HPFT

Adult Inpatient Services Operational Policy

HPFT Policy

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Executive Lead	Executive Director Quality and Safety
Lead Author	Service Line Lead, Acute Services
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Title of document	Adult Inpatient Services Operational Policy		
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4.1	07/08/2020	13/02/2021	Head of Nursing
Staff need to know about this policy because (complete in 50 words)	This policy provides the framework and general principles for assessment, treatment and care that each service user using inpatient adult mental health services should experience.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	• The Crisis Assessment and Treatment Team must undertake an assessment before any inpatient admission proceeds, in order to explore alternatives to admission • Physical health and wellbeing will be assessed and appropriate treatment provided for all service users admitted to an inpatient unit • All service users should understand the purpose of their admission, what treatment they will receive and the plan for discharge; this is delivered through collaborative care planning.		
Summary of significant changes from previous version are:	• Updated to reflect changes to the admission process for service users requiring assessment, namely admission to the Acute Admission Unit (Swift) • Updated to reflect the implementation of the Care Act (2014) • Appendices have updated checklists for physical health screening; transfer between inpatient wards and admission checklist • Updated to reflect impact of Covid-19 pandemic		

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PART 1 – Preliminary Issues:

1. General Principles

Acute inpatient services provide care for people whose mental health needs are so severe or complex that they cannot receive the care or treatment that they require in a community setting.

Hertfordshire Partnership NHS University Foundation Trust (HPFT) provides acute inpatient services as part of an integrated whole system approach, which is delivered in partnership with community mental health services. The system incorporates various alternatives to admission which will be offered first when clinically appropriate.

People who are admitted to acute inpatient wards should receive interventions which promote recovery and wellbeing. The inpatient multidisciplinary team will provide a holistic assessment of the person's health and social care needs and develop a person centred recovery care plan taking into account the views of the service user and carers and builds on the personal strengths and resilience of the service user.

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All inpatient staff must have the Trust Values as core principles in all of their interactions with service users and their carers.

Safety is of paramount importance in planning care and treatment of people admitted to the Acute Care Pathway. All care planning must be underpinned by robust assessment of risk.

In-patient services are committed to providing treatment and care in a way that that preserves peoples' rights, their privacy and dignity and offers a safe and therapeutic environment, which is in line with standards and principles to Eliminate Mixed Sex Accommodation (EMSA).

HPFT staff will practice within the current legal and ethical frameworks. They will observe and respect people's right to confidentiality of information in accordance the HPFT Policy and Guidance on the Management of Care Records and the Inter-agency Protocol on Sharing Information.

This Operational Policy outlines the general principles of care for people who are admitted to HPFT acute inpatient wards. Local protocols may be developed separately for specific wards, however these must not deviate from the standards outlined in this Policy.

This policy is impacted (including its appendices) by the major incident management of Covid-19. Trust guidance is updated on an ongoing basis in line with government guidance and should be read on the HPFT Hive communication website The Hive

2. Definitions

- AAU Acute Assessment Unit
- NSF National Service Framework
- CATT Crisis Assessment and Treatment Team
- ADTU Acute Day Treatment Unit
- CMHT Community Mental Health Team
- MDT Multi-Disciplinary Team

- PICU Psychiatric Intensive Care Unit
- CAMHS Child and Adolescent Mental Health Services
- CPA Care Programme Approach
- NFA No fixed abode
- EMSA Eliminating Mixed Sex Accommodation
- RAID Rapid Access Interface and Discharge
- HPFT Hertfordshire Partnership University NHS Foundation Trust
- GP General Practitioner

3. Duties and Responsibilities

The ward team is multi-disciplinary and includes a Modern Matron, Team Leader, consultant psychiatrist, junior medical and nursing staff, occupational therapy staff, psychology and administrative staff.

3.1 Consultant Psychiatrist

- Provides clinical/medical leadership to the ward team.

- Ensures that clinical standards are met by the team (face to face reviews, risk assessments, physical health checks, medicines reconciliation, discharge/transfer documentation).

- Makes accurate diagnoses and records these on the EPR.

- Completes HONOS Clustering on all new admissions and ensure that they are kept up to date.

- Attends the daily morning handover meetings at which each inpatient's care is discussed and predicted dates of discharge are set and reviewed. If absent or on leave, ensures that this responsibility is delegated appropriately to another medical colleague.

- Conducts face to face reviews of inpatients based on clinical need and ensures that each patient is seen face to face at least once a week by the consultant, or ensures that this responsibility is delegated appropriately if absent or on leave.

- Undertakes ward based assessments under the Mental Health Act, prepares reports and attends Mental Health Act Tribunals and Managers Hearings for patients under their care.

- Ensures handover of clinical information when patients are discharged or transferred from their care.

- Undertakes weekly supervision of trainee medical staff and follow HPFT policy regarding supervision of SAS doctors.

- Works closely with the Team Leader and Modern Matron to monitor Key Performance Indicators, complaints, and compliments and agree action if indicated. To listen and

feedback to the Team Leader (or vice versa) any general concerns or issues raised by staff.

- Participates in ward clinical governance meetings and staff meetings.
- Assists the Team Leader to identify staff training/performance issues.
- Supports teamwork on the ward and line management with the objective of providing a culture of 'openness'.

3.2 **Junior Medical Staff**

- Assess all admissions to the ward and ensure that clinical documentation is complete and updated.
- Ensure that all physical assessments, examinations and relevant medical tests are undertaken and correctly documented and repeated when clinically relevant.
- Ensure that every service user is medically reviewed face to face by a doctor at least once a week, in addition to the consultant review.
- Hand over clinically relevant information to medical and nursing colleagues where appropriate.
- Follow HPFT policy in all areas relevant to their clinical role, including physical health care, medicines reconciliation and discharge documentation.
- Have supervision at agreed intervals with their supervising consultant.
- Practice within the limits of their competence and seek advice from senior colleagues when appropriate.
- To complete discharge notifications and discharge summaries when a service user is discharged,

3.2 Modern Matron

- Provides strong leadership and line management to Team Leaders and the ward staff within the MDT.
- Is a visible, accessible & authoritative presence in clinical areas.
- Responsible with the Consultant and Team Leader for ensuring a safe, effective and quality service is provided on the ward.
- Works within the Modern Matron's Charter to ensure good standards of infection prevention & control, privacy & dignity, cleanliness & health & safety.

- Responsible for the professional management of the clinical environment, allocating & providing sufficient resources & opportunities to deliver person centred nursing care, involving service users & carers.

- Organises and chairs the monthly Business and Governance Meetings.

Meets regularly with service users and carers as requested via a weekly Modern Matron surgery.

3.3 **Team Leader**

- Delivers a high quality service working with service users & staff to ensure practices that respond effectively to both individual & Service need.

- Has oversight & 24 hour responsibility & accountability for the provision & management of high quality nursing care & the treatment of service users within the inpatient service areas.

- Is a visible presence on the ward, attending daily handover meetings on a regular basis (minimum weekly) and also providing leadership in the daily clinical work of the ward, including participating in ward reviews at least monthly.

- Provides effective clinical leadership to ensure all nursing staff receive the appropriate supervision & support in conjunction with an agreed professional development plan.

- Is responsible for ensuring effective management and leadership of the shifts – including (but not exclusively) the use of the Patient Status at a Glance Board (PSAG), the shift planners, handovers sheets and staffing level boards are completed

- Is responsible for establishing & maintaining team systems & processes for effective operation of the team, including outcome measurements, audit & annual Service policy review.

- Ensures that ward staff are monitoring service users in accordance with HPFT's Safe and Supportive Observation Policy. Is responsible for ensuring they have in place systems to oversee and report significant changes that support robust handover and ongoing continuity of care in a timely manner.

- Oversees implementation of the Managed Entry and Exit Policy (MEEP)and ensures that all ward staff have a good understanding of their duties under this Policy.

- Ensures that systems are in place to provide appropriate induction for any Bank/Agency or new staff unfamiliar with the ward at the commencement of shift and a full handover at the end of the shift.

- Ensures that the responsibilities for general and intermittent observations will be conducted by different members of staff.

- Ensures that every service user on the ward has an identified Named Nurse who will see the service user for regular one to one sessions to discuss on-going needs.

3.4 Nursing Staff

- Work in close collaboration with other professionals in assessing service users' needs, devising recovery care plans & evaluating outcomes that promote service user empowerment throughout the process.

- Participate with the wider MDT in the assessment & treatment to provide high quality, individualised care, which addresses the needs of the service users.

