PURPOSE

It is the Bay of Plenty District Health Board (BOPDHB) MH&AS aim that service users of the MH&AS will be assisted to plan for their transition from inpatient services or exit from the Service to ensure appropriate and effective ongoing follow-up is available if required.

OBJECTIVE

- To ensure the safe and appropriate transition of service users
- To identify and manage risks related to transition.
- To encourage co-ordination of the transition process using multidisciplinary services as required.
- To encourage effective communication between staff, the person and their family / whānau. Activated Enduring Power of Attorney (EPoA) or court appointed Welfare Guardian.
- To reduce the risk of unplanned, re-admissions.
- To ensure an appropriate length of stay for service users.

STANDARDS TO BE MET

1. Transition Criteria

1.1 Transition from a MH&AS may occur when either:

a) The assessed needs of the service user and goals identified during the assessment and treatment process have been achieved.
b) The assessed needs of the service user are unable to be appropriately met by the treating service or are better met by an alternative service provider.
c) The service user has no contact with the service, has not responded to a minimum of two (2) attempts of different modalities to engage with the service and a decision based on multi-disciplinary team (MDT) discussion and feedback from case manager has indicated that no risk issues have been identified (except patients subject to the Mental Health Act).
d) The service user "self-discharges" by negotiation or against medical advice; (except patients subject to the Mental Health Act). or,
e) The service user moves out of the catchment area.

2. Transition Planning

2.1 All service users who receive MH&AS will have a transition discharge plan.

2.2 The transition discharge plan is commenced during entry to the service and developed during assessment, delivery of care and review of care.

2.3 Details that may be included in a service user's transition discharge plan are as follows (but not limited to):

a) Preferred ongoing health provider (e.g. GP, Iwi health provider)
b) Community resources likely to be required or of benefit to the service user's recovery / ongoing care
c) Other people likely to be involved
d) Other details as identified by the person who receives the service and their family / whānau.

2.4 All service users will have an allocated staff member responsible for transition planning who will ensure that prior to transition:

a) A documented multidisciplinary review of the service user's treatment occurs.
b) The transition plan is developed collaboratively with the service user and family / whānau / caregivers Activated EPoA or court appointed Welfare Guardian (where the service user's consent is given), who will have access to a copy.
c) The transition plan will identify and manage risks associated with the transfer of care including expressed concerns of the family / whānau Activated EPoA or court appointed Welfare Guardian. Evidence of review will be documented in the clinical notes.
d) Arrangements are satisfactory to the service user, their family / whānau Activated EPoA or court appointed Welfare Guardian and to the other providers prior to their transition.
e) Findings from needs assessment, cultural assessment or drug and alcohol assessment are integrated into the transition plan, and have been documented in the clinical notes.
f) Assistance is provided to develop a Wellness and Transition Plan (person centred care plan for MHSOP in- patients with cognitive impairment) that identifies early detection or warning signs of a relapse and the appropriate action to take and staff/services to contact. CPM.M5.36 Wellness and Transition Plans – MH&AS
g) The appropriate Mental Health outcome measures are collected from the service user as specified in policy 2.5.2 protocol 9 Mental Health Outcomes Information (MH-Smart) Collection
h) Referrals have been completed and that contact has been established with the service user's general practitioner or other health care providers.
i) Sufficient health information is shared with the service user's proposed external service provider(s) to ensure that service users have access to appropriate, timely and high quality care that meets their needs and furthers their recovery/care needs.
j) This information will be forwarded prior to transition and should include but not be limited to:
    i. Service User Details (name, age, address, contact details, next of kin)
    ii. Mental health history
    iii. Diagnosis and presenting issues
    iv. Current medication
    v. Risk assessment, treatment and discharge plans
    vi. The results of specialist assessment (A&D or Needs assessment)
    vii. Any other information as negotiated in a Memorandum of Understanding with that provider.

2.5 A copy of the electronic Transfer of Care summary is provided and explained to the service user and is sent to the GP within 24 hours of the service user's transition.

2.6 Service user's will be offered a copy of the Wellness and Transition Plan at the time of their transition or a copy will be sent to them at their listed postal address within seven (7) days of their transition, either from an inpatient ward or from the secondary service to another service.

3. Standards for Inpatient Transition Planning

3.1 Ultimate responsibility for the transition documentation rests with the responsible SMO who is responsible for the service user's management and includes the monitoring of the transition process.

3.2 Where the service user is new to the service or when for any other reason there is no case manager involvement it may be appropriate to appoint an inpatient lead nurse to this co-ordination role.

