

# Mental Health Commission

## Code of Practice

### Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001.



## **VISION**

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Working Together for Quality Mental  
Health Services



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## Preamble

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The Mental Health Commission, established under the Mental Health Act 2001, is an independent statutory body. One of its statutory duties is to promote, encourage and foster high standards and good practices in the delivery of mental health services [Section 33(1)]. Section 33(3)(e) of the Mental Health Act 2001 obliges the Mental Health Commission to: *“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”*. In accordance with Section 33, the Commission is bringing out this code of practice on admission, transfer and discharge to and from an approved centre.

The first theme of the Quality Framework for Mental Health Services is the provision of a holistic, seamless service and the full continuum of care, provided by a multi-disciplinary team. This code of practice is in line with this theme and falls specifically within the criteria specified under Standard 1.2, which states that *“Each service user experiences a planned entrance to and exit from every part of a mental health service”*. In addition, the code addresses several other areas of the quality framework which fall under standards 1.1, 2.2, 3.1, 3.2, 6.1, 7.3, and 8.1. These include the areas of care and treatment planning, choice, respecting rights, informed consent and active involvement of service users and their families/carers or chosen advocates (with consent) in care and treatment. A key principle underlying this code is the commencement of discharge planning for the individual as soon as possible following admission to an approved centre so that the individual’s journey towards recovery can occur at the earliest point possible in his/her admission.

The code of practice overlaps with several legal provisions under the Mental Health Act 2001 and the associated Mental Health Act 2001 (Approved Centres) Regulations 2006. The Act and the regulations are legal requirements that must be complied with by the relevant parties. Therefore, in addition to the requirements of this code, the provisions for admission, transfer and discharge of involuntary patients under the Act must be followed. The code also includes reference to Article 7 – Clothing, 8 – Residents’ Personal Property and possessions, 15 – Individual Care Plan, 18 – Transfer of Residents, 20 – Provision of Information to Residents, 23 – Ordering, Prescribing, Storing and Administration of Medicines, 27 – Maintenance of Records, and Article 32 – Risk Management Procedures, of the regulations. The code supercedes the *“Guidance Note on Discharge from Approved Centres to Alternative Care Settings (including Nursing Homes)”*, which was issued by the Commission in May 2006.

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There is a pressing need for a uniform system of care in approved centres and community mental health services throughout Ireland where individuals are guaranteed a standard of care in line with international best practice. One of the key objectives in devising this code is to provide a framework for the consistent approach to admission, transfer and discharge of all individuals to and from approved centres in Ireland based on international good practice. This does not mean that health professionals' autonomy in relation to decision making is compromised, rather an overarching framework is provided to assist in ensuring that safe systems of care continue to be enhanced and are available to service users.

# Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre

*This Code of Practice has been prepared by the Mental Health Commission, in accordance with Section 33(3)(e) of the Mental Health Act 2001, for the guidance of persons working in the mental health services.*



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## Glossary

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### Admission

In this code, admission refers to the admission of an individual (voluntary or involuntary) to an approved centre. An individual with mental illness or mental disorder must only ever be admitted for inpatient mental health care and treatment to an “approved centre”.

### Advocate

In a mental health context, an advocate is a person who acts as a voice on behalf of persons with mental illness or mental disorder. The role of an advocate can range from advising on and defending the rights of a particular individual to, on a broader level influencing the planning, delivery and evaluation of mental health services.

### Approved Centre

A “centre” means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act (Section 63, MHA 2001).

### Child

A person under 18 years of age other than a person who is or has been married (Section 2, the 2001 Act).

### Community mental health team (CMHT)

An expanded multi-disciplinary team of clinicians who work together to serve the needs of service users across the lifespan. The team should include psychiatry, nursing, social work, clinical psychology and occupational therapy with ready access to other professionals/therapies and expertise.

## **Confidentiality**

Confidentiality refers to a duty that a person owes to safeguard information that has been entrusted to him or her by another. In the healthcare context, care providers have confidentiality duties in regard to service users that are founded on and emphasised by both longstanding ethical duties and legal principles.

## **Consent**

Consent refers to an individual's agreement or approval of a certain specified action or actions e.g. treatment/care/transfer of personal information. Consent is comprised of three key components: the provision of adequate information, decisional capacity, and voluntarism. The individual must:

- be capable of understanding in simple language the nature, purpose and likely effects of the action he/she is consenting to;
- understand the main benefits, risks and possible alternatives, and consequences of not receiving the proposed care and/or treatment
- be capable of retaining information for a sufficient period of time and be able to arrive at a decision; and
- be able to communicate his/her decision.

The individual's decision must also be made freely and in the absence of coercion.

## **Discharge**

In this code, discharge refers to when a resident (voluntary or involuntary) leaves an approved centre.

### **Discharge against medical advice**

Refers to a resident who decides to discharge himself/herself against medical advice (DAMA).

## **Discharge plan**

An information exchange tool and management plan focused on the discharge of a service user and his/her needs post-discharge including the management of risk. The discharge plan is a component of the individual care and treatment plan that defines expectations, roles and responsibilities.

## **Follow up**

Processes and actions that take place after a resident has left the approved centre.

## **Individual care and treatment plan**

A documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The care plan is recorded in the one composite set of documentation [Article 3, MHA 2001 (Approved Centres) Regulations 2006].

## **Independent sector**

Private and voluntary mental health service providers.

## **Key-worker**

The person who co-ordinates the delivery of the individual care and treatment plan. The key worker is responsible for keeping close contact with the resident, family/carer and chosen advocate and for advising other members of the multi-disciplinary team of changes in the service user's circumstances.

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## Mental disorder

Is as defined in section 3 of the 2001 Act and as set out below –

3.- (1) In this Act [Mental Health Act 2001] “mental disorder” means mental illness, severe dementia or significant intellectual disability where –

(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or

(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

(2) In *subsection (1)*—

“mental illness” means a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

“severe dementia” means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

“significant intellectual disability” means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

## **Mental health services**

Services which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist (Section 2, MHA 2001).

## **Multidisciplinary team (MDT)**

A mental health team comprising of a variety of professional staff. Core team members should include: psychiatrists, psychiatric nurses, clinical psychologists, social workers and occupational therapists. Other specialist therapists may also be available.

## **Needs**

Needs may be physical, psychiatric, psychological, social, housing, informational or educational (including formal education if a child) requirements for well-being. Needs may or may not be perceived or expressed by the resident.

## **Patient**

Person to whom an admission order or renewal order pursuant to the Mental Health Act 2001 relates.

## **Primary care**

Includes the range of services that are provided by general practitioners (GPs), public health nurses, general nurses, social workers, practice nurses, midwives, community mental health nurses, dieticians, dentists, community welfare officers, physiotherapists, occupational therapists, home helps, health care assistants, speech and language therapists, chiropodists, community pharmacists, psychologists and others.

