NICE National Institute for Health and Care Excellence

NICE Pathways

Discharge from inpatient mental health services to community or care home support

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/transition-between-community-or-care-home-and-inpatient-mental-health-settings
NICE Pathway last updated: 09 February 2021

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.

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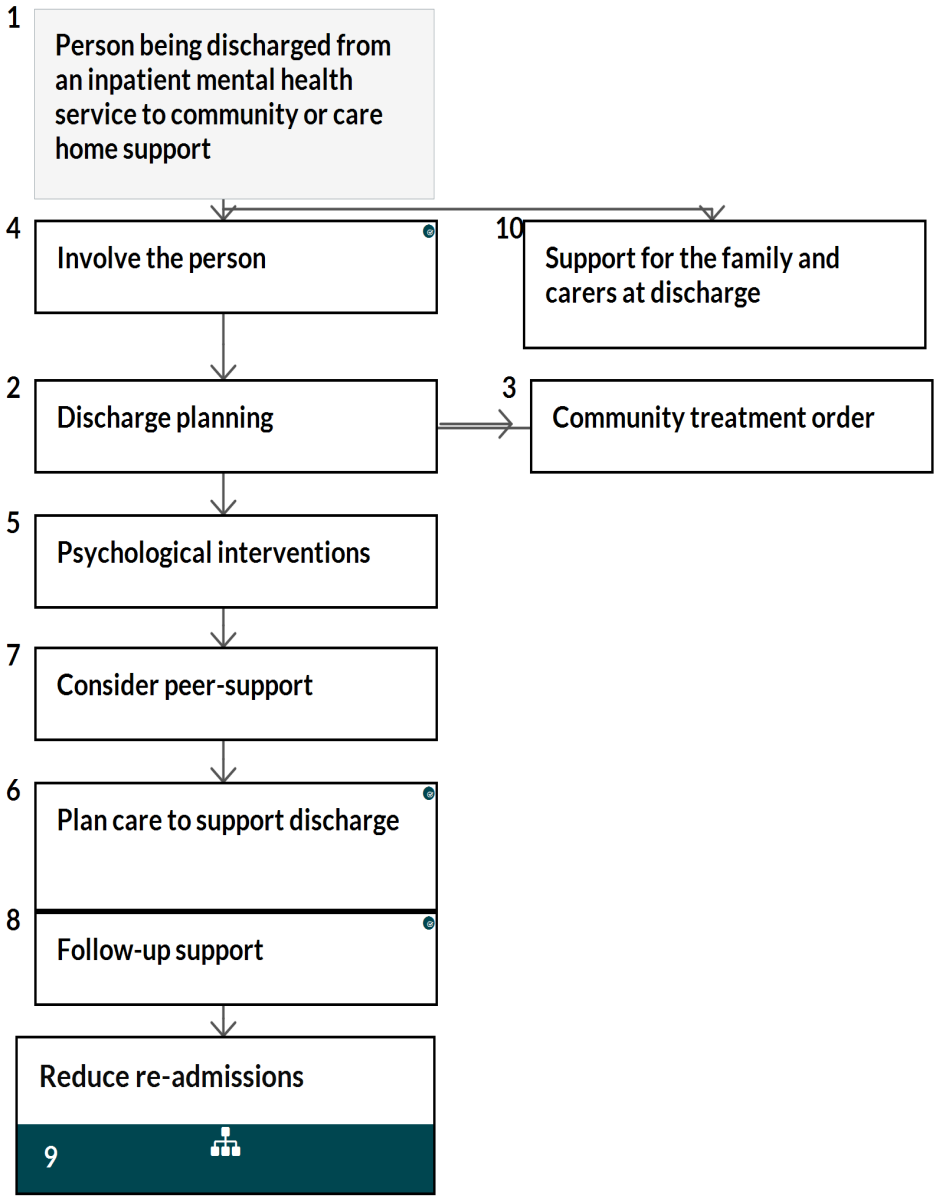

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1 Person being discharged from an inpatient mental health service to community or care home support

No additional information

2 Discharge planning

Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. See also discharge and transfer of care in the NICE Pathway on service user experience in adult mental health services.

