WORCESTERSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST

Worcestershire **NHS**
Mental Health Partnership NHS Trust

PSYCHIATRIC INTENSIVE CARE UNIT (PICU) OPERATION POLICY

This document needs to be read in conjunction with the evidenced based Policy Implementation Guide and other policy documents e.g. Clinical Supervision.

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1   **Introduction**

1.1   The Worcestershire Mental Health Partnership NHS Trust aims to deliver a high quality health and social care service that promotes social inclusion and independence for people with mental health problems or a learning disability.

1.2   The unit is a 9 bedded Psychiatric Intensive Care Unit (PICU), encompassing a multidisciplinary led philosophy. The Psychiatric Intensive Care Unit is a Trust wide service and therefore accepts referrals from inpatient wards within the catchment area of Worcestershire Mental Health NHS Trust. Although PICU is a structured physical environment it should not be regarded as purely a locked ward, a secure unit or a challenging behaviour unit. The therapeutic management is assessed and based on specialist intensive interventions and not containment.

1.3   The Unit will provide expert, supportive, short term, individualised care for those who are in an acutely disturbed phase of a serious mental disorder, resulting in increased risks that require the person to be treated in a controlled environment for a brief period of time. The therapy will be provided, in line with the Mental Health Policy Implementation Guide, National Minimum Standards for Psychiatric Intensive Care Units (DoH 2002) by a multidisciplinary team, which will also have an advisory role to other Mental Health Inpatient Units within Worcestershire's Mental Health Services.

1.4   The Unit provides therapeutic intervention with the emphasis on safety, individualised care, professional rapport and staff development. Quality auditing processes will ensure positive service development.

2   **Psychiatric Intensive Care Unit Approach to Care**

2.1   The unit (PICU) is a nine bedded, predominately nurse led service for people whose psychiatric condition requires them to be treated in an environment of therapeutic security for a brief period of time. The unit will provide expert, supportive, individualised care for those whose acute episode of mental illness is resulting in disturbed behaviour that requires a safe specialist environment.

2.2   The therapy will be delivered by a multi-disciplinary team, which will also have an advisory role to other mental health units within Worcestershire Mental Health Trust. Service users are encouraged to take an active role in planning their care and treatment pathway leading to discharge.

2.3   The unit is an important and integral part of the service user pathway which reflects the Trusts vision of care. This approach to care requires a fundamental respect for and courtesy towards the individual. All patients will be treated equally whilst respecting their individual needs through their ethnic origin, gender, social class, sexual preference, religion, age, language, mental or physical disability or geographical location.

2.4   The operation of the unit is based on a holistic model, providing thorough, ongoing assessment of each patient's psychological, physical and social needs, offering individualised care based upon these assessments. The introduction and impact of the refocusing model introduced throughout the Trust underpins and reinforces the collaboration between staff and service users in making a difference to patient care and experience of their stay in hospital

2.5   Through provision of a daily structure and a range of effective clinical interventions, the team expects to balance the therapeutic needs of the patient with the need for support and security, whilst minimising the individual's dependence upon staff within the unit.

2.6 All patients are encouraged to take an active part in their programme of care, within the constraints of the Mental Health Act, whilst maintaining their own safety and that of those around them.

2.7 The unit is a clinical environment which offers intensive nursing support and interventions to individuals who are assessed as requiring higher levels of care.

2.8 Patients are encouraged to maintain close contact with friends and relatives in accordance with their own wishes, whilst maintaining the overall safety and security of the unit and those within it.

2.9 The unit is designed for short-term care (periods of weeks rather than months), and a stay of six months would be deemed extremely exceptional. The Department of Health's Minimum Standards advocate a maximum of six months.

3 **Referral, Assessment, Admission and discharge integrated care pathways**

Referrals

3.1 The unit will operate a referral-based service which accepts referrals from a number of sources. Each referral will be considered for admission by a process of pre-admission assessment undertaken by members of an assessment team following a referral. The PICU will accept referrals from ward manager & deputy ward manager or the RMO of any the Trusts acute wards and Crisis Resolution and Home Treatment. For Out of Area Treatments (OAT's), referrals will be accepted from the Clinical Manager High Risk Service, the PICU Manager (or equivalent) or Responsible Medical Officer (RMO).

3.2 Referrals will be accepted by a phone call to the shift co-coordinator who will identify the assessment team for that duty (this person will be identified at the start of each nursing shift and will be a regular member of staff and not an agency nurse. Individuals will be identified as the PICU pre admission assessment team; it will consist of Band 5 nurses and above. To promote consistency, the ideal process would be for the nurse making the referral assessment to be the admitting nurse and finally become the patient's Named Nurse. All effort should be made to achieve this.

3.3 The PICU Referral Form will be completed by the designated assessment team on all referrals. All sections of the Referral Form must be completed with particular regard to the rationale for referral. Where an assessment of a patient who is not an in-patient within Worcestershire Partnership Trust, has been completed, a typed assessment in addition to the standard form will be completed. This report will include information on the following headings:

- Reason for Referral
- Assessment of Mental and Behavioural State On Interview
- Risk Assessment
- Recommendations

PICU Pre Admission Assessments

3.4 Designated members of the High Risk Service/PICU clinical team will assess every referral to the PICU. The overall aim of the assessment is to identify problematic behaviours and risks associated with them and to clarify with the patient what is happening and how they feel about any incidents. The assessment should also ensure that the patient fits within the parameters of the admission criteria to PICU. This practice is necessary in order to address the following issues:

- Ensure appropriate use of PICU beds

- Prevent delayed discharge and increase efficiency

- Reduce deskilling amongst team members from the General Adult catchment wards

- Ensure that the levels of disturbance and or dangerousness presented by a referral can be managed safely

3.5 Following a referral, if an assessment is indicated, it will take place as soon as possible. The waiting time for an assessment will depend on the perceived urgency of the situation. It is expected that patients from Trust facilities will be assessed within one working day of referral. When the PICU assessment team has been formed they will contact the referrer and agree a mutual convenient time for the assessment to take place. The Assessment Team will also be able to give advice over the telephone. This may be appropriate if it is not felt an assessment is indicated (by either the general adult or PICU service)

3.6 The unit will offer a 24 hour a day emergency service. Anyone referred for admission to the unit should meet one or more of the admission criteria. Decisions relating to an emergency 'out of hours' admission are made by the PICU nursing team in consultation with the on call medical staff and the Mental Health Act assessment team as appropriate. Referrals from 'out of area' will not be accepted outside of normal working hours.

3.7 The assessment will ideally be performed jointly by two members of staff from the unit and one from the acute ward making the referral.

3.8 The assessment will be based on the PICU assessment documentation; it will include an interview with the patient, treating nursing staff and hopefully the Consultant Psychiatrist. The aim is to identify problematic behaviors displayed by the patient and the associated risks. Once identified, suggestions as to the most appropriate action to deal with these problems will be given to the referring team. Findings should also be communicated back to the Unit via the unit referral meeting.

3.9 The possible outcomes of an assessment are admission to the unit (which will occur in a planned manner as soon as possible) or advice given to the treating team with or without arrangements to re-assess the patient. If a significant delay in admission is expected, interim management advice will be given. If part of the advice is to refer the patient elsewhere, the treating team will perform this referral.

3.10 Staff making the assessment from both the unit and the locality ward will sign an agreed 'Suggested Outcome' section on the assessment form. The original assessment forms will remain with the PICU Assessment Team. On returning to the unit, a typed copy of the assessment will be completed by the unit administration and faxed to the referring ward (including the completed referral) for their records. The forms will to be filed in the Referral Folder which will be kept in the unit. The second copy will be filed in the patient's Medical record.

3.11 If the assessment team is unable to agree a plan, they should seek assistance from senior members of the High Risk Service e.g. the Service Manager, Ward Manager or Consultant Psychiatrist.

Pre-Assessment Guidelines

3.12 The overall aim of the assessment is to identify problematic behaviours and risks associated with them and to clarify with the patient what is happening and how they feel about any incidents. The assessment should also ensure that the patient fits the admission criteria to the unit.

3.13 The assessment should be with close reference to the admission (and exclusion) criteria of the unit and the assessors should also focus on the possibility of the patient's eventual

transfer back to an open ward i.e. they should concentrate on needs which can be met by the unit within an appropriate time period.

3.14 During the actual assessment, the team will scrutinize the patient notes (including risk assessment and management plan), liaise with ward staff and the RMO (if possible) and interview the patient. Initially, the presence of a defined mental illness must be established, or signs suggestive of a mental illness that require further assessment. Following this, reasons why the patient would benefit from the unit should be assessed. As stated in the admission criteria, these fall into four main criteria.

Externally directed aggression

3.15 This may be towards property or other individuals and when assessing these incidents always look at:

- Antecedents to the behaviour

- Details of the actual behaviour

- Consequences of the action (i.e. what happened to the patient afterwards and how the staff and other patients reacted both immediately and in the short term). These factors may provide clues as to how the behaviour could be modified in the future.

3.16 When interviewing the patient always give clinical credibility to the risk of violent behaviour and assess it carefully.

3.17 Assess the *motivation* behind the act and the *impulsiveness or planning* of it as well as the patient's attitude to it.

3.18 Was the act *accompanied by a strong affect*? Was it driven by any *psychotic features*?

3.19 Assess for "*threat or control-override*" symptoms (delusions of persecution and passivity, including thought insertion, withdrawal and broadcast.

3.20 Also be aware of the *non-verbal expression of hostility* such as increased motor activity, pacing, invasion of personal space etc.

3.21 When looking at the individual's history, pay careful attention to any *previous* similar events or a *gradual increase* in severity of them.

3.22 Look at past forensic history, use of weapons and history of *substance abuse.* Also try to ascertain previous *threats* of violence and how both the staff and the patient managed this.

3.23 Try to gauge a level of the patient's *impulse control* (e.g. how would you react if ……… or what do you tend to do if such and such happens?) and look for objective evidence to confirm or deny this.

3.24 Try to get *collateral information* on the history (if not already done by the ward staff).

3.25 Remember that as well as antecedents, behaviour and consequences, there are three other features to consider in an incident, the *subject*, the *victim* (person or object) and the *situation*. Try to understand how features within all of these three contributed to the incident(s) and how they could be modified to manage the risk.

Internally directed aggression

3.26 When assessing an individual's suicidal intent following an act of deliberate self harm (DSH), apart from diagnosis, the following must be considered:

3.27 **Timing and Planning**

- Did the event occur at a time and place where the individual believed they would not be found?

- Was it concealed or openly revealed?

- Was there evidence of pre-planning associated with the attempt or was it more spontaneous?

- What was the motive surrounding the attempt.

3.28 **Method Used and Severity**.

- How did the individual commit the act?

- What did they expect to happen?

- What was the likelihood of severe harm?

- Are they willing to accept help at the moment?

3.29 **Frequency**.

- Is there a history of self harm?

- If so, what and how frequent?

- Is there a pattern of escalating seriousness or severity?

3.30 **Precipitating / Associated Factors**.

- How efficient is the support network?

- Have there been any recent life events?

- Was the act committed under the influence of any substances or alcohol?

- How does the patient normally react to stressful events?

3.31 **Mental State**.

- Are there any psychotic symptoms that provoked the attempt?

- What is the current suicidal ideation and intent?

- Is this consistent or does it vary?

- If it varies what are the associated factors?

- How does the patient resist suicidal tendencies?

3.32 **Environment**.

- Is there anything that can be modified in the patient's environment to decrease the opportunity to partake in DSH?

- Are there enough staff resources to maintain a safe environment?

- If not, what can be done?

- How long has the patient been under close supervision for and what is the form of this supervision? (If one to one close observation has been needed for more than 72hrs then a review of the management strategy should be considered)

3.33 **Absconding**

- Apart from absconscion, the patient should also benefit from short term treatment on PICU and have the potential for making reasoned change to their behaviour. Those with poor potential for change should not be admitted e.g. chronic organic brain syndromes unless for a very short length of stay.

3.34 **Considerations when making the assessment should include:**

- Have all reasonable interventions been tried?
- Failure of current interventions:
  - Insufficient resources/skill mix to detain patient
  - Environment unsuitable for successfully detaining patient
  - Aggression used to support goal of absconding
  - At what time did the patient abscond? (E.g. handover)
- Admission Indicated:
- Patient is assessed as being of a high risk
  - Judgment seriously impaired and some risk factors
  - The consequences of offending are serious and related to their psychiatric condition
- Alternatives to Admission Indicated:
  - Has previously absconded and returned without incident and identified as being of low risk
  - Committed a serious offence and may require a forensic unit.
  - Security is needed for its own sake and is unrelated to any major mental illness

3.35 Unpredictability

Unpredictability is associated with a patient's presentation in which there is difficulty making an accurate assessment of mental and behavioural state. It may be indicated when there is one or more of the following descriptions is demonstrated:

Is the patient new to the Mental Health Service and an unknown quantity?

