Team Name: Mental Health Team Lead: Regional Director-Mental Health & Spiritual Health Care Approved by: Executive Director-West	Reference Number: CLI.5610.PL.003 Program Area: Mental Health Policy Section: Clinical
Issue Date: June 20, 2018 Review Date: Revision Date:	Subject: Information Transfer at Care Transition-Mental Health

POLICY SUBJECT:
Information Transfer at Care Transition-Mental Health

PURPOSE:
The purpose of this policy is to promote client safety by implementing effective information transfer at care transitions through standardized approaches.

BOARD POLICY REFERENCE:
Executive Limitations (EL-01) Global Executive Restraint & Risk Management
Executive Limitations (EL-02) Treatment of clients

POLICY:
The Psychosocial Assessment (specific to each mental health program) and/or the Community Mental Health Closing/Transfer Summary (CLI.5610.PL.003.FORM.01) that details all relevant client service information is used as a standardized approach for documentation and information transfer and is included as a component of the health record.

Sharing the provider's foresight, intuition and gut sense to guide continued critical thinking and decision-making around what to be worried about, what could go wrong, and what to look out for is a critical component within Information Transfer at Care Transition.

Clients and families are supported during care transitions and given information that they need, to make decisions and support their own care.

Information shared aligns with the Personal Health Information Act and Southern Health-Santé Sud Policies and Procedures.

DEFINITIONS:
Care transition: Any point in care when one care provider is transitioning care responsibility to another care provider e.g. transfer to Emergency Department, Interfacility Transfer.

Client: Any recipient of healthcare services. Includes clients, patients and residents.

Handover: Information transfer from one provider to another provider assuming responsibility of care, within the same care location and includes but is not limited to: transferring responsibility of care between shifts, or shorter periods of time such as breaks or change in care assignments.

Health Care Provider: All individuals who provide direct or indirect care as a result of their position and role in client care.

SBAR–Clinical: (CLI.4110.PL.010.SD.01) is a tool that asks for articulating the situation, background, assessment and recommendations to capture critical and relevant information as a standardized approach for information transfer at care transition. The SBAR-Clinical (verbal or written) supports communication and highlights a summary of pertinent information, to guide ongoing quality care for referral, consultation or mitigating risk during care transition.

Information transfer: Communication at care transitions of pertinent information relevant to the care of the client to assist the receiving provider to immediately identify and prioritize ongoing care needs and monitoring requirements.

Service Bridging: To provide continued support to the client awaiting transfer to another community Mental Health program (CMHP) area because at times there may be a waiting period for service.

IMPORTANT POINTS TO CONSIDER:

- Information Transfer supports safe care by providing information reflective of critical inquiry, emphasizing critical thinking and clinical judgment, informed by the condition and care needs of the client.
- Information Transfer includes involving and informing the client, family and/or designate in care and providing them information that they need to support and guide their care.
- The community health care provider ensures that, as per assessment, a vulnerable client has the necessary supports in place to ensure that they are able to attend the recommended health care service. Options may include client attending independently or the client being supported by family or friend.
- At a minimum, information communicated at care transitions includes:
    - Client's first and last name, PHIN, Date of Birth
    - Primary contact person (including the Substitute Decision Maker, Power of Attorney and/or Health Care Proxy)
    - Rationale for sending/transferring client
    - Safety concerns (Violence Prevention Program Status)
    - Most recent Psychosocial Assessment, Community Mental Health Services Closing/Transfer Summary and any Psychiatry Assessment reports
    - Allergies
    - Existing Health Care Directive/Advance Care Plan

- Current medications
- Diagnosis(es)
- Recent functional or medical changes
- Relevant test results and procedures.

<u>PROCEDURE:</u>

Transfer of care within the Mental Health Program:

- When the Community Mental Health Worker (CMHW) assigned to the client identifies that the client's needs may be better served within another community mental health program (CMHP) area the CMHW reviews this client with their current program Regional Manager.
- If approved by the manager for presentation for transfer to another CMHP area, the CMHW follows the steps as detailed within the relevant client presentation program requirements.

Program Requirements:

<u>Part One</u>

1. Adult mental health program
   - Present client at weekly Adult Clinical Review Committee – to book a time slot, contact Adult Program Administrative Support.
   - Prior to presentation complete the program specific Psychosocial Assessment.
   - Following presentation, the presenting clinician completes the Community Mental Health Clinical Review Form (CLI.5610.PL.003.FORM.02) which details recommendations from the Review Panel
   - If approved for transfer and with client agreement proceed to part 2.
2. Seniors mental health program
   - Present client at weekly Seniors Intake Meetings – to book a time slot, contact Seniors Access administrative support.
   - The presenting clinician summarizes most recent program specific Psychosocial Assessment that must reflect recent client issues.
   - If approved for transfer and with client agreement proceed to part 2.
3. Intensive Case Management (ICM) mental health program
   - CMHW forwards the client's most recent program specific Psychosocial Assessment and Community Mental Health Closing/Transfer Summary to Regional Manager – ICM for review.
   - Regional Manager – ICM to connect with CMHW via phone or in-person to review and clarify transfer requests and the needs of client.
   - A discussion between the Regional Managers of the involved programs occurs and transfer direction is given by their program Regional Manager.
   - If approved for transfer and with client agreement proceed to part two.
4. Crisis Stabilization Unit (CSU)
   - Contact the CSU Practitioner on duty to present client profile and need for admission to the CSU.
   - Complete the appropriate referral form (see references) and Mental Status Exam as required by the CSU Practitioner. All complex client referrals will be forwarded to the Regional Manager – Crisis Services, during regular business hours.

