Humber NHS
NHS Foundation Trust

Adult Acute Bed Management Guidelines

Principles

Guidance from recent documents sets out the following baseline standards for the support of people in acute mental health crisis:

- Patients should be treated in the least restrictive environment which is consistent with their clinical and safety needs
- In-patient admissions and pressure on beds should be reduced
- Equity of access to an alternative to admission for patients and families must be ensured.

Any patient, including those who do not live in Hull or the East Riding, presenting or referred to Humber NHS Foundation Trust mental health services requiring an urgent admission will be admitted without delay following an appropriate gate keeping assessment being undertaken.

Patients can expect:

- To be admitted within 4 hours of the gate keeping assessment (unless circumstance or subject to patient/carer choice dictate otherwise) once it has been determined that they require admission to an acute bed.
- Discharge is to be discussed from the point of admission and an appropriate strategy to support safe discharge identified within 72 hours of admission. This will be carried out as part of a structured review of care needs in line with the Care Program Approach (2008) and will review the package of care required, the risk assessment process, and the identification an appropriate clinical strategy to support a planned discharge.
- To be transferred between units no more than once during their admission unless there is a pressing clinical reason to do so.

Requests for Non-emergency admissions of out of area patients should go to the adult mental health Bed Manager who will liaise with the unit managers and the referring organisation.

Admissions

Admissions will only take place after the undertaking of a comprehensive gate-keeping assessment.

Gate keeping is characterised by:

- The Crisis Resolution and Home Treatment [CRHT] service being actively involved in **all** requests (over any 24hr period) for admission - to identify the least restrictive option and consider the provision of Intensive Home Treatment [IHT] as an appropriate alternative to admission and will utilise a multi-disciplinary approach to facilitate safe decision making.
- CRHT service being aware of **all** pending mental health act (MHA) assessments and liaison with the adult mental health Bed Manager prior to them being undertaken.

N.B The CRHT service comprises two teams – Hull (operates 24hr 7days) and East Riding (operates 7 days 08.00 – 20.00hrs). Between 2000 hours and 0800 hours the Hull team have the responsibility to gate keep all admissions.

All informal admissions should be assessed by one of the CRHT teams, however it is recognised that this cannot always happen due to the location of the patient or potential risk to the patient in the event of a delay occurring. When the request is originating from the Hospital Mental Health Team or a Community Mental Health Treatment Team, gatekeeping can be achieved through a comprehensive discussion with regard to the rationale for admission and the provision of Home treatment as a suitable alternative.

It is the responsibility of the practitioner undertaking the assessment to ensure that the following documentation is completed and shared with the admitting inpatient unit in a timely manner to support the clinical safety and risk management of the patient:

- Community Mental Health Assessment (which includes the drug and alcohol screening tools)
- Electronic Galatean Risk Inventory Scoring tool [e-GRiST] (Adult, Older Adult, Learning Disability or CAMHS)
- Mental Health Cluster Tool [MHCT] (if unable to do electronically a ‘paper copy’ is required)

It may not always be possible to fully complete the assessment documentation (due to the patient’s clinical presentation and capacity to participate in the assessment process), in these instances the difficulties in completing the documentation should be adequately recorded to inform the inpatient unit and maintain defensible record keeping standards.

All admissions will be managed by the adult mental health Bed Manager and the admitting team and where possible will first be directed to Avondale mental health assessment unit for initial assessment and identification of treatment needs; this will be for a period of up to 72hours.

Admission may be directed to a treatment unit in the following circumstances:

- Detention under Section 3 of the Mental Health Act where there is less need for an initial assessment period.
- A gender specific unit is required due to vulnerabilities or level of risk.
- In the event that the assessment unit does not have capacity for further admissions.
- In the case of Community Treatment Order [CTO] recall where the person is assessed as needing a period of inpatient treatment of more than 72hrs

Admissions to other arms of the service are to be gate kept in line with forensic or rehabilitation policies for admission.

Transfer of Humber patients from out of area Bed back to the Trust.

Patients to be transferred from out of area beds will be managed in the same manner as direct admission and coordinated initially by the adult mental health Bed Manager.

Bed Management - Acute Units

Following admission, the patient will not be transferred to another unit within 3 days so as to enable the opportunity for a comprehensive assessment to be undertaken and supported discharge to be considered. Exceptions to this are: if the patient requires transfer to PICU or if a single sex unit is required due to potential risks or vulnerabilities.

The '*live bed state'* is available for staff and on call managers to view on the Trusts V Drive the address for this is V:\HMHTT\Nursing and Service Delivery\Bed State (Live). The *'live bed state'* is to be updated by the Nurse in Charge of the shift following each handover in addition to when a patient enters onto a period of leave. This is to ensure that it remains accurate and support the acute bed management strategy.

Leave beds are reported within the *'live bed state'* and are to be allocated into three priorities these are Red, Amber, and Green.

- Red, refers to a detained patient entering into a period of overnight leave, or an informal patient entering into a period of leave less than 48hrs or 2 nights.
- Amber, refers to a detained patient entering into a period of leave greater than 72hours or an informal patient entering into a period of leave exceeding 2 nights.
- Green, refers to a person entering into a period of leave with the plan being to discharge immediately following this.

