Discharge Planning from Goldfields Community Mental Health Service Procedure

Effective: 22 August 2018

1. Background

Discharge planning is a key component of the care delivered by Goldfields Community Mental Health (CMH). Planning for discharge at intake demonstrates a commitment to recovery for the patient, carer, personal support person and or advocate and ensures consideration of other services occurs during and after CMH care.

All patients regardless of legal status have a right to be involved in the preparation and review of their SMHMR907 Treatment, Support and Discharge Plan whether or not they have the capacity to consent or whether or not the plan can be implemented. The patient's opinion and preferences should always be sought and given due consideration.

If the patient does not have capacity to consent and the plan cannot be implemented without their consent, then a person who is authorised by law, such as a parent or guardian, may consent on the patient's behalf.[1]

This procedure outlines the requirement of CMH clinicians in relation to discharge of patients from the CMH.

2. Procedure

2.1 Discharge Process

- All clinicians are to begin discharge planning at intake. Recovery focused, discharge goals and treatment options are to be negotiated with the patient, carer, personal support person/s and or advocate as soon as practicable.
- Carer, personal support person/s and or advocate or nominated persons consents are to be obtained at relevant steps of the process where appropriate (Appendix 1 - Consent to Release Information, Appendix 2 - Consent ROI Carer or Parent and Appendix 3 - Consent ROI Mature Minor), placing a copy in the patient's medical record.
- Where a client is referred to CMH and the referral information does not indicate significant risk, and the client declines service provision from CMH, the clinician is to, in writing, refer the client back to the referring agency / GP where relevant and place a copy in the patient's medical record. (Appendix 4 - Declined Care Letter).
- Where a patient of CMH who is considered not "at risk" refuses continuation of, or disengages with, service provision, the clinician is to provide the patient with a Non-Contact with GMHS Letter (Appendix 5) letter, placing a copy in the patient's medical record, and sending a copy to the referring agency / GP where relevant.

[1] Clinicians' Practice Guide to the Mental Health Act 2014

- Where the patient continues to decline service provision or does not make contact with this service, the clinician is to send the Proposal to Discharge Letter (Appendix 6) to active patients within four weeks of providing the Non-Contact with GMHS Letter (Appendix 5) placing a copy in the patient's medical record and sending a copy to the referring agency / GP where relevant.
- Where a patient has missed their last appointment, the clinician is to send the Appendix 7 - Did Not Attend Appointment Letter placing a copy in the patient's medical record and sending a copy to the referring agency / GP where relevant.

2.2 Minimum Standard for Discharge Plan

The patient's completed discharge plan is to address each of the following:

- An outline of treatment
- Risk assessment taking into account progressive risks
- Medication adherence
- Accommodation
- Transport
- Relapse triggers and markers
- Family and social supports, re-entry to work / study
- Referral to other alternative service within the community
- Be available in the patient's medical record and an electronic copy available on PSOLIS
- Provision of the completed Treatment, Support and Discharge Plan to the patient and their GP on the day of discharge
- A re-entry plan.

2.3 Discharge from CMH can occur when

- Discharge goals in the Management Plan have been reached.
- A comprehensive clinical review and consultation with the patient, carer, personal support person/s and or advocate had been completed.
- The discharge plan and National Outcome Casemix Collection (NOCC) review has been presented and endorsed by the Multidisciplinary Team (MDT) and ratified by the Consultant Psychiatrist
- The patient moves from the service catchment area
- The patient refuses treatment.

2.4 Process

- The agreed Treatment, Support and Discharge Plan is to be signed by the Case Manager, patient, carer personal support person/s and or advocate and a copy provided to the patient, carer and personal support person/s and or advocate, GP/Referrer and/or relevant agency where appropriate.
- PSOLIS is updated with relevant discharge, NOCC and Risk assessment information.

- The Treatment, Support and Discharge Plan, with the completed Appendix 8 - Deactivation Form is to be provided to administrative staff for processing and subsequently placed on the patient's medical record.
- GP and referrer (if different) are advised of the discharge. For adult and elderly streams the Treatment, Support and Discharge Plan or summary letter stating current issues, interventions, medication regime, follow up service and recommendations is to be forwarded to the GP or referring agency.
- For CAMHS the Treatment, Support and Discharge Plan is to accompany the CAMHS003 CAMHS Care Transfer Summary or summary letter stating current issues, interventions, medication regime, follow up service and recommendations is to be forwarded to the GP or referring agency.
- The patient, carer, personal support person/s and or advocate and any relevant service provider is to be advised on how to re-access the service if necessary, and provided with emergency contact numbers.
- Where there is a need for a specific behavioural/crisis or return to work/school plan, as identified in the case management plan, a copy of this additional plan may be added to the Treatment, Support and Discharge Plan. Crisis plans may be provided to other agencies as deemed appropriate by the MDT as part of duty of care without the informed consent of the patient. The Crisis plan is to be given to the patient, carer, personal support person/s and or advocate.