- ➢ If approved for transfer and with client agreement proceed to part two.

5. Child & Adolescent:
   - ➢ Present client at weekly Child & Adolescent Clinical Review Committee – to book a time slot, contact the Child & Adolescent program administrative support for directions.
   - ➢ Complete the program specific Psychosocial Assessment and Community Mental Health Closing/Transfer Summary.
   - ➢ If approved for transfer and with client agreement proceed to part 2.

Part Two

1. In all mental health program areas the CMHW's arrange a meeting to discuss the plan with the client, including the rationale and recommendations for connecting with the most appropriate services and seeks consent to proceed. If the client is in agreement:
   - ➢ The transferring CMHW informs the applicable program's administrative support of the transfer and provides a Community Mental Health Closing/Transfer Summary.
     - o Exception: If a Psychosocial Assessment has been completed with no treatment provided (i.e. Seniors Consultation Assessment) send only the Community Mental Health Clinical Review form and Psychosocial Assessment.
   - ➢ The receiving administrative support updates the applicable program registry and follows that program case assignment process.
   - ➢ It is the responsibility of the initial CMHW to continue to support, and bridge service, for the client awaiting transfer to another Mental Health program where there may be a waiting period for that service.

   Context of Service Bridging:
   - o Follow up contact with client awaiting transfer as required. (e.g. long wait time, monitoring mental status).
   - o In person meeting may be needed should there be a change in Mental Status, as required consult with a Regional Manager prior to scheduling for continued service planning.
   - o If client situation is complex, with change in mental status, connect with applicable crisis services (i.e. MHLN, crisis worker, Access worker).
   - o Service Bridging time will vary based on various program wait times.
   - o Once the transfer is confirmed the bridging clinician will complete all required transfer of care documentation and the file will be transferred to the receiving service clinician.
   - ➢ The open/close status of the client will not change during a service bridge. The Community Mental Health Closing/Transfer Summary is completed upon transfer.
   - ➢ The urgency rating is determined, by the receiving program, based on the information provided within Community Mental Health Closing/Transfer Summary and any other documentation received with the transfer by using the Triage for Referrals to the Community Mental Health Program (CLI.5610.PL.002) policy.

Part Three

Documentation and notification of client care transitions

1. CMHW's will prepare:
   - ➢ A progress note documenting the presentation at Clinical Review is placed in the health record.

- All program CMHW's will complete a Community Mental Health Closing/Transfer Summary when the client's care is transferred to another program area.

2. CMHW's will provide notification when a request to transfer care has been approved (not approved):
   - The originating CMHW is responsible for emailing the outcome information to:
     - Administrative Assistants for current and receiving program,
     - Regional Managers for current and receiving program,
     - Access worker for current and receiving program and
     - The CMHW receiving client if transfer approved.
3. Care transitions within the Crisis Stabilization Unit:
   - The Crisis Stabilization Unit Clinicians will complete the Crisis Stabilization Unit: Client Status Change of Shift Report (CLI.5610.PL.003.FORM.03) at shift change, following the SBAR-Clinical format noting the shift's observations, each client's condition and active needs as witnessed per shift.
   - Each client within the 8-bed facility to be identified and any client concerns or potential risks to be communicated within this document.
4. Information transfer by Mental Health Liaison Nurses (MHLN) in Emergency Departments (ED):
   - The Psychiatric Emergency Nurse Assessment (PENA) is the Emergency Department Information System (EDIS) compatible consultation assessment that is utilized across provincial Emergency Departments with Mental Health Nurses to ensure a standardized document is used with EDs for client transfers to other facilities.

<u>Audit</u>

- The Mental Health program conducts file audits of Mental Health client health records to evaluate compliance with this policy and documentation requirements.

<u>SUPPORTING DOCUMENTS</u>:

CLI.5610.PL.003.FORM.01	Community Mental Health Closing/Transfer Summary
CLI.5610.PL.003.FORM.02	Community Mental Health Clinical Review
CLI.5610.PL.003.FORM.03	Crisis Stabilization Unit: Client Status Change of Shift Report

<u>REFERENCES:</u>

CLI.4110.PL.010.FORM.01	SBAR-Clinical
CLI.5610.PL.001.FORM.01	Referral Form-Adult
CLI.5610.PL.001.FORM.01.F	Referral Form-Adult French
CLI.5610.PL.001.FORM.02	Referral Form-Child and Adolescent
CLI.5610.PL.001.FORM.02.F	Referral Form-Child and Adolescent French
CLI.5610.PL.001.FORM.03	Referral Form-Crisis Services
CLI.5610.PL.001.FORM.03.F	Referral Form-Crisis Services French
CLI.5610.PL.001.FORM.04	Referral Form-Seniors Consultation Team
CLI.5610.PL.001.FORM.04.F	Referral Form-Seniors Consultation Team French
CLI.5610.PL.002	Triage for Referrals to the Community Mental Health Program