 hours of the person's presentation to a declared mental health facility. A second Form 1 (s27) must be completed by a Consultant Psychiatrist (unless the first examination was conducted by a Consultant Psychiatrist) as soon as possible.
- If the consumer is detained under the Mental Health Act, they must be provided with a copy of the 'Statement of Rights' Form (s74 (Schedule 3)), and a verbal explanation of the document. **NOTE:** This must be documented in the eMR, and in iPM).

If the consumer is being admitted in a voluntary capacity, ensure that a Section 5 (1) is completed, and the reason for this has been fully explained to the consumer and they understand the MHS expectations.

For all consumers, Designated Carers and/or Principal Care Providers must be notified within 24 hours of admission as an involuntary or voluntary patient,

e) Arrival on the Mental Health Unit

Upon the consumer's arrival on the MHU, the admitting nurse must:

- Receive handover and the transfer of care from ED, ensuring that the referrer has included all components of the Introduction/Situation/Background/ Assessment/Responsibilities, Risks and Recommendations (ISBAR) tool as outlined in SESLHDBR/040 Clinical Handover for Mental Health Services (ISBAR).

NOTE: This must include a formal identification of the consumer as per SESLHDPR/288 Identification of Patients within Inpatient Mental Health Care Settings.

- Inform consumers of the MHU's smoke-free policy and devise an appropriate management plan for consumer's with an active smoking status, as per NSW Health PD2015_003 NSW Health Smoke-free Health Care Policy.
- Search the consumer and their belongings and remove any contraband items. Add these items to the valuables form or send them home with family/carer.
- Initiate a suicide safety plan, for people who have presented with suicidal crisis, or self-harming behaviour, which should include strategies to address increased distress and potential engagement in self-harming or suicidal thinking and behaviour while in the MHU.
- Complete the Mental Health Admission Checklist (see APPENDIX A). Complete the Physical Appearance Module in eMR.
- Review all areas of risk, leave arrangements (with specifications), the care level and legal status in the free text area in the eMR Mental Health Current Assessment Module.
- Initiate the NSW Health Standard Adult General Observations (SAGO) Chart.
- Review the need for other charts (eg, sleep, drug and/or alcohol withdrawal) and initiate any that may be needed.
- Initiate commencement of the Consumer Wellness Plan in eMR.
- Review the medication chart and ensure that appropriate medications have been charted (incorporating both regular and PRN).
- Complete the Valuables Form for the relevant site and send home items (with the designated carer/family) wherever possible:
  - If the consumer has large sums of money, advise them to keep only a nominal amount while in hospital, for personal use, see local site storage of personal items.
  - If the consumer does not have a designated carer/family to send valuables home with, then valuables should be sent to the relevant hospital's cashier's office/safe, as per local protocols.
- Update the bed list, and ensure the iPM system and the MHU electronic patient journey board (EPJB) are updated, as per local standard operating procedure.
- Conduct a brief assessment of the consumer to clarify current status (understanding of reason for admission, mental status examination, level of distress, risk levels and consumer's needs from a nursing/bio-psychosocial viewpoint eg, goals and strengths).
- Complete the NSW Health Mental Health Care Plan Form and include it in the consumer's (paper) medical record, identify calming strategies and document these in eMR.
- Explain the process and purpose of the nomination of Designated Carer's to the consumer. Ask the consumer who they identify as the person(s) who provides support to them, then support the consumer to complete the Nomination of Designated Carer Form. Ask the treating Psychiatrist whether a Principal Care Provider has been nominated. Ensure Designated Carers and Principal Care Providers are aware of the admission.
- If the consumer declines to complete the Designated Carer form and/or excludes family or carers then: discuss with the treating Psychiatrist whether the consumer

lacks capacity to exclude or nominate; document the outcome of this discussion; ensure the team regularly revisits the question of consent and Designated Carers with the consumer during the admission.

