Alberta Health Services

PROCEDURE
LEVEL 2

TITLE
SAFE AND SUPPORTIVE TRANSFERS AND DISCHARGES

SCOPE
Provincial: Addiction & Mental Health Inpatient Units

DOCUMENT #
AMH-03-03

APPROVAL LEVEL
Vice-President

SPONSOR
Addiction & Mental Health

INITIAL EFFECTIVE DATE
November 23, 2011

CATEGORY
Patient Safety

REVISION EFFECTIVE DATE
April 1, 2016

PARENT DOCUMENT TYPE & TITLE
Policy Level 2: Safety Precautions

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this procedure, please contact the Policy & Forms Department at policy@albertahealthservices.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, and practice support documents.

OBJECTIVES

- To facilitate the safe transfer and discharge of patients from Addiction & Mental Health inpatient units.
- To plan and co-ordinate the safe transfer and discharge of patients from Addiction & Mental Health inpatient units.
- To assign appropriate staff and/or support services to assist with the safe transfer and discharge of patients.
- To outline the appropriate steps to be taken by staff and Physicians to support the successful transfer or discharge of a patient from an Addiction & Mental Health inpatient unit.

APPLICABILITY

Compliance with this procedure is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary) working in Addiction & Mental Health Inpatient Units.

PROCEDURE ELEMENTS

1. Consent

1.1 Treatment for the management of patients at risk of harm to self or others is provided as authorized by law and in accordance with the Alberta Health Services *Consent to Treatment/Procedure(s)* Policy and its procedures.

2. Transfer of a Patient to a Receiving Unit/Facility

2.1 Prior to any transfer of a patient, staff at the referring facility shall first determine if the patient is a **formal patient**, as defined in the *Mental Health Act*.

2.2 In accordance with the *Mental Health Act*, formal patients may be transferred between units and facilities for the purpose of providing treatment/procedure(s) that are not available at the referring unit or facility and returned to the referring unit or facility upon conclusion of the treatment/procedure(s).

2.3 The Psychiatrist or Physician, in collaboration with the interdisciplinary team, shall:

a) Assess the patient and, if appropriate, shall order a transfer of the patient to another inpatient unit. The order shall be placed in the patient's **health record**.

b) Ensure that any patient transfer is planned and co-ordinated and takes into consideration the following, but is not limited to:

(i) the patient's observation level;

(ii) the patient's condition, including mental status;

(iii) the patient's assessed potential for risk of harm to self and others;

(iv) the patient's treatment plan;

(v) the patient's schedule of medication and use of unscheduled (i.e., as-needed) and necessary prescription medication;

Note: A written Physician's order of unscheduled and necessary prescription medication is required.

(vi) the readiness of the receiving unit for non-urgent transfers; and

(vii) the requirement for and availability of an appropriate escort.

2.4 Where transport is necessary, prior to booking Emergency Medical Services (EMS) or support services for the patient transfer to an alternate unit/facility,

there must be a Physician's order authorizing the transfer on the patient's health record.

2.5 In non-emergency circumstances where patients are being transferred to an alternate unit/facility, the referring or sending unit shall be responsible for making arrangements for the transfer, and confirming the name of the receiving physician and designated unit/facility with all parties including, but not limited to, the receiving unit, the receiving Physician and security/Protective Services, where applicable.

3. Reporting and Documenting a Patient's Condition Prior to Transfer to a Receiving Unit/Facility

3.1 The patient's **health care professional** from the referring unit shall provide:

a) a verbal report about the patient's condition to the patient's health care professional at the receiving unit; and

b) a detailed report about the patient's condition to the Emergency Medical Services staff involved in transferring the patient.

3.2 The reports (see section 3.1 above) about the patient's condition shall include, but not be limited to the patient's:

a) level of risk to harm self and others;

b) observation level;

c) status under the *Mental Health Act*;

d) mental state;

e) physical condition, including any infection prevention information as appropriate;

f) treatment plan;

g) medications and allergies; and

h) any additional information that may be pertinent to the safe transfer of the patient (e.g., patient access to personal property).

3.3 Nursing staff may write a nursing transfer report for inclusion with the transferred health record.

3.4 The agreement and plan of the patient transfer shall be documented in the patient's health record. Copies of all appropriate documentation shall accompany the patient being transferred.

4. Decision-making and Safety Planning for Patient Appointments

4.1 Patients with off-unit (including off-site) appointments shall be assessed by staff in order to determine:

a) whether to proceed with the appointment; and

b) whether and what type of accompaniment (e.g., Nurse, family, Psychiatric Aide) is required for the appointment.

