Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
AVONDALE CLINICAL DECISIONS UNIT

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*03.08.2022*	*New SOP. Approved at MH Practice Network (03.08.2022).*
1.1	*03.08.2023*	*Reviewed with minor amends. Approved at MH Practice Network (Clinical Network) on 3 August 2023.*
1.2	*21.11.2023*	*Minor amends made to paragraph relating to interpreters, as part of an SI action. Approved by Director sign-off (Kayleigh Brown (Divisional Clinical Lead) – 21/11/23). Date of next review kept the same.*

Contents

1. INTRODUCTION

This document provides operational guidance for people working in Humber Teaching NHS Foundation Trust's Adult Mental Health Inpatient Service, especially Avondale Clinical Decisions unit. This service sits within the Mental Health Division – Unplanned Care. This Standard Operational Procedure aims to support improvement within the service ensuring safe, evidence-based care and treatment, providing a simpler and more efficient pathway into and through the inpatient service. This document will ensure that all staff are aware of the processes and pathways within Avondale and the service.

Avondale CDU focus on providing care and treatment for people who are experiencing moderate to severe mental health problems such as, Schizophrenia, Bipolar Disorder, Personality Disorder, Severe Depression, and Severe Anxiety that may require hospital admission. Some Individuals may not have had contact with services and require admission to hospital to assess their mental health and possible diagnosis. The care the service offers is collaboratively planned and tailored to meet individual needs. The principles of choice, recovery and personalisation are always promoted. Care is reviewed and evaluated on a regular basis. All interventions are focussed on enabling service users to achieve their optimum level of recovery and independence. The service adopts the principles of 'least restrictive' care.

Access to the beds is managed by the Mental Health Crisis Intervention Team (MHCIT) who have responsibility for gatekeeping all Assessment and Treatment unit beds. This document will provide an outline of the pathway through the inpatient service from the point of admission to transfer of care. The nature of the services is such that it is not possible to cover all eventualities within this policy. The units will need to consider the principles of this policy and other trust policy and guidelines when making decisions to best meet the needs of the individual service users.

2. SCOPE

This procedure applies to all staff, students, agency staff and external professionals who are employed to work on Avondale or with Avondale Clinical Decisions Unit. This procedure should be used in conjunction with the trust policies and procedures relevant to the environment or individuals working within the environment.

3. DUTIES AND RESPONSIBILITIES

The Chief Executive retains overall responsibility for ensuring effective implementation of all policies and procedures. The Trust Board – will ensure that this standard operating procedure is acted on through delegation of implementation to General Managers/Service Managers/Modern Matrons/Lead Professionals.

Service Managers, Modern Matrons and appropriate professional leads will ensure dissemination and implementation of the policy within the sphere of their responsibility. They should also ensure staff are supported the pathway through the inpatient service from the point of admission to discharge.

Charge Nurses/team leads will disseminate and implement the agreed SOP. The Charge Nurse/Team Leader will ensure mechanisms and systems are in place to provide the pathway through the inpatient service from the point of admission to discharge.

All staff both clinical and non-clinical employed by the Trust will familiarise themselves and follow the agreed SOP and associated guidance and competency documents. They will use approved documentation and complete relevant paperwork as per policy and Standard Operating

Procedures as relevant to each clinical activity. They will make their line managers aware of barriers to implementation and completion

4. SERVICE AIMS AND OBJECTIVES

AIMS

- We provide excellent quality and effective care based on evidence-based practice that promotes recovery, inclusion and choice.
- We promote and support the provision of care based on the least restrictive option.
- We involve service users and their carer's/significant others in planning their care and in improving our services.
- We provide efficient services supporting a culture of learning and innovation.
- We value and develop our workforce.
- We provide a multidisciplinary approach, working with all stakeholders to ensure integrated working along the care pathway.

OBJECTIVES

- To provide 24/7 access to inpatient care
- To provide evidence-based bio psychosocial assessments and interventions.
- To work collaboratively with service users and their carer's.
- To provide clear service user/carer information that promotes choice.
- To ensure that discharge planning begins at the point of admission to ensure that discharge from hospital is facilitated at the earliest opportunity
- To ensure referrals to other services or agencies are completed in a timely manner to ensure there is no delay in discharge
- To establish risk and if required share information with other relevant agencies such as safeguarding concerns.
- To provide a safe and supportive environment which facilitates recovery, choice and inclusion.
- To provide a robust transfer pathway between inpatient units based on the needs of the patient.
- To ensure that Mental Health Act Legislation is adhered to
- To ensure appropriate access to advocacy services
- To facilitate leave from the unit
- To complete timely reviews in line with the Care Programme Approach (CPA)/Clinical Review process
- To work effectively with other Trust and non-Trust services.
- To monitor delivery of service impact through an agreed set of Key Performance Indicators and Quality measures.
- To adhere to Trust policies and guidelines
- To audit compliance and create action plans for areas of improvement
- To obtain feedback from service users and carers and implement improvements where possible

The purpose of Inpatient care is to provide treatment when a person's cannot be provided with appropriate safe treatment in the community. and where the situation is so severe that specialist care is required in a safe and therapeutic space. Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible.

If the assessment and or gatekeeping completed by the MHCIT identify the need for admission, the MHCIT staff will liaise with the identified inpatient unit, to provide information on the Service User's

current presentation and risks. This should be in liaison with the bed manager Assessment documentation which includes a risk assessment and initial plan of care are the minimum information that needs to be provided to the admitting unit

5. STAFFING STRUCTURE

5.1 Safer staffing numbers

Early 5 (2 RMN, 3 HCA)
Late 5 (2 RMN, 3 HCA)
Night 5 (2 RMN, 3 HCA)

5.2 Roles Of Multi-Disciplinary Team

Consultant Psychiatrist– Responsible clinician for all patients at Avondale and is involved in daily reviews, care provision and risk management. The consultant Psychiatrist is an integral part of the clinical review and care programme approach meetings which establish plan of care and recovery support

Medical team –support the psychiatrist with daily reviews, provide physical health care and management, they also provide mental health assessment and risk management. As part of the discharge process, the medical team will also provide patients and their general practitioners an immediate discharge letter, summarising their hospital stay.

Specialist Clinical Pharmacist: The clinical pharmacist provides advice on medicines optimisation, individualising treatments for best outcomes for service users, and supporting other clinicians with treatment recommendations taking into account any other co-morbidities, contraindications and drug interactions. Specialist clinical pharmacists are the point of contact for nursing and clinical staff regarding specialist medicines management issues and will audit and monitor drug usage to promote cost-effective prescribing**.**

Social Worker – Social Workers place a strong focus on prevention and early intervention using a strength-based approach that considers all aspects of a person's life using the principles of the Care Act and supporting people's choice, control and human rights. Social workers are experts in the application of relevant legislation and have statutory responsibilities in relation to the Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014 and Human Rights Act 1998 and safeguarding.

Social Workers are integral to multi-disciplinary teams and provide a range of interventions to support people to achieve sustainable recovery, through effective discharge pathways, where they have independence and their discharge from services is long term.

Nursing team – Nursing team consists of registered mental health nurses and healthcare assistants who provide assessment, collaborative care planning, interventions to support recovery including medication management and are integral to the day to day operational structure of the unit. The nursing team provide 24 hour intervention, observation and risk assessments which contribute to the overall assessment of our patients.

Clinical psychologist – The Psychologist for Avondale is split between the two groups (in-patients and staff). The psychologist on the Avondale unit conducts assessments for patients, where the outcome is then discussed in the patients review. This often helps inform in-patient care plans for their stay and ongoing treatment and/or discharge. They may need to undertake a formulation on a persons history and current requirements. Clinical psychologist also hosts recovery groups for patients, reflective practice for staff and post incident psychological debriefs and staff support.

RENEW dual diagnosis support – Dedicated dual diagnosis specialist provide support to patients following screening of substance use and attend daily review meetings on Avondale so assessment and follow up care can be planned prior to discharge.

Pharmacy Technician – Avondale have their own dedicated pharmacy technician who provide medication management support across the service, ensures medicine reconciliation is correct and reduces room for medication errors.

Home Based Treatment – attend clinical review and care programme approach meetings and facilitate follow up care where required post transfer of care from hospital. Home based Treatment team are involved in the Gatekeeping process which aids with the plan of admission and what Avondale's aim will be of treatment whilst an inpatient, their process also seeks the opinion of patient, family and carer and their goals for admission.

Activity Co-ordinators – provide holistic therapeutic activity as a distraction and also a coping mechanism that patients can use on the ward and build up techniques that are transferrable to their lives in the community. The provision of meaningful activity, also provides holistic observation which forms part of patient assessment. The activity coordinators on Avondale are supported by Occupational Therapist who work across the Mental Health Crisis Intervention Team pathway.

Occupational therapist – offer individual needs assessment on the unit and also within persons own home. They can assess a person and make adaptations and put things in place to increase their function of daily tasks and comfort level. This can also be highlighted and organised for home assessment so these adaptations can be mirrored in their usual setting.

Housekeepers – provide a clean environment for patients and staff, abiding by infection control guidelines and they support the preparation and provision of meals on the unit.

5.3 Leadership Team

The leadership team on Avondale Clinical Decisions unit is essential in providing both clinical leadership and managerial support across the team. High standards of care are associated with good clinical leadership structures, which support safe and effective practice to in-patient areas. This structure includes:

- Band 8 Modern Matron
- Band 8 Service/Operational Manager
- Consultant Psychiatrist
- Band 7 Team Leader
- Band 7 Clinical lead
- Band 7 Clinical Psychologist
- 6 x Band 6 Specialist Nurses

Avondale CDU functions as part of a wider team within the Mental Health Crisis Intervention Team who provide triage, assessment and gate-keeping and transfer of care into in-patient services. Avondale work collaboratively with the MHCIT which includes the Home-Based Treatment team who provides increased support for people as an alternative to admission or following assessment at Avondale as a least restrictive option to in-patient stay as a means to promote recovery in the community.

When a person's care is transferred to Avondale continuous mental health assessment, health screening, therapeutic interventions, recovery focused care planning and MDT working will establish patient and carer needs and establish a route for their individual circumstances.

The leadership team that overarches the MHCIT, HBT and Avondale provide collaborative clinical support across the service pathway and host regular senior leadership forums to discuss developments and processes required across the service.

6. PROCEDURE

As a developing unit, Avondale has a long-term developmental plan which aims to drive the service and team in the direction of clinical excellence, providing a service which reflects the needs of patients, their Carers and families within the Hull and East Riding locality. The development is supported by wider professionals and research strategies, ensuring best practice is identified and incorporated into service delivery changes and the shared vision of the team.

Avondale clinical decision unit collaborative working arrangements within the Unplanned care pathway:

Avondale Clinical Decisions Unit is the inpatient assessment facility within the Mental Health Crisis Intervention Team at Miranda House.

Mental Health Crisis Intervention Team provides triage and assessment of people experiencing mental health difficulties and/or a mental health crisis within the local authority areas of Hull and East Riding of Yorkshire. When a transfer of care is required to an in-patient facility for focussed interventions or assessment, the MHCIT urgent care team provide the gatekeeping assessment for all admissions into Avondale CDU.

Risk assessment is provided for all transfers of care into an inpatient facility, supported by clinical discussions between practitioners to ensure patients transfer to an inpatient facility is person centred and able to meet individual needs. Where there is a clinical disagreement, there is an escalation process within MHCIT and Avondale CDU to clinical leads across the service. Both services are further supported by a service manager and modern matron as part of the business and clinical escalation process when required.

MHCIT provide a referral pathway for Mental Health Act assessment and access to Approved mental Health Practitioners across the inpatient services, facilitating support for Avondale with both the Mental Capacity Act and Mental Health Act.

The MHCIT Home based Treatment Team; provide an alternative to hospital admission within the community, facilitating interventions, including risk management strategies away from the inpatient environment. The Home Based Treatment Team provide community based support, following discharge from Avondale CDU, based on individual care planning, which is identified and agreed as part of the patients person centred care planning.

MHCIT bed management team further support the movement of patients across the inpatient service by strategically managing bed availability trust wide. The bed management team support the gatekeeping process, by identifying bed capacity and support Avondale CDU with transfers of care to treatment units in order for bed flow to be maintained on the decision unit.

The teams within MHCIT provide peer support across the service, which is supported by a joint leadership approach within the leadership team. This involves clinical leads having weekly meetings, supported by the service manager, where clinical issues arising and organisational changes can be discussed and actions agreed to continually evaluate and develop the service.