- Allocate the consumer to a room, giving consideration to any risk issues that may relate to the location of the room.
- Orientate the consumer to the MHU and provide them with information including, but not limited to, the following:
  - An outline of the policies and procedures of the MHU
  - "MHU based Welcome Pack"
  - Mental Health Act Statement of Rights (in appropriate language for consumer)
  - Evacuation points
  - Information about the Acute Mental Health Inpatient Unit
  - Information about mental health for consumers and families/carers
  - Treating team
  - Amenities
- Inform the consumer that a search of their room will occur whenever necessary for safety reasons. SESLHDBR/080 Search to maintain safety in SESLHD Mental Health Inpatient facilities
- Complete Outcome measures.

An Adult Admission Assessment, which is in adhoc on eMR, can be completed. This covers all requirements for Comprehensive Care, such as falls risk, pressure injury delirium screening and a malnutrition score.

f) Direct Admissions for Consumers Actively linked with the Community (see also Appendix C)

- Consumers who are actively linked with the community are required to be allocated to a treating team upon entry to a MHU, or by the next business day, (see APPENDIX C) or refer to SESLHDBR/051 Transfer of Mental Health Patients to other Public Mental Health Facilities and Private Hospitals if required).

g) For Transfers' between Mental Health Units on the same Mental Health Service Site, or to a General Hospital Ward on the same Hospital site

- If consumers are transferred between MHUs within the same MHS site, a full Clinical Handover between Nursing and Medical Teams must occur.
- The consumer must be oriented to the new Unit, with their Designated Carer and/or Principal Care Provider immediately informed of the transfer.

h) For Transfers between SESLHD Mental Health Service Sites or from an external public or private mental health facilities

- Refer to SESLHDBR/051 Transfer of Mental Health Patients to other Public Mental Health Facilities and Private Hospitals.

i) Requirements and Documentation

The following steps must be completed by MHS nursing and/or medical staff:

- Commence the admission checklist (see Appendix A) and document the admission in eMR.
- Ensure Consumer and carer information is correct for the episode of care in eMR and iPM
- The admitting clinician is to complete the Mental Health Current Assessment and the Past History Module in eMR.
- If the consumer has a Community MH Care Coordinator, contact the Community Mental Health Team to advise them of the admission. If the admission occurs after hours, note on the admission clinical notes and document in the nurses' communication book, for morning staff to contact the Care Coordinator.
- Ensure routine ECG, blood and urine tests, and urine drug and BBV screening have occurred, or that the appropriate forms/requests have been completed.
- Ensuring ECG, blood and urine tests, and screening results available on eMR, are reviewed and documented.
- If previous (paper) files have not been collected, collect the inpatient/hospital and/or community medical notes (if relevant).

j) Explanatory Notes

1. Where repeated hospitalisations are sought through abnormal illness behaviour, or hospital admission has been associated with regressed or harmful behaviour, admission to a MHU should be reconsidered.
2. **Adolescents:** The selection of model of inpatient care should be informed by the NSW Health Framework Accessing inpatient mental health care for children and adolescents. Generally, adolescents and young people requiring admission should be admitted, if possible, to a specialist unit rather than an Adult MHU. Adult MHU admission should only occur for people aged between 16 and 18 years and after all attempts to locate a suitable adolescent unit bed for them have been exhausted. An admission to an adult unit (including PECC) may be considered where a consumer cannot be safely cared for on a paediatric unit. In general, young people under the age of 16 should not be admitted to an adult unit and may need to be admitted to a paediatric unit with appropriate MH support, if a specialist unit bed is not located.
3. An acute presentation of an underlying condition eg an acute organic brain syndromes or substance use / dependence should be managed medically, unless the psychiatric disorder is more prominent than the medical needs.
4. All families and carers, regardless of whether the consumer has given consent to share information by nomination of Designated Carers, should be offered support via a referral to the Family and Carer Support Program. The question of consent should be revisited with the consumer at regular intervals during the admission. Consent is needed to share personal information with family and carers, however listening to carers, and receiving and requesting information, does not require consent. General information about mental health services and diagnoses can, and should, be shared with family and carers, regardless of consent.

4.2 DISCHARGE PLANNING/TRANSFER OF CARE PROCESSES

Transitions between services and care providers are times of significant risk for mental health consumers and their families/carers. Collaborative and comprehensive discharge planning/transfer of care improves safety for the consumer, their family/carer and the wider community, and is directed by NSW Health PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services. In consultation with NSW Health PD2022_043 Clinical Care of People Who May Be Suicidal.

