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NHS Sussex Partnership NHS Foundation Trust

Acute Adult Inpatient Mental Health Service Operational Policy

Department of Psychiatry – Eastbourne District General Hospital

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Key Policy Issues:

- Values and Philosophy
- Acute Care Pathway
- Standards
- Transfers and Discharges

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Department of Psychiatry – Eastbourne District General Hospital
Operational Policy

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1.0 Introduction

Department of Psychiatry (DOP) – Eastbourne District General Hospital (EDGH)

The DOP is a 54 bedded acute inpatient hospital. The 54 beds are divided between 3 wards, Amberley and Bodiam (working age) and Heathfield (integrated adult ward). Each ward caters for a single gender population. Accommodation is in either dormitories or single rooms without en-suite facilities.

The DOP provides multi-disciplinary care and treatment to adults with acute mental health need. The unit places a strong emphasis on the delivery of high quality evidence based care with an emphasis on wellbeing and recovery delivered within the least restrictive environment required to support the provision of safe and therapeutic care. Patients and carers are encouraged to take a full and active part in their treatment whilst in hospital.

2.0 Purpose of Acute Inpatient Care

The purpose of an Acute Mental Health service is to provide a high standard of humane treatment and care in a safe and therapeutic setting for patients in the most acute and vulnerable stage of their illness whose circumstances or needs are such that they cannot, at that time, be treated and supported safely and appropriately at home (DH 2002, Crisis Care Concordat 2014).

This policy is applicable to all acute adult inpatient mental health wards apart from Psychiatric Intensive Care units (PICU) and wards for adults with a Learning Disability who have their own Operational Policies.

3.0 Aims

Our key clinical standards are to:

- Work jointly with the Crisis Resolution and Home Treatment Team (CRHTT) to ensure that people receive the right care at the right time in the right place. *Please see CRHTT Operational Policy for a full description of their gatekeeping and facilitating early discharge functions.*

- Provide care which is holistic, person-centred and facilitates recovery focusing on the persons strengths and underpinned by humanity, dignity and respect

- Provide an environment that is welcoming, safe, clean, spacious, well decorated and furnished promoting the individuals privacy and dignity.

- Provide a sacred space and respect for people's spiritual and cultural needs.

- Ensure staff have the knowledge and skills required to deliver safe, effective and high quality care.

- Ensure that each service user has:

  - A Responsible Clinician/Consultant Psychiatrist
  - A named nurse / team
  - A comprehensive collaborative assessment of their mental and physical health needs and risks that reflect their diverse and unique needs

- A collaborative personalised care plan that addresses the identified needs and risk or any advanced statements that have been made by the service user
- Access to an Occupational Therapist and Clinical Psychologist
- A therapeutic day, which incorporates a range of psychological and recreational interventions
- Access to advice and support from a Mental Health Act Administrator when an individual is detained under the Mental Health Act 1983
- Medication reconciliation completed and has access to advice and support regarding their medication management via their named nurse or individual time with the Doctor or Pharmacist/Pharmacy Technician
- Daily 1-1 time with their allocated worker

* Ensure that risk assessments and care plans are reviewed if there is a change in presentation or circumstances

* Provide evidenced based assessment and interventions underpinned by the implementation of NICE guidelines for Schizophrenia; Depression; Self Harm; Short Term Management of Violence and Aggression; Physical Health Care, Borderline personality disorder: recognition and management and Bi-polar Affective Disorder

* Hold regular Multi-Disciplinary Team (MDT) clinical care reviews that fully involve the person (and their carers where appropriate) to monitor the effectiveness of the interventions to date and to plan for discharge from the point of admission

* Work closely with Adult Social Care to ensure that the social care / health interface is managed to achieve the best service for the person using the service.

* Make available and promote information and resources for service users and carer(s), which is accessible and available in alternative formats such as easy read and large print upon request

* Promote local Carers Group and liaison with the Carers Support Service

* To work with a range of advocacy services to ensure service users rights are fully respected

* Ensure a second opinion from another Consultant Psychiatrist can be sought at any stage at the discretion of the treating Consultant Psychiatrist

* To ensure that a Care Programme Approach (CPA) meeting is held prior to all discharges from the ward; when an individual is discharged they will be given a copy of their discharge care plan which will include information on how to access help in the event of a crisis. Relevant information will be shared with other teams/services/GP involved in their care with 1 working day

Our key performance standards are

* Average length of stay for a person over 18 and under 65 of 28 days

* Average length of stay for a person over 65 of 50 days

* Every person admitted and discharged will have their Health of the Nation Outcome Scale (HoNOS) score and Payment by Results (PbR) cluster reassessed and recorded

- All service users will receive a primary diagnosis from the Consultant Psychiatrist using the International Classification of Diseases (ICD) 10 coding convention

- Delayed transfers of care maintained at below 7.5%

- At the point of discharge, the G.P, service user and community team will be informed of the service users medication through the use of the Kent Surrey and Sussex electronic Discharge Notification and Prescription sheet

- All patients will be followed up within guidance standards within 7 days of discharge (see appendix 5)

The Good Practice Guidelines (Appendix 2) incorporates the standards into every day practice.

4.0 Configuration of the Wards

The DOP meets the national guidelines for a modern, safe and therapeutic environment. The Hospital consists of 3 wards. Heathfield ward is an 18 bed older adult ward for women who are over the age of 65 but can take people below this age if suitable. Amberley ward is an 18 bed female ward and Bodiam ward is an 18 bed male only ward.

Heathfield ward is on the ground floor, sleeping accommodation is a mixture of single rooms and dormitories. Service user accommodation for Amberley and Bodiam is split between two floors. The sleeping accommodation and main ward areas are on the first floor and comprise of a mixture of single rooms (not en-suite) and dormitories. Each ward has a kitchen area and lounges. There are shared communal areas on the ground floor including a dining room, lounge area and internal courtyard garden.

The Mental Health S136 Place of Safety Suite is based on the ground floor, and covers Eastbourne and the surrounding areas (Please see S136 local protocol for exact geographical boundary).

