**Learning Disability Inpatient Services - Transfer Checklist**

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| **Current Unit**  | **Transfer Unit** |  **Out of Area ( Organisation & Unit)** | **Legal Status** |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | Completed | Comments / Actions |
| 1 | **Legal**  | Yes / No |  |
| 1.1 | Has the patient been assessed to have capacity to agree to transfer and MCA documentation completed  |  |  |
| 1.2 | If no, has transfer been agreed & recorded as MCA / Best Interest Decision meeting |  |  |
| 1.3 | Transfer of Responsible Clinician Form completed |  |  |
| 1.4 | Assessment of capacity to consent to treatment completed  |  |  |
| 1.5 | T1 / T2 / T3  |  |  |
| 1.6 | Mental Health Legislation informed of transfer  |  |  |
| 1.7 | Managers Hearing / MH Tribunal arrangements  |  |  |
| 1.8 | Reasonable adjustments required on transfer ; |  | Date of each adjustment completed |
|  | Confirm solicitor |  |  |
|  | Confirm all contact details inc NR / NoK |  |  |
|  |  |  |  |
| **2** | **Joint Working – Green Light**  | Yes / No |  |
| 2.1 | Has the purpose of transfer been identified? |  |  |
| 2.2 | Transfer agreed at joint MDT between both service areas |  | Interventions Required |
| 2.3 | Patient Centred Care Plans available and updated  |  |  |
| 2.4 | Activity Checklist / Plan available and updated  |  |  |
| 2.6 | Positive Behavioural Support Plan completed with psychological formulation |  |  |
| 2.8 | Epilepsy Management plans  |  |  |
| 2.9 | FACE Risk Assessment |  |  |
| 2.10 | HoNOS |  |  |
| 2.11 | MPAS-ID |  |  |
| 2.12 | Physical Health Management & Plans available & updated  |  |  |
| 2.13 | Health Action Plan  |  |  |
| 2.14 | Hospital Passport  |  |  |
| 2.15 | Communication Passport |  |  |
| 2.16 | Sensory Profile |  |  |
| 2.17 | Environmental assessment  |  |  |
| 2.18 | Autism Assessment  |  | Date of referral  |
| 2.19 | Lorenzo Alert reviewed  |  |  |
|  |  |  |  |
| **3** | **Medications** | Yes / No |  |
| 3.1 | EPMA checked prior to transfer |  |  |
| 3.2 | EPMA checked on transfer |  |  |
| 3.3 | Self-Administration of medication (SAM) assessment completed  |  |  |
| 3.4 | Level of SAM agreed  |  |  |
| 3.5 | Medications transferred as required |  |  |
| 3.6 | Medications available on transfer  |  |  |
|  |  |  |  |
| **4** | **Patient / Carer Information**  | Yes / No |  |
| 4.1 | Transfer information shared |  |  |
| 4.2 | Patient Monies been handed over and recorded on transfer |  |  |
| 4.3 | Patient property handed over and recorded  |  |  |
| 4.4 | Welcome Pack completed  |  |  |
|  |  |  |  |
| **5** | **Other**  | Yes / No |  |
| 5.1 | Informed of transfer; |  |  |
|  | Nearest Relative |  |  |
|  | Next of Kin |  |  |
|  |  |  |  |
|  | GP |  |  |
|  | Social Worker |  |  |
|  | Community Learning Disability Team |  |  |
|  | Intensive Support Team |  |  |
|  | IMHA |  |  |
|  | IMCA |  |  |
| **5.2** | **Last case note audit date & outcomes from transfer team** |  |  |
| **5.3** | **Other** |  |  |