3.3 Post admission and pre transition planning meetings will be coordinated by the identified lead transition planning clinician. Those in attendance will include the patient, close family / whānau, Activated EPoA or court appointed Welfare Guardian and relevant members of MDT (psychiatrist, case manager, lead nurse etc) and where appropriate support from family / whānau and / or different Lived Experience roles. Other agencies involved (NGO's, Housing agencies etc) will also be invited to these meetings as required.

3.4 When it is known that community mental health follow-up will be required, a referral should be made as soon as practicable so that a case manager can be identified early in the admission.

3.5 The case manager should maintain enough contact with the ward to ensure that effective transition planning takes place (minimum standard one contact per week). The case manager, lead nurse and other members of the MDT work closely together throughout the discharge planning process.

3.6 Consumer and Family information packs are to be provided as soon as practicable on admission and utilised as a working tool throughout the service user's journey through the inpatient service.

3.7 A transition planning checklist will be updated at every juncture of the process. This will be completed collaboratively with the patient and family / whānau if possible. A copy will be kept in the patient's health record and another by the patient to be kept in their information pack.

3.8 A Wellness and Transition Plan will be completed collaboratively with the service user and their family / whānau. A copy of this will be kept in the service user's health record and by the patient in their information folder. Wellness and Transition plan standards are also detailed in CPM.M5.36 Wellness and Transition Plans – MH&AS.

3.9 Where it is not practical to hold a transition planning meeting prior to a transfer of care, a meeting will be arranged for the earliest possible time following the transfer of care.

3.10 All service user's with community mental health case manager involvement will receive a follow up visit within seven (7) calendar days. If this is not possible the reason must be clearly documented in the service user's health record.

3.11 Inpatient Transfer of Care Summaries are completed using the MCP Transfer of Care template by the Psychiatric Registrar or delegated House Officer.

3.12 Administration staff will ensure that the completed electronic MCP Transfer of Care summary for the current inpatient episode of care is printed out prior to the record returning to the community team and:

a) A copy placed in the service user's health record.
b) A scanned copy emailed to the Case Manager and Psychiatrist

3.13 Administration staff will ensure that the patient health record is sent to coding within 48 hours of the transfer of care and returned to the appropriate satellite file storage facility for access by the community team.

4. Transfer of Care

4.1 Transfer of care procedures between responsible clinicians and DHBs are detailed in policy 6.1.2 protocol 6 Transfer of Care

5. Service Exit Against Medical advice

5.1 When a voluntary service user requests to exit the service contrary to the advice of the clinician or MDT review, the standards for transition planning will still be maintained.

5.2 If exit from the service is still requested by the service user, the case manager will arrange a transition planning meeting with the service user, family / whānau, activated EPoA or court appointed Welfare Guardian and other members of the MDT involved in the service user's care and will document the patient's health record as follows **"*Discharged against Medical Advice*"**

5.3 Service users who choose to exit from the service against medical advice will be given information at the time of exit on how to regain entry to the MH&AS.

6. Re-Entry

6.1 Service users and their family / whānau, Activated EPoA or court appointed Welfare Guardian and where appropriate, are given information at the time of transition / exit on how to regain entry should they require it, including whom to contact.

6.2 See also CPM.M5.25 Referral

7. Information Systems

7.1 The designated nurse / case manager / responsible clinician will ensure that the appropriate MH-SMART outcome measures collected from the service user are entered into the MH&AS Information System.

7.2 The staff member responsible for the service users transition planning will ensure that a Linked Referral is closed as per the MH&AS WebPAS User manual (page 38)

7.3 Administration staff / Clinician will ensure that the Primary Referral is closed for service users who are being discharged from the MH&AS entirely as per the MH&AS WebPAS User Manual, page 38.

REFERENCES

- Guidelines for Discharge Planning for People with Mental Illness. MoH. July 1993.
- Health & Disability Service Standards NZS 8134: 2021
- Mental Health (Compulsory Treatment and Assessment) Act 1992 & Amendments 1999
- Mental Health WebPAS Training Manual
- Southland District Health Board Mental Health Service Feb – Mar 2001: A Report by the Health and Disability Commissioner

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.5.1 Inpatient Discharge Planning
- Bay of Plenty District Health Board policy 6.5.1 protocol 0 Discharge Planning - Inpatient Standards
- Bay of Plenty District Health Board policy 6.1.2 protocol 6 Transfer of Care
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.9 Admission to Acute Inpatient Mental Health
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.25 Referral
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.30 Treatment Plan
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.M5.36 Wellness and Transition Plan