## **Policy**

A written statement of clearly indicates the position of the organisation on a given subject.

**Procedure**

Written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts.

**Protocol**

An accepted code of behaviour in a particular situation.

**Privacy**

The right of a person to control information about himself/herself, including the collection, use and disclosure of that information.

**Public sector**

All government and publicly-funded organisations.

**Referral**

A request from one provider or organisation to another to provide care and treatment/service; or direction, to the service user or on behalf of the service user, to obtain additional care/services from another organisation or provider.

**Regulations**

Refers to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

**Resident**

A person receiving care and treatment in an approved centre (Section 62, the 2001 Act). The term "resident" includes both voluntary and involuntary patients.

**Service user**

A person who uses any type of mental health service, including a "resident" in an approved centre.

**Staff**

Staff refers to all employees including permanent staff, temporary staff, agency staff, and locums.

**The 2001 Act**

Refers to the Mental Health Act 2001.

**Transfer**

In this code, transfer refers to a resident's (voluntary or involuntary) move and the transfer of care within an approved centre, between approved centres (including from an independent sector facility to a public sector facility and vice versa, and to the Central Mental Hospital and vice versa), from an approved centre to a health facility abroad\*, and at times, from an approved centre to a general hospital.

*\*There are no legal provisions under the Act for the transfer abroad of an involuntary patient.*



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## Part 1: Introduction

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### 1. Purpose of the Code

- 1.1** Section 33(3)(e) of the Mental Health Act 2001 obliges the Mental Health Commission to: *“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”*.
- 1.2** The 2001 Act does not impose a legal duty on persons working in the mental health services to comply with codes of practice, but best practice requires that codes be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow a code of practice could be referred to during the course of legal and/or disciplinary proceedings.
- 1.3** This code of practice provides good practice guidance on the processes of admission to an approved centre, transfer from an approved centre and discharge from an approved centre. It will enable service providers to develop their own admission, transfer and discharge policies in accordance with the guidance.
- 1.4** The primary objectives of this code are:
- a) To create a more **positive journey** for the service user through the mental health service by improving the continuity and co-ordination of mental health care and treatment;
  - b) To encourage the active **involvement**, from admission to discharge, of a resident and his/her family/carer or chosen advocate, where appropriate (i.e. with the consent of the resident) including the provision of adequate **information**;
  - c) To promote **collaboration** and **improved communication** between all parties involved in these processes, including between approved centre staff and primary care/community mental health services, and other relevant agencies, and to emphasise the importance of adequate **exchange of information** between service providers to ensure continuity of care from admission to aftercare;
  - d) To aid in the **safe and efficient** transfer of a resident from an approved centre to another facility;
  - e) To promote the view of discharge as an **ongoing and active process**.

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- 1.5** The provisions of the code are not designed to set out a prescriptive model of the ideal service or to replace clinical judgment but rather to provide guidance to enable all professionals working with mental health service users to make decisions which are in keeping with the best interests of the person and are in line with international best practice.

## **2. Scope of the Code**

- 2.1** The code of practice is relevant to all partners involved in the delivery of mental health care and treatment including service users, families/carers, advocates, staff in approved centres, community mental health teams, general practitioners/ primary care teams, advocacy services and outside agencies.
- 2.2** Many of the provisions of the code are particularly relevant to service providers and staff working in approved centres, including management, consultant psychiatrists, registered medical practitioners, psychiatric nurses, social workers, clinical psychologists, occupational therapists and administrative staff.
- 2.3** The code applies to anyone who is admitted, transferred or discharged to and from an approved centre including **both voluntary and involuntary patients** in approved centres, referred to as “residents” in this code in line with the Act (Section 62). **It is important to note that the code is without prejudice to any legal requirements for the admission, transfer and discharge of involuntary patients under the Mental Health Act 2001.**

## **3. Monitoring and Review**

- 3.1** The Inspector of Mental Health Services will monitor the processes outlined in this code in the course of inspections in accordance with Section 51 of the Act. Inspections with this code will commence from **January 2010**.
- 3.2** As required by Section 33(3)(e) of the 2001 Act, the Commission shall review codes of practice periodically, after consultation with appropriate bodies. It is intended that this code will be reviewed no later than 5 years from the date of issue.

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## Part 2: Enabling Good Practice through Effective Governance

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It is crucial that appropriate governance structures are put in place to enable implementation of this code. The ultimate responsibility for corporate governance in an approved centre lies with the Registered Proprietor and for clinical governance lies with the Clinical Director.

### 4. Policies & Protocols

- 4.1** Approved centres should put in place written admission, transfer and discharge policies in accordance with the guidance contained in this code.
- 4.2** The approved centre's policies should include the procedures for involuntary admission, transfer and discharge pursuant to the 2001 Act.
- 4.3** Community mental health services should have a protocol in place for planned referral to an approved centre, where appropriate. This should include reference to pre-admission assessments, eligibility for admission to an approved centre and referral letters.
- 4.4** Every approved centre should have a protocol in place for dealing with urgent referrals, including referrals from emergency departments and primary care. This protocol should make reference to general practitioners/primary care teams being requested to telephone in advance and follow up with a fax of written referral if possible.
- 4.5** Every approved centre should have in place a protocol for dealing with individuals who self-present or who present in the company of a relative, parent or guardian. This protocol should address the assessment that takes place.
- 4.6** Approved centres should include in their admission policy, where appropriate, procedures for the admission of children in accordance with the Code of Practice on Admission of Children under the Mental Health Act 2001.
- 4.7** The approved centre's admission policy should indicate the roles and responsibilities of the multi-disciplinary team in relation to assessment following admission.
- 4.8** The approved centre's policy on individual care and treatment plans as per Standard 1.1 of the Quality Framework should specify who may be a key-worker, his/her role and arrangements for when the key worker is absent.

- 4.9** A communication protocol should be developed between approved centres and both general practitioners/primary care and community mental health services for timely communication and exchange of information from the time of referral to discharge. This protocol should include reference to pre-admission assessments, referral letters, provision of appropriate information to the service user and discharge summaries. It should also include reference to both verbal and written communication and to the mechanisms (i.e. form, mode, content) by which information can be best communicated.
- 4.10** The approved centre's policy on medication required in accordance with Article 23 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 should include the handling of medication, both prescribed and non-prescribed, which is brought into the approved centre by the resident. It should also make reference to prescriptions and the supply of medication on discharge, as appropriate.
- 4.11** The approved centre's policy on personal property and possessions in accordance with Article 8 of the Regulations should take account of the best interests of the person and respect his or her right to dignity, bodily integrity, privacy and autonomy. It should also include reference to risk assessment.
- 4.12** Approved centres should work with the relevant social, housing and homeless agencies to develop a protocol for information sharing and discharge planning for homeless persons with mental illness admitted to approved centres. The protocol should make reference to joint working at the earliest possible opportunity following the admission of a homeless person and to the management of his/her discharge.
- 4.13** The approved centre's transfer policy should make reference to how the transfer is arranged and effected in a safe and timely manner. It should also include provisions for emergency transfers (e.g. transfer to psychiatric intensive care units), and where applicable provisions for transfers abroad. The safety of the resident and staff involved in the transfer process should be key considerations in this policy.
- 4.14** Approved centres and community mental health services should work collaboratively to develop local follow-up policies. Follow-up policies should include reference to relapse prevention strategies and crisis management plans, the roles and responsibilities of

the various health professionals in providing follow-up care, when and how much follow-up contact residents should have, and a way of following up and managing missed appointments.