The pathway of care across the MHCIT is vital in maintaining excellent care delivery across the service and improving patient's journeys within mental health care facilities.

6.1 Admission Process

- Provision of a holistic assessment of mental health needs. Avondale MHCDU provide ongoing assessment of mental health needs which may include the use of standardised tools such as: Brief Psychiatric Rating Scale (assessing experiences of psychosis, low mood and level of suicidality), Hospital Anxiety and Depression Scale (assessing experiences of low mood and anxiety), Recovery of quality of life (ReQoL 10), Broset (aids prediction of violent or aggressive behaviour) 1-1 nurse led sessions, Daily clinical review meetings with full MDT where observed symptoms and behaviours along with patient and carer feedback and assessment outcomes are discussed.
- If a patient's first spoken language is not English, the ward has access to language line 24/7 and access to face to face interpreters if needed. Mental health interpreters reduce the risk of misunderstanding and misdiagnosis which can in turn lead to the wrong treatment and intervention for an individual. The use of an interpreter should be identified at point of assessment and admission to the ward.
- When a patient has an existing community care team, this team will link in with the Avondale team so there is consideration of the ongoing care plan.
- Screening of physical health needs is offered during the assessment. Using standard tools such as NEWS 2, HIP, routine bloods, urine analysis and drug screening, electrocardiogram, and other biological testing appropriate to individual's needs.
- Therapeutic interventions aimed at recovery, the unit use a supportive engagement structure aimed at providing 1-1 quality sessions to establish an individual's needs, triggers, risk, and management of symptoms. Supportive engagement timescales are agreed with the patient at point of transfer to Avondale and through the MDT throughout their stay. This ensures we are providing recovery orientated services that focus on the strengths of the individual and encouragement to maintain independence choice and control. We recognise that patients are experts by experience and will make sure that these values are embedded in our service and apparent in everything we do.
- Effective partnership with carers and families, we recognise and acknowledge that carers and families are part of the extended care team and need appropriate information and support in their own right. They will be offered a carer contact which is a nurse led intervention establishing carer's needs, their interpretation and their preferred outcome. Onward referral can be made for a carer's assessment. Dependant on patient consent to share information carers and families will be invited to their clinical review meeting or Care programme approach.
- If a person comes into hospital under care programme approach standards these will remain and guidelines followed. If a person is not under Care programme approach a formal clinical review meeting organised and documented within agreed local and national standards. All formal meetings will be arranged within a 5 day period, to inform timely assessment and transfer planning. Interested parties will be invited to attend the meetings with the patient, to include families and carers mental health teams, and 3rd sector services to support recovery and joint working
- Interventions by the psychologist will include assessment readiness to undergo psychological interventions, advice for specialist risk assessment, formulation, assessment of cognitive function and recommended referrals to complex needs team, learning disability services and community psychotherapy.
- Social support may be highlighted as a need, we have a social worker who meets with patients on a 1-1 basis establishing individual needs and how they can provide support, either by helping them solve the issue themselves or by signposting to suitable specialists. Safeguarding issues may arise in which support can be sourced and provisions put in place to ensure the safety of self and others.
- Interface with community mental health teams takes place 3 days per working week. Which involves a CMHT discharge co-ordinator who will discuss and accept referrals for ongoing care of existing patients. We recognise that time delays in care provision can increase stress for people, therefore this service ensures prompt referral and seamless communication within teams.

- Home based treatment provides support for people within their own homes as an alternative to hospital admission and to support early discharge. Where there is a treatment plan agreed following assessment on Avondale, a referral to HBT may be appropriate as a least restrictive option. A member of the HBT team takes part in the daily review meetings on Avondale and aim to make a joint care plan with the patient prior to transfer into their care.
- Where a treatment need is identified we can utilise the Trust treatment units which are as follows:
  Newbridges – all male treatment unit located in East Hull
  Westlands – all female treatment unit located in West Hull
  Mill View Court – mixed treatment unit located in Cottingham on the Castle Hill site
- To arrange 3 day follow up post transfer from Avondale into a community setting. This is to provide follow up support at a potentially vulnerable time post discharge from hospital setting.

6.2 Referral Process

Referrals to Avondale CDU will be received from MHCIT, HBT, MHLS and MH teams within our local community. All referrals are gate-kept by MHCIT and HBT. The referral process to Avondale CDU should be as follows post gate-keeping:

Telephone or face to face contact with the shift co-ordinator using the SBARD model (situation, background, assessment, recommendation, decision) to highlight rationale for transfer to in-patient service and discuss any current risks, triggers, clinical appropriateness of the environment to meet the person's needs and routes to recovery.

Documentation available on Lorenzo to include updated risk assessment (FACE), cluster and assessment/clinical note. This should be made available prior to patients transfer and/or in agreement from the shift co-ordinator. If a person has had assessment under the mental health act, assessing practitioners will provide mental health act paperwork or emergency mental health assessment to the nurse in charge. Where a person is transferred from an acute hospital following assessment for physical health the person will need an immediate discharge letter, highlighting if they are fit for transfer to Avondale MHCDU or any follow up intervention needed. If there are concerns for a person's Physical Health, medic to medic communication will need to take place prior to transfer of care to Avondale MHCDU. If receiving a patient from out of area we will accept communication documents via secure e-mail as they may not share the same electronic systems as Humber Trust.

6.3 Assessment and Intervention

An Initial care plan will be completed on admission to Avondale MHCDU which is individualised and aimed at meeting the care needs of the person whilst undergoing a period of assessment. Care plans are based on information received at point of assessment prior to admission to an inpatient service and where possible should include the patient, carers and families. Formal care plan reviews will take place at the clinical review meeting or where appropriate at the CPA meeting with the multi-disciplinary team and patient present.

Assessment is conducted with a combination of observations from the MDT to include 1-1 with the person feedback from carers/families, medical reviews and with the use of structured validated assessment tools, as listed below:

- **ReQoL 10** – an outcome measure of mental health and wellbeing, which is completed on admission.
- **Hospital anxiety and depression scale** gives clinically meaningful results as a psychological screening tool and can assess the symptom severity of **anxiety** disorders and **depression** in patients with illness and the general population.
- **Brief Psychiatric Rating Scale** is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations, and unusual

behaviour. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored

- **Broset** – is a reliable and validated instrument to predict increased violence and aggression
- **Alcohol use disorders identification test** provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking
- **Brief screening tool** identifies substance use and aids to signpost to relevant support services
- Assessments for opiate, benzodiazepine and alcohol withdrawal are utilised if an identified need is there for the individual to manage the physical complications of alcohol and substance use (CIWA- AR, CIWA B, Cows, SADQ). If a need is identified then a full substance use assessment (dual diagnosis) will be carried out by specialist services (RENEW)
- Glasgow anti-psychotic side effect scale –GASS is used to monitor side effects from anti-psychotic medications.

Supportive engagement and 1-1 sessions provide the opportunity for ongoing assessment and views of the patient and their needs. Supportive engagement (to be read in conjunction with policy and guidelines) is an agreed intervention between patient and assessing team in order to develop therapeutic rapport and establish risk management strategies. Supportive engagement provides a framework to manage risk within the inpatient environment, agreed levels based on their individualised care needs and risk are established with the patient and through MDT discussion, both on admission and reviewed during daily review meetings. Engagements are also discussed in nursing handovers throughout the 24 hour period in response to changes in presentation and risk management.
Practitioners are allocated per shift to named patients to carry out positive engagement and assessment of specific needs; they also work as a point of contact for the individual throughout that timeframe.

Supportive Engagement Policy

6.4 Risk Assessment and Management

Risk assessment should be a core component of mental health in any setting, any risk assessment should be structured, evidence based and as consistent as possible across settings and service providers. The assessment of clinical risk and subsequent management of the identified risk is integral to care planning and understanding of the person's individual needs and interventions provided/required to meet those needs and manage risk. Humber teaching NHS foundation trust use FACE as their standardised risk management tool which incorporates formulation as part of the assessment of Risk. All patients should have a risk assessment which is completed prior to admission, reviewed and updated throughout admission and at point of transfer to community services.
Risk management on Avondale DCU is further supported by:

- Clinical discussion in daily review meetings/handovers
- Supportive engagements
- Family reception meetings
- Assessment of mental health
- Medication management

6.5 Safety huddles

Safety huddles are completed on the ward every morning at 08:30hrs. A safety huddle is a short multidisciplinary briefing and is focused on the patients most at risk and what interventions can be provided to reduce the risk.

6.6 Safeguarding

Safeguarding is a key function of mental health services. Avondale MHCDU practise in line with policy and procedures:

- Safeguarding adults policy and procedure (N-024)
- Safeguarding Children policy and procedure (N-045)

The Unit has an identified safeguarding lead. All identified safeguarding concerns are logged with HUMBER safeguarding team, this then may be escalated to local authority safeguarding boards. All safeguarding concerns are logged within the consideration log and on datix, this is part of the Humber strategy to monitor safeguarding events within inpatient units.

Safeguarding Adults Policy

Safeguarding Children Policy

6.7 Reducing Restrictive Interventions

Reducing restrictive practices (RRI), such as restraint, seclusion and rapid tranquilization, is essential to provide mental health services that are safe places for all patients, visitors and health staff. Providing a safe environment for all is underpinned by a comprehensive review of the research and evidence relating to restrictive interventions. There is an increasing body of good practice and evidence to support health services in reducing restrictive practices.

Avondale CDU are committed to reducing restrictive practices and promoting positive engagement with patients, we pledge to continue to implement and develop safe wards interventions and to continue to develop a package of proactive care and that all inpatient staff are trained and implement local protocol and guidance regarding leave from inpatient units. Avondale CDU has a seclusion suite and all staff receives training in the use of seclusion. The use of seclusion is a restrictive intervention and is only used as a response to maintain safety for patients within our care and staff as a last resort for the shortest possible duration and the least possible force. The use of seclusion is audited by the modern matron.

Seclusion or Segregation use of Policy

The trust has a single approved model of physical restraint for mental health and learning disability services, ‘De-escalation management intervention ‘(DMI) which all staff receive training and support from the positive engagement team.

Physical Restraint Policy

The use of Rapid Tranquilisation is defined as parenteral medication to manage aggressive or violent behaviour, to urgently sedate and reduce risk to the patient and others within the environment.

Rapid Tranquillisation Policy

As with the use of all restrictive interventions they are monitored at national and local level and staff receive regular updates and training in these practices. Both patients and staff receive de-briefs following incidents.

Avondale works closely with the patient experience team which gives us additional support and knowledge about the use of restrictive interventions and effects they have on those in our care.

Please see individual policies and procedures for further information

6.8 Safewards

Avondale CDU are part of the trust RRI group and provide interventions through the SAFEWARDS model, with an dedicated lead on the unit. Safewards is a continual developing model on the unit and aims to enable understanding of the variation between conflict-containment and how this impacts on care delivery and the care environment. On Avondale CDU some of the modules are well established, with some of the following implemented within Avondale CDU:

Positive Words Soft Words
Mutual Expectations
Calm down methods
Knowing each other
Discharge messages

6.9 Occupational therapy and Meaningful activity

Activities available on the unit

- Creative expression (art)
- Pamper nights
- Murals
- Mindfulness colouring
- Expressive literature
- Sporting activities (Pool and table tennis)
- Outdoor games
- Gardening
- Video games
- Group activities
- Board games
- Movie nights
- Knitting and Crochet
- 1:1 Occupational therapy interventions (graded exposure, personal care assessment, assessment through activity, goal setting and enabling individuals to be able to engage in activities/occupations that are meaningful to them)
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Why are these activities meaningful?

- With Avondale being an assessment unit, it is crucial to assess all aspects of individuals needs including through activity/occupation. Assessment through activity is beneficial, purposeful, it is a distraction from an individual's reality, and it is used as a grounding technique.
- Activity can be motivating, and it enables individuals to develop a sense of purpose.
- Activity supports individuals to develop a structure or routine to their day; it is an acquisition of skills and supports individuals to feel useful.
- Activity gives staff the ability to observe patients' social interaction; it is therapeutic and enables patients to trust staff by developing a therapeutic rapport.
- Activity improves an individual's health and wellbeing; staff can enable patients to access employment or support them with their educational needs.
- Without any structure or routine, this can lead a further deterioration to an individual's mental health.
- Activity can support self-expression and enable patients to discover coping strategies.
- Activity can promote self-care and improve confidence.
- If a patient is struggling to complete meaningful activities due to a mental or physical health need, an occupational therapist can assess this and facilitate them into achieving their goals and enable their home environment to achieve this.

