Adult Mental Health Services

Admission of a Patient to one of the Adult Acute Inpatient wards

Standard Operating Procedure

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
</tr>
<tr>
<td>Ratified by:</td>
</tr>
<tr>
<td>Date ratified:</td>
</tr>
<tr>
<td>Name of originator/author:</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
</tr>
<tr>
<td>Date issued:</td>
</tr>
<tr>
<td>Review date:</td>
</tr>
<tr>
<td>Target Audience</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>4.1</td>
</tr>
<tr>
<td>4.2</td>
</tr>
<tr>
<td>4.3</td>
</tr>
<tr>
<td>4.4</td>
</tr>
<tr>
<td>4.5</td>
</tr>
<tr>
<td>4.6</td>
</tr>
<tr>
<td>4.7</td>
</tr>
<tr>
<td>4.8</td>
</tr>
<tr>
<td>4.9</td>
</tr>
<tr>
<td>4.10</td>
</tr>
<tr>
<td>4.11</td>
</tr>
<tr>
<td>4.12</td>
</tr>
<tr>
<td>4.13</td>
</tr>
<tr>
<td>4.14</td>
</tr>
<tr>
<td>4.15</td>
</tr>
<tr>
<td>4.16</td>
</tr>
<tr>
<td>4.17</td>
</tr>
<tr>
<td>4.18</td>
</tr>
<tr>
<td>4.19</td>
</tr>
<tr>
<td>4.20</td>
</tr>
<tr>
<td>4.21</td>
</tr>
</tbody>
</table>
1. **AIM**

   The aim of this standard operating procedure is to set out the specific standards for when a patient is admitted to one of the Adult Acute Mental Health Inpatient wards.

2. **SCOPE**

   The contents of this standard operating procedure apply to clinical staff working within the Trusts’ Adult Mental Health Services.

3. **LINK TO OVER ARCHING POLICY**

   This standard operating procedure is to be read in conjunction with the following Trust polices:
   
   - Admission Policy

   In addition it is the responsibility of clinical staff to be aware of and adhere to the record keeping standards as set out by their professional body.

4. **PROCEDURE**

4.1 **Pre Admission.**

   All referrals for a mental health assessment go to the Trust Crisis and Access Teams and as part of this assessment the clinical staff will in line with the level of identified clinical risk consider the least restrictive way in which to provide treatment to any patient identified as requiring an episode of care.

   If it is felt that the patient requires an episode of inpatient care the assessing clinician will contact the Bed Manager for the local acute admission unit to ascertain if a bed is available.

   At the time of requesting the bed the Access Team clinician will provide the following information:

   - Patient personal details.
   - Legal status of the patient.
   - Patients’ capacity to consent to the admission.
   - Whether or not the patient is already known to service (this will allow the ward staff to gain further detail from the patients electronic record).
• Reason for admission.

• Current clinical risk profile of the patient. Any physical care needs (this will allow any required adjustments to be made to the ward area or aids such as wheelchairs to be obtained).

• If known details of any advance statement, or WRAP that the patient has in place.

• Current medication.

• Expected time of patient arrival on the ward, and who will be accompanying them.

4.2 Documentation to be Completed by the Access Staff

Where possible the access staff should complete the following documentation:

Patients already known to a treatment team;

• Update the FACE clinical risk assessment on Silverlink to reflect the change in the patient’s clinical presentation and risk profile. Consideration should also be given to how admission to the ward will impact on any identified risks.

• If necessary update the Full Health and Social needs assessment to reflect any changes.

• An MCA1 in relation to the patients’ capacity to consent to the admission.

• Recluster the patient to reflect the deterioration in mental health and increase need which led to admission. (cluster 14 will be the appropriate cluster for most inpatients)

Patients who are new to Service

• Full Health and Social needs assessment.

• FACE clinical risk assessment.

• An MCA1 in relation to the patients’ capacity to consent to the admission.

• Complete the Clustering tool. (cluster 14 will be the appropriate cluster for most inpatients)

• Check MAPPA status and if subject to MAPPA make a record on the
alert section of the clinical record and notify MAPPA of the admission.