- 4.15** The approved centre's discharge policy should include procedures for the management of discharge against medical advice.
- 4.16** Approved centres that admit people with intellectual disability should develop a protocol for the admission and discharge of people with intellectual disability for mental health care and treatment. This protocol should address the specific post-discharge needs of this group, including the provision of residential accommodation, where necessary.
- 4.17** Approved centres should work with alternative care settings, including nursing homes, to develop a protocol for the discharge of older persons.
- 4.18** Approved centres should have in place a written policy on privacy, confidentiality and consent in line with the provisions of Section 5 "Privacy, confidentiality and consent". Such a policy must be consistent with the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.
- 4.19** All approved centres should audit their admission, transfer and discharge policies to ensure that they are being fully and effectively implemented and adhered to in clinical practice. Article 29 of the Regulations provides that the written policies and procedures of an approved centre must be reviewed at least every 3 years, with due regard to any recommendations made by the Inspector of Mental Health Services or the Mental Health Commission. The policies should specify the roles and responsibilities of staff in this regard.

## **5. Privacy, confidentiality and consent**

- 5.1** Personal information should be handled with the highest level of professionalism. A person's right to privacy should be respected and the duty of confidentiality upheld. Personal information should not be communicated to a third party e.g. family, carer,

advocate, health professional in another health care setting or outside agency, without the service user's consent, outside the course of that necessary to fulfil legal and professional requirements.

## **6. Staff Roles & Responsibilities**

- 6.1** All approved centres should clearly establish the roles and responsibilities of members of staff in the admission, transfer and discharge processes.
- 6.2** The various roles and responsibilities assigned should be clearly documented.

## **7. Risk Management**

- 7.1** Approved centres must comply with Article 32 of the Regulations in respect of risk management procedures.

## **8. Information Transfer**

- 8.1** Fax may be used to facilitate timely transfer of information. However, reasonable safeguards should be employed to ensure the confidentiality of information. Fax machines should be located in secure areas, the receiving facility should be notified in advance of sending information, a cover sheet should be sent with all faxes and information should be checked by both the sending and receiving facility for clarity, legibility and completeness.
- 8.2** In general, email is not considered to be secure and should not be used for the transfer of confidential information.

## **9. Staff Information & Training**

- 9.1** All health professionals working in approved centres should be familiar with the content of the admission, transfer and discharge policies of that approved centre and adhere to the procedures outlined in them/it. A copy of the policies should be available on the units of every approved centre. Documentary evidence that relevant staff have read and understand the policies should exist.

- 9.2** The Mental Health Commission's Code of Practice Relating to Admission of Children under the Mental Health Act 2001 and the Mental Health Commission's Reference Guide to the Mental Health Act 2001 should be accessible to all staff.
- 9.3** Approved centres admission, transfer and discharge policies should include reference to appropriate training of relevant staff. This should include, but is not limited to, training in relation to individual care and treatment planning, multi-disciplinary team working, risk assessment and risk management.



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## Part 3: Admission Process

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**Note: The content of this section is without prejudice to the legal requirements for involuntary admission as set out in Sections 8 to 16 of the Mental Health Act 2001.**

### 10. Pre-admission Process

Admission should be planned, in so far as is possible, by engaging in a pre-admission process. The provisions of 10.1 and 10.2 should take place; however, it is recognised that these provisions may not occur in all instances because of the urgent nature of some referrals, because a service user has already completed some of these steps or because a service's referral pathway differs in some way from the pre-admission process set out below.

#### 10.1 Primary Care

**10.1.1** An assessment should be carried out by primary care before an individual is referred to community mental health services in line with the agreed communication protocol (*See Section 4 Policies & Protocols*).

**10.1.2** A referral letter should be sent by primary care to community mental health services, with the individual's consent, in line with the agreed communication protocol. The letter should include information on whether the referral is urgent, presenting complaint, current mental state, past psychiatric history, medical history, current medications, relevant risk factors and other relevant information e.g. social circumstances and alcohol or drug problems. All information received should be kept in the clinical file.

#### 10.2 Community Mental Health Services

**10.2.1** A pre-admission assessment should be carried by a designated member or members of the community mental health team prior to referral to an approved centre. This assessment should include risk assessment.

**10.2.2** Following assessment of an individual's need for inpatient care and treatment, the individual's eligibility for admission to an approved centre on the basis of catchment area, age and health insurance status, should be established prior to referral.

**10.2.3** In cases where the referral is planned, a referral letter should be sent by community mental health services to the approved centre prior to admission or by prior

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arrangement it should be presented by the individual or his or her family (e.g. in the case of a child) to staff upon arrival. Alternatively, if a referral phone call takes place, the details of the call should be documented. It is imperative that all relevant information is sent (by referral letter or phone) to staff in the approved centre.

## 11. Unplanned Referral to an Approved Centre

Where unplanned referral to an approved centre occurs, the following steps should be followed.

### 11.1 Urgent Referrals

**11.1.1** Where a person presents as an urgent referral, he or she should be assessed as soon as is practicable and a record of this assessment should be maintained. This assessment should include a risk assessment. Urgent referrals should be dealt with in accordance with the service's protocol for urgent referrals (*See Section 4 Policies & Protocols*).

### 11.2 Self-Referrals

**11.2.1** Where a person presents as a self referral, he or she should be assessed as soon as is practicable and a record of this assessment should be maintained. This assessment should include risk assessment. Assessment should be carried out in accordance with the service's protocol for self referrals (*See Section 4 Policies & Protocols*).

In the case of **both** urgent referrals and self referrals, the following should apply:

**11.2.2** Every reasonable effort should be made to make contact with the individual's GP/ primary care team or community mental health team to obtain all relevant information.

## 12. Admission Criteria

**12.1** Admission should only occur when the individual's primary complaint is one of mental illness or mental disorder<sup>1</sup>.

**12.2** The best interests of the individual must be the primary consideration when deciding whether or not to admit with due regard being given to the interests of others who may be at risk of serious harm if the person is not admitted.