6.10 Carers, family and friends

Avondale has a holistic and patient-centred approach to nursing. Together we work with patients and their carers to assess their presenting needs and create recovery based care plans.

Working with family and friends is important to us as they can provide the multi-disciplinary team with collateral information to help us support their loved ones. Therefore at the first available opportunity we aim to contact the nearest relative to complete a reception meeting, and introduce ourselves and the service as a whole. Following this, we are available 24 hours a day over the telephone, and face to face during visiting hours to answer any queries or concerns. Pending patient consent, we welcome friends and family to attend the multi-disciplinary team meeting to discuss a continued plan of care. If the patient does not give consent for us to share information, we will continue to listen to their support networks views, as these are important in a person's recovery.

We have close links with East Riding Council, City Healthcare Partnership and MIND to support patient's friends and families, should they themselves require extra support.

In addition to contact with carers, family and friends, Avondale Clinical decisions unit ask for feedback from patients, their family and carers which is captured and reported upon monthly. The 'Friends and Family Tests 'provide Avondale se to with rich feedback, which we can use to improve the services we provide.

6.11 Medication management

Avondale uses Electronic prescribing and medications administration to safely prescribe medication, improve patient safety such as transcribing and minimising medication errors, save staff time and improve the prescribing process. Avondale has a dedicated clinic where the administration of medications take place, in order to support privacy and dignity, allows patient time to discuss medication and receive information. Avondale have dedicated medication rounds at 10.00, 14.00, 18.00 and 22.00 however medication rounds can be flexible depending on individual patient needs. Avondale have a pharmacy technician who will ensure medication is correct by completing the medication reconciliation tool, receiving GP summaries and summary care records, both the technician and staff can then electronically order medication which is prescribed on admission.

6.12 Key performance indicators

Key performance indicators on Avondale provide a measure for the success of the service in meeting its aims in line with both Trust and National policy and standards. For Avondale these indicators are

- Supervision
- Sickness monitoring
- PADR and appraisal
- Training
- Family and friends surveys
- CPA within 7 days
- 3 day follow up
- HIP assessment completed on admission
- Delayed discharge
- Data quality
- Complaints
- Safer staffing

Key performance indicators are measured through audit and reported monthly via the level 3 performance report, which is then shared with the team.

6.13 Supervision

Clinical or practice supervision provides a cornerstone of effective practice to support delivery of safe, high quality care. Supervision is "*an accountable process which supports assures and develops the knowledge skills and values of an individual group or team*" (Skills for Care 2007).

On Avondale Clinical Decisions unit provides regular supervision via a planned supervision structure as per Humber Teaching NHS Foundation **Trust Supervision policy (For Clinical, Practice and Non-Clinical) (N-039).** In addition to clinical and non-clinical supervision, peer group supervision is facilitated across both Avondale and the Mental Health Crisis Intervention Team on a monthly basis. This group provides further supportive structures across the teams and assists in joint team working approach to improve the care delivery to patients in contact with the service.

6.14 Reflective Practice Groups

A reflective practice group is currently facilitated by a Clinical Psychologist for one hour each week and is open to all clinical staff. In order for care to be patient centred it is expected that all staff, regardless of their level of professional or vocational training, are able to recognise and adapt to the needs of patients. Therefore staff benefit from a safe space to focus on the interpersonal aspects of care delivery. Reflective practice groups have been shown to promote self-awareness, clinical insight and quality of care as well as facilitating stress management and team building.

6.15 Staff Wellbeing

Avondale clinical decision unit have dedicated leads on staff wellbeing within the environment. Support both the physical and emotional wellness of staff is paramount to providing safe and effective care to patients. The wellbeing team provide dynamic activities to ensure staff are taking time out and maintaining their health whilst at work, lunch breaks and hydration are embedded within the team's working day. In addition to this, the building at Miranda House has a wellbeing room available to all staff, team days are arranged annually, alongside annual appraisals to support the team and individuals development and health.

6.16 Clinical and Non clinical Meetings

Multi-Disciplinary Team Meeting and Clinical review/CPA/Morning meeting

Morning meeting occurs every working week day and consists of the MDT, on Wednesday Morning Doctors and consultant are teaching therefore it is ran by the rest of the professionals involved in the MDT. Every patient is discussed and plans are made as to what that person may need in terms of their care and treatment.

Clinical review meetings happen within 5 days of admission, the patient can invite whom they wish and the Consultant psychiatrist will be present, clinical review meetings occur if the patient is not on CPA.

The Care programme approach (CPA) remains central to the safe and supportive delivery of care to patients and their Carers. The CPA continues to provide national and local guidance to co-ordination of care allowing services to support individuals with complex mental health problems to ensure their needs and choices remain central.

Team Meetings

Team meetings take place on Avondale Clinical decisions Unit on a Tuesday every week, and include a Registered Practitioner meeting, Health Care Assistant/support/activity work meeting and whole team business meeting which run concurrently. Team meetings provide peer groups time to reflect and discuss issues in relation to their role within the ward environment. In addition, the whole business meeting, provides time for the team to problem solve, share concerns and innovations and policy and practice updates from a trust wide perspective. The meetings are facilitated by a member of the leadership team and minuted for sharing across the whole team. The leadership team meet weekly to discuss team issues, clinical practice, performance indicators and staff wellbeing.

Weekly Inpatient Senior Meeting – Monday Morning All moderate incidents of harm and all incidents of self-harm or safer staffing incidents as reported above are reviewed weekly by the Division and membership includes the Service Manager and Matrons, Charge Nurses/Team Leaders or deputies, with a mechanism for escalation to the General Manager and Clinical Lead where needed. This meeting ensures the following;

- To provide oversight of the care and management of those inpatients who present the most serious threat to their own safety or the safety of others
- To deploy clinical expertise to provide advice and support to inpatient staff in the management of highly complex cases.
- To review on a weekly basis all moderate/severe harm incidents and identify any themes or risks which will benefit from senior clinical or managerial support or influence.
- To maintain oversight of compounding factors associated with staffing, acuity, bed capacity and risk which requires pro-active management across the care group to relieve.
- Take appropriate action to relieve acute pressure points and/or consider escalation to senior leaders in the Trust where containment of risk is problematic.
- Establish when compounding features require consideration of closure of beds and follow the escalation procedures.
- To review delayed transfers of care and commission action to resolve where greater authority can be brought to effect discharge or minimise delay

Handover

Handover takes place at the beginning of every shift, it is hosted by the nurse in charge and informs upcoming shift of people's presentation in relation to mental health, reasons for admission, triggers, care that needs to be provided or completed, risk updates, a person's interests and ways to engage the person, action plan for the duty. The co-ordinator will then allocate workers to keywork and engage for the duty and also delegate certain tasks to the staff. Avondale use a shift log to aid this process. Communication on Avondale is structured using SOAPP tool (subjective, objective, assessment, plan a, plan b) this aids staff to document and communicate effectively and defensibly.

6.17 L.E.A.V.E

Avondale has both formal and informal patients. Formal patients leave would be prescribed by a section 12 approved Dr and will have stipulations to whom, when, where and how long leave can take place. If a person is informal and requests to leave the unit they have the right to do so under the mental health act 1983. In these circumstances a person must be assessed prior to leaving the unit, this can be completed by a registered practitioner and risk assessed and documented under the L.E.A.V.E section in the electronic notes. Avondale CDU recognise leave as an important part of assessment and the recovery process in order to support the process of leave there are resources available to assist staff with their assessment of risk both prior and post leave and information which is provided to patients to enhance their safety whilst away from the unit.

6.18 Transfer of patients between units

The decision to transfer patients is based on clinical need and is discussed with patients and their carers at their clinical review or CPA meeting. Transfer refers to the movement of a patient within Humber inpatient clinical services. Following assessment on Avondale a transfer may take place to one of the following treatment units:
Westlands
Newbridges
Mill View Court

Avondale CDU has access to PICU when there is an escalation in care required and following referral process. In addition to transfer to the above units Avondale also liaise, refer and transfer to the older adult pathway when needs are identified.

6.19 Bed management

Transfers of care to Avondale Clinical decision's unit, take place following a gate keeping assessment which is provided by the Mental Health Crisis Intervention Team. The bed management team work alongside all Humber Teaching NHS Foundation Trust adult in-patient facilities and Mental Health Crisis Intervention Team to maintain a flow of available beds throughout the service between the hours of 8am to 6pm 7 days a week. Outside of these hours, the Mental Health Crisis Intervention Team facilitates bed management in liaison with the in-patient services clinical staff.

The bed management team include:
Band 7 clinical lead nurse
Band 4 Bed management support worker

Where high demand is placed upon the services impacting on bed availability, and/or disagreements arise regarding suitable placement for a patient, there is an escalation plan in place via the bed management team and service leads. Out of hours, this escalation would follow the pathway of contacting the managers on call for support.

6.20 Follow up process

On Avondale Clinical decisions Unit, 3 day follow up discussions are had with the patient and where possible carers and family at their clinical review or Care plan Approach meeting (CPA). Where a transfer of care is planned to a Community Mental Health Service within Humber Teaching NHS Foundation Trust, to include Home Based Treatment teams, the follow up should be provided by those services as part of ongoing care and support of the patient.
The Community Team will liaise with Avondale so there is consideration of the ongoing care plan at the time of transition.

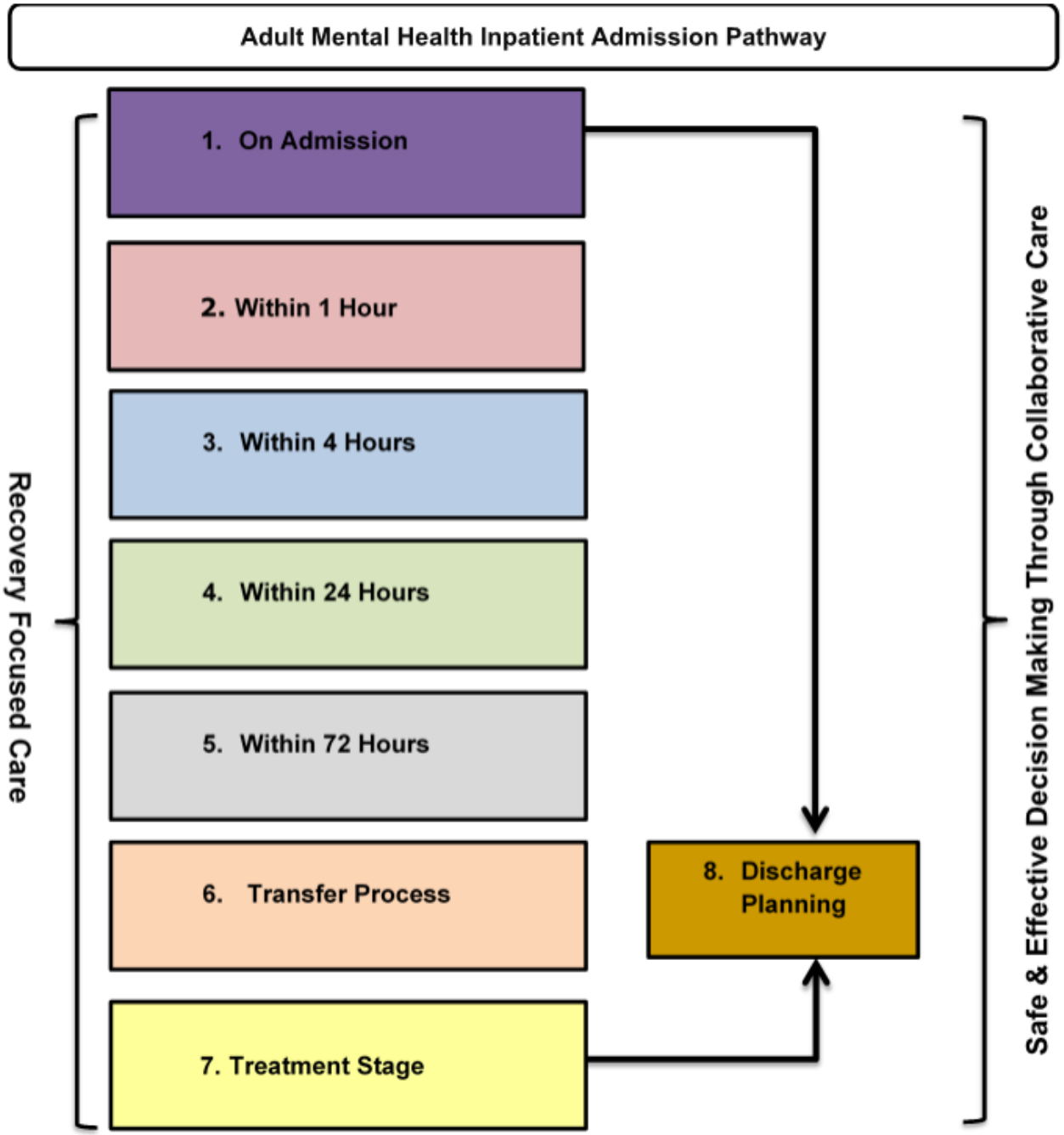
When a patient is to be transferred to the care of their G.P (no ongoing mental health team support), the follow up will be planned and provided by the team on Avondale as follows:

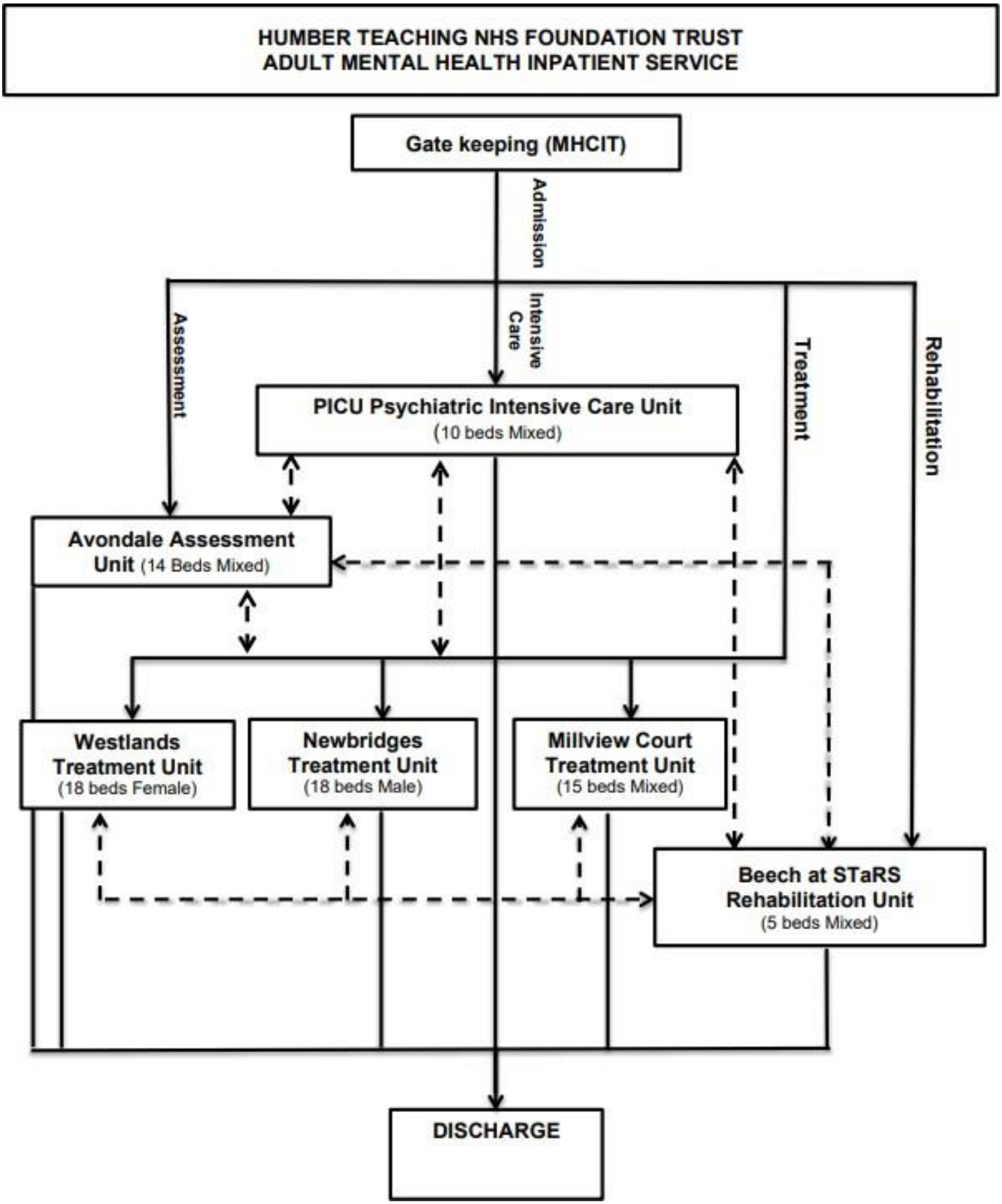
Face to face contact is to be agreed with the patient and where possible their carer's and family within 3 days of transfer into the community. Telephone contact should only be planned for if the patient prefers this option and a risk assessment has taken place. A contingency plan should be agreed with the patient prior to leaving the ward, and failed contact should be discussed within the MDT and strategies to achieve the follow-up should be agreed which may include cold calling the patient. Where a clinical discussion has taken place and concerns for the safety of a patient considered, then a letter to the G.P should be considered outlining the failed contact. The follow process should be considered essential in supporting a patient's safety following a period of in-patient support, which can be a difficult time where patients are at their most vulnerable.

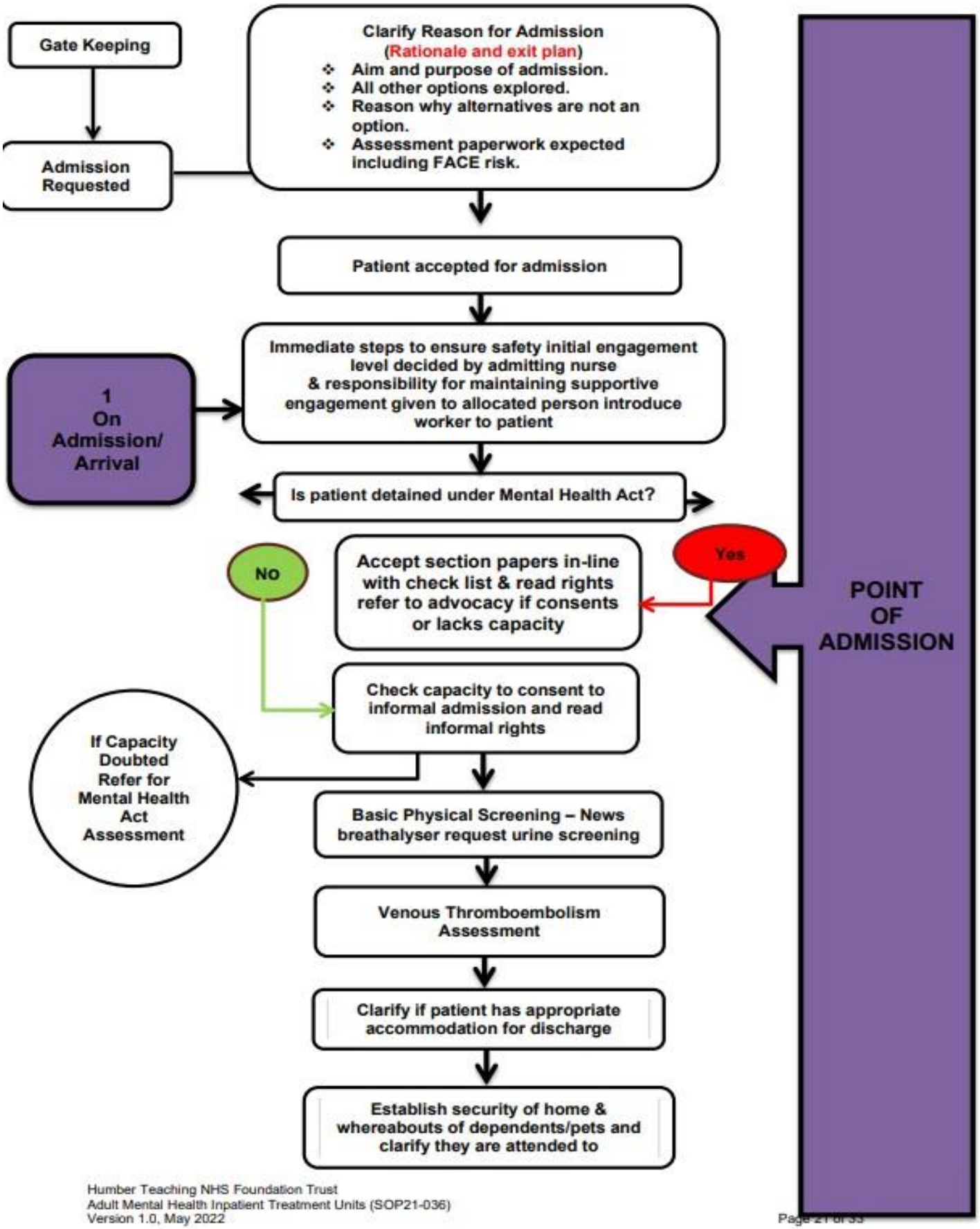
All follow ups MUST be added as contact activity on Lorenzo as this is how all our reports are based and submissions made for various reports. Scanned images on Lorenzo or notes in clinical charts are not acceptable to use as contacts as they cannot be reported on. This also includes any patients seen by the units. Please also note that any contacts added to Lorenzo after 6.00pm will be refreshed the following day so may not show on initial reports. You may receive an 'outstanding contact notification' during this refresh period.

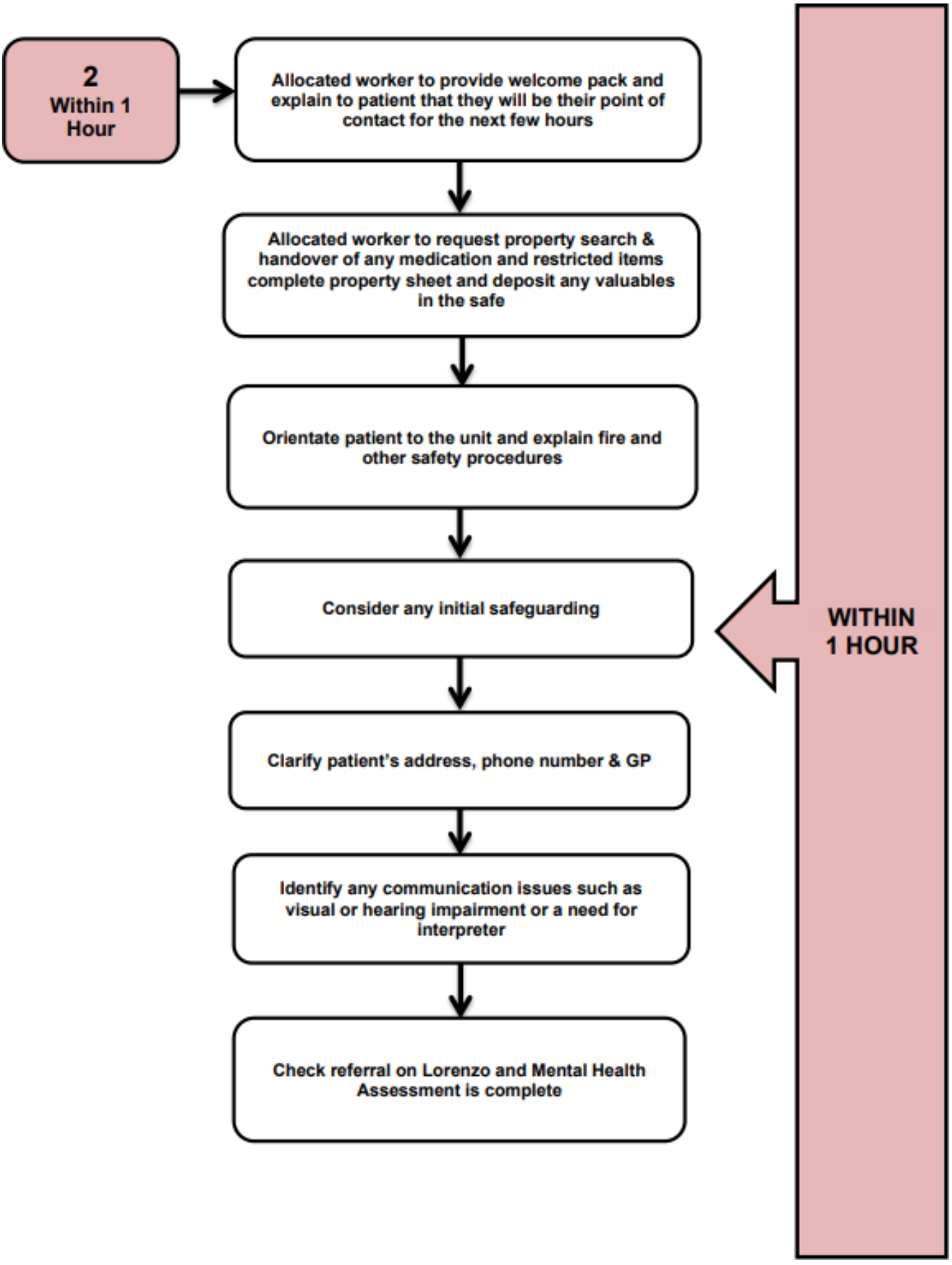
Any breach will require the usual investigation and logging on Datix and reported to Board. Web ID reference numbers must be supplied to BI Hub on completion. The CPA 7 day follow up period is still relevant and will continue to be monitored. If the 3 day follow up has not been achieved, the 7 day follow up will apply. Please be aware the follow up does not count if the patient is seen the same day as discharged, the follow up timescale begins the day AFTER discharge.

