TRANSITION PLANNING (DISCHARGE AND TRANSFER OF CARE)

This section outlines the competences required to transition patients from inpatient care to other services. The most common transition is discharge from inpatient to community services. However, a patient may experience other transitions, for example, transfer from acute inpatient care to inpatient rehabilitation or psychiatric intensive care. This section refers to all types of service transitions. These competences are for those with a core profession and/or those with sufficient and appropriate training.

Knowledge of transition planning

An ability to draw on knowledge that transitions of care from inpatient settings can be potentially destabilising and provoke strong feelings, and so constitutes a time of greater risk and reduced safety
An ability to draw on knowledge that transitions from inpatient care should be well planned even when the transition is last minute or unexpected (for example, due to bed pressures)
An ability to draw on knowledge of national and local guidelines on transition planning
An ability to draw on knowledge that because most inpatient services are very fast paced, transitions (for example, discharge) can occur quickly and should be explicitly discussed with the patient and their family and carers from admission
An ability to draw on knowledge that a personal transition plan should be devised, prioritising patient needs and incorporating strategies such as a graded approach to the transition (for example, trial leave at home before discharge)
An ability to draw on knowledge that transitions are also interpersonal endings and should be thought about accordingly, bearing in mind many patients have a history of traumatic interpersonal relationships
An ability to draw on knowledge that a transition may be experienced a loss if the patient is being discharged back to a care home or supported accommodation when previously they were living independently

Helping the patient and their social network prepare for a transition

An ability to advise the patient and their family and carers of the date and time of any proposed transition, and to ensure that this is done with as much advance notice as possible
An ability to recognise that a transition can be a very difficult and distressing time for the patient and that emotional support, care, and reassurance may be required

Considerations for transition planning

An ability to discuss the patient's feelings about the transition and to work with them to identify barriers that make it less likely that they will maintain contact with the new service or engage with their new accommodation
An ability to discuss the plan for follow up support with the patient, and their family and carers, in collaboration with the receiving services/accommodation, prior to the transition
An ability to ensure that a transition between inpatient and community services is carried out in a timely manner and is communicated effectively to the patient's family and carers and relevant services
An ability to work in partnership with the transitioning service to collaboratively develop a safe discharge plan, in collaboration with the patient and their family and carers
An ability to discuss the patient's, and their family and carers, concerns about the transition, and troubleshoot any potential problems
An ability to consider what information is appropriate to share with the patient's family and carers about the transition (keeping in mind that their involvement is likely to support a more successful transition)

An ability to understand that the patient's family and carers may find particular transitions (for example, discharge) a challenge (for example, by having a loved one return home after a hospital admission) and that they may need support managing this
Where there are indications that transitions of care will present significant challenges to the patient, an ability to implement appropriate strategies, such as:
identifying a care plan which aims to maintain continuity of support during the transition
where appropriate, helping the patient to develop skills in independence, assertiveness, and self-advocacy
An ability to assure effective communication with professionals within and between services by providing written communication that identifies:
the relevant clinical issues, the current care plan, and any identified risks
the rationale for referral or transfer of care
expectations regarding feedback from the service
An ability to utilise trusted assessments, where possible, to reduce repeated and unhelpful re-assessment at points of transition

Care planning

An ability to undertake a thorough assessment of the patient's personal, social, practical, and safety needs before considering transition of care. It should:
be collaboratively undertaken with the patient and their family and carers, and understand their hopes and concerns
be underpinned by a formulation of the patient's needs including psychological, social and cultural aspects
based on the principles of personal recovery, prioritising aspects such as interpersonal relationships, self-identity, and self-esteem, living well despite symptoms
prioritise the patient's safety and ensure strategies are put in place to manage any risk behaviours

Recognising and managing challenges to transition

An ability to monitor the progress of a transition (for example, undertaking follow-ups calls)
An ability to identify when a transition has been compromised and to identify the reasons for this, for example:
institutional/systemic factors (such as long waiting lists or organisational change)
miscommunication between services
lack of cooperation or trust between services
lack of clarity about who is responsible for acting on a transfer request leading to failure to act
the patient's locality falling within another trust's remit
difficulties or issues with accommodation (if they are being discharged)
An ability to address concerns about a compromised transition, for example, through further verbal and/or written communication
Where possible and appropriate, an ability to offer bridging support if this increases the probability that the patient will engage with the new service

Knowledge of Community Treatment Orders (CTOs)

An ability to draw on knowledge that a CTO is a treatment order which outlines conditions that the patient has to adhere to following discharge from a Mental Health Act (MHA) section
An ability to draw on knowledge that CTOs have been demonstrated to have limited efficacy in improving treatment adherence and recovery outcomes for patients
An ability to draw on knowledge that a CTO is a form of restriction and should only be considered when:

a thorough assessment and formulation of the patient's presenting crisis and needs is undertaken
the costs and benefits for the patient have been carefully considered and the advantages outweigh the disadvantages
that all other care strategies have been exhausted

Implementing CTOs

An ability to consider whether a CTO is needed based on the benefit to the patient, the purpose of its use, and the conditions required for it to be used
An ability to ensure that the patient and their family and carers have had the opportunity to discuss the details of the CTO, its implications, why it is being imposed, and how to appeal
An ability to communicate the CTO plan to relevant parties, including the patient, their family and carers, and other involved services, offering the opportunity for discussion and to ask questions

Working with endings in relationships due to transitions

An ability to help the patient reflect on their experience of inpatient care, making connections between their feelings about endings and other losses or separations as a result of a transition
An ability to help the patient explore any feelings of anxiety about managing without inpatient care
An ability to help the patient reflect on the process of inpatient care as well as what they have learned and gained from it
An ability to help the patient express any feelings of hostility and disappointment with the limitations of the inpatient service
An ability to actively discuss with the patient what they have found unhelpful or could be improved about their inpatient stay and support the process of honest feedback and complaints, where appropriate.