Maintaining links with the community

Before discharge offer:

- phased leave (the person can have trial periods out of hospital before discharge)
- phased return to employment or education (the person can gradually build up hours spent in employment or education).

This is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community.

Before discharging a person who is in education or training, arrange a planning meeting between them and a named person from the education setting to plan their return to learning.

Discharge assessment

Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should include risk of suicide. It should:

- relate directly to the setting the person is being discharged to
- fully involve the person
- be shared with carers (if the person agrees)
- explore the possibility of using a personal health or social care budget and ensure the person understands about charges for social care

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- cover aftercare support, in line with section 117 of the Mental Health Act 1983
- cover aspects of the person's life including:
  - daytime activities such as employment, education and leisure
  - food, transport, budgeting and benefits
  - pre-existing family and social issues and stressors that may have triggered the person's admission
  - ways in which the person can manage their own condition.
  - suitability of accommodation.

3 Community treatment order

Decide whether a community treatment order or guardianship order is needed (see the Mental Health Act Code of Practice) based on:

- the benefit to the person (for example, it may be helpful for people who have had repeated admissions)
- the purpose (for example, to support the person to follow their treatment plan)
- the conditions and legal basis.

Ensure that the person who will be subject to the order has the opportunity to discuss why it is being imposed. Explain:

- the specific benefit for the person
- how to access advocacy (including their entitlement to an Independent Mental Health Advocate), and what this means
- what restrictions the order involves
- when it will be reviewed
- what will happen if the person does not comply with the order, and that this may not automatically lead to readmission.

Ensure that the conditions, purpose, legal basis and intended benefit of the order are explained to families, carers and others providing support.

4 Involve the person

Before discharging people with mental health needs, discuss their housing arrangements to ensure they are suitable for them and plan accommodation accordingly. This should take into

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account any specific accommodation and observation requirements associated with risk of suicide.

Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support support (in line with the Homelessness Reduction Act 2017) to find and keep accommodation. This should:

- be started before discharge
- continue after discharge for as long as the person needs support to stay in secure accommodation
- focus on joint problem-solving, housing and mental health issues.

Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:

- contact details, for example of:
  - a community psychiatric nurse or social worker
  - the out-of-hours service
- support and plans for the first week
- practical help if needed
- employment support.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

1. Access to independent advocacy services

5 Psychological interventions

Before discharge, offer a series of individualised psychoeducation [See page 11] sessions for people with psychotic illnesses to promote learning and awareness. Sessions should:

- start while the person is in hospital
- continue after discharge so the person can test new approaches in the community
- cover:
  - symptoms and their causes

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  - what might cause the person to relapse, and how that can be prevented
  - psychological treatment
  - coping strategies to help the person if they become distressed
  - risk factors
  - how the person can be helped to look after themselves.
- be conducted by the same practitioner throughout if possible.

Consider psychoeducation sessions for all people with other diagnoses as part of planning discharge and avoiding readmission.

Consider a staged, group-based psychological intervention for adults with bipolar disorder who have had at least 1 hospital admission and are being discharged from hospital. This should include:

- evaluation by a psychiatrist within 2 weeks of discharge
- 3 sequential sets of group sessions led by trained practitioners that focus on, respectively:
  - people's current mental health and recent experiences in hospital
  - psychoeducation or cognitive behavioural therapy
  - early warning signs and coping strategies.

See also the NICE Pathways on bipolar disorder and psychosis and schizophrenia.

6 Plan care to support discharge

Ensure that there is a designated person responsible for writing the care plan in collaboration with the person being discharged (and their carers if the person agrees).

Write the care plan in clear language. Avoid jargon and explain difficult terms.

Ensure the care plan is based on the principles of recovery [See page 11] and describes the support arrangements for the person after they are discharged.

If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning.

Ensure frequent, comprehensive review of the person's care plan and progress toward discharge.