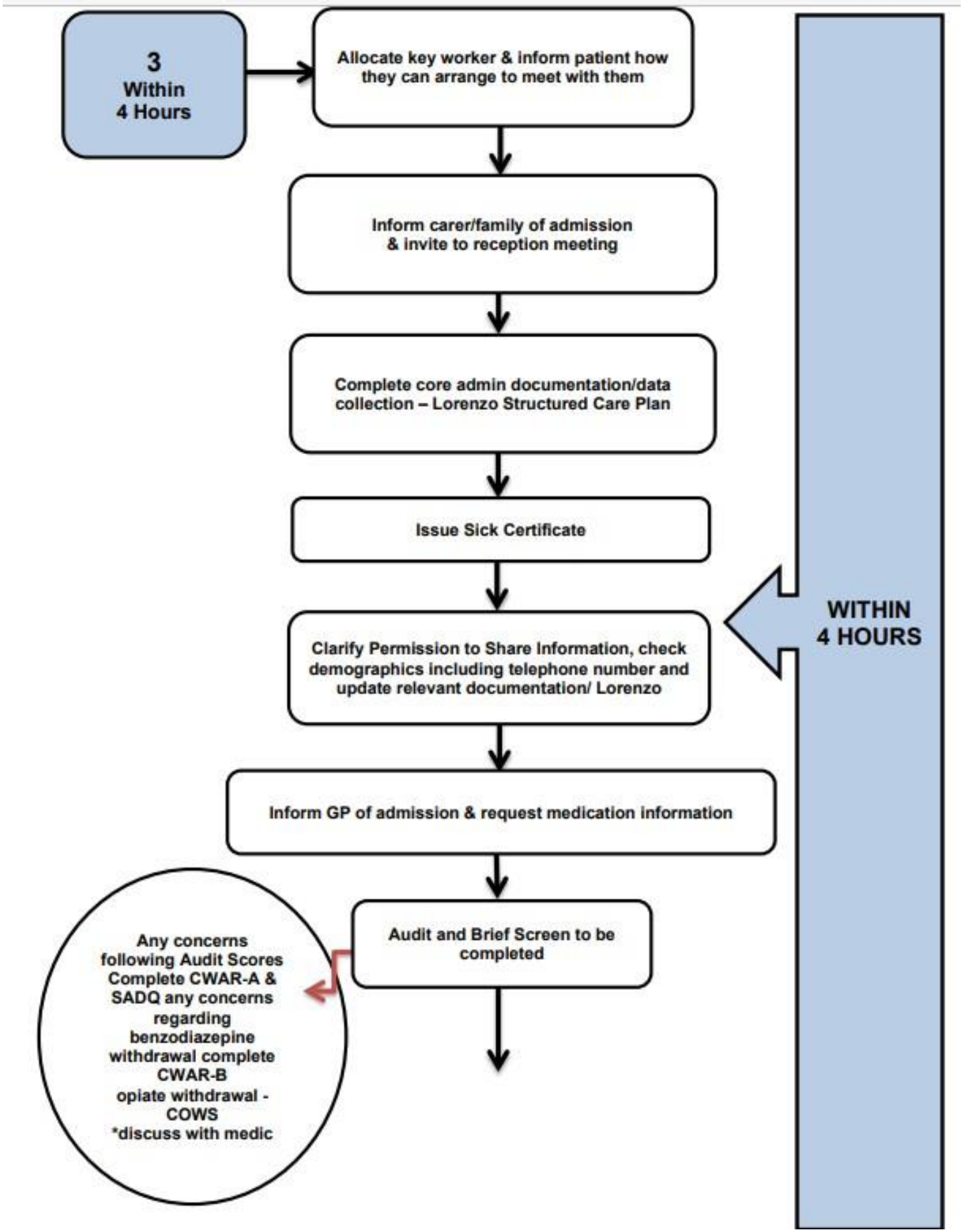
7. ADULT MENTAL HEALTH INPATIENT PATHWAY

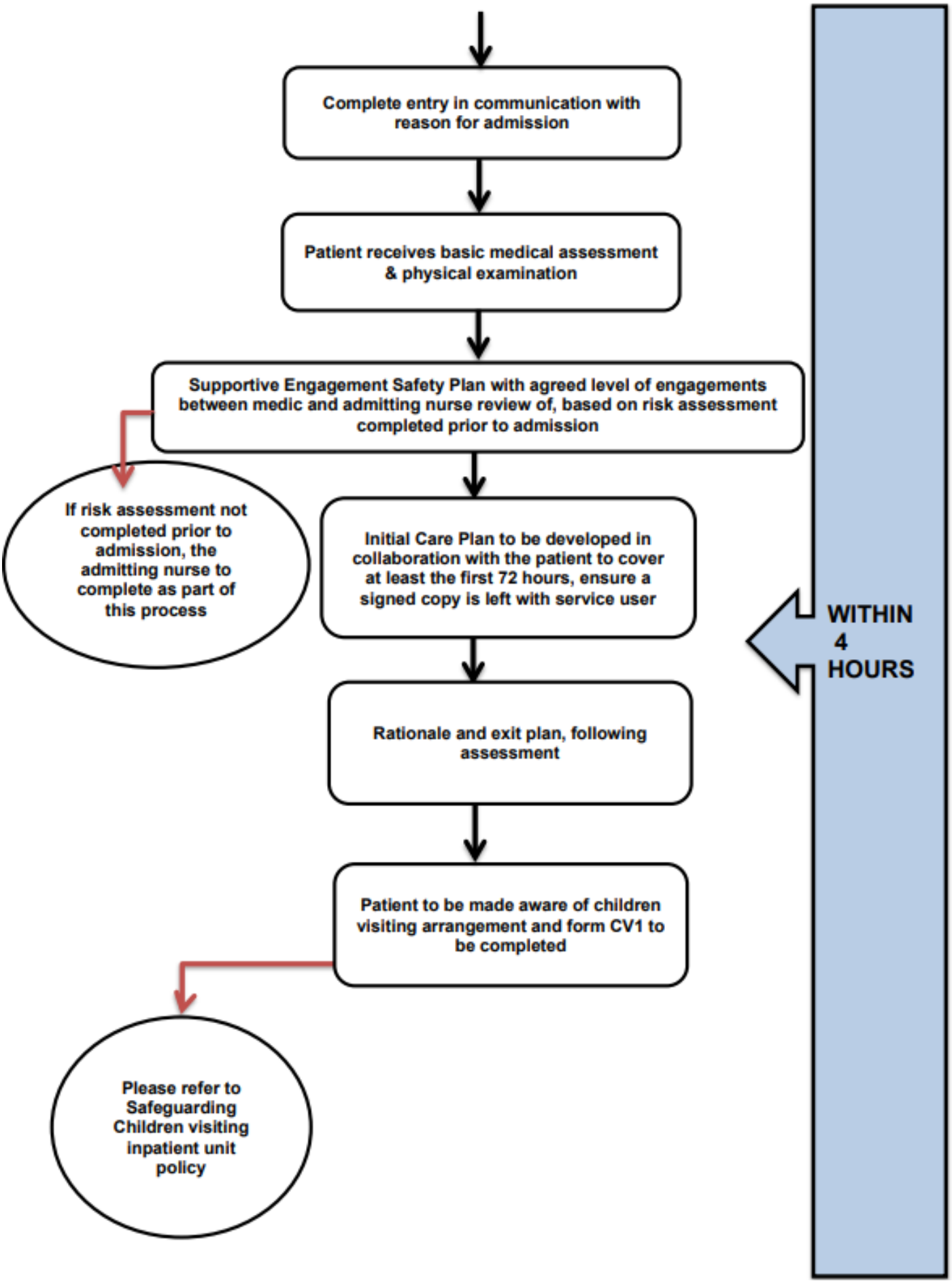


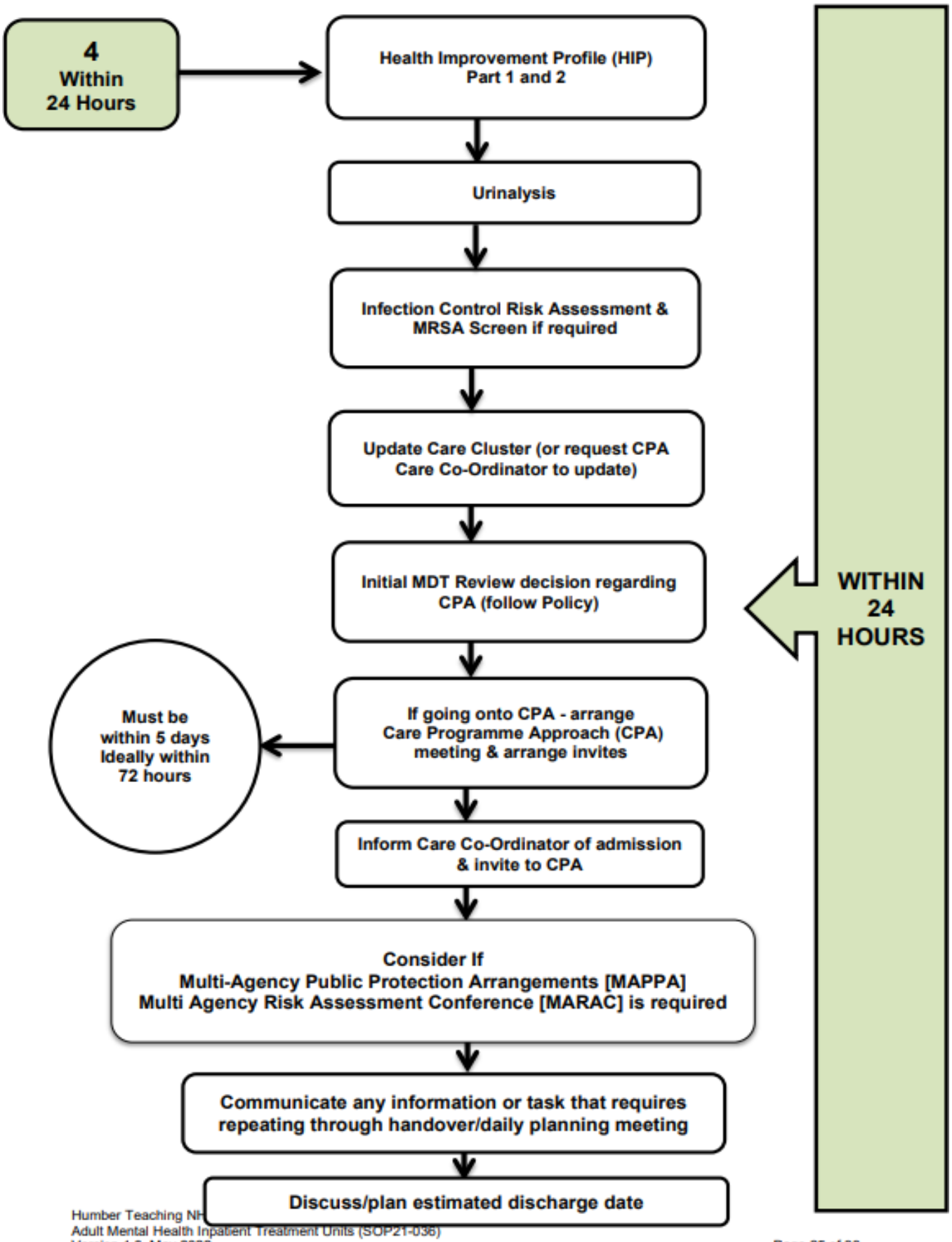

HUMBER TEACHING NHS FOUNDATION TRUST
ADULT MENTAL HEALTH INPATIENT SERVICE
Gate keeping (MHCIT)
Admission
Assessment
Intensive Care
Treatment
Rehabilitation
PICU Psychiatric Intensive Care Unit
(10 beds Mixed)
Avondale Assessment Unit (14 Beds Mixed)
Westlands Treatment Unit
(18 beds Female)
Newbridges Treatment Unit
(18 beds Male)
Millview Court Treatment Unit
(15 beds Mixed)
Beech at STaRS Rehabilitation Unit
(5 beds Mixed)
DISCHARGE