5.0 Eligibility Criteria

5.1 Working Age wards

- Amberley and Bodiam Wards are designed to address the acute mental health needs for a designated Working Age population
- People admitted will be normally over the age of 18 and under the age of 65 (can admit older adults if clinically appropriate)
- When all alternatives to admission have been explored and excluded due to the needs of the person requiring admission
- For assessment and treatment of an acute mental disorder
- The person can be safely managed in the unit

In most situations, the following will not be suitable for admission to this hospital:

- People whose primary diagnosis is one of organic illness, acquired brain injury or substance misuse
- Mothers with mental health problems whose baby needs to stay with them
- Young people under the age of 18

5.2 Older Persons' ward

- Heathfield Ward is designed to address the acute mental health needs for a designated Older Persons OPMHS population
- People admitted will be normally be 65 years and over
- Younger people aged below the age of 65 years are admitted for assessment and treatment if clinically appropriate
- When all alternatives to admission have been explored and excluded due to the needs of the person requiring admission
- For assessment and treatment of an acute mental disorder
- The person can be safely managed in the unit

In most situations, the following will not be suitable for admission to these wards:

- People whose primary diagnosis is one of organic illness, acquired brain injury or substance misuse
- Mothers with mental health problems whose baby needs to stay with them
- Young people under the age of 18
- People who may present with aggressive and or threatening manner which may require intervention either through medication or a low stimuli environment

6.0 Acute Care Pathway

6.1 Prior to admission:

The service user is seen and assessed by the referrer within 24 hours leading up to the request for admission. The admission to the DOP needs to be for the assessment and treatment of an acute mental health problem.

6.2 Crisis Resolution and Home Treatment Team (CRHTT) and Gatekeeping

The CRHTT screen and/or assess all referrals to the acute care services and act as gatekeepers to the inpatient beds. The CRHTT have direct access to the inpatient beds. Good practice suggests this is in consultation with the Responsible Clinician (RC) and community team.

After 21:00, the Senior Nurse Practitioner (SNP) fulfils the gatekeeping role for the CRHTT as well as having responsibility for co-ordinating the appropriate use of beds and liaising with the admitting clinician about suitability.

The CRHTT conduct the 'Acute Care Screening' (Appendix 1) which initially identifies the clinical needs of the individual, the reasons for referral and current risks. This will be uploaded on Carenotes under the "assessment" tab.

An assessment of risk will be used to inform the clinical assessment. If significant risk is indicated during the Acute Care Screening then a multi-disciplinary risk strategy will be formulated before admission occurs. If risks indicate, a Psychiatric Intensive Care Unit (PICU) may need to be considered.

6.3 Bed Management

All requests for admissions are gate-kept by the CRHTT who will contact the Bed Manager or allocated person to ensure that beds are used in the most efficient and effective way.

The Bed Manager – is on duty between 09:00hrs to 21:00hrs Monday to Friday and 09:00hrs – 17:00hrs at weekends. Outside of these times, requests for beds can be made via the unit coordinator and or the SNP.

6.4 Admission

The service user and carer (when in attendance) will be welcomed and orientated to the ward, introduced to team members, explained the daily routine of the ward, and given the ward welcome and information pack.

A handover of the service user's details, current risks and mental health problems will occur between the admitting clinician/CRHTT/SNP and a qualified member of staff on the ward.

The service user will be nursed on within eyesight observations until the mental health and risk assessment has been completed.

On admission, the service user will receive a

- Comprehensive biopsychosocial assessment (Adult inpatient assessment)
- Risk Assessment
- Physical health examination and assessment, routine blood tests and baseline physical observations National Early Warning Scores (NEWS) and completion of the Body Map if clinically indicated
- Capacity assessment
- Modified Universal Screening Tool (MUST) assessment
- Falls Assessment (for all people over the age of 65 and younger people who have compromised mobility)
- Venous thromboembolism (VTE) assessment (for all people over the age of 65 and younger people who have compromised mobility)
- Reading of S132 rights (if applicable)
- Assessment of smoking status and if required nicotine replacement therapy

The following will also be completed

- An Inpatient Care Plan which will include a decision on the level of therapeutic observations
- Personal Description
- Photographing patients
- Property disclaimer
- Property check
- Carers information sharing form (under carers tab)
- Medication reconciliation – this is the process by which medication prescribed for service users on admission, corresponds to the medication they were taking before admission or were buying over the counter unless there is clear clinical justification for changing or discontinuing any of the medicines. Done correctly, this will reduce the risk of harm to patients and may help to reduce the length of inpatient stay. This will also include seeking information about the service users physical health

  In order to optimise accuracy, this needs to be a two-tier process:

Level 1 – this should be routinely carried out by medical staff for all patients on admission, ideally as part of the clerking and initial prescribing process. This must be completed within 24 hours of admission and should be recorded in the clinical notes as well as the drug chart

Level 2 – this will subsequently be carried out by pharmacy staff (pharmacy technician or pharmacist), as soon as possible after admission, and is usually more detailed. It provides a double-check of currently prescribed primary care medication and cross-checks it with the medication chart completed by the Trust doctor

It is extremely important that reliable information on medication is used and also that this comes from more than one source wherever possible, e.g. Summary Care Records, GP surgery prescribing summary, Care Home medication chart etc.

NB: Care Notes has an ASSIST button to support staff in knowing which assessments require completion. Guidance can also be found in Appendix 3 – Inpatient Clinical Process guide.

Please refer to the Clinical Risk Assessment and Safety Planning Policy, The Therapeutic Engagement and Observation Policy, The Searching Patients and their Property Policy, the AWOL Policy, the Medicines Code and Photographing Patients Policy for further guidance.

The following will also be informed of the admission:

- GP
- Community teams
- Carer if not involved in the assessment (service user permission permitting)

6.5 Inpatient Treatment

The MDT will review the care and treatment of the individual, which includes reviewing the initial assessment, mental health and risk formulation, capacity and establish any physical health issues. The planning for discharge will begin at this point with the team establishing if there are any anticipated barriers to prevent discharge in a timely manner.

Shortly following admission, the CRHTT will visit the ward to introduce themselves to the service user and explain their role. There are times this may not be appropriate and this will be discussed and agreed between the ward team and CRHTT.

The Lead Practitioner will be contacted within 2 working days of admission to discuss the events leading up to the admission and to be invited to attend clinical reviews.

Carers will wherever possible, be actively encouraged to be fully involved in the process of care.

6.6 Within the first week of admission

The MDT, which includes the Consultant Psychiatrist, will develop a mental health formulation, a working diagnosis, and care and treatment plan whilst in hospital. This will include involvement in therapeutic activity programmes, individual time with staff, specialist assessments and interventions, as well as discussing and agreeing discharge needs.