- Supports the Team Leader and Charge Nurses to ensure that the service is managed effectively and efficiently in all aspects.

- Participate in ward rounds/reviews and feedback on the service user's progress and concerns and contribute to the Risk Assessment.

- The Named Nurse informs the service user of ward routines including ward rounds and CPA Reviews.

- The Named Nurse meets the service user individually on a regular basis during the course of the admission to attempt to address their concerns. They review the Care plan with service users at least weekly.

- Follow the Managed Entry and Exit Policy and have a good understanding of the management of leave.

- Inform the Community Care Co-ordinator of any planned leave from the ward or of any service user Absent Without Official Leave (AWOL).

- Facilitate escorted leave when an up-dated risk assessment indicating that this is appropriate and medical agreement has been given. (Guidelines for good practice are given in the Section 17 Leave Policy).

- Make service users aware of how to access the Advocacy Service and the Patient Advisory Liaison Services (PALS).

- Facilitate a mixture of ward based meaningful activities on a daily basis and service user groups including a weekly group addressing any issues about life on the ward.

- Offer day to day guidance and support to carers, including inviting them to CPA reviews if appropriate.

3.4 Occupational Therapy

Occupational Therapy (OT) is part of a service user's treatment throughout admission. The OT assesses occupational performance in the areas of self-care, productivity and leisure. In collaboration with the service user and MDT colleagues, the Occupational

Therapist implements the appropriate occupational intervention and treatment plan using therapeutic activity groups and individual sessions. Potential risks associated with activities are discussed with the MDT and appropriate management plans created.

3.5 Arts Therapy

The Arts Therapies Service, which may include Art Therapy, Drama Therapy and Music Therapy (as available) provides psychological treatment for service users. Sessions may be in the form of open groups or for individual sessions as agreed within a care plan.

3.6 Psychology

Key functions of Psychological services within the acute setting include:

- Clinical assessment work – including psychometric assessments
- Brief intervention/therapy work – drawing upon a range of therapeutic models
- Group work – drawing upon a range of therapeutic models, and accommodating different entry/exit points and lengths of stay
- Family work – including family meetings drawing upon Systemic practice and Open Dialogue principles
- Consultation – for staff, service users, their family and networks including one off psychological meetings to consider difficulties and problem solving
- Staff support – including through supervision, reflective practice and delivering formal teaching sessions upon psychological issues
- Service development – including through representation at key service meetings (e.g. governance meetings) and through undertaking audit, service evaluation, research and training activities

Psychological Services staff attend ward reviews and CPAs when required and it is part of their role to assist in identifying further support and services that may be of benefit to the individual after discharge from the ward. The service includes qualified (i.e. Clinical Psychologist and Counselling Psychologist) and unqualified (i.e. trainees studying for their formal qualifications) staff.

3.7 Inpatient service user and Carer Experience Group

The involvement of Experts by Experience can be helpful to service users, carers and staff on many levels. For service users and carers there is the sense of ownership of services, increased awareness and understanding of services and choices. Involvement work can be a significant step on the recovery journey – giving chances to participate in group work, develop skills and confidence. In addition, there are often improved relationships and better understanding between service users, carers and staff

For further information on involvement of Experts by Experience please refer to the “Recruitment and Involvement of Experts by Experience” Policy.

Terms of Reference

- To ensure that there is a proactive programme in place that covers all inpatient services across Hertfordshire to develop learning from service user and carer feedback
- To ensure that service users and carers views are taken into account for all new service developments
- To provide themes and feedback from complaints and compliments, Having your Say, Peer experience listeners, service user feedback surveys
- To provide a governance forum for service users and carers and to feed into the West SBU practice governance and risk forums
- To share good practice across the inpatient services

3.8 The Bed Management Team

The Bed Management Team provides an agreed procedure for collaboration across the Trust to ensure the needs of the service user are met and to ensure that beds are found as swiftly and efficiently as possible. For full details of the Bed Management process and criteria, please see the Bed Management Policy.

The role of the Bed Management Team is to ensure the efficient and effective use of all beds in the Trust, and to minimise the use of private sector beds, beds will be identified taking account:

- All informal admissions and admissions under Section 2 of the MHA should go to the Acute Assessment Unit (Swift ward) unless there is a clinical reason for them not to do so
- The safety of service users and staff
- Clinical appropriateness of admission
- The views of the service user and their carer
- Single sex accommodation issues
- Making the best use of available beds at any point within a 24-hour period
- Ensuring that communication between all parties involved in the process is effective

4 Eligibility for Admission

Acute inpatient beds are appropriate for adults of working age who are registered with a Hertfordshire GP and are experiencing an episode of functional mental ill health that is too severe or complex to be adequately and/or safely managed in a community setting.

People who have no registered GP in the United Kingdom are eligible for admission under the Mental Health Act of if the request is made from a Place of Safety. Please refer to the Bed Management Policy.

Admissions may be on a voluntary basis or enforced formally under the Mental Health Act (1983).

Prior to any offer of informal admission, including admissions from the S136 suites, a preliminary trusted assessment should have been completed by the CATT, RAID or street triage teams which supports the requirement for inpatient admission. The service user must be informed that they will be swabbed for Covid-19 and asked to self-isolate upon admission until the result is back.

The suitability of the acute adult inpatient ward environment must be considered by the Bed Manager for every admission in order to ensure that it is the most appropriate clinical setting for that patient. When the Bed Manager is not available, the Clinical Lead will adopt this function. Alternatives such as Psychiatric Intensive Care Unit, Mother and Baby Unit may be more appropriate and should be considered.

The physical health of the person to be admitted must be considered before admission is accepted. If there is a possibility that the patient's symptoms are primarily or partly due to physical illness, they should be sent to the local general acute hospital for medical assessment and clearance. No patient should be accepted for admission from a general hospital without documented evidence that they have been medically cleared for transfer to a psychiatric unit. It is the responsibility of the bed manager and in their absence the Clinical Lead, to ensure that the necessary documentation has been received and that medical oversight of this has been obtained from the junior doctor on-call, where appropriate. Please refer to Appendices 2 and 3. If a service user has been tested positive for Covid-19 or is displaying symptoms for Covid-19, careful consideration to be given with regards to cohorting them on the ward to prevent an outbreak and spread of infection.

The minimum age of people admitted to acute adult inpatient wards is normally 18 years.

Exceptions to the above may occur in the following circumstances:

Young People

A young person who requires urgent inpatient admission and no CAMHS beds available locally or nationally within required time frame. After determining the level of risk/need of the young person, the young person may be admitted to acute wards as an emergency measure however this must be agreed by the 2nd on-call Manager, Executive Team Member on call and the responsible consultant psychiatrists from both CAMHS and Adult Services (which will be the on call consultants from both Service out of hours) on call consultant psychiatrist. Any person under 18 has to be placed on 1 to 1 observation with CAMHS staff and the CAMHS Consultant retains responsibility for them for the duration of their admission.

Admission of a young person aged less than 18 years to an adult inpatient ward is in breach of the National Mandate in relation to 16/ 17 year olds being admitted to adult, must be reported as Level 3 SI (except for Thumbswood Mother and Baby unit which allows 17 year olds to be admitted).

Frail Adults

Older people who have functional mental disorders may be admitted to acute adult wards if they are not physically frail and it is considered that there needs can be appropriately met in the acute inpatient ward setting. Please refer to the Trust's Frail Functional Assessment and Treatment Policy for further information regarding admission criteria to the Frail Functional Ward.

People with Learning Disabilities

People with a dual diagnosis of a mild learning disability and an acute mental health problem may be admitted to inpatient mental health unit if the therapeutic environment meets their needs appropriately. Close working relationships are required between ward staff and the relevant work with the Learning Disability services. Please refer to section 26.4 for the Trust's commitment to access to healthcare for people with a learning disability.

People with Substance Misuse Problems

People with mental health problems may have co-morbid substance misuse issues which require treatment concurrently with their mental health care. People whose primary problem results from substance misuse are not normally eligible for admission to acute inpatient units. Requirement for inpatient detoxification from alcohol or illicit substances is not a reason for admission to a mental health assessment and treatment ward.

For information about the treatment of staff and their relatives please refer to Treatment of Staff and their Dependents Policy.

Transfers from other HPFT Units/Wards and from Independent/Out of Area Providers will be dealt with on a case by case basis. See the Bed Management Policy.

5. Prior to Admission

CATT must be consulted prior to any admission to consider with the referrer whether treatment at home or through one of HPFT's 'alternatives to admission' would be more appropriate than in-patient care.