If the admission is outside of normal working hours and the Access clinician has to attend another assessment it will be agreed with the bed manager as to whether or not the ward clinicians will take information over the phone and complete the Full Health and Social needs assessment and FACE clinical risk assessment, or if these documents will be completed at a later time (but before the end of their shift) by the clinician in the Access Team.

However in all cases the Access clinician will complete the MCA1 in relation to the patient’s capacity to consent to the admission.

If the patients’ first language isn’t English the ward staff are to be informed of this so that arrangements can be made for an interpreter to be present during the patient’s admission and orientation to the ward.

4.3 Action on Patient’s arrival to the Ward

All staff involved in the patients admission need to be mindful of the fact that admission to hospital can lead to an increase in the level of stress /distress being experienced by the patient and that the provision of timely information and support can help to alleviate this. However staff should not feel that they need to provide everything to the patient as soon as they arrive on the ward as this can make them feel overwhelmed. In view of this whilst there are some aspects of the admission which need to be completed as soon as is practical it is acceptable for other parts of the admission process to take place over a 72 hour period.

The actions below have been split between time frames but can be adapted to meet individual patient needs.

On Admission or as soon as Practical

- Contact the on call Doctor and notify them of the patient’s arrival on the ward.

- Ask the patient if they have brought any of their prescription medication with them. If yes remove and store in treatment room so that the Doctor can check the prescription as part of the medicine reconciliation process.

- Multi-disciplinary admission record to be completed. Including the physical health and wellbeing and physical examination section. Other than the physical examination section this document can be completed by either the Nurse or Doctor .In the event that any sections on the document cannot be fully completed a note is to be made as to the reason why and arrangements made for it to be revisited for completion
the next day, and no later than 48 hours following admission.

- Medicines reconciliation form to be completed.
- MCA 1 and where indicated the MCA 2 to be completed for the prescribed treatment.
- Prescription to be completed for current medication.
- If the patient has any allergies this must be recorded on the patients prescription chart and an alert put onto the electronic patient record.
- Complete the consent to share information sheet. This is important as staff involved in the patients care need to know what information the patient is happy or not to be shared with their relatives /friends. In the event that a patient declines consent this must be recorded on the sheet and arrangements made for the decision to be revisited at regular intervals throughout their stay on the ward. Following each discussion with the patient about the sharing of information with their relative/friend an entry is to be made in the patient’s clinical record.

- An admission care plan is to be put in place to cover the patients’ orientation to the ward and to allow clinical staff time to undertake a more detailed assessment of the patients’ clinical presentation and care needs. However it is only an interim care plan to cover the first 72 hours of a patient’s admission and after this time it is to be discontinued and more detailed care plans put in place.

- Where needs and risks have been identified at the point of admission care plans are to be put in place. Where possible these are to be formulated in conjunction with the patient and signed by them. The patient is to be offered copies of their care plans to keep in their “My care folder”. If the patient declines or is not well enough to be involved in the development of their care plans a record of this is to be made in their clinical record.

- MRSA risk assessment to be completed.

- Where clinically indicated the following are to be completed a:
  
  - MUST
  - Choking risk assessment.
  - Falls risk assessment.
  - Moving and handling risk assessment.

For any patients who are known to have been under the care of another Mental Health provider ward staff are to make a request through the
Trust Information Governance Department for copies of their clinical records to be forwarded to the ward so that they can be reviewed to inform decision making around future care and treatment.

The admitting nurse should also ascertain if the patient requires a Fit Note. If yes the patient is to be asked if they wish to submit it to their employer or want ward staff to do it on their behalf. The date for when a further Fit Note needs to be issued is to be recorded in the ward diary.

In the event that a patient is admitted with the same or a similar name to an existing patient an alert to this effect is to be placed on the electronic record of both patients Patient identification can be undertaken in a number of ways, and these are clearly set out in the Trust Patients Identification Policy.