Timely and clear verbal communication, and documentation, are essential elements of safe and effective discharge planning/transfer of care for mental health consumers.

a) Key Principles

Consumers and carers are partners in care planning, including discharge planning/transfer of care, and staff are to make every effort to support and maintain the consumer's right, choice and self-determination.

Carers have a right to be fully involved in discussions about discharge, or transfer to a different unit. Carers have a right to be informed of any transfer between units and should ideally be notified prior to the transfer. Carers have a right to be involved in discharge planning discussions, and for any concerns they raise to be taken into account. Carers need adequate notice of plans for discharge to ensure practical arrangements can be made, and to ensure adequate support and information are provided.

Planning for discharge/transfer of care commences as soon as practicable after the consumer's admission to the service.

Care planning, including discharge planning and transfer of care practices, are based on trauma-informed and recovery-oriented principles and practices.

There is continuity of care following discharge/transfer. Effective coordination and continuity of care following transfer of care relies on clear and timely verbal communication and documentation between the treating team, the consumer, their family/carer and the receiving service.

Consumers are not discharged without issues of homelessness being addressed, with active support and guidance for accommodation finding being offered, when required, and documented as part of discharge planning.

Discharge planning and transfer of care must take into account a consumer's language, culture, and diversity (e.g. Aboriginal and/or Torres Strait Islander background), gender and/or sexual orientation.

The Clinical Excellence Commission (CEC) recommends the use of ISBAR (Introduction; Situation; Background; Assessment; and Recommendation) as a key communication guide to achieve a standardised handover procedure that is thorough and person-centred and involves the consumer and carer.

b) Working with Consumers, Families and Carers

Mental Health Services **MUST:**

- Identify a key contact/coordinator from the multidisciplinary treating team, who is responsible for ensuring that each step of the discharge planning process is completed.
- Estimate the date of discharge in collaboration with the consumer and their family/carer, involving family/carers in discharge planning as early as possible, ideally well before the discharge date.
- Carry out regular mental state examinations and assessments of the consumer's personal strengths and vulnerabilities, social supports, safety and practical needs. These assessments should consider factors such as:
  - harm to self or harm to others (including children in contact with the consumer)
  - risk from others
  - parenting and family responsibilities
  - housing, homelessness or risk of homelessness
  - medication history (including non-adherence with psychiatric medication)
  - history of trauma
  - history of substance use
  - co-existing physical health and other disabilities
  - history of domestic violence as a victim or perpetrator
  - vulnerability to elder abuse
  - access to firearms or weapons
  - existing and planned support services, and their location.
  - Psychosocial stressors
- Develop and document management strategies for identified risks
- Support the consumer to update or develop their Wellness Plan, which will include contingency plans for changes in circumstances including deteriorating mental or physical health, and emergency contacts.
- Support consumers who have presented with or voiced suicidal thinking, distress, have attempted to take their own life, or engaged in self-harming behaviour, to develop a suicide safety plan for managing distress, thoughts of suicide and/or self-harm (commonly referred to as a "MH safety plan").
  At a minimum, this plan should include:
  - Early warning signs of increased suicidal distress (both internal and observable by others), and specific coping strategies.
  - Lethal means counselling and contingency planning with the Consumer and Designated Carer or Principal Care Provider to restrict access to lethal means and create a safe environment outside of the hospital.

- Specific foreseeable changes that may lead to increased suicidal distress, and specific contingency plans to implement if a foreseeable change occurs
- Identified social and professional supports that the consumer can contact in times of emergency, including contact details.

- Ensure all relevant information for discharge is discussed with the consumer and family/carer, as well as provided in writing. This includes providing a hard copy of a suicide prevention safety plan to both the consumer, and their Designated Carer/Principal Care Provider. This discussion, and the provision of information, should be clearly documented in the consumer's eMR.

