PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) Mental Health & Addiction Service's (MH&AS) policy intent that service users of the MH&AS will be assisted to plan for their discharge from Inpatient Services or exit from the service to ensure appropriate and effective ongoing follow-up is available if required.

OBJECTIVE

- To ensure the safe and appropriate discharge of patients.
- To identify and manage risks related to discharge.
- To encourage co-ordination of the discharge process using multidisciplinary services as required.
- To encourage effective communication between staff, the client and their family / whanau.
- To reduce the risk of unplanned, re-admissions.
- To ensure an appropriate length of stay for inpatients.

STANDARDS TO BE MET

1. Discharge Criteria

1.1 Discharge from a MH&AS may occur when either:

a) The assessed needs of the consumer and goals identified during the assessment and treatment process have been achieved.
b) The assessed needs of the service user are unable to be appropriately met by the treating service or are better met by an alternative service provider.
c) The service user has no contact with the service, has not responded to two (2) attempts to engage with the service and a decision based on multi-disciplinary team (MDT) discussion and feedback from case manager has indicated that no risk issues have been identified (except patients subject to the Mental Health Act).
d) The service user "self-discharges" by negotiation or against medical advice; (except patients subject to the Mental Health Act). or,
e) The service user moves out of the catchment area.

2. Discharge Planning

2.1 All service users who receive MH&AS will have a discharge plan.

2.2 The discharge plan is commenced during entry to the service and developed during assessment, delivery of care and review of care.

2.3 Details that may be included in a service user's discharge plan are as follows (but not limited to):

a) Preferred ongoing health provider (e.g. GP, Iwi health provider)
b) Community resources likely to be required or of benefit to the service users recovery / ongoing care
c) Other people likely to be involved
d) Other details as identified by the person who receives the service and their family/whanau.

2.4 All service users will have an allocated staff member responsible for discharge planning who will ensure that prior to discharge;

a) A documented multidisciplinary review of the service user's treatment occurs.
b) The discharge plan is developed collaboratively with the service user and family / whanau / caregivers (where the service user's consent is given), who will have access to a copy.
c) The discharge plan will identify and manage risks associated with the discharge including expressed concerns of the family / whanau. Evidence of review will be documented in the clinical notes.
d) Arrangements are satisfactory to the service user, their family/whanau and to the other providers prior to their discharge
e) Findings from needs assessment, cultural assessment or drug and alcohol assessment are integrated into the discharge plan, and have been documented in the clinical notes.
f) Assistance is provided to develop a relapse prevention plan (person centred care plan for MHSOP in- patients with cognitive impairment) that identifies early detection or warning signs of a relapse and the appropriate action to take and staff/services to contact. See Relapse Prevention Plan: (*Ref: Form MHS RPP*)
g) The appropriate Mental Health outcome measures are collected from the service user as specified in policy 2.5.2 protocol 9 Mental Health Outcomes Information (MH-Smart) Collection
h) Referrals have been completed and that contact has been established with the service user's general practitioner or other health care providers.
i) Sufficient health information is shared with the service user's proposed external service provider(s) to ensure that service users have access to appropriate, timely and high quality care that meets their needs and furthers their recovery/care needs.
j) This information will be forwarded prior to discharge and should include but not be limited to:
    i. Service User Details (name, age, address, contact details, next of kin)
    ii. Mental health history
    iii. Diagnosis and presenting issues
    iv. Current medication
    v. Risk assessment, treatment and discharge plans
    vi. The results of specialist assessment (A&D or Needs assessment)
    vii. Any other information as negotiated in a Memorandum of Understanding with that provider.

2.5 A copy of the electronic discharge summary is provided and explained to the service user and is sent to the GP within 24 hours of discharge.

3. Standards for Inpatient Discharge Planning

3.1 Ultimate responsibility for the discharge documentation rests with the responsible SMO who is responsible for the patient's management and includes the monitoring of the discharge process.

3.2 Where the client is new to the service or when for any other reason there is no case manager involvement it may be appropriate to appoint an inpatient lead nurse to this co-ordination role.