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<sup>1</sup> See glossary

**12.3** If it is clinically determined that the individual is in need of immediate inpatient mental health care and treatment after reference to the above criteria, he or she should be admitted to the approved centre. This should occur regardless of whether he or she meets any additional criteria of the approved centre (e.g. catchment area, health insurance status) unless a safe direct admission to the appropriate approved centre can be arranged.

### **13. Decision to Admit**

**13.1** The decision to admit should be made by a registered medical practitioner or a consultant psychiatrist whichever is appropriate, in consultation with the individual, members of the multi-disciplinary team where possible, and the individual's family/carer or chosen advocate, if appropriate (i.e. with the consent of the individual or in the case of a child).

**13.2** The decision to admit should be made after exploring alternative treatment options.

**13.3** An individual should be admitted to the unit most appropriate to his/her needs, save in cases of emergency.

**13.4** An individual should be informed of the reasons why he/she is being admitted.

### **14. Decision Not to Admit**

**14.1** A decision not to admit an individual following referral should be documented and should be communicated back to the individual's referring GP or community mental health services and the individual's family/carer or chosen advocate, if appropriate (i.e. with the consent of the individual or in the case of a child).

**14.2** The decision not to admit should be made after exploring alternative treatment options. Referral to a more appropriate service in accordance with the individual's existing needs should be made, where necessary, and a record of this should be maintained.

**14.3** An individual should be informed of the reasons why he/she is not being admitted.

## 15. Assessment following Admission

- 15.1** A resident should have an initial assessment on admission followed by a more comprehensive assessment as soon as possible, which has multi-disciplinary input in so far as is practicable (*See Section 4 Policies & Procedures*).
- 15.2** Assessments should be carried out in an area, which ensures that the privacy and dignity of the resident and the safety of the resident and staff are preserved.
- 15.3** Assessment should include, but is not limited to, current mental health state, risk assessment, the presenting problem, past psychiatric history, full physical examination, medical history, medication history and current medication, family history (where relevant), social and housing circumstances (where relevant), informational needs, and any other relevant information e.g. work situation, educational, dietary requirements.
- 15.4** Where there are child protection issues, appropriate action should be taken in accordance with Children First Guidelines..
- 15.5** All assessments should be fully documented in the resident's clinical file.

## 16. Rights & Information

- 16.1** Information on a person's rights under the 2001 Act should be readily available in the approved centre.
- 16.2** A resident should be made fully aware of his/her rights upon admission. Staff should check that a resident understands his/her rights and his or her understanding of these rights should be documented in the clinical file. A resident's rights should be revisited and discussed with him/her during his/her stay to ensure understanding.
- 16.3**
- a) Upon admission, a resident should be orientated to staff and the unit to which he/she is being admitted and supplied with a resident information booklet.
  - b) A booklet should be written in plain understandable language and should include, but is not limited to, information on the approved centre's policies and procedures.

c) Approved centres must comply with Article 20 of the Regulations regarding the provision of information to the resident, which includes providing information relating to:

- details of the resident's multi-disciplinary team;
- housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
- verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;
- details of relevant advocacy and voluntary agencies;
- information on indications for use of all medications to be administered to the resident, including any possible side-effects.

d) The provision of information to the resident should be documented in the clinical file.

e) A resident and his/her family, carer or chosen advocate where appropriate (i.e. with the consent of the resident or in the case of a child) should have the opportunity to discuss with staff any issues arising from the information provided.

**16.4** A resident should be provided with individualised information in a timely manner upon admission including information on his/her initial care and treatment plan.

**16.5** a) Information should be adapted both in form and content to meet the needs of the resident. Information should be made available in both written and oral form. Interpretation services should be made available, where necessary. Information booklets could be made available in other languages commonly seen in the approved centre, where possible.

b) Where a resident is unable to understand information given, such information should be conveyed, where appropriate (i.e. with the consent of the resident), to a personal

representative such as a family member, carer, chosen advocate, or the person best able and who is willing to represent the resident's interests.

## **17. Individual Care and Treatment Plan**

- 17.1** Every resident must have an individual care and treatment plan in accordance with Article 15 of the Regulations.
- 17.2** Standard 1.1 of the Quality Framework for Mental Health Services should be followed in terms of the nature and content of the care and treatment plan developed.
- 17.3** The plan should focus on the individual's recovery. It should also include a risk management plan and a preliminary discharge plan, outlining any possible obstacles to discharge e.g. social factors.

## **18. Resident and Family/Carer/Advocate Involvement**

- 18.1** The resident should be actively involved in the admission process and in the development of his/her care and treatment plan.
- 18.2** The resident should be encouraged to involve his/her family/carers in his/her care and to inform them of the admission, where appropriate.
- 18.3** The resident's family/carers &/or chosen advocate should be involved in the admission process and in the development of the care and treatment plan with the resident's consent.
- 18.4** Advocacy services should be made available to the resident as required.

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## 19. Multi-disciplinary Team Involvement

- 19.1** Where possible, multi-disciplinary involvement in the admission process should occur.
- 19.2** The resident should be introduced to the multi-disciplinary team responsible for providing his/her care as soon as possible following admission.

## 20. Key-worker

- 20.1** There should be a key-worker system in place in all approved centres.
- 20.2** A resident should be assigned the most appropriate person to be his/her key-worker as soon as possible after admission and the name of the key worker should be documented in the resident's clinical file.
- 20.3** The key-worker should make himself/herself known to the resident and his/her family, carer or chosen advocate, if appropriate (i.e. with the consent of the individual or in the case of a child), as soon as possible in the resident's stay taking time to explain his/her role.
- 20.4** The key-worker should have responsibility for co-ordinating all stages of the resident's stay in the approved centre and should serve as a point of contact for the resident and his or her family, carer or chosen advocate addressing their informational needs and informing them about what is happening and the likely proceeding steps in the inpatient process. He or she should work with other members of the multi-disciplinary team to ensure that liaison with relevant outside agencies takes place.

## 21. Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies & Information Transfer

- 21.1** Staff in the approved centre should establish verbal as well as written communication, where possible, with the relevant general practitioner/community mental health staff upon referral of an individual, particularly in the case of urgent or self-referrals where information may be lacking.

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**21.2** Where the decision is made to admit an individual, his/her general practitioner/primary care team/community mental health team should be notified of the admission as soon as is practicable. This notification should include information on the intended care to be provided to the resident, and the projected length of stay where possible.

## **22. Record-Keeping and Documentation**

**22.1** An integrated approach to record-keeping should be adopted in approved centres. All members of the multi-disciplinary team should work to one set of documentation. Each approved centre should have procedures in place that address access to records on a 24 hour basis.

**22.2** It is considered good administrative practice to use an admission form for voluntary patients which includes a general consent for admission. This does not negate the need to obtain consent for specific treatment interventions.

**22.3** In the case of an involuntary admission, statutory forms are required to be completed in accordance with the 2001 Act.

**22.4** All assessments and examinations on admission should be clearly and fully recorded in the resident's clinical file.