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Send a copy of the care plan to everyone involved in providing support to the person at discharge and afterwards. It should include:

- possible relapse signs
- recovery goals
- who to contact
- where to go in a crisis
- budgeting and benefits
- handling personal budgets (if applicable)
- social networks
- educational, work-related and social activities
- details of medication (see communication during transfer of care and service organisation in the NICE Pathway on medicines optimisation, and the NICE Pathway on managing medicines in care homes).
- details of treatment and support plan
- physical health needs including health promotion and information about contraception
- date of review of the care plan.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

3. Communication on discharge

7 Consider peer-support

For people being discharged from hospital, consider a group-based, peer-delivered self-management training programme as part of recovery [See page 11] planning. Sessions should:

- continue for up to 12 weeks
- be delivered in groups of up to 12 members
- provide an opportunity for social support
- cover:
  - self-help, early warning signs and coping strategies
  - independent living skills
  - making choices and setting goals.

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Consider providing peer support to people with more than 1 previous hospital admission. People giving peer support should:

- have experience of using mental health services
- be formally recruited, trained and supervised.

8 Follow-up support

Consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.

At discharge, the hospital psychiatrist should ensure that:

- Within 24 hours, a discharge letter is emailed to the person's GP. A copy should be given to the person and, if appropriate, the community team and other specialist services.
- Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care.
- Within a week, a discharge summary is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should include information about why the person was admitted and how their condition has changed during the hospital stay.

If the person has a learning disability, dementia or is on the autistic spectrum, the hospital team should lead communication about discharge planning with the other services that support the person in the community. This could include:

- older people's services
- learning disability services
- the home care service.

See also the NICE Pathways on autism spectrum disorder, dementia and home care for older people.

If a person is being discharged to a care home, hospital and care home practitioners should exchange information about the person. An example might be a hospital practitioner accompanying a person with cognitive impairment when they return to the care home to help their transition (see also sharing information when care is transferred in the NICE Pathway on managing medicines in care homes).

In collaboration with the person, identify any risk of suicide and incorporate into care planning.

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Follow-up a person who has been discharged within 7 days.

See also the NICE Pathway on social care for older people with multiple long-term conditions.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

3. Communication on discharge

9 Reduce re-admissions

See Transition between community or care home and inpatient mental health settings / Transition between community or care home and inpatient mental health settings overview / Reduce re-admissions

10 Support for the family and carers at discharge

During discharge planning, consider group psychoeducation [See page 11] support for carers. This should include signposting to information on the specific condition of the person they care for.

Recognise that carers' circumstances may have changed since admission, and take any changes into account when planning discharge.

Before the person is discharged:

- let carers know about plans for discharge
- discuss with carers the person's progress during their hospital stay and how ready they are for discharge
- ensure that carers know the likely date of discharge well in advance.

Carer's assessment

Practitioners involved in admission and discharge should always take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge.

Identify carers (including young carers) who have recognisable needs. If the carer wishes it,

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make a referral to the carer's local authority for a carer's assessment (in line with the Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.

See the NICE Pathway on supporting adult carers for recommendations on identifying, assessing and meeting the caring, physical and mental health needs of families and carers.

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Education sessions for people affected by mental illness and their families and carers. Psychoeducation uses shared learning to empower people to cope better. Sessions can cover areas such as recognising symptoms and triggers, preventing relapses and developing coping strategies. Carers learn how best to support the person. Sessions typically start while the person is in hospital and run beyond discharge so the person can test approaches in their home setting

There is no single definition of recovery for people with mental health problems, the guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. In this guidance it is used to refer to someone achieving the best quality of life they can, while living and coping with their symptoms. It is an ongoing process whereby the person is supported to build up resilience and set goals to minimise the impact of mental health problems on their everyday life.

Glossary

carers

(carers are people who helps another person, usually a relative or friend, in their day-to-day life; this is not the same as someone who provides care professionally or through a voluntary organisation)

coping strategies

(coping strategies are the methods a person uses to deal with stressful situations; the term is used in this guidance to refer to ways that people cope with their mental illness or related symptoms, some coping strategies can have negative consequences for a person using them or for the people around them)

Discharge letter

(a short document that includes the details of a person's current prescription, the reasons for any changes in medicines, and their immediate medication treatment plan)

discharge summary

(a summary of what happened during a person's admission and hospital stay from a medical perspective: it must include the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and reasons why)

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Sources

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the

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recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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