The Justice Health & Forensic Mental Health Network
PO BOX 150 Matraville NSW 2036
Tel (02) 9700 3000
http://www.justicehealth.nsw.gov.au

Release Planning and Transfer of Care Policy – Adult to External Providers

Policy Number 1.141

Policy Function Continuum of Care

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Summary A smooth patient transition from custody to the community is essential to reduce health risk and ensure transfer and continuity of care post-release for high risk adult patients.

Responsible Officer Executive Director Clinical Operations (Custodial Health)

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☒ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Juvenile Justice Centres)
- ☐ Long Bay Hospital
- ☐ Forensic Hospital

Previous Issue(s) Policy 1.141 (March 2013)

TRIM Reference POLJH/1141

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

A smooth patient transition from custody to the community is essential to reduce health risk and ensure transfer and continuity of care post-release. This policy provides procedures to be implemented prior to, and at the time of release, for high-risk Justice Health and Forensic Mental Health Network (JH&FMHN) adult patients exiting custody from the ambulatory health care setting. The aim of this policy is to ensure a coordinated approach to release planning for patients with chronic and/or complex health conditions and other high-risk patients by frontline staff, in order to facilitate on-going patient care in the community.

2. Policy Content

2.1 Mandatory Requirements

All patients who have a known release date must be reviewed by the Primary Health Nurse (PHN) to determine whether they are already receiving release planning services or if they require referral for release planning. This process should commence 30 days prior to release from custody where possible. This will ensure the provision of support and transfer of care into the community upon release, for patients with chronic and/or complex health conditions and other high risk patients.

2.2 Implementation - Roles & Responsibilities

- The Integrated Care Service (ICS) monitors patients with chronic and/or complex health conditions, from reception through to the post-release period in the community, to ensure seamless, timely and appropriate health care. Patients identified at anytime during the custodial period to have chronic and/or complex health conditions should be referred to the ICS.
- All other patients who are high risk e.g. pregnant women, patients with an acute mental health problem, all patients on Opioid Substitution Treatment (OST), and patients on other prescribed medications must have comprehensive release planning by the relevant clinical stream e.g. Primary and Women's Health, Mental Health, Drug and Alcohol etc.
- During any consultation with a patient in the Health Centre, the PHN will assess the patient for chronic and/or complex health conditions. Where these are identified, the patient is to be referred to the ICS. The PHN will assess all patients with release from custody pending, who have not been referred to ICS, to determine whether the patient has chronic and/or complex health conditions, or is otherwise high risk. A referral is to be made to the ICS or relevant clinical stream for release planning.
- Clinicians should involve the Aboriginal Health Worker where possible for all Aboriginal and/or Torres Strait Islander patients.
- The relevant clinician for "other" high-risk patients e.g. Midwife for pregnant women, must apply a Movement Alert in the Patient Administration System (PAS) that identifies high-risk patients with the wording *"Identified high needs patient – must exit custody via the Health Centre"*. The Health Problem Notification Form (HPNF) should also state *"High needs Patient must exit custody via Health Centre/ the private operators* staff that the patient must exit via the Health Centre.
- All patients with chronic and/or complex health conditions and other high-risk patients must have a *Release Summary and Transfer of Care Form* completed on the JH&FMHN *electronic* Health System (JHeHS) or for Mental Health patients the *MHoAT Discharge Summary* form by the relevant Nurse. This

is formulated from information contained in the patient's Reception Screening Assessment (RSA), Chronic Disease Screen (CDS), Multidisciplinary Care Plan, health record progress notes, medication chart, pathology results, investigations, PAS appointments and any other necessary information relevant to their on-going care in the community.

- A Memorandum of Understanding with CSNSW/private provider ensures that the Nursing Unit Manager (NUM) or delegate at each Health Centre receives prior notification of patients with an impending release. This enables the PHN to identify, and manage or refer patients with chronic and/or complex health conditions and other high risk patients, and to ensure that the patient exits custody via the Health Centre on the day of release.

3. Procedure Content

The procedure content includes patients with chronic and/or complex health conditions and other high-risk patients who have planned releases, unplanned/unexpected releases and those who have declined release planning. *Please refer to Appendix 1 for flow charts 1 to 8 of preparation for patient releases.*

3.1 Preparation For Release

3.1.1 Four (4) Weeks Prior to Release

1. The NUM or delegate will receive notification of impending releases via the CSNSW Sentence Expiry Report, and Drug and Alcohol Release Planning Office for patients on OST. The ICS will send out impending release dates to the NUM for patients registered with the ICS.
2. The NUM or delegate must also advise CSNSW/ the private operators of patients with chronic and/or complex health conditions and other high-risk patients who may be granted parole (and due for release within 7 days) or released via Audio Video Link (AVL), that must exit custody via the Health Centre, with a *Health Problem Notification form* stating *"High needs patient must exit custody via Health Centre*." The NUM or delegate must apply a Movement Alert in PAS *"Identified high needs patient – must exit custody via the Health Centre."*
3. Patients with chronic and/or complex health conditions and other high-risk patients on remand with a bail application pending, must be provided with an ICS business card and an OST information card if applicable, to enable them to make contact following release.
4. Each relevant clinical stream is responsible for coordinating and planning on-going care post-release. For example the Public Sexual Health Nurse is responsible for patients on treatment for Hepatitis B, C, and HIV. Additionally, the Clinical Nurse Consultant (CNC) Infection Prevention and Communicable Diseases is responsible for coordinating and planning on-going care in the community and for liaison with Tuberculosis (TB) Services for patients with TB.
5. For pregnant women the PHN must contact the JH&FMHN Midwife to ensure appropriate appointments are booked post release. Antenatal records including copies of pathology and ultrasound results are forwarded onto the relevant Local Health District (LHD). A copy of this information is also provided to the patient in the event that she presents to an alternative health service.
6. For all patients on OST and in particular, pregnant women on OST, the PHN in the absence of the Drug & Alcohol Nurse must complete and email/fax the (*Post Release/Approved Leave Care Planning*

