Birmingham and Solihull Mental Health NHS Foundation Trust

PSYCHIATRIC DECISION UNIT (PDU)
Standard Operational Procedure

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SOP LEAD	Urgent Care Clinical Service Manager	
SOP AUTHOR	Operational Manager – A&UC	
APPROVED VIA:	Urgent Care Clinical Governance Committee	
ANTICIPATED REVIEW DATE:	March 2025	

SOP STATEMENT

This Standard Operating Procedure (SOP) details the processes and procedures of the Psychiatric Decision Unit (PDU). The PDU will provide a 24/7 facility to enable clinical decisions to be agreed and outcome plans delivered following initial assessment from Liaison Psychiatry and Street Triage teams. PDU will also provide an enhanced assessment and support for service users initially assessed at the Place of Safety and by the Liaison and Diversion team.

Contents

1. Introduction

1.1 Rationale

The purpose of this Standard Operating Procedure (SOP) is to ensure that the purpose of the Psychiatric Decision Unit (PDU) is clearly understood and that it operates with clarity and consistency. Delivery of this service to service users will be reviewed against aims and outcomes.

1.2 Scope

This SOP is applicable to the delivery of the service within the PDU and directly outlines the requirements for staff delivering a service within the PDU and guides those referring to it. The framework will also apply to (but not exclusively) the Urgent Care Pathway, and Home Treatment.

2. Service Overview

The PDU resource is not a psychiatric acute ward, it intends to offer a safe and comfortable place for service users to receive an extended assessment and decision-making service for up to 24hours as an alternative to remaining in an A&E department. This assumes no concomitant physical health treatment or criminal justice requirement, and no detention under section 135 or 136 MHA. Onward referral may include (not exhaustively) going home (with or without home treatment) or admission to a respite facility or mental health inpatient unit. An overview of this pathway is shown in Appendix 2.