Referrals to CATT, during office hours, are made via SPA, the local Adult Community Mental Team and Rapid Assessment Intervention and Discharge (RAID) or by the medical teams. Outside office hours, referrals are accepted from consultants, General Practitioners, RAID, and the Safeguarding Out of Hours Service (SOOS), Herts doc, CATT clients and the Police Surgeon.

It is the responsibility of the team arranging the admission (usually CATT or RAID) to ensure that any relevant advice, information and signposting is given to the service user and their carers. The Care Act 2014 places a duty to prevent and delay the onset of need for more intensive support services such as inpatient admission and therefore we should consider alternatives to admission at every opportunity. The consideration of social needs should be considered as part of their initial assessment. If requested or is an appropriate for the Carer, staff must consider providing information and advice on local support services and their right to a Carers Assessment.

It is acknowledged that particularly high risk situations may occasionally arise during a Mental Health Assessment when the clinical presentation indicates that delay would create significant risk. In such situations the service user will be admitted and CATT informed of the action taken. A CATT assessment will take place the following day to determine if the service user can be maintained safely in the community with a home treatment package.

Team Leaders or their delegated representatives will ensure the above standards are met prior to admission.

Careful consideration to be given to the service user's Covid status and their compliance with swabbing, self-isolation and need for cohorting.
Should a service user refuse to be swabbed, the ward local cohorting plan needs to be implemented.

6. The Admission Process

All informal admissions and those under Section 2 of the Mental Health Act should be admitted to the AAU (Swift ward) unless there are clinical reasons that a single sex ward is needed.
All admission under Section 3 of the Mental Health Act should be admitted to a treatment ward closest to a servicer user's home.
Please refer to the Acute Admissions Unit Policy.

The Bed Manager arranging the admission should notify the ward and ensure that a suitable bed is available. The admitting team must hand-over information about the care of the service user to the admitting nurse that is accepting the admission. This will include significant known risk issues, including physical health risks and issues relating to Covid-19, communication, involvement and capacity issues, safeguarding issues and those related to children in the service users care. Please refer to the Admission Checklist (Appendix 6)

The service user will be allocated an admitting nurse on the ward who will ensure the service user is welcomed and given information about the ward and the Mental Health Act (if appropriate).

On admission service users will be given the following information:

- Service users Information Pack
- Leaflets on any medication prescribed (if appropriate)
- Legal Rights leaflets for detained service users (if appropriate)
- Advice on the Managed Entry and Exit Policy (MEEP) door system within the ward environment
- A welcome pack
- Having Your Say leaflet
- Information about advocacy service
- Information about smoking policy if appropriate?
- Covid-19 leaflet including swabbing and self-isolation.

The ward doctor will clerk the person in as soon as possible after admission. Out of hours, this is the responsibility of the first on call doctor who has the responsibility of covering that unit. The medical clerking includes recording of the psychiatric history, mental state examination, physical examination.

On admission all service users should have a comprehensive physical examination by the admitting doctor within 24 hours of admission. This must be recorded on the Physical Examination Form on the EPR. Please refer to the Physical Healthcare Policy for detailed guidance about requirements for physical assessment and investigations.

The ward/unit nursing staff will ensure that a physical health assessment is completed on admission within the first 24 hours. The National Early Warning Score must be used for this initial assessment and for continuing the monitoring of a patient's well-being throughout their stay on the ward/unit.

The Dyphagia Screening Tool must be completed by nursing staff within 72 hours of admission Please refer to the Dysphagia & Nutrition Policy.

An initial Care Plan will be agreed by the admitting nurse, the admitting doctor, relevant carers (if present) and whenever possible the service user. The Care Plan should be completed immediately following the completion of the risk assessments by the admitting nurse, ideally on the day of admission and all information must be recorded on the electronic patient record. This should include any risk factors relating to Covid-19 and its management.

All service users admitted to an inpatient environment will be allocated a Named and an Associate Nurse. Please refer to the Named Nurse Policy for the standards expected of the Named Nurse.

Following admission, on the first working day the Named Nurse (or delegate representative) will notify the relevant community team that the admission has occurred.

Service users admitted under Mental Health Act will be read their rights under the Act and will be given information leaflets regarding their detention and legal rights as soon as possible after admission by nursing staff. This should be documented on the EPR. Information must be given in an appropriate format taking into account their language needs and intellectual level. Please refer to the Hospital Managers Internal Policy.

Service users admitted to the Assessment Ward will have an initial face to face multidisciplinary assessment involving a consultant psychiatrist (or their delegated representative) and a member of the ward nursing and CATT within 24 hours of admission. At this assessment an initial care plan will be agreed and put in place, their risk will be reviewed and updated and their capacity initially assessed. Please refer to the Mental Capacity Act

Service users admitted directly to treatment wards will have an initial assessment with the consultant or their delegated representative on the first working day following admission.

The medical secretary or ward clerk will notify the patient's GP of the admission on the first working day after the admission has taken place, with a written request for information about their health and medication. Please refer to the Medicines Reconciliation Policy.

The Service user's carers and care co-ordinator (if allocated) will be contacted and invited to attend a ward review, subject to agreement. HPFT welcomes input from carers and advocates on the service user's behalf. The need to offer a Carers Assessment should be considered in every case. See Carers Policy.

The service user should be offered the support of an Advocate. This is particularly important where there are any communication or capacity issues which may prevent the patient from participating in decisions about their care.

7. During Admission

The consultant psychiatrist (or their delegated representative) will conduct a face to face review of the service user's care and treatment at least once a week, during which their physical and mental health needs will be reviewed, their views on treatment and capacity assessed. An advanced Covid care plan may need to be put in place if risks have been identified. Their care plan will be updated using the ward round template.

The Named Nurse (or their delegated representative) is responsible for building a therapeutic relationship with the service user and establishing their care plan in collaboration with them. The care plan should be reviewed by the Named Nurse at least weekly, updated accordingly and a copy given to the service user. Capacity to consent to the care plan should be reviewed and recorded at regular intervals.

The CAT Team will attend ward reviews, or have regular contact with the Team Leader (or delegated representative) to consider whether early discharge with intensive home support and/or access to alternatives to admission could be considered by the Named Consultant and multi-disciplinary team.

The community care co-ordinator, where relevant should be invited to attend ward based reviews and be involved in discharge planning from the outset of admission. If the patient does not have a care co-ordinator, the ongoing need for this should be considered at an early stage of admission. If appropriate, a care co-ordinator should be requested from the relevant community service. All service users who will remain on CPA will require a named care co-ordinator to be allocated before they are discharged from the Acute Care Pathway.

They will be offered information about their care and treatment in an accessible format. Leaflets are available from Choice and Medication on the Trust Website and also from reputable internet sites e.g Rethink, RCPsych and MIND.

Physical Health

To support physical health and well-being, all staff should support service users in opportunities to increase their daily activity levels within our in-patient settings. This includes all physical activities such as gentle to moderate activities, for example daily living tasks, gardening and walking, to more active pursuits – eg playing sports and gym activities.

In order to safely support this engagement, the medical staff will assess and document safe and appropriate levels of physical activities for service users to participate in, based on the individuals physical health as part of the initial physical health check using the Physical Health Screening Form (Appendix 5) . This form should be placed in a file in the ward office and also scanned onto the EPR for all staff to access. Health and fitness goals should be incorporated into the individual's recovery focused care plan.

Communication, involvement and capacity needs

HPFT have a responsibility to ensure that all people access appropriate services, have their views represented throughout the assessment and care planning process, and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that

- Reasonable adjustments are made to ensure that each person has the same opportunity for health. (Equality Act 2010) (Care Act 2014)
- Assume that each person presented to the service has capacity. If assessment shows they don't, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)
- If an individual has substantial difficulty in communicating or being involved in the assessment and care planning processes, then appropriate actions are taken to ensure that the individual is enabled or represented during the process (eg reasonable adjustments or advocacy). (Care Act, 2014)

Adjustments will include:

- spending time with the individual to gain an understanding of their preferences for treatment
- asking them where they would prefer to be treated,
- providing additional support to assist with communication, this support will be available via easy read material/visual prompts, pictorial cues and/or audio equipment. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
- Referring an individual to a specialist learning disability services for additional support, should they continue to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- Seeking permission and contributing to the Health Action Plan or Purple Folder when appropriate

- Male and female service users will not share sleeping accommodation, share toilet or washing facilities. They will not have to pass through sleeping, toilet or washing areas of the opposite gender to access their own, in accordance with Eliminating Mixed Sex Accommodation (EMSA) criteria.