4.2 The assessment shall consider but not be limited to details outlined above, in section 2.3 b).

4.3 The required, ongoing care and treatment of the patient shall be provided by appropriate Addiction & Mental Health staff during any accompaniment of patients between departments and within a facility.

4.4 The patient's unit maintains responsibility for the care of the patient throughout off-unit appointments within the facility, including those circumstances where a patient is not accompanied to an appointment.

5. Discharge Against Medical Advice for Voluntary Inpatients

5.1 If a voluntary inpatient from an Addiction & Mental Health inpatient unit wishes to self-discharge (i.e., leave against medical advice), nursing staff should determine why the patient wishes to leave and, where possible, staff should encourage the patient to stay, at least until an assessment by a Psychiatrist or designate can be completed.

5.2 Where possible and prior to the patient leaving the unit, the attending Psychiatrist or on-call Physician shall be called to assess a voluntary inpatient wishing to self-discharge.

5.3 If immediate action is necessary to prevent serious bodily harm to the patient or others, the staff shall intervene until a Psychiatrist or Physician can assess the patient.

a) Interventions shall be consistent with the principles of least restraint and may include:

(i) offering a quiet place to rest and consider the decision;

(ii) engaging the patient in meaningful conversation; and

(iii) using pharmacological, physical, mechanical restraints or seclusion, if there is a reasonable likelihood of serious bodily harm to the patient or others if such interventions are not used.

Note: A Physician's order shall be in place prior to the use of any pharmacological restraints.

5.4 The attending Psychiatrist or on-call Physician shall be made fully aware of the immediacy of the situation.

5.5 In circumstances where a voluntary inpatient is assessed by the Psychiatrist and the patient continues to advise that he/she shall self-discharge, and the Psychiatrist deems that the patient does not fit the criteria to have a Form 1 admission certificate issued under the *Mental Health Act*, staff shall not interfere with the patient leaving the unit but shall make reasonable efforts to offer to:

a) review the patient's safety plan with the patient, including access to local urgent care or emergency services;

b) follow up with the patient via phone call, per section 6 below;

c) provide the patient with information on current medications and any previously arranged diagnostic or follow-up appointments; and

d) assist the patient to gather any stored personal property.

5.6 Staff shall ask the patient to provide a signature documenting their wishes to leave against medical advice for inclusion in the patient's health record. Additional documentation regarding the patient's discharge against medical advice, including the discussion with the patient, shall be noted in the patient's health record.

5.7 Documentation in the health record shall include:

a) what transpired (i.e., provide a description of the events that took place prior to the patient leaving the unit);

b) information outlining the necessity of the use of restraints, if used;

c) if the Physician was informed of the patient's intention to leave;

d) if the Physician spoke with the patient;

e) the patient's ultimate decision to stay and be assessed or to leave;

f) if a discharge against medical advice form was reviewed, signed by the patient and a copy given to the patient - or not;

Note: It is recommended that staff utilize the *Discharge Plan* Form.

g) any other specific information that was provided to the patient, including items covered in section 5.5 above;

h) any information that the patient provided to the **health care provider** who communicated with the patient (e.g., "I have an appointment to see my Family Physician tomorrow"); and

i) any additional comments, observations, and descriptions of behaviour as appropriate.

6. Followup of Patients After Discharge

6.1 For all patients, including those who consent in section 5.5 b), the patient's health care professional shall ensure that the patient has a copy of his/her personal safety plan and shall make reasonable efforts to confirm that:

a) an appointment for followup care is to occur within a maximum of seven (7) calendar days with an appropriate health care provider (e.g., General Physician, outpatient mental health provider, other support provider); and

b) the receiving health care provider and other persons, with appropriate patient consent, receive a copy of the patient's personal safety plan and any relevant medical documentation;

or

c) arrangements are in place for a followup telephone call within seven (7) days of discharge.

6.2 If the followup plan includes a telephone call per section 6.1 c), then prior to discharge the patient's health care professional shall:

a) explain the purpose of the phone call to the patient (or the patient's **agent** or **guardian**); and

b) request the verbal consent of the patient to phone the patient. If consent is received, the patient's health care professional shall –

(i) confirm the phone number(s) for patient and emergency notifications, and

(ii) discuss the special requests of the patient (e.g., no phone messages, timing of calls).

6.3 For those patients identified in section 6.1 c), within seven (7) calendar days of discharge, a health care professional authorized to perform a restricted psychosocial intervention shall make reasonable efforts to attempt to contact the patient (e.g., one attempt may be to the patient's emergency contact, if the patient has consented).

Note: Professional judgment shall determine if there is a concern for the safety of the patient. In such a case, consent is not required prior to contacting the emergency contact.