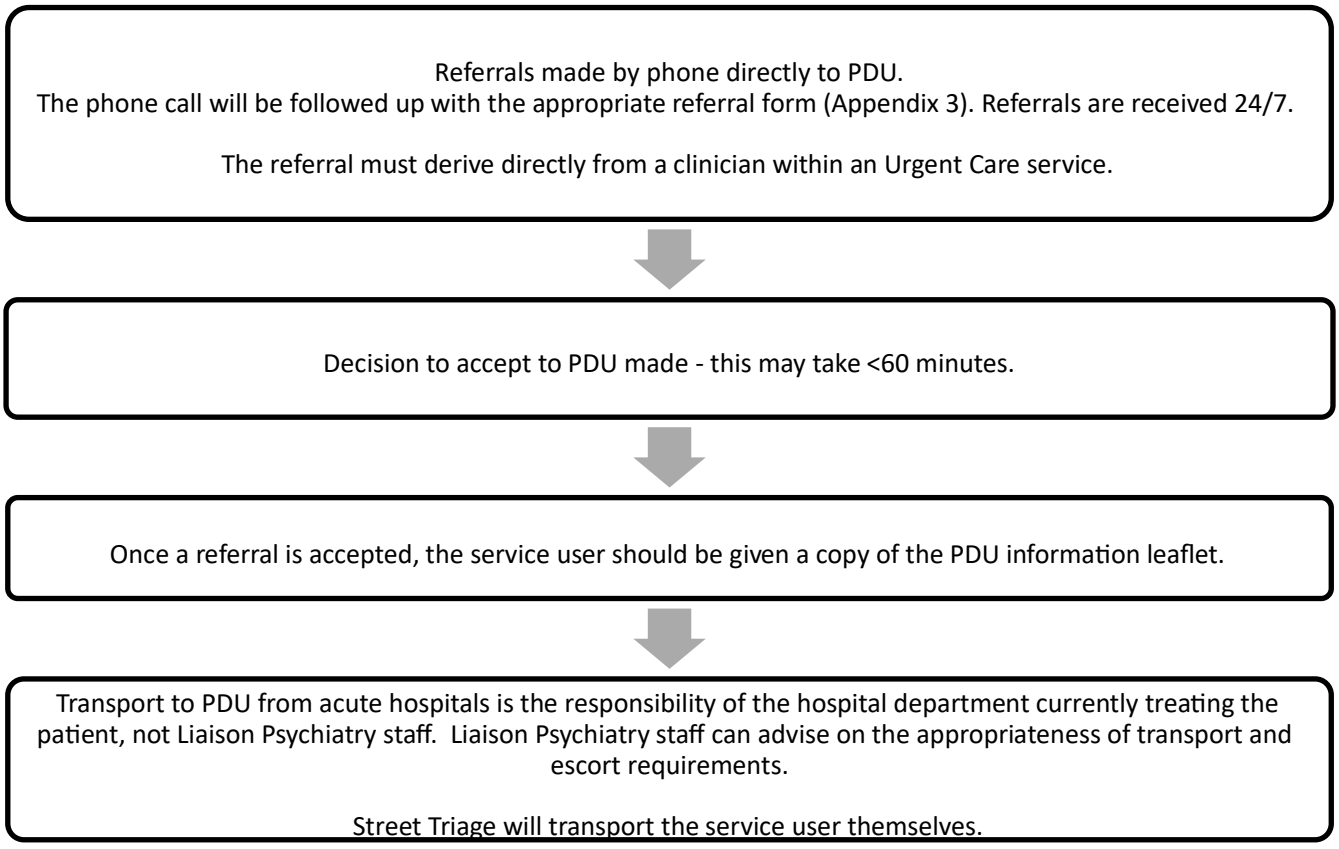
2.1 Access Criteria

- The service user must be aged 18 or over.
- Service users identified as having a primary mental health problem who are complex and may require further assessment to decide a plan of care.
- Referrals from Liaison Psychiatry are for service users attending the A&E department or the Clinical Decisions Unit (CDU) or Medical Assessment Unit (MAU/AMU) as well as the medical wards.
- Where referred from Liaison Psychiatry, the service user must have been seen by an acute hospital medic and recorded as fit for discharge. The interpretation of fit for discharge is medically well enough to go home i.e., no expectation of the PDU providing any medical monitoring, treatment, or intervention over and above what the service user or relative would expect to undertake. Service users must not be receiving active treatment for alcohol or drug withdrawal or intoxication. The service user must not be receiving intravenous treatment.
- For Street Triage referrals, the paramedic must be satisfied that immediate medical assessment/treatment is not required.
- Where Street Triage is unable to attend to a referral, and where the outcome is waiting for protracted lengths of time for mental health services to respond, they can refer remotely for service users that are deemed appropriate. They will need to have satisfied themselves regarding the exclusion criteria and need to call the PDU, speak to the nurse in charge and gain their agreement for the remote referral.
- The service user must have capacity and agree to be transferred over to the PDU.

2.2 Exclusion Criteria

- Service users who pose an immediate risk of violence towards others or whose risk profile is such that attendance at the unit would not be risk appropriate.
- Service users who are under custody of the police.
- Sentenced or remand prisoners who attend A&E.
- People who are heavily intoxicated with alcohol or drugs, whereby it is impossible to assess their mental state.
- People who are withdrawing from drugs or alcohol where this is likely to impact on physical health.
- People who require urgent medical attention, or if based on referral information, the team do not deem medically fit.
- Service users who deemed to lack capacity.
- Service user who poses an immediate risk of suicide.

2.3 The Referral Process



2.4 Enhanced PDU Referrals

The process for an enhanced PDU referral from different referring locations is detailed below.

Home Treatment Team

- All referrals must be specific and the purpose of PDU must be clear.
- The Home Treatment team must agree and document a plan of care for service users whilst in PDU. This care plan must detail specific timeframes for agreed interventions and detail contingency plans, as the service user has the right to leave PDU at any time.

- Referrals and care plans from Home Treatment Teams must be screened by the Nurse in Charge on PDU and they will determine if a service user is suitable to attend PDU.
- Referrals from Liaison Psychiatry and Street Triage will remain a priority for PDU.
- When a service user attends PDU following a Home Treatment team referral, the service user will remain open to the referring Home Treatment Team.
- If medical review is requiring, it will the responsibility for the Host HTT to facilitate the medical review.
- HTT will be responsible for providing transport if required.