- Ascertaining whether a ward has any vacant beds for new admissions will be done in the terms of 'male' or 'female' beds. This will ensure that wards are not obliged to accept an admission when they cannot guarantee delivering same gender facilities.

- If a breach of EMSA criteria should take place, the Team Leader, Modern Matron and Head of Nursing will be informed and the event will be reported as a Serious Incident under the "Learning from Adverse Events policy."

Drugs and alcohol

- The use of illegal drugs, tobacco and alcohol is prohibited on the ward. If a service user is found to have them on admission they will be removed and illegal drugs will not be returned on discharge. Should carers, relatives or friends bring alcohol or drugs onto the ward or be under the influence of any substance they will be asked to leave and the police may be notified.

Use of Mobile Phones, Cameras and Social Media

- The personal mobile 'phones of staff should not be used in the clinical areas and may therefore be stored in a locker in the staff rest rooms.
- In the event of an emergency or needing to be urgently contacted, staff should provide family with the ward's lane line number.
- Reference to the Trust's Use of Mobile 'Phones by Service Users and Visitors Policy should be made.

Smoking

- Smoking is strictly prohibited in any part of HPFT's premises, or anywhere in the grounds. This includes areas that are outside but that form part of the HPFT's premises. Please refer to HPFT's Smokefree Policy.

8 Care Programme Approach

In-patient services will comply with all the requirements of the HPFT policy on Care Programme Approach (CPA) incorporating Care Management

Everyone using in-patient services on discharge, will be placed on CPA rather than Standard Care for the duration of their admission.

The first ward round/review following the person's admission to the ward will be designated a CPA review and a CPA care plan and risk assessment agreed and recorded.

A Named Nurse is identified from within the ward team who has specific responsibilities in relation to the co-ordination of care, having regular contact with the service user and with the community Care Co-ordinator.

During the course of the admission, service users and carers will be encouraged to be involved in the formulation of the CPA care plan, this will include relevant care and treatment during their inpatient stay and identify the services required upon discharge.

CPA reviews will occur on the ward at regular intervals during the period of in-patient care. The first ward round/review following the person's admission to the ward will be designated a CPA review and a CPA care plan and risk assessment agreed and recorded. When an unplanned discharge occurs the CPA review will be arranged in the community by the Care Co-ordinator at the earliest possible date.

The service user, and appropriate carers, if agreed will be given a copy of the CPA care plan having had the opportunity to contribute on its content. Staff must also document in the EPR if the service user or carer declines a copy.

Staff will be mindful of the needs of carers in relation to the treatment and care of their relative. Service users will be encouraged to share information with the carer. Carers will be advised of the support they can receive from Carers in Hertfordshire and local information regarding support for carers will be on the ward notice board.

Formulating a CPA Care Plan

In-patient services are committed to a whole system approach and to maximise their connections with all community services and other agencies. In particular, strong working relationships with the Adult Community Mental Health, Older Peoples Services, Learning Disability services, ADTU and CATT are seen as crucial in order to connect the service user with the community during the period of in-patient care.

Multidisciplinary reviews with staff from both in-patient and community teams, including the care coordinator, the service user, relevant carers, and any other services or agencies involved in supporting the person will take place to review and support plans.. These plans will be formally agreed at the CPA review meeting.

Following the service user's admission and the initial assessment, a comprehensive multi-disciplinary health, psychological, social care and risk assessment will be completed during the first week of the admission. Any family difficulties, including child protection issues, will be identified. If the child protection issues have been identified earlier, then the named nurse will ensure that any necessary actions have been taken with regards to on going concerns. The assessment of physical health needs is seen as an integral part of this comprehensive assessment.

The Named Nurse will co-ordinate the assessment in conjunction with the care co-ordinator. The needs identified form the basis of the CPA care plan which will include medical and psychological aspects of treatment together with details of how any community social care and physical health needs will be met. It will record the persons individual recovery goal and the support and treatment need to aid them on their recovery journey. It could include treatment, including any therapeutic activities, interventions and any identified aftercare needs for those patients subject to S117.

Aftercare for all service users admitted to hospital for treatment for mental disorder should be planned within the framework of CPA, whether or not they are detained or will be entitled to receive after-care under S117 of the Act. But because the of the specific statutory obligation it is important that all patients who are entitled to after care under S177 are identified and that records are kept of what after care is provided to them under that section. This should be identified on their care plan. For further guidance please see the Trust's policy on Aftercare under S117 of the Mental Health Act 1983.

Recreational Workers and Therapy staff will also record detail of recreational and therapeutic intervention. The care plan is monitored daily, up-dated according the agreed care plan and shared at ward round reviews

Carer needs will be identified and a Carers Assessment arranged by the Named Nurse or care co-ordinator if this is appropriate.

The CPA care plan will also address any issues that emerge during the admission or that are anticipated when the service user is being discharged from in-patient care. This may include ensuring the service user is registered with a local GP; identify housing needs that may affect discharge, support through the Housing Worker should be offered if relevant. It will also consider what ongoing needs are for example, Acute Day Treatment Unit (ADTU), intensive home treatment from CATT or on-going intensive

care from the Support and Treatment Team or Targeted Treatment Team. It must also consider any social care or daily living issues.

Liaison with CRI/Spectrum, who are the Hertfordshire provider of drug and alcohol services will take place to ensure that any drug and alcohol problems are identified and appropriate support offered.

The CPA care plan may also identify the need for on-going involvement in home or community activities during the in-patient episode. This may be arranged with the help of the Adult Community Mental Health Service during the period of the in-patient episode providing it is clinically appropriate and agreed by the clinical team

During the service user's in-patient admission if any Welfare Benefits issues have been identified they should be recorded in their care plan and immediate assistance should be offered.

All service users will be encouraged to complete an Advanced Directive indicating their views on treatment should in-patient admission be required at any future date. Further information on Advanced Directives is to be found in the HPFT Policy, 'Advance Decisions to Refuse Treatment and Advance Statements (2012).

9. Handovers and Transfers between Inpatient Units

Transfers between inpatient wards within HPFT may be appropriate for service users for clinical reasons, for example transfer from AAU to a treatment ward.

The decision to transfer a patient should be based on clinical need and the service user and carers preferences should be taken into account where possible.

Transfer to general hospitals must involve sharing of relevant clinical information with the receiving team accompanied by documentation about their mental health condition and treatment.

The responsible consultant or his/her delegated deputy should be involved in the decision to move the patient and the choice of ward. The consultant must ensure that clinical information is handed over in a timely fashion to the receiving consultant

Team Leaders (or delegated representative) will facilitate the transfer and exchange relevant information with their nursing counterparts. Transfers must always follow the guidelines as per the Trust Transfer & Discharge Policy and admission must be in accordance with this policy.

Decisions to transfer people between wards should not take place after 8pm, except in exceptional circumstances.

If transfers have to take place in urgent situations it should have been agreed in advance which patients may be suitable to transfer.

10 Discharge from the Mental Health Inpatient Services

Discharge planning commences at the beginning of any in-patient episode and is addressed within the Care Plan, formulated at ward reviews, and confirmed and agreed within ward review meetings.

Before final discharge, a final review takes place with the patient and includes carers, the community care co-ordinator and any relevant people that the service users wishes to attend. If the patient is being discharged completely from the Acute Care Pathway, this meeting will take the form of a CPA. It may be appropriate to revise the CPA level at that point.

Attention will be given to the home and community situation to ensure identified social care and functional needs have been addressed and return home is practical and safe prior to discharge. This includes consideration for all patients of whether social outcomes as defined by the Care Act are being achieved; if two or more outcomes are unable to be achieved then referral to the community team for a full social outcomes assessment should be made. At point of discharge, patients should be given advice, information and signposting about support services in their community in order to prevent readmission/relapse and delay the need for more intensive ongoing support services.

Swabbing for Covid-19 should take place 72 hours before discharge. Please refer to the Hive for most up to date information Guidance on the completion of a Covid-19 swab test on Paris.

The final CPA review, prior to discharge, should identify the date of the first community review, the level of CPA on discharge and the name of the care co-ordinator. The date for the 72 hour follow-up contact will be agreed in accordance with the HPFT Policy Follow-up after Discharge from Mental Health In-patient Units. Might want to insert something about suicide risk and why this is so important?