**Patient Identification**

Within the mental health inpatient services it has been agreed that as patients often have periods of leave from the ward areas as part of their treatment plan they will not be routinely asked to wear wrist bands. In view of this the preferred method of identification is through the use of photographs attached to the inside of the patients prescription chart and all wards have been issued with digital cameras and printers.

As part of the admission process the admitting Nurse is responsible for:

- Gaining the patients consent for a photo to be taken, and recording this on the relevant section of the admission assessment.
- Taking, printing and securely attaching the photo to the inside of the patient’s prescription chart.
- Recording the patients name and date of birth onto the back of the photo.
- As part of the initial risk assessment, where a patient has cognitive problems determining if there is also a need for the patient to wear a wrist band.

**4.4 Specific Requirements for Patients Admitted who are Subject to Detention under the Mental Health Act 1983.**

In the case of a patient admitted to the ward who is subject to detention under the Mental Health Act 1983 the Nurse in Charge of the ward at the time of the patients admission should be in receipt of the original detention papers which relate to that patient. Once the legality of these section papers has been confirmed the Nurse in Charge of the ward must complete a form H3 to formally receipt and accept the detention on behalf of the Hospital Mangers. An attempt must then be made to explain the patients legal rights to them, and a form 14a completed. In the
event that the patient refuses to have their legal rights explained to them or if they lack capacity at the time of admission arrangement must be made for further attempts to be made, and this will be recorded on the form 14a and an entry made in the patients clinical records to this effect.

Staff should refer to the following Trust Procedure for the receipt and scrutiny of section papers and the procedure for informing detained service users of their legal rights under section 132 of the Mental Health Act 1983 for full details.

4.5 RAG Rating

On arrival to the ward all new patients are to be RAG rated as Red. This rating will remain in place until a review at 72 hours or at the patient’s first Multi- disciplinary review. The RAG status for the patient is to be recorded in both the clinical records and on the ward patient information board.

4.6 Orientation and Provision of Information to the Patient

All new admissions to the ward are to be met on arrival and shown to their bedroom and provided with a copy of the admission information pack. The patient is to be shown the personal safe which is available in their room and advised that any items of value are either sent home with relatives or stored in the personal safe at all times. It must be made clear to the patient that should they chose to leave any of their valuables unattended at any time the Trust will not be liable in the event of the items being misplaced.

Once the patient has unpacked they are to be orientated to the ward, informed of the ward routine including meal times, availability of hot drinks, smoking policy, visiting times, use of mobile phones, and how to access the advocacy service.

4.7 Information to Carers

If the Cares haven’t attended the ward with the patient and the patient consents staff are to phone the cares and inform them of the admission.

At the earliest opportunity the patient’s Carers/family are to be provided with a copy of the Carer’s information pack. Ward contact number and name of the allocated named nurse.

If not already done the Carers are to be asked if they wish to be referred for a Carer’s assessment. If yes the referral will be made by the ward staff.

The provision of written information to Carers helps to inform their decision making so it is important that they are provided with up to date and relevant information (subject to the patients consent). When an information leaflet
is given to a Carer it is to be recorded in the patient’s clinical record and a note made of the leaflet number/reference number. This will enable the service to track the leaflet should there ever be a query raised around it at some point in the future.

4.8 Searching of a patient.

Within the Trust the searching of a person or their property is not undertaken routinely and as such should only be carried out in exceptional circumstances, for example, where the dangerous or violent criminal propensities of patients create a self-evident and pressing need for additional security (Code of Practice Mental Health Act 1983, section 16.12 (Dept. of Health, 2008)), or if it is suspected that the patient may have illicit substances or prescription drugs about their person. In such circumstances nursing staff have a statutory duty to provide both a safe and therapeutic living and working environment for patients and staff and to protect the public. Therefore searches are an essential and justifiable component for safe practice. In the event that a decision is made to undertake a search on a newly admitted patient’s staff are to refer to the Trust Policy and Procedure for the Searching of a Person (Patient and Visitor) or their property.

Removal of any illicit drugs or alcohol

- **Alcohol removed from the patient**
  It is to be made clear to the patient that alcohol is not permitted on the inpatient wards. Any alcohol the patient on their person will be disposed of by 2 staff members with the patient present, if they wish. The alcohol will be poured down the sink and the bottles/cans safely disposed of. A record is to be made in the clinical records indicating what was disposed of and by whom.