Senior Urgent Care Nurse

- Referrals from the Senior Urgent Care Nurse must be screened by the Nurse in Charge on PDU.
- The Senior Urgent Care Nurse is responsible for providing feedback on any complex referrals.
- The Senior Urgent Care Nurse is responsible for completing the Decline Referral Log when required (Appendix 5).

Place of Safety (POS)

- PDU can support service users in Place of Safety, who have undergone a Mental Health Act assessment.
- Referrals from Place of Safety must be screened by the Nurse in Charge of PDU.
- Place of Safety must have a clear plan from the assessing team, which they are able to handover to PDU.

Call before you Convey

- West Midlands Ambulance Service and West Midlands Police can contact Call before you Convey to support access to relevant information to inform clinical decision making and provide advice or support to identify and access the most appropriate pathway for a patient.
- Call before you Convey may advise that the most appropriate pathway for a patient is for them to be brought to PDU.
- Call before you Convey must advise the Nurse in Charge of PDU that a patient is due to be handed over.
- This process should be considered in line with the *SOP for Direct Access to PDU by WMAS.*

Forward Thinking Birmingham (FTB)

- All referrals must be specific and the purpose of PDU must be clear.
- FTB must agree and document a plan of care for service users whilst in PDU. This care plan must detail specific timeframes for agreed interventions and detail contingency plans, as the service user has the right to leave PDU at any time.
- Referrals and care plans from FTB must be screened by the Nurse in Charge on PDU and they will determine if a service user is suitable to attend PDU.
- Referrals from Liaison Psychiatry and Street Triage will remain a priority for PDU.
- When a service user attends PDU following a FTB referral, the service user will remain open to FTB.
- If medical review is required, it will the responsibility for FTB to facilitate the medical review.
- FTB will be responsible for providing transport if required.

Day Support

- Referrals for day support must be screened by the Nurse in Charge of PDU and, if appropriate, the Senior Urgent Care Nurse.
- Day support may be required in the following instances:
    - Physical health observations during/following Clozapine titration
    - Post-ECT observations (where the service user has no available alternative care)
- The referring team will be responsible for providing transport if required.

There are other occasions where a PDU or Enhanced PDU referral may be appropriate, and these should be discussed with the Urgent Care Clinical Services Manager.

2.5 During the Stay

- All service users should come to the PDU of their own free will. It is the responsibility of the referrer to determine that the service user has capacity to make this decision before they arrive at the PDU. The service user's safety, privacy and dignity will be paramount throughout their stay, in the least restrictive environment. If the person is known to services, staff will advise these teams and arrangements will be made for them to be involved in the service user's care.
- Service users will be clearly informed about the PDU facilities on arrival, including their rights.
- If a service user is wanting to leave, their capacity will be assessed under the Mental Capacity Act (MCA). If a service user has capacity, they are able to make the decision to leave the PDU (Appendix 6).
  In these instances, if the service user was referred by Home Treatment, the relevant Home Treatment Team should be notified. If the staff in PDU have concerns about the service user's safety, they should escalate this to the police via 999 for a safe and well check to be carried out.
- If the service user is prevented from leaving the PDU because they do not have the capacity to leave, the means used to keep them must be proportionate to the risk of the service user.
- Common Law powers can be used in the PDU area which is not covered by MHA or MCA or when there is no opportunity to form a judgement about the service user's mental capacity or mental state in situation where urgent intervention is needed to avert serious consequences. This power is short and lasts only crisis subsides or appropriate support implemented.
- Police should be contacted (on 999), the circumstances and risks explained to them, and they should be asked for immediate assistance or to do a safe and well check. If necessary, they can detain the service user using their powers under s136.
- Request should be made to the Local Authorities for the service user to be assessed under the MHA.
- All capacity assessments and associated actions should be recorded in the service user's notes on Rio.

2.6 Assessment

A physical and mental health assessment should take place with a nurse. This assessment should be fully documented on RiO in line with Record Keeping Policy. If it is felt necessary, the service user will be reviewed by a doctor.

2.7 Crisis Care Plan

If a service user is not known to BSMHFT services, PDU will generate and agree an urgent care crisis plan with the service user and carers (if applicable). If the service user is known to BSMHFT services, PDU will review and liaise with the Care Coordinator.