3.3 Post admission and pre discharge planning meetings will be coordinated by the identified lead discharge planning clinician. Those in attendance will include the patient, close family / whanau, relevant members of MDT (psychiatrist, case

manager, lead nurse etc) and where appropriate support from family / whanau and / or consumer advisor roles. Other agencies involved (NGO's, Housing agencies etc) will also be invited to these meetings as required.

3.4 When it is known that community mental health follow-up will be required, a referral should be made as soon as practicable so that a case manager can be identified early in the admission.

3.5 The case manager should maintain enough contact with the ward to ensure that effective discharge planning takes place (minimum standard one contact per week). The case manager, lead nurse and other members of the MDT work closely together throughout the discharge planning process.

3.6 Consumer and Family information packs are to be provided as soon as practicable on admission and utilised as a working tool throughout the patient's journey through the inpatient service.

3.7 A discharge planning checklist will be updated at every juncture of the process. This will be completed collaboratively with the patient and family / whanau if possible. A copy will be kept in the patient's health record and another by the patient to be kept in their information pack.

3.8 A relapse prevention plan will be completed collaboratively with the patient and their family / whanau. A copy of this will be kept in the patient's health record and by the patient in their information folder. Relapse prevention plan standards are also detailed in CPM.M5.36 Relapse Prevention Plans

3.9 Where it is not practical to hold a discharge planning meeting prior to discharge, a meeting will be arranged for the earliest possible time following discharge.

3.10 All patients with community mental health case manager involvement will receive a follow up visit within seven (7) calendar days. If this is not possible the reason must be clearly documented in the patient's health record.

3.11 Inpatient Discharge Summaries are completed using the standard BOPDHB electronic discharge summary template by the Psychiatric Registrar or delegated House Officer.

3.12 Administration staff will ensure that the completed electronic discharge summary for the current inpatient episode of care is printed out prior to the record returning to the community team and:

a) A copy placed in the patient's health record.
b) A scanned copy emailed to the case manager and psychiatrist
c) A copy mailed to the patient at their discharge address

3.13 Administration staff will ensure that the patient health record is sent to coding within 48 hours of the discharge and returned to the appropriate satellite file storage facility for access by the community team.

4. Transfer of Care

4.1 Transfer of care procedures between responsible clinicians and DHBs are detailed in policy 6.1.2 protocol 6 Transfer of Care.

5. Discharge Against Medical advice

5.1 When a voluntary service user requests to be discharged contrary to the advice of the clinician or MDT review, the standards for discharge planning will still be maintained.

5.2 If discharge is still requested by the service user, the case manager will arrange a discharge planning meeting with the service user, family / whanau other members

of the MDT involved in the service user's care and will document the patient's health record as follows **"*Discharged against Medical Advice*"**

5.3 Service users who choose 'Discharge Against Medical Advice' will be given information at the time of discharge on how to regain entry to the MH&AS.

6. Re-Entry

6.1 Service users and their family / whanau, where appropriate, are given information at the time of discharge on how to regain entry should they require it, including whom to contact.

6.2 Also see CPM.M5.25 Referral

7. Information Systems

7.1 The designated nurse / case manager / responsible clinician will ensure that the appropriate MH-SMART outcome measures collected from the service user are entered into the MH&AS Information System.

7.2 The staff member responsible for the service users discharge planning will ensure that a Linked Referral is closed as per the MH&AS WebPas User manual (page 38)

7.3 Administration staff / Clinician will ensure that the Primary Referral is closed for service users who are being discharged from the MH&AS entirely as per the MH&AS WebPAS User Manual, page 38.

REFERENCES

- Guidelines for Discharge Planning for People with Mental Illness. MoH. July 1993.
- Health & Disability Service Standards NZS 8134:2008
- Mental Health (Compulsory Treatment and Assessment) Act 1992 & Amendments 1999
- Mental Health WebPAS Training Manual
- Southland District Health Board Mental Health Service Feb –Mar 2001: A Report by the Health and Disability Commissioner

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.5.1 Inpatient Discharge Planning
- Bay of Plenty District Health Board policy 6.5.1 protocol 0 Discharge Planning - Inpatient Standards
- Bay of Plenty District Health Board policy 6.1.2 protocol 6 Transfer of Care
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Mental Health
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.36 Relapse Prevention Plans