- **Prescription/over the counter drugs removed from patients**
  Any medicines brought into hospital by a patient remain their property and will not normally be destroyed or otherwise disposed of without their agreement.

  In the event that the patient is unable to consent to the disposal or not of these medicines agreement can be sought from their carer.

  If the patient/Carer refuses to agree to the disposal of the medicines they can either:

  o Be held in a sealed bag in a separate section of the medicines cupboard from all other stock until they can be returned to the patient on discharge.
Or

- If the patient insists; be returned home.

However, the patient and or their Carer must be advised that as the treatment regime will be reviewed whilst the patient is on the ward it is likely that the supplied discharge medication will be different, and that this may pose a real risk that the wrong medication may be taken in future.

If there are safety concerns in relation to the medication being returned home, the Nurse in Charge in consultation with the Consultant Psychiatrist may make a decision to refuse to return the medicines and have them destroyed.

For the safe disposal of any medicines, staff should refer to the guidelines issued by their supplying pharmacy.

All actions taken should be fully documented within the patient’s clinical record.

- **Suspected Illegal Drugs**
  The Trust does not condone the use of illicit substances and in accordance with its duties under the Misuse of Drugs Act (Home Office 1971) will not knowingly permit the use of or dealing in illicit substances on its premises.

Any illicit substances found on patients will be:

- Placed in an envelope.
- An entry will be made in the controlled drug register under the heading of unidentified substance.
- The envelope will be labelled with a reference number linking it to the entry in the controlled drugs register.
- The envelope will be sealed. Both the Nurse in Charge and the witnessing staff member will sign and date across the sealed flap of the envelope.
- This envelope will then be locked in the ward controlled drug cupboard. In order to maintain patient confidentiality their name will not be documented in the controlled drug register.
- The Chief Pharmacist, Accountable Officer for Controlled Drugs should be notified of the unknown/illicit substance as soon as it is practicable and arrangements will be made for the removal and safe disposal of the substance by the Trust Pharmacy Department.
- If staff involved in the removal of illicit substances from a patient have reason to suspect that the quantity involved is greater than for personal use advice should be sought from the Modern Matron with regard to the need for the matter to be reported to the police.
NB Under no circumstances will any suspected illicit substances be returned to the patient.

If the patient refuses to hand over the illicit substance for destruction they are to be placed on 1-1 nursing observation and the need for further action, including searching will be discussed with the Modern Matron and the patient’s Consultant Psychiatrist.

- All actions taken will be recorded in the patient’s clinical record, or in the case of a visitor, on the ward report.
- An Electronic Incident Form (IR1) will be completed and submitted for all incidents.

4.9 Named Nurse Allocation

All patients admitted to the ward will have an allocated Named Nurse who is responsible for the coordination of their care and liaising with other agencies/family and Carers during the patient’s episode of inpatient care.

Where possible for continuity purposes it is desirable that the admitting nurse takes on the role of named nurse, but if this is not possible for any reason another nurse is to be allocated. However when allocating another named nurse it needs to be made sure that the allocated nurse is not:

- Due to go on a period of leave
- Away from the ward for an extended period due to study leave or long term sickness.
- Due to go on an extended rotation of night duty.

The patient is to be notified as to who their allocated named nurse is and when they will next be on duty.

The above bed information board is to be updated with the name of their named nurse and Consultant Psychiatrist.

4.10 Informing other workers/agencies of the patient’s admission

It is the responsibility of the nurse completing the admission of the patient to inform any other relevant parties involved in the care of the patient that they have been admitted to the ward. Whilst this is not an exhaustive list people needing to be informed of the admission could include:

- The patients General Practitioner.
- Home Carers including meals on wheels.
- The Care Coordinator.
4.11 **Obtaining specialist advice**

There may be times when a patient is admitted who has specialist needs and in these cases staff should contact the relevant Trust advisor. Examples of this could be manual handling, infection control, fire safety and adult or children safeguarding issues. In these cases staff should contact the relevant specialist within their locality to gain advice and support around the development and implementation of the agreed plan of care.

