Justice Health and
Forensic Mental Health Network

NSW GOVERNMENT

Justice Health NSW Policy

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

Issue Date: 04 April 2023

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

Policy Number 1.141

Policy Function Continuum of Care

Issue Date 04 April 2023

Next Review Date 04 April 2026

Risk Rating High

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 patients leaving custody.

Responsible Officer General Manager, Primary Care

Applies to

☐ Administration Centres
☒ Community Sites and programs
☒ Health Centres - Adult Correctional Centres or Police Cells
☐ Health Centres - Youth Justice Centres
☒ Long Bay Hospital
☐ Forensic Hospital

CM Reference POLJH/1.141

Change summary

- Amalgamation with Policy 1.142 Discharge Planning – Medical Subacute Unit and Aged Care and Rehabilitation Unit Long Bay Hospital.
- Policy 1.142 Discharge Planning – Medical Subacute Unit and Aged Care and Rehabilitation Unit Long Bay Hospital will be rescinded.

Authorised by Chair, Policy Steering Committee

Revision History

#	Issue Date	Number and Name	Change Summary
4	April 2023	1.141 Release Planning and Transfer of Care Policy – Adult to External Providers	• Amalgamation with Policy 1.142 Discharge Planning – Medical Subacute Unit and Aged Care and Rehabilitation Unit Long Bay Hospital. • Policy 1.142 Discharge Planning – Medical Subacute Unit and Aged Care and Rehabilitation Unit Long Bay Hospital will be rescinded.

3	December 2019	1.141 Release Planning and Transfer of Care Policy – Adult to External Providers	• Changes to flowchart re connections • Additional information re connections • Removal of arrangement of Medicare Card by D&A • Additional information re responsibility of the D&A Release Planning Services office for patients being released
2	September 2016	1.141 Release Planning and Transfer of Care Policy – Adult to External Providers	• Updated title • Inclusion of JHeHS • Inclusion of Pregnant women procedures • Inclusion of D&A procedures • Amalgamation
1	March 2013	1.141 Release Planning and Transfer of Care Policy – Adult Ambulatory Setting	• New policy

PRINT WARNING

Printed copies of this document, or parts thereof, must not be relied on as a current reference document.

Always refer to the electronic copy for the latest version.

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Table of Contents

1. Preface 5
2. Policy Content 5
   2.1 Mandatory Requirements 5
   2.2 Roles and Responsibilities 5
3. Procedure Content 6
   3.1 Preparation for Release 6
      3.1.1 Four (4) Weeks Prior to Release 6
      3.1.2 Day of Release 9
   3.2 Unplanned/Unexpected Releases 9
   3.3 Declined Release Planning 10
   3.4 Transfer of Care from Long Bay Hospital to Correctional Centres 10
   3.5 Health Record Return to Health Information Records Service (HIRS) 11
4. Definitions 11
5. Related Documents 11

1. Preface

A smooth patient transition from custody to the community is essential to reduce health risks and ensure transfer and continuity of care post-release. The aim of this policy is to provide a coordinated approach to release planning via procedures to be implemented prior and at the time of release for Justice Health NSW (JHNSW) adult patients exiting custody from the ambulatory and inpatient health setting.

2. Policy Content

2.1 Mandatory Requirements

All patients who have a known release date must be reviewed by the Nurse to determine whether they are already receiving release planning services or if they require referral for release planning. The Release Summary and Transfer of Care form completed on the Justice Health electronic Health System (JHeHS) advising that the patient is now fit for discharge must be given to Corrective Services NSW (CSNSW) with all other accompanying documents as required.

A copy of the Release Summary and Transfer of Care form must also be given to the patient as a record of health problems and treatment to be given to the community General Practitioner (GP) on release where indicated, or to be kept with the patient

Forensic patients must only be discharged from the custodial settings if they have the appropriate order from the Mental Health Review Tribunal and in accordance with Ministry of Health Policy Directive PD2025_042 *Forensic Mental Health Services*.

All patients who have a known release date must be reviewed by the Nurse to commence release planning and/or require referral to the relevant stream for release planning. This process should commence at least 30 days prior to release where possible.

2.2 Roles and 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 any time during the custodial period to have chronic and/or complex health conditions should be referred to the ICS via a PAS referral a minimum of four weeks prior to release.
- The Integrated Care Service (ICS) must send the 180 Day Earliest Release Date Report to the Nursing Unit Manager (NUM) on a weekly basis and/or the NUM can also run a report from PAS that will provide a list of patients that will be attending court or have an impending release date.
- Clinicians should involve the Aboriginal Health Worker or the Aboriginal Chronic Care Program (ACCP) where possible for all Aboriginal and/or Torres Strait Islander patients.
- All other patients who are high risk e.g. pregnant women, patients with an acute mental health problem, all patients on Opioid Agonist Treatment (OAT) and patients on other prescribed medications must have comprehensive release planning by the relevant clinical stream e.g. Midwifery, Primary Care, Custodial Mental Health, Drug and Alcohol, Population Health etc.