Request form JUS200.202) to the Drug & Alcohol Release Planning Office, unless the patient has been reviewed by the Connections Program.

7. For identified high-risk patients not enrolled with ICS, the PHN must create a release planning waitlist on PAS. The PHN must check and complete the *Release Summary and Transfer of Care Form* on JHeHS to ensure that the patient's community contact and address details are accurate and up to date. If the information is not available in the existing health record/JHeHS forms, the PHN must consult with the patient to confirm post release contact and address details where possible.

8. For patients not enrolled on the ICS who have chronic or complex health conditions, the PHN must inform the ICS team via the ICS telephone hotline number 1800 880 894 or via email .ics@justicehealth.nsw.gov.au to assist with release planning.

9. For Patients with a disability the PHN must contact the CSNSW Disability Service for assistance (telephone 02 9289 2136 or email: sds@dcs.nsw.gov.au). For patients with a cognitive disability e.g. intellectual disability, acquired brain injury, alcohol related brain injury, Alzheimers, cerebral palsy, Asperger's, Autism, dementia, traumatic brain injury, and foetal alcohol spectrum disorder, information should be provided in an accessible and appropriate format. The disability must be recorded as a health condition in JHeHS. For assistance with including disability support services in the patient's transfer of care arrangements, contact the Coordinator, Cognitive Disability Services for assistance and contact ICS.

10. The PHN or Care Coordinator must ensure the patient is informed about all post release appointments and that they should contact their GP post-release to reschedule any appointments that they cannot attend. Where a patient has multiple health care needs they should be under the care of the ICS who can co-ordinate appointments and arrange a multidisciplinary case conference with community based services if required. Patients of the ICS are required to sign the patient letter to acknowledge receipt of information related to appointments in the community post-release. The PHN must scan and email the signed letter to the ICS.

11. The PHN must provide the patient with a copy of their release plan details, current medications, health management and relevant health promotion advice prior to release. The *Release Summary and Transfer of Care Form* and *Multidisciplinary Care Plan* must be printed from JHeHS and the 'Medilist' should be signed into the patient's property by the property custodial officer.

12. To request release medication, a current medication chart must be faxed together with a release medication cover sheet by the PHN, at least 2 weeks prior to release. Seven days medication and a Patient Medication Summary are supplied on release (OST medication is not supplied as a release medication). For specialist population health medication up to 30 days supply is provided on release. In the case of stimulant medication a quantity up to a maximum of 30 days may be supplied at the discretion of the treating psychiatrist.

13. Patients who are on the self-medication program may take the remainder of their prescribed medications with them on release if the quantity is sufficient.

14. Arrangements for Medicare Cards should be made by CSNSW Offender Services and Program (COSP) or the private operator's psychology. The PHN should make a referral to, or recommend the patient contact COSP/the private operator's psychology to facilitate a new card if required. Patients on the Connections Program will have a Medicare card arranged for them.

15. Patients who are mentally unwell and/or under the care of the Risk Intervention Team (RIT) and scheduled by the psychiatrist under the *Mental Health Act 2007* must be escorted to a psychiatric inpatient facility for assessment and on-going care upon their release from custody. The MHN (or in their absence, the PHN with the assistance of the Nurse Manager, Custodial Mental Health) must ensure arrangements are in place to transport the patient to a mental health facility in the community upon release. The MHN must relay this information to CSNSW, organise transfer by NSW Ambulance Service, and if the receiving facility is known, give a clinical handover.

3.1.2 Day of Release

1. When the patient has been released, health centre administration staff (under the direction of PHN) must end PAS alerts, cancel waiting list entries, referrals and any future dated health ventre appointments. ICS alerts and Medical Appointments Unit (MAU) external appointments must remain. The 'Contact Service Director Population Health' PAS alert must not be removed as this is required if/when a patient returns to custody.
2. The PHN must ensure the patient is provided with the Medilist and release medications. The PHN should ensure the patient is administered any prescribed OST prior to release (the ability to do so will also depend on the time of the release).
3. The PHN must record an entry regarding patient's release date and related transfer of care arrangements in the Health Record.