- Past history of impulsive behaviour?

- Acts without consideration of consequences?

- Acts with little thought or planning?

- The patient is overtly hostile, angry or confrontational.

- Patient displays heightened arousal and is unable to meet goals

- Non verbal and verbal responses to psychotic symptoms

Is comprehensive assessment hindered by:

- Difficulty in establishing therapeutic rapport?

- Lack of insight into mental health problem?

- Inability / unwillingness to cooperate with assessment?

- Is the behaviour causing safety concerns for patient and others?

- Can a PICU manage the potential dangerousness of the unpredictable behaviour?

4   **Admission**

Criteria for admission

In line with the National Minimum Standards for PICU and Low Secure Environments (DoH 2002),

- Patients will have undergone a pre-admission assessment by the PICU assessment team prior to admission.

- Individuals will generally be from within Adult Mental Heath Services; however assessment will always be based on clinical need.

- Patients will only be admitted if they display a significant risk of aggression, absconding with an associated serious risk, suicide or vulnerability in the context of a serious mental disorder.

- Individuals who are detained under the appropriate completed assessment/treatment section of the mental health act under provisions of Section 2, 3, 35, 37, 38 or 48.

- The admission for PICU is due to a new episode or an acute exacerbation of the patient's condition.

- It has been demonstrated that multidisciplinary management strategies in the referring acute admission unit have not succeeded in containing the present problems.

- There must be mutual agreement between the referrer and the assessment/PICU team on the positive therapeutic benefits expected to be gained from the time limited admission including clear rationale for assessment and treatment.

4.2   **Behaviours requiring PICU**

Problem behavior will fall under one, or more of the following headings:

- **Externally directed aggression** towards people or property resulting in significant risk to others or extreme aggression

- **Internally directed aggression** resulting in a significant risk of suicide and current management measures are proving unsuccessful and if the patient is likely to respond to intensive therapy within a PICU setting

- **Absconding** Patients in which the consequences of persistent absconding are serious enough to warrant treatment in a PICU. PICU's do not provide "security for security's sake" and there will always be a primary clinical reason for admission.

- **Unpredictability** that potentially poses a significant risk to self or others and requires further assessment

It may be possible under exceptional circumstances to offer direct entry into the PICU for those individuals who have a history of consistently requiring this level of care and security. The multidisciplinary team should identify these individuals, including representatives from the PICU team, during the Care Planning Approach forum, prior to discharge from hospital. Factors must be formally identified which would indicate direct entry into the PICU facility in any potential future relapses.

4.3   **Criteria for exclusion**

In line with the National Minimum Standards for PICU and Low Secure Environments (DoH 2002), there are categories of patients who should not be treated within a PICU.

- The patient is assessed as presenting too high a degree of risk for a PICU

environment and may require admission to forensic services.

- Restricted patients (Section 37/41) should not be admitted unless there is provision to transfer them to an acute ward if warranted by their clinical condition.

- Patients who could / would present a grave and immediate risk if they were to abscond. These individuals would possibly require a more secure environment such as that provided by a Low Secure / High Dependency Unit.

- Primary diagnosis of substance misuse.

- The behavior is a direct result of substance misuse and not an exacerbation of mental illness.

- Primary diagnosis of dementia.

- Primary diagnosis of learning disability

- The patient's physical condition is too frail to allow safe management within the PICU. Although there are no strict age limits regarding admission (in keeping with the National Service Framework for the Care of Older People), individuals whose general **physical level of functioning**, **emotional maturity** or **physical condition** preclude admission to a PICU will not be admitted. Careful consideration must be given to the safety and care of patients at either end of the age spectrum and the appropriateness of a PICU.

- Individuals with a primary diagnosis of a personality disorder, whose behavior is unlikely to be modified by brief intensive care and treatment. Unless urgent necessity in in-patient areas within the Trust dictates otherwise and the admission to PICU is for an agreed time limited plan and discharge plans are in place.

4.4 Pathways for Admission

Integrated Care Pathway

From Worcestershire General Adult Admission wards

Referral is made to the PICU

PICU staff will complete an assessment on the admission ward

24 hours

Needs of the patient are evaluated

PICU admission indicated

Admission is not indicated

Patient incorporated into PICU clinical management framework

Package of clinical support is negotiated between PICU and admission ward staff

2-8 weeks

On going communication between PICU and admission ward staff during admission

When PICU discharge criteria are fulfilled

7 days

Transfer back to Admission ward with the provision of further liaison if required

Integrated Care Pathway

From Worcestershire's Community based Psychiatric Services

In the event of a patient demonstrating disturbed behaviour in a community setting and the clinical team consider an admission is indicated, a referral direct to the PICU may occur. It should be recognized that disturbed behaviour in the community can quickly recede following admission to an acute ward. It is therefore recommended that only in exceptional circumstances will a direct admission to PICU be necessary.

Referral is made to PICU

Referring agent is advised that patient will be jointly assessed by PICU staff on the catchment area acute ward.

24 hours

Assessment is made by PICU and community staff

PICU admission indicated   Admission is not indicated

Patient incorporated into PICU clinical management framework	Package of clinical support is negotiated between PICU and admission ward staff

2-8 weeks

On going communication between PICU and admission ward staff during admission

When PICU discharge criteria are fulfilled

7 days

Transfer back to Admission ward with the provision of further liaison if required

Out of Hours

There will, on occasions, be individuals who are placed upon the unit overnight without a prior PICU assessment. Possible scenarios in which this may occur are:

- When agreed by both PICU staff and acute adult staff that an individual would need direct admission. This may have been identified previously within the patient's care plan.

- When, usually out of hours, the level of disturbance is so severe that on-call doctors and the nurse in charge of PICU deem it necessary that the patient is placed within an intensive care environment. In a situation where there is disagreement between professionals regarding the appropriateness of a PICU admission the On Call senior Manager will make the decision.

If this occurs then the patient will be placed on the PICU and the assessment team will formally assess the patient the following day and suitable arrangements made in conjunction with the appropriate agencies. These could include: formal admission to the PICU for further assessment treatment, transfer to an open ward with advice re management, referral to forensic services whilst on PICU, involvement of the police or negotiation with acute adult services to admit for a rigid, time limited period with fixed, measurable and achievable outcome measurements. It is conceivable that some individuals may be inappropriately transferred to PICU out of hours and with good working relationships with other wards, this method will hopefully address and rectify any problems that may arise.

Integrated Care Pathway

From Worcestershire's out of Hours Psychiatric Services

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┌─────────────────────────────────────┐
│  Out of Hours Emergency Assessment   │ ◄─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─ ─
└─────────────────────────────────────┘
                  │
                  ▼
┌─────────────────────────────────────┐
│  Patient detained under Section 2 /3 │                          6
└─────────────────────────────────────┘                        hours
                  │
                  ▼
┌─────────────────────────────────────┐
│          Emergency Referral          │
└─────────────────────────────────────┘
                  │
                  ▼
┌─────────────────────────────────────────────────┐
│  Agreement with PICU, CR/HT and acute ward staff │
│  in relation to the pathway.  In the case of a   │
│  dispute / disagreement the 2nd level senior     │ ◄─ · ─ · ─ · ─ · ─
│  manager on call will make the decision where to │
│  admit the patient.                              │
└─────────────────────────────────────────────────┘
                  │
                  ▼
┌─────────────────────────────────────┐
│       Patient placed on PICU         │
│            OVERNIGHT                  │
└─────────────────────────────────────┘                          12
                  │                                            hours
                  ▼
┌─────────────────────────────────────┐
│     Assessed by PICU staff next am   │ ◄─ · ─ · ─ · ─ · ─ · ─ · ─
└─────────────────────────────────────┘
                  │
                  ▼
┌─────────────────────────────────────┐
│        Usual patient pathway         │
└─────────────────────────────────────┘
         ╱        │        ╲                                    2-8
        ▼         ▼         ▼                                  weeks
┌──────────┐ ┌──────────┐ ┌──────────┐
│Admission │ │Community │ │Admission │ ◄─ · ─ · ─ · ─ · ─
│acute adult│ │placement/│ │To PICU   │
│ward      │ │Home      │ └──────────┘
└──────────┘ │Treatment │      │                                7
     │       └──────────┘      │                              days
     ▼                         ▼
┌──────────┐        ┌─────────────────────────────┐
│Regular   │        │Transfer back to Admission   │
│liaison   │        │ward when discharge criteria │ ◄─ · ─ · ─ · ─
│with PICU │        │are fulfilled with the       │
└──────────┘        │provision for further        │
                    │liaison if required.         │
                    └─────────────────────────────┘
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Income Generation Bed Pathway for Admission

PICU Clinical Team receive referral with supporting clinical information

Referral Accepted

Yes   **No** → Contact referring team with rationale for clinical decision.

Internal

No ← Bed Available → Yes

Advise PCT on use of IGB

Advise PCT the need to access bed elsewhere

External

Yes ← Bed Available

Fax referral documentation to referrer

No

Referral accepted

Advise referrer of clinical rationale and reasons

Yes   No →

Inform Finance Department of admission ← Patient admitted / transferred to IGB ← Referring clinical team arrange transport, escort and transfer to PICU

Referring clinical team invited to attend clinical reviews

Patient is ready for transfer back to own clinical team. ← If referring clinical team do not attend clinical reviews then weekly update are sent.

PICU staff arrange transport, escort and transfer back to referring team

Inform PCT of the termination of IGB

Inform Finance Department of Discharge

Note: - Please Refer to PICU Operational Policy for more detailed Guidance

Referral and Assessment for PICU form

Patients Full Name	Date:	Referred by:	Location:

Up to date CPA Documentation enclosed as follows:

	Completed and present in clinical file	Completed. Care coordinator to send within 72 hours	Not completed
Needs assessment			
Risk Assessment			
Care Plan			
Carers Assessment			

Current Medication: from Prescription card

Regular:
prn (used regularly)
Depot - Date last administered

Reason for referral to PICU

Source of Admission to Hospital:	Emergency / Planned Admission:	Source of Referral: Ward:	Name of referrer:
		CMHT:	
	Date admitted to hospital:	CR/HT:	
		OAT:	

Referring RMO:		Referring Keyworker:	Care Co-coordinator:
			Address:
M.H.A. Section:		Date of Renewal:	Consent to Treatment Expiry date:

Action Suggested (Referrer):	Action Suggested (Assessment Team)

Suggested Outcome

Agreed Outcome:

Signed assessment team:	Signed Referrer:
Date:	Date

Discussed at Referral Meeting:

4.5   Admission for the section 136 MHA '83 suite

In the case of a patient being admitted directly from the 136 suite it would be inappropriate to take the patient out of the building and through the admission entrance. The route for admission in this instance would be through the main entrance and air lock from the Elgar corridor.

Referral / Assessment to PICU Checklist

- Referral form completed.
- If referral not received electronically photocopy original. The referral letter will be attached to the clinical case file and a second copy will be maintained in a central file within the unit.
- Assessment form completed with reference to admission criteria.
- Assessment form signed by both assessment team and referrer.
- Assessment form copied to patient notes.
- Liaison with referrer and advice given.
- If necessary, arrangements made to reassess.
- If patient is to be admitted, arrangements made with PICU and referring team.
- If not to be admitted, report written and sent to referrer.

4.6   Alternatives to Admission

Alternative Interventions to Admission

- Offer advice and information on medical and nursing interventions and care planning.
- Offer advice on the specific management of problematic behavior.
- Agree on further reviews of a developing problem and possible re-assessment where indicated.
- Release staff where able to initiate plan.
- Support applications for referral to other specialists units.

The PICU will aim to co-operate with the admission wards to make best use of the resources available ensuring that the safety of the Unit is not compromised.

A flexible and creative problem solving approach will be used to ensure the maximum benefit to the service user. The referral process will not be considered complete if the assessors are unable to agree a plan. In this case the assessing staff will seek assistance from senior clinical staff to resolve the situation.

5   The Admission Process

It is the responsibility of the admitting nurse to ensure that the following procedure is followed and documented:

- All admissions to the PICU will be via the admission entrance other that those directly from the 136 suite.

- Welcome the patient and orientation to the Unit, offer drink where appropriate.
- Check Section papers.
- If accompanied by police and handcuffs are being used these can be removed in this area.
- Property search and documentation.

When the patient is brought through to the main part of the PICU the following processes can begin to be undertaken.