If a service user chooses to take their own discharge against medical advice, their capacity to make that decision should be assessed. If they have capacity and there are no grounds to detain them under the Mental Health Act, they should be asked to sign a form that indicates that they have chosen to discharge themselves against medical advice. If they do not have capacity, they will require to be detained under Section 5.4 or Section 5.2 of the MHA (1983) until they can formally assessed under the MHA.

When an unplanned discharge occurs, risks will be assessed and the Team Leader (or their delegated representative) will consider the most appropriate short term follow-up and take appropriate action by contacting the relevant agencies. The bleep-holder and first on call manager must be advised of the situation. Ward staff must ensure that the service users carers are notified immediately, and relevant Community Services and the GP must also be informed immediately (messages left if out of hours). In such situations, the service user will be advised to have a swab for Covid-19 before leaving the ward as well as advised on self-isolation and social distancing in line with the latest government guidance Easy Read Swab test guidance for Service Users. Stay at Home Guidance

The use of drugs or alcohol whilst an in-patient, may lead to immediate discharge if this is clinically appropriate. The use of illegal drugs is a criminal offence and if this occurs on the ward the police will be notified according to the agreed procedures.

People who have had an unplanned discharge are still required to have 72 hour follow-up so the ward must ensure that the relevant Team or allocated Care Co-ordinator are aware of this responsibility in accordance with the HPFT Policy "Follow-up after Discharge from Mental Health In-patient Units" and an early CPA review.

The GP must be notified of the discharge by ward staff (usually the Ward Clerk) within 24 hours by sending a discharge notification form. The patient receives a copy of this information which contains the medication list, diagnosis and follow up information.

A discharge summary is sent to the GP and service user within 14 days together with the final CPA Care Plan and risk assessment. The discharge summary is uploaded onto the EPR by the medical secretary where it can be accessed by other involved HPFT staff such as the care co-ordinator and community consultant.

11. Services for In-Patients

11.1 Advice is offered by nursing and community staff on a range of issues including:

- Rights under the Mental Health Act
- Patient Advocacy Service (POhWER)
- Patients Advisory Liaison Services (PALS)
- Housing Issues
- Drug and Alcohol Problems
- Welfare Benefits
- Local Carers Groups

11.2 Any cultural specific services will be arranged for service users from different ethnic backgrounds and an interpreter will be identified if this is required.

11.3 Facilities for service users include a ward telephone and newspapers. Such items as toiletries, confectionary and soft drinks are also available on most sites. When a shop is unavailable staff holds a small supply of emergency toiletries.

11.4 Spiritual and religious guidance/chaplaincy for all denominations is available on request.

11.5 A service user forum/Community Meeting is held weekly for service users to raise and discuss any issues regarding the service they are receiving.

11.6 An advocacy service is available to service users and this can be accessed through the POhWER service.

11.7 Ward activities are organised daily by nursing staff and the Recreational Worker for service users and are programmed on the ward notice board. These may include games, discussions and organised activities.

11.8 On the ward there is a picture board showing photographs of staff to aid identification

11.9 Service Users on Election Days entitled to vote are assisted to exercise their rights. The Team Leader must ensure that there are sufficient staff on duty to facilitate any service user who wishes to exercise their right to vote.

12. Managing Risk

12.1 The creation and maintenance of a safe environment for service users, visitors and staff is of high importance. Personal privacy and dignity will be respected, distressed service users and carers will be offered individual support and guidance. Service users will be offered PPE as appropriate Guide to the latest PPE requirements

12.2 Regular health and safety inspections occur to ensure the physical safety of the ward.

12.3 The inpatient service will have sufficient staff with appropriate qualifications and experience on duty at all times to manage the number of service users on the ward. The number of staff required will reflect the levels of risk and will be reviewed daily, or more frequently, by the Team Leader/Site Nurse (or delegated representative).

12.4 The service operates a Managed Entry and Exit Policy (MEEP) to manage the risk of absconding whilst managing the requirements of those who have liberty to gain exit and entry to the wards.

12.5 The nursing handover between shifts should highlight the relevant risks for each service user, the reason for admission, the risk profile and any changes in risk.

13. Bed Management

13.1 The Team Leader (or delegated representative) will inform, via teleconference, the adult services Bed Manager twice daily of the numbers of in-patients on the ward, the level of care they require and any specific clinical issues that cause concern. They will also provide an update on the bed tracker, including any Community blocks due to lack of allocation of Care Co-Coordinators. This will include progress on Predicted Date of Discharge (PDD) and Delayed Transfers of Care (DTC).

13.2 All service users will be reviewed on a daily basis and alternatives to admission will be considered in line with the person's recovery.

13.3 Further details regarding bed management are to be found in the HPFT Bed Management Policy which should be followed at all times. The policy can be found by following this hyperlink Policies - Bed Management on Mental Health Acute and Assessment Inpatient Units.

14. Induction, Staff Support, Supervision, Appraisal and Training in the use of this Policy/Service

14.1 Staff development and training is a high priority for HPFT and each member of staff has an annual appraisal and a Personal Development Plan identifying training needs

14.2 Regular staff support is offered via supervision and also by access to external HPFT counselling for members of staff

14.3 Clinical, managerial and/or professional supervision is provided for staff by a more senior member of the nursing staff. Sessions are at least 6 weekly as per HPFT

Supervision Policy and offer an opportunity to focus upon their professional role and clinical practice and all supervision is offered in line with the HPFT's Supervision Policy.

14.4 All newly appointed staff undergo a comprehensive induction programme in line with HPFT policy. There is a corporate induction organised by the Human Resources Department which all new staff must attend. It is the responsibility of the line manager to insure a comprehensive local induction is carried out and signed off.

14.5 All staff, including bank and agency staff are required to have an induction period however this may be locally agreed according to the length of time they are expected to be employed

14.7 Training courses form an integral part of every nurses' Personal Development Plan. Training Bulletins are issued regularly by the Trusts' Training and Development Department. Mandatory courses must be attended and regular bank staff will be expected to attend

14.8 All ward staff are required to undergo specific training in relation to the assessment and management of risk. This is as follows:

- PPE guidance, Donning and Doffing PPE Non-aerosol generating procedures (AGPs)
- Knowledge and understanding of the HPFT Policy CPA incorporating Care Management
- Recurrent (minimum 2 yearly) risk assessment and management training. Service Line Lead to ensure that this is adhered to and records maintained by Modern Matron and professional leads.
- RESPECT training (Bank staff must also complete RESPECT training)
- Fire training
- Staff are required to have relevant and mandatory training, knowledge and understanding of Health and Safety procedures and ensure these are followed in accordance with HPFT policies
- Staff are required to have relevant training and have knowledge, understanding and be competent in performing Basic Life Support procedures
- Relevant training and knowledge of Childrens Safeguarding Procedures
- Learning for Adverse Events Policy including Reporting and Managing Adverse Incidents/Accident Procedure
- To have understanding and knowledge of the Adult Safeguarding Procedures
- Staff must attend basic training on Moving and Handling and attend refresher courses at the required intervals
- Staff are required to be certificated in Basic Food Hygiene
- Basic understanding of the risk factors associated with substance misuse and detoxification
- Ligature training
- Information Governance

	Permanent Staff	**Temporary Staff**	**Student/ Learners**
Induction to Service	**Induction on 1st day**	**Induction on 1st day**	**Induction on 1st day**

How will you Support Staff?	**Weekly 1:1** **Feedback**	**Daily briefing**	**Weekly 1:1**
Supervision Arrangements	**Shadow by senior member of staff on**	**Weekly 1:1** **Feedback**	
Appraisal	**Monthly**	**End of Shift**	**Monthly**
Training	**Half day in each area** **For taught courses, contact Learning & Development**		

15. Comments, Complaints and Compliments

15.1 All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure (see Policy document).

15.2 The policy requires all verbal or written complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager at Trust Head Office, Waverley Road, St. Albans. Comments and Compliments, once responded to, should be sent for information to the Complaints Team at Trust Head Office. Leaflets outlining the procedure are available [in or on location].

16. Capacity to Consent

The Mental Capacity Act 2005 and associated Code of Practice provide the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life changing events or everyday matters. (Please refer to the MCA Code of Practice and the Hertfordshire policy on mental capacity for further information)

17. Communications

The treatment and information service users are given should meet the individual's communication needs especially where there are specific language and sensory communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service user's should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

18. Records Management, Confidentiality and Access to Records

PARIS is the Electronic Patient Record (EPR) used by HPFT. Staff are required to record all contacts with the service user on PARIS. If difficulty arises, such as there is no access to a computer, a written note can be made in the paper light record.