2.8 Medical Support

The unit has the following medical support system in place:

Monday-Friday, 9am-5pm	***Weekends (Saturday & Sunday)***	***Out of hours (weekday & weekend evenings)***
1 x Consultant Psychiatrist providing cover when required. 1x Senior Medic providing cover when required. 1x Junior Doctor on shift.	1x Consultant Psychiatrist providing cover for 3 hours in the morning and 3 hours in the afternoon (as per PDU Medics rota).	1x Senior Medic cover between 5:30pm-9:30pm The on-call medical duty system is the default service where out of hours medical input is required.

2.9 Discharge

- All discharge and aftercare arrangements must be made in a manner which ensures a safe and smooth transition from the PDU hospital to returning home or to a communitybased treatment/care. PDU will liaise with CMHT, GP and other appropriate clinical stakeholders regarding follow up care.
- Where relevant, planning for discharge should commence as soon as possible following admission. This should be done with the full involvement of the service user and/or their family/carer(s) where appropriate, and in collaboration with all professionals and other agencies involved in their care.
- The procedure for discharge will be facilitated by the named nurse/practitioner, in collaboration with the community Care Coordinator and the MDT.
- The Crisis Care Plan must be completed, dated, and signed off by PDU and the service user if not known to services.
- Transport arrangements should be considered during the discharge planning process and any onward transport requirements should have a risk formulation. The Trust will only provide transport if there is a clinical need to do so.
- The service user should be asked to make their own arrangements wherever possible. This should be determined when discharge plans are first discussed with the service user.
- The PDU manager on duty will oversee any delays in service users remaining on the unit as the 24-hours approach. Where a service user remains on the unit for close to, and over 24 hours, the escalation process in Appendix 4 should be followed.

  24-hours is not a fixed reportable target however clinicians and managers should understand that this is not an inpatient unit but a decisions unit. Therefore, a person should only remain for the minimum period required to complete a clinical management plan that can move the person out of the department in a timely and effective way.

- Medication management will be conducted in accordance with Trust protocol.

3. Reference Documents

- BSMHFT Care Records Management Policy

4. Appendices

4.1 Appendix 1 - Equality Impact Screening Form

Equality Analysis Screening Form

Title of Proposal	Psychiatric Decisions Unit (PDU) SOP		
Person Completing this proposal	XXXX XXXX	**Role or title**	Operational Manager, Acute & Urgent Care
Division	Acute & Urgent Care	**Service Area**	Urgent Care
Date Started	11/11/21	**Date completed**	11/11/21

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

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Who will benefit from the proposal?

All staff and service users.

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**

Age	**X**			

Page

Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	**X**			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**X**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**X**			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	**X**			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	**X**			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				

Religion or Belief	**X**			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**X**			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	**X**			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	**X**			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

