Appendix 1

PSYCHIATRIC DECISION UNIT (PDU) OPERATIONAL FRAMEWORK

VERSION NO & DATE	**2**	**7/1/16**
RATIFYING COMMITTEE	**Urgent Care Clinical Governance Committee**	
DATE RATIFIED		
NEXT ANTICIPATED REVIEW DATE:		
PROTOCOL LEAD	**Head of Service – Urgent Care**	
ASSOCIATE DIRECTOR	**Associate Director Acute and Urgent Care**	

** delete as appropriate*

PROTOCOL CONTEXT:

The psychiatric decision unit (PDU) will provide a 24/7 facility to enable clinical decisions to be agreed and outcome plans delivered as a result of initial assessment from RAID, Street triage teams.

PROTOCOL REQUIREMENT (see Section 2)

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- Patients will be received from A&E, CDU or MAU areas within acute hospitals across Birmingham and Solihull where referred by RAID
- Street Triage will have direct access for appropriate referrals
- Street Triage will be able to remotely screen referrals made by Emergency Services and refer if appropriate
- It is expected that Service Users remain within PDU for less than 12-hours

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1: Introduction

1.1 Rationale The purpose of this framework is to ensure that the purpose of the Psychiatric Decision Suite (PDU) is clearly understood and that it operates with clarity and consistency. The delivery of this service will enable the service to be provided to service users which can then be reviewed against aims and outcomes.

1.2 Scope This framework 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 be (but not exclusively) RAID, Bed Management and Street Triage

1.3 Principles The Trust is committed to ensuring a high quality patient experience combined with effective and efficient use of NHS resources.

1.4 Service Description The PDU resource intends to offer a safe and comfortable place for patients to receive an extended assessment and decision making service for up to 12-hours as an alternative to remaining in an A&E department or being taken into custody. 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.

2: The Protocol Procedures

2.1 Access criteria

2.1.1 The service user must be aged 18 or over

2.1.2 Patients identified as having a primary mental health problem who are complex and may require further assessment in order to make a decision as to a plan of care

2.1.3 RAID referrals are for patients attending the A&E department or the clinical decisions unit (CDU) or medical assessment unit (MAU/AMU) as well as the medical wards.

2.1.4 Where referred from RAID the service user must have been seen by the 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 patient or relative would expect to undertake). Patients must not be receiving active treatment for alcohol or drug withdrawal or intoxication (cross reference with pending substance misuse clinical guidelines The patient must not be receiving intravenous treatment

2.1.5 Street Triage referrals; paramedic must be satisfied that immediate medical assessment/treatment is not required. In the absence of the paramedic, the wider street triage team must make an informed judgement as to whether any medical assessment/treatment appears to over-ride the need to attend the PDU

2.1.6 Where Street Triage is unable to attend a referral, and where the outcome is waiting for protracted lengths of time for mental health services to respond, they can refer remotely for patients that are deemed appropriate. They will need to have satisfied themselves re

exclusion
criteria and need to call the PDU and speak to the nurse in charge and gain their agreement for the remote referral.

2.1.7 The patient must have capacity and agree be transferred over to the PDU.

2.2 Exclusion criteria

2.2.1 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
2.2.2 Service users who are under custody of the police
2.2.3 Sentenced or remand prisoners who attend A&E
2.2.4 People who are heavily intoxicated with alcohol or drugs, whereby it is impossible to assess their mental state.
2.2.5 People who are withdrawing from drugs or alcohol where this is likely to impact on physical health
2.2.6 People who require urgent medical attention, or if based on referral information, the team do not deem medically fit

2.3 The process

2.3.1 Referrals will be made by phone/fax directly to the PDU. The telephone call will be followed up with a referral form. The referral form in appendix A will be used until such time as an electronic referral process is available.
2.3.2 The referral must derive directly from a clinician within an urgent care service.
2.3.3 Referrals will be received 24/7
2.3.4 A decision to accept to PDU may take up to 30 minutes
2.3.5 Once a referral is accepted the patient should be given a copy of the PDU information leaflet
2.3.6 Transport to PDU from acute hospitals is the responsibility of the hospital department currently treating the patient, not RAID staff. However, RAID staff will advise on appropriateness of transport and escort requirements
2.3.7 Street triage will transport patients in themselves

2.4 DURING THE STAY

2.4.1 All patients should come to the PDU of their own free will the patient's safety, privacy and dignity will be paramount throughout their stay in the least restrictive environment. If the patient is known to services, staff will advise these teams and arrangements will be made for them to be involved in the patients care.