6.4 Upon contacting the patient, the health care professional shall find out how the patient is managing since being discharged.

a) If the patient reports that they are managing well, then the health care professional shall address any questions from the patient, end the call, and document the discussion for retention in the health record.

b) If the patient reports that they are not managing well, then the health care professional shall conduct a risk screen.

(i) If significant risk is present, the health care professional shall activate, as appropriate, the local process for urgent or emergent care, document the information, and submit the completed documents per local processes for retention in the health record.

(ii) If risk is limited, the health care professional shall ensure that the patient has a safety plan in place and contact information for crisis assistance services, and then document the information and submit the completed documents per local processes for retention in the health record.

6.5 If the health care professional is unable to contact the patient or the patient's emergency contact, the health care professional shall:

a) notify the followup health care provider;

b) document the attempts to contact the patient; and

c) submit the documentation per local processes for retention in the health record.

6.6 For all patients, in accordance with Section 32 of the *Mental Health Act*, staff shall, in a timely fashion, provide notice regarding the patient's discharge to the patient's **nearest relative** (unless the patient objects), guardian and family physician (if known), including recommendations for treatment.

a) It is further recommended, but not mandated, that staff communicate this information to the patient's community interdisciplinary team and agent, and, if the patient has consented and it is appropriate, the patient's family members.

b) Followup appointments for patients to attend outpatient mental health programs shall be made, where appropriate.

DEFINITIONS

Agent means the person(s) named in a Personal Directive who can make decisions on personal matters according to the wishes expressed by the patient.

Formal patient means a patient detained in a designated mental health facility under two admission certificates or two renewal certificates, in accordance with the *Mental Health Act* (Alberta).

Guardian means where applicable:

For a minor:

a) as defined in the *Family Law Act* (Alberta);
b) per agreement or appointment authorized by legislation (obtain copy of the agreement and verify it qualifies under legislation) (e.g., agreement between the Director of Child and Family Services Authority and foster parent(s) under the *Child, Youth and Family Enhancement Act* (Alberta); or agreement between parents under the *Family Law Act*; or as set out in *Child, Youth and Family Enhancement Act* regarding guardians of the child to be adopted once the designated form is signed);
c) as appointed under a will (obtain a copy of the will; also obtain grant of probate, if possible);
d) as appointed in accordance with a Personal Directive (obtain copy of Personal Directive);
e) as appointed by court order (obtain copy of court order; e.g., order pursuant to *Child, Youth and Family Enhancement Act*); and
f) a divorced parent who has custody of the minor.

For an adult: An individual appointed by the court to make decisions on behalf of the adult patient, when the adult patient lacks capacity.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope and role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, Students, Volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

Nearest relative means, in the *Mental Health Act* (Alberta) and in this document, with respect to a formal patient, or a person who is subject to a Community Treatment Order:

a) the adult person first listed in the following list, relatives of the whole blood being preferred to relatives of the same description of the half-blood, and the elder or eldest of two or more relatives being preferred, regardless of gender:
   - spouse or adult interdependent partner;
   - son or daughter;

- father or mother;
- brother or sister;
- grandfather or grandmother;
- grandson or granddaughter;
- uncle or aunt;
- nephew or niece;

OR

b) any adult person the Alberta Health Services Governing Body designates in writing to act as nearest relative if there is no nearest relative within any description as above, or if, in the opinion of the Alberta Health Services Governing Body, the nearest relative would not act or is not acting in the best interest of the formal patient or the person subject to a Community Treatment Order.

REFERENCES

- Alberta Health Services Governance Documents:
  - *Consent to Treatment/Procedure(s)* Policy (#PRR-01)
  - *Consent to Treatment/Procedure(s) Formal Patients and Persons Subject to Community Treatment Orders under the Mental Health Act* Procedure (#PRR-01-04)
  - *Safety Precautions* Policy (Addiction & Mental Health) (#AMH-03)
  - *Use of Observation, Privileges and Passes* Policy (Addiction & Mental Health) (#AMH-01)
- Alberta Health Services Forms:
  - *Discharge Plan* (#19369)
- Non-Alberta Health Services Documents:
  - *Form 1: Admission Certificate* (*Mental Health Act,* Section 2)
  - Form 6: *Memorandum of Transfer to Another Facility* (*Mental Health Act,* Section 22[1])
  - *Mental Health Act* (Alberta)

VERSION HISTORY

Date	Action Taken
November 23, 2011	Initial approval/effective
December 02, 2015	Revision approved
April 1, 2016	Revision effective date
March 16, 2017	Non-substantive change
December 2018	Scheduled for Review