Health and Social Care in Northern Ireland

REGIONAL BED MANAGEMENT PROTOCOL FOR ACUTE PSYCHIATRIC BEDS

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Review date	This policy will be reviewed every three years or at times considered necessary as a result of operational or legislative changes

1.0 INTRODUCTION

1.1 Following assessment, all patients requiring admission to an acute psychiatric bed must be admitted to an appropriate facility to meet their individual needs in a timely and efficient manner. This requires service providers to have effective bed management arrangements in place, including escalation policies to deal with bed pressures. Communication with the patient, their family and carers is an integral part of the bed management protocol, especially when alternative arrangements need to be put in place.

1.2 This bed management protocol has been reviewed by a Regional Group comprising representatives of clinicians and managers from each of the five Trusts.

1.3 The terms of reference for the working group were to review the existing protocol and bring it up to date.

1.4 The original Bed Management Regional Group (2008) considered best practice within Northern Ireland and elsewhere. It considered lessons to be learnt from effective bed management initiatives in acute medicine and surgery and has made recommendations taking into account:

- the human rights framework;
- the document *"Who's Been Sleeping in My Bed? The incidence and impact of bed over occupancy in the mental health acute sector"* Mental Health Act Commission (England) December 2006 and;
- recommendations made by professional bodies in these matters.

1.5 The current challenge facing mental health providers is to ensure that acute beds are available in a timely, accessible manner to people who require them. The Royal College of Psychiatrists (2011) recommends that acute bed occupancy should average 85%.

1.6 National Confidential Inquiry (2015) reported that "suicides following discharge from a non-local ward have increased". The clinical message is **Acute admissions out of [Trust] areas should end – they are likely to add to suicide risk at the time of discharge**.

1.7 The Bamford Review has given indicative numbers for acute beds. However, it also emphasised the need for a whole-systems approach to the management of mental illness, in which no one part of the service can be considered in isolation. Against this background, and with ongoing investment in community based mental health services, HSC Trusts, in collaboration with commissioners are reviewing their future acute bed capacity requirements.

2.0 MANAGEMENT FRAMEWORK

2.1 It is clear that effective bed management requires managers and clinicians to work together to ensure that the use of inpatient beds is efficient and appropriate.

2.2 A system of bed management is likely to be less efficient where there are many points of access to admission. Evidence from the National Audit of Crisis Response and Home Treatment Teams in England suggests that where there is a single 'gate-keeping' function within Crisis Response and Home Treatment (CRHT), then beds are better managed.

2.3. In each of the Trusts in Northern Ireland the CRHT services undertake this gatekeeping function with the Bed Co-ordinator administering the process.

2.4 There should be a designated manager (or managers), in each Trust, who shall be responsible for co-ordinating all bed management issues. Such a person will have current knowledge of:

- the total number of beds
- the number of patients occupying beds;
- the number of beds allocated to patients on leave;

- the number of patients who have been identified as being clinically fit for imminent discharge;
- the patients inappropriately placed in another ward;
- the number of patients under special observations and associated risks.

2.5 It is noted that this function is in place in each Trust however different terminology is used including: Night Co-ordinator, Bed Manager, Patient Flow Team. It is recognised that such arrangements may differ between the working week and out of hour's periods.

2.6 Each Trust will develop clear and explicit arrangements for pre-admission assessment procedures that recognise specific needs, such as those people for whom an application has been made for detention for assessment under the Mental Health (Northern Ireland) Order 1986.

2.7 It is assumed that most people will be managed in community settings and that admission to a bed will be necessary only where clinical and risk factors indicate that it is necessary to do so. Before admission to an acute inpatient unit, the gate-keeping service should discuss with the referring agent whether admission is necessary or whether community based facilities such as acute day hospital, crisis house or acute home treatment would be more appropriate.

2.8 Where a clinical decision has been made to admit a patient to an inpatient mental health bed, then the admission should take place in a timely, appropriate and sensitive manner - taking into account the needs and wishes of the patient and the needs and wishes of their carers.

2.9 Wherever possible Trusts should arrange admission to the acute mental health unit, within their area, closest to the home address of the patient. Where this is not possible, then it should be recognised that all acute mental health inpatient beds in a Trust area should be equally available to all residents of that Trust area. [It is noted that this requirement will change when there is only one acute inpatient unit per Trust].

