Pre Admission Assessment and Treatment Plans

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Policy Review Team	Group Operations Director Director of Nursing and Quality Hospital Director
Lead Officer	Director of Nursing and Quality
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It is the personal responsibility of every individual referring to this policy to ensure that they are viewing the latest version, which can be viewed at www.inmind.co.uk/staff-documents

1.0 INTRODUCTION

1.1 It is important that the Service Users assessed for treatment within Inmind Services are appropriately placed within services that meet their needs in the least restrictive environment commensurate with risk and within which they can have reasonable expectations of a pathway towards recovery.

1.2 In mind cares for people who are detained under the Mental Health Act or those who are informal.

2.0 REFERRALS

2.1 Referrals are received from various sources including NHS England, CCG's community nurses, social workers, solicitors, and Consultant Psychiatrists. the Relationship Manager for the service or the Hospital Director.

2.2 Standard referral information will be requested.

2.3 All people admitted to Inmind will be assessed in order to ensure that the person meets the services admission criteria or is deemed to benefit from the care and treatment that is available.

3.0 PROCEDURE FOR ADMISSION

Initial document assessment

The Hospital Director/Manager will assess that the person is potentially suitable for admission to the service.

The Hospital Director/Manager will advise referring agencies of the outcome of the initial assessment. Referrers will be requested to provide additional relevant clinical information if required so that a pre-admission assessment can be organised.

3.1 Pre Admission Assessment

The objective of the pre-admission assessment is to establish / verify that:

- That the person meet the services basic criteria for admission.

- That the appropriate services clinical team can meet the person's requirements.

- Confirm that the referring agency accepts continuing responsibility for the person referred and will identify named people (Social Worker, Care Coordinator) to maintain contact with the person and participate in planning for the person's future care when they are ready for discharge from the service.

The assessor/s will see and where possible talk with the person referred. Discuss their needs with the current care team and peruse clinical records as required for the purpose of the assessment.

A consensus decision will be reached by the assessing clinical team as to whether or not the service is best able to meet the needs of the person referred.

If admission is considered inappropriate the service will write to the referrer giving reasons for the decision.

If admission is appropriate the service will write to the referrer confirming an offer of admission.

A clear summary of the assessment team's findings and a preliminary plan for the persons continuing care and treatment must be provided to the referrer should for submission to any potential funding panel.

3.2 Pre admission Planning

Prior to admission the following must be undertaken:

- Verify if the person is detained under the Mental Health Act 1983 (MHA) if appropriate.

- Confirm the funding arrangements are in place.

- Confirm that all relevant information, medication etc is available.

3.3 Admission

It is the responsibility of the Mental Health Act Administrator and the Responsible Clinician to ensure that no person is admitted without the correctly completed legal documentation.

If detained under the Mental Health Act It is the responsibility of the Nurse in Charge of the shift to ensure that the person's rights are read under S132 of the Mental Health Act 1983, and appropriate Mental Health Act leaflets are given.

It is the responsibility of the Nurse in Charge of the shift to ensure that the person is given a copy of the service user guide and is oriented to the unit. A named nurse will be identified to assist the person in settling in.

It is the responsibility of the Nurse in Charge of the shift to ensure that the person is introduced to peers, care staff and clinical team members as soon as is practicable.

It is the responsibility of the Nurse in Charge of the shift to ensure that the person is aware of our procedures and protocols in relation to safety and security on site.

Hospital Director will ensure that the unit's admission and discharge register is accurate at all times.

The RC sees the person as soon as practicable following admission. People will be offered a comprehensive assessment (including a physical health assessment)

A clinical assessment including risk assessment concerning potential for harm to self or others will be undertaken. The assessment will include the person's family, employment, educational and social circumstances.

4.0 Initial Treatment Plan

4.1 In order for people to be supported to be as independent as possible, it is vital that there is a thorough assessment of the individual's needs and strengths. This will be done in collaboration with the person, any carers and the multi-disciplinary team.

4.2 To this end each individual will have a Primary/Named Nurse who will be responsible for the assessing, planning, implementation and evaluating of their nursing care. The Primary/Named Nurse, in collaboration with the Multi-Disciplinary Team (MDT), will be responsible for planning a full plan of care. The plan should comprise a series of short-term achievable aims which will work towards longer-term goals.

4.3 An initial care plan and risk assessment will be completed within 24 hours of admission.

4.4 Individuals, both informal and detained, will be encouraged to play an active part in their assessment, planning, implementation and review of care. The person should be allowed to express agreement or disagreement with their plan. Care plans and reviews should be discussed with the person regardless of capacity. If the person lacks capacity, discussions can take place if necessary at a "Best Interests" meeting. (See Capacity Policy)

4.5 Each person is encouraged to raise any issues relating to their care and treatment. From this a comprehensive care plan, should be devised which will cover key aspects of the individuals presentation where there are identified needs.

4.6 All individuals should be regularly offered an opportunity to sign their care plan indicating agreement and be given a copy of it even if they do not sign.

4.7 All care plans will be reviewed formally with the multi-disciplinary.

4.8 All Service Users should give their consent verbally and preferably in writing, to all treatments and procedures, and all implications of the treatment and the options available should be explained to them. Documentation giving written consent will be held on the Service Users' records.

4.9 Service Users have the right to speak privately with their Named Nurse, support worker and other professionals.

4.10 Service Users who choose not to discuss any matters related to their care with staff of the opposite sex may ask for a same sex professional, and this will be respected and effected.

4.0 Equality Impact Assessment

4.1 All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Hospital Director and the hospital will then actively respond to the enquiry.

5.0 References

Essential Standards of Quality and Safety: *Outcome 4 – Care and welfare of people who use services*

Health & Social Care Act 2008: *Regulation 9 – Care and welfare of people who use services*

6.0 Related Policies

CC05 Assessing Capacity
CC55 Mental Health Act Policy
CH27 Equality Diversity and Inclusion

signed for and on behalf of the executive management board:

Albert Chelliah
Director of Operations

Allan Bailey
Director of Nursing and Quality

Date: October 2016

Appendix 1

REFERRAL ASSESSMENT

Name	**Date of Birth**
Date of Assessment	**Assessed At**
Legal Status	**Expiry Date**
Marital Status	**Religion**
Ethnic Origin	**Place of Birth**
Next of Kin	**National Insurance Number**
Family	**Contact at Place of Assessment**

Education

IQ

Employment History

Appearance

Current Diagnosis

Past Diagnoses

Psychiatric History

Current Medication

Current Care Plans

Current Consultant Details

Current GP Details

Physical Health

Mobility

Continence

Sensory Impairment

Intellectual Functioning

Diet

Sleep

Substance Abuse

Index Offence

Forensic History

Strengths

Challenging Behaviours

Interactions

Compliance

Self-care

Interests

Current O/T or Activities

Current Leave

Current Risk Factors

Previous Risk Factors

Description of Current Facility

Expected Outcomes from the service

Funding

Other Issues

Current Staff – Comments

Service user Comments

Assessor Comments and Recommendations

1st Assessor:

Position:

Signature: _____

2nd Assessor:

Position:

Signature: _____