- Commence 72 hour nursing assessment, including initial assessment of risk.
- Update NCRS
- Inform relatives of transfer, visiting times and property that is restricted within PICU, giving rationale.
- Request a copy of the patient's Care Programme Approach (CPA) from the care coordinator if these have not accompanied the patient
- Commence CPA for new patients.
- Add patient to shift detail board.
- Set level of observation required (this should be done with medical staff whenever possible)
- Mental Health administrator to be informed of patients admission.
- Request old notes and drug charts/discharge summaries.
- For each patient admitted a 72 hour nursing assessment will commence. The admitting nurse and unit medical staff, in consultation if appropriate, will prescribe a treatment plan for the first 72 hours. Good practice would signpost to the brief screening tool being repeated at this stage. While it is good practice for risk to be assessed by the multi-disciplinary team, it is not good practice for medical staff to prescribe nursing observation. The admitting nurse should hold responsibility for determining appropriate observation. This will ensure that best use is made of nursing resources for the whole PICU population. Where ever possible all effort should be made to agree observation with medical staff. The admitting nurse will ensure that all staff on duty are made aware of the initial treatment plan.

5. 1 Allocating a Named Nurse

The admitting nurse will organize for the completion of the 72 hour assessment in accordance with duty rosters and a named nurse will be allocated. It is good practice to allocate the patient to a nurse who has nursed them previously and has a good relationship with them. Attention must be given to allocation in relation to gender and patients preferences.

It is the responsibility of ALL staff when returning from off duty to read admission details and treatment plans of the new patient.

5. 2 Continuing Nursing Intervention

After the initial treatment plan and the appointment of the Named Nurse, the process of enabling the patient to return to the locality ward has begun. Interventions will be in line with Trust policies and will reflect the Core Interventions from the National Minimum Standards for PICU (DoH 2002).

Following allocation, the Named Nurse, and Co workers will conduct a more in-depth assessment. The Named Nurse selects a framework on the patient's needs and identified obstacles to the patient's functioning. All new and reviewed treatment plans will be presented at each handover during the day it was initiated or reviewed. The named nurse will coordinate with other team members.

5.3 Carers, Relative and Family

On admission if no advanced directive is available the named nurse must establish with the patient which family member/ carer / relative they wish to be contacted in case of crisis. The named nurse will establish all contact numbers for that identified individual. At this time in the admission process the family member / carer / relative must be asked by the named nurse of any specific risk issues relating to the individual that they are concerned about or aware of.

5. 4 Discharge and Transfer Process

Discharge planning is essential to the smooth and efficient operation of a PICU and should begin prior to admission to the unit. All too often, patients can show evidence of dependence on the unit and this presents difficulties when moving back to open wards. Efficient discharge and transfer of patients is essential to prevent blockage of beds and relies upon good working relationships and communication with other Trust services and units. It is acknowledged that the effective use of beds is dependent upon an atmosphere of cooperation.

Clear transfer indicators and criteria should help alleviate potential problems when the patient returns to the acute admission ward.

5.5 Transfer Criteria

A patient should be considered for transfer from PICU if one or more of the following criteria apply:

- The patient has demonstrated increased control over problematic behaviors that would allow them to function in a general adult admission ward.
- The patient is appropriately utilizing unescorted leave from the unit successfully.
- The patient's residual problematic behavior is assessed as not resulting from a treatable major psychiatric disorder.
- The patient has achieved the maximum benefit from the available treatment and is unlikely to respond further to a prolonged stay.
- The patient is demonstrating extreme disturbed violent behavior, the management of which is beyond the resources available within the unit.

5.6 Transfer Process – To Acute Wards

Within the routine management of patients on PICU, clinical review and CPA meetings will take place. These will adhere to Trust policy and it is expected that all relevant professionals involved in the patients care will attend these meetings.

- Once a patient has been assessed by PICU medical and nursing staff and subsequently identified as being near to transfer back to an open ward environment the PICU staff will contact the referring ward to arrange a meeting to discuss appropriate handover arrangements. The PICU expects the referring ward to respond promptly (depending on the acute bed status) to any requests for transfer back once the PICU multi-disciplinary team has assessed the need for intensive care is no longer required.

- Locating an appropriate bed on an open ward is the responsibility of the open ward team; actual physical transfer arrangements are the responsibility of the PICU staff.

- Once a patient has been identified as no longer requiring PICU then the transfer should take place as swiftly as resources will allow.

- A transfer summary will complied and part of the transfer documentation.

5.7 Unexpected or Urgent Transfers

It is acknowledged that, given the demands on such a service there will be occasions when pre-planned transfer is not possible. It is therefore expected that, through close communication with other wards via both nursing and medical staff that efficient transfer of patients can be achieved.
Good bed management will ensure that if there is not a vacancy on the unit to accommodate an urgent admission, individuals will have previously been identified who could potentially be transferred back to provider teams should the need arise.

Ideally, the most suitable patient will be transferred. Unfortunately, due to pressure on acute beds and urgency of situation, it may be the case that the most suitable patient from the admitting provider unit will have to be transferred back thus resulting in a "swap" or "simultaneous exchange" of patients. It is hoped that good relationships will minimize such occurrences and that acute wards throughout the Trust will be as accommodating as they can be.

5.8 To Other Wards / Units

Inevitably some patients will not be able to be returned to open wards. These are the patients who potentially block PICU beds. Hopefully good pre-admission assessment by
PICU staff will have identified such patients and suggested appropriate alternative arrangements at that time but inevitably, given the nature of the clientele that PICUs deal with, some patients will be identified after admission to PICU. They fall mainly into two categories: 1) Those needing increased security and 2) Those needing an extended period of Low Secure care.

Should PICU require the input of Forensic Services, appropriate referrals will be arranged and advice taken.

The decision that an individual requires longer term low secure care should not be taken lightly as it potentially consigns the patient to an extremely extended period in hospital (even the waiting list for such units tend to be at least a number of months thus further blocking a bed on the PICU). The decision should be taken in consultation with provider teams and appropriate specialist services following a CPA meeting. Once this decision has been reached, appropriate referrals will be made.

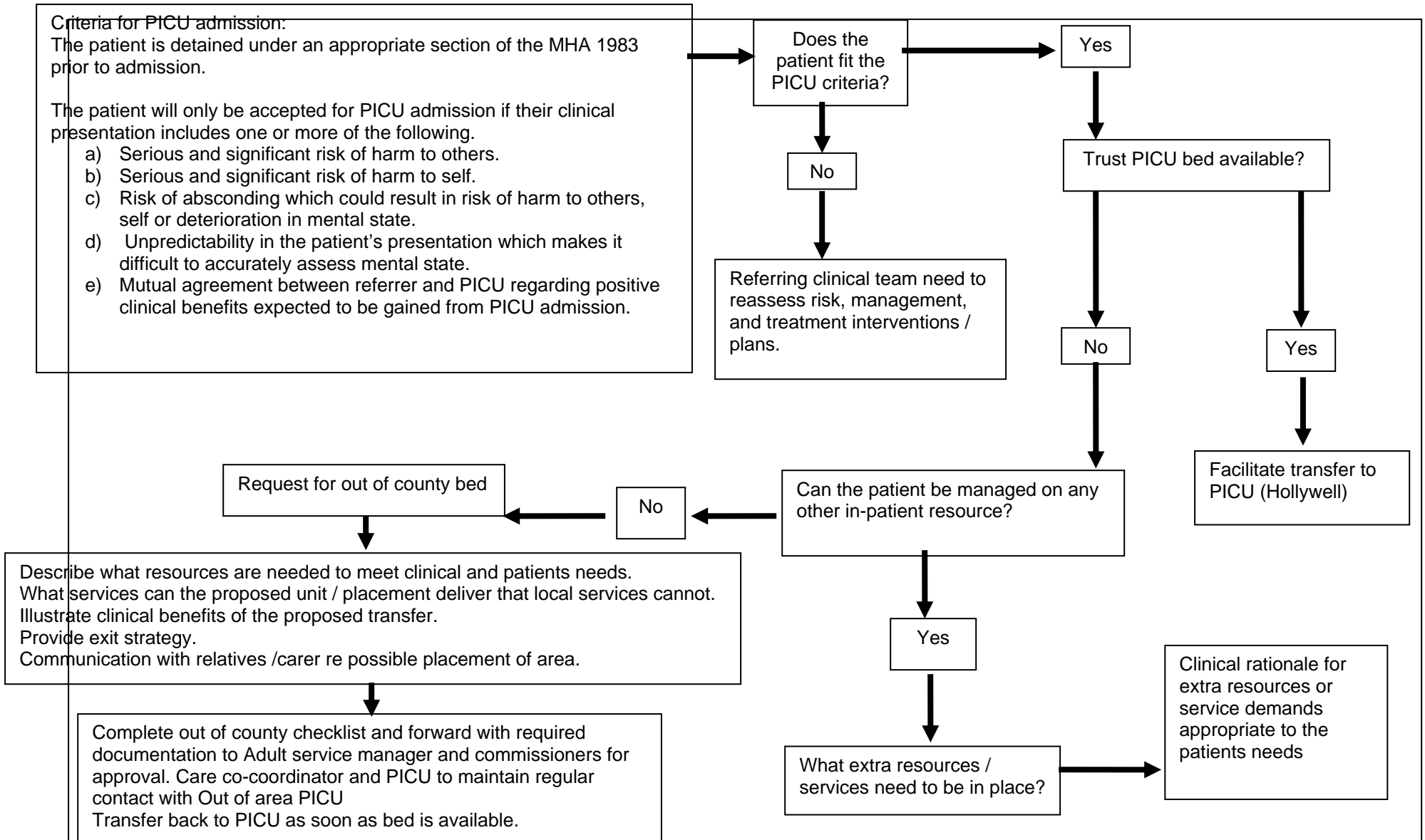**5.9   To Low / Medium Secure Units**

If an individual requires transfer to a low or medium secure unit the named nurse or the associate nurse will discuss / inform the relatives / family / carer of the situation and the time and date of the transfer. The relatives / family / carer will also be given the necessary contact details for the unit to which they are being transferred and be updated if there are any problems or delays with thee transfer.

5.10   Post Transfer

Following transfer back to the open ward, PICU staff and the patient's named nurse on the acute admission ward will remain in contact to monitor progress on a regular basis (at least weekly) for up to 4 weeks. The patient will be re-assessed by the PICU staff as necessary.

5.11   Out of Area Treatments (OAT's)

Only in exceptional circumstances will patients be sent out of area to receive intensive care treatment. This will be as a result of all other viable options being exhausted and the out of county pathway being followed. In the event that someone is sent out of county then this will be time limited and the next PICU vacancy will be allocated for their return. It will not be considered good practice to transfer a patient to an out of county resource outside of normal working hours.

Criteria for PICU admission:
The patient is detained under an appropriate section of the MHA 1983 prior to admission.

The patient will only be accepted for PICU admission if their clinical presentation includes one or more of the following.
   a) Serious and significant risk of harm to others.
   b) Serious and significant risk of harm to self.
   c) Risk of absconding which could result in risk of harm to others, self or deterioration in mental state.
   d) Unpredictability in the patient's presentation which makes it difficult to accurately assess mental state.
   e) Mutual agreement between referrer and PICU regarding positive clinical benefits expected to be gained from PICU admission.

Does the patient fit the PICU criteria?

Yes

No

Trust PICU bed available?

Referring clinical team need to reassess risk, management, and treatment interventions / plans.

No

Yes

Request for out of county bed

No

Can the patient be managed on any other in-patient resource?

Facilitate transfer to PICU (Hollywell)

Describe what resources are needed to meet clinical and patients needs.
What services can the proposed unit / placement deliver that local services cannot.
Illustrate clinical benefits of the proposed transfer.
Provide exit strategy.
Communication with relatives /carer re possible placement of area.

Yes

Complete out of county checklist and forward with required documentation to Adult service manager and commissioners for approval. Care co-coordinator and PICU to maintain regular contact with Out of area PICU
Transfer back to PICU as soon as bed is available.

What extra resources / services need to be in place?

Clinical rationale for extra resources or service demands appropriate to the patients needs

6   Standard Operational Procedures

The expectation is that all staff will follow Trust policies, procedures and protocols / guidelines which can be found on the Trust Intranet or in the PICU staff office.

Particular attention is drawn to the following key Trust policies which all staff must be familiar with, understand and implement are:

Protocol for Rapid Tranquilization	**Incident reporting policy**
Medicines policy	**Serious Untoward Incidents (SUI) policy and procedure.**
Care Programme Approach policy	**Management of actual or potential aggression.**
Clinical supervision policy for nurses.	**Policy on management of use and possession of drugs.**
Policy on management of use and possession of alcohol.	**Seclusion Policy**
Policy for the issue and use of remote activated personal attack alarms	**Fire Safety Policy**

A number of guidelines have been developed to aid / guide professional practice.

These guidelines put into operation the Trust policies within the PICU.

7   The Psychiatric Intensive Care Unit Team

Trust guidelines support job descriptions and KSF outlines and staff will have objectives and PDP, discussed and agreed with their line manager, reviewed on a quarterly basis.

The quality of care that patients receive is linked to the way that the staffing group is organized. Fundamental to this idea is the view that each patient should be assigned a named nurse, who is responsible for the person and the care that is prescribed.

