JISC UPDATE April - May 2016

Waiting for psychiatric beds – what do we do?

A colleague in Avon and Wiltshire is trying to establish what colleagues do about detaining patients when there is a universal psychiatric bed crisis.

We have, on average 5+ MHA assessments a week, and patients can wait up to several days for a psych bed. Our AMHPs (approved mental health professionals) have generally been reluctant to put in the application – not knowing where the bed will be located - so the patients have been lying in beds, with the medical recommendations floating around their notes, but legally remaining informal.

In the case of them trying to leave, we have been told to apply a section 5(2), which seem a bit of nonsense as this is a holding power to trigger a MHA, which they have already undergone!

I believe that these patients need to be detained to the acute trust in the first instance, but the acute trust is resisting this saying it 'exposes them to risk'. The process of finding a bed takes the same time whether or not the patient is detained to the acute trust or not, but in my view it offers a safer and more legal framework through which to start treating the patient, and safeguards the patient's rights.

What do others do? I am particularly interested in those where patients in are observation wards/CDUs/annexes off ED where the exact status (inpatient or not) is particularly unclear.

Responses

1. Kent responds: We work by detaining patients to the acute Trusts pending a bed - this safeguards the patients, allows the protection of the MHA and also actually speeds up the process. If the patient is not detained to the Acute Trust then the AMHP would need to return to complete the assessment when a bed is identified and it may not be the same AMHP and so the assessment needs to be redone; all very time consuming and cumbersome.

The Acute Trusts have however been a little resistant to this - and you may want to check if your Acute Trust is registered with the CQC as having MHA as a regulated activity. If the Acute Trust wants their doctors to be able to use Section 5(2) then they need to be registered and as such need to have an affiliated governance process for it - this then means that detaining a patient to the Acute would not place them at any risk at all. We had to do a large education piece around this - especially to make sure that papers were processed correctly, and then transferred correctly when a bed is identified. There is an SLA between our MH Trust MH Administrators and the Acute Trusts which helps. In relation to your question about observation wards or CDUs or annexes off ED where the exact status (inpatient or not) is particularly unclear - the differentiating question I use is "is this patient still subject to the A&E access standard?" (4hrs). If not and they are still in an Acute Trust bed/area, then in my book they are inpatients.

Wiltshire replies: 'That is really helpful and pretty much answers all my points. I think the anxiety for the trust is coming from a (in my view misplaced) fear that if they are detained to the acute trust, the urgency for finding a mental health bed is somehow lessened. The reality is that the MH trust bed finding process doesn't generally differentiate between 'actually sectioned' or 'section pending''

2. Salisbury: In my experience it's easier to transfer a patient who is detained - since the question 'can't you take them off section' is usually simpler than 'couldn't they just go home with crisis team follow up' when beds are short.

The registration for the MHA can cause anxiety but essentially the site managers need to know how to accept section papers etc. and there needs to be an agreement with the mental health trust about RC roles.

Pointing out that *no-one can be legally detained* under a section 5(2) unless the Trust is registered has focussed minds in my experience. It is worth pointing out if risk to the Trust is the concern.

As for the where is an admission - in Southampton and Salisbury we sought the acute trust's legal advice - gave differing answers but seemed to come down to whether there was admission paperwork and a nurse always in the area. The idea of if out of the 4 hour target also sounds sensible.

Alternatives to acute psychiatric admission

A North Wales as a manager for Psychiatric Liaison Services was tasked to look at alternatives to admission. An *alternative to an acute psychiatric admission* is an admission/stay in a mental health crisis house but very few

of these exist? Does anyone know if any exist in Scotland as this is the area I have been asked to look at to compare services (colleagues are looking at England and Wales) and if so could you provide details of these and any models in use.

One response: There is a respite flat in Renfrewshire which can be used for this purpose.

Acute and mental health trusts information systems

From London – does anyone know of any liaison psychiatry services where progress has been made in getting mental health trust IT systems to speak to acute trust IT systems, to share clinical records?

Responses:

1. In Cambridge, MHTrust uses RiO (not the latest) and Acute Trust uses Epic as their electronic patient records (EPR). We feel strongly that our notes need to be part of the acute trust's notes. So we fought a hard battle to use templates on epic which serve to also be point of care data entry e.g. Type of contact, time we start and end (not just face-to-face) etc. While epic and Rio have capability to speak to other EPRs, there isn't the budget to put in place. So we "route" our epic notes to our admin NHS.net (epic uses NHS.net) and they upload the pdf to Rio.

Sounds rather clumsy but it has meant that:

a) We now have all our notes available in Rio for MH colleagues
b) We can capture data at the point of care - although we are still working on getting a dedicated network to allow us to actually use the coding we have developed to run reports from the database that we are producing

Our main lessons:
- All or most EPRs have the capability to speak to each other but it is hard to get anyone to pay for it
- Process change/mapping is vital at implementation
- Access to the data is only step one; suitable hardware to deal with such a huge database from extracting info directly from the acute trust system is another cost that no one wants to pay for
- We can access both systems from both trust's computers

2. In Ayrshire, mental health services used an electronic record system called FACE. We could access it from any computer in the general hospital. We set up a liaison template into which we would type in the psych assessment & do a summary & management plan part. It was possible for this to be printed out, put in the medical records & sent to the GP with any additional correspondence later. It had its faults, was clunky at times & people still made some notes by hand whilst seeing the patient. I also found that if it was particularly busy it was logistically easier to write in the medical notes. However it did cut down on some of the duplication. I preferred it to Glasgow's system of 2 separate paper record systems. One tip, we found that the printed sheets needed to be stuck onto a continuation sheet in the medical case notes. If not they tended to get lost or misfiled. Printing them on coloured paper also helped.

3. Last year's JISC for the RCPsych liaison site had discussed this issue:

A 'workable technical solution':

1. MH trust laptop connects to acute Trust guest wifi network (this needed permission from acute ICT)

2. They use a virtual private network to access the electronic record system (an existing function but needs new accounts & training for all staff)

3. Staff take notes directly onto the laptop while interviewing patients (Never mind the tech, this is the most challenging part and requires a lot of training in touch-typing, interview skills, and overcoming technophobia and assumptions about the clinical interview)

4. Each ward has two printers. We have installed all the printer drivers (this needed MH ICT to give us admin rights on the laptops or get an engineer spending a day on this)

5. We then select the nearest printer, print the notes wirelessly and file in the written clinical record (even this presents a challenge: if we file loose sheets they are ignored and refilled with correspondence; we need to cut them to size and paste/tape them onto history sheets!)

Jackie Gordon

Worthing