Adult Mental Health Acute Care Pathway

Simplified illustration of the model

Primary Care Mental Health Services

Referral

Single Point of Access: expert opinion, advice and triage

Crisis Resolution

Admission

Home Treatment

Home Treatment

Peer support/ community services/ other alternative services

Other alternative services

Community rehabilitation/ community services/ peer support

October 2012
Inpatient services provide individualised whole person care that promotes recovery and inclusion.

Overall LPT pathway

1. Pre-admission
   All admissions will go through the Single Point of Access (SPA)

2. Pre-admission
   Preparation for admission

3. On admission (within first 4 hours)
   Initial care plan/risk management

4. Admission (within first 24 hours)
   Orientation/information giving

5. Comprehensive assessments (the first 72 hours)
   Priority needs and interventions

6. Comprehensive Assessments (within first week)
   Comprehensive assessment

7. Weekly cycle - recovery
   To promote recovery

8. Discharge
   Planning and discharge
Stage 1
Pre-admission SPA Screening

Person comes to the attention of acute care pathway
- defined as possibly requiring admission into an acute admission ward in near future - In Crisis

Telephone call - referral - initial response and collection of data - electronic referral form completed

Not known to services
- Reasons for referral
- Up to date risk assessment
- Background information
- Cultural, religious and language information from referrer

Known to services
Order notes from medical records, check Trust EPR system for all relevant information

Request medication history from referrer

Outcome of screening

Assessment
- Clarify mental state
- Clarify capacity for decision
- Comprehensive risk assessment

Admission

Not appropriate for acute assessment
Not accepted - feedback to referrer

Signpost

Outcome of initial assessment including clustering

Accept for Home Treatment

Identify CPA Co-ordinator

Identify named CRHT worker and team members primarily delivering care plan

Develop partnerships with other agencies/services Crisis Houses etc.

Go to Stage 8
Discharge planning

Signpost to other service

Formal admission

Informal admission

Provisional clustering entered on database

Go to Stage 2 Pre-admission

Acute assessment and Home Treatment
Stage 2
Pre-admission preparation

Decision to admit to be agreed with SPA

- Formal admission under the Mental Health Act
- Informal voluntary admission

Pre-admission checklist (exact actions will vary with circumstances)
- Inform carers of admission (if appropriate)
  - Information about hospital
  - Telephone contacts
  - Visiting information
- Secure accommodation
- Collect benefits book
- Collect medications
- Assist packing of bag
- Advise policy for mobile phones, musical instruments, communication systems
- Inform those that need to know

Collect information on records, care plans, risk assessment, reasons for admission

Is the patient responsible for others, e.g. dependent children?

- Y: Ensure no immediate safeguarding issues, jointly with social services if necessary
- N: Make patient/relatives aware of child visiting arrangements and make a case note entry for MDT review to assess risks/safeguarding the child. (Inform the Health Visitor of any child under the age of 5 years old.)

Clarify admission arrangements i.e. transport, time of arrival, escort etc.

Go to Stage 3
Admission

Key objectives
Patients should be treated in the least restricted environment which is consistent with their clinical needs.

Inpatient admissions and pressure on beds should be reduced.

Equity of access to an alternative to admission for patients and families must be ensured.
Stage 3 Admission
commence normally within first 4 hours

**Patient accepted for admission**

- 0 - 4 hours

**Arrival**

- Take appropriate steps to ensure safety as a priority from known risks with appropriate observation and interventions from arrival
- The patient and accompanying person are met on arrival, shown to an appropriate area and offered refreshments
- The patient is introduced to a member of staff who will be their point of contact for the first few hours
- Complete admission checklist and meet and greet checklist

**Orientation/information giving**

- Show the patient around the ward, explaining the fire drill, any significant issues of safety and an explanation of the need for a locked door or any other hindrances to comings and goings
- Check the patient property to ensure no risk / banned items, recording any property retained by staff on relevant form
- Reinforce the hope and optimistic approach to recovery. Clarify expectations staff have of the patient in terms of the patient's structured day, respect of property, personal dignity to others, need for observation and regulations concerning smoking, alcohol & drugs
- Inform the patient who will be their named nurse and that the named nurse will be introduced to them when they are next on duty

**Assessments**

- Is the patient detained under the MHA?

  - N
    - Complete Mental Health Act checklist and obtain copy of SW report
    - Provide patient with information regarding Mental Health Act
    - Identify any communication issues such as preferred language/need for an interpreter/visual or hearing impairment
    - All community assessment paperwork is available to the admitting team when the patient arrives on the ward, including mental health and current risk assessment
    - Ascertain from the referring agency information as to the security of the patients home, whereabouts of children or pets
    - Clarify who has medical responsibility and expectations if shared care
    - Complete core admin documentation/data collection (on checklist)
    - Patient receives standard medical and nursing assessments and physical examination
    - Assessment of capacity to consent
    - Complete Shared Plan of Care - 72 hours
    - Complete Shared Plan of Care Risk and Observation
    - Next go to Stage 4

  - Y
  - Clarify the rationale for admission

**Priority areas for immediate intervention:**

- safety, physical health, self-care and social needs
Stage 4 Admission
within first 24 hours

The ward is a safe environment for service users, staff and visitors, that promotes a therapeutic and safe experience.

Service users and carers are provided with information about the ward, their care and treatment and are actively involved in planning individual care.

Patient is given the ward information booklet with information on advocacy explaining any necessary points to promote understanding.

Establish who are the relatives and carers and if the patient consents to them being giving information or being involved in current care - record in notes (give appropriate information if consent given).