3.2 Unplanned/Unexpected Releases

1. When short notice is received for a patient's release, advice on the options available for release medication can be sought directly from the Pharmacy Department.
2. If an ICS patient has been unexpectedly released the ICS must be informed as soon as possible via the ICS telephone hotline number 1800 880 894 or via email .ics@justicehealth.nsw.gov.au and a *Release Summary and Transfer of Care* form should be completed on JHeHS where possible. The ICS team will attempt to make contact with the patient, facilitate linkage to a community care provider and refer him/her to the Connecting Care Program in the community if appropriate.
3. The PHN must contact the Public Sexual Health Nurse for patients on treatment for Hepatitis B, C, and HIV and/or the CNC Infection Prevention and Communicable Diseases for patients on TB treatment.
4. The MHN, or the Nurse Manager, Custodial Mental Health in the absence of a MHN, must contact the relevant external community health care providers regarding mentally unwell / RIT patients who are scheduled and released without prior warning.
5. The MHN/Court Liaison CNC must liaise with the local relevant community psychiatric facility to hand over clinical information on patients who are transferred to a mental health facility pursuant to Section 33 of the *Mental Health (Forensic Provisions) Act 1990*.
6. If a patient who has chronic and/or complex health needs (not previously referred to the ICS) is released unexpectedly, the PHN should contact the ICS for assistance.
7. The PHN must advise the Drug and Alcohol Release Planning Office of patients released unexpectedly, who are on OST.
8. The PHN must advise the JH&FMHN Midwife of any unexpected release of a pregnant woman.

3.3 Declined release planning

If a patient declines release planning services the PHN must document in the patient Health Record and where applicable inform ICS, the Public Sexual Health Nurse/CNC Sexual Health & Hepatitis, the CNC Infection Prevention and Communicable Diseases, Drug & Alcohol Release Planning Office and/or JH&FMHN Midwife.

3.4 Health Record Return to Health Information Records Service (HIRS)

Upon release from custody the patient's current Health Record volume must only be returned to HIRS after the actions outlined above have been undertaken for planned and unplanned releases and declined release planning from custody. The Health Record should then be returned to HIRS.

4. Definitions

Must

Indicates a mandatory action or requirement**.**

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

Care Coordinator

The primary health care worker responsible for patient.

5. Legislation and Related Documents

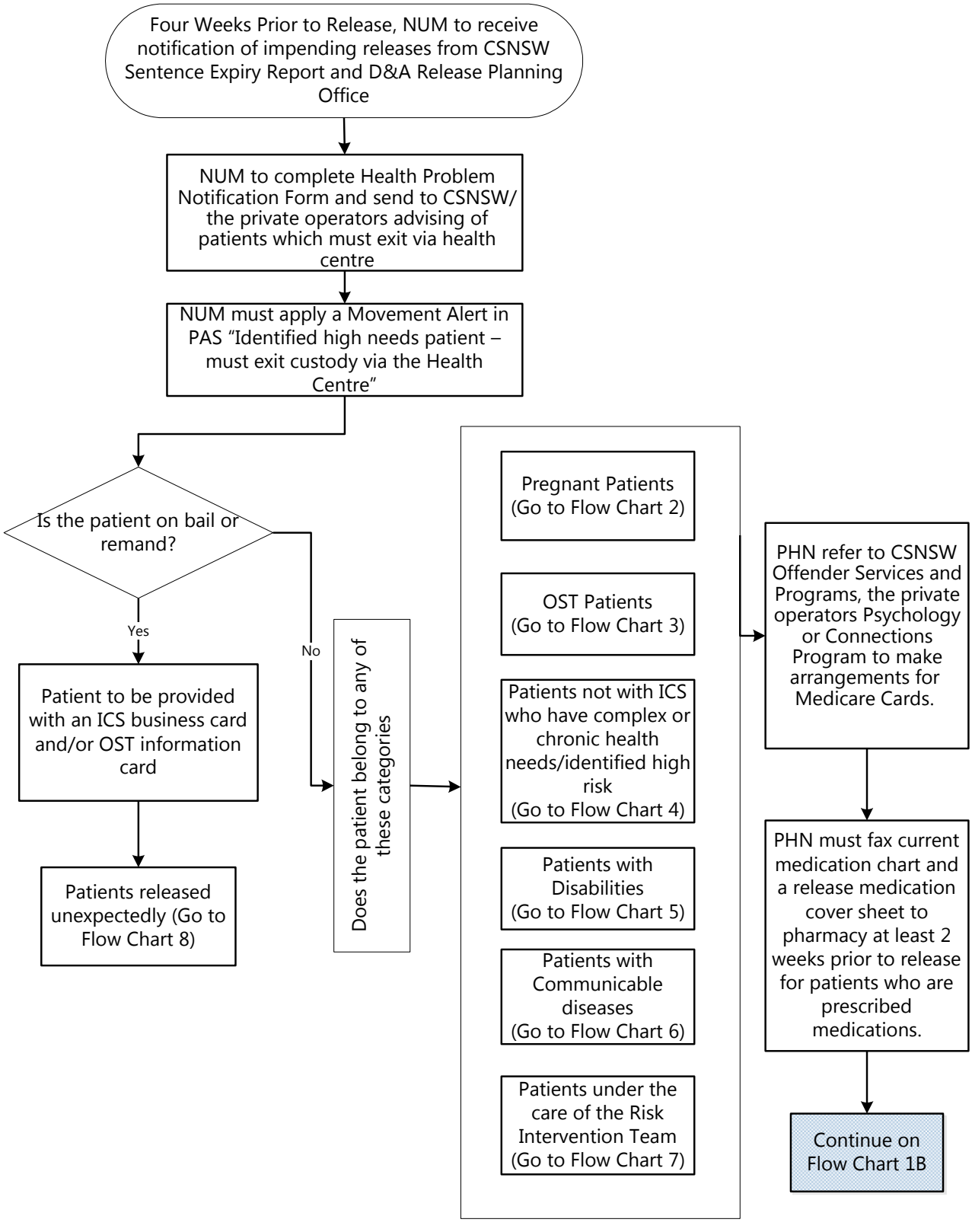
Legislation	*Mental Health Act 2007* *Mental Health (Forensic Provisions) Act 1990*
Ministry of Health	PD2011_015 *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* PD2014_050 *Principles for the Management of Tuberculosis in New South Wales* *Tuberculosis in NSW*
JH&FMHN Policies	1.225 *Health Assessments in Male and Female Adult Correctional Centres* 1.020 *Medication Management* 4.020 *Health Records* *JH&FMHN Guidelines for the Management of Constipation*
JH&FMHN Manuals	*Chronic Care Toolkit, Version 1, 2010* *Drug and Alcohol Procedure Manual 2014*
RACGP	*Standards for health services in Australian prisons*