- 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/Private Provider". The Health Problem Notification Form (HPNF) should also reflect the same.
- All patients with chronic and/or complex health conditions and other high-risk patients must have a Release Summary and Transfer of Care Form or for Custodial Mental Health patients the MHoAT Discharge Summary form completed on JHeHS 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 (MCP), health record progress notes, medication chart, pathology results, other clinical investigations reports/results, PAS appointments and any other necessary information relevant to their on-going care in the community.

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.

3.1 Preparation for Release

3.1.1 Four (4) Weeks Prior to Release

Health Centre and Long Bay Hospital

1. Health Centres and Long Bay Hospital should follow the Health Centre Release Planning Procedure to release plan for the patient.
2. The NUM or delegate will receive notification of impending releases via the 180 Day Earliest Release Date report from the Manager ICS, the CSNSW Sentence Expiry Report, and the Drug and Alcohol (D&A) Release Planning Services office for patients on Opioid Agonist Treatment (OAT). The ICS will send out impending release dates to the NUM for patients registered with the ICS.
3. The NUM or delegate must also advise CSNSW/Private Provider 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 (HPNF) 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." For patients who may be released afterhours, the NUM must advise CSNSW to contact the After Hours Nurse Manager (AHNM) on [redacted] Option 1.
4. 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 which has important telephone numbers such as General Enquiries, NSW Mental Health Helpline, the Pharmacy Department and OAT.
5. For identified high-risk patients not enrolled with ICS, the Nurse must create a release planning waitlist on PAS. The Nurse 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 Nurse must consult with the patient to confirm post release contact and address details where possible.

6. For patients not enrolled in the ICS who have chronic and/or complex health conditions, the Nurse must refer the patient to the ICS via PAS.
7. For Patients with a disability the Nurse must contact the CSNSW Disability Service for assistance via telephone [redacted] or email: [redacted] For patients with a cognitive disability e.g. intellectual disability, acquired brain injury, alcohol related brain injury, Alzheimer's, Cerebral Palsy, Asperger's, Autism, Dementia, Traumatic Brain Injury, and Foetal Alcohol Spectrum Disorder, information should be provided in a simple format. The disability must be recorded as a health condition in JHeHS. For assistance, including disability support services in the patient's transfer of care arrangements, JHNSW staff should contact the Coordinator, Cognitive Disability Services for assistance and contact ICS.
8. For pregnant women the Nurse must contact JHNSW 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. For pregnant patients involved in the Substance Use in Pregnancy and Parenting Service (SUPPS), the SUPPS coordinator should be involved in the release planning for all pregnant women with substance use issues.
9. The Nurse or Care Coordinator must ensure the patient is informed about all post release appointments and should inform patient to 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 that are enrolled with the ICS are required to sign the patient letter to acknowledge receipt of information related to appointments in the community post-release. The Nurse must scan and email the signed letter to the ICS.
10. The Nurse must provide the patient and their community GP/Treating Physician/Psychiatrist/ or any other discipline/service involved in their transfer of care, with a copy of their release plan details, current medications, health management and relevant health promotion advice prior to release (*Consent to Liaise* JUS020.035 and *Consent to Obtain Health Information for Continuation of Care* form JUS020.083 must be completed prior to sharing information). If the patient refuses, release planning and/or sharing of their health information, the Nurse must document this in the patient's electronic health record. The Release Summary and Transfer of Care Form and Multidisciplinary Care Plan (MCP) must be printed from JHeHS and the 'Medilist' if available, should be signed into the patient's property by the property CSNSW Officer.
11. To request release medication, the release medication cover sheet is to be emailed to [redacted] at least 2 weeks prior to release.
12. Further information on release medications can be found in JHNSWs 6.049 *Medication Guidelines*. Seven days medication and a Medilist Medicat are provided to the patient on release (OAT medication is not provided as a release medication). For specialist population health medication a quantity of up to 30 days 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. Patients enrolled in the Sachet Program are NOT to be given remaining sachets on discharge. Medications are to be from JHNSW Pharmacy Department.
14. Arrangements for Medicare Cards should be made by CSNSW Offender Services and Program (COSP). The Nurse should make a referral to or recommend the patient to contact COSP or Private Provider Psychologist to facilitate a new card if required.