**22.5** Documentary evidence of resident, and family/carer or chosen advocate involvement in admission, including the provision of information to these parties, should be kept in the resident's file.

**22.6** Approved centres must comply with Article 27 of the Regulations in respect of maintenance of records.

**22.7** Clinical files should be well maintained (*See Appendix 2 and the relevant guidance documents of professional bodies*). They should be legible, signed and dated. Full names should be provided as initials will not suffice. Signature banks for all members of staff and students should be made available and be updated regularly.

## **23. Day of Admission – Some Practical Considerations**

### **23.1 Personal Property & Clothing**

**23.1.1** Approved centres must comply with Article 7 and 8 of the Regulations in respect of personal property and possessions and clothing.

**23.1.2** A resident's clothes, in general, should not be taken from him/her on admission. Where clothes are taken, the rationale for this decision should be clearly documented in the resident's clinical file.

## **24. Specific Groups**

### **24.1 Homeless People**

**24.1.1** A homeless person should be identified on admission, and a record of his/her "no fixed abode" status recorded.

**24.1.2** A homeless person with mental illness should be admitted to an approved centre if in need of immediate inpatient care regardless of catchment area. Local policy should take into consideration the importance of continuity of care for each homeless person.



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## Part 4: Transfer Process

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**Note:** The content of this section is without prejudice to the legal requirements for the transfer of an involuntary patient as set out in Sections 20 to 22 of the Mental Health Act 2001. There are no legal provisions under the 2001 Act for the transfer abroad of an involuntary patient.

### 25. Transfer Criteria

**25.1** The following criteria should apply when considering the transfer of a resident:

- a) It is believed to be in the best interests of the resident to be transferred to another facility **&**
- b) The resident is in need of obtaining special treatment or care that can only be provided in another facility **or** is no longer in need of obtaining special treatment or care in another facility **&/or**
- c) The resident requests to be transferred either to another approved centre, which may be closer to his/her home or to an independent facility for which he/she has health insurance cover.

### 26. Decision to Transfer

**26.1** The decision to transfer should be made by a registered medical practitioner or the clinical director whichever is appropriate, in consultation with the resident, members of the multi-disciplinary team where possible, and the resident's family/carer or chosen advocate, if appropriate (i.e. with the consent of the resident or in the case of a child).

**26.2** The decision to transfer should be agreed with the receiving facility.

### 27. Assessment before Transfer

**27.1** An assessment of the resident should be carried out prior to transfer. Risk assessment and risk management are integral here.

## 28. Resident Involvement

- 28.1** Every effort should be made to respect the resident's wishes regarding transfer and to obtain his/her consent before a transfer takes place, however there may be circumstances where it is not possible to obtain consent.
- 28.2** A resident's family/carer &/or chosen advocate, where appropriate, (i.e. with the resident's consent) should be involved in the transfer process.
- 28.3** Transfer options available should be discussed and any concerns or questions that the resident and/or his or her family/carer or chosen advocate may have about the transfer should be addressed. Any relevant information conveyed by the resident or his or her family, carer or chosen advocate, particularly with regard to risk assessment and suicidal intent should be documented and conveyed to the receiving facility. Involvement should be documented in the resident's clinical file.

## 29. Multi-disciplinary Team Involvement

- 29.1** Members of the multi-disciplinary team should be involved in the transfer process in so far as is practicable.
- 29.2** The key-worker should have responsibility for co-ordinating all stages of the resident's transfer to the receiving facility. He or she should liaise with members of the multi-disciplinary team in both facilities in preparation for transfer.

## 30. Communication between the Approved Centre and Receiving Facility & Information Transfer

- 30.1** Approved centres must comply with Article 18 of the Regulations in respect of information transfer.
- 30.2** Direct verbal communication and liaison should take place between the approved centre and the receiving facility prior to the transfer taking place. This should include a discussion of the reasons for transfer, the resident's care and treatment plan (including needs and risk) and whether the resident requires accompaniment on transfer. Arrangements should be made accordingly for the arrival of the resident at the receiving facility.

- 30.3** It is imperative that full and complete written information regarding the resident is transferred when he or she moves from an approved centre to another facility. This information should be sent in advance or at least accompany the resident upon transfer. The written information should be sent to a named individual within the receiving facility and a record to this effect should be maintained. Written information sent should include the individual care and treatment plan and a brief referral letter addressing the reason(s) for the transfer (*Appendix 3 includes a sample transfer form which may aid services in devising their own transfer form*). The information should be checked by both the transferring approved centre and the receiving facility to ensure completeness.
- 30.4** It is vital that staff in the receiving facility familiarise themselves with all written information received in a timely fashion, particularly as it relates to risk assessment.

## **31. Record-Keeping & Documentation**

- 31.1** The decision to transfer a resident should be documented in the resident's clinical file.
- 31.2** A copy of the referral letter should be kept in the resident's clinical file.
- 31.3** Documentary evidence of the involvement of the resident and his or her family, carer or chosen advocate in the transfer process should be kept.
- 31.4** Documentary evidence of the resident's consent to transfer should be kept in the resident's file, where applicable. Where consent has not been obtained, the reasons for this should be documented in the resident's clinical file.
- 31.5** In the case of the transfer of an involuntary patient, statutory forms are required to be completed in accordance with the 2001 Act.

## **32. Day of Transfer – Some Practical Considerations**

- 32.1** A time should be arranged for the transfer of the resident. Planned transfers should take place early in the day and before 17.00 hours in so far as is practicable. If transfer takes place after 17.00 hours, the reason for it should be clearly documented in the resident's clinical file.

- 32.2** Transport should be arranged for the transfer if required.
- 32.3** The return of property should be in accordance with the approved centre's policy on personal property and possessions, with attention being paid to risk assessment.
- 32.4** The transferring approved centre maintains responsibility for the resident until care is accepted by the receiving facility.
- 32.5** On arrival to a new unit, the admission policy of the receiving facility, if it is an approved centre, should be implemented.

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## Part 5: Discharge Process

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**Note: The content of this section is without prejudice to the legal requirements for the discharge of an involuntary patient as set out in Section 28 of the Mental Health Act 2001.**

### 33. Decision to Discharge

**33.1** The decision to discharge should be made by a registered medical practitioner or the responsible consultant psychiatrist whichever is appropriate, in consultation with the resident, members of the multi-disciplinary team where possible, and the resident's family/carer or chosen advocate, if appropriate (i.e. with the consent of the resident).

### 34. Discharge Planning

**34.1** A comprehensive and structured discharge plan should be developed as a component of the individual care and treatment plan. Discharge planning should commence as soon as possible after admission. This plan should be developed, reviewed and updated as per the care plan.

**34.2** The discharge plan should focus on the resident's recovery and should include, but is not limited to: an estimated date of discharge, documentary evidence of communication with the relevant general practitioner/primary care team or community mental health staff, a follow-up plan, and early warning signs of relapse and risks.