Inform CPA co-ordinator or any other care workers currently involved with service user, requesting any appropriate information/advance directives.

Issue the patient a sick note if required.

Identify if patient meets the criteria for 7 day follow up, making appropriate referrals.

Next go to Stage 5 - Assessment - first 72 hours.

Carry forward (within 1 day)

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Stage 5 Comprehensive assessment
- the first 72 hours

The patient and named nurse meet to complete the initial ward assessment and negotiate their C/P within the first 72 hours of admission taking into consideration discussion/decisions from daily ward review. All assessments are signed and dated.

The patient is able to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessments.

The named nurse to contact any co-ordinator involved and/or CRHT team. Identify requirements for early discharge package and maintain at least weekly contact to promote co-ordination and communication across the system of care.

Replace the Shared Plan of Care - 72 hours with an Individualised Plan of Care.

Findings from risk assessments are communicated across relevant agencies and care settings as appropriate in accordance with the Trust’s Information Governance Policy.

AIM
To provide a comprehensive assessment to inform the MDT Review Care Plan.

Go to Stage 6
A comprehensive holistic assessment of strengths, areas of concern and needs is completed including the following:

- assessment of risk
- vulnerability
- child protection/childcare
- mental health state
  - behaviour
  - cognitive
  - hallucinations/delusions
  - mood
- patterns of substance misuse including alcohol
- engagement
- physical wellbeing including:
  - diet/healthy eating
  - physical activity/exercise
- relationships
- social contacts
- educational needs (literacy and numeracy)
- accommodation
- employment
- smoking cessation
- language/cultural issues
- spiritual needs

The principle carer is offered an interview within 3 working days of admission with a named professional during which
- the carers views about on-going and future involvement are recorded
- the carer is given an explanation and an information sheet about ward procedures
- the carer is offered information on carer advocacy, welfare rights and mental health services
- the carer is offered an assessment of their own needs (refer via Social Care Direct/CMHT)

Medical staff to review clustering/HONOS+

Assessments to be presented within the first week at the MDT care review meeting to discuss the service users care, with input from the community care co-ordinator.

Go to Stage 7
To promote an effective integrated care pathway to manage care whilst in hospital and ensure a smooth transition out of hospital.

Stage 7 Weekly cycle - recovery

**The patients involvement is sought in all decisions about their care and treatment**

**Daily**

The patient has a structured day and the opportunity to have supportive one-to-one sessions with staff every day.

There is a daily (Mon - Fri) ward review between the nursing staff, doctors and other relevant members of the MDT which includes a discussion of risk factors and patient needs - tasks are identified and allocated to individuals and includes discharge planning.

There is a nursing handover at each shift which includes a discussion of risk factors and patient needs - tasks are identified and allocated to individuals.

**Twice weekly**

Patients have a minimum twice-weekly documented session with their named or allocated nurse to review their progress.

**Weekly**

Patients have the opportunity to meet their consultant on a weekly basis.

Before the weekly review, the named nurse should complete a nursing review at the same time. It is also good practice for the named nurse and CPA co-ordinator to liaise weekly to discuss progress.

A multi-disciplinary review at least weekly with the patient/carer/advocate allowing them to air their views in relation to the care package and ongoing management of risk. CPA review within first 2 weeks to be arranged.

Named nurse at least weekly to liaise with relevant locality community team or CRHT as appropriate to discuss progress, on-going management of risk, discharge planning and estimated discharge/transfer date.

**Review outcome** - to record the following (if applicable):
- brief summary including consent, MHA issues/status, change in health and functioning and risk issues
- if to repeat any assessments/risk profiles
- identify on-going needs and who will make any necessary referrals specifying a time period for the referral and recording when sent e.g. dual diagnosis, drug and alcohol etc.
- identified needs /agreed interventions (including any changes)
- estimated discharge /transfer date
- predicted follow up (7 days/117/CPA/CTO/guardianship)
- date of next formal review

**Service user to be involved in developing their care plan**
- views recorded in the notes
- deciding what is in the care plan, when/where/with whom to share information
- copy to be given to the patient and carer if patient agrees
- care plan reviewed weekly, non-mandatory care plans can be added as required

Repeat stage 7 (weekly cycle) or go to stage 8 (discharge planning).
Stage 8 Discharge

Discharge planning is initiated at time of admission
- involvement of patient and significant others in planning discharge
- provisional discharge date set
- identification of community care co-ordinator
- identification of community resources to meet needs
- review of discharge date and needs through daily and weekly reviews

Screening for possible early discharge via daily review process

Refer to SPA for early discharge, assessment and support where appropriate

Is early discharge possible?
- Consider as per CPA, but some review elements may be outside of hospital.
- 7 day CPA follow-up - involvement of early discharge team

CPA review to include;
- resources required for discharge
- involvement of carers/advocates, family as appropriate
- contact after discharge
- update of risk assessment
- recovery care plan
- health and social care responsibilities under S117
- set next CPA review date

Unplanned self-discharge?
- No
- Follow process on the unplanned self-discharge form

Discharge in line with medical advice

Medically agreed discharge either;
- not on CPA (no follow up or outpatient care only)
- CPA follow up - community care from LPT, 7 day follow up
- consider if CTO appropriate

Within 24 hours of discharge
- complete discharge checklist
- complete inpatient CPA 05 – including crisis and contingency plans and emergency contact details
- Complete GP discharge summary, send to GP, patient, carers, care co-ordinator
- Net promoter score/satisfaction survey