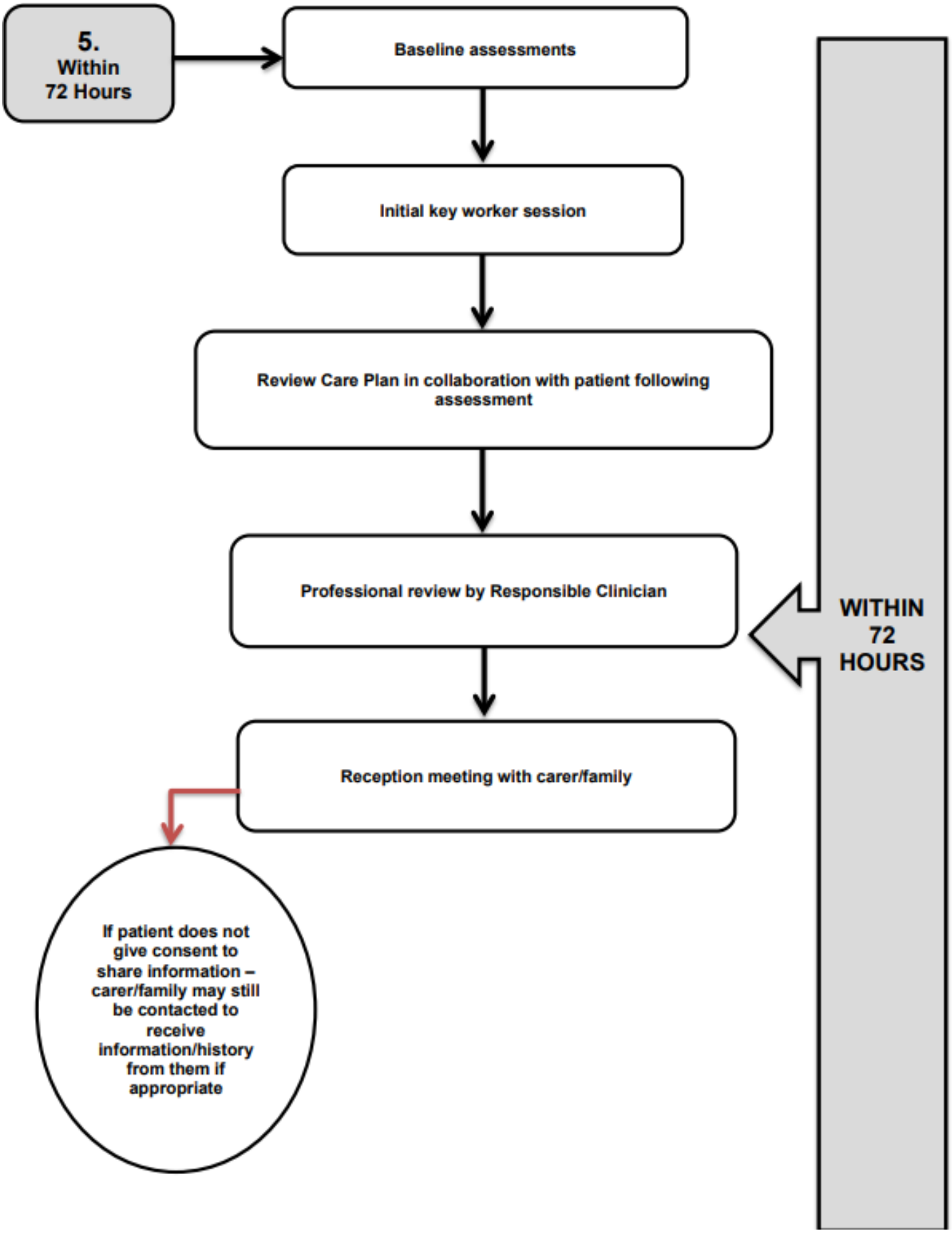

Gate Keeping
Admission Requested
Clarify Reason for Admission
(Rationale and exit plan)
Aim and purpose of admission.
All other options explored.
Reason why alternatives are not an option.
Assessment paperwork expected including FACE risk.
Patient accepted for admission
1 On Admission/ Arrival
Immediate steps to ensure safety initial engagement level decided by admitting nurse & responsibility for maintaining supportive engagement given to allocated person introduce worker to patient
Is patient detained under Mental Health Act?
Yes
NO
Accept section papers in-line with check list & read rights refer to advocacy if consents or lacks capacity
POINT OF ADMISSION
Check capacity to consent to informal admission and read informal rights
If Capacity Doubted Refer for Mental Health Act Assessment
Basic Physical Screening – News breathalyser request urine screening
Venous Thromboembolism Assessment
Clarify if patient has appropriate accommodation for discharge
Establish security of home & whereabouts of dependents/pets and clarify they are attended to

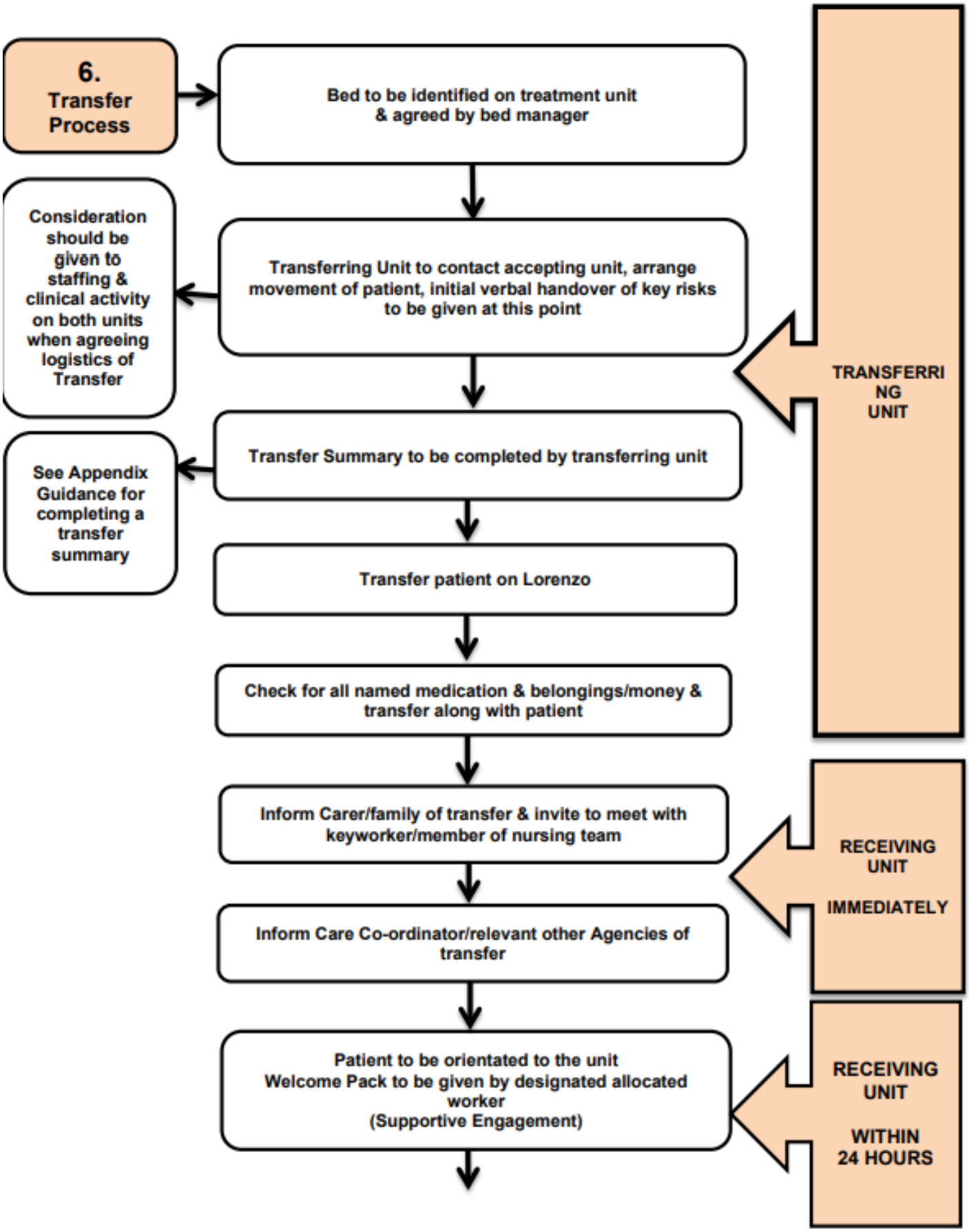

2
Within 1 Hour
Allocated worker to provide welcome pack and explain to patient that they will be their point of contact for the next few hours
Allocated worker to request property search & handover of any medication and restricted items complete property sheet and deposit any valuables in the safe
Orientate patient to the unit and explain fire and other safety procedures
Consider any initial safeguarding
Clarify patient's address, phone number & GP
Identify any communication issues such as visual or hearing impairment or a need for interpreter
Check referral on Lorenzo and Mental Health Assessment is complete
WITHIN 1 HOUR

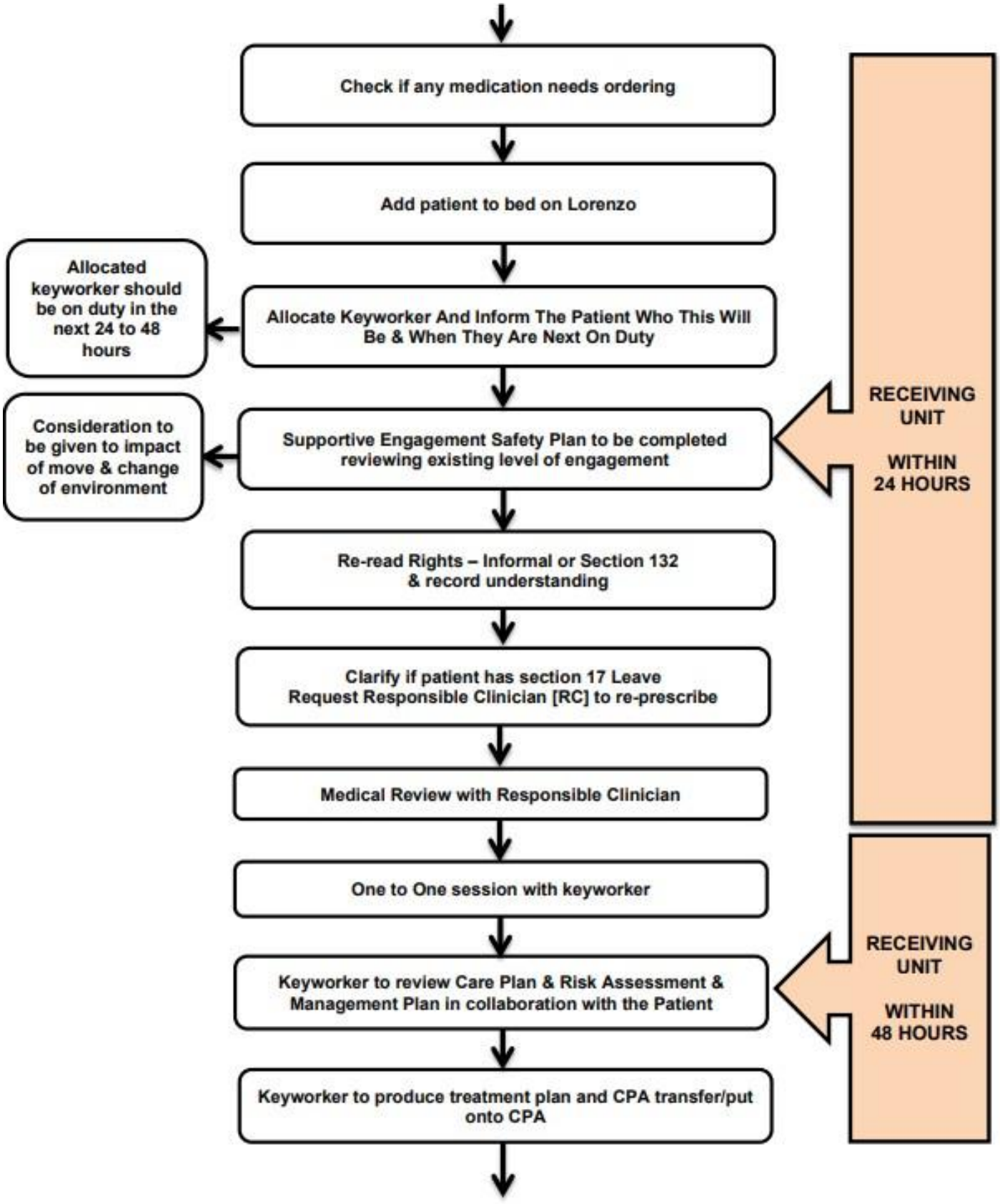

3
Within
4 Hours
Allocate key worker & inform patient how they can arrange to meet with them
Inform carer/family of admission & invite to reception meeting
Complete core admin documentation/data collection – Lorenzo Structured Care Plan
Issue Sick Certificate
Clarify Permission to Share Information, check demographics including telephone number and update relevant documentation/ Lorenzo
Inform GP of admission & request medication information
Audit and Brief Screen to be completed
Any concerns following Audit Scores Complete CWAR-A & SADQ any concerns regarding benzodiazepine withdrawal complete CWAR-B
opiate withdrawal - COWS
*discuss with medic
WITHIN
4 HOURS