Clinical Streams

15. 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, HIV, advanced liver disease and/or hepato cellular carcinoma. 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.

Drug and Alcohol Services

16. The Connections Program aims to improve the integration of care for recidivist patients in correctional centres who have current D&A health concerns and are being released to the community. It is a linkage model program that aims to assertively engage patients with relevant health and welfare service providers post release. Patients can be referred up to four weeks prior to their confirmed release date – these requests are prioritised according to clinical risk factors. All Network staff can refer patients to the program via PAS. Any patient accepted onto this program has an individual clinical assessment completed and a post release support plan is developed in conjunction with the patient to address their individual needs. Generally, these patients are on this support program for a period of 4 weeks post release.
17. For all patients on OAT and in particular, pregnant women on OAT, the Nurse in the absence of the D&A Nurse must complete and email/fax the (Post Release/Approved Leave Care Planning Request form JUS200.202) to the D&A Release Planning Services office. All patients on an OAT program whilst in custody have their post release dosing arrangements organised by this service in consultation with the community health providers. The details of this confirmed arrangement are available in JHeHS in the Release Summary of Care form.
18. The Substance Use in Pregnancy Service (SUPPS) supports pregnant women who are in custody with substance use issues. SUPPS is a proactive approach to in - custody care, release planning and community engagement. SUPPS works in conjunction with the Connections Program to ensure a smooth transition to community.

Custodial Mental Health

19. Patients who are mentally unstable and/or are under the care of the Risk Intervention Team (RIT) and scheduled by a Psychiatrist, or a Nurse who has been accredited to schedule patients or Medical Officer under the *Mental Health Act 2007* must be escorted via NSW Ambulance to nearest declared psychiatric inpatient facility for

assessment. The NUM or delegate must ensure arrangements are in place to transport with NSW Ambulance to ensure that the patient to ensure that the transfer to the nearest declared mental health facility occurs upon release from custody. The NUM or delegate must relay this information to CSNSW, organise transfer by NSW Ambulance Service, and if the receiving facility is known, provide a clinical handover.

20. Sentenced patients admitted to LBH Mental Health Unit (MHU) under the *Mental Health Cognitive Impairment and Forensic Provisions Act 2020*, released to the community and scheduled under the Mental Health Act (Civil) may require transfer to a local mental health facility via Ambulance NSW and NSW Police Force or in some cases may directly be released from Long Bay Hospital MHU to the community with a referral to the local Community Mental Health Team for follow-up.

3.1.2 Day of Release

1. When the patient has been released, Health Centre administration staff (under the direction of the Nurse must end PAS alerts, cancel waiting list entries, referrals and any future dated Health Centre appointments. ICS alerts and Medical Appointments Unit (MAU) external appointments must not be removed on PAS. 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 Nurse must ensure the patient is provided with the Medilist and release medications. The Nurse should ensure the patient is administered any prescribed OAT prior to release (the ability to do so will also depend on the time of the release). The last dosing details are to be sent via fax/ email to the patients community dosing point on the day of release even if the patient was not dosed it is to be made clear in the correspondence to the community dosing point.
3. The Nurse must record an entry regarding patient's release date and related transfer of care arrangements in the Health Record.
4. A copy of the Release Summary of Care form should be printed off and provided to the patient as it contains written confirmation of the patient's OAT dosing point in the community.
5. The Medication Order and Medication Administration Chart must be stopped by the nurse upon release.

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, please refer to the Late Notice Release/Discharge section in JHNSW's 6.049 *Medication Guidelines* and if after hours contact the AHNM on [redacted] Option 1.
2. If an ICS patient has been unexpectedly released the ICS must be informed as soon as possible via email [redacted] 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 health provider and refer the LHD if appropriate.
3. The Nurse must contact the Public Sexual Health Nurse for patients on treatment for Hepatitis B, C, and HIV and/or the Clinical Nurse Consultant (CNC) Infection Prevention and Communicable Diseases for patients on TB treatment.
4. The NUM must contact the relevant external community health care providers regarding mentally unwell / RIT patients who are scheduled and released without prior warning.

5. The NUM/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 19 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.
6. If a patient who has chronic and/or complex health needs (not previously referred to the ICS) is released unexpectedly, the Nurse should contact the ICS for assistance. If this occurs after hours the AHNM may be contacted on [redacted] Option 1.
7. The Nurse must advise the D&A Release Planning Service office of patients released unexpectedly, who are on OAT. This office will arrange a dosing point at short notice for these patients in a geographic location close to where they are residing to ensure a smooth transition of care.
8. The Nurse must advise JHNSW Midwife of any unexpected release of a pregnant woman.