Staff should complete the "all physical health care assessment" and ensure that any identified needs are incorporated into the care plan.

Active discharge planning should begin from admission. The Primary Nurse, Acute Consultant Psychiatrist, Lead Practitioner, service user, and carer when possible, should work together to begin the discharge process and to identify early on in the admission future needs and any potential barriers to discharge.

When a service user is not known to the mental health services and it is anticipated that on discharge Community follow up will be needed this will be discussed with the relevant community team for them to allocate a Lead Practitioner.

The CRHTT will discuss with the inpatient and community teams whether the person is appropriate for supportive discharge.

6.7 Risk Management

Effective risk management is essential for the safe delivery of acute inpatient care. Risk covers the following domains:

1. Risk to self: suicide and self-harm
2. Risk to self: neglect and vulnerability including exploitation by other and sexual vulnerability
3. Medication and engagement with services
4. AWOL risk
5. Dual Diagnosis (substance misuse and mental health needs) and impact on risk
6. Risk to others: Violence and aggression
7. Risk of Slips, trips and falls
8. Risks related to Physical Health care needs
9. Protective factors
10. Safeguarding vulnerable children and adults

The risks will be assessed at the point of admission (or transfer from another ward), during regular MDT reviews and through the completion and evaluation of the care plan.

If a significant change in presentation or an increase in risk occurs, this will result in an MDT review with an appropriate plan put into place.

If an individual becomes increasingly disturbed and displays aggressive or suicidal behaviours, or attempts to leave which could result in increased risk to themselves or others, then an assessment of their immediate needs will be undertaken. This assessment will consider any environmental factors, level of risk and compliance with current care.

Please refer to Sussex Partnership's Clinical Risk and Safety Planning and the Prevention and Management of Violence and Aggression Policies for further information.

The assessed level of risk will be used to determine the level of therapeutic observation, which will be reviewed throughout the service users stay in hospital.

Please refer to the Therapeutic Engagement and Observation Policy.

6.8 Care Plans

On admission (or transfer from another ward), the identified nurse will complete the inpatient care-plan on Carenotes (see appendix 4)

For the dementia wards, a consideration of capacity is also included in the care plan.

The first section of the care plan is designed to enable staff , the service user and their carer (when relevant) to understand triggers, strengths and helpful strategies when feeling distressed or agitated.

The second section guides staff and the service user to describe the types of care required while they are in hospital, namely

- Supporting my risks
- Supporting my mental health needs
- Supporting my physical health care needs
- Supporting my social, practical and communication needs
- My Medication
- Working towards my discharge from hospital

In all cases where it is known or assessed that an individual may require physical interventions the care plan must focus on primary, secondary and tertiary interventions, including de-escalation and evidence of the service user's preferences for future restraint to support the team in the management of such behaviour (NICE NG10 – short-term management of violence and aggression).

The care plan should include any advanced decisions / statements where these are known.

The service user's perspective and goals are best written in the first person.

The care plan must be reviewed on a regular basis, wherever possible this should be weekly and must include the service user and carer if appropriate. The review of the care plan is recorded in the section 'Monitoring my Progress'. The care plan should also be reviewed and updated following an incident.

It is important that the care plan is signed and dated and that the service user is offered the opportunity to do so as well.

The service user should be given a copy of the care plan and if this is not possible then the reasons why is recorded. If the service user agrees, a copy can also be given to the carer.

All professional staff involved with the service user should add to the relevant section of the care plan.

6.9 Blanket Restrictions and access to mobile phones

The term 'blanket restriction' refers to rules or policies that restrict a service user's liberty and other rights which are routinely applied to all service users within a service without individual risk assessments to justify their application. Blanket restrictions include restrictions to accessing the internet, access to or banning mobile phones and chargers, restricting incoming and outgoing mail, including electronic mail.

The Mental Health Act Code of Practice (2015) provides clear guidance in regards to the use blanket restrictions and the use of mobile phones and mobile devices.

It is recognised that when a service user is admitted to hospital, communication and contact with family and friends is an essential element of support and comfort.

Therefore, for each service user being admitted, an individual decision will need to be made in regards to the person retaining their mobile phone.

Please refer to the Mobile Phone protocol for more guidance

6.10 Maintaining contact with community services

When a service user is known to a Lead Practitioner, in-reach into the hospital will occur from admission with the guiding principle that the Lead Practitioner's role continues regardless of the location of the service user. There is evidence that such involvement has a positive effect on reducing risk on discharge. Face-to-face contact is always preferable, but in order to compliment such visits, web-ex or telephone calls may be appropriate.

It is anticipated that a service user will remain on CPA for a relevant period post discharge until a review has taken place and it is clinically indicated that step down to standard care is appropriate.

6.11 Inpatients leaving the ward

Spending time off of the ward forms an essential aspect of care and is generally a reflection of the patients progress towards an improved state of health, and ultimately to their discharge. Any leave from mental health wards needs to be safe, therapeutic and part of a planned process.

6.11.1 Patients detained under the Mental Health Act ('the Act')

Patients detained in hospital have the right to leave hospital lawfully if they have leave of absence from their Responsible Clinician ('RC') under section 17 of the Act.

Section 17 leave allows for the RC of a patient to grant that patient leave of absence from the hospital for a specified period. The RC has no power to grant leave to patients who have been remanded to hospital by a Court under sections 35 and s36 of the Act or those subject to an interim hospital order under section 38.

The RC will take into account various factors when authorising section 17 leave, including the reason for the leave, assessment of risk, the patient's capacity around the leave arrangements and what supports the patient might need.
Where a detailed capacity assessment is required this may be completed on the Trust Capacity Assessment Form (Carenotes / Assessment tab).
Section 17 leave may be withdrawn by the RC, at any time, if they consider it necessary, in the interest of the patient's own health and safety or for the protection of others. Please refer to the Section 17 Leave Policy for more detail.
For patients who lack capacity, the MDT will need to complete a best interest statement and record on FACE assessment. Please refer to the 'Mental Capacity Act' (2005) Policy for further guidance.

6.11.2 Non-detained patients

Where a patient has consented with capacity to an informal admission then access to the community needs to be collaboratively planned with the patient, the MDT and (if appropriate) the carer.

Principles

Leaving the ward should be graded and progressive in line with the patient's condition and progress, starting with short periods from the ward, which may be accompanied, and building up to longer periods of unaccompanied time in the community preceding discharge.