If a patient is wanting to leave, we will assess their capacity under the Mental Capacity Act, if it appears that they are lacking capacity, the best interest test will be then be used to consider whether it is necessary and proportionate to restrain them from leaving – the necessary and proportionate test could be met if it is the case that they pose a significant risk of harm to themselves or others.

If the patient has capacity, then as a last resort we may need to look at unlawfully detaining on the basis that our concern for their safety/others outweighs the detriment of the unlawful detention.

If restraint/detention is not possible for whatever reason and the patient does manage to leave then the police ought to be contacted (on 999), the circumstances and risks explained to them and they should be asked to do a safe and well check. If necessary they can detain the patient using their powers under s136.

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, and if it is felt necessary the patient will be reviewed by a Doctor.

Crisis care plan

If a service user is not known to our services PDU will generate and agreement an urgent care crisis plan with the patient and carers if applicable.
If patient known to services then PDU will review and liaise with care coordinator.

Medical Support

The unit has a consultant physiatrist providing cover 7 days a week. The on-call medical duty system is the default service where out-of-hours medical input is required.

Home treatment assessment

If, on assessment, it is thought a patient may be home treatable, a home treatment assessment will be requested. Home treatment need to respond within 4 hours to the request. If the nurse in charge, following their assessment, thinks that it is safe to do so, they can arrange to send the patient by taxi to be seen at a home treatment base, or by home treatment at home if there's prior agreement in place.

Discharges

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 community-based treatment/care.

Where
relevant, planning for discharge should commence as soon as possible following admission. This should be done with the full involvement of the patient 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 patient if not known to services.

Transport arrangements should be considered during the discharge planning process, 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 patient should be asked to make their own arrangements wherever possible. This should be determined when discharge plans are first discussed with the patient.

2.3.8 The PDU manager on duty will oversee any delays in service users remaining in the unit as the 12-hours approach. 12-hours is not a fixed reportable target, however clinicians and managers should understand that this is not an inpatient unit but a decisions unit, and as such a person should only remain there for the minimum period required to effect a clinical management plan that can move the person out of the department in a timely and effective way

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

4: Responsibilities

Post(s)	Responsibilities	Ref
All Staff	To comply with the contents of this framework	
Service, Clinical and Corporate Directors	To ensure the framework is complied with	
Protocol Lead	To ensure the framework is reviewed, at least every three years.	
Others…..	For colleagues in acute Trusts to be aware of the protocol	

5: Development and Consultation process

The PDU project group, chaired by the associate director has overseen the development of this document. Consultation regarding the development of the criteria for service and protocol guidance has included:

- acute hospital staff
- mental health commissioners
- RAID staff
- Clinical governance committee
- ECT staff
- Bed management staff
- Home treatment staff

Consultation summary		
Date protocol issued for consultation	02.12.2014	
Number of versions produced for consultation	5	
Committees / meetings where protocol formally discussed	**Date(s)**	
PDU Project Group	November 20 & 27; December 01 2014	
Where received	**Summary of feedback**	**Actions / Response**

6: Reference documents

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7: Bibliography:

None

8: Glossary

None

9: Audit and assurance

Element to be monitored	Lead	Reporting Method	Frequency	Reporting Committee
Number of patient stays on the unit in excess of 12 hours	Urgent Care Lead	Local CGC report	Quarterly	Urgent Care Clinical Governance Committee
Number of patients arriving at PDU without an up to date risk assessment	Urgent Care Lead	Local CGC report	Quarterly	Urgent Care Clinical Governance Committee
Number of patients arriving at the PDU who meet one or more of the exclusion criteria	Urgent Care Lead	Local CGC report	Quarterly	Urgent Care Clinical Governance Committee

10. Appendices

Appendix A Referral Form

Appendix B Referral pathway – core hours

Appendix C Referral pathway – out of hours

Appendix D Admissions Flow Chart

Appendix E PDU Escalation

Appendix A

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)	
RAID: UHB ☐ City ☐ Heartlands ☐ Good Hope ☐ Solihull ☐	Other Solihull HTT (out of hours) ☐ Street Triage ☐ HTT ☐
If the referral was via RAID (A &E) - Did they breach? Please tick	
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 - 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