The PICU nursing staff will be led by a ward manger (band 7) and two deputy ward managers (band 6). The ward manager has 24 hour responsibility for the management of the PICU.

Clinical Leaders

- Responsible for ensuring that clinical standards are monitored
- Act as Named Nurse or Co-worker
- Be a role model to other members of the team
- Act as a co-coordinator for team activities and development
- Be a focus point for problem solving
- Act as an advocate for the team or individuals as required
- Act as a Team Motivator.
- Act as a resource for the team, providing clinical guidance, advice and support
- • Take an active part in the SDR process
  • Liaise between ward manager and staffing group

- Support team members in their duties
- Develop others within the team through clinical supervision and mentorship programmes

Role of the Qualified Nursing Staff

- Act as Named Nurse or co-worker
- Lead the team in the absence of the team leader
- Provide membership to Nursing Assistants, OTA's, Students and other professionals during their placement
- Provide support to team members
- Act as Team Motivator
- Support team members in their duties
- Develop others within the team through clinical supervision, mentorship and preceptorship programmes

Role of the Health Care Assistant

- Act as support worker
- Implement treatment plans
- Contribute actively to all stages of the nursing process
- Use observations to provide informal assessment
- Be a role model to team members
- Act as team motivator
- Be an effective participant within the team

Role of the Named Nurse

- Will always be qualified members of the team.
- Responsible for all stages of the nursing process; assessing, planning, implementation and evaluation.
- Liaise with members of the multi-disciplinary team
- Present new and reviewed treatment plans
- Ensure that the Risk Assessment Policy has been implemented
- Identify themselves to the patient's 'significant others'
- Ensure all responsibilities and requirements of the Mental Health Act (MHA) 1983
- Will have clinical autonomy providing they observe practices and procedures that are commensurate with the NMC Code of Conduct.

Responsibilities of the Named Nurse

- The Named Nurse bears overall responsibility for the accurate documentation of the patient' progress notes.
- The Named Nurse is responsible for ensuring that one to one time is spent with their patient/s
- The Named Nurse will meet weekly with associated workers to discuss their patients' care plans.
- The Named Nurse is responsible for inviting relatives and other professionals to the weekly patient review rounds. (MDT round)
- The Named Nurse is responsible for reporting on their patients' progress at weekly MDT rounds.
- The Named Nurse is responsible for all the practical aspects of their patient's discharge/transfer (including, returning property and arranging transport.
- The Named Nurse is responsible for handing over their patients when going on annual leave or extended study leave. They will also inform their patients of such a change and document this communication

Role of the Co-worker

- The Co-worker's role is to work with the Named Nurse.
- The Co-worker will be a qualified or student team member
- Will assume role of the Named Nurse in the Named Nurses absence
- Will ensure that clinical issues are highlighted to the Named Nurse
- Will ensure that all responsibilities and requirements of the MHA 1983 are acted upon
- Will identify themselves to the patients' 'significant others'

Role of the Consultant Psychiatrist

- To be a key member of the multidisciplinary team
- To take a key role in the Multidisciplinary team for the unit
- To be involved in referral assessments
- To supervise/advise the medical staff (staff grade/SHO) on the day to day management of the patients and any referrals
- To take a key role in weekly multidisciplinary team patient review rounds
- To write medical reports and present cases in the hearings for Hospital Managers and Mental Health Tribunals
- To take an active role in coordinating, planning and implementing CPA arrangements
- To take an active role in developing the service as part of the Multidisciplinary team.
- To liaise with medical colleagues, providing information on Psychiatric Intensive Care

Role of the Staff Grade Psychiatrist

- To be a key member of the multidisciplinary team
- To take part in referral assessments
- To complete medical admission procedure
- To provide day to day reviews and management of in-patients
- To attend the multidisciplinary team patient review meetings
- To write medical reports and present cases in the hearings for Hospital Managers and Mental Health Act Tribunals
- To provide necessary support to the unit staff
- To liaise with medical colleagues, providing information on Psychiatric Intensive Care
- To take an active role in developing the service

8   Shift Management

The number of staff on duty on the PICU depends upon the clinical demands, the observational status of those patients resident at the time and the perceived management problems of the overall patient population. Minimum staffing levels are set at 5 staff on both early and late shifts and 4 staff at night.

Staff development is recognized through the Personal Development Review process, the PICU Ward Manager will ensure the continuity of this process.

A monthly service meeting will take place to discuss clinical development, current practice, policy and procedures. It is also be used by the PICU Ward Manager to share information with the unit team. . All clinical staff will be trained in the MAPA. It is the responsibility of the PICU Manager to ensure safe minimum staffing levels required to ensure effective management of the unit.

Supervision is available for all staff working in the unit and the emphasis will be on personal professional development.
Staff meetings are held every two weeks to facilitate good communication within the unit team, and to discuss any business or problems that may arise.

In order to promote individual patient care the following Shift Management System has been implemented within the ****** Unit:

The Shift Coordinator will identify the security nurse for the shift.

A Shift Coordinator holds the responsibility for shift management. This may be any grade of RMN, or Student Nurse in education with an allocated RMN taking responsibility.

Where the Shift Coordinator is a junior member of staff, they will be closely supervised and supported by the senior nurses on duty.

8.1   The Role of the Shift Co-coordinator

- Check that all staff expected to be on duty have arrived; reporting to the unit manager/bleep holder if any additional staff are required.
- Receive handover from the previous shift co-coordinator.
- Check all resuscitation equipment. Report any faults immediately to ECT Manager and Assistant Resuscitation Officer (internal 33211) 01905 760352 and make provisions for repair and replacement
- Add the Key-worker's name to the board as soon as they are appointed to a patient.
- Ensure that any patient who does not have a Key Worker or co/support worker on duty, is allocated a nurse to deliver prescribed care for that shift.
- Exercise common sense in terms of prioritising resources and the skill mix to ensure all patients' needs are met.
- Allocate a nurse to every patient during every shift and record this clearly on the board.
- Receive telephone calls directed towards the Nurse-in-Charge.
- Keep a record of all staff leaving the clinical area, (who should state their intended destination and expected duration of absence from the Unit
- Facilitate staff break times.
- Ensure that on-coming shifts are adequately staffed.

8.2   Handover Between Shifts

- Information about each patient will be handed over by the allocated nurse where possible. Generally information will be handed over starting from the two previous shifts.

- The maximum number of staff should be present during handovers for presentation of new and reviewed care plans. All new patients will be subject to comprehensive presentation at handovers, including mental state and Care Plans

- Named Nurses will liaise with other members of the team for their patients

- A minimum of two members of staff will remain in the clinical area during the handover period. This may need to be increased dependent upon the needs of any shift. The Shift Co-coordinator is responsible for this decision.

- Shift Co-coordinators are highlighted on the unit duty rota. If no one is highlighted, the off going shift Co-coordinator is responsible for appointing one before the new shift takes over.

All new members of the unit staff will be subject to a comprehensive induction programme.

8.3 Multi-Disciplinary Team Functioning

The multi-disciplinary team carries out clinical work. It is likely that all patients detained within the unit will be subject to enhanced CPA provision in accordance with Trust CPA policy and risk management guidelines.

8.4 Reviews

During the week (Mondays to Fridays) there will be a daily review of each patient carried out, on the unit, by the nursing staff. There will be a weekly MDT meeting to review all patients in detail. During weekends at and at bank holidays the on-call doctor will provide daily medical support to the unit. This would include face-to-face review of any patient who may be of cause for concern, as identified by the nurse in charge.

The minimum requirement for an in-depth review is every two weeks, however it should be recognized that some patients may require more frequent in depth or discharge planning meetings. All appropriate professionals will be invited to attend, plus any carer family member or relative friend requested by the patient with a specific time to attend the review and to be informed of any changes in the plan. If relatives, family members or carers cannot attend the clinical review then the named nurse will make contact and give a clinical update. The Ward Manager and Staff Grade doctor will ensure in-depth reviews take place at the appropriate time.

8.5 Daily Review of Patients' Activities

The daily structure is flexible to allow for the integration of individual patients' needs and the demands of the treatment programme in line with the refocusing model of care.

Protected engagement time is between 2- 4 pm each day and a range of planned activities will take place within PET time in addition to staff undertaking 1-1's with patients .

This PICU recognises each individual's need for privacy and to spend time on his or her own, or with others.

Patients are encouraged to keep their own rooms clean and to a standard, which would satisfy Health and Safety requirements, with assistance as appropriate.

9 Security

9.1 The role of the Security Nurse

The shift coordinator will identify the security nurse at the start of very shift. The security nurse role is to assist in the maintenance of a safe and therapeutic environment for both staff and patients. The aim of the security nurse is not to replace good nursing practice but to enhance the safety of the PICU by implementing a formal and defensible process.

The security nurse is responsible for:

- Completing the environmental checklist and security of the PICU throughout the assigned shift.
- The security nurse should always be a permanent member of staff. This may be a Band 3 or Band 5 but should not be the nurse in charge as this would compromise the integrity of both roles.
- Ensuring the physical integrity of the PICU and to report any faults and / or implement the appropriate process to rectify the faults.
- Allocation, storage and testing of all alarms, security passes, fire keys and room keys for both staff and visitors.
- Opening the doors to external areas and ensuring knowledge and awareness of staff and patients in these areas. No external doors should be opened without the knowledge of the security nurse.
- All searches undertaken i.e. room, staff visitors must be undertaken with the security nurse present.
- Promotes security and safety awareness throughout the shift.

The oncoming and out going security nurse will undertake the security checklist at each shift handover.

9.2 Staff and Visitors' Access to the PICU

Access to the PICU for all staff working on the unit, other Trust staff and all other visitors professional and non professional will be through the main unit entrance. Swipe card access is on different levels in relation to PICU staff and Trust Staff.

- All staff that have Trust swipe cards will be able to access the unit and resources within the air lock. Access to the PICU from this point will only be for designated staff that have swipe card access.
- All staff will leave personal belongings in the lockers provided in the staff room. No personal items are allowed on the PICU i.e. mobile telephones, wallets etc.
- Visitors to the PICU will be met by the security nurse in the air lock.
- Visiting professionals and relatives will use the lockers provided within the air lock for leaving personal belongings.
- Visiting professionals and relatives using the visitors room will be escorted into the room from the air lock and that door will then be locked.
- The patient will be brought into the room from the PICU.
- At no point will both doors will be unlocked at the same time.

- At no point will a patient be in the visitor's room with the door to the air lock unlocked. At no point will a patient be in the visitors room without staff supervision. It is the security nurses responsibility for locking and unlocking the doors to the visitors room.

9.3 Staff Alarms and Fire Keys

The monitoring board for the attack alarm is situation in the staff base.

- At the commencement of each shift staff will be allocated a set of keys and alarms for the duration of the shift by the security nurse.

- These will be tested at the commencement of each shift and handed over at the end of each shift – all key sets will be accounted for before any staff leave the unit at the end of a shift.

- Every visitor to the PICU will be given an attack alarm by the security nurse.

(reference Policy for the issue and use of remote activated personal attack alarms WMHPT)

9.4 External Security

The monitoring and recording equipment for all the external security will be situated in the ward managers office.

The cameras are situated to provide the maximum coverage to ensure that the PICU external area is safely maintained.

9.5 Windows

The windows installed by SAPA building systems in all individual bedrooms
Can be adjusted to increase / decrease ventilation and will be managed by the nursing staff. Patients will have no control over this system and must request a member of staff to alter the slide for ventilation.

All other windows are restricted opening and must be opened only with the knowledge of the security nurse.

10   Restricted items

For reasons of safety and security certain items are classified as restricted and are not permitted within the unit. The following list is not exhaustive and common sense should prevail:

- Drugs
- Alcohol including perfume and aftershave.
- Sharps, e.g., Knives, razors, scissors, needles.
- Glass containers, ornaments.
- Canned drinks
- Metal coat hangers
- Pornographic literature
- Cameras, tape recorders and mobile phones
- Toxic substances, e.g., bleach.

- Matches
- Flammable liquids, e.g., lighter fluid.
- Aerosols.
- Glue.
- String/wool/rope.
- Electrical items or anything with an electrical cable including MP3 players, mobile phone chargers and portable DVD players.
- Any other item assessed by the Nurse in charge of the unit at that time as beinbg inappropriate or unsafe.

N.B: Visitors to the unit must hand in to the security nurse any of the above items or any other item, which any reasonable person may deem a security risk.

Failure to comply may lead to non-entry to the unit.

The taking of photographs or use of tape recording equipment is not permitted without prior permission from the Multi-disciplinary Team.

Any restricted item which is illegal or a weapon and is removed from either a patient or visitor will be disposed of by the appropriate service / professionals.