  NB: The patient, carer, personal support person/s and or advocate is to complete a Consent to Release Information (see Appendix 1, 2 and 3) before any information can be provided to external agencies, except where agencies have statutory powers to obtain such information.

2.5 Cross Boundary Discharge

- Transfer/discharge of a patient who moves from the Goldfields to another area is to be negotiated and organised by the Case Manager.
- Patients who move permanently to another mental health service catchment area and require ongoing mental health treatment is to be monitored for a maximum of two weeks. During this time, the Case Manager is to negotiate transfer to the local mental health service. If the patient needs face to face intervention in this time, the Case Manager is to negotiate provision of service with the local mental health team.
- High risk situations or patients with complex treatment needs are to be followed up by the Case Manager with an initial phone call and letter to the relevant mental health service and further phone contact until notification from the appropriate mental health service that contact with the patient has been made.

2.6 Outreach Discharge

Refer to Appendix 9 - Outreach Discharge Flowchart.

2.7 Patient Re-entry

Patients discharged from CMH can be readmitted according to the GMHS Mental Health Triage Procedure.

For continuity of care, where it is possible and deemed appropriate and following discussion with the Triage Officer, patients who are re-referred are to be allocated to their previous Case Manager.

3. Definitions

Nominated Person	Is someone who is formally nominated by a person experiencing mental illness. The nominated person can be any adult the patient chooses (s. 274)[2].
NOCC	National Outcomes and Casemix Collection
Compromising HoNOS	Health of the Nation Outcome Scale or HoNOSCA or HoNOS 65+, Kessler 10+ and Life Skills Profile

4. Roles and Responsibilities

The Clinical Director and Regional Manager, Mental Health (RMMH) are to:

- oversee and ensure clinical governance within the GMHS
- assist Case Managers and RMMH in the resolution of any issues or problems that arise in the use of this procedure
- ensure that the principles and requirements of this procedure are applied, achieved and sustained
- develop systems to ensure all GMHS staff are provided with training and are made aware of their obligations and accompanying documentation relative to this procedure.

The Team Leader/ Clinical Nurse Manager (CNM) are to:

- ensure that all GMHS staff receive sufficient training, instruction, and supervision in the use of this procedure
- ensure the patient has consented to provision of information to external services
- ensure comprehensive discharge planning and communication with the patient, carer, personal support person/s and or advocate, GP or other service / agency occurs prior to discharge of the patient from CMH
- monitor compliance and ensure staff comply with this procedure.

All Staff are to:

- ensure they comply with all requirements of this procedure
- promote a recovery oriented, patient-centred culture within clinical practices, policies, operational directives, guidelines and the Australian Law to ensure a safe, equitable and positive environment for all
- work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

[2] Mental Health Act 2014

5. Appendices

Appendix 1 - Consent to Release Information
Appendix 2 - Consent ROI Carer or Parent
Appendix 3 - Consent ROI Mature Minor
Appendix 4 - Declined Care Letter
Appendix 5 - Non Contact with GMHS Letter
Appendix 6 - Proposal to Discharge Letter
Appendix 7 - Did Not Attend Appointment Letter
Appendix 8 - Deactivation Form
Appendix 9 - Outreach Discharge Flowchart

6. Compliance

This procedure is a mandatory requirement under the *Mental Health Act 2014*. Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

7. Evaluation

All processes and practices of this procedure is to be monitored, evaluated, and developed as part of an overall quality improvement process at least every three years or as necessary should any changes to legislation or an incident occur where the procedure has not been satisfactory.

Regular audits of discharged patients to ascertain correct completion of discharge paperwork.

This process is to include a routine review of patient's and processes followed to discharge planning.

8. Standards

National Safety and Quality Healthcare Standards (Second edition 2017) – 2.10d, 4.12c 6.4b, 6.5b, 5.10a, 5.13d
EQuIPNational Standards (11-15) – 12.4.1, 12.8.1, 12.8.2
National Standards for Mental Health Services - 2.11, 7.12, 10.4.4 and 10.6.8

9. Legislation

Mental Health Act 2014

10. Forms

SMHMR907 Treatment, Support and Discharge Plan
CAMHS003 CAMHS Care Transfer Summary

11. Related Policy Documents

WACHS Documentation – Clinical Practice Standard
GMHS Mental Health Triage Procedure

12. Related WA Health System Policies

Statewide Standardised Clinical Documentation for (SSCD) for Mental Health Services
Triage to Discharge Mental Health Framework for Statewide Standardised Clinical Documentation
Department of Health Admission, Readmission, Discharge and Transfer Policy
Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia

13. Policy Framework

Mental Health Policy Framework

This document can be made available in alternative formats on request for a person with a disability

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