The adult mental health Bed manager will aim to ensure the availability of 1 male admission bed and 1 female admission bed at all times, however, if there are no vacant beds available across the Trust the use of leave beds should be used in priority order utilising green beds first before considering moving forward to amber and then red.

If a patient requires returning to the unit from leave, and the bed is in use by another patient an untoward incident (DATIX) should be generated by the nurse in charge.

Patients who are on leave should have a contingency plan in place covering what to do if they need to return early and their bed has been filled in an emergency.

Acute Bed Management Strategy meetings are held fortnightly, unit managers or designate are required to attend to discuss the current occupation of beds, and clinical/operational challenges to support effective management strategies to be developed. The strategy meeting at times may be required more frequently during periods of high bed occupancy and discharge crises.

Bed Management- PICU (72 hour admission)

Admissions to PICU are primarily gate kept by the PICU Consultant. Out of hours this transfers to the senior nurse on duty on PICU.

In an emergency a 72 hour admission for assessment can be requested by inpatient units using the appropriate referral form. This may include an admission directly from the community. When patients are admitted to PICU for 72 hours an acute bed for their return should be identified.

Patients identified as being ready for transfer from PICU to a community inpatient unit (adult acute, rehab or older adult) should be identified to the adult mental health Bed Manager at the earliest opportunity so that transfer can be planned and organised in a manner supportive of the patients recovery.

In order for a patient to be transferred from PICU to a treatment unit the following should apply

- The patient is accessing leave regularly
- Has not been in seclusion for a period of >72hrs
- E-GRiST and MHCT has been reviewed
- The patient has had a full CPA review.

Bed Management- Rehabilitation Service

Rehabilitation services receive referrals from the community as well as acute inpatient units; all referrals for the rehabilitation service are to go to St. Andrew's Place in the agreed format and will be considered in the referral meeting. If rehabilitation units are full the process from referral to admission may take up to 4 weeks.

At times when the acute mental health beds are under pressure, it may be necessary to transfer patients from acute units without following the full process. Direct admission to rehabilitation services should not occur as this would introduce a potential risk in terms of staffing and management of acute mental health presentation. In the event that there are no available beds within the adult acute inpatient units and direct admission to rehabilitation services is unavoidable in terms of immediate support to the patient, this must go through the adult mental health bed manager / on call manager, and additional staffing sought to support the patient and staff group.

If a patient is transferred to alleviate bed pressure the rehabilitation service will record it as an untoward incident (DATIX).

Medical Responsibility

Medical responsibility will sit with the consultant in charge of the respective inpatient unit for the duration of the patient's admission.

Disputes

Where there are disputes:

- Dispute at the Gate (disagreement between referrer and gatekeeper)
- Decision made to admit or transfer but there is disagreement re the most clinically appropriate inpatient bed.
- Availability of a bed within the service area.

The practitioners involved are to ensure that the dispute is escalated to a senior clinician / Consultant Psychiatrist / Manager who will ensure that they apprise themselves of the full details of the situation so as to inform safe decision making and resolve the dispute (see appendix 1 Dispute Resolution flowchart)

Disputes about responsible clinician or consultant medical cover will be forward to the Clinical or Medical Director.

Internal Transfers

Transfers between units should only occur between 9 am and 8 pm (except where clinical or operational needs are immediate) following discussion with the adult mental health Bed Manager.

Transfers should be carefully considered particularly where the following applies:

- There is a definite discharge plan which has been agreed between the patient and the care coordinator.

Maintaining continuity of care between units is of paramount importance therefore:

1. The 72 hour assessment will be transferred between units
2. A clear note of why the transfer is being made should be made in the patient's health and social care record.
3. A full handover between transferring and receiving teams will take place.
4. A clear note of the handover between teams will be made in the patient's health and social care record. Both the transferring and receiving unit should sign this note.
5. Nursing care plans should be reviewed by a member of the receiving team on transfer and either changed or countersigned.

Accessing out of area beds, when there are no available inpatient beds.

The decision to admit has been taken following the Gatekeeping assessment and

- There is no immediate bed available within the inpatient estate.
- It is not clinically appropriate for the patient to be cared for in the community with the support of IHT until a bed becomes available.

During working hours the adult mental health Bed Manager is to escalate this to managers (CRHT Team Manager, Inpatient Service Manager), and out of hours to the on call manager who will support the identification of possible solutions, or support the accessing of out of area beds in consultation with the on call director.

The process for accessing an out of area bed is undertaken by the adult mental health Bed Manager or CRHT Hull (out of hours) this involves:

- Initial discussion with surrounding NHS Trusts re bed availability prior to a wider search of NHS providers.
- Search of private sector bed availability.
- The above must be in consultation with the patient and carers / family and geographical location taken into consideration to support the patient's recovery and social network support.
- The adult mental health Bed Manager is to ensure that the use of an out of area bed is reported to business planning on the next working day and facilitate repatriation as soon as possible.

Original ‘Adult Acute Bed Management Protocol’ document approved by Acute Care Forum 23rd June 2011

Reviewed and changes made - April 2015
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To be reviewed 3 yearly

Appendix 1
Dispute Resolution