All matters relating to service users' health and personal affairs and matters of commercial interest to HPFT are strictly confidential and such information must not be divulged to any unauthorised person.

Requests for access to records whether by the service user or a third party including where legal access is requested should be referred to the Team Leader or centrally.

In order to provide evidence that the best possible care and treatment is given to the service users, staff must follow the record management and confidentiality polices listed below.

- Care Records Management Policy
- Clinical Information Filing Policy
- Protection & Use of Service User Information Policy
- Formal Access to Service User Records Policy
- Freedom of Information Act Policy
- Written & Electronic Communications Policy
- Corporate Records Management Policy

19. Access to Records (Including Legal Access to Records)

Members of staff have a statutory duty (Data Protection Act 1998) to inform services users that information is being held by the Trust which records details of their health and social care assessment, treatment and progress, and that these records are identifiable. Service users must also be informed of the right to request access to their records. This information should be given verbally and by offering the service user the relevant information leaflet. The mental health professional should inform the service user that all information is confidential but may be shared on a 'need to know' basis.

If a legal representative needs to see records for a Managers' or Tribunal hearing, s/he must present written authority to disclose. If the RMO has agreed that there is nothing that needs to be kept from the service user, the solicitor will then have free access (subject to making an appointment to view with the staff).

All records MUST be printed off PARIS for the solicitor to view. They will then make any notes they wish and leave the print-out on the premises; they may not put them in their briefcase and take them away This is to prevent loss or theft of sensitive material. In the future it is anticipated that there will be a special code to allow solicitors to view the record directly on PARIS. When this comes into force it will be necessary to have an audit trail to guarantee that confidentiality is not breached. Staff should follow, at all times, the Protocol on Non-HPT Authorised Visitor Access to PARIS

20. Request for information by Independent Mental Capacity Advocate (IMCA)

Where someone lacks capacity and the criteria to instruct an IMCA are fulfilled then the IMCA should be allowed access to the relevant records. A form must be completed by the IMCA to say that they are requesting access

If the RMO assesses some information should not be disclosed to the service user the solicitor must be told. He/she will have free access to the record but is not allowed to reveal the information to the service user, unless the Managers or Tribunal Panel rule that fairness requires disclosure

If a solicitor requests access to records for ANY other reason, for example a court case, he/she should be reminded that this is handled under the Trust's formal access to records procedure and a written request must be made to medical records, enclosing client's authority.

On no account should information be disclosed to a solicitor unless the procedures detailed in section 24.3-24.5 above have been followed. Handing over records without the procedures being followed is a breach of HPFT Policy and could lead to breaching the confidentiality of the service user

Applications for access to records have to be made in writing and can be sent direct to the Modern Matron.

21. Health and Safety

Every employee and those persons working on behalf of HPFT have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. To cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.

HPFT have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor.

22. Governance

Each service area will have their own Business/Practice Governance Meeting which will meet on a monthly basis. This meeting then reports into the Inpatient & Rehabilitation Service Business and Governance Meeting as well as a report into the Patient Safety Meeting when appropriate.

Both of these meetings then report into the SBU Quality & Risk Management Meeting which is chaired by the Clinical Director.

The service aims to improve the quality of the service in the following ways:

Service User and carer experience

The service areas will actively participate in obtaining feedback from service users and carers to ensure that all views are heard and actioned so that improvements in the service user and carer experience can be implemented. This feedback can be in the form of Having Your Say; Modern Matron Surgeries; Expert by Experience Groups, Community Meetings and any informal discussions.

Clinical Effectiveness

All service areas will engage in an effective clinical effectiveness programme, much of which is managed through the Practice Audit & Clinical Effectiveness Team (PACE) who are responsible for undertaking and managing the Audit Programme for the HPFT. This should not preclude any Team or individual from undertaking audits which will improve the clinical outcomes for service users.

Safety

All service areas through the Acute & Rehab Patient Safety Meeting and local Practice Governance Meetings will actively participate in local; national; external and internal initiatives that ensure the development of strategies and initiatives that provide an environment where patient safety is at the forefront.

23. Embedding a culture of Equality & RESPECT

The HPFT promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the HPFT is required to take appropriate remedial action.

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Service user, carer and/or staff access needs	All inpatient units are accessible to all sections of the local population including black and minority ethnic groups; people with disabilities; people of both genders, regardless of their sexuality, and those in the

(including disability)	process of gender reassignment and older people. The treatment provided by the inpatient units meets the individual needs taking into consideration: • Age • Culture & Ethnicity • Gender and Gender Reassignment • Relationships and Sexual Orientation • Spirituality
Involvement	Inpatient units will actively engage with service users, carers and the public on the use of the buildings in which they are based. This will include use of current systems such as Having Your Say, PALS and Complaints, Compliments and Comments. The inpatient units will also look to make use of modern technology and will liaise with service user and carer groups to improve ways in which they collect feedback. The information service users are given will meet the individual's communication needs especially where there are specific language and sensory communication requirements.
Relationships & Sexual Orientation	Staff take account of the needs of people in different relationships. This will include consideration of sexual orientation and any needs or barriers to the required care in association with relationships and/or sexual orientation. Staff offer support to carers and family members, involving carers and family members in the care planning process.
Culture & Ethnicity	Staff provide a service that ensures the culture and ethnicity of service users is reflected in the planning of their care. Staff understand how to ask questions in the assessment process about culture and ethnicity, and that any related identified needs are documented and catered for in the agreed care plan.
Spirituality	The assessment process takes account of spirituality ensuring all aspects of the HOPE model are utilized in the care planning process. **H** – Sources of Hope **O** – Needs re: organised religion **P** – Personal belief structure (including non-faith) **E** – Effects on care of practicing spiritual beliefs. (positive and negative)
Age	The inpatient wards are available to adults 18 years and over.
Gender & Gender Reassignment	Staff provide a service that ensures the gender, including gender reassignment, status of the service user is taken into account of in the assessment and care planning process, and that any related needs are considered.
Advancing equality of opportunity	The inpatient wards will reflect on information from service user and carer feedback within the unit's team meetings, to inform continuous improvement of services. This supports continued commitment to equality of opportunity in the service.

24. Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

25. Process for monitoring compliance with this document -

Action:	Lead	Method	Frequency	Report to:
Report	Clinical Lead	Report	Annually	West SBU Quality and Risk Management Committee
Dip Audit	Practice Governance Lead	Report	Annually	West SBU Quality and Risk Management Committee

PART 3 – Associated Issues

26. Version Control

Version	Date of Issue	Author	Status	Comment
V3	01/01/2012	Practice Governance Lead	Archived	Ratified
V4	13th February 2018	Clinical Lead	Archived	
V4.1	7th August 2020	Head of Nursing	Current	Updated re-Covid-19

27. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

28. Associated Documents

- Bed Management Policy
- Care Programme Approach Incorporating Care Management
- Dysphagia and Nutrition Policy
- Guidance on Risk Assessment and Management
- Follow up After Discharge from Mental Health In-patient Units
- Fair access to Care Services in Hertfordshire
- HPFT Health and Safety Policies
- Hertfordshire Inter-agency Response to Allegation of Abuse of Vulnerable Adults
- Hospital Managers Internal Policy
- Named Nurse Policy
- Physical Health Policy
- Policy on Prevention and Management of Violence
- Policy, Procedure and Guidance on the Management of Care Records
- Post Incident Support to Staff
- Policy Document on Learning from Adverse Events, Reporting and Managing Adverse Incident/Accident Procedure, and Investigation and Root Cause Analysis of Incidents, Complaints and Claims Procedure.
- Policy on Advanced Directives.
- Safe and Supportive Observations Policy
- Smoking Cessation Policy
- Treatment of Staff and their Dependents Policy

29. Supporting References

- The Mental Health Act 1983 and Code of Practice
- The Modern Matron Charter
- The Carers Recognition Act
- The Human Rights Act
- The Data Protection Act
- The Health and Safety at Work Act
- NHS and Community Care Act
- Mental Capacity Act and Code of Practice
- DoH Mental Health Policy Implementation Guide
- Safety First, Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
- National Service Framework for Mental Health
- The Care Act 2014

33. Comments and Feedback – List people/ groups involved in developing the Policy.

Head of Nursing	Practice Governance Lead
Service Line Lead	Deputy Service Line Lead
Head of Occupational Therapy	Modern Matron
Psychology	Acute Service Line Lead
Clinical Director	
Bed Manager	