2.10 The planning of discharge should commence at the point of admission. Such planning should include consideration of all agencies that might be involved in managing the discharge process and should lead to the estimation of a date of discharge around which appropriate planning can be made. Particular attention should be given to the identification and discharge planning of patients who, on assessment in keeping with the 2010 regional guidance on risk assessment and management in acute adult mental health services, demonstrate a high level of risk.

2.11 Bed utilisation is set out in the diagram at Appendix 1.

3.0 MANAGEMENT OF ACUTE ADMISSION WHERE NO UNOCCUPIED BED IS AVAILABLE

3.1 Each Trust should seek to manage acute patient needs within their Trust boundaries.

3.2 It is recognised that to admit a patient to a bed already allocated to another patient temporarily out on leave, could carry with it a significant clinical risk. It is expected that the responsible Patient Flow Co-ordinator (bed manager) will be aware of the nature and extent of any risk that might be involved should a patient be admitted to a leave bed. In order to achieve this it will be necessary for Trusts to have a policy on leave from inpatient care that is explicit about how such leave is planned and implemented. The leave policy should include the management of patients who are absent without leave and should also include what to do if unexpected readmission occurs of a patient out on leave whose bed has been used.

3.3 Trusts should have escalation policies for bed management. This policy will define levels of bed usage as Level 1, 2, 3 or 4:

- Level 1 - A time when any foreseeable number of psychiatric admissions could be accommodated within bed vacancies in the Trust;

- Level 2 - Where any foreseeable number of psychiatric admissions can be accommodated in the local Trust though some undesirable measures would have to be taken to accommodate these; and
- Level 3 - Where significant clinical risk is so great that it is not possible to accommodate any new acute admissions to beds.
- Level 4 –There are no beds available

3.4 It is the responsibility of Trusts and Commissioners to plan for an appropriate number of psychiatric beds within their Trust area to manage the acute psychiatric needs of inpatients arising from their populations.

3.5 Trusts should ensure that they have in place robust bed management strategies to manage their existing bed complement, which should include;

- Red alert when admission beds are low;
- Home Treatment Teams providing input/visiting wards to assess who might be discharged to home treatment;
- Multi-disciplinary discussion held every day from Monday to Friday to facilitate discharges and free up beds for weekends;
- Patients on weekend leave should, where possible, return on Monday morning (not Sunday evening).
- Contingency plans(see section 4) in place to ensure wards can accommodate admissions (especially at weekends);
- Use of leave beds to accept admissions before an out of area place is required;

3.6 Admissions of patients to other Trust areas should be exceptional. The Protocol for the Transfer of Adult Mental Health Patients Between Trusts (HSCB 2015) provides the requirements for these situations.

3.7 In exceptional circumstances there may be a vacant bed in a particular Trust but the Senior Manager on call (Level 8A or above) may consider that an admission is not possible - if the clinical and nursing demands of the existing inpatient population are adjudged by the Senior Manager on call *with* the Consultant on call, to be such that further admissions to a particular ward would be unsafe.

In such circumstances the ward will be deemed closed to all admissions of this kind, both within and outwith the Trust

3.8 Where Trusts need to close beds, for a period of time,(due for example to a fire in the ward or a decant) then this should be discussed with Commissioners and communicated to other Trusts including Out of Hours services.

In addition the Trust Director on call should be notified and HSCB notified next working day.

4.0 MANAGEMENT OF SITUATION WHERE NO "IMMEDIATELY AVAILABLE" BED IS IDENTIFIED

4.1 The pathway described in Appendix 1 suggests that where no bed can be found in the acute ward, then an available bed should be considered in an alternative ward such as a:

- Psychiatric Intensive Care Unit;
- Older people's Unit (Dementia or Addictions are excluded); or
- An acute bed may be sought in another Trust area, (see Section 5).

4.2 Where senior clinical decision makers (medical/nursing) have decided to transfer a patient to another ward in the hospital (non-acute) senior service managers should be informed. In such cases, managers may, in discussion with the on-call consultant(s), consider that transfer to an acute bed in another Trust would be a safer option. The reasons for such transfers should be documented.

4.3 If such a bed is found, then a patient, for whom it is most clinically appropriate to transfer there, should do so. In addition appropriate supports should be considered for this patient in the alternative ward.

4.4 It should be recognised that such a transfer should be with the patient's consent and that all risk factors to that patient and to others should be taken into account when deciding upon the transfer.