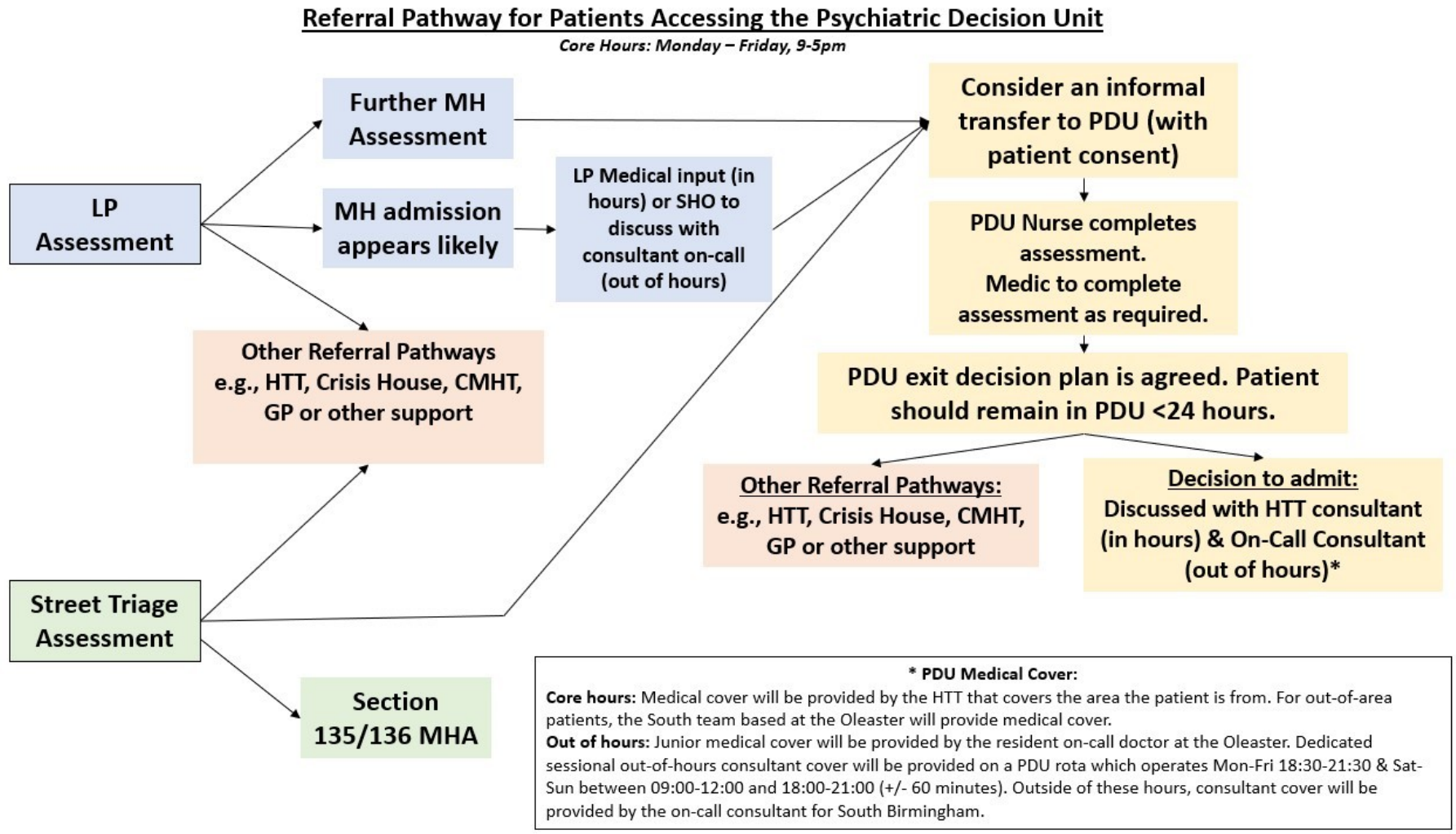
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?

N/A
How will any impact or planned actions be monitored and reviewed?
N/A
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Equality and Diversity Lead Bina Saini The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

4.2 Appendix 2 – Referral Pathway



4.3 Appendix 3 – Referral Form

PDU Referral & Data Collection Form

Date of referral: ……
Time of referral: ……
Name of clinician making referral: ……
Name of PDU clinician taking this referral: ……

Patient Surname		Patient Forename		RIO Number	
Gender		Age		Ethnicity	

Referral Source: (please tick)	
Liaison Psychiatry: UHB ☐ City ☐ Heartlands ☐ Good Hope ☐ Solihull ☐	Other HTT ☐ *Erdington* ☐ *Sutton* ☐ *Central* ☐ *Sparkhill* ☐ *Handsworth* ☐ *Ladywood* ☐ *South West* ☐ *South East* ☐ *Solihull* ☐ Street Triage ☐ Place of Safety ☐ Bed Management Team ☐
If the referral was via Liaison Psychiatry (A&E), did they breach?	

☐ No

☐ Yes - 4 hour

☐ Yes – 8 hour

☐ Yes – 12 hour

☐ 12 hour DTA

Reason for admission to acute hospital/street triage attendance:	Reason for referral to Treatment Suite
Risks identified (including risks of infection control):	

PLEASE COMPLETE THE DATA COLLECTION SECTION ON THE REVERSE OF THIS FORM

Date of arrival at PDU:……..