10.1   Psychiatric Intensive Care Unit Environmental Checklist

Date:

Checklist Items *Tick [Safe] or Cross[Unsafe]*	Shift											
	AM				PM				Night			
COMMUNAL CHECKS												
Patient Allocation on Board												
Patients												
Put up 1-1 tracker												
Fire doors												
Fire extinguishers												
Cutlery Crockery												
Meal Times												
Windows												
Remote Controls												
Toilets [Communal area]												
Shower room												
Courtyard, Gates & Fence												
DVD's own & Patients												
CD's own & Patients												
Games												
Check unused rooms secure												
Activity room chairs												
Activity room Sofa												
Activity room Cabinet												
Fixtures and Fittings												
Keys & Alarms												
Unused keys in locker												
Used keys Accounted & Recorded												
BEDROOMS CHECKS	1	2	3	4	1	2	3	4	1	2	3	4
Wardrobes												
Windows												
Toilets												
Restricted Items												
Fixtures and Fittings												
Place N/A in box if room not in use												
Crash Current												
Crash Handover												

11 Guidelines for Conducting Searches

11.1 Individual Patients and Patients' Property

Foreword

These guidelines have been formulated with due regard to the Mental Health Act Commission Guidelines, Mental Health Act 1983, Code of Practice (March 1999) and Human Rights Act 1998.

The searching of an individual patient or patient's property is a delicate procedure and should be managed with the utmost integrity and highest professional regard. It is a potentially provocative procedure and may be construed as degrading by the individual. Therefore, the following guidelines should be followed so that the greatest possible attention is paid to the dignity and welfare of the patients at all times.

Searching of visitors is addressed within the visiting guidelines.

Guidelines

- The searching of an individual or an individual's property may only be implemented at the request of the shift co-coordinator, should they have reasonable grounds to suspect that the patient is in possession of items which may present a potential or immediate risk to their safety or that of others (including drugs or alcohol). Searches must be conducted with the approval of the shift co-coordinator.

- The implementation of a search must demonstrate that all-previous means and measures have been utilized and have proven fruitless in providing a satisfactory solution to the apparent problem. It should therefore be a 'last resort measure' and not utilized as a possible primary solution.

- Communication with the patients is essential to provide explanations and a forum for them to express their anxieties regarding the search procedure.

- In the event of a search, the permission of the patient must be sought whenever practicable, but it is not required in order to carry out the search. The patient may wish to be present during a search of bedroom area. Staff numbers should be considered in order to maintain safety.

- If a patient refused permission for a search to be conducted, all relevant documentation must be completed, e.g. 'Personal Search Record' form and advice/organizing on sought from the Ward Manager, Unit Manager, and Consultant in working hours or On Call Manager if out of hours.

11.2 rocedure – Individual Searches

- The member of staff will seek consent and give an explanation of the process.

- Patients will be searched individually in the privacy of their own room or a room designated to conduct searches unless extenuating circumstances are apparent.

- Two members of staff will carry out the procedure and at least one of them will be of the same sex as the patient. One staff will be a trained nurse, consideration of urgent necessity may, very occasionally dictate otherwise.

- The patient must be informed of the circumstances resulting in a personal search, (if not already aware), and an opportunity will be given for giving any relevant information to the staff prior to the search procedure.

- Any item of clothing will be removed by the patient under the supervision of staff and searched in conjunction with their body.

- Patients should empty their own pockets where practicable.

- **INTIMATE BODY SEARCHES WILL NOT BE PERFORMED.**

- The staff conducting the search are responsible for ensuring that the patient is properly clothed before removing them to another location.

11. 3 Personal Property Searches

- The member of staff will seek consent and give an explanation of the process.

- The patient should be in attendance whenever practicable during the search procedure.

- Property to be searched by 2 members of staff at all times; one member of staff will be a trained nurse of the same sex as the patient concerned. (Consideration of urgent necessity may occasionally dictate otherwise).

- All property will be replaced as it was found and the utmost care will be taken to prevent damage to personal effects.

- The search and the results will be recorded in the patient's notes.

11.4 Documentation

Full use of incident reporting procedures will be made. Unit staff will ensure that the 'Personal Search Record' form is correctly filed and record details of the following in the patient's notes:

- Why the patient was searched.

- Where the patient was searched.

- Time the patient was searched.

- What items, if any, were removed and to where.

- If items belonging to the patient were removed, the fact that the patient was informed and a receipt was provided.

- The fact that the patient was informed of where the items are being kept.

- In the event of suspected illicit substances being removed, the fact that the patient was informed that these will be handed to relevant agencies for destruction.

- Complete an incident form.

Personal Search Record

Ward:	Consultant:	PIMS No:

In accordance with the Mental Health Act 1983, Code of Practice and Human Rights Act 1998, it is necessary to obtain the patients permission to undertake a personal search. In the case of a bodily search, it is imperative that a nurse of the same sex as the patient does this.

This form is to be completed by the shift co-coordinator and retained in the patients notes
Name of Patient
Date: Time:
Search of: Property/Person/Both*   *delete as applicable
Name of Nurse undertaking search: Signature:
Name of 2nd Staff member undertaking Search: Signature:
Gender: Patient: 1st Nurse: 2nd Staff member:
Reason for Search:
I confirm that I give permission for a personal search of Property/Person/Both*   Patient Name: Patient signature: Date:
If the patient refuses for a search to be carried out, the Unit Manager/Ward Manager/Consultant/ or On Call Manager should be contacted and authorisation is sought.   I .... give authorisation for a search of Property/Person/Both* to be carried out on the above patient.   Authorising Person: Name: .... Signature: ....   Date: ....   If a verbal message of authorisation is taken then the form must be signed on the next working day.
Where was the Patient searched:
Links to Risk Management Plan:
Outcome of Search:
Items removed: (If any):

Patient property receipt:	Incident Reporting Number:

For Properties removed followed Patient Property Procedure: Yes/No/N/A*
For illicit substances appropriate procedure for destruction followed: Yes/No/N/A*
To be completed on Admission:
Property Retained by Patient:

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The Trust cannot accept any responsibility whatsoever for any loses or damages to money or other valuables or property retained by the patient. Patients are advised to arrange for relatives to look after any valuable items, personal property or cash. If this is not possible, patients are advised to hand over to the Shift Coordinator, any money or property brought into hospital by them or received by them after admission. This will be placed in safe custody and receipt issued.

I have read the above notice and accept sole responsibility for any money, other valuables or property retained in my possession.

Patients Name:............................ Patients Signature:........................... Date:.......................

Patient not consenting/or patient does not have capacity for informed decision:

Actions taken:

Shift Coordinator Name:............................... SC Signature:.......................Date:........................

Witness Name:................................. Witness Signature:......................... Date:........................

Removal of Sharps, Medication, as identified by guidelines (**Retained by the Ward**)

Removal of Valuables: (**Retained by Hospital**)

Receipt No:	Receipt No:	Receipt No:
Receipt No:	Receipt No:	Receipt No:
Receipt No:	Receipt No:	Receipt No:

Valuables sent home: Identified Carer:

12 Withholding Patients' Correspondence

12.1 Mental Health Act 1983, SECTION 134 (Patients' Correspondence)

When required, correspondence will be appropriately managed from patients detained under the Mental Health Act and stored in an appropriate place of safety.

12.2 Key Issues

- What correspondence can be withheld from dispatch
- What correspondence cannot be withheld from dispatch
- What information must be kept in relation to withheld mail for dispatch
- The role of the MHA administrator
- Powers of the MHA Commission

12.3 Definition of section 134:

Under Section 134 (1) a postal packet addressed to any person by a patient detained in a hospital under this Act and delivered by the patient for despatch may be withheld if that person has requested that communications addressed to him/her by the patient should be withheld. This request must be in writing to the Hospital Managers (MHA Administrator).

12.4 Definition of a Postal Packet:

A postal packet includes a letter, postcard, printed packet or parcel.

12.5 Restrictions to informal patients' correspondence:

There are no restrictions on informal patients' correspondence.

12.6 Correspondence where the powers of 134 do not apply:

The powers of Section 134 do not apply to correspondence sent by detained patients to the following persons:-

a) Any government minister or MP

b) Court of Protection

c) Health Service Commissioner

d) Mental Health Review Tribunal

e) Health Authority

f)   Mental Health Act Commission

g) Hospital Managers

h) The patients' legal adviser

i)   The European Commission of Human Rights

The withholding of postal packets from the Post Office addressed to a detained patient applies only to Special Hospitals (Section 134 (1)(b)

12.7 Procedure for withholding Patients' Mail:

- If a request has been received in writing it must be sent to the MHA Administrator.

- The Responsible Medical Officer and Clinical Team must be informed.

- An entry must be made to this effect in the case notes.
- The patient must be informed of the decision.

- Any mail sent for despatch by the patient must be given to the MHA Administrator on behalf of the Hospital Managers and will be placed in an appropriate place of safety.

- A register will be kept by the Mental Health Administrator giving details of:

  a)   The fact that the package or item has been withheld.

  b)   The date and the grounds on which it was withheld.

  c)   The name of the appointed person who withheld it.

  d)   The description of the item withheld.

- The nominated person to withhold patient mail will be the Mental Health Act
- Administrator.

- The nominated persons appointed to inspect post will be the Mental Health Act Administrator, Ward Manager, the Clinical Manager and Adult Service Manager.

- If a packet has been opened and inspected a notice must be inserted stating:

  e)   That the packet had been opened and inspected
  f)   That nothing has been withheld
  g)   The name of the person who opened the packet, the name of the witness and the name of the hospital.

12.8 Mental Health Act Commission powers:

Under Section 121 (7) of the Mental Health Act 1983 the Mental Health Act Commission has the power to review any decision to withhold a packet under Section 134 of the Act.

## 13. Record of Physical Intervention

Record of Physical Intervention

Ward:	Consultant:	NCRS No:

This form is to be completed by the shift co-ordinator and retained in the patients notes		
Name of Patient:		D.O.B:
Ethnicity:	MHA Status/Section	
Date:	Time Restraint began:	Duration of Restraint:
Location of Restraint:	Observation Level:	*Number of Previous Restraints in this admission:*
Gender: Patient:	Female Staff No:	Male Staff No:

Circumstances Leading to Restraint:

Patients Response to Restraint:

Outcome Of Restraint: (As required medication, de-escalation etc)

Details of any injury to staff or patient during restraint – please indicate on the chart over leaf any injuries to the patient

Check list	Y/N	Staff Initials
Recording and Informing (if necessary)		
Full Entry in clinical case notes		
Incident form for staff		
Incident form for patient		
Duty RMO informed		
Consultant Informed		
Relatives Informed		
Possible Outcomes		
Review Risk Management Plan		
Patient moved to side room		
Medication Review		
Observation Reviewed		
Has the patient been offered the opportunity to reflect on the incident ?		
Did the patient accept ?		
Have the staff been offered the opportunity to reflect on the incident ?		
Did the staff accept ?		

Head

Right Arm
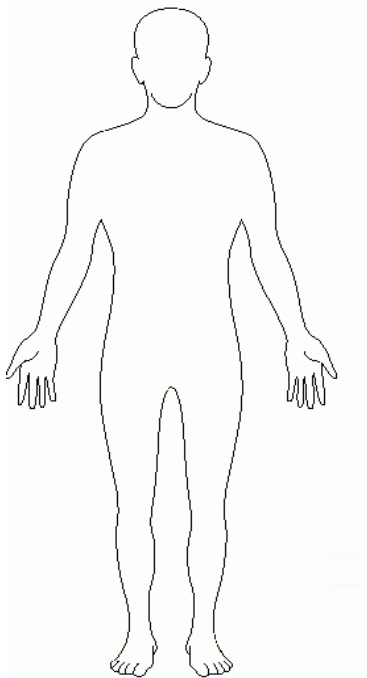
Left Arm

Feet

Name of Staff Identified to complete observations:

_____

Time	Pulse	Blood Pressure	Respiration	Temp.	Recovery Position	Fluid Balance	
						Input	Output
___.00							
___.15							
___.30							
___.45							
___.00							
___.15							
___.30							
___.45							
___.00							
___.15							
___.30							
___.45							

Restraint completed at :

Medical Assessment completed - _____

(minimum standard: within 2 hours of commencement of restraint)

14.   Absent Without Official Leave (AWOL)

A patient will be considered absent without leave under the following circumstances:

a) They are subject to detention under the requirements of the Mental Health Act and have left the unit without the explicit and written authorisation of the unit RMO or agreement with the unit team, if the terms of Section 17 require so.

b) They are on Section 17 leave and have not returned at the appropriate time and are considered to be a risk to themselves or others. The particulars and physical characteristics section of the AWOL form must be completed upon admission and kept in the patient's notes.

14.1 Reporting Procedure

If it is suspected or known that a patient has gone AWOL, the shift co-coordinator will be informed immediately.

The shift co-coordinator will determine, in conjunction with the team, whether a patient is considered absent without leave.

Unless the patient is known to have left the grounds, an immediate search will be made to confirm this.

The shift co-coordinator will ensure an AWOL (MisPer) form is completed and telephone the incident to the police, obtaining a log number.