4.12 **Involvement of Carers in care planning**

Carers should where possible be involved in the care planning process throughout a patient’s episode of inpatient care, and agreement for this involvement should be sought from the patient at a time when they have the capacity to provide informed consent. The involvement of Carers is key to safe and effective leave and discharge planning.

4.13 **Care planning when patients decline or lack the capacity to be involved**

There may be times during a patient’s episode of care and particularly at the point of admission when the patient may either decline or lack the capacity to be involved in the planning of their care. In these circumstances staff are to clearly document in the patients clinical records why the patient has not been involved in the development of their care plan.

As a patient’s engagement /capacity can change at any point during an episode of care it is important that staff make ongoing attempts to involve the patient. All further attempts to engage the patient are to be recorded in the patients’ clinical records.

4.14 **Advance Decisions /Statements**

Some patients who have had previous involvement with the mental health services may have made an advance statement /decision of their wishes in-respect of their care and treatment should they ever require a future episode of inpatient care.

Staff should refer to the Trust Policy for Advance Directives and Advance Decisions for full details but below are the definitions.

**Advance Statements** – It is a general statement of a person’s wishes and views. People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of mental capacity. It can reflect their religious beliefs or other beliefs that they have and allows the person to state how they would like to be treated should they not be able to communicate their wishes in the future. Advance Statements can be used to nominate a person to be consulted with at a time a decision has to be made.
although at present their view is not legally binding. However, if the nominated person has also been granted Lasting Power of Attorney to make personal welfare decisions, the decision of the person with Lasting Power of Attorney will be binding. Advance Statements can also be used to inform health professionals of how they would prefer to be treated medically.

Whilst an Advance Statement does not bind doctors and professional staff to a particular course of action if it conflicts with their professional judgment or if the treatment preferences described are not considered appropriate or necessary (e.g. taking into account available resources), it is important to consider an Advance Statement when planning care and treatment.

**Advance Decision** – Advance Decisions are governed by the Mental Capacity Act 2005 and relate to refusals of specified treatment if specified circumstances arise in the future at a time when the person no longer has mental capacity. Advance Decisions are sometimes known as ‘advance directive’, ‘advance refusal’ or ‘living will’. However, the statutory term is “Advance Decision” and that is the term which is used within the Trust Policy. An Advance Decision to refuse treatment can only be made by an individual aged 18 and over with capacity to make Advance care and treatment Decisions. In the event of them losing capacity in the future, a properly made Advance Decision is as valid as a contemporaneous Decision (that is, one made at that time).

There are no set formats for Advanced Decisions; they can be written, witnessed oral or written statements, printed cards or notes of a discussion recorded in the clinical record. All versions are acceptable but the important element is that the Advance Decision is clear and unambiguous. A valid Advance Decision which is applicable to the circumstances which arise is legally binding in the same way as a contemporaneous refusal by a person with capacity. Professionals may be legally liable if they treat a patient in the face of a valid and applicable Advance Decision.

**The exceptions to this are:**

- That refusal of life sustaining treatment must be in writing (and must comply with a number of other requirements as set out in the Trust policy).
- Advance Statements and Advance Decisions to refuse medical treatment cannot be used when the patient has the capacity to consent to or refuse the proposed treatment.
- That the terms of the Mental Health Act 1983 take precedence and prevail over Advance Decisions when it comes to treatment for mental disorder.

In the event that a patient’s wishes as stated in their advance statement/decision cannot be met the Consultant Psychiatrist in charge of the
patients care is where possible to have a full discussion with the patient
the outcome of which is to be recorded in the patient clinical record
along with the rational for why the patient’s wishes could not be respected.

4.15 WRAP (Wellness, Recovery, Action planning)

The Wellness Recovery Action Plan is a framework which allows patients to
develop an effective approach to overcoming their distressing symptoms,
and unhelpful behaviour patterns. WRAP was originally developed by Mary
Ellen Copleeland and a group of mental health service users who wanted to
work on their own recovery and is increasingly being used by patients who
are under the care of the Trusts Mental Health services.