The care plan will provide evidence that the potential benefits/risks of leaving the ward have been considered and will identify interventions that have been put into place to help support the patient and carer (if appropriate), during any time off the ward. A copy of the care plan will be given to the patient, carer (if appropriate) and relevant professionals.

All periods off the ward will be continually, collaboratively evaluated to ensure that the risk assessment and care plan remain appropriate and that the patient continues to receive the appropriate support whilst working towards discharge.

Where leaving the ward is not considered appropriate due to concerns about safety

If it is felt that leaving the ward would present a significant risk to the patient or others, these concerns should be discussed with the patient and carer (if appropriate) and the patient should be asked to remain on the ward. If, after that discussion, the patient remains adamant that they want to leave, and they meet the legal requirements for detention under the Act, then this must be considered.

If the patient does not meet the legal requirements for detention under the Act, and is not agreeable to remaining on the ward, then discharge or discharge against medical advice must be considered. Please see the Discharge against medical advice Policy for further guidance.

7.0 Discharge

7.1 Planning discharge

The following good practice principles apply to the discharge process:

- The Named Nurse and Lead Practitioner are pivotal in jointly planning the discharge process i.e. liaison with MDT members, carers, external agencies, development of discharge care plan including crisis planning etc.
- Clear communication systems facilitating a flow of information between the people involved in the patient's treatment/care will assist in the development of a comprehensive CPA discharge care plan.
- Follow up within 7 days is required for all service users admitted to an acute inpatient unit and planning for this should begin at admission. See appendix 2 for guidance.
- Supported discharge will be facilitated by the CRHTT and will involve liaison with the acute care MDT, service user carer and community team.

7.2 Prior to Discharge

A Care Programme Approach (*CPA*) meeting chaired by the Consultant or nominated deputy, will be held which the service user and family/carers will be invited to attend and supported to contribute. The CPA is care management for all those in contact with specialist mental health and social care services. The CPA aims to achieve effective care co-ordination in specialist mental health services through a joint framework for assessment of need, eligibility and resource allocation. Each professional involved in the service user’s care will have regular contact with the service user and an identified Lead Practitioner will be appointed if one is not already in place.

Where possible, the Acute MDT should identify an expected discharge date for the service user as soon as is practicable after admission. The provisional discharge date will be identified far enough in advance to permit the necessary arrangements to be made and required meetings to take place. It is important that throughout the service users admission that discharge and discharge planning is discussed and the ongoing care needs incorporated into the individuals inpatient care.

7 Day Follow up (CPA7) (guidance at appendix 5) must be completed.

7.3 Discharge from the inpatient ward

Wherever possible, this will occur as part of a planned process involving all relevant professionals including Consultant or nominated deputy, the service user and carers. Discharge from an inpatient ward is a clinical decision and made by the multi-disciplinary team based on clinical need. This will be summarised on the MDT review sheet, which will include a review of needs and risks.

In the event of a service user being of No Fixed Abode, the mental health and risk assessment will inform how best to arrange accommodation on discharge. This may include referral to the Council's Homeless Persons unit or local Third Sector provider of temporary accommodation.

All patients with a mental health diagnosis will be subject to CPA on discharge including patients subject to Section 117 arrangements.

At the point of discharge, the service user will be given discharge information comprising:

- Details of follow-up arrangements
- Information of any treatment/medication

The Discharge Notification and Prescription sheet will be fully completed by the Ward Doctor, including International Classification of Diseases (ICD-10) code, and sent to the GP, uploaded to eCPA.
The Lead Practitioner has a responsibility for ensuring the CPA Care Plan is reviewed during the process of discharge, which will include a crisis contingency plan and who to contact in an emergency.

7.4 Role of CRHTT in Supportive Discharge

Supportive discharge means discharge at a time earlier than would happen if intensive home treatment was not available. This is still part of an acute episode of care. Facilitating discharge is a core function of the CRHTT. The CRHTT MDT will work with the Inpatient MDT to identify patients who are suitable for Supportive Discharge. This will often occur daily during weekdays.

As part of the Supportive Discharge process, the CRHTT will meet with the service user and assess their suitability for discharge. It is expected that as part of this assessment CRHTT there will be a review of the risk assessment and development of an initial care plan to support discharge from the ward.

8.0 Substance Misuse

It is acknowledged that alcohol and substance misuse can be a common experience amongst people with complex mental health problems. This may be exacerbated by the individual's vulnerability, attempts at self-medication or other reason but it can contribute to the exacerbation of mental health problems and compromise behaviour as well as treatment and care outcomes.

With this in mind, together with the legal obligation we have towards the prevention of substance misuse, the Trust has a strict no alcohol and drugs policy. Sussex Police can be contacted to discuss any issues on substance misuse and advice about possible Police involvement.

8.1 Management of Dual Diagnosis – Substance Misuse (SMS) and Mental Health (MH) Problems

When a patient is admitted who experiences both mental health and substance misuse problems, the care team will:

- Aim to establish on admission the current level of substance misuse and the impact on a person's mental health.
- Complete a comprehensive SMS and MH assessment.
- When clinically indicated undertake regular drug/alcohol screening to support decisions about care/treatment options.
- Work with SMS providers to develop a shared treatment plans in relation to the substance misuse and mental health needs.
- Regularly review the impact on other patients of adverse behaviours due alcohol/drug misuse.
- Liaise between mental health, statutory and voluntary agencies.
- If illegal substances are used within the service police will be contacted to investigate and respond with regard to the legal aspects of substance abuse

9.0 Medical Emergencies

9.1 Life Threatening

1) Call **2222** for emergency assistance
2) Nursing and medical team to implement appropriate lifesaving interventions pending arrival of the crash team
3) Nurse to be allocated escort patient to A&E Department
4) Nurse-in-charge to:

    a) Inform duty Doctor, Consultant, On-call Manager and Next of Kin.

b) Complete the ‘Transfer to General Hospital’ form
c) Conduct de-brief meeting and support staff/service user
d) Complete incident form
e) Inform Ward Manager/Matron
f) Document in clinical notes

Please refer to the Transfer of Sussex Partnership Patients to a Local General Hospital Policy for further information.