The remainder of the AWOL form will be completed and faxed to the Police by the shift co-coordinator. *"RISK AREAS"* will have been highlighted on the form for police information.

The Shift-Co-coordinator is responsible for ensuring that all necessary parties are informed namely the Ward Manager, Service Manager, Unit Medical Staff and Level 2 Senior manger on call if out of hours and family / relatives and carers.
The Shift-Co-coordinator should at this stage advise senior managers of the possible risk to themselves or others and if the individual is likely to attract press attention. Other persons considered to be at risk should also be informed however, prior to contacting other persons considered to be at risk, it is important that issues of confidentiality are considered. At this stage, depending on the circumstances it may be appropriate to contact the family / carers.

The Shift Co-coordinator is responsible (where staffing levels allow), for organizing a search outside the grounds. Additional staff may be requested from other areas if required.
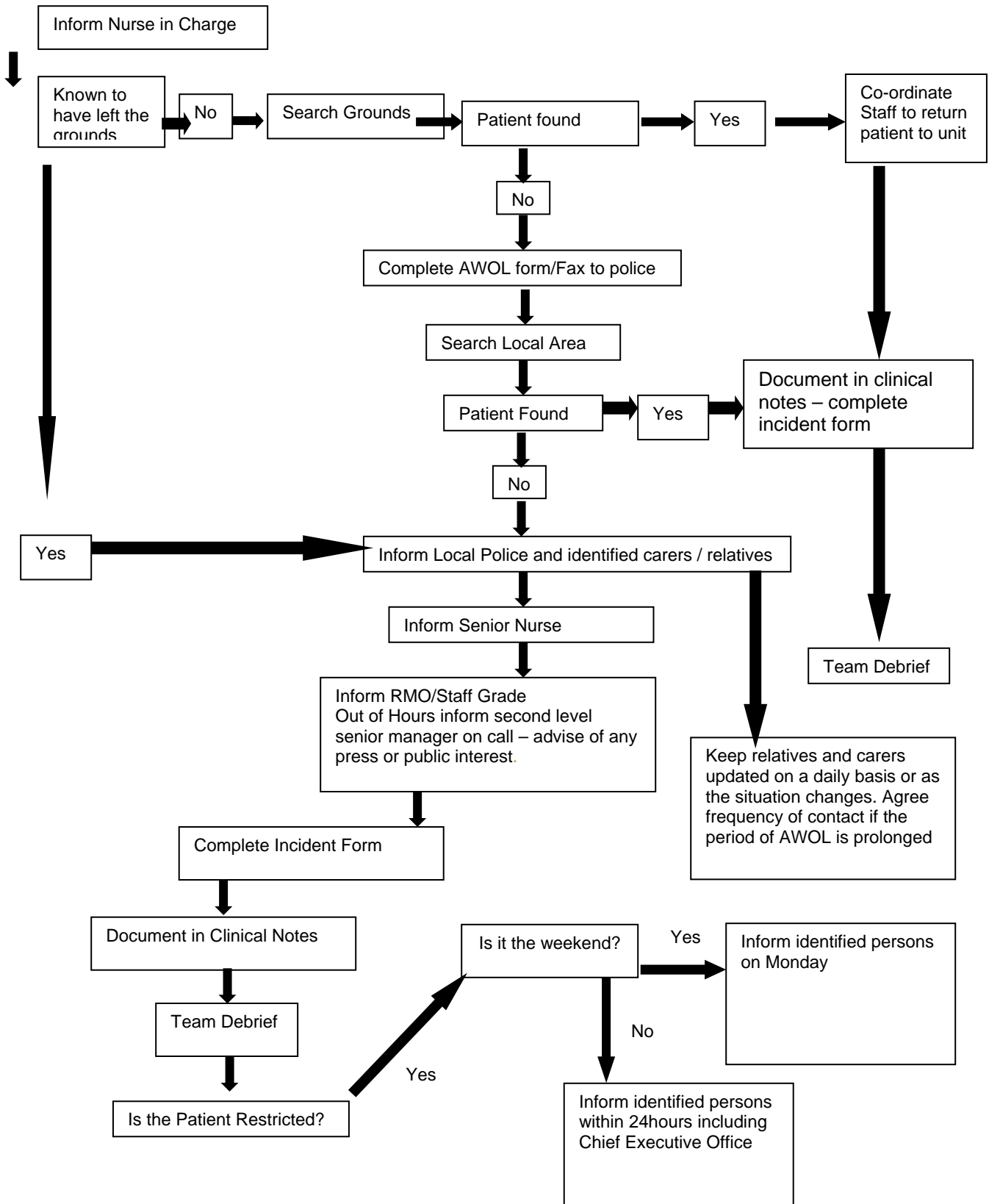
Staff searching for a missing patient, will not take undue risks and will ensure that they have sufficient numbers to return the patient if found.

The shift co-coordinator will ensure that statutory reporting requirements are carried out e.g. for restricted patients, the Home Office, for those subject to probation, their probation officer. Within a reasonable time frame, (usually within 1 working day)

- Chief Executives office to be informed.

- When a patient is found and returned to the Unit the shift co-coordinator will ensure that all relevant personnel are informed.

- The Shift Co-coordinator is responsible for ensuring that an Incident Form is completed and full details are recorded in the patient's notes.

- The Ward Manager is responsible for organizing a Team Debrief, to examine the case, its effect and implications for future practice. This will be conducted in a supportive and developmental manner and will not be punitive in any way.

- The AWOL Flow Chart will be referred to by the staff member conduction the procedure.

If the patient remains missing then the nurse in charge of subsequent shifts is responsible for keeping the family / relatives / carers up to date with the situation and any changes. For periods of prolonged absconding there needs to be an agreement with the family / relatives and carers in relation to the frequency of contact made by the clinical team.

ACTION TO BE TAKEN IF A PATIENT IS SUSPECTED TO HAVE GONE AWOL

Inform Nurse in Charge

Known to have left the grounds → No → Search Grounds → Patient found → Yes → Co-ordinate Staff to return patient to unit

Patient found → No → Complete AWOL form/Fax to police → Search Local Area → Patient Found → Yes → Document in clinical notes – complete incident form

Patient Found → No

Known to have left the grounds → Yes → Inform Local Police and identified carers / relatives

Inform Local Police and identified carers / relatives → Inform Senior Nurse

Inform Senior Nurse → Inform RMO/Staff Grade
Out of Hours inform second level senior manager on call – advise of any press or public interest.

Inform Local Police and identified carers / relatives → Keep relatives and carers updated on a daily basis or as the situation changes. Agree frequency of contact if the period of AWOL is prolonged

Document in clinical notes – complete incident form → Team Debrief

Inform RMO/Staff Grade → Complete Incident Form → Document in Clinical Notes → Team Debrief → Is the Patient Restricted? → Yes → Is it the weekend?

Is it the weekend? → Yes → Inform identified persons on Monday

Is it the weekend? → No → Inform identified persons within 24hours including Chief Executive Office

AWOL (MisPer) REPORTING FORM		
NAME:	**D.O.B.:**	**WARD/UNIT:**
MHA Section:	**Diagnosis:**	**Ethnicity**	**Subject to MAPPA**

Last known location

Home Address	**N.O.K.** **Name** **Relationship** **Address**

PHYSICAL DESCRIPTION Height Colour of eyes Colour of Hair Build	Distinguishing features

RISK AREAS

Self

Others

POSSIBLE LOCATIONS

Police Log Number:	**Senior Manager informed:**	**RMO informed:**
NOK Informed:		
Reported By	**Signed**	**Date**

15. **Ethnicity, Culture and Gender Guidelines**

Ref Worcestershire Mental Health Partnership Trust
Race and Equality Scheme 2005 - 2008

All PICU's have the responsibility to ensure that all patients receive equality of treatment without prejudice to ethnicity, culture and gender. Each patient will be treated with dignity, respect and courtesy. Privacy, especially with patients whose illness makes them vulnerable, is essentially an issue for staff to ensure. Female patients in particular are often very vulnerable in secure settings; however, the needs of vulnerable male patients must also be addressed. The cultural and gender issues will be audited via a patient and carer questionnaire in order to identify good practice and gaps in service provision.

- Each patient regardless of race, colour, creed, sex, religion, social background, sexual orientation, disability or age, will be treated with dignity and respect at all times.

- Individual needs/wishes will be met to the best of the PICU's ability and reflected in individual care plans.

- Each shift should have the appropriate gender mix of staff to reflect the needs of the patients

- Interpreters will be available to ensure clarity and understanding of all aspects of care and to ensure informed consent is given, or issues around care and consent are understood.

- Faith Leaders will be available to all clients when requested. The Key-worker will assist if required.

- Availability of independent advocates, solicitors, befrienders and signers (for audibly challenged) will be open to patients.

- The PICU notice board will clearly display access to these services.

- All unit staff will ensure assistance is given, if needed.

- Every effort should be made to ensure that female staff are available to attend to the personal needs of female patients.

- All clinical assessment tools will be sensitive in relation to ethnicity, culture and gender and will examine, address and plan care specific to these issues.

- Every effort should be made to ensure that male staff are available to attend to the personal needs of male patients.
- Adequate sanitary protection and disposal are always available.

- Female bedrooms should only be entered by female staff and male bedrooms should only be entered by male staff, unless in an emergency situation. e.g., fire, self-harm, harm to others.

- It is a feature of some mental health problems that patients can become disinhibited at times. Staff should make every effort to protect these patients and ensure that all patients are dressed in a manner that will not leave them open to ridicule, suggestive comments or abuse from other patients. Common sense should prevail.

- Male and female named nurses should be available, depending on individual patients' preferences.

- It is recognized that at times patients may feel at risk from patients of the opposite gender and also at times from staff. This issue should always be clearly documented where expressed and addressed in individual risk management plans.

- To promote feelings of safety and security for patients, unit staff will be available and visible to patients within the unit, e.g., day areas, corridors, dining areas etc.

- All patients will receive an information pack which will inform them of the resources available.

15.1 Guidelines for Visiting

VISITING TIMES

MONDAY – FRIDAY   **4pm to 8.30pm – or by prior arrangement**
WEEKENDS AND BANK HOLIDAYS   **2pm to 8.30pm – or by prior arrangement**

All visitors will place bags and items in the visitors lockers provided within the air lock before entering either the visitors room or the main PICU any restricted item will be confiscated at this point. In the case of illegal substances and weapons the police will be informed and requested to attend.

Introduction
***Unit operates flexible visiting, but we consider it helpful to organize visiting along the lines of 'a working day', so as not to interfere with patients' 'therapeutic programmes'.

All visitors, including other mental health professionals must ring the bell and sign the visitor's book. Best practice would be demonstrated by health care professionals pre-booking appointments to see either staff or patients so as not to interrupt with patient's therapeutic programmes.

The number of visitors, who are allowed to visit a patient at any one time is at the discretion of the shift co-coordinator, and is dependent on the individual patient and the psychological atmosphere on the unit at that time. However under normal circumstances no more than two visitors per patient will be permitted.

All patients are entitled to maintain contact with and be visited by whom so ever they wish, apart from in exceptional circumstances to be decided by the Unit Team after careful discussion. Every effort will be made by the Unit Staff to assist, to make contact with relatives, friends and supporters where appropriate. This is in line with the Code of Practice to the Mental Health Act, 1983.

The shift co-coordinator will induct a patient's nearest relative or carer, to the unit and make them aware of relevant policies and procedures, (for example, visiting times, where visits are to be held, signing in procedures, and items which are not permissible on the unit.

15.2 Exclusion of visitors

Legislation relevant to the visiting of patients in hospital includes the Occupiers Liability Act 1957. The nurse in charge of the unit is the representative of the Trust, which occupies hospital premises in terms of the Occupiers Liability Act. Two principle grounds, which may justify exclusion, are;

a. Restriction on clinical grounds

b. Restriction on security grounds

The decision should be taken within the MDT forum and the grounds for the decision clearly documented and explained to the patient and to the person concerned. A particular visitor may exhibit behaviour or propensities to disruption or subversion to a degree that exclusion become necessary as a last resort, e.g. incitement to abscond, smuggling of illicit drugs/alcohol/weapons, an unacceptable degree of aggression or unauthorized media access. A decision to exclude a visitor on any of these grounds will be clearly documented and explained to the patient and, where appropriate to the person concerned. Staff should inform Service Manager (in hours) and on call Manager (out of hours) and complete an incident form.

Within all acute in-patient services the refocusing model of care is applied. One of the principal objectives is to improve quality of patient care. One of the key themes is protected engagement time (PET) where there is a period of time each day when the unit is closed to visitors. This is to allow the staff to engage with individuals in a calmer more managed environment.

- Patients' wishes will be respected if they refuse visitors or request visitors to leave.

- No visits shall take place during meal times unless by prior arrangement.