Appendix List

Covid 19 Guidance Links

Link	Title	Link
1	**HPFT Hive – Covid-19**	**The Hive**
2	**NHS England**	NHS England
3	**Public Health England (PHE) latest guidance and information Coronavirus (Covid-19)**	**Public Health England (PHE) Latest guidance and information on Coronavirus (Covid 19)**
4	**Swabbing**	
5	**Covid-19 leaflet for swabbing and self-isolation**	**Swab Test - Easy Read Leaflet**
6	**COVID-19 National Testing Programme for Keyworkers**	**Covid 19 National Testing Programme for Keyworkers**
7	**Patient Cohorting – Easy Read Guidance**	**Patient Cohorting – Easy Read Guidance**
8	**Guidance on the completion of a Covid-19 swab test on Paris**	**Guidance on the completion of a Covid-19 swab test on Paris**
9	**Guidance on Service User leave during Covid-19**	**Guidance on Service User leave during Covid-19**
10	**Stay at Home Guidance**	**Stay at Home Guidance**
11	**Guide to the latest PPE Requirements**	**Guide to the latest PPE Requirements**
12	**Visitor Guidance COVID19**	**Visitor Guidance Covid-19**
13	**Donning and doffing PPE**	**PPE Non-aerosol generating procedures (AGPs)**
14	**Reporting of suspected/confirmed COVID -19 deaths on Datix**	**Reporting of suspected/confirmed COVID -19 deaths on Datix**
15	Management of a suspected case of Covid 19 flow chart	**Management of a suspected case of Covid-19 flow chart**
16	Masks, comms and Posters	**Masks, Comms and Posters**

The National Service Framework

Legal Responsibilities delegated by Hertfordshire County Council to HPFT within the Partnership Agreement

Introduction

The core document underpinning the Social Services functions delegated to the new organisation by Hertfordshire County Council (HCC) is the Partnership Agreement between HCC and Hertfordshire Partnership University NHS Foundation Trust. This was agreed on the basis of a new flexibility to promote integrated services between Health and Social Services and is allowed under section 31 of the Health Act (1999).

Legislative basis for HPFT's delegated social care responsibilities

The legislative basis for Social Services responsibilities towards vulnerable people is extremely complex, and has grown in piecemeal fashion. There is no single overarching piece of legislation. The key statutes underpinning these social care responsibilities are :

National Assistance Act (1948), especially Section 21 which relates to the duty to provide accommodation to a wide range of people who are deemed as being 'in need of care and attention' and for whom this is not otherwise available, and Section 29 which relates to the duty to provide domiciliary services to specified client groups, including those 'who suffer from a mental disorder of any description'.

Local Authority Social Services Act (1970) established the legal basis for Social Services departments and created the post of Director of Social Services. Schedule 2 outlines their permitted functions, both obligatory and discretionary.

Chronically Sick and Disabled Persons Act (1970) Section 2 relates to the provision of a specified range of different types of welfare services, and a 'strong' duty to provide any of such services to an individual who is entitled to help under Section 29 of the 1948 Act where the authority is satisfied that the service is necessary to meet their needs.

Chronically Sick and Disabled Persons Act (Services, Representation and Consultation) (1986) strengthens the 1970 Act duty to provide or arrange services, and adds a duty to undertake an assessment if the disabled person or carer so requests, and to 'have regard' to whether the carer can continue to provide care.

National Health Services Act (1977) (especially Section 21 and Schedule 8) which attempts to delineate the respective Health and Social Services responsibilities in respect of the prevention of illness and the care and after care of ill people. It includes the provision of domiciliary support to expectant and nursing mothers.

Mental Health Act (1983) especially those provisions relating to Approved Social Workers, aftercare services, community supervision and guardianship.

Children Act (1989 and 2004) comprehensive legislation underpinning social services legal duties to children, including child protection and services for other 'children in need'.

NHS and Community Care Act (1990) particularly Section 47 which relates to the duty to assess needs and to arrange appropriate services on the basis of that needs assessment.

Carers (Recognition and Services Act) (1995) which places a duty on the authority to carry out an assessment of carers needs if so requested by the carer and to take those needs into account when carrying out the community care assessment.

Community Care (Direct Payments) Act (1996) which sets out the provisions whereby payments can be made directly to a person who has been assessed as having community care needs to enable them to purchase and control their own care in lieu of provision of services by the authority.

Carers and Disabled Children Act (2000) this further strengthens carers' rights, including the right to an assessment, including 'substantial and regular' carers where the person they are caring for is refusing help and therefore is not receiving community care services. It also introduces the concept of carers' services, allowing carers to receive services in their own right rather than as a by-product of a community care service provided to the cared-for person.

In addition to legislation there is a considerable amount of policy and practice guidance around social care, much of which is issued under Section 7 of the Local Authority and Social Services Act 1970, giving it considerable force.

Identification of the Trust's client groups for social care purposes

The Partnership Agreement identifies three separate client groups as recipients of social care services from HPFT: the child and adolescent MH services client group; the adult MH services client group, and the Drug and Alcohol services client group. This paper concentrates on the two adult groups. In the future it is intended that this should be expanded for older people (over 65) with mental health needs.

The Drug and Alcohol group are defined as 'persons with drug or alcohol problems aged 16 or over'.

The adult mental health services client group is defined in the document as meaning 'persons who are between the ages 17 and 64 inclusive with mental disorder'. The term 'mental disorder' is not further defined in the document, but if the definition used in the 1983 Mental Health Act is adopted, this must be a broad one, which encompasses not only people with mental illness but also those with 'arrested or incomplete development of mind psychopathic disorder any other disorder or disability of mind' (MHA Section 1.2).

All three groups are subject to certain exclusions outlined in Appendix 2 of the partnership agreement, primarily covering those services where there is prior agreement that they are provided by another organisation.

Eligibility for social care help

Not all people in the above client groups will necessarily be assessed as eligible for social care support. However, the legal threshold for accessing a community care assessment is a low one, and is unlikely, virtually by definition, to exclude many in these groups.

Section 47 of the NHS & CC Act places a duty on authorities (and now by extension on HPFT) to carry out an assessment 'where it appears …. That any persons for whom thy may be in need of such services….' The recent 'Fair Access to Care Services' section 7 guidance reinforces the need for setting a low threshold for accessing such an assessment to avoid 'screening out' people before sufficient information is known about their needs.

Government agenda for social care

In addition to the statutory legal framework, an organisation's social care responsibilities need to be understood developed in the context of the government's general social policy agenda.

Amongst the elements of this agenda are : Modernising Social Services, The National Service Framework, Welfare to Work, Direct Payments, Equalities Initiatives, Carers and Advocacy Initiatives, Social Inclusion, No Secrets etc. A list of such initiatives is given in Section 4.11 below).

Hertfordshire Partnership NHS
University NHS Foundation Trust

Brief Transfer Checklist from A&E to Mental Health Units

Name of Patient:……

DoB…….. NHS Number…….

I confirm that the above named individual is medically fit for discharge from the A&E Department to a psychiatric unit (please note that medical facilities and supervision are limited on a psychiatric unit and the patient should be as medically fit as if they were being discharged home)

Signature of Medical Team member …….

Name & Job Role in Capitals..……

A&E being transferred from ……..…… Date ……..

Have bloods been taken YES/NO? (please delete as necessary)

If bloods have been taken have the results been checked and signed off by an A&E Doctor? YES/NO? (please delete as necessary)

Signature of A&E Doctor…….
Please attach copy of blood test results to this form

Please list current medical conditions

Please specify current medications

Please specify if there are any ongoing medical treatment plans / monitoring required / follow up being organised

Patient has been asked if they have any item or substance that could cause harm to them or another person?(E.g. drugs, alcohol, item that could be used as a weapon and prescribed medications) Yes / No (please delete as necessary)

Before acceptance to a psychiatric bed, this form needs to be approved by bleepholder and admitting psychiatric doctor.

Signature from bleepholder confirming receipt of form and that following discussion with on call psychiatric junior doctor they are in agreement that admission to a psychiatric ward is appropriate

…….

Guidance for use of form:

The check list has been designed to help ensure that patients transferred from A&E are medically fit and safe to be transferred to an acute psychiatric ward. Below is some short guidance on the completion of the check list:

1. The HPFT assessor will take responsibility for ensuring that this form is completed by the relevant responsible clinicians before any transfer from the A&E department to a psychiatric bed is made. They will liaise with the HPFT bed manager and on-call junior doctor to sign the form off and agree admission.