9.2 Non-life threatening and requiring A&E

1) Nursing and Medical team to assess and treat as necessary
2) Nurse to organise safe transfer with nurse escort to A&E Department
3) Nurse-in-Charge to inform Duty Doctor and complete incident form
4) Document in clinical notes

9.3 Non-life threatening but not requiring A&E

1) Contact ward or duty Doctor
2) Implement appropriate intervention
3) Complete incident form
4) Document in clinical notes

10.0 Psychiatric Emergencies

If a service users behaviour is becoming increasingly unpredictable and dangerous, either to themselves or others, a review of risk will take place. The staff will apply a range of de-escalation measures, but if an increase in medication or rapid tranquilisation is assessed to be appropriate the Ward/Duty Doctor to be contacted. Nursing staff and prescribing Doctor will seek advice from Consultant or nominated deputy on call for rapid tranquilisation.

Where possible any decision to transfer a service user to a safer area will be made jointly by medical and nursing staff. The Consultant or nominated deputy should be kept informed.

In an actual or potentially violent situation, PICU facilities may be necessary by the Nurse-in-Charge. Where the situation is assessed to be unmanageable, the Police will be contacted. The senior nurse on duty will facilitate a forum for defusing as soon as possible after the event. Where possible any decision to transfer a service user to a safer area will be made jointly by medical and nursing staff. The Consultant or nominated deputy should be kept informed.

Further information can be found in the Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policies..

11.0 Safeguarding Children and Adults

Safeguarding Children

The Children’s Act 1989/ 2004 and ‘Working together to Safeguard Children’ (HM Government 2015) sets out the grounds for the protection of children at risk and those in “need”.

The welfare, risks and needs in respect of children are legally paramount and must be considered and evidenced as part of any assessment. Any referrals to Local Authority Children's services regarding a child protection concern will be copied to the Trust's relevant locality named nurse for safeguarding children.

Please refer to the Trust's Safeguarding Children Policy for further details and guidance.

Safeguarding Adults

Having policy and procedures to safeguard adults is a legal requirement and something which ensures better proportionate, timely and professional approach is taken when vulnerable adults are at risk. Staff will follow the Sussex Multi-Agency Policy and Procedures for Safeguarding Vulnerable Adults.

12.0 Visiting

The hospital visiting times are:

- Amberley and Bodiam 4pm until 9pm Mon to Friday and 10am till 9pm weekend and bank holidays

- Heathfield 3pm until 9pm and 10am until 9pm weekends and bank holidays

These are published throughout the hospital and service users, carers, friends and relatives are requested to follow these. However, it is recognised that for some people, the planned times are not suitable and these can be varied with prior knowledge and agreement with the ward staff.

In line with national guidance, children and young people under the age of 18 are not permitted to visit the ward. To ensure families can remain in contact, the DOP has a dedicated Family room for people visiting with children.

Where the visits are found to be having a detrimental effect upon the service user's recovery and wellbeing or where staffs assess the visits to increase risk, the visitors should be counselled and advised of the impact of the visit or their behaviour.

In exceptional circumstances where the service user's wellbeing is compromised and/or where staff are threatened, the Trust reserves the right to stop the visitor/s coming on site.

13.0 Record Keeping

Clinical records are electronic based through Carenotes, which is shared Trust wide and available 24 hours a day.

An ASSIST bar has been incorporated into Carenotes so the admitting clinicians can see which assessment/documents need to be completed as part of the admission process.

14.0 Staffing within the DOP

The DOP is staffed by a multi-disciplinary group of professionals, supported by administrative and housekeeping staff.

Components of the ward teams are:

- Ward Manager
- Charge Nurses
- Staff Nurses
- Nursing Assistants
- Consultant Psychiatrist and Junior Doctor
- Occupational Therapists
- Occupational Therapy Technicians
- Psychologist (shared resource)
- Ward Administrator
- Pharmacist/Pharmacy Technician (shared resource)
- Housekeeping staff

In addition, the hospital provides a range of staff to support the clinical teams:

- Matron
- Hospital Administrator
- Chaplain
- General Manager (shared resource)
- Mental Health Act Administrators
- Medical Secretary
- Therapeutic Activities Worker
- Receptionist
- Mental Health Advocates
- Bed Manager

Staffing skill mix is maintained at a level to provide safe care. The staffing ratio for each ward is regularly reviewed according to assessed needs, dependency and therapeutic observation levels. These are regularly monitored and can be altered to meet the needs of he patients and demands and expectations placed upon the staff.

15.0 Training and Development of Staff

We recognise that the staff are our most important asset and their continued development is essential if we are to provide a high quality service. All inpatient staff will receive an induction and are required to complete training in keeping with the Mandatory Training and Induction Policy. In addition, there is a commitment to their development of staff and their education through the use of:

- Annual appraisals
- Professional training programmes
- Preceptorship programme
- Clinical and managerial supervision
- Reflective practice groups
- Role specific development / apprenticeship programmes
- Input and support from service user and carer groups and members
- Continued Professional Development including revalidation processes for qualified nurses
- The care certificate for HCAs
- Application of the Code of Conduct for HCA's

16.0 Equality, Diversity and Human Rights

Sussex Partnership NHS Foundation Trust is committed to being an organisation, which promotes equality of opportunity and is free from unlawful discrimination on any grounds in line with the Equality Act 2010.

Our aim is to achieve a service that will be truly representative of all sections of society where patients feel safe and their dignity is respected. The Trust provides equality and fairness for all in our services and we do not discriminate on grounds of:

- Gender (including sex, marriage and civil partnership status, pregnancy, maternity, gender re-assignment)
- Race (including ethnic origin, colour, nationality and national origin)
- Disability
- Sexual orientation
- Maternity
- Religion, religious beliefs and similar philosophical beliefs
- Age

Respecting the rights of the individual service user and balancing those rights and responsibilities of the staff looking after them has always been an integral part of the delivery of mental health services. The Human Rights Act 1998 is a law that came into force in October 2000. From this date for the first time, it has made it unlawful for any public authority, in this case Sussex Partnership, or any of its staff to breach many of the fundamental rights and freedoms contained in the European Convention on Human Rights.

17.0 Development, Consultation and Ratification

This policy has been consulted upon with a range of stakeholders including the MDTs, Service Directors, Clinical Directors, Nurse Consultants and other clinical staff working in inpatient services. This policy has been ratified by the Clinical Policy Forum and the Acute Care Forum. This policy has been subject to on-going review, since its inception following the publication of NICE guidance on observation practice, based on the experience of care-face staff in its use and implementation.

18.0 Monitoring Compliance

Good practice suggests that regular and frequent audits of compliance with this policy will be undertaken. These will be undertaken by the Matrons and Ward Managers in collaboration with their locality clinical audit lead – as a minimum these audits will be on an annual basis.