- Visiting may be possible outside these times in special circumstances, but only by prior arrangement with the unit staff.

- Visiting may take place only in the area designated for visiting and at the discretion of the shift team.

- Visitors will not be permitted to wander unescorted around the unit.

- All visitors are required to observe the Unit smoking policy and to use designated

smoking areas.

- Professional visitors who are not known to the unit will be required to provide identification.

- All visitors (including official visitors, such as Solicitors, Social Workers, etc.) where appropriate will be met by the Unit shift co-coordinator and required to sign in and out of the unit in the visitors' book which is kept within the air lock. Visitors who refuse to give required information will not be allowed to enter the unit.

- The patient or nearest relative will be asked to provide a list of approved visitors, (including addresses), prior to these individuals visiting.

- Notices outlining restricted items will be placed in prominent positions throughout the unit.

- All property brought in by visitors (including money) will not be given directly to patients. All items will be given to Shift manger for safe keeping and a receipt issued. Visitors' bags will not be searched unless there are grounds to suspect they may be deliberately bringing non-permitted articles into the Unit i.e. previous attempts, suspicious behavior, general intelligence and information and statements by other patients or visitors.

- If a decision is taken to request a search of a visitor's bag, the individual will be given the reason for this. A Search Form will be completed and signed as per the Search Policy prior to any search being carried out. If a visitor refuses permission for a bag to be searched, then the bag will not be allowed onto the unit. The shift co-coordinator will then inform the unit manager (in hours) and on call manager (out of hours) immediately. The Service Manager will be informed, as soon as practicable by the shift co-coordinator.

15.3 Guidelines for children visiting PICU

Ref: Worcester Mental Health Partnership NHS Trust – The visiting of Psychiatric In-Patients by Children (Ref Safeguarding Children)

Children visiting the unit will be on a pre-planned basis only.

All ward staff likely to come into contact with the person under 18 have been subject to a Criminal Records Bureau (CRB) check.

All PICU staff will have access on the ward to copies of:

- The Mental Health Act Code of Practice

- Mental Health Act Commission Guidance Notes on issues relating to children and adolescents detained on adult wards

- Relevant child protection guidance including local Area Child Protection Committee/Local Safeguarding Children Board procedures

Staff of the appropriate gender are available at all times to provide close observations of the person under 18 years.

The PICU is committed to facilitating visits by children where possible; however the welfare of the child will be paramount and visits should only take place if the child is not put at risk. In a small minority of cases there will be some concern about a visit going ahead the following should be considered:

- The child's welfare should be safeguarded and regarded as paramount by all staff.
- Members of staff will facilitate and monitor the child's visit whenever contact is believed to be in the best interest of the child.

The application of this policy will be an integrated **part of the patient's ongoing risk assessment** and will therefore be amended regularly.

The nurse in charge of the ward has responsibility to ensure that the PICU visiting room offers a safe environment – any staff member who is concerned about risk has the responsibility to report this to their manager.
The PICU manager should have the right to cancel visits subject to the status of
the ward at the time (e.g. levels of self-harm/violence from other patients and staffing levels). The reasons for the cancellation should be explained to the visitor and the patient, and noted in the records.

Where it becomes apparent, during the course of the patient's treatment, that the person concerned may pose a risk to the child, then this should be disclosed to the multi-disciplinary team including the child protection co-coordinator. Staff also have the responsibility if concerns are raised about someone other than the patient harming the child.

15.4 General Policy

On admission, staff should ensure the information provided to patients and their families regarding children visiting, complies with this policy. Children under 14 years must always be accompanied by an adult.

Visits shall, where possible, take place in a visiting room, which will be in an area away from the general ward environment. The accompanying adult will be responsible for the welfare of the child during the visit.

15.5 Supervised Visits

A supervised visit is a visit when a member of staff is in attendance at all times to supervise the service user. This visit will occur when there are identified risks for the child. The visit will take place in the visiting room. The patient's nearest relative/friend should be advised that this will be a supervised visit as soon as practicable, and prior to the visit. The visit will be time limited and can be cancelled at any time by the nurse in charge if the supervision cannot be provided.

Decisions not to allow visiting will always be based on the child's best interests. It will depend on the adult's mental state, the child's wishes/ needs and/or other factors including the general level of anxiety/ disturbance that could question the safety of the child.

A refusal to allow a visit will be explained to the patient and the adult responsible for the child by the nurse in charge and the decision recorded in the patient's notes together with the reasons for the decision being made. In these circumstances, other forms of contact such as telephone or letter could be considered.

Decisions not to allow visits need to be continually reassessed. If requested, the patient or the relative should be afforded the opportunity to meet with the Responsible Medical Officer to discuss any issues that may arise from a clinical decision not to allow visits by children.

15.6 Guidelines for Visiting Workmen

For reasons of safety and security the following procedures have been agreed for visiting workmen wishing to enter the unit to carry out routine or other works. All visiting workmen will ensure that they do not compromise the unit security procedures thus ensuring that all work is carried out within the safe system of practice, promoting safety and security within the unit.

Procedure

Wherever possible, visiting workmen are asked to telephone the unit prior to their visit, informing the Shift Co-coordinator of their intention to attend the unit.

When at the entrance of the unit, the door bell will be used to communicate arrival. The workmen will state their name and intention of visit. The shift co-coordinator will receive visiting workmen into the airlock system and they will then sign the visitor's book.
Discussion will take place on.

- The work to be carried out

- The length of time the work is expected to take

- The tools required to carry out the work.

- The shift co-coordinator will assess the number of tools that can safely enter the unit at one time. These tools will be listed, signed in and out of the unit.

- Visiting workmen will then be advised of this and will make arrangements for non-essential tools to be returned to vehicles or be left within the unit reception, if this is appropriate.

- The shift co-coordinator will inform visiting workmen of the procedures relating to fire and emergency alarms.

- All workmen will sign the visitor's book and be issued with an alarm.

- During times when there is concern regarding the unit environment, the shift co-coordinator will assess whether the workmen require an escort whilst working within the unit or any other safety measures.

- Visiting workmen will inform unit staff if their work requires them to carry out work in more than one area of the unit. They must not wander around the unit without informing

staff of their whereabouts.

- If workmen are carrying out work unescorted, the unit staff will ensure general observation of the area.

- All tools must remain with the workmen. At no time will tools/equipment be left unattended. This will be considered a serious breach of security and can affect the safety of patients and staff within the unit.

- When difficult or delicate situations are being managed within the unit, non-essential, routine work may need to be re-scheduled.

- When work is completed the area must be checked to ensure tools and equipment are not in evidence.

- Any issues relating from workmen visiting will be raised initially with the shift coordinators and the unit manager. The service manager will be informed of any unresolved issues as soon as is practicable.

16. Staff Development and Training

16.1 Introduction

By their very nature Psychiatric intensive Care Units can be turbulent, constantly changing and stressful environments to work in. Therefore, a systematic approach to staff support is imperative. These structures should offer support and an opportunity to explore practice issues within both formal and informal forums. All staff should have access to a forum in which they feel 'safe' expressing their views.

Staff within PICU have access to the following formal and informal forums, which promote best practice and support staff in their work.

16.2 Unit Staff Meetings

These are held on a regular monthly basis and all available staff are expected to attend. This is the forum where changes can be discussed and agreed. Where information from the Trust is cascaded and discussed and where staff can issues relating to concerns they may have about any aspect of patient care or the unit functioning.

16.3 Induction, Preceptorship and Mentorship Programme

All new staff will undergo the Unit Induction Training Pack. This process will assist new staff in settling in to the intensive care environment and enhance their understanding of the unit, service and the Trust.

All students seeking placement on the unit will have a mentor identified prior to commencement of their placement. It is expected that students arrange a meeting with their identified mentor prior to commencing their placement and discuss the Unit's operation and philosophy. This is also a useful time to address any existing anxieties the students may be experiencing and agree shits etc.

16.4 Line Management Supervision

All staff will engage in LMS on a monthly basis. The LMS tree will be displayed in the staff base of the unit informing the lines of supervision. The areas identified within LMS for professional development will be included in the individuals Staff Development Review. The Line Management Supervision process is a win tracker within the refocusing models and results will be published each month indicating % targets.

16.5 Clinical Supervision

All staff have access to clinical supervision. The clinical supervision relationship is more about continuous profession support with practice issues. Each member of staff meets each month with an identified clinical supervisor. There is a record kept of the issues discussed of which the supervisee keeps as a record for their professional development as evidence of progressing practice. (Ref Clinical Supervision Policy).

16.6 Shift Handovers

All staff on duty from all disciplines should attend this formal meeting wherever possible. Although this forum usual addresses issues of the day, it inevitably allows staff to reflect on recent incidents and the strategies employed to deal with them. Informal staff support may be gained.

16.7 Staff Development Reviews

All team members have regular appraisals in the form of a Staff Development Review. This process is part self-appraisal and focuses on setting personal development objectives and identifying training and strategies to meet the identified training needs.

16.8 Staffing Establishment, Skill Mix and Grade Mix

The Unit operates on agreed minimum staffing levels on each shift, an agreed ratio of qualified/unqualified staff and an understanding that skill mix is considered when rotas are compiled.

16.9 Education Forums

Each month a visiting speaker will give a short presentation of their service or a subject which is of professional interest to the PICU Staff and impacts on clinical practice. Other events in the education forum are Journal discussions and critiquing research articles

16.10 Service Meeting

A service meeting is held once a month in addition to the PICU staff meetings. This is a forum where senior staff from the service attend and information from the Leadership meeting and other forums is disseminated and cascaded.

16.11 Staff Training Needs

PICU staff are required to have a core set of competencies which are identified within the Unit training matrix. There is a staff development pathway which is applicable to PICU for both qualified and unqualified staff. All training should be identified within individuals SDR's, service plan and head of service plan.

17. Clinical Supervision Guidelines

17.1 Introduction

In line with the Trusts Clinical Supervision Policy and continuing development of good clinical practice, a system of clinical supervision has been established in the PICU.

This guideline does not concern itself with providing a rationale for clinical supervision to occur, this is widely agreed upon. This guideline is concerned with how clinical supervision will take place, how it is structured and what is its process, including procedures for recording, monitoring and audit.

17.2 Process of Supervision

Clinical supervision sessions will be held in private areas free from extraneous distraction.

Sessions will be confidential unless there is a clear concern regarding a possible breech of professional conduct and/or issues which may be detrimental to patient care.

Any continuing concerns regarding standards of clinical practice must be reported to the relevant manager with the FULL KNOWLEDGE OF THE SUPERVISEE.

The supervision process is dynamic and concerns regarding standards of practice may require ad hoc sessions to be arranged, in between existing agreed ones.

Clinical staff may from time to time require specialist supervision, for specific areas of practice e.g., Forensic, DBT etc., where particular skills/knowledge lie outside the remit of the usual supervisor. In such cases it is quite appropriate to seek specialist supervision.

17.3 Record Keeping and Audit.

Both supervisor and supervisee must keep a brief record of the overall content of each meeting, including date, time and duration and a short synopsis of any agreed actions. This must be signed by both parties. Personal details should NOT be included

These records must be kept in a secure environment and may be required by the manager.

Any concerns must be reported to the manager and a note to this effect recorded in the supervision files.

A date and time for the next supervision session must be agreed and recorded.

Records of attendance at any educational courses directly related to supervision must be made available to the manager.

Any difficulties arising in the relationship between supervisor and supervisee should be discussed within meetings and recorded.

In the event of continuing difficulties in the supervisor/supervisee relationship either party must inform the appropriate manager for guidance in order to resolve the problem where possible, with the full knowledge of the other party.

An audit of supervision sessions will be carried out six monthly, an audit tool will be devised for this purpose.

17.3 Standards for Clinical Supervision

There will be a formalised, agreed contracted regular system of clinical supervision in the PICU for all grades of staff including health care workers.

Time between each clinical supervision session will be no longer than eight weeks.

A minimum of forty five minutes or a maximum of one and a half hours will be allocated for supervision.

Clinical supervision will take place in a quiet room free from interruption; the time will be protected (except in emergencies).

A brief record of matters discussed during the session will be made and signed by both parties.

A record of action agreed will be kept and reviewed and evaluated at the next session.

This guideline will be subject to review in the light of new developments in clinical practice at periodic intervals and routinely every twelve months.

18. Guidelines in the event of PICU Service Suspension

In the event that the PICU service has no current in-patients the PICU shift co-coordinator will clarify with the acute wards that there are no patients suitable or in need of transfer. The shift co-coordinator on PICU will then contact the clinical co-coordinators at Newtown and shift coordinators at Kidderminster, Bromsgrove and Hillcrest and inform of the intention to temporarily suspended PICU services.

During the time the service is suspended staff will be re-deployed across the acute in-patients service or into other arrangements with the agreement of their manager. A minimum of three PICU staff must be available across the unit in order to facilitate patient assessment and transfer as required. PICU staff will not be counted on the numbers on the acute ward areas as they will need to respond within one hour to assess referral requests.

