This quick reference guide provides a summary of the main points contained in the best practice statement - admissions to adult mental health inpatient services. The aim of the statement is to offer guidance on practice to health professionals with the emphasis throughout on multidisciplinary, inter-agency working and collaboration.

**Pre-admission/initial assessment of need**

- positive reasons for and perceived benefits arising from admission to an inpatient setting should be evident
- all options including inpatient admission and community-based care are considered
- where risk assessment allows, pre-admission assessment should take place in a private and safe environment, outwith the admission ward
- ascertain if there is an existing advance statement, single shared assessment or other action plan, eg crisis care plan, wellness recovery action plan (WRAP) or integrated care pathway (ICP) care plan
- needs of carer(s) and relevant others are assessed

**Risk assessment and management**

- risk assessment and management is integral to every stage of the admission process
- accurate risk assessment helps reduce risk of suicide or deliberate self-harm
- when assessing risk, both historical (static) and current (dynamic) risk factors are considered
- risk assessment should be developed and delivered in collaboration with the patient, carer(s) and relevant others
- the development of risk assessment and management plans should reflect the patient’s strengths
- observation levels must be appropriately discussed with the patient and communicated to all members of the care team

**Admission to hospital – exchange of information**

- all staff involved in the admission process should be aware of the potential for increased stress and distress of a person being admitted and should therefore provide information and support throughout the admission procedure
- the first 72 hours are particularly important in an individual’s admission, requiring orientation, guidance, information, engagement and reassurance
- the named nurse/key worker and their role should be clearly identified during the admission process or at the earliest appropriate opportunity
- all information with regard to a patient’s medication should be accessed to ensure the correct medications are being prescribed
- other agencies/services engaged with the patient should be informed of their admission status and invited to exchange any relevant information (appropriate consents being sought)
Assessment and planning for recovery

- Assessment and planning for recovery should be a partnership between the patient, carer(s), relevant others, health professionals and other relevant disciplines/agencies.
- Development of any plan for recovery should reflect a patient’s past and current wishes.
- Health professionals carry out an assessment of need by combination of clinical interview that is person-centred and recovery-focused, and using standardised assessment tools and outcome measures.
- Recovery plans should be developed in partnership with the patient and health professionals to ensure shared understanding of identified needs, the patient’s specific goals and proposed/planned interventions/strategies.

Holistic assessment of psychosocial, occupational and physical needs and strengths

- Health professionals, in relevant disciplines, working in partnership with the patient, carer(s) and relevant others are involved in assessing the patient’s holistic needs and identifying their strengths while recognising that psychological assessment during this process is key.
- Clinical psychology services and other disciplines trained in the use and application of psychological theories aim to enable other service providers to develop psychologically-informed ways of thinking.
- Physical needs and their potential impact on mental health and wellbeing are assessed by medical staff and other relevant health professionals who have the appropriate knowledge and skill base.

Planning recovery and working towards discharge

- Planning recovery and working towards discharge is a partnership between the patient, carer(s), relevant others and healthcare providers and should begin as early as possible in the inpatient episode of care.
- Community mental health teams and/or primary care teams play a core role in support on discharge. Information on inpatient episode of care, progress to date and current risk assessment and management plan should be available to all persons/agencies involved in the discharge process.
- The discharge of the patient is planned prior to discharge and all relevant information should be communicated, at the appropriate time, to the patient and to those involved in continuing provision of care.
- An interim discharge care plan, prior to discharge, which should be facilitated through multidisciplinary pre-discharge meetings, is required.
- Discharge planning incorporates current/ongoing risk assessment and management plans and should reflect the move to community.
- The need for long-term monitoring and management of physical parameters (e.g., weight, lipids, glucose, etc.) for patients, for example on antipsychotic medication, must be identified and communicated to appropriate community resources.

For further information please refer to the full version of the best practice statement which is accessible via our website: www.nhshealthquality.org