Please Note. Mental health policy and legislation requires clinicians to keep Designated Carers and Principal Care Providers informed and involved at all stages of care, especially at admission, discharge, transfer between units, or overnight leave. If a consumer has declined to nominate a Designated Carer, or has excluded a family member or carer, and the treating psychiatrist has not nominated a Principal Care Provider, the treating Psychiatrist must assess whether the consumer has capacity to exclude someone from being informed of their discharge/transfer, or of planned leave. The resulting decision must be documented in the consumer's eMR, including whether or not any family or carer was informed of the admission/discharge/leave/transfer and if not, why not.

c) Working with Other Services

Mental Health Services **MUST:**

- Engage the receiving service, for example, the community mental health team, other health provider or support service, in discharge planning
- Ensure that when a consumer is being transferred to another MH Service or Department the referring clinician provides clear details to the receiving Service/Department, both in a verbal handover and in documentation, of what is being requested, and what has been agreed by the receiving Service/Department. Also with an indication of the urgency and degree of risk.
- Ensure there is documentation of follow up plans for physical health risks, including contact with the consumer's family and their GP regarding these risks, as is expected with mental health risks
- Establish mechanisms to enhance the transition experience, and reduce the risk of the consumer being lost to care, for example:
  - Facilitate the consumer's engagement with the receiving service by telephone, videoconference/telehealth or face-to-face contact prior to discharge.
  - Ensure accurate contact information for the consumer's family/designated carer(s) is provided to the receiving service, and that the consumer's family/designated carer(s) are also provided with contact details for the receiving service.
  - Use mental health peer workers, if the consumer requests this, to support the consumer transitioning from inpatient to community based services.

- Offer consumers and their family/carer input from Aboriginal Health Workers or culturally diverse workers for discharge planning, and offer access to translating and interpreting services, where appropriate.

- For consumers who live in social or community housing, make early contact with the relevant community housing provider to ensure that rental obligations are considered, and occupancy is maintained.
- Services involved in current and ongoing treatment must establish a follow-up procedure for consumers who do not keep, or are reluctant to engage with, the planned follow-up arrangements as part of discharge planning.

d) Planning for Transfer of Care

- Family and carer communication of treatment and discharge planning must be an active and ongoing process, particularly at times of discharge, transfer of care and leave taking.
- There should be engagement of General Practitioners and Private Psychiatrists, in discharge planning, to ensure an understanding of shared responsibilities.
- Wherever possible, Community Managed Organisations who may be providing intensive support to consumers in the Community, should be invited to discharge planning meetings (either in person or virtually), to ensure there is an understanding of what will be provided, and to be clear about when these services would commence.
- Any recommendations sought from second opinions/Forensic Reports that were not actioned at discharge should be documented in the Discharge Summary to ensure follow up services are aware of these recommendations, and the rationale for no action being taken.
- Planning for discharge/transfer of care/overnight leave should take into account festive seasons/public holiday periods when Community Managed Organisations may not be able to provide services. When a consumer goes on overnight leave the Community Mental Health Acute Care Team should be made aware.
- For consumers with substance use concerns, ongoing Drug and Alcohol support/contact should be offered at discharge, even though a consumer may have declined Drug and Alcohol support during an admission.
- Transfer of care discussions are to include the consumer, their goals, their carer where appropriate, and practical considerations such as:
  - estimated time and date of discharge
  - transportation needs
  - availability of family/carers, and any concerns raised by family/carers
  - access to suitable services
  - supports post-discharge
  - other responsibilities such as parenting and family issues
  - safety planning where the consumer is a victim of domestic and/or family violence, or other abuse.
  - appropriate referrals for ongoing mental health care and supports.
  - appropriate referrals for any identified physical health risks

- correct discharge address and telephone contact details for the consumer and family/carer have been updated in the electronic Medical Record (eMR and iPM)
- commencement of the Mental Health Transfer and Discharge Checklist (see Appendix B) for all consumers.
- Discussion of the Your Experience of Service Survey (YESS) with the consumer, giving them supporting documentation (e.g. brochure) and a paper copy, or the online link, with the service code identifier to complete.
- Discussion of the Carers Experience Survey (CES) with the carer, giving the carer supporting documentation and a paper copy, or the online link, with service code identifier, to complete.