2. The content of the form should be completed and signed by an A&E Doctor

3. Any blood results or relevant investigations should be attached to this form and a copy sent with the Service User to the identified inpatient ward.

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Check List for Transfer Between Medical Wards and Mental Health Unit

Name……..……..
D.O.B……..……..
NHS Number ……..…….

1. **Are any of the following currently applicable to the patient:**

Currently receiving intravenous fluids	Yes / No
Currently receiving intravenous medications	Yes / No
Nasogastric Tube in situ	Yes / No
Grade 4 Pressure sore	Yes / No
GCS of <12	Yes / No
Diarrhoea / Vomitting in last 24 hours	Yes / No
Patient currently receiving continuous cardiac monitoring	Yes / No
Patient having hourly monitoring of bp / urine output	Yes / No

If Yes to any of the above, patient is not medically fit for transfer to a psychiatric unit

2. **Are any of the following currently applicable to the patient? If yes please provide details and discuss with psychiatric team before transfer:**

PEG in situ	Yes / No
Recent loss of mobility	Yes / No
GCS 12-14	Yes / No
Raised WCC / CRP /	Yes / No

ongoing infection requiring treatment	
Compromised Skin Integrity	Yes / No (If Yes please provide body map)
Physical obs required (eg neuro obs, bp monitoring etc)	Yes / No
BMI < 17	Yes / No

3. **Personal care:**
   Self caring ☐ Requires assistance ☐
   Needs 1 to 1 ☐ Needs 2 to 1 ☐

4. **Is any special equipment required?**

5. **Mobility:**
   Bed bound ☐ Wheelchair ☐ Walking aid☐ Fully mobile ☐

6. **Falls risk**
   High ☐ Medium ☐ Low ☐

7. **Is any specialist advice required? (eg Tissue Viability Nurse, Moving and Handling etc)**

8. **Is there sensory impairment?**
   Sight ☐ Hearing ☐ CVA ☐ Other ……...

9. **Please list current medical conditions**

10. **Please list current medications**

11. **Please specify if there are ongoing treatments / monitoring / follow up plans and who should be contacted if patient's medical condition deteriorates**

I confirm that …… ……
is medically fit for discharge and can safely be transferred to a psychiatric ward.

Please attach a copy of brief discharge summary to this form along with recent blood tests and other relevant investigations

Medical team doctor's signature ……

Name in capitals……..

Role…….

Date:……

HPFT assessor ……..

Role…….

Date:……

Guidance for use of form:

The check list has been designed to help ensure that patients transferred from medical wards are medically fit and safe to be transferred to an acute psychiatric ward. Below is some short guidance on the completion of the check list:

1. The HPFT bed manager and HPFT assessor will take responsibility for ensuring that this form is completed by the relevant responsible clinicians before any transfer from an Acute Trust bed to a psychiatric bed is made. The form should be approved by the admitting psychiatric doctor or a medical member of the RAID team

2. The responsibility for completion of this form lies with the Acute Trust doctor responsible for agreeing that the patient is medically fit for discharge

3. Recent blood results or relevant investigations should be attached to this form and a copy sent with the Service User to the indentified inpatient ward.

Hertfordshire Partnership NHS
University NHS Foundation Trust

Physical Health Screening

To support Service Users accessing physical activities to support physical health & well-being on acute in-patient wards
(Medical Staff: please complete this form as part of the Physical Health Checks for each service user on admission)

Name of Service User	
Assessed on (date)	

Question	Please answer with detail where appropriate
Does the service user have any serious health conditions that would impact on their ability to participate in physical activities?	
Does the service user have a health condition that could be exacerbated by physical activity?	
Is the service user normally physically active?	
Could the service users' current medication impact on their ability to engage in physical activity?	
Are there any particular physical activities that the service user should avoid doing due to their physical health?	
Is the service user currently pregnant or has been in the last 6 months?	

This Service User is able and should be encouraged to participate in activities during their in-patient stay at the following levels (please circle 'Yes' or 'No' on every level)

Low impact/Low level exertion	Medium impact/medium level exertion	High impact/high level exertion
Short slow walks Relaxation exercises Walking around the building Adapted Tai Chi exercises Light gardening eg – potting seedlings, raised bed weeding	Brisk Walks of up to 1 hour Non cardio equipment in gym or external area Sports – eg football, badminton, Medium gardening activities – eg planting shrubs, pushing wheelbarrow	Jogging/running Cardio equipment in gym or external area Heavy digging Moving heavy objects
Yes/No	Yes/No	Yes/No

Name:

Signature

Acute Inpatient Admission Checklist – First 72 hours

Service User: **Admitting Nurse:**

Date & Time:

	Completed	Comments	Signed
To be completed in the <u>FIRST HOUR</u> of admission:			
ADMITTING NURSE:			
Check covid-status and offer swab			
Inform Duty Doctor of service user's arrival			
Personal search for contraband items			
Confirm admission is gate kept by CATT (CATT early discharge template)			
Show bed room/space & given Welcome Pack			
Offer food & drink			
Section papers if detained			
H3 or H4 to be completed			
Photocopy section & transfer forms, place copies in cream folder, originals to MHA administrator			
Complete abscond care plan			
Ask Duty Doctor to prescribe Nicotine Replacement Therapy (NRT)			
Allocate Named Nurse			
Update PSAG board & bed stats			
To be completed in the first <u>SIX HOURS</u> of admission:			
ADMITTING NURSE:			
Read service user S132 rights & give leaflet if detained			
Complete S132 monitoring form - copy to MHA office if detained			
Give service user informal rights leaflet			
Record of baseline physical observation (BP, Pulse, Resps, O2 sats)			
Weight, height & BMI			
Blood glucose, urine drug screen, pregnancy test for all women of childbearing age			

Screening for pressure sore risk/Risk Assessment/Body mapping			
Initial property search			
If appropriate, inform Next of Kin			
Complete initial 72 hour care plan			
Record and process property and valuables			
Risk Assessment			
PARIS entry made			
MEDICAL STAFF:			
Medical clerking			
Bloods form			
Physical examination undertaken & Inpatient physical examination form completed on Paris			
Medication Chart & PRN completed			
To be completed in the first <u>TWELVE HOURS</u> of admission:			
ADMITTING NURSE:			
Inform community team of admission			
MEDICAL STAFF:			
Capacity Assessment to Consent to initial care plan (exclude needs for DOLS)			
Bloods taken			
ECG completed			
To be completed in the first <u>24 HOURS</u> of admission:			
ADMITTING NURSE/ CATT Nurse			
Identification of social Circumstances – housing needs, house keys etc.			
Invite Care Co-ordinator to attend ward review in first 7 days			
Refer for Care Co-ordinator if none allocated			
Identify any safeguarding concerns on admission			
Invite family/ carers to attend ward review			
MEDICAL STAFF:			

Consultant led MDT review with CATT and ward nurse			
Treatment plan agreed			
Set Predicted Date of Discharge (PDD) and inform patient of PDD			
Refer to housing worker/ Spectrum/ other agencies as needed			
HONOS Clustering to be completed by Consultant			
Capacity to consent to treatment assessed and capacity form completed			
Leave status decided and documented			
Inform GP of admission and obtain medical history from the GP			
Medicines Reconciliation			
To be completed in the first <u>72 HOURS</u> of admission:			
ADMITTING NURSE:			
Nutrition & Dysphagia form completed – care plan completed if required			
Moving & handling needs assessment			

Notes for the Admitting Nurse:

- The admitting nurse(s) should be allocated at the commencement of every shift and recorded on the Patient Status at a Glance (PSAG) board
- It is the responsibility of the Admitting Nurse to ensure that the above areas are all completed within the agreed timescale
- The Admitting Nurse can delegate areas to another member of staff, but it remains their responsibility to ensure all areas are completed appropriately
- Any areas not completed by the end of the Admitting Nurse's shifts must be handed over to the identified Admitting Nurse in the forthcoming shift
- The PSAG board must be updated at the end of every shift – and more often as information changes
- Any 'blockages' to completing the above areas in the agreed timescale must be noted on the PSAG board in red and reported to the Nurse in Charge/Team Leader for action
- In the absence of the allocated Named Nurse, the Nurse in Charge must ensure that all areas awaiting completing are handed over at the beginning of every forthcoming shift

Our Values

we are...	you feel...
Welcoming	Valued as an individual
Kind	Cared for
Positive	Supported and included
Respectful	Listened to and heard
Professional	Safe and confident

Our Values

Welcoming Kind Positive Respectful Professional