**34.3** Time periods should be specified within which each discharge action should be completed to ensure the timely implementation of various procedures within the discharge process. All multi-disciplinary team members should be aware of their roles and responsibilities as specified in the discharge plan.

**34.4** A discharge meeting should take place before discharge. This meeting should be attended by the resident, his/her key worker, relevant members of the multi-disciplinary team and the resident's family, carer or chosen advocate where appropriate (i.e. with the consent of the resident).

### 35. Pre-Discharge Assessment

**35.1** A resident should have a comprehensive assessment prior to discharge, which is multi-disciplinary in so far as is practicable. It should include an assessment of psychiatric

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and psychological needs, a current mental state examination, comprehensive risk assessment and risk management plan, informational needs, any social and housing needs that the resident may have and any other relevant information.

**35.2** Where necessary, suitable accommodation should be secured before a resident is discharged.

**35.3** The assessment should be documented in the resident's clinical file.

## **36. Multi-disciplinary Team Involvement**

**36.1** A multi-disciplinary team approach to discharge planning should be adopted, as appropriate, and relevant members of the multi-disciplinary team should actively manage the discharge process.

## **37. Key-worker**

**37.1** The key-worker should co-ordinate the discharge process.

**37.2** He/she should liaise with the resident, family, carer and/or chosen advocate, where appropriate (i.e. with the consent of the resident) and work with other members of the multi-disciplinary team to ensure that liaison with the general practitioner/primary care team and/or community mental health services and relevant outside agencies takes place.

**37.3** The key-worker should check that all relevant documentation has been completed by relevant members of the multi-disciplinary team.

## **38. Collaboration with Primary Health Care, Community Mental Health Services, Relevant Outside Agencies & Information Transfer**

**38.1** Community mental health staff should be involved in the discharge process from an early stage. Where feasible, planned contact between a resident and the relevant community mental health services/general practitioner/primary care team should be established prior to discharge.

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- 38.2** General practitioners/primary care teams and/or community mental health services should always be informed of the discharge of a resident. Every reasonable effort should be made to inform them within 24 hours. If not feasible, a record should be made of the reason(s) and it should be followed up as soon as possible.
- 38.3** When a resident is discharged, a discharge summary should be sent to the general practitioner/primary care team/community mental health services responsible for follow up care within 3 days of discharge. This may occur as follows:
- a) A comprehensive discharge summary is sent to the general practitioner/primary care team/community mental health services responsible on discharge or no later than 3 days, or
  - b) If this is not practicable, a preliminary discharge summary (& prescription information) may be sent initially, followed by a comprehensive discharge summary within 14 days.
- 38.4** Discharge summaries should include information regarding diagnosis, prognosis, medication, mental state at discharge, any outstanding health or social issues at discharge, follow up arrangements, the names and contact details of key people for follow-up and risk issues such as signs of relapse. *(Appendix 4 includes a sample discharge summary for illustrative purposes only, which may aid services in devising their own discharge summary).*

## **39. Resident and Family/Carer/Advocate Involvement & Information Provision**

- 39.1** A resident and his/her family/carer and/or chosen advocate, where appropriate (i.e. with the resident's consent), should be actively involved in the discharge process and a written record should be made of any involvement in the resident's clinical file.
- 39.2** Involvement should include the option to attend and be involved in discharge meetings, ongoing discussion regarding the discharge plan with the multi-disciplinary team and key worker, and the opportunity for the resident and his/her family/carer and/or chosen advocate to voice any concerns they may have regarding discharge.

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**39.3** Every effort should be made to identify the support needs of the family/carer, where appropriate, prior to discharge.

**39.4** Comprehensive information should be provided by the key-worker to the resident and his/her family/carer and/or chosen advocate, where appropriate (i.e. with the resident's consent), in plain understandable language upon discharge, which should include generic and individualised information.

a) Generic information should include contact details of community mental health services and details of how to access these services, contact details of other support services such as advocacy services, relevant voluntary organisations, relevant community groups and supported employment services, a crisis point of contact and details of how to re-access inpatient services (including during out of hours).

b) Individualised information should include information on the resident's medication and how to take medication, possible side effects, information on diagnosis and any follow up arrangements made prior to discharge.

**39.5** The key-worker should discuss the information provided with the resident and his or her family/carer and/or chosen advocate, where appropriate (i.e. with the consent of the resident), prior to discharge to ensure that the resident understands the information given and to address any questions or concerns he/she may have prior to discharge.

**39.6** Discharge preparation groups should be used, where feasible, to bridge the gap between inpatient and community care.

## **40. Notice of Discharge**

**40.1** Approved centres should provide the resident, his/her family/carer and/or chosen advocate where appropriate (i.e. with the consent of the resident), with a minimum of 2 days notice of discharge. If this does not occur, the reason(s) for it should be clearly documented in the resident's clinical file.

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## 41. Follow-up & Aftercare

**41.1** A timely post-discharge follow-up appointment with the relevant services e.g. general practitioner/primary care team, community mental health services, where indicated, should be made prior to discharge.

- a) The resident and his/her family, carer, or chosen advocate where appropriate (i.e. with the consent of the individual) should be notified of the date of this appointment verbally and in writing. This should be documented in the discharge plan.
- b) The clinical judgement of the relevant members of the multi-disciplinary team should be used when deciding the appropriate time lapse between discharge and the date of the follow up appointment.
- c) It is considered good practice that individuals with severe mental illness and a history of deliberate self-harm within the previous 3 months or who are assessed as being at risk of suicide should have a follow up appointment within one week of discharge.

## 42. Record-Keeping & Documentation

**42.1** All aspects of the discharge process should be fully recorded in the resident's clinical file. This should include the following:

- a) Documentary evidence that discharge planning commenced on admission where feasible, or as soon as possible thereafter;
- b) The individual's discharge plan.
- c) Evidence of review of discharge plan and consultation with resident and family/carer/advocate if appropriate prior to discharge;
- d) The information given to resident and family/carers/advocates, where appropriate, (i.e. with the consent of the resident);

- e) The date of discharge;
- f) Necessary referrals undertaken;
- g) Follow up appointment dates and times;
- h) A copy of all discharge summaries.

**42.2** In the case of the discharge of an involuntary patient, statutory forms must be completed in accordance with the 2001 Act.

### **43. Day of Discharge – Some Practical Considerations**

**43.1** Property should be returned to the resident on the day of discharge in accordance with the centre’s policy on personal property and possessions.

**43.2** A medical certificate and prescription should be furnished if required.

**43.3** Transport arrangements should be implemented in accordance with the individual’s discharge plan.

### **44. Specific Groups**

#### **44.1 Homeless People**

**44.1.1** Before discharge, the multi-disciplinary team should endeavour to ensure that the resident has been referred to the appropriate housing authority where appropriate (i.e. with the consent of the resident).