A WRAP is developed and belongs to the patient and it is up to them to
decide how and when to use it. If a patient has a WRAP in place clinical staff
should discuss with them how best to use it to inform care planning during
their inpatient stay.

For patients who are not familiar with WRAP the occupational therapy staff in
the localities run WRAP groups and patients should be encouraged to attend
these so that they can get the information to make a decision as to whether
or not developing a WRAP would be useful for them.

4.16 Recording Third Party Information

It is important that the source of any information contained within a
patients clinical record can be identified, therefore when recording any
information which has been provided by a third party clinical staff are to
state at the start of the entry who has provided the information to them
and whether or not the information was provided face to face or over the
phone.

4.17 Information Which is for Non-Disclosure

There may be occasions during the course of a patient’s episode of
care when sensitive information is disclosed to staff. Sometimes this
information is provided with express instructions that it is not to be
disclosed to the patient i.e. if it forms part of a police or safeguarding
investigation, or the clinical team may feel that disclosure of the information
could be detrimental to either the mental health of the patient or safety of
another person. In these situations staff should.

- **Information provided with the express instruction that it is not to be disclosed** - Record at the start of the entry in **bold** that the
  information contained in the entry is not for disclosure. The clinician
  should then detail who provided the information and the reason why it is
  not to be disclosed.
• **Information that could be detrimental to the mental health of the patient** - Record at the start of the entry in **bold** that the information contained in the entry is not for disclosure without discussing with the patients lead clinician first. This is due to the fact that information which may be detrimental to the patient at the point of care when the entry is made may not be detrimental at a later date so the decision needs to be kept under review. The clinician should then clearly state why the information could be detrimental to the patient.

• **Information provided which if disclosed could pose a risk to the safety of another person** - Record at the start of the entry in **bold** that the information contained in the entry is not for disclosure. The clinician should then detail who provided the information, the reason why it is not to be disclosed, who would be at risk should disclosure occur, and what the nature of the risk is.

4.18 **Recording of Safeguarding Children Information**

It is important that staff identify any children that a patient may have parental responsibility for or access to. This is to be documented on the health and social needs assessment and any risks posed taken into account on the clinical risk assessment and in the case of identified risk a risk management plan is to be put in place.

In addition to this where there is regular contact with a child this needs to be taken into account in the planning of the patients care, with particular attention to:

The arrangements for children to safely visit whilst the patient is receiving a period of inpatient care. (staff should refer to the Trust Policy on the visiting of patients on the inpatient areas).

• A care plan is to be put in place to provide guidance to staff around the arrangements for when a child visits.

• Any increased risk to the child if the patient is being considered for leave from the ward.

• Any increased risks/ required support when plans are being put in place for the discharge of the patient.

Due to the sensitive nature of the information which is shared between agencies around safeguarding children it is important that any entries made in the patients clinical record relating to safeguarding investigations or case conferences are very clearly marked as highly confidential and sensitive.
4.19 **Recording of Safeguarding Adults Information**

With regards to clinical record keeping and safeguarding adults it is essential that staff:

- Maintain contemporaneous records of all observations, actions and discussions. It is important that all records are based on factual observation and not opinion.

- Develop a care plan in conjunction with any other services involved in the investigation to address any concerns and immediate risks to the vulnerable adult or others. The care plan should clearly state what the risks are and clarify who can visit and any specific arrangements needed to safely facilitate the visit.

4.20 **Admission of an Under 18**

The standards within this standard operating procedure apply regardless of the patient’s age. However in the case of an under 18 staff must also refer to the Trust policy for the provision of an age appropriate environment and guidelines to inpatient staff on the care and treatment of patients under the age of 18.

4.21 **Admission of Patient with Identified Dual Diagnosis Needs**

The standards within this standard operating procedure apply regardless of a patients identified needs. However as appropriate staff should also refer to the following for on of an age appropriate environment and guidelines to inpatient staff on the care and treatment of patients under the age of 18.