The audits will ensure that all staff in inpatient settings have received training on the implementation of the policy and procedure.

This policy will be reviewed every two years to ensure that any audit findings, trends or lessons revealed through patient and staff related Incident reports and their associated action plans are addressed. Reviews will also take account of changes in national standards, policies and guidance.

The monitoring of compliance will also include reviewing and updating the Care Quality Commission's Key Lines of Enquiry (KLOE) self-assessments. The review utilises the results of various audits, patient and carer feedback, CQC, Mental Health Act visits, learning from serious incidents and complaints. This information will assist in the future development of the services.

19.0 Dissemination and Implementation of Policy

The Policy team will place updated versions of this policy on the trust's intranet. The Trust's Partnership Bulletin will alert stakeholders to the issuing of the policy and any subsequently revised versions. Matrons will ensure that clinical staff are alerted to the issue, reissue and review of versions of this policy and that training requirements – as set out in section 15 of this policy – are complied with.

20.0 References

- DH Everybody's Business: modern standards and service models (*NSF*)
- Nursing and Midwifery Council (2015) Code of Professional Conduct: Standards for conduct, performance and ethics, available from the NMC www.nmc-uk.org
- Sussex Multi-Agency Policy and procedures for Safeguarding Vulnerable Adults (2015)
- Sussex Child Protection and Safeguarding Procedures (2016)
- General Medical Council Code of Conduct (2010)
- Mental Health Act (Code of Practice 2015) 1983- amended 2007
- Mental Capacity Act including the Deprivation of Liberty 2005 (Code of Conduct 2007)
- DH (2002) Mental Health Policy Implementation Guide. Adult Acute Inpatient Care Provision
- DH (2009) New Horizons – Towards a Shared Vision for Mental Health – Consultation
- DH/Home Office/NHSE – Crisis Care Concordat (2014)
- NMHDU (2009) Working together to provide age appropriate environment and services for mental health patients under the age of 18
- NICE (2004) Self-Harm The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care
- NICE (2006) Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care
- NICE (2009) Borderline Personality Disorder – recognition and management
- NICE (2009) Depression in Adults – recognition and management
- NICE (2009) Psychosis and schizophrenia: management
- NICE (2013) Self‑harm
- NICE (2017) Short Term Management of Violence and Aggression
- HM Government. Working together to safeguard children (2015)

21.00 Cross-Referenced Clinical Policies

- Absent without Leave (AWOL) policy
- Child Visiting policy
- Clinical Risk Assessment and Safety Planning Policy
- CPA policy
- Eliminating Mixed Sex Accommodation, maintaining safety, privacy and dignity
- Food and Nutrition Policy
- HCA Code of Conduct
- Information for Detained Patients (S132) Policy

- Mandatory Training and Induction Policy
- Medicines Code
- Mental Capacity Act Policy
- Mobile Phone Policy
- NEWs Protocol
- Open Door Policy
- Photographs in Medicines Administration Policy
- Physical Health Care Policy
- Prevention and Management of violence and Aggression (PMVA) Policy
- S136 Policy
- Safeguarding Children policy
- Safeguarding Vulnerable Adults Policy
- Searching Patients and their Property Policy
- Seclusion and long term segregation Policy
- Section 17 leave of Absence policy
- Therapeutic Engagement and Observation Policy
- Transfer of a patient to a General Hospital policy

Appendix 1

Acute Care Screening Form

Date & time of call:	**CIS Number:**

Service User's Personal Details			
Name:	DOB:	M F	Ethnic origin:

Address:		Marital status: Post Code:
Home ☏ :	Mobile ☏ :	Indicate if NFA: ❑

Next of kin: Address: Contact ☏ :	GP: Address: ☏ :

MHA status:	Is the person subject to a CTO?	Known to Mental Health services? Known to Acute services?

Name of Referrer: **Discipline:**	Place where the referrer's assessment was carried out A&E, Home, CMHT, police custody, UTC, s136 Other:

Referrer ☏ :	Fax Number:	Consultant Psychiatrist:

CPA **Yes** ❑ **No** ❑	Lead Practitioner and/or contact person in the community.

Is the Consultant Psychiatrist aware of the referral? **Yes** ❑ **No** ❑ If yes, when was the referral discussed?

When was the patient last seen by the Community team and by whom?

CPA Crisis Care Plan. Has the level of support and treatment been increased in the community prior to the request for admission? If so how?

When was the risk assessment last reviewed……………………………

Copy of Risk Assessment accessed? **Yes** ❑ **No** ❑

Current Community support – family, friends, carers etc..

Has the referral been discussed with the Service User? **Yes** ❑ **No** ❑

Is the person currently using any substances?			
Is detoxification being requested?			
Are there any children living at home?			
Are there any safeguarding children / adult alerts?			
Does the person have an advanced directive? **Yes** ❑ **No** ❑ **If yes, where is it located?**			
Is the person currently involved in the criminal justice system? **Yes** ❑ **No** ❑			
Engagement with services	**Good**	**Average**	**Poor**
Compliance with medication	**Good**	**Average**	**Poor**
Current Medication:			

1	**2**	**3**
4	**5**	**6**

Reasons for referral to Acute Care – ***Brief summary of present mental state; nature of the crisis;*** **CURRENT RISKS *including recent self harm, risk to others, vulnerability, neglect, environment, other*; expectation of referrer and service user – referrals rationale for bed (if bed requested).**

PHYSICAL HEALTH

Does the service user have any on-going physical health care needs or require any specilst support / equipment?

Is the service user being admitted from an Acute Hospital Yes No

IF YES – REASONS FOR ADMISSION

Is the person medically fist for discharge?

ONGOING PHYSICAL HEALTH CARE NEEDS IF TRANSFERRED TO AN ACUTE MENTAL HEALTH WARD

Name: **Signature:** **Discipline:**

Team: **Locality:** **Date/time:** **Phone no:**

Outcome

CRHT assessment required: Yes ❑ No ❑ Date and time of assessment:

1. Admitted to CRHT ❑

2. Admitted to Inpatient ward ❑ **If not assessed 'face to face' prior to admission, please give reason why.** **Expected admission time:**	**Referrer advised to contact PICU Ward ❑**	**Bed co-ordinator contacted ❑** **Admitted to:**

3. Not appropriate for Acute Care ❑

<u>Rational for decision</u>

Outcome discussed with referrer: Date: Time:

Copy of Acute Care Screening uploaded to Carenotes (if admitted) ❑

CRHT (if screened by inpatient or SNP) ❑

Discussion with ward ❑ Name of nurse info handed over to:

Name:	**Signature:**	**Discipline:**	**Date:**

<u>Bed co-ordinator / Ward Clark to fax screening to relevant CMHT next working day</u>.