Appendix B

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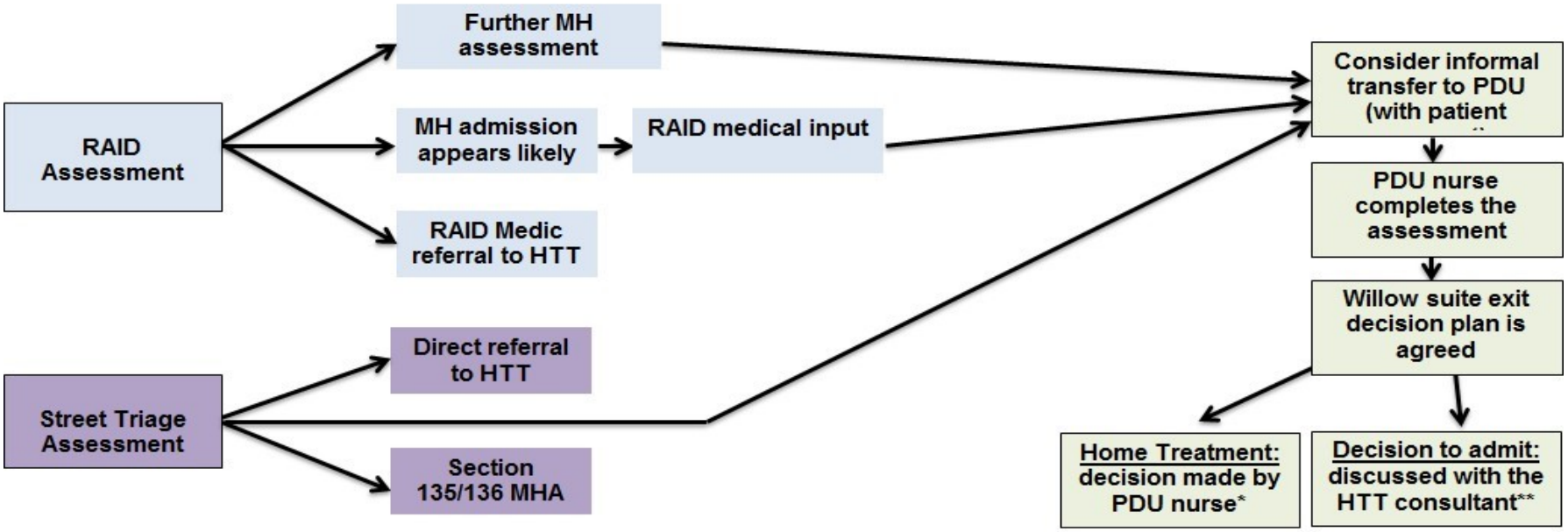
PROCESS PATHWAY FOR PATIENTS ACCESSING THE WILLOW PSYCHIATRIC DECISION SUITE

Core hours (**Monday - Friday 9-5pm)**



CONTACT TELEPHONE NUMBERS:

On – call (via switchboard)	0121 301 2000
RAID QEHB duty mobile	07985 883550
RAID BHH duty mobile	07985 882241
RAID GHH duty mobile	07985 883048
RAID Solihull duty mobile	07985 882035
Willow suite	0121 301 2098 / 07985 883156
Bed management	0121 301 2345
Street triage	07867 166402

*If the treatment plan by the PDU nurse is to send a patient home directly from the PDU, they must consider whether medical input (discussion or assessment) is required before the patient leaves