**44.1.2** The key-worker or social worker should contact and liaise with relevant social, housing, and homeless services to arrange a supported community residence or suitable alternative accommodation for the resident. He/she should work in partnership with the relevant statutory authorities and voluntary agencies to make arrangements for continuing support in the community.

**44.1.3** A record should be kept of the type of accommodation to which the person is discharged.

## **44.2 Older Persons**

**44.2.1** When discharging an older person to continuing care in an independently managed nursing home or publicly funded and managed unit, the inspection reports of the facility for the past three years, where available, should be reviewed to facilitate selection of the most appropriate facility for that person.

**44.2.2** This review should include particular attention to the programme of care and social activity in the facility, the availability of skilled and knowledgeable care and nursing staff, the availability of specialised services and facilities for those with dementia, the palliative care programme within the facility, and the service's policies on such issues as the management of complaints, the use of restraint, and the management of allegations of abuse.

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## References

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Available on request.

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## Appendices

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**Appendix 1** Flowcharts

**Appendix 2** Excellence in Mental Health Records

**Appendix 3** Transfer Form Sample

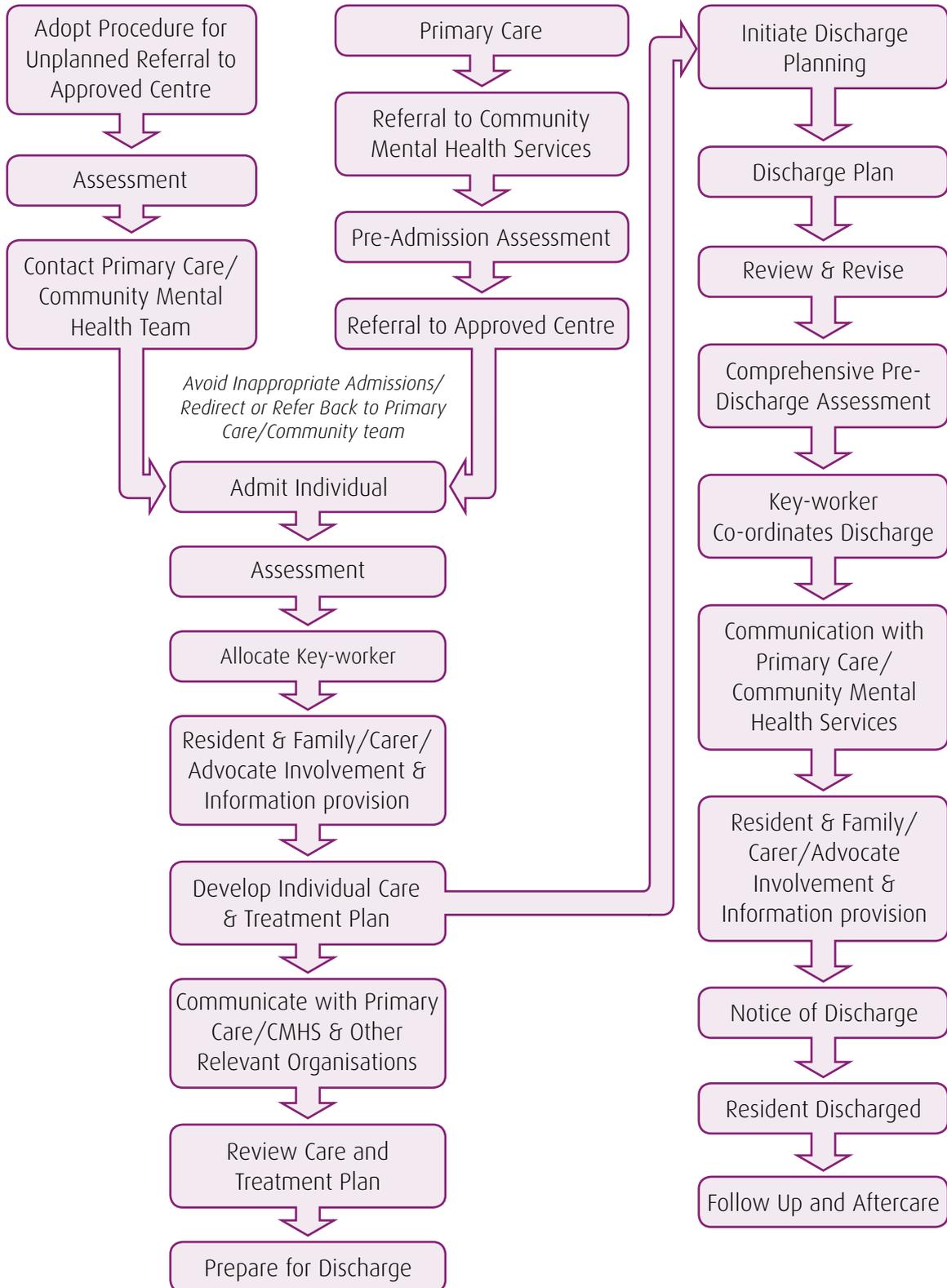
**Appendix 4** Discharge Summary Sample

## Appendix 1: Flowcharts

### Approved Centre Admission to Discharge Pathway

#### Unplanned Referral

#### Pre-Admission Process

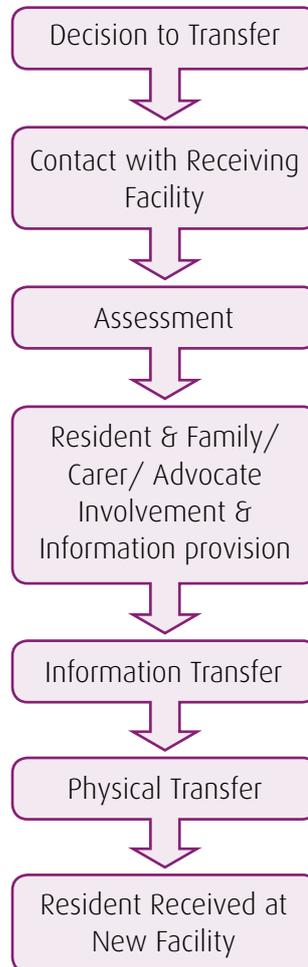


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### Transfer Pathway<sup>2</sup>

*Emergency Transfers  
only in exceptional  
circumstances*



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<sup>2</sup> The flowcharts are a guide to the key steps involved in the processes of admitting, transferring and discharging a resident. They should be viewed in conjunction with reading the relevant sections of the code of practice.