Journal Article — Poroch N, Tongs J, Longford E, Keed S (2012). *Aboriginal health workers at Winnunga Nimmityjah Aboriginal Health Service caring for the needs of Aboriginal people* in the new ACT prison and the needs of their families. Aboriginal and Islander Health Worker Journal, Vol. 36, No. 1, 2012:

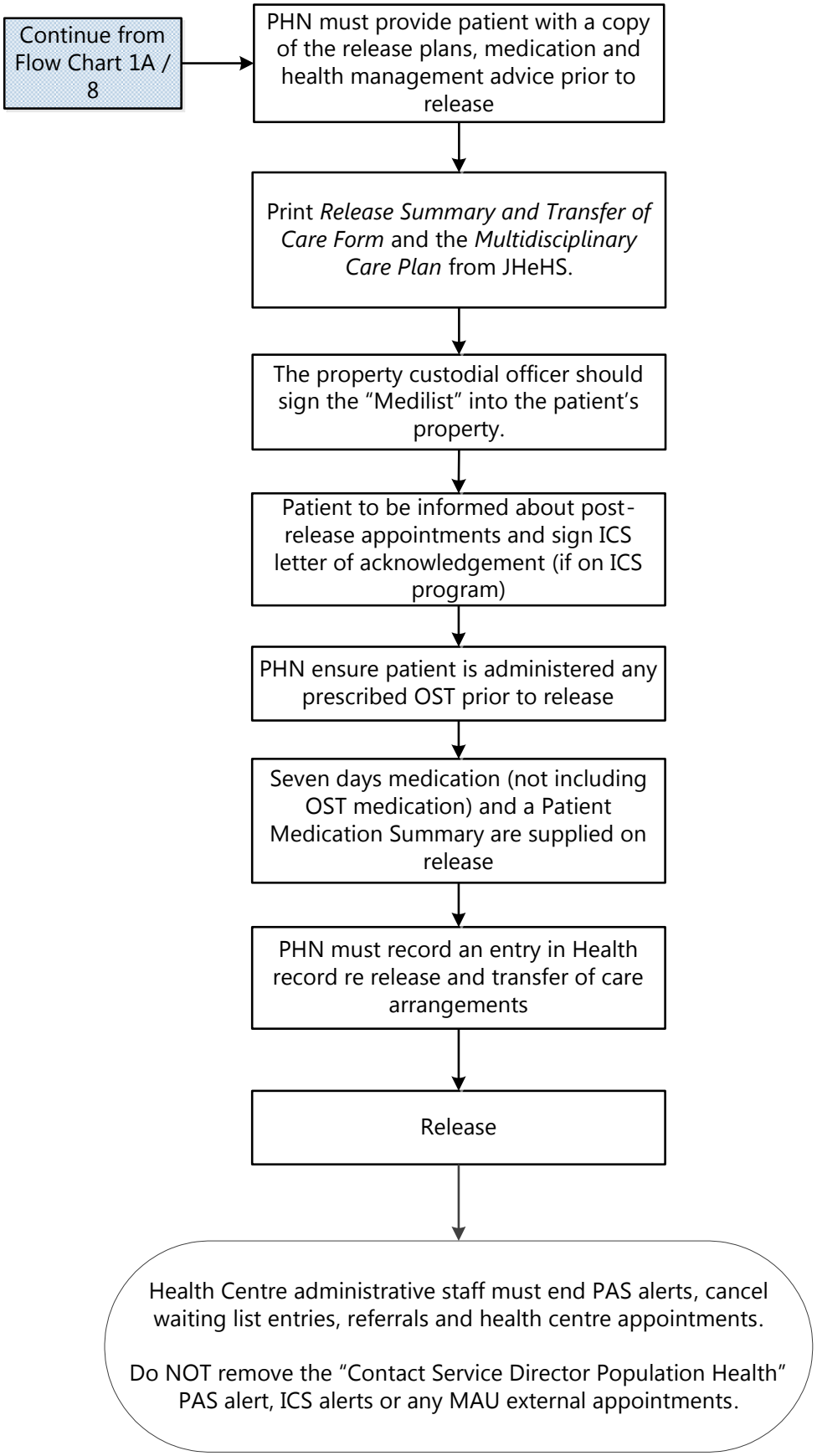
Appendix 1 (Flow Chart 1 to Flow Chart 8)

Flow Charts for Release Planning and Transfer of Care.