****Designated Willow Suite PDU medical Cover:**

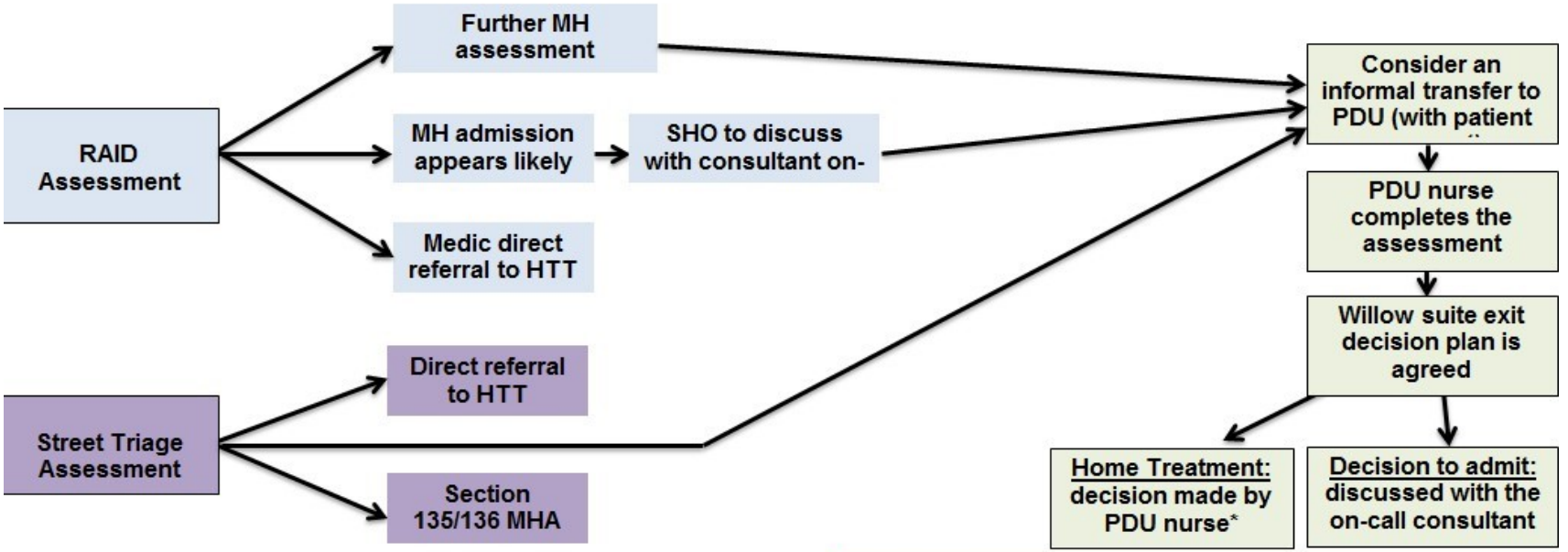
During core hours, medical cover will be provided by the home treatment team that covers the area the patient is from. For out-of-area patients the South team based at the Oleaster will provide medical cover