PLEASE NOTE The recording of the correct address and contact details for consumers, and family/carers, is extremely important for ongoing care and support, and should be double checked to ensure the details are correct at the time of discharge and/or leave from a MHU.

e) At the Time of Discharge/Transfer: With Consumers and Families/Carers

The *Discharge/Transfer Summary* document or, on the rare occasion a Discharge Summary is unavailable a *Discharge Information Handout* (see below), is a crucial document for consumers and their families, providing information on care and safety of consumers.

It **is imperative that the *Discharge/Transfer Summary,* or a *Discharge Information Handout,* is given to the consumer and their family/carer at the time of discharge, and a copy kept in their medical record**.

The nominated mental health key contact/coordinator, or delegate, MUST take time to go through the *Discharge/Transfer Summary, or Discharge Information Handout,* with the consumer and their family/carer, to ensure they understand the information, and to answer any questions.

Information in the *Discharge/Transfer Summary must comply with* SESLHDPR/223 Medical Discharge Summary Completion standards *and should include, but not be limited to:*

- correctly entered diagnosis
- current medication list and any side effects
- agreed care plan
- identified risks, contingency plans, relapse prevention strategies as discussed, and steps to take if relapse is likely,
- Plan for managing thoughts of suicide and/or self-harm (commonly referred to as a “safety plan”).
- telephone contacts for access/re-entry to the MHS

- contact numbers and appointment details of health professionals or support services to which the consumer has been referred for ongoing care, for treatment and other therapeutic interventions
- physical health care follow up
- description of any parenting or family responsibilities
- family and carer information/contact details
- consumer's correct discharge address and telephone contact details

Information that is auto populated in the discharge summary in the electronic medical record (e.g. telephone numbers, GP details, medications, diagnosis), should be routinely checked for accuracy.

On the rare occasion that a *Discharge/Transfer Summary* is not available at the time of discharge then a *Discharge Information Handout* should be given to the Consumer and their Family/Carer, and a copy kept in their medical record.

- The content of this handout will vary according to the consumer's clinical needs, the setting and other local factors, but should include:
  - the consumer's name and current contact details
  - date of discharge from service/facility
  - carer's name and contact details
  - Current discharge medication, given to the consumer and any advice about possible side effects and safety measures
  - current medical concerns/treatment/follow-up
  - follow up health care arrangements or details of support services, such as:
    - CMHS: name, address, telephone contact details, name of contact person and appointment details
    - GP telephone number and appointment details
  - early warning signs of relapse, identification of risks and strategies to reduce each identified risk
  - contingency plans and relapse prevention strategies
  - emergency telephone contacts for access/re-entry to the MHS
  - information or standard handouts about educational or community support services
  - information on family and carer support services.

The consumer must also receive a copy of their *Wellness Plan* and a hard copy of their suicide safety plan to assist in managing thoughts of suicide and/or self-harm (commonly referred to as a "MH safety plan").

f) At the Time of Discharge/Transfer: With Receiving Service Provider/s

The *Discharge/Transfer Summary* document must be forwarded to the receiving service provider, and any other support services, preferably within 12 hours of discharge/transfer, or earlier as clinically indicated.

The discharging (referring) service should telephone the receiving service provider, and any other support services, to advise that the consumer has been discharged, where the consumer's follow up appointment is within 24 hours of discharge.

g) Follow-up in the Community

Timing of follow up contact in the Community should be based on clinical need/priority, current level of social supports, and discussed at the time of discharge with the consumer/family/carer as part of the discharge planning process.

The Community MH Team should contact the consumer within seven days of discharge from an acute inpatient MHU, including a PECC. Where the consumer has been unable to identify a Designated Carer there must be face-to-face follow-up contact within 48 hours of discharge. Where the consumer has been unable to identify a Primary Care Provider or has limited social supports, the follow up contact should occur within 48-72 hours of discharge. This contact must include clear plans for next actions/follow-up. Identification of clinical deterioration should be escalated and managed as appropriate.

Where the CMH Team is unable to contact the consumer, (or the consumer is a young person), they should contact the consumer's family/carer to gain their perspective on how well the consumer is settling in the community, and to identify any concerns that need to be addressed, or to identify additional referrals that could assist this process.