Time of arrival at PDU…….
Date of discharge from PDU : …… Time of discharge from PDU:…….
Total time at Unit (HH:MM) ……
Name of PDU Clinician completing this form: ……

Assessed in hours (8am - 5pm): ☐ **Assessed out of hours (5pm - 8am):** ☐

Known/open to BSMHFT services? Yes ☐ No ☐

If open to BSMHFT, does the patient have a crisis plan? Yes ☐ No ☐ **Please**

complete if admitted to a bed:

Status: In patient – detained ☐ In -patient informal ☐

MHA Section: Sec 2 ☐ Sec 3 ☐ Other ☐

Bed Type: Acute Bed ☐ PICU Bed ☐ Private Bed ☐

PLEASE COMPLETE THE FOLLOWING INFORMATION ONLY IF MHA ASSESSMENT HAS BEEN COMPLETED AT THE UNIT:

Time MHAA initiated (HH:MM)	Time MHAA completed (HH:MM)	Time of arrival of AMHP (HH:MM)

If not admitted, BSMHFT/other services referred onto

CMHT ☐ HTT ☐ EIS ☐ AOT ☐ BHM ☐ Homeless Team ☐

Drug/Alcohol services ☐

GP ☐ Out of area mental health service ☐ Other ☐

Diagnosis ICD10 (Please tick)

- □ F00-F03 Dementia
- □ F04-F09 Other organic including symptomatic mental disorders
- □ F10-F19 Mental and behavioural disorders due to psychoactive subst.
- □ F20-F29 Schizophrenia, schizotypal and delusional disorders
- □ F30-F39 Mood (affective) disorders
- □ F40-F69 Neurotic, behavioural and personality disorders

- □ F70-F79 Mental retardation
- □ F80-F99 Other mental and behavioural disorders
- □ X60-X79 Intention self-harm
- □ n/a

Any gaps identified in exit point/onward referral? (Please give any relevant details)
Additional Outcomes/Comments

4.4 Appendix 4 –

Escalation Process

- Clear plan in place
- Review patient, other pathways explored i.e., HTT review completed

12 hours

- 12 hour wait reported to Urgent Care Manager
- Bed Management informed of delay
- Notify receiving organisation or team of timeframe remaining out of breach time
- Notify receiving organisation or team of escalation intention

24 hours

- Inform Bed Management of breach
- Ensure Eclipse is completed
- Update risk assessment
- Inform Clincal Lead & Head of Service of breach

Out of hours the daily update should be shared with the on-call manager

- Notify receiving organisation or team of breach and that it has now been escalated
- Manager to inform FTB on-call/service manager of escalation
- **Escalation to include the following information:**
- Intended plan
- Confirmation of Eclipse submission
- Timeline of wait
- Assurance that an updated risk assessment has been completed

Immediate PDU (Lead Nurse) Actions:

- Ensure senior clinical review of PDU each morning by 10am and produce update report.
- Ensure all 24-hour delays are escalated to Urgent Care Manager.
- Report all delays over 24 hours on Eclipse, with accompanying timeline.
- Prioritise medical reviews to ensure that those waiting the longest are seen and reviewed as soon as possible.
- Ensure that the plan for each patient is clear.
- Update risk assessments as and when required to reflect length of stay.
- In hours, where there is no medical cover or ward review, the Clinical Director should be informed immediately.
- Out of hours, where there are difficulties with accessing medical cover, the on-call manager should be notified.

Other Actions:

- Head of Service/Clinical Lead to notify Associate Director of breach.
- Bed Management to request consideration for out of area bed from relevant Director.
- Associate Director to inform Executive Team, where a delay over 28 hours may arise.

