Length of stay on the Psychiatric Decision Unit (PDU): An Analysis

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Introduction

The PDU was developed to offer an alternative pathway for patients in a mental health crisis presenting to A&E departments in Birmingham, and assessed by the RAID team or being initially seen by street triage in the community.

These patients have been identified as needing further assessment in order to develop an appropriate management plan and this takes place on the PDU.

The urgent care directorate has decided on the maximum length of stay at the PDU as 12 hours and there is a set escalation policy for patients who stay longer.

The aim of this study is to:

1)To examine pathways through the PDU of patients who breach the 12 hours maximum stay, in order to identify the factors that lead to prolonged stay on the PDU.

2)To examine the outcomes of the patients who stayed on the PDU for longer than 12 hours.

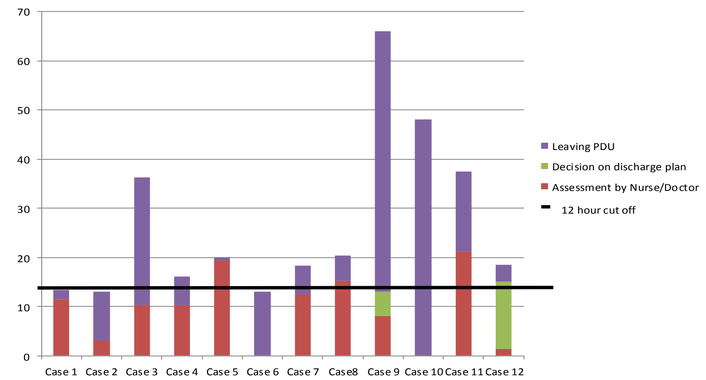
Method

This retrospective observational study examines 12 patients identified using the RiO database. These patients attended an A&E department in Birmingham and were assessed by RAID or were referred to the unit via street triage between 9th and 14th September 2016.

Following identification of the 12 patients (7 male, 5 female; age range 18-64 years), we obtained their RiO records and found information regarding their demographics and timeline of getting to the PDU, being assessed, a decision made about their discharge and being discharged from the unit.

Results

Figure 1: Patient Pathway through PDU: Number of hours taken to conduct an assessment, decide on discharge plan and leave PDU



Key Findings:

- There are two main factors that prolong patients' stay on the PDU: conducting a timely assessment and the time taken for the patients to leave PDU (see figure 1).
- 92% of the patients arrived on the PDU out of hours (5pm—8am) which results in them having to wait until the morning to be seen by a doctor for an assessment.
- Delays with transport to PDU often resulted in patients arriving on the PDU out of hours, which prolonged the assessment process.
- Assessments were also delayed due to patients being too tired or intoxicated to engage in an assessment.
- In addition there was no clear guidance on who conducts the assessments on the unit.
- Some patients required a further assessment by other health professionals which prolonged this stage further.
- For the majority of the patients there was little therapeutic input whilst on PDU.
- Delays in leaving PDU were due to the time taken to receive confirmation from respite and also if they had to wait for a psychiatric inpatient bed.
- The majority of patients (90%) went home or into respite care with access to either the home treatment team or a CMHT. Only 10% were admitted to a psychiatric hospital (see figure 2).

Figure 2: Outcome of patients leaving PDU

Patient Outcomes	Number of Patients
Admission to a psychiatric hospital	3
Respite care with home treatment team	2
Home with access to home treatment team	3
Home and back to CMHT	3
Not assessed	1

Discussion

The time taken to conduct an assessment was identified as the main factor for breaches of the 12 hours maximum stay on the PDU. The findings point to issues behind the assessment process such as waiting for a medical assessment carried out by senior psychiatrists who are only available at set times. This highlights a need for an overall review into the assessment process, the clinician conducting it and the timing. There is also a need of reviewing the referral criteria of patients who need further assessment. A review of patient transport to PDU is also required as the results show that this is another factor holding up the assessment process. The findings also point towards a review into referral pathways from the PDU to respite care, the home treatment team and the community mental health team. The conveyance of patients to the PDU has been delaying transfers to the unit which meant that the time to being assessed was prolonged.

Recommendations

- Review referral process and inclusion/exclusion criteria
- Review processes of when the patient is on PDU
- Review role of nurse in charge and consultant psychiatrist
- Review pathways for on-going referrals: HTT, respite
- Review transportation