PLEASE NOTE:
Documentation of the completion of requirements for Discharge/Transfer of Care is very important for continuity of care, and the Transfer and Discharge Checklist should be completed (see Appendix B).

If it was not possible to complete a requirement for discharge, this should be detailed in the consumer's eMR, so all services are aware of what has been completed and what is required to be completed, to ensure comprehensive ongoing care.

It should be documented in the eMR that a consumer has been given a copy of their Discharge/Transfer Summary, OR a Discharge Information Handout, that the information has been explained to the consumer/family/carer, and any questions answered. If this was not possible, then it should be documented why the consumer/family/carer did not receive the appropriate discharge paperwork.

5. DOCUMENTATION

Adult Admission Assessment (CareCompass) including Valuables Form
*Mental Health Admission Checklist paper form (S1034)
*Mental Health Transfer Checklist paper form (S1035)
*Mental Health Discharge Checklist paper form (TBA)
MH Assessment (aka Mental Health Current Assessment)
MH Discharge/Transfer Summary (or Discharge Information Handout only if Discharge/Transfer Summary unavailable)
MH My Wellness Plan (aka Consumer Wellness Plan)

MH Past History Module
MH Physical Appearance
MH Physical Health Exam
Nomination of Designated Carer Form
NSW Health Mental Health Care Plan Form
NSW Mental Health Act (2007)

- Schedule 1 (s19) Form or alternative (s20, s22, s23, s24, s25 or s26)
- Form 1 (s27)
- 'Statement of Rights' Form (s74 (Schedule 3)
- Section 5 (1)

***Please note: sites are required to develop their own process that documents how the checklists will be reviewed, the frequency of their review, and who is responsible for ensuring that the local process is followed.**

6. AUDIT

Monthly QARS Inpatient and Community file audits tabled at the local Clinical Governance meetings
A monthly Electronic Discharge Summary report is monitored at local Clinical Governance meetings.

7. REFERENCES

NSW Health

- PD2022_043 Clinical care of people who may be suicidal
- Accessing inpatient mental health care for children and adolescents, A Framework
- PD2015_003 - NSW Health Smoke-free Health Care Policy
- PD2019_045 - Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services
- PD2017_033 - Physical Health Care Within Mental Health Services
- GL2021_006 - Physical Health Care for People Living with Mental Health Issues
- GL2014_002 - Mental Health Clinical Documentation

SESLHD

- SESLHD MHS Short Term Escalation Plan (S.T.E.P.) Matrix
- SESLHDGL/082 - Clinical Risk Assessment and Management – Mental Health
- SESLHDBR/040 - Clinical Handover for Mental Health Services (ISBAR)
- SESLHDBR/080 - Search to Maintain Safety in SESLHD Mental Health Inpatient facilities.
- SESLHDPR/288 - Identification of Patients within Inpatient Mental Health Care Settings
- SESLHDPR/615 - Engagement and Observation in Mental Health Inpatient Units
- SESLHDPR/484 - Patient Leave from Acute Inpatient Units – Mental Health Service
- SESLHDPR/318 - Firearms and/or Prohibited Weapons: Notification to Police of Consumers Suspected of Having Access to a Firearm and/or Prohibited Weapon

- SESLHDGL/074 - Clinical Documentation in Mental Health
- SESLHDGL/051 - Access and Patient Flow Operational Framework for Mental Health Service
- SESLHDBR/051 - Transfer of Mental Health Patients to other Public Mental Health Facilities and Private Hospitals
- SESLHDBR/039 - Accredited Persons in Mental Health Ambulatory Care Settings
- SESLHDPR/318 - Firearms and/or Prohibited Weapons: Notification to Police of Consumers Suspected of having Access to a Firearm and/or Prohibited Weapon
- SESLHDBR/089 - Companion Animals in SESLHD Inpatient Mental Health Facilities
- T22/57315 Flexible Visiting in Mental Health (Memo – August 2022)
- Mental Health Admission Checklist (S1034) *(Pads are to be ordered via Stream Solutions)*
- Mental Health Transfer and Discharge Checklist (S1035) *(Pads are to be ordered via Stream Solutions)*