It will be the responsibility of the PICU shift co-coordinator to redeploy staff to acute ward areas at the commencement of each span of duty. It will be the responsibility of the shift co-coordinator to keep the managers informed and updated on a shift basis of the situation.

19. Fire and Safety

The PICU will have a system of automatic detection. If there is a fire within the PICU
Fire alarms will sound continuously within the unit. This will activate the alarm which gives an intermittent tome to inform other wards and areas that there is a fire on the PICU.

When the fire alarm sounds staff will proceed with a horizontal evacuation within the unit which will lead to patients and staff being evacuated into the secure garden areas.

All external fire doors will fail open after four minutes with the exception of the air lock door which will be key controlled my a member of staff. The fire keys will be part of the access allocation that staff receive when the commence duty and every member of staff on duty will have a fire key attached to keys and personal alarm.

There will be no manual break glass points within the PICU and all call point systems will be key operated.

The security nurse will ensure that all staff on duty have the required keys, alarms and passes for that span of duty.

20. Relationship with s 136 MHA '83 Suite

Although the 136 suite is situated within the same building as PICU there is no direct relationship between the two units. The 136 Suite is staffed and managed by CR/HT staff. There are operational guidelines for the 136 Suite which signpost the functioning of the unit.
The PICU staff will respond to requests for assistance from the CR/HT when there is a situation which requires additional support but will not be used to staff the suite.

APPENDIX

Guidelines for Environmental Checklist

Introduction

"The physical environment of a PICU or Low Secure environment is one of its defining aspects." (NIMHE, 2004)

"Mental health service users, especially when acutely ill, are vulnerable to a number of potential risks. Often these risks are related to their own behaviour or to the behaviour of other patients (such as self-harm, aggression and violence, and sexually disinhibited behaviour), or are a direct result of their mental illness. Others relate to safety risks from their care or treatment. This makes mental health service users a particularly vulnerable group of patients within the NHS" (NHS National Patient Safety Agency, July 2006)

The above statements make clear Mental Health service users are a particularly vulnerable group within the NHS, as in society in general, and the physical environment in which we deliver care must facilitate and not hinder the safe and effective delivery of care.
The environmental checklist is a staff incentive to assist in the maintenance of a safe and therapeutic environment for both staff and patients. The aim of this checklist is not to replace good nursing practice, but to enhance the safety of the ward by utilising a formal and defensible procedure, based upon current best practice and research. By utilising this structure we can maintain a safe environment through;

- Regular assessment of the ward environment
- Record faults or errors in the ward environment
- Facilitate rectifying recorded faults
- Increase the safety of the ward environment for the benefit of patients and staff
- Creation of a presentable and easy to access format to create awareness of ongoing risk/s.

The other important factor in the implementation of this checklist is the formalisation of pre-existing good practise regarding environmental awareness, particularly with new or bank staff.

Aim

This is to provide a supportive and safe environment, for both staff and patients.

Objectives

1- Identify environmental risk.
2- Record the risks.
3- Rectify the risks, utilising pre-existing ward policies and procedures.

Section 1 – Communal Risks

Section 1 of this form deals with the general and shared areas of the Ward, and therefore immediately impact upon the whole ward community, rather than any particular individual or group.

Patients

Rationale: Patients accounted for.

Action: Ensure Patients accounted for.

Patient Allocation on Board

Rationale: Patient Allocation on Board.

Action: Ensure Patient allocation on Board, and adjust as necessary.

Put up 1-1 tracker

Rationale: Ensure 1-1 Tracker current.

Action: Daytime ensure 1-1 tracker present. Night shift to put up new 1-1 tracker on the display board.

Fire doors

Rationale: Reduce risk of absconsion and ensure that in the event of a fire that doorways are not blocked by furniture or damaged as to make them inoperable.

Action: Ensure fire doors are secure and undamaged. Ensure doors not impeded/obstructed.

Fire extinguishers

Rationale: To reduce the risk of fire equipment being utilised for inappropriate purposes and to ensure equipment is accessible and working in an emergency situation.

Action: Ensure Fire extinguishers are secure and present, and the appropriate type. Also be aware that last checked date appropriate. If not then inform senior member of staff and arrange for testing.

Cutlery / Crockery

Rationale: To ensure that the risk of self harm or harm to another is reduced if stored by patients, and that harm from damaged crockery can be reduced.

Action: Ensure Cutlery and Crockery is accounted for. Also ensure that it is undamaged and safe for use.

Windows

Rationale: To help reduce the potential for absconsion. However this is equally important to ensure the comfort of patients within a secure environment.

Action: Ensure windows are working, that locks are safe, and blinds are undamaged.

Remote Controls

Rationale:
To avoid incidents of both harm to self and others. This is also important in ensuring the replacement o f components as required.

Action: Remote controls to be accounted for and checked for damage and/or missing batteries.

Toilets [Communal area]

Rationale:
To ensure Patient and staff safety.

Action: Toilets are to be checked for;
Damage
Poor maintenance/cleanliness
Risk factors [Wet floor/damaged items]
Secreted items – i.e. Drugs/weapons/items to self-harm

Shower room

Rationale:
To ensure Patient and staff safety.

Action: Shower room to be checked for;
Damage
Poor maintenance/cleanliness
Risk factors [Wet floor/damaged items]
Secreted items – i.e. Drugs/weapons/items to self-harm

Courtyard, Gates & Fence

Rationale:
To avoid the risk of absconsion, harm to patients from defective equipment, and harm to both staff and patients from deposited weapons, notes, drugs or other items deposited internally or externally by others.
To ensure Patient and staff safety.

Action: Ensure that courtyard is;
Clean
Free from hazards/equipment.

Ensure that the gate and fence are;
Undamaged
Secure and locks in place, and that
No items secreted or present externally or internally of
Gate and fence perimeter.

DVD's own and Patients

Rationale:
 'To reduce the risk of lost/damaged property, inter-patient conflict and potential incidents of self harm or harm to others.

Action: All DVD's are allocated to patients one per patient at any one given time. Any DVD on the unit must be returned when no further in use, and returned to staff keeping or individual lockers.

CD's own and Patients

Rationale:
To reduce the risk of lost/damaged property, inter-patient conflict and potential incidents of self harm or harm to others.

Action: All CD's are allocated to patients one per patient at any one given time. Any CD on the unit must be returned when no further in use, and returned to staff keeping or individual lockers.

Games

Rationale: To ensure that;
Patient distractions are reduced in line with providing a low stimulus environment.

To reduce the risk of conflict with patients who are unable to sleep.

To reduce the potential for items to be used for self harm or harm to others.

Action: Games inclusive of board, computer and card games are to be placed in the games cupboard prior to patients retiring to bed.

Check unused rooms secure

Rationale:
To ensure that;
Items cannot be deposited in rooms.
That on admission rooms is clean, safe and appropriate for a newly admitted patient.

Action: Unused rooms are to be locked and safe.

Beds are to be made and room clean.

Activities room Chairs   *Rationale:* Activities' room chairs are to check to ensure safe for use and items have not been removed for utilisation in self harm or external aggression.

Action: Chairs are to be checked for;
Damage
Missing components i.e. screws
That the appropriate numbers are present.
That restricted items have not been secreted by patients/staff/visitors.

Activities room Sofa   *Rationale:* Activities' room sofas are to checked to ensure safe for use and items have not been removed for utilisation in self harm or external aggression.

Action: Sofas are to be checked for;
Damage
Missing components i.e. cord or strips of material
That items have not be secreted by patients/staff/visitors
i.e. Check under cushions and physically reposition sofa/s.

Activities room Cabinet   *Rationale:* To ensure restricted items are secure.

Action: Activities room Cabinet must be locked and undamaged.
Ensure nothing is stored on top of the cabinet.

Fixtures and Fittings   *Rationale:* To ensure patient and staff safety from accidental harm and utilisation of items for potential use in internal or external aggression, fixtures and fittings are to be checked for safety and presence.
This is also important to ensure illicit substances, or objects are not secreted which may be used for aggression to self or others.

Action: Fixtures and Fittings checked, include the following examples;
Screws
Lights
Panels
Prints
Handles
Clocks
Plug sockets

Section 2 – Staff Equipment

Section two is concerned with safety and operation of staff tools. These are tools essential for the safe and effective management of potential incidents upon the Unit.

Keys and Alarms

Rationale: To maintain staff safety

Action: Ensure all staff is allocated keys and alarms whilst on duty. Staff must also ensure that any Professionals visiting the unit are allocated an alarm by the security nurse.
To ensure Access cards are working.

Used keys Accounted & Recorded

Rationale: To reduce the risk of keys being lost or misused and placing patients or the community at potential harm from absconsion, or the accessing of restricted areas by non-authorised persons.

Action: Used keys in must be accounted for and allocated using the allocation sheet.

Check Alarms are Working

Rationale: To ensure the safety of staff, and prompt response to incidents

Action: Alarms must be checked to be working utilising the alarm testing equipment in the Nursing Office at the commencement of each shift.
Any unusable Alarms need to have batteries replaced and retested.

Unused keys in locker

Rationale: To reduce the risk of keys being lost or misused and placing patients or the community at potential harm from absconsion, or the accessing of restricted areas by non-authorised persons.

Action: Security Nurse accepts keys and signs key in after use. Unused keys in must be placed in secure locker in the nursing Office.

Spare Key/Access Cards Allocation - NAMES

Rationale: To ensure appropriate allocation of Key/Alarm and Access Card allocation to Bank/Agency staff, and the return of same.

Action: Record name of staff member on sheet in allocated space.

Section 3 - Patient Rooms

To ensure individual bedrooms are safe for those patients using them, and for staff entering them in the execution of their duty of care.

All room checks should be as transparent as possible, with the permission of the patient. These are not room searches.

BEDROOMS CHECKS

Wardrobes
Rationale: To minimise the risk of accidental or deliberate internal or external harm.

Action: Wardrobes must;
Be checked for damage
Closed unless authorised to be open by NIC
Be free from potential ligature points

Windows
Rationale: To ensure both safety and comfort for the patient.

Action: Windows must be checked for;
Damage i.e. Pane, lock, and surrounding frame.
Ability to open to allow patient access to fresh air.

Toilets
Rationale: To ensure dignity, safety and hygiene of patient.

Action: Toilets must be checked for;
Damage
Operation
Restricted items and secreted sharps.
Cleanliness.

Restricted Items
Rationale: To ensure safety of both staff and patient from the use or misuse of restricted items.

Action: Restricted items in the bedroom must be removed, informing the patient of the item and reasons. If warranted, based upon risk assessment of ward manager or NIC, a room/personal search may also be required.

Fixtures and Fittings
Rationale: To ensure patient and staff safety from accidental harm and utilisation of items for potential for internal or external aggression fixtures and fittings are to

be checked for safety and presence.
This is also important to ensure illicit substances or objects are not secreted, which may be used for aggression to self or others.

Action: Fixtures and Fittings checked, include the following examples;
Screws
Lights
Panels
Prints
Handles
Clocks
Plug sockets

Place N/A in box if room not in use   *Action:* If room not currently in use place N/A in appropriate room box.

Section 4 - Handover

To ensure that checks are appropriate, both the Current and member of staff being handing crash keys must both be present on checks. This provides both duplication in observations, and ensures protection to the staff in regards witness of actions and reduced vulnerability in isolated areas.

Crash Current   Staff member handing over Security Nurse Keys

Crash Handover   Staff member accepting Security Nurse keys

Section 5 - The reporting of faults/potential risks

To ensure effective communication and resolution of actual or potential environmental risks, the following section is included.

The recording of faults/potential risks here does not exclude the utilisation of the appropriate reporting tools or procedures. However items recorded here can be used as the basis for those procedures, and are utilised in handing over potential risks to both current NIC and staff, and the proceeding shift. Therefore the staff can be aware of the present or potential risk

Bibliography

National Institute for Mental Health in England (2004), *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments.* DOH

NHS National Patient Safety Agency (July 2006), *the first report of the National Reporting and Learning System and the Patient Safety Observatory with safety in mind: mental health services and patient safety* DOH

Further Information

Worcestershire Mental Health Partnership NHS Trust Fire safety Policy
- Regarding staff responsibilities for maintaining a fire free environment.

Worcestershire Mental Health Partnership NHS Trust Psychiatric Intensive care Unit Operational Guidelines
- Regarding restricted items, search policy and incident reporting.

Worcestershire Mental Health Partnership NHS Trust. Security Policy December 2001
- Regarding General site security and Key/Pass issues.

Worcestershire Mental Health Partnership NHS Trust. Accident and Incident Reporting Policy
- Regarding Incident Reporting

Worcestershire Mental Health Partnership NHS Trust. Substance Misuse Policy
- Regarding Disposal of Illicit Substances, and relevant protocol.