Completed ❑ Date faxed: Signature:

Appendix 2 – Good Practice Standards

On admission

- Nurse on within eye sight enhanced observations until risk assessment and search of property completed
- Comprehensive mental health and risk assessment and assessment of capacity
- Orientation to the ward
- Physical examination (within 24 hours) and routine investigations. NRT if required
- Contact family/ carer/ (complete carers information sharing form on Carenotes)
- GP/ Community teams informed
- Dols assessment (over 65 or when clinically indicated
- VTE
- MUST
- NEWs
- Care plans
- S132 Rights if applicable

Within 3 working days of admission

- Individual time with staff and therapeutic activity
- Comprehensive MDT review
    - Review of admission assessment including completion of outstanding assessments or investigation
    - Review of care since admission
    - Planning care and agreed risk formulation
    - Barriers to discharge
    - Contact/ screening from Therapy team
    - Initial contact from CRHT
- GP, medicines reconciliation
- Physical health management
- Contact with Community Services
- Review HONOS and PbR Cluster

Within 7 working days of admission

- Continued regular 1:1 time and therapeutic activity
- Clear MDT plan of care
    - Review of capacity
    - Treatment plan
    - Risks
    - Discharge month, barriers to discharge and estimated discharge data
    - Physical health
    - 'Choice' policy considered
- Contact and visit from Lead Practitioner
- Contact and visit (if clinically appropriate) from CRHT
- Contact with and involvement from carer/ relatives
- Allocation of Community worker if not known
- Plan estimated CPA discharge meeting and invite people
- Therapy plan and input

At least weekly

- MDT plan of care and revised risk assessment and formulation and actions completed or outstanding
- Response to treatment and physical health
- Contact with Lead Practitioner
- Continued review by CRHTT
- Continued contact and involvement with family/ carers (where relevant)
- Barriers to discharge proactively managed

28/30 Days

If patient still in hospital after 28 days:

Acute- Community review to take place

Discharge

- CPA discharge or Section 17 as appropriate completed
- Patient
    - Medication
    - Benefits
    - Post discharge support family, 7 day follow up Community and next visit
- CPA- risk assessment and care plan
    - Revised and updated by Lead Practitioner. Include Crisis Care Plan and contacts in an emergency
- Discharge summary completed by SHO/ Medical team
- Discharge notification and prescription sheet completed
    - Given to patient and carer (if agreed):
    - Send to GP and Community

APPENDIX 3 – INPATIENT CLINICAL PROCESS STANDARDS

carenotes

NHS
Sussex Partnership
NHS Foundation Trust

Inpatient Clinical Process Guide

(to be used alongside the Standard Operating Procedures and User Guides)

- **Standard Operating Procedures:** http://susi.sussexpartnership.nhs.uk/cis/standard-operating-procedures-sop-s
- **User Guides:** http://susi.sussexpartnership.nhs.uk/document-library/it/clinical-information-systems/carenotes-guides

New Admission (First Inpatient Episode)

1. Check if patient known in Carenotes via Search
2. If not known, create a new Electronic Patient Record (EPR), GP Details Form and Address Form – Patient Demographics tab
3. If known, check patient demographics, GP details and address are correct – Patient Demographics tab
4. Create Inpatient episode – Referrals tab
5. Create Ward and Bed Details (ensuring that the actual start date is entered) – Referrals tab
6. Create Team Member for Inpatient Consultant – Referrals tab
7. Create or edit Personal Description Form (In line with AWOL policy) – Patient Demographics tab
8. Create or edit/replan Risk Assessment Form - especially inpatient specific section– Risk Management tab
9. Create or edit/replan Adults Assessment – Assessment tab
10. Mental Capacity Assessment (Over 16) – Assessment tab (if applicable)
11. Photo Consent Form – paper copy signed and uploaded - Patient Demographics Tab
12. Edit consent summary – Patient Demographics
13. Create Physical Assessment on Admission – Physical health tab
14. Create VTE Assessment – for all people over the age of 65 + or as required - Assessment tab
15. HONOS/HONOS 65 – Outcomes tab
16. MEWS/ NEWS/PEWS – complete on paper and upload to Physical health tab
17. Adults Inpatient Care Plan – Care planning tab
18. MUST nutrition screening – complete on paper and upload to Physical health tab
19. Adult Step 2 Falls Risk assessment – all over the age of 65 + people with compromised mobility – physical tab
20. Property Log/Disclaimer – complete on paper and upload to patient Demographic tab
21. Section 132 rights - where appropriate on MHA tab

While on the Ward

1. Inpatients acute care MDT clinical review– Care Planning tab
2. MEWS/NEW/PEWS – complete on paper and upload to Physical health tab
3. All physical health assessment – Physical health tab
4. Any physical health related items e.g. blood results, investigations etc. -uploaded to physical health tab
5. Clinical notes (non appointment) – complete via 'notes' button or via Activity tab
6. Absence/AWOL – Referrals tab
7. Adult Inpatient Care Plans (CPA/Standard Care/Inpatient) – Care Planning tab
8. Therapeutic Observation Records – Care Planning tab or upload to risk management tab
9. Medication form – Medication Tab
10. ICD10 – Outcomes Tab
11. Update Inpatient Episode with 'Delayed Discharge' information if relevant.