Other

- NSW Mental Health Act (2007)
- National Safety and Quality Health Service (NSQHS) Second Edition: Standard 1. Clinical Governance Standard (1.3)
- National Safety and Quality Health Service (NSQHS) Second Edition: Standard 6.07 & 6.08: Communicating for Safety; Communication at Clinical Handover
- National Standards for Mental Health Services 2010: Standard 10. Delivery of Care (10.3.6)
- NSW Police Force – Firearms Registry Disclosure of Information by Health Professionals

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
August 2022	DRAFT	Draft for comment period.
August 2022	1	Endorsed by Executive Sponsor for publication
September 2024	2	Revised to address SAER recommendation and updated to reflect new NSW Health documents *PD2022_043 Clinical care of people who may be suicidal* and *Accessing inpatient mental health care for children and adolescents, A Framework* DDCC endorsed out-of-session
11 October 2024	2	Clinical Council endorsed out-of-session. Approved for publication. Document published.
4 November 2024	2.1	Typos corrected – no change to procedure.

Appendix A: Mental Health Admission Checklist

Health
South Eastern Sydney
Local Health District

Facility:

MENTAL HEALTH
ADMISSION CHECKLIST

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Attending Medical Officer:		Nurse at Admission:	
Registrar/Medical Officer:		CMH Clinician:	
Admission Date:		Admission Time:	

ON ADMISSION		YES	N/A	Staff Initial
Primary or Allocated Nurse	Property search completed & documented	☐	☐	
	Valuables form completed (copy in file & copy to consumer)	☐	☐	
	Rights & Responsibilities brochures & Unit Information provided	☐	☐	
	Privacy information provided	☐	☐	
	ID confirmed & armband attached	☐	☐	
	Consumer orientated to the ward & inform of 'No Smoking' Policy	☐	☐	
Medical Officer	Document Medication by History (incl. Medication Reconciliation) commenced	☐	☐	
Primary or Allocated Nurse	Engagement and observation level documented on medical record & smart board	☐	☐	
	Physical observation chart commenced	☐	☐	
	Primary nurse/nursing team allocated	☐	☐	
Medical Officer/ Admitting Officer	**MHA PROCEDURE AND DOCUMENTATION COMPLETED**			
	s19-26, s32 First Form 1 OR Voluntary 5(1)	☐	☐	
	Statement of rights [S74(3)] given & explained	☐	☐	
	Designated Carer / Guardian nominated (S72) & informed of admission	☐	☐	
Consultant Psychiatrist	s19-26, s32 Second Form 1 OR Voluntary 5(1)	☐	☐	
Primary or Allocated Nurse	Admission documented in medical record	☐	☐	
	Clinical Documentation completed in eMR (including ALL SECTIONS)	☐	☐	
Medical Officer/ Admitting Officer	**STANDARD ASSESSMENTS POWERNOTES (ALL MUST BE COMPLETED)**			
	MH Current Assessment	☐	☐	
	MH Past History	☐	☐	
	MH Physical Examination	☐	☐	
	MH Family Focussed Assessment	☐	☐	
	MH Substance Use Assessment	☐	☐	
	Transcultural Assessment	☐	☐	
	LSP-16	☐	☐	
	Inpatient Care Plan (including Safety Plan)	☐	☐	
	Medication chart (incl. PRN medication) eMEDs	☐	☐	
	Nicotine dependence assessment & plan made	☐	☐	
Primary or Allocated Nurse	**STANDARD MEASURES POWERFORMS (ALL MUST BE COMPLETED)**			
	SM1 (HoNOS /HoNOS65+/ HoNOSCA) & entered electronically	☐	☐	
	SR1 (K10 / SDQ) & entered electronically	☐	☐	
	Metabolic Monitoring Form commenced	☐	☐	
	Ontario Falls Assessment Tool	☐	☐	
	Meal ordered on eMR	☐	☐	
	Notification of admission			
	☐ Community MH Clinician ☐ GP ☐ Private	☐	☐	

Nurse in Charge	NAME		SIGNATURE		DATE	

THIS CHECKLIST COMPLEMENTS THE ADMISSION PROCEDURE AND SHOULD NOT REPLACE PRACTICE STANDARDS. TO BE COMPLETED WITHIN 48 HOURS.