3.3 Declined Release Planning

If a patient declines release planning services the Nurse 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, the relevant Mental Health Nurse, D&A Release Planning Service office and/or JHNSW Midwife.

3.4 Transfer of Care from Long Bay Hospital to Correctional Centres

1. Prior to a patient being discharged to a correctional centre with possible discharge risks, a multidisciplinary case management meeting including a member of Integrated Care Service (ICS), CSNSW Classification Officer and the Nursing Unit Manager (NUM) or delegate from the receiving Health Centre must be convened. This meeting will include the possibility of reclassification of the patient to an alternative correctional centre and/or a decision by the treating Medical Officer (MO) to place the patient on a medical hold to attend future appointments and treatment in accordance with JH&FMHN policy 1.263 *Medical Holds*.
2. *A Health Problem Notification Form (HPNF) – Adult* must be completed on Patient Administration System (PAS) for all patients indicating cell placement recommendations based on clinical needs. See JH&FMHN policy 1.231 *Health Problem Notification Form (Adults)*.
3. If a patient requires special transport considerations upon discharge, a *Medical Certificate Consideration for Special Transport Form* (JUS200.035) must be completed and sent for authorisation in accordance with JHNSW policy 1.395 *Transfer and Transport of Patients* (this form must be given to CSNSW with the original copy filed in the patient's Health Record) or 6.142 *Transfer of Forensitc Patients from Correctional Centres*.
4. Staff must notify the receiving centre when medically discharged if equipment and/or specific supplies are required and should be available prior to patient transfer.
5. Nursing staff should inform the Pharmacy Department at least 48 hours, where possible, prior to the patient's discharge to ensure medications that are not stocked at the receiving centre can be sent with the patient to the designated correctional centre. Patients prescribed more than five medications should be referred to the Pharmacy Department at least five working days beforehand (or as soon as discharge date becomes known) to facilitate clinical medication review by the Pharmacist where possible. Refer to JHNSW's 6.049 *Medication Guidelines*.

6. On the day of discharge, nursing staff must contact the receiving Centre's NUM or delegate by phone to give a clinical handover. The Medical Officer (MO) may also contact the receiving Centre's MO or Nurse Practitioner (NP) by phone or e mail to give a handover. The MO must review and transfer or reconcile all ongoing medication orders from the National Inpatient Medication Chart (or JHeHS eMeds) onto the in-use Medication Chart (either Long Stay Medication Chart or JHeHS eMeds) and update the medication management plan.
7. A Medical Discharge Summary must be completed on Patient Administration System (PAS) within 24 hours of a documented decision to discharge a patient. The Nursing Discharge Summary and referrals must be completed on the LBH Nursing Discharge Summary Form (JUS010.004) and filed in the patient's health record.
8. Nursing staff must complete LBH Inpatient Discharge Checklist (JUS010.815) (Return to Correctional Centre) and place in patient's health record.

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

Upon release from custody the patient's and after all the actions outlines above have been undertaken – all volumes of the patients Health Record must be returned to HIRS.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

Nurse

The Nurse responsible for the patient from any speciality

Care Coordinator

The primary health care worker responsible for patient.

Medication Chart

Refers to a paper-based (Long Stay Medication Chart, National Inpatient Medication Chart) or electronic medication order.

Patient Health Record

A hybrid record of paper-based and electronic information pertaining to the health of the patient

5. Related Documents

Legislations	*Mental Health Act 2007* (NSW) Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW)

Justice Health NSW Policies, Guidelines and Procedures	1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* 1.231 *Health Problem Notification Form (Adults)* 1.263 *Medical Hold* 1.395 *Transfer and Transport of Patients* 6.049 *Medication Guidelines* 6.127 *Management of Patients with a Chronic Condition* 6.142 *Transfer of Forensitc Patients from Correctional Centres* 9.048 *Health Records*
Justice Health NSW Forms	JUS020.035 *Consent to Liaise* JUS020.083 *Consent to Obtain Health Information for Continuation of Care* JUS200.202 *Opioid Substitution Treatment (OST) Post Release/Approved Leave Request* JUS200.035 *Medical Certificate Consideration for Special Transport* *Health Problem Notification Form (HPNF) - Adult*
NSW Health Policy Directives and Guidelines	PD2022_012 *Admission to Discharge Care Coordination* PD2014_050 *Principles for the Management of Tuberculosis in New South Wales* PD2025_042 *Forensic Mental Health Services* *Tuberculosis in NSW*
Other documents and resources	*Standards for health services in Australian prisons*