4.5 It is best practice if decisions to transfer are considered in advance as part of the Trust's escalation policy rather than at the time of the decision to admit the acutely ill patient.

4.6 If no such available bed can be found (across the Region), then the Trust should make arrangements for the **creation of an extra place** in the acute admission facility. The creation of such a place should be made in consultation with senior medical, nursing and managerial staff, in order to ensure clinical care of that patient and all other patients is safe. It is noted that additional beds in wards can in itself bring significant pressures to staff and risks to patients.

This does not apply to PICU wards.

4.7 It should be recognised that from time-to-time it would be appropriate to find a place for a patient to remain where there is not a designated acute bed immediately available. Examples of such arrangements would include:

- the patient remaining in a medical assessment unit; or
- remaining in a day room of a mental health facility unit until a bed becomes available;

4.8 Where significant clinical risk arises from such management arrangements, then **a local incident review** should be undertaken to understand why this has occurred and to disseminate learning.

5.0 ADMISSIONS OUTSIDE TRUST AREAS

5.1 It is recognised that from time-to-time the safest management plan will be to admit a patient to another Trust area (this includes patients to PICU). It should be recognised that such admissions carry their own risks in that communication between distant inpatient units and local community mental health teams will be less well developed and the transfer of clinically significant information in such circumstances must be carefully managed. This requires consultant to consultant agreement.

5.2 Where it is thought clinically necessary to admit a patient to another Trust, then there should **be a recorded transfer of responsibility between clinical teams** and managerial contact between Patient Flow Co-Ordinators. The person's own key worker and Consultant (if previously known to Mental Health services) should be informed, on the next working day.

5.3 It is the responsibility of the referring Trust to provide all available information, when a patient is known, and to send this with the patient to the receiving Trust. This should include, as a minimum demographic details, case history, most recent mental state examination and reason for admission, information about current treatment and care and up to date assessment of risks/safety plan.
Such communication of information must be in keeping with the Departmental guidance on Inter-Hospital Transfer of Patients and Patient Records (2009) and the Protocol for the Transfer of Adult Mental Health Patients between Trusts (HSCB 2015)

5.4 Where the patient is not known it will be the responsibility of the referring agent to provide all available information to the receiving hospital.

5.5 In order to ensure the safest clinical practice for the patient consideration should be given to **when** it is appropriate to return the patient to their local unit. This will include consideration of the patient's needs, their clinical condition/relevant risk factors and the bed management situation within the trust.

5.6 When it is clinically appropriate to transfer the patient, the residents own Trust should consider if the home treatment service in the local Trust could be provide an alternative to in-patient care.
If the patient does not require on-going acute care the local trust Head of Home Treatment service should identify the appropriate service to provide the 7 day follow up appointment.

5.7 Trusts will wish to review occurrences of admissions outside their local area to identify reasons for this and to take preventative measures if appropriate. Admissions out of the Trust area are reported to the HSC Board on a quarterly basis. Instances when there have been particular issues/ concerns should be brought to the Regional Bed Management Network for discussion, interpretation of the Protocol and to ensure consistency.

6.0 ADMISSION OF YOUNG PEOPLE UNDER THE AGE OF 18

6.1 It is recognised that it is never desirable to admit a person under the age of 18 to adult mental health services. It is however recognised that from time-to-time Child and Adolescent Mental Health Services (CAMHS) may be unable to accommodate acutely ill young people within age specific facilities.

6.2 If there are no vacancies at Beechcroft it may be necessary to admit a young person to an adult ward. In such cases, a Trust specific protocol should be implemented to allow use of adult beds and ensure maximum safety to the young person.

6.3 The transfer of the young person back to specialist CAMHS should be regarded as an immediate priority.

6.4 There should be no circumstances in which a child is admitted to an adult ward outside of their own Trust area.

7.0 ADMISSION OF PEOPLE OF NON-WORKING AGE (OLDER ADULTS)

7.1 The original regional working group recognised that it is inappropriate to discriminate between adults of working age and those above working age. The group recognised that non-working age adults with a functional psychiatric illness, who have the same needs as people of working age, should be treated in a similar way. This means that this protocol applies equally to them, though an out of Trust placement for an

older person will only be accepted if they can be admitted to an appropriate ward.

7.2 It is recognised that patients with dementia should not be included within this protocol and that units specifically designed for the treatment of people with dementia should not be considered as being available for people with acute functional illness.