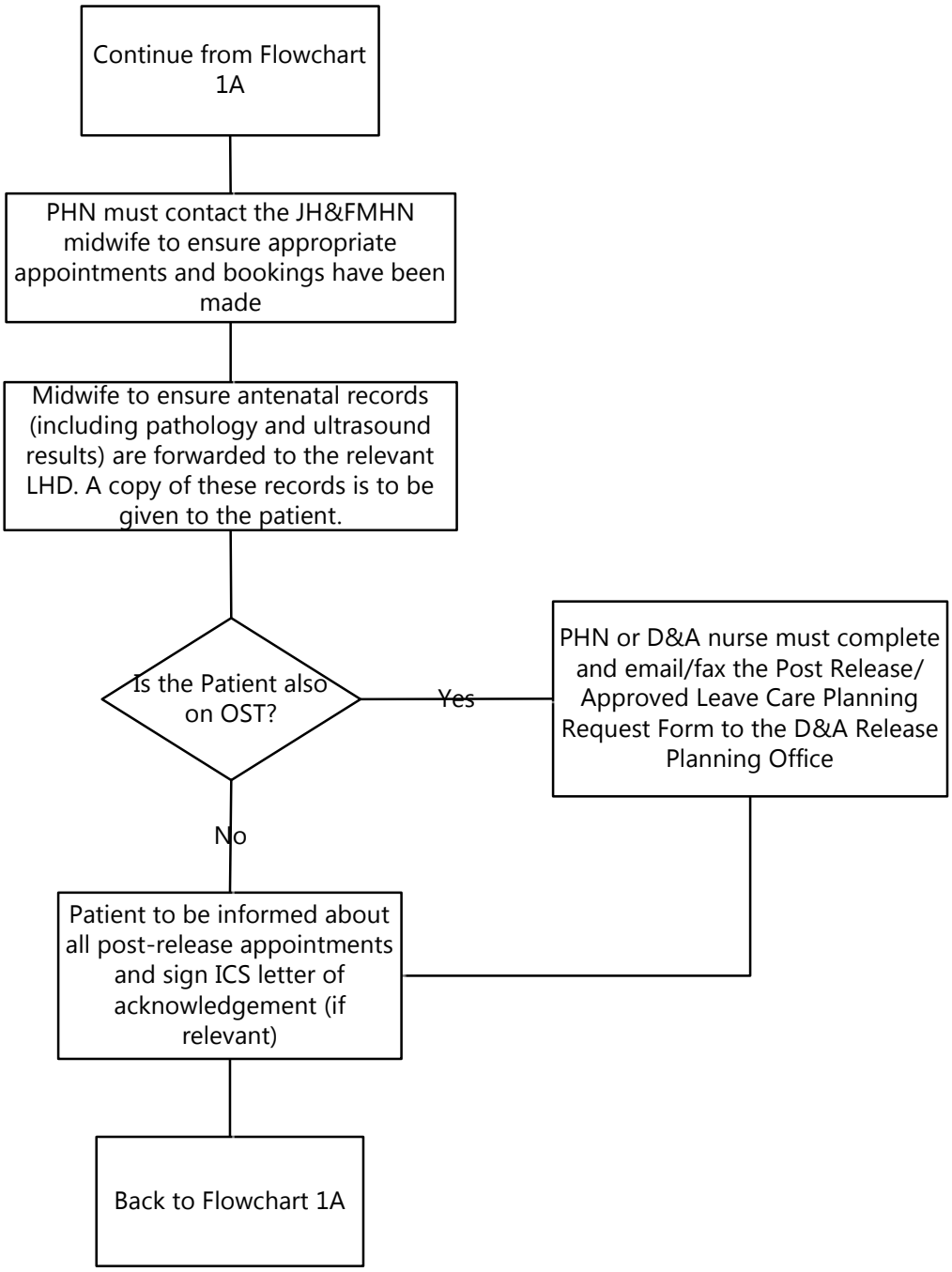
Flowchart 1A - Four Weeks Prior to Release