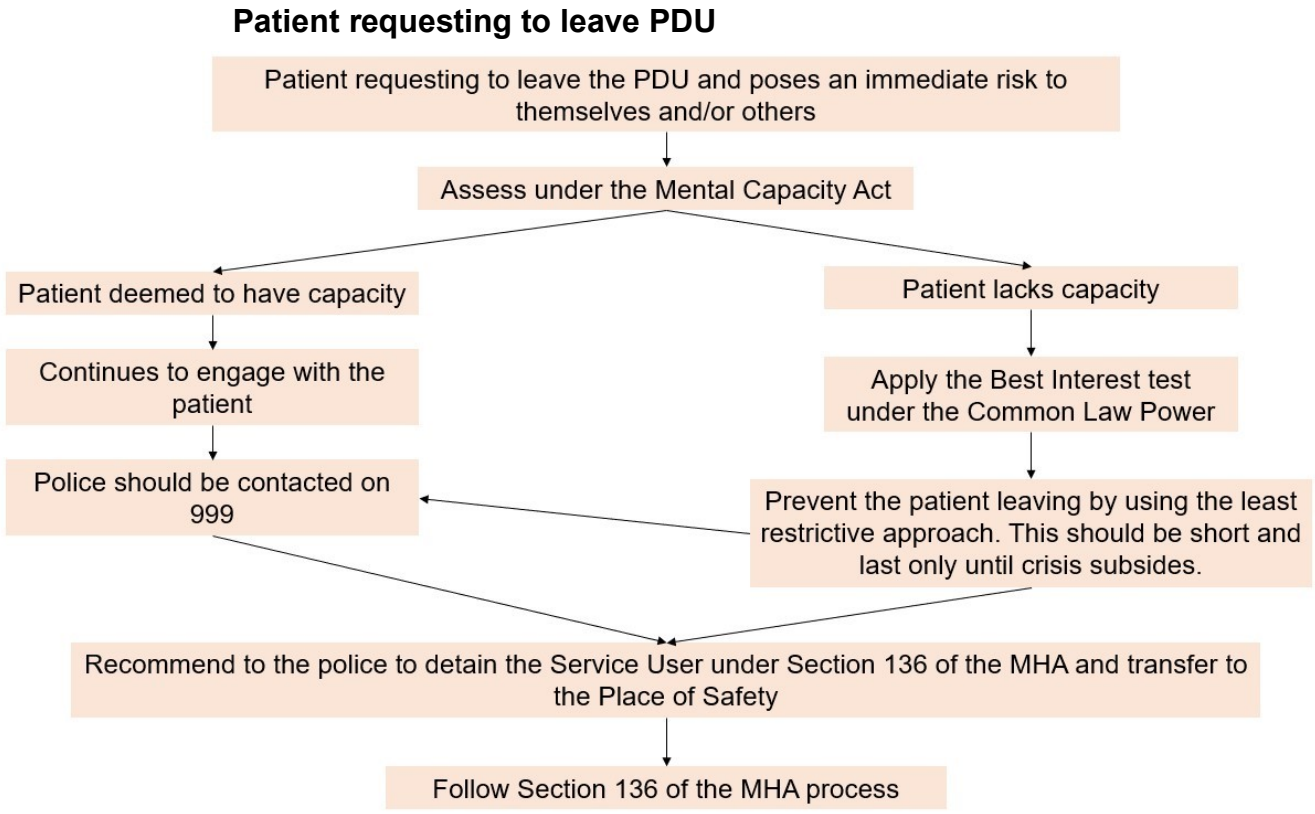
4.5 Appendix 5 –

PDU Decline Referral Logs

Psychiatric Decision Unit Decline Referral logs

Date	Rio Number	Referral team	Senior Urgent Care Nurse	Reasons for decline

4.6 Appendix 6 –



What are the key principles of the MCA?

1. **A presumption of capacity** - Every adult (aged 16 or over) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

2. **The right for individuals to be supported to make their own decisions** - A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

3. **The right to make what might be seen as eccentric or unwise decisions-** A person is not to be treated as unable to make a decision merely because he makes an unwise decision. It is important to acknowledge the difference between unwise decisions, which a person has the right to make and decisions based on a lack of understanding of risks or inability to weigh up the information about a decision.

4. **Best interests** – A decision made, under this Act on behalf of a person who lacks capacity must be made, in their best interests.

5. **Less restrictive intervention** -Before the act is done, or the decision is made, it should be considered if the outcome is less restrictive of the person's rights and future freedom of action.

4.7 Appendix 7 –

When we assess a patient's capacity, we make an assessment based on the patient's ability to make a specific decision at a specific time. Capacity to make this decision may fluctuate, and a patient may be able to make that decision e.g. to consent to examination, but not to be able to make other decisions e.g. to decide to leave the ED.