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## Appendix 2: Excellence in Mental Health Records

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### Guidelines on Clinical Records

- Quality of record should ensure that continuity of care is always guaranteed
- Complete records contemporaneously [note time of event and time of recording (24 hour clock)]
- Frequency of recording – must be sufficient to show accurate picture of patient at all times
- Avoid late entries, if required do not squeeze in
- Do not predate entries
- All healthcare professionals encouraged to read each other's entries
- Avoid subjective comments or if necessary explain, record the facts
- Do not alter, delete or destroy any original record
- Record must provide evidence of planning and provision of care
- Record must be up to date, accurate and unambiguous
- Write notes clearly and legibly
- Request others to rewrite record if unclear
- Ensure record is permanent and capable of photocopying
- Avoid initials
- All entries must be signed off and recorder clearly identifiable by name and status
- Students and assistants entries must be counter-signed
- Maintain register of sample signatures and keep it up to date
- Record must be made in chronological order, explain any variance
- Identify names and status of other healthcare professionals involved
- Identify when other professionals contacted and any advice given
- Avoid abbreviations, make acceptable list for organisation
- Use only acceptable official grading systems
- Record all advice given to patient

- Record any decisions made
- Be systematic by maintaining all patients records together and having patient's name and record number on every page of the record
- Use care plans to assist
- Supervise standards of recording by those in positions of responsibility
- Regularly audit standards of recording

### **Additional Pointers**

#### ***Prescription Writing***

Must be

- Accurate
- Appropriate
- Unambiguous

Any advice given including details of foreseeable and unforeseeable risks must be documented.

#### ***Abbreviations***

- Abbreviations should be kept to a minimum in clinical records and must only be used in the context of care
- References must be approved locally
- To be avoided in transfer or discharge situations

#### ***Retrospective Notes***

- Record the date and time the entry is made date and time the entry refers to

## **Narrative Case Notes – Guidelines**

- Keep sentences short
- Use big words sparingly
- Be simple and direct
- Notes must be legible
- Avoid broad generalities
- Minimise confusion
- Be specific
- Identify purpose of the notes
- Avoid jargon
- Watch abbreviations
- Distinguish facts from opinion
- Is the note clear and objective?
- Is it relevant?
- Support your professional opinions?
- Are you following best practice?
- Does the record convey a high respect for the client?
- Is the design, structure and content one that can show the patient's legal status?
- Evidence of a treatment plan?
- Evidence of classifiable diagnosis?
- Evidence of periodic review?
- Think before you write!
- Put line under the end of each entry

## Professional Reports

- Have a front page with the title of the case
- Have a contents page with page numbers (if report exceeds 8 pages)
- Identify who you are
- Detail the purpose of the report
- Have a brief summary at the beginning for quick reference by the reader
- Have an introduction where you clearly define the issues you are addressing in your report
- Give all background information/history where relevant
- State the facts of the case, as you know them
- Provide information on any examination or investigations you carried out yourself
- Give your professional opinion based on the facts and any published research, standards or guidelines available
- Have a conclusion, which summarises the main points of the case and your opinion
- Make sure to distinguish between facts, information reported to you and your professional opinion
- Do not stray from your area of expertise
- Convey a high respect for the client?
- Use simple, clear, plain English
- Explain any technical or medical terms, if report is for the layperson
- Use a glossary if you refer to many technical or medical terms
- Keep the report as short as possible but include all relevant information
- Any published material referred to or consulted in the preparation of the report should be included in the appendices
- Re-read the report and ensure you are satisfied with your conclusions
- Ask a colleague to read the report and comment on it
- Keep a copy for yourself on file

## Appendix 3: Sample Transfer Form

### THE FOLLOWING ARE SAMPLE FIELDS ONLY

Resident's Details	
Name:	
Address:	
Phone Number:	Mobile Number:
DOB:	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)
Gender (tick ✓ as appropriate):	Male <input type="checkbox"/> Female <input type="checkbox"/>
Nationality:	
PPSN:	<input type="checkbox"/>
Medical Card Number:	<input type="checkbox"/>
Legal Status:	Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/>
Diagnosis:	
Present Medication:	
Known Allergic Reaction:	

Next of Kin	
Name:	
Address:	
Phone Number:	Mobile Number:
Relationship to resident:	

Referral Details	
Name of GP / Primary care team:	
Phone Number:	Mobile Number:

Transfer from:	
Name of Approved Centre:	
Phone Number:	
Name of unit:	
Name of Referring consultant:	
Name of Key-worker:	

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<b>Transfer to:</b>
Name of hospital:
Phone Number:
Name of unit:
Name of receiving consultant:
Reason(s) for transfer:

<b>Decision to Transfer:</b>
Date of transfer: <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)
Time: <input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/> (24 hour clock e.g. 2.41pm should be written as 14.41)
Decision to transfer made by:

Transport arranged:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Risk Assessment conducted:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:		
Escort required/arranged:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has relative(s) been informed of transfer:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Consent for transfer given by resident:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signature of resident:		
Has the resident consented to have his/her file transferred:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Has the following information been included for transfer:</b>		
Resident notes:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Care and treatment plan:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug prescribing and recording sheets:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Medication supply:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Property:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Information being sent checked for completeness:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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<b>Further comments/clinical observations:</b>

Signed:
Print name:
Job Title:
Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)

## Appendix 4: Sample Discharge Summary

### THE FOLLOWING ARE SAMPLE FIELDS ONLY

Resident's Details	
Name:	
Address:	
Phone Number:	Mobile Number:
DOB:	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)
Gender (tick ✓ as appropriate):	Male <input type="checkbox"/> Female <input type="checkbox"/>
Nationality:	
PPSN:	<input type="checkbox"/>
Medical Card Number:	<input type="checkbox"/>

Consultant Psychiatrist Contact Information	
Name:	
Address:	
Phone Number:	Mobile Number:

Admission Details	
Date of admission	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)
Type of admission:	Planned <input type="checkbox"/> Unplanned <input type="checkbox"/> Emergency <input type="checkbox"/>
Approved Centre name:	
Unit Name:	

Discharge Details:	
Date of discharge	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)
Approved Centre name:	
Unit Name:	

Presenting Complaint:
Diagnosis (ICD 10)

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Medications:
Known allergic reaction:
Mental state at discharge:
Individual care and treatment plan/discharge plan:    Yes <input type="checkbox"/> No <input type="checkbox"/> Attached <input type="checkbox"/>
Management advice/follow up arrangements:
Prognosis:
Information given to resident & relatives:
Has the resident consented to the giving of information to his/her relatives?

<b>Key-worker Details:</b>
Name:
Job title:
Phone Number:
Form sent to Key Worker:    Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Other Key People for Follow Up:</b>
Name:
Job title:
Phone Number:

<b>Additional Details:</b>
Housing Needs:
Social Needs:
Voluntary agency:
Other support:
Risk Issues:

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Relapse Prevention Strategy: Yes <input type="checkbox"/> No <input type="checkbox"/> Attached <input type="checkbox"/>
Crisis Management Strategy: Yes <input type="checkbox"/> No <input type="checkbox"/> Attached <input type="checkbox"/>

Signed:
Print name:
Job title:
Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)







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