CPA DISCHARGE PROTOCOL

1 Pre-admission To prevent admission

To prevent inappropriate admissions:

For any service user in the red zone of a CMHT or any CC or a lead professional thinking of referring for admission: refer to Crisis Home Treatment Team asking the following:

- Can admission be prevented with their support and home treatment?
- If not, ask them to review the cases asap to support earliest possible discharge.

At the point of admission or before if possible:

- CC and CMHT Dr or lead professional to update contact details, core assessment and risk assessment.

State clearly in progress notes on RiO:

- Reasons for admission
- Outcomes to be achieved from the admission
- Accurate list of medicines the patient is prescribed/taking
- What will need to be done for safe discharge
- Expected length of stay

Delayed Discharge Early Warning Signs form to be completed and given to the bed manager and passed to primary nurse

CMHT zoning priority
Admitted SU to go on CMHT red zone if the length of stay is likely to be less than three months

CMHT CC to be allocated within seven days by **team manager** or referral made to CMHT if client not already known, case to be held on team managers caseload until allocated.

2 Within 1st week of admission

CC and ward Dr to ensure updated core and risk assessments available in RiO to enable informed ward round decisions.

Primary nurse (or nominated deputy eg charge nurse, or ward manager) to agree weekly time(s) to talk and communicate either face to face or by phone with **CC**.

At the first ward round:

- primary nurse ensures the delayed discharge form is brought along
- Factors likely to block discharge identified and planned for
- Problems/needs identified, inpatient care plan agreed and any irrelevant community care plans in RiO closed or put on hold
- Date of pre discharge case review to be set. Issues to discuss may include:
  > Accommodation, benefits, complex, physical healthcare needs
  > Equipment/adaptations required on discharge
  > Referral to complex needs/forensic or other

Ward manager to notify **bed manager** of likely delay to discharges after ward rounds.
Primary nurse/ward clerk to ensure benefits issues are sorted from day of admission.
CC to attend ward round in person or if not feasible by telephone conference and notify team manager of any possible delayed discharge reasons.
Primary nurse to check with **CC** if CPA meeting is already planned.
RiO CPA management pages to be amended accordingly to prevent CPA breaches.

3 Preparing for discharge

Discharge planning case review or CPA

Primary nurse and CC to meet with the service user to develop the post discharge community care plan ensuring all community actions are recorded on the plan. These can remain closed until discharge.

Primary nurse (supported by charge nurse and the **CC**) to organise the pre-discharge planning meeting with ward administrator inviting service user, carer, CC advocate, CHTT, involved community agencies eg housing which the CC will advise around plans for safe aftercare.

Clozapine patients: ensure arrangements are in place for blood testing and collection of medication. If the patient is changing consultant, ensure ZTAS (Clozapine service) are informed.

Carers to be formally asked by **ward manager/primary nurse** of progress made during period of leave to inform plans.

Check will the service user be resuming contact with children either their own or other children ie siblings, step-children, grand children at home or outside of the home. Have any risks been identified that suggest the service user poses a risk to children?

If risks have been identified does the risk management plan form part of the care plan? Has the consultant psychiatrist been directly involved in their discharge planning?
Has a referral been made to children's social care?

Key

CC	Care coordinator	CMHT	Community mental health team		
TTO	Tablets to take out	CHTT	Crisis and Home Treatment Team	DSH	Deliberate self-harm

CPA DISCHARGE PROTOCOL

4 Discharge CPA

At the discharge CPA

Consultant, primary nurse and CC to develop the:

Community care plan, with care needs, interventions and risk management to be recorded and names of those community staff responsible for care plan actions to be updated.

Completed inpatient care plan items to be closed.

CPA management and review pages on RiO to be completed to reflect CPA meeting.

5 48 hours before discharge

Ward Dr to order TTOs and advise CMHT doctor of the prescription.

Primary nurse to complete the Preparing for discharge checklist:

- TTOs ordered
- Carers informed of discharge date
- CC to give location. Time and date of follow-up appointment
- Sick certificates signed by ward doctor
- Discharge care plan and crisis plan agreed and signed by service user
- CPA one month post discharge date set and added to RiO CPA Management
- Progress notes have been validated

Does the support of home treatment team need to be requested?

6 On the day of discharge

Documentation and information:

Primary nurse to check:

- Service user has a signed copy of their care plan
- Service user knows who to contact in a crisis – Crisis card given to service user/carer
- Service user has money for transport home
- Service user has a key to home
- Service user has food available
- Service user has TTOs
- Service user has information about their condition and medication
- Service user has the date of the 48 hour/7 day follow up appointments.
- Arrangements have been made for repeat prescriptions and service user informed
- Cash and valuables returned to service user (ask user to sign property form)
- Medical certificate given to user
- Discharge entered on RiO
- Service user's name removed from fire list, nominal list, bed list, MHA list (if applicable).

Ward Dr to complete the discharge notification to the GP stating:

- Medication and prescribing arrangements
- Risks
- Date of first follow up appointment booked and given to the service user

Primary nurse to check that completed needs on the inpatient RiO care plan are closed.

7 Within 7 days of discharge

For service user with **severe illness:**
More than 3 month history of DSH **CC** to undertake a face to face contact **within 7 days** of discharge.

Preventing suicide
For service user who was admitted with suicide risk or attempted suicide, or suicide attempt during admission, or current risk of suicide, **CC** to follow up **within 48 hours.**

Documentation and information:

Ward Dr to complete:

- discharge summary
- update the RiO core and risk assessment summary of admission
- ICD formulation in the formulation screen of RiO
- send summary to GP.

Essence of discharge summary and updated RiO is:

- reason for admission
- key symptoms and problems at admission
- key interventions tried and response
- major risk behaviours
- care plan follow-up arrangements.