SES025100

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

MENTAL HEALTH ADMISSION CHECKLIST

SES025.100

S1034 141118

NO WRITING

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Appendix B: Mental Health Transfer & Discharge Checklist

Health
South Eastern Sydney
Local Health District

Facility:

MENTAL HEALTH TRANSFER & DISCHARGE CHECKLIST

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Attending Medical Officer:		**Nurse at Discharge:**	
Registrar/Medical Officer:		**CMH Clinician:**	
Discharge Date:		**Discharge Time:**	

	DISCHARGE/TRANSFER PREPARATION	YES	N/A	Staff Initial
Medical Officer	Discharge/Transfer date identified	☐	☐	
	Plan discussed with consumer, designated carer/responsible person	☐	☐	
	Plan discussed with Clinical Care Coordinator/Community MH Clinician	☐	☐	
	Plan discussed with Acute Care Team or other facilities	☐	☐	
	Referrals completed to relevant services (e.g. D&A, GP, Psychologist, etc.)	☐	☐	
	INTER- or INTRA-HOSPITAL TRANSFER			
Medical Officer	Section 78 completed if transfer to another hospital	☐	☐	
	Documented Medical Clearance	☐	☐	
	Document reviewed by a MO within last 48hrs	☐	☐	
Primary or Allocated Nurse	**Copies** of all relevant clinical documents (incl. medication charts) provided	☐	☐	
	Originals of all legal documents provided (**copies** retained in med record)	☐	☐	
	Notify receiving service / unit of **actual** departure time	☐	☐	
	Notify designated carer / guardian of departure	☐	☐	
	Notify receiving service / unit of **planned** departure time	☐	☐	
	Check transport for transfer confirmed	☐	☐	
	Details of transfer documented in eMR	☐	☐	
	DISCHARGE/ COMMUNITY CARE TRANSFER			
Allied Health	Allied Health assessment & report completed	☐	☐	
Medical Officer	Discharge medication prescription completed	☐	☐	
	Medication Chart sent to CMHS (or GP) if consumer on depot medication	☐	☐	
	MH Discharge/Transfer Summary eMEDs completed	☐	☐	
Primary or Allocated Nurse	Clozapine Coordinator notified (if consumer on Clozapine)	☐	☐	
	Care Plan completed (incl. Safety Plan)	☐	☐	
	Patient's own medications assessed and returned if appropriate	☐	☐	
	Copy of CTO provided to consumer	☐	☐	
	SM1 (HoNOS/ HoNOS65+/HoNOSCA) completed & entered electronically	☐	☐	
	SR2 (K10) completed & entered electronically	☐	☐	
	Relevant services & supports are informed of discharge & documented	☐	☐	
	Follow-up appointment arranged, documented - consumer/ carer advised	☐	☐	
	Leave/Discharge information form completed & copy provided	☐	☐	
	YES Survey completed and entered in eMR	☐	☐	
	MH Discharge/Transfer Summary eMEDs provided to:			
	☐ Consumer ☐ Designated Carer	☐	☐	
	Discharge documented in eMR	☐	☐	
Admin Staff	**MH Discharge/Transfer Summary eMEDs provided to:**			
	☐ CMHS ☐ GP ☐ Private Psychiatrist	☐	☐	

Nurse in Charge	NAME		SIGNATURE		DATE	

THIS CHECKLIST COMPLEMENTS THE TRANSFER OF CARE PROCEDURE AND SHOULD NOT REPLACE PRACTICE STANDARDS.

SES025101

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

MENTAL HEALTH TRANSFER & DISCHARGE CHECKLIST

SES025.101

S1035 141118

NO WRITING

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Appendix C: Direct Admission to Acute Mental Health Units

This flowchart is intended for use in situations where a consumer who is currently linked with a Community Mental Health (CMH) Team is experiencing an acute relapse/ deterioration in mental state and may require admission to an **Acute Mental Health Unit**