8.0 MANAGEMENT OF ADMISSION

8.1 Effective bed management will require frequent review of all inpatient admissions by senior clinical decision-makers who have the power to implement discharge plans (including the power to discharge).

8.2 Throughout the patient's admission a multi-disciplinary care plan should be developed and maintained. The care plan should include identification of risk factors and a discharge plan including barriers to discharge. Where leave is necessary, as part of the care plan, then information given to the patient about that period of leave should be recorded. The estimated date of discharge should be communicated to the patient, their carer and to other agencies involved in their care at the earliest opportunity.

8.3 Where meetings are required to manage the discharge of patients thought to be at substantial risk of harm to themselves or to others, then such meetings should be arranged well in advance with appropriate communication to all stake-holders.

8.4 Before discharge, patients and their carers, if appropriate, should be made aware of review arrangements and of who they should contact after discharge should problems arise.

8.5 Consideration should be given to the involvement of Home Treatment Services for facilitated early discharge, shortly after admission, and at other appropriate points throughout the period of admission.

9.0 PERFORMANCE MANAGEMENT

9.1 Trusts in co-operation with the Health and Social Care Board have developed a performance management framework monitoring bed usage by clinical teams with analysis of diagnostic groupings, length of stay and use of facilitated early discharge procedures.

9.2 Bed management will be improved by sharing of activity data between Trusts. A live, accessible information system is being developed to provide information across the region.

9.3 A regional network will be established for the interaction of the Lead Clinicians and the Bed Managers/Lead Patient Flow Co-ordinators in each Trust. This will ensure that each Trust is aware of the escalation status of each other Trust on a regular basis.

10.0 INTERFACE WITH GENERAL PRACTITIONERS

10.1 It is essential that General Practitioners have a single point of access for arranging psychiatric admission. Where it is agreed between a referring General Practitioner and a local Trust (where the patient presents) that admission is necessary, it is not the responsibility of the General Practitioner to find a bed. The Bed Manager in the local Trust has responsibility to ensure appropriate care for those with acute psychiatric needs, taking into account clinical risk factors arising in the whole of the service.

10.2 Where a patient is acutely ill and requires immediate psychiatric care, then appropriate care must be delivered. There should not be a waiting list of patients in such circumstances.

Addendum May 2019

Bed finding responsibility

When a person presents for assessment 'out of Trust' and an admission is required, they should contact the Trust of origin a) to seek additional information or access a management plan and b) to source a bed. C) The trust of origin may decide that, knowing the patient , they can provide an alternative e.g. home treatment

If a bed is not available in the trust of origin, it is the responsibility of the person(Trust) who has assessed the patient to source a bed.

If a bed is available in the trust of origin arrangements should be made to transfer the patient to the trust of origin.

If the patient is assessed under the Mental Health Order and a bed is required in these circumstances, it is the responsibility of the Trust of origin to assist the referring doctor/ASW to find the bed

Link with Trust of origin

For patients placed out of Trust it is essential that, within 3 working days a video link/ tele link/ face to face contact is made with appropriate clinicians/practitioners, from the Trust of origin, who know the patient and are able to provide background information and inform the management plan. The purpose of this is to support the exchange information and agree transfer date or discharge plan.

It is the responsibility of the Trust to which the patient has been admitted to initiate this link up.

Closest Bed

Where an 'out of Trust' placement is sought, the Trusts should be approached in order of geographical proximity. If however the closest Trust indicates that they cannot provide a safe admission (decision by senior manager, ref 3.7 in protocol) the next nearest trust should be approached. In addition, consideration should be given to the number of 'out of Trust' admissions placed in any single Trust so that the burden of responsibility is shared.