TRANSFER of Ward within SPFT

1. Transferring Ward to create a new "*Ward and bed details*" form for the Receiving Ward with a bed status as 'Planned' with a planned date and time – Referrals tab
2. Transferring Ward to close their ward – change status from 'Bed Occupied' to ' Bed Closed' and put actual end

Inpatient Clinical Process Guide – Version 05 Final – March 2018

APPENDIX 4 INPATIENT CARE PLAN

Patient's name:	**Date of Admission:**	**Ward:**
Mental Health Act Status:	**Primary Nurse:**	
Other people involved in my care:		

Triggers to my difficulties:	**Things that help me when I am feeling distressed or agitated:**
My strengths and interests:	**My Therapeutic day while I am in hospital:**
What I feel needs to change so I can be discharged from hospital:	

Area of care	Summary of current needs from my perspective	Summary of current needs from my staff member's perspective	Our Goals	Interventions – what will help me achieve this?	Monitoring my progress
Supporting my safety and risks					
Supporting my mental health difficulties					
Supporting my physical health					
Supporting my social, practical					

Area of care	Summary of current needs from my perspective	Summary of current needs from my staff member's perspective	Our Goals	Interventions – what will help me achieve this?	Monitoring my progress
and communication needs					
My medication					
Working towards my discharge from hospital					

My views of my care plan:		
Patient's Signature	**Date**	**Copy given to patient**

Name and role of staff members contributing to my care plan:	
Name **Role**	**Signature** **Date**
Name **Role**	**Signature** **Date**
Name **Role**	**Signature** **Date**

Permission given to share the care plan with carer – Yes No – if yes state name of carer the patient agrees the care plan to be shared with.

If No – reason why

Care plan shared with carer **Yes** **No**	**If Yes – state date**

Appendix 5 - 7 day Follow up process and guidance

Sussex Partnership NHS
NHS Foundation Trust

CPA7 / 7 DAY FOLLOW UP GUIDANCE (Updated July 2017)

- **All service users discharged from our inpatient units must be followed up, in person (face to face or by telephone), within the first seven days of discharge.** *NB – the day of discharge is Day 0 and any contact on this day is not used for the outcome measure. The follow-up contact must be between Day 1 and Day 7.*

Recording of Contact/Attempted Contact

- Actual Contact – complete and outcome a diary appointment form in the usual way using 04-CPA7 follow up as an event
- Attempted Contact(s) – complete CPA7 record form (activity tab in Carenotes)

Exceptions –

Exception Description	Reporting Process and evidence required
Patients with Dementia discharged to Carehomes – a proxy contact is valid	The appointment should be pre-planned by the Trust in agreement with the Care Home. Evidence of the follow up by the Trust clinician, with either the patient, or the Care Home staff should be recorded as a 7 day follow up diary appointment on Carenotes by the Trust clinician.
Person was readmitted within 7 days	Evidence of admission to the new ward recorded on Carenotes (Ward & Bed Details Form completed – referrals tab in Carenotes)
Patient discharged to another NHS Psychiatric Inpatient Facility or private PICU or Private Mental Health Acute Ward	Record of transfer (including full name and address of ward or unit) to be recorded clearly in Carenotes.
Deceased	Carenotes process for recording notification of death to be followed.
Where legal precedence has forced the removal of the patient from the country	Clear clinical notes relating to the circumstances of this removal to be added to Carenotes.

Working Principles

In the event that the planned follow up appointment does not take place, all reasonable efforts must be made to contact the patient. Reasonable efforts must include ALL of the following as a minimum and be evidenced in the patients' record using the CPA7 Record Form (activity tab in Carenotes):-

1. Documented telephone call.
2. Letter encouraging the patient to contact an identified ward / team / person.
3. Where the patient's home address is known, 2 visits to their residence.
4. Where the patient has a known carer, an attempt to contact the carer by phone.

Please Note

- *Patients who, in the past have been identified as having capacity and have refused follow up, are no longer exceptions to this outcome measure and must be followed up in line with the above guidance*
- *Patients discharged to the care of a general hospital must be followed up by SPFT staff either face to face or by telephone (this is to be requested and undertaken via Mental Health Liaison Teams)*
- *Patients discharged out of area, within the UK, must be followed up by SPFT staff and evidence of a full handover of care to the local community team*
- *Patients who leave the country on discharge for* **any** *reason must be followed up in line with the above guidance.*

Recommended process - for 7 day follow up:-

Time point	Action	Responsible team	Suggested role
Admission	• Identify those at risk of becoming a DTOC at first ward review and develop a plan to address (those who have unstable or have lost their current accommodation or with specific mental health needs) • Identify estimated date of discharge (EDD) and record on Carenotes • Notify community team (generic email) that patient has been admitted. • Confirm contact details including mobile numbers and obtain consent for use from patient.	Admitting clinical team	Primary Nurse, RC, Admitting consultant
1 week prior to discharge	• Ensure that discharge planning meeting is held and includes plan for follow up within outlined times below. Record plan clearly in patient records and begin to establish arrangements • Invite allocated LP to DPM either in person or via SKYPE/conference call • Ward administrators informs the community team of the daily discharges and the admin lead double checks that the list daily to ensure that follow up plans are in place. (Follow up if plans not in place) • Check contact details with patient (mobile phone number, email address, responsible person (may include NOK) contact details, address) and confirm the follow up, including date, details with the patients. • Book follow up visit within responsible community team identify worker for those who are not going to receive ongoing follow up, agree alternative solution and book in the same way. • Clearly document if patient declines to give any/all of these details or if they do not have a phone/are NFA and make alternative arrangements.	Admitting clinical team	RC, Admitting consultant Ward Administrator Ward Administrator Ward Administrator Ward Administrator
Day before discharge	• Consent and confirm the details with the patient and text (where available) details for visit and confirm with patient (Community team admin) • Record confirmation in patient notes and book appointment in patient diary on Carenotes. **Use event code 04- 7 day follow up,** • Share information in written form with GP via secure email and include in discharge notification.	Community team	Community team administrator
Day of Discharge (Day zero)	• Confirm staff members(s) will be available and have details for visit. • Re-confirm with patient • Agree contingency plan* for use if patient does not attend or where staff member allocated unexpectedly unable to attend	Community team Ward team	Community team administrator Allocated team member
Day 0 - 7	• Allocated person(s) in each team to check reports via Report Manager to ensure that all discharges have been identified and picked up by the relevant team who will follow the	All teams	Allocated member of staff in each team.

	process detailed below		
Day one	• Text reminder to patient (Where available) or contact patient by phone.	Community team	Community team admin
Day two/ three	• Carry out visit (allocated staff) and record • Where client is not available or does not attend send reminder text and phone call and email and rearrange with the patient for day 3	Community team	Allocated team member Community team/ allocated team member / clinician
Day three/ four	• Repeat day two/ three and record contract and on patient notes • Where client is again not available repeat above and mail / email where possible. • Contact Responsible Person (may include NOK) where consent in place.	Community team	Allocated team member Community team admin
Day five	• Carry out contingency plan, recording actions taken	Community team	Allocated team member
Day six / seven	• Administrator ensures that clinical staff have recorded fully.	Community team	Admininstrator