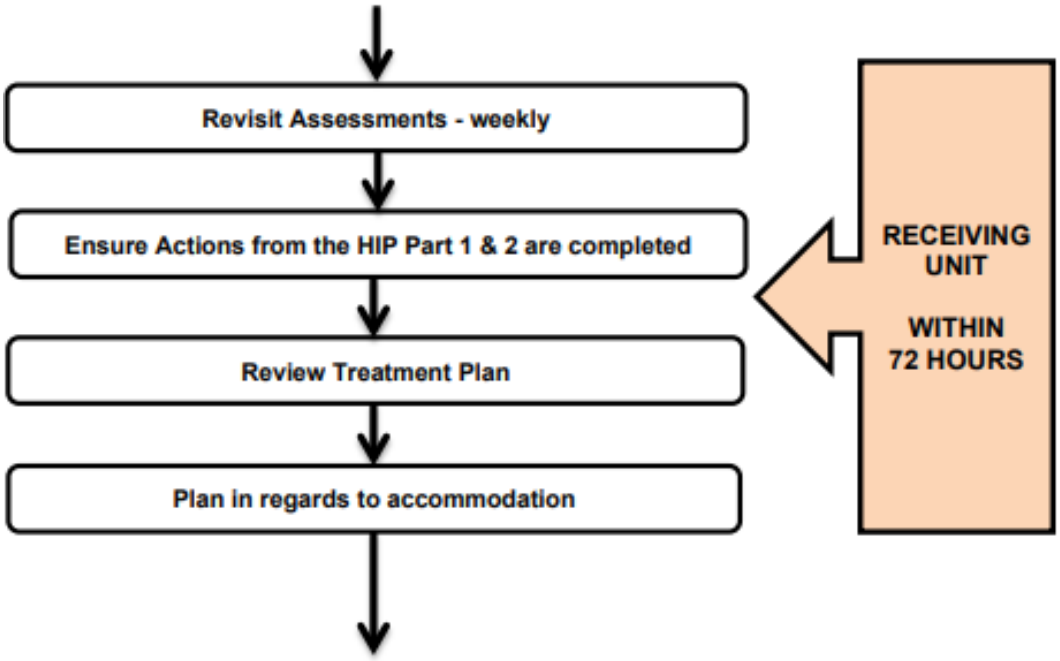

Complete entry in communication with reason for admission
Patient receives basic medical assessment & physical examination
Supportive Engagement Safety Plan with agreed level of engagements between medic and admitting nurse review of, based on risk assessment completed prior to admission
If risk assessment not completed prior to admission, the admitting nurse to complete as part of this process
Initial Care Plan to be developed in collaboration with the patient to cover at least the first 72 hours, ensure a signed copy is left with service user
WITHIN 4 HOURS
Rationale and exit plan, following assessment
Patient to be made aware of children visiting arrangement and form CV1 to be completed
Please refer to Safeguarding Children visiting inpatient unit policy

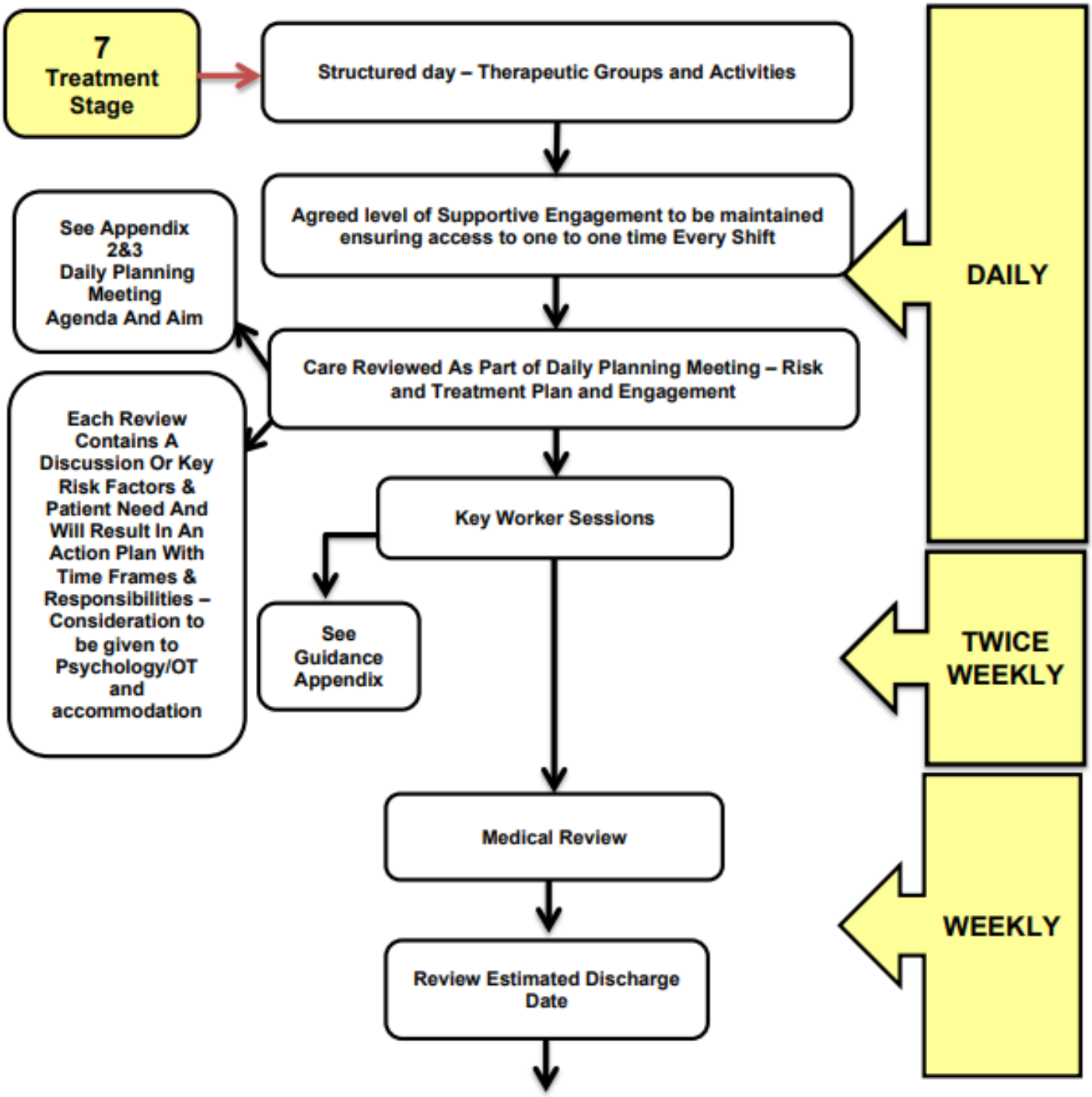

4
Within
24 Hours
Health Improvement Profile (HIP)
Part 1 and 2
Urinalysis
Infection Control Risk Assessment &
MRSA Screen if required
Update Care Cluster (or request CPA
Care Co-Ordinator to update)
Initial MDT Review decision regarding
CPA (follow Policy)
WITHIN
24
HOURS
Must be
within 5 days
Ideally within
72 hours
If going onto CPA - arrange
Care Programme Approach (CPA)
meeting & arrange invites
Inform Care Co-Ordinator of admission
& invite to CPA
Consider If
Multi-Agency Public Protection Arrangements [MAPPA]
Multi Agency Risk Assessment Conference [MARAC] is required
Communicate any information or task that requires
repeating through handover/daily planning meeting
Discuss/plan estimated discharge date

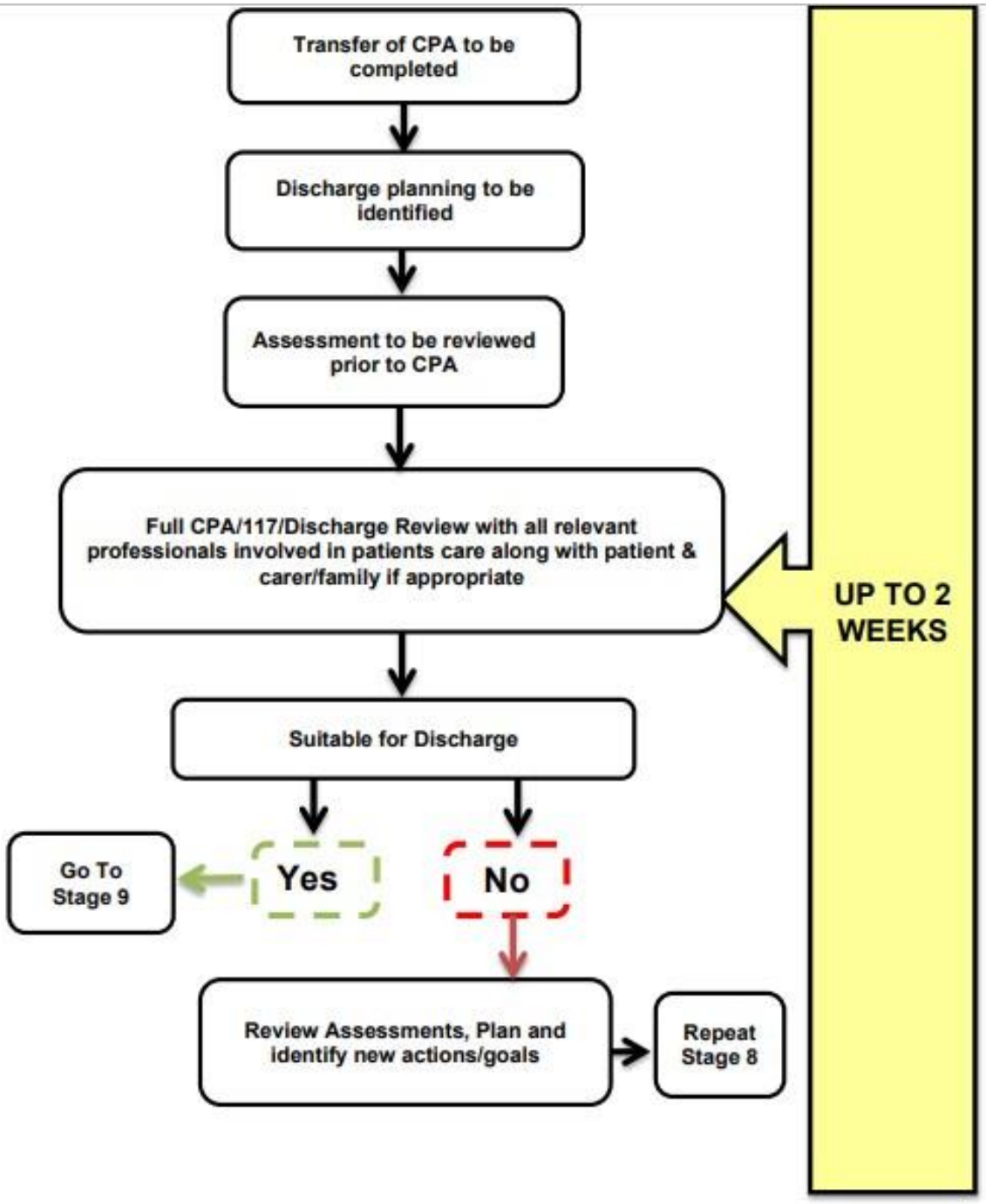

5.
Within
72 Hours
Baseline assessments
Initial key worker session
Review Care Plan in collaboration with patient following assessment
Professional review by Responsible Clinician
Reception meeting with carer/family
If patient does not give consent to share information – carer/family may still be contacted to receive information/history from them if appropriate
WITHIN
72
HOURS