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Appendix C

PROCESS PATHWAY FOR PATIENTS ACCESSING THE WILLOW PSYCHIATRIC DECISION SUITE

***Out of hours (NOT* Monday - Friday 9-5pm)**



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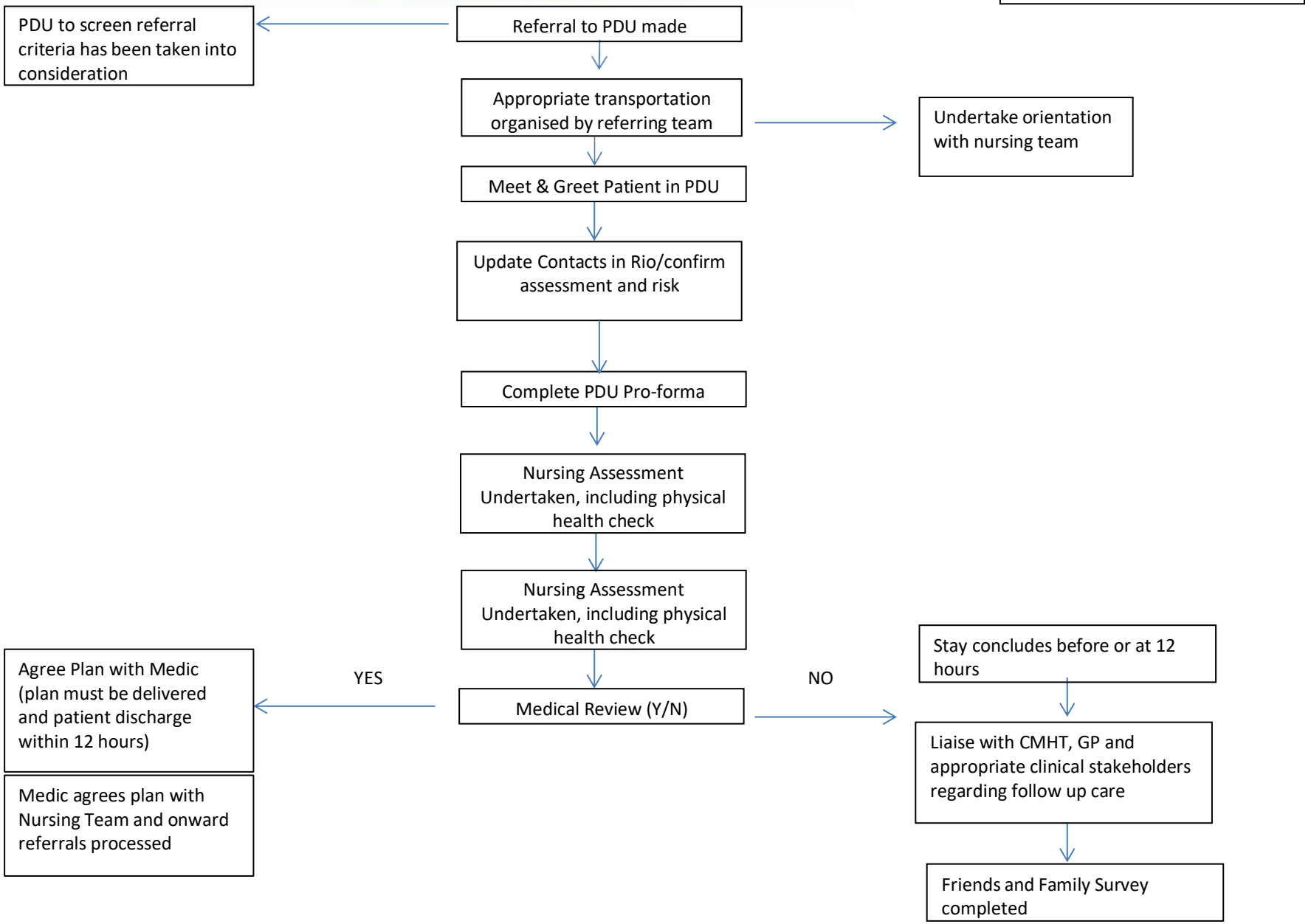
Bed management	0121 301 2345
Street triage	07867 166402

Designated Willow Suite PDU medical Cover:

- Junior medical cover out-of-hours will be provided by the resident on-call doctor to the Oleaster Unit
- Dedicated sessional out-of-hours consultant cover will be provided on a PDU rota. This cover will operate on weekdays between 18:30-21:30 and weekends between 09:00–12:00 and 18:00-21:00 (+/- 60 minutes). Outside of these hours consultant cover will be provided by the on-call consultant for South Birmingham

Appendix D


Referral to PDU made
PDU to screen referral criteria has been taken into consideration
Appropriate transportation organised by referring team
Undertake orientation with nursing team
Meet & Greet Patient in PDU
Update Contacts in Rio/confirm assessment and risk
Complete PDU Pro-forma
Nursing Assessment Undertaken, including physical health check
Nursing Assessment Undertaken, including physical health check
Medical Review (Y/N)
YES
NO
Agree Plan with Medic (plan must be delivered and patient discharge within 12 hours)
Medic agrees plan with Nursing Team and onward referrals processed
Stay concludes before or at 12 hours
Liaise with CMHT, GP and appropriate clinical stakeholders regarding follow up care
Friends and Family Survey completed

PDU Escalation

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Appendix E

8 Hours

- Clear plan in place
- Review patient, other pathways explored – i.e HTT review completed
- 8 Hour wait reported to Urgent Care Manager
- Bed Management informed of delay
- Notify receiving organisation or team of timeframe remaining and of breach time
- Notify receiving organisation or team of escalation intention

Immediate PDU (Lead Nurse)Actions

- Ensure senior clinical review of PDU each morning by 10am and produce update report
- Ensure all 12 hour delays are escalated to Urgent Care Manager
- Report all delays over 12 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
- 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.

12 Hours

- Inform Bed Management of breach
- Ensure Eclipse completed
- Update risk assessment
- Inform Clinical 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
- On escalation provide the following:

- Intended plan
- Confirmation of Eclipse submission
- Timeline of wait
- assurance that an updated risk assessment has been completed

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- 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 14 hours may arise