May 2019

11.0 REFERENCES

Bamford Review (2005) A Strategic Framework for Adult Mental Health Services

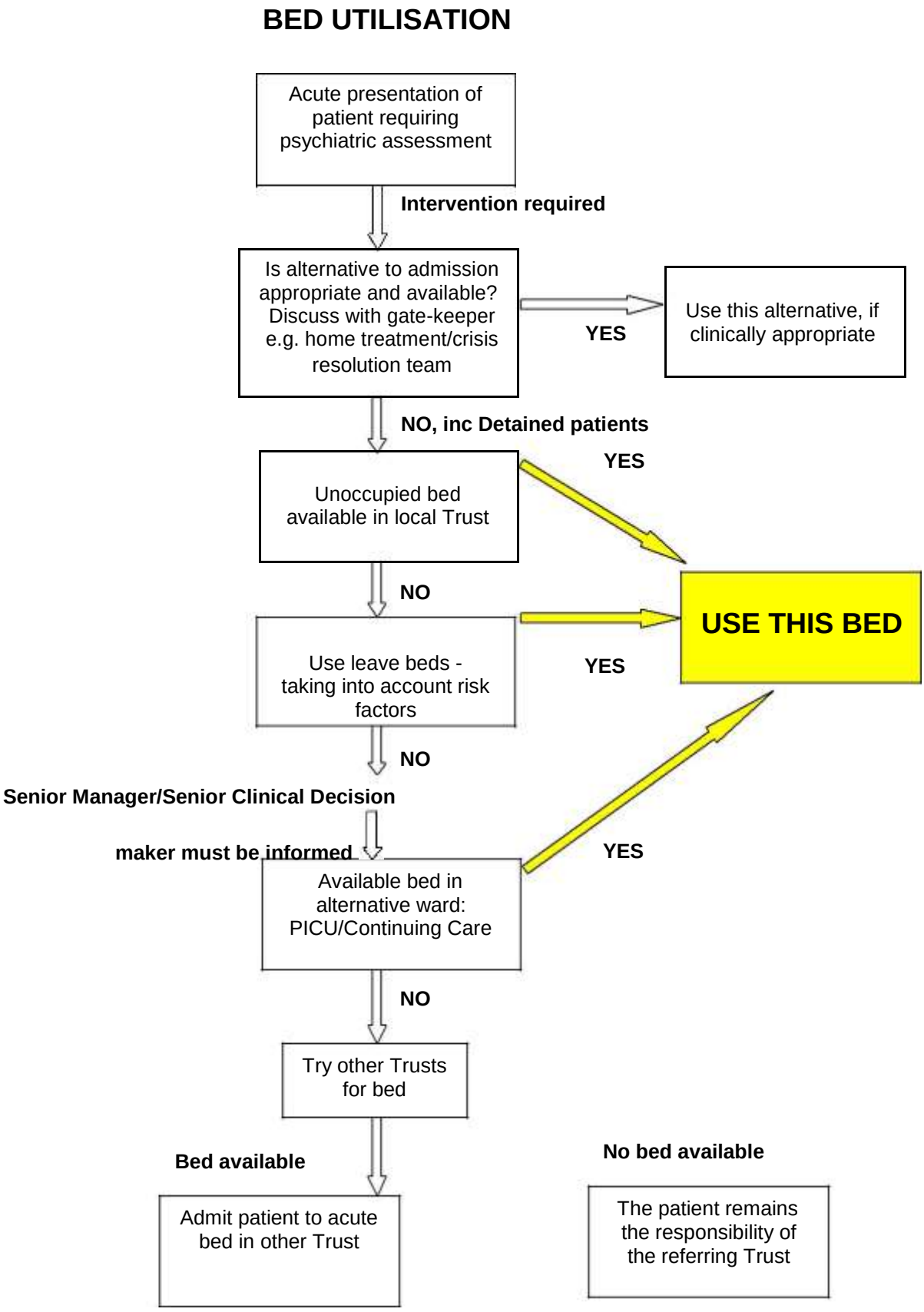
Mental Health Act Commission (England) - *Who's Been Sleeping in My Bed? The Incidence and impact of Bed Over Occupancy in the Mental Health Acute Sector (*December 2006)

DHSSPS Promoting Quality Care: Guidance On Risk Assessment And Management In Mental Health And Learning Disability Services – Revised May 2010

Royal College of Psychiatrists - *Do the right thing: how to judge a good ward.* Occasional Paper OP79 (June 2011)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report – July 2015

Appendix 1


BED UTILISATION
Acute presentation of patient requiring psychiatric assessment
Intervention required
Is alternative to admission appropriate and available? Discuss with gate-keeper e.g. home treatment/crisis resolution team
YES
Use this alternative, if clinically appropriate
NO, inc Detained patients
Unoccupied bed available in local Trust
YES
NO
USE THIS BED
Use leave beds - taking into account risk factors
YES
NO
Senior Manager/Senior Clinical Decision maker must be informed
Available bed in alternative ward: PICU/Continuing Care
YES
NO
Try other Trusts for bed
Bed available
Admit patient to acute bed in other Trust
No bed available
The patient remains the responsibility of the referring Trust