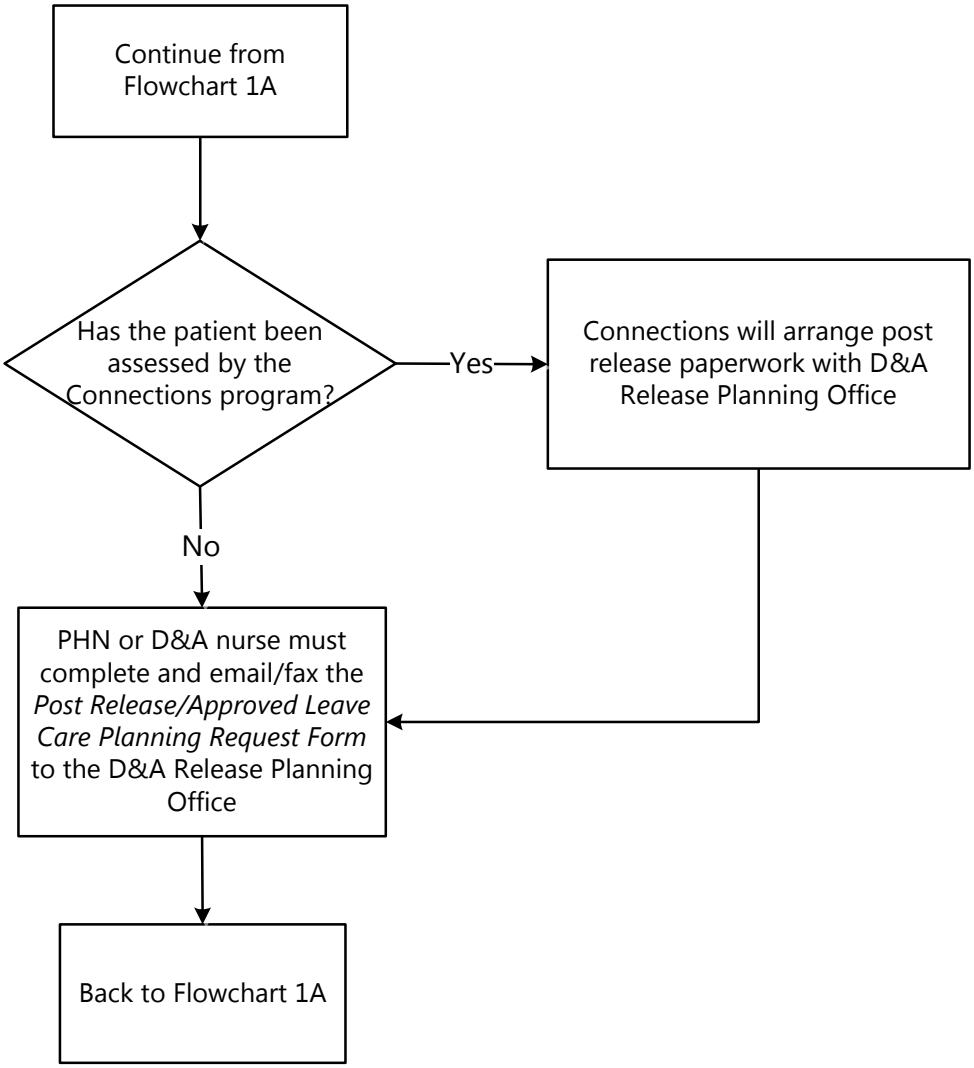
Flowchart 1B



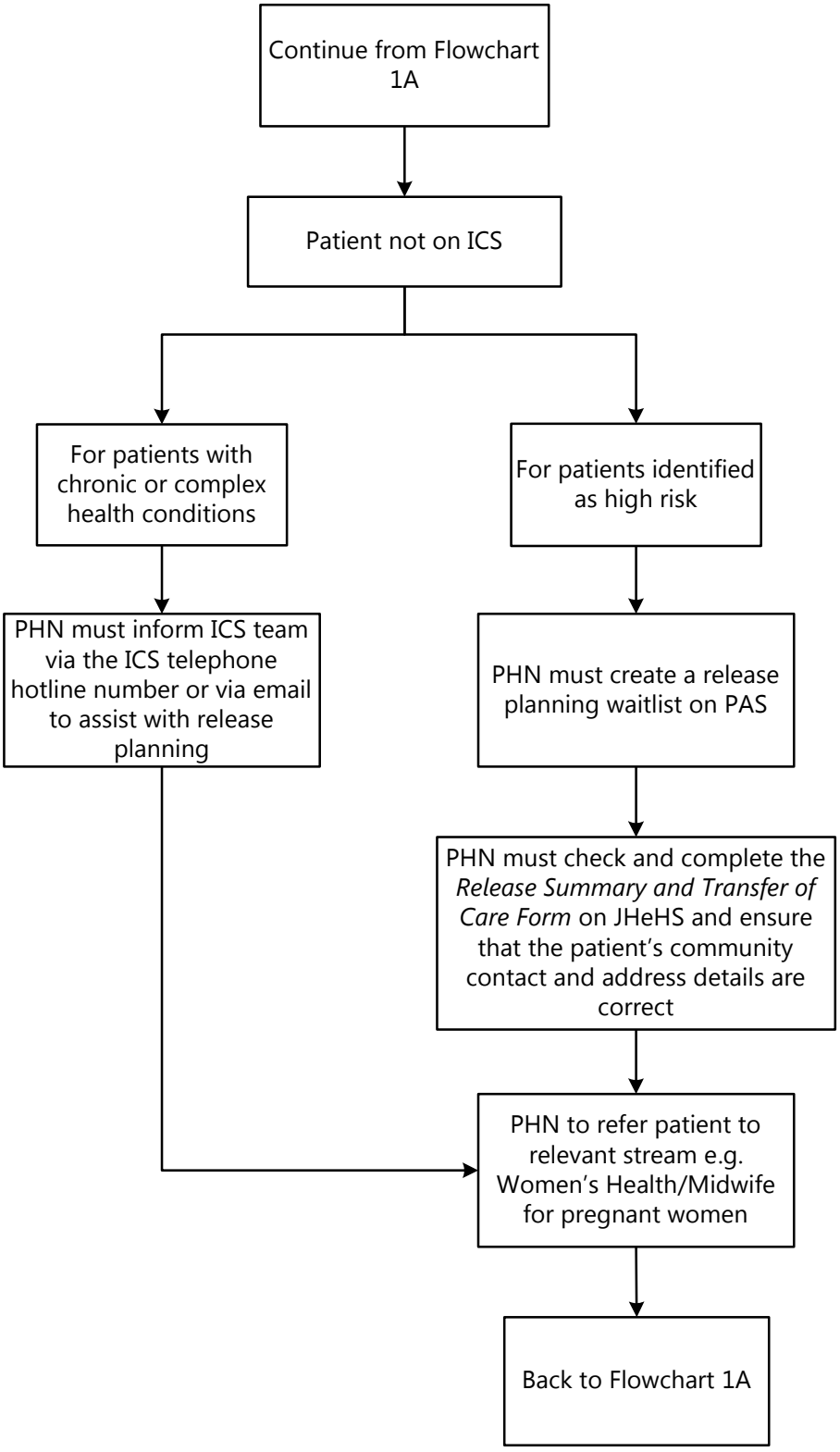
Flowchart 2 – Pregnant Patients



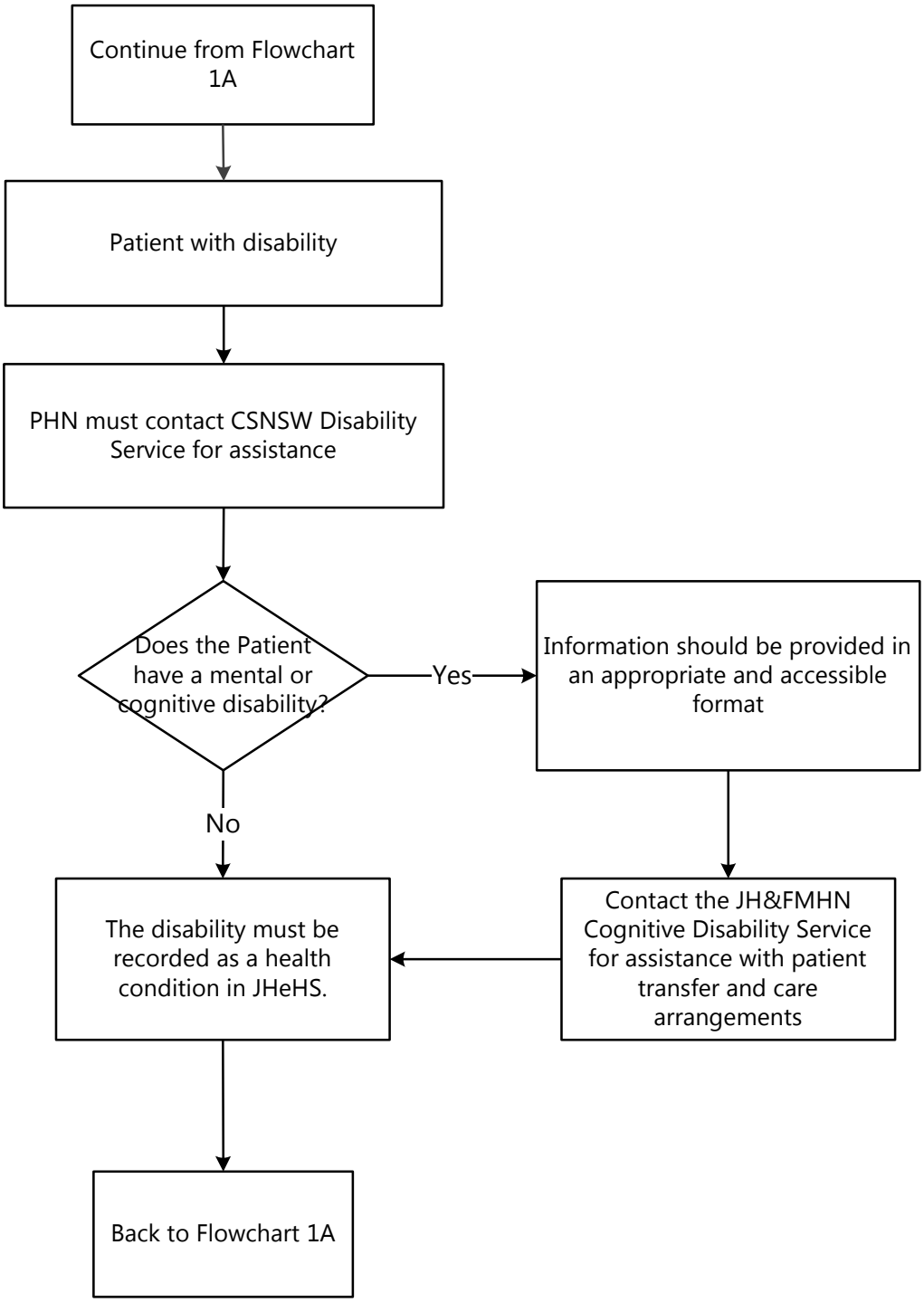
Flowchart 3 – OST Patients