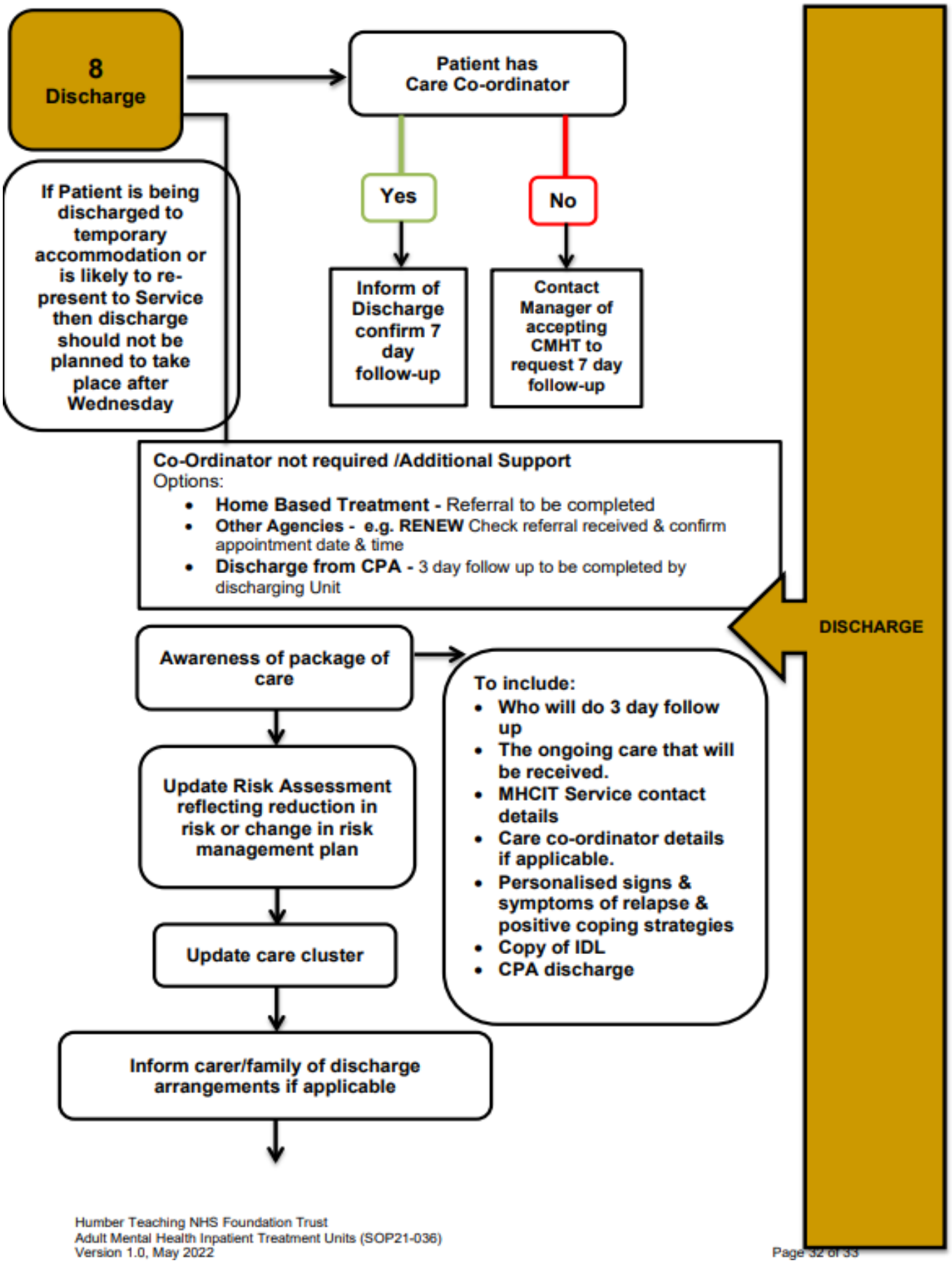

6. Transfer Process
Bed to be identified on treatment unit & agreed by bed manager
Consideration should be given to staffing & clinical activity on both units when agreeing logistics of Transfer
Transferring Unit to contact accepting unit, arrange movement of patient, initial verbal handover of key risks to be given at this point
See Appendix Guidance for completing a transfer summary
Transfer Summary to be completed by transferring unit
Transfer patient on Lorenzo
Check for all named medication & belongings/money & transfer along with patient
TRANSFERRING UNIT
Inform Carer/family of transfer & invite to meet with keyworker/member of nursing team
Inform Care Co-ordinator/relevant other Agencies of transfer
RECEIVING UNIT IMMEDIATELY
Patient to be orientated to the unit
Welcome Pack to be given by designated allocated worker
(Supportive Engagement)
RECEIVING UNIT WITHIN 24 HOURS

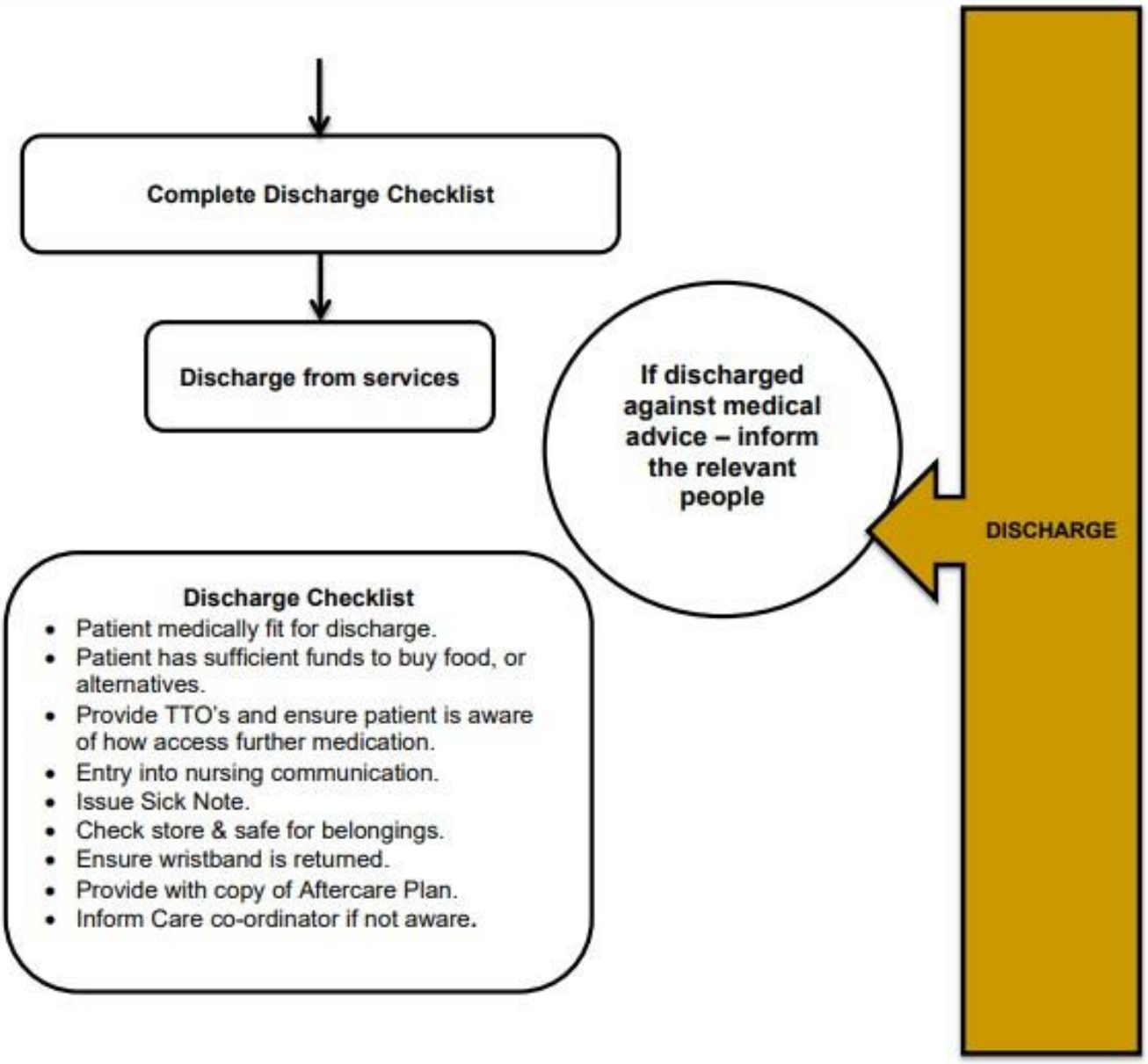

Check if any medication needs ordering
Add patient to bed on Lorenzo
Allocated keyworker should be on duty in the next 24 to 48 hours
Allocate Keyworker And Inform The Patient Who This Will Be & When They Are Next On Duty
Consideration to be given to impact of move & change of environment
Supportive Engagement Safety Plan to be completed reviewing existing level of engagement
RECEIVING UNIT
WITHIN 24 HOURS
Re-read Rights – Informal or Section 132 & record understanding
Clarify if patient has section 17 Leave Request Responsible Clinician [RC] to re-prescribe
Medical Review with Responsible Clinician
One to One session with keyworker
Keyworker to review Care Plan & Risk Assessment & Management Plan in collaboration with the Patient
RECEIVING UNIT
WITHIN 48 HOURS
Keyworker to produce treatment plan and CPA transfer/put onto CPA


Revisit Assessments - weekly
Ensure Actions from the HIP Part 1 & 2 are completed
Review Treatment Plan
Plan in regards to accommodation
RECEIVING UNIT
WITHIN 72 HOURS


7 Treatment Stage
Structured day – Therapeutic Groups and Activities
Agreed level of Supportive Engagement to be maintained ensuring access to one to one time Every Shift
DAILY
See Appendix 2&3 Daily Planning Meeting Agenda And Aim
Care Reviewed As Part of Daily Planning Meeting – Risk and Treatment Plan and Engagement
Each Review Contains A Discussion Or Key Risk Factors & Patient Need And Will Result In An Action Plan With Time Frames & Responsibilities – Consideration to be given to Psychology/OT and accommodation
Key Worker Sessions
See Guidance Appendix
TWICE WEEKLY
Medical Review
Review Estimated Discharge Date
WEEKLY


Transfer of CPA to be completed
Discharge planning to be identified
Assessment to be reviewed prior to CPA
Full CPA/117/Discharge Review with all relevant professionals involved in patients care along with patient & carer/family if appropriate
UP TO 2 WEEKS
Suitable for Discharge
Yes
No
Go To Stage 9
Review Assessments, Plan and identify new actions/goals
Repeat Stage 8


8
Discharge
Patient has
Care Co-ordinator
Yes
No
If Patient is being discharged to temporary accommodation or is likely to re-present to Service then discharge should not be planned to take place after Wednesday
Inform of Discharge confirm 7 day follow-up
Contact Manager of accepting CMHT to request 7 day follow-up
Co-Ordinator not required /Additional Support
Options:
Home Based Treatment - Referral to be completed
Other Agencies - e.g. RENEW Check referral received & confirm appointment date & time
Discharge from CPA - 3 day follow up to be completed by discharging Unit
DISCHARGE
Awareness of package of care
To include:
Who will do 3 day follow up
The ongoing care that will be received.
MHCIT Service contact details
Care co-ordinator details if applicable.
Personalised signs & symptoms of relapse & positive coping strategies
Copy of IDL
CPA discharge
Update Risk Assessment reflecting reduction in risk or change in risk management plan
Update care cluster
Inform carer/family of discharge arrangements if applicable


Complete Discharge Checklist
Discharge from services
If discharged against medical advice – inform the relevant people
DISCHARGE
Discharge Checklist
Patient medically fit for discharge.
Patient has sufficient funds to buy food, or alternatives.
Provide TTO's and ensure patient is aware of how access further medication.
Entry into nursing communication.
Issue Sick Note.
Check store & safe for belongings.
Ensure wristband is returned.
Provide with copy of Aftercare Plan.
Inform Care co-ordinator if not aware.