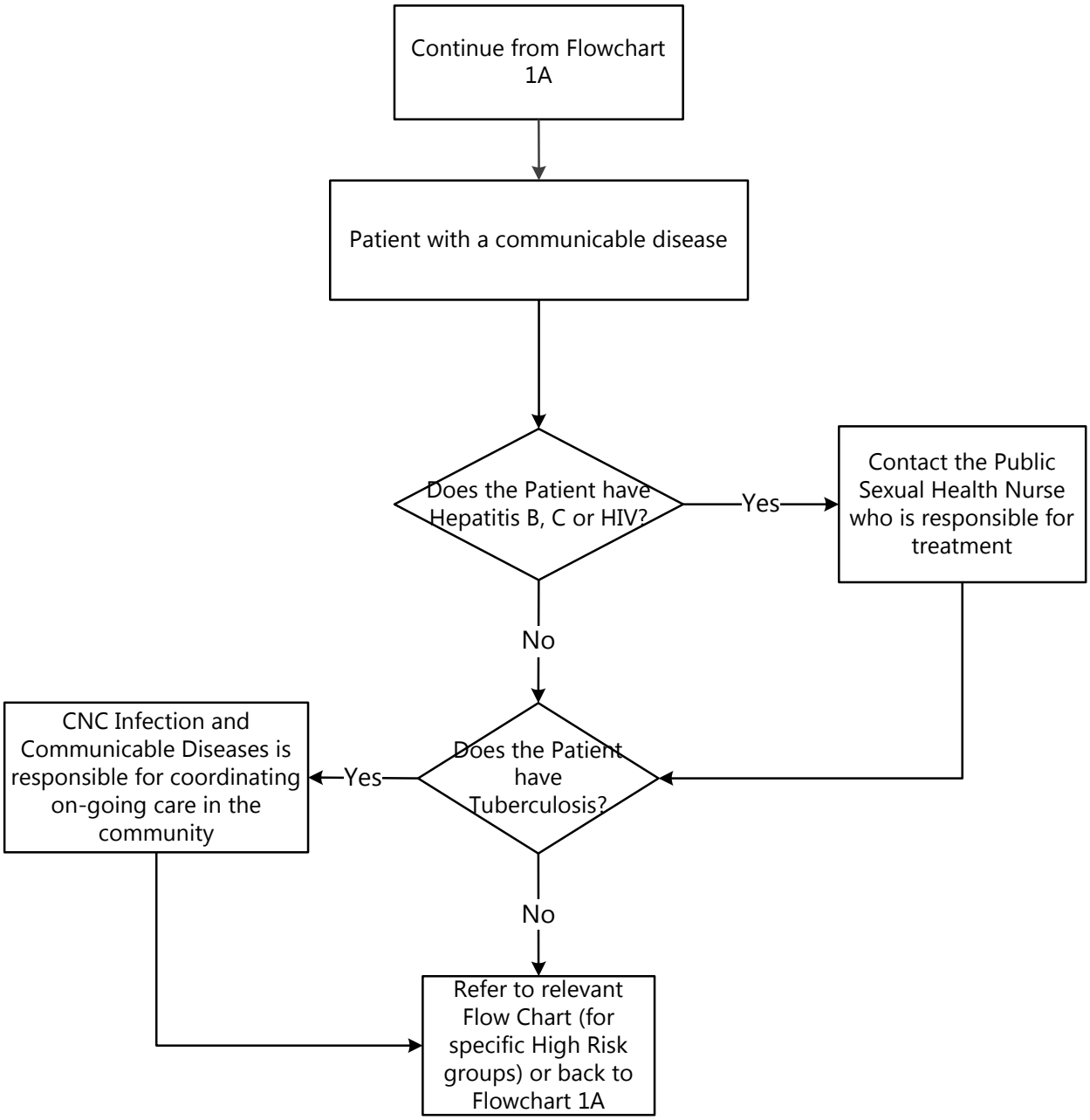
Flowchart 4 – Patients not with ICS who have complex or chronic health needs/identified high risk



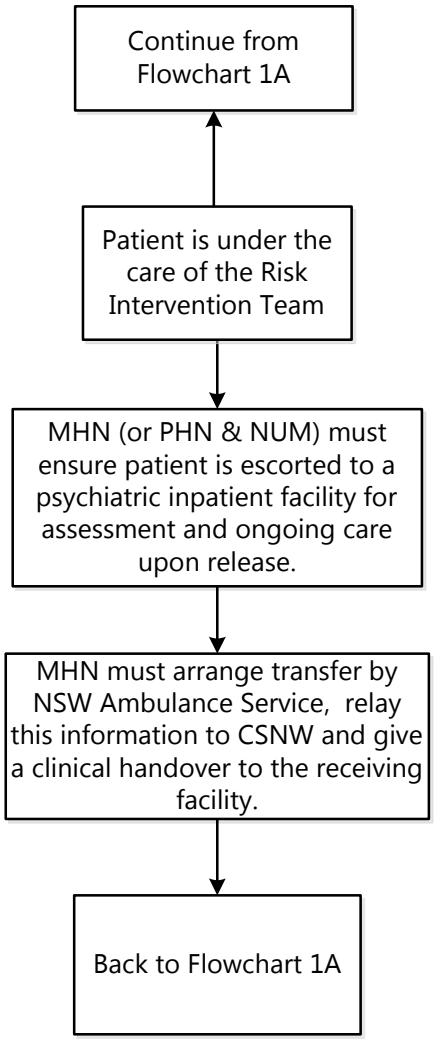
Flowchart 5 – Patients with Disabilities



Flowchart 6 – Patients with Communicable Diseases



Flowchart 7 – Patients under the care of Risk Intervention Team



Flowchart 8 - Unplanned/ Unexpected Releases