Cambridgeshire and Peterborough NHS Foundation Trust

ADULT/OLDER PEOPLE MENTAL HEALTH BED MANAGEMENT PROTOCOL
Version 1.0

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Are there any training needs?	No

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1 Principles for bed management

Following assessment, all patients requiring admission to an acute psychiatric bed must be admitted to an appropriate facility to meet their individual needs in a timely and efficient manner. Effective bed management will require frequent review of all inpatient admissions by senior clinical decision-makers who have the power to implement discharge plans (including the power to discharge).
Communication with the patient, their family and carers is an integral part of the bed management process, especially when alternative arrangements need to be put in place.

Robust bed management strategies to manage CPFT existing bed complement, should include:

- Reporting when admission beds are low;
- Crisis Resolution & Home Treatment Teams providing input/visiting wards to assess who might be discharged to home treatment;
- Multi-disciplinary discussion held every day from Monday to Friday to facilitate discharges and free up beds proactively ahead of weekends and bank holiday periods;
- Patients on weekend leave should, where possible, return on Monday morning (not Sunday evening);
- Contingency plans in place to ensure wards can accommodate admissions (especially out of hours);
- Use of leave beds to accept admissions before an out of area placement is requested

2 Consideration for use of a patient leave bed

Whilst recognising the demand for inpatient beds and levels of acuity currently experienced there is an acknowledgment that leave beds may on occasion be required for use to facilitate urgent admissions from the community.

Consideration should be given at the point of a bed being requested regarding the level of risk associated with not facilitating an immediate transfer or admission.

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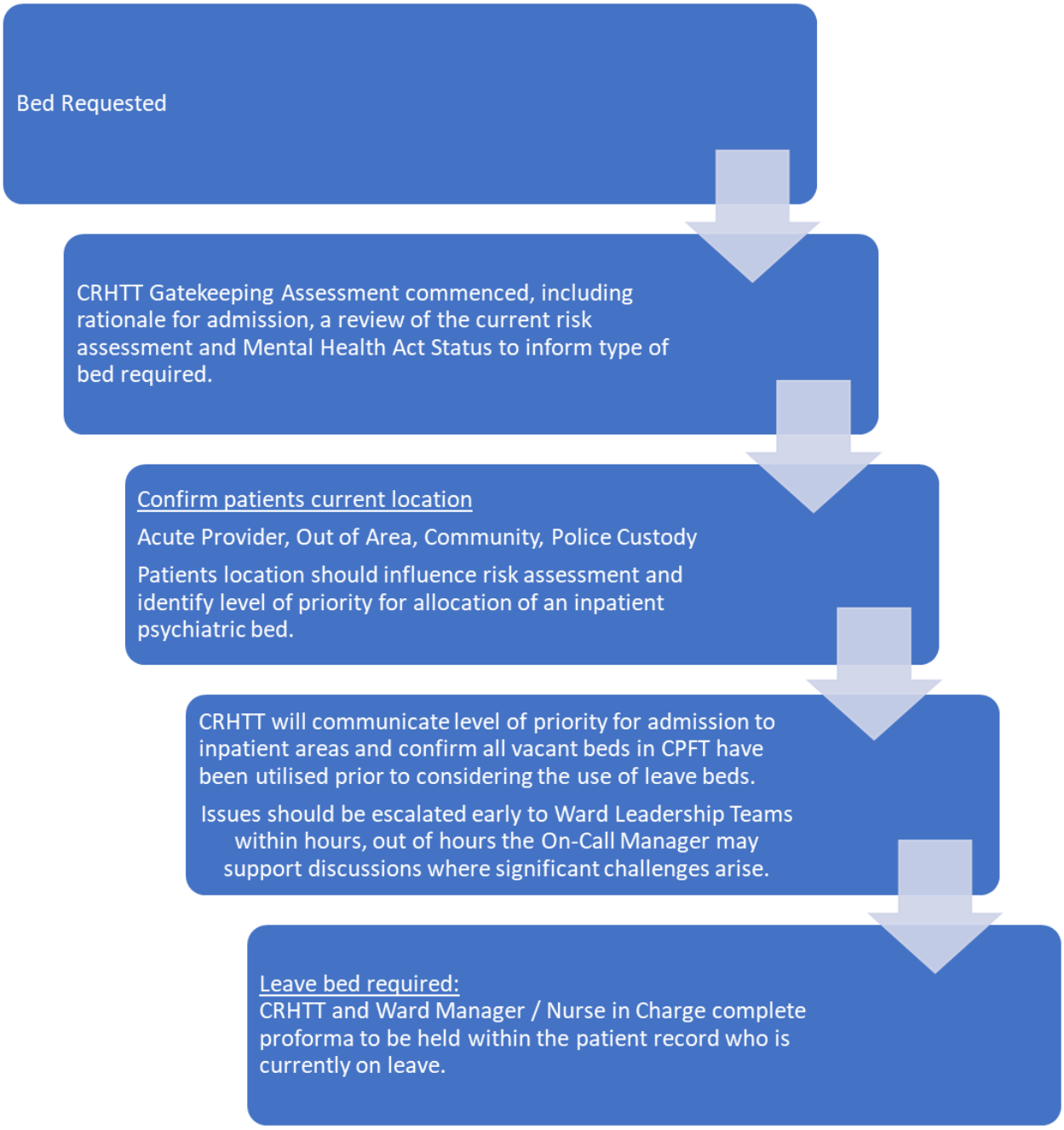


3 **Management of situation where no 'immediately available' bed is identified for admission or patient on planned leave requests a return and bed now occupied.**

The pathway described in Appendix 2 suggests that where no bed can be found in the ward referred to, then an available bed should be considered in an alternative ward such as:

- Alternate mental health ward in Directorate.
- Use of any 'closed' or 'reserved' beds within the mental health wards
- Out of area bed or
- Alternate mental health bed in ASMH/OPMH as relevant (Dementia are excluded);

If no such available bed can be found (across the Trust), then arrangements should be made for the creation of a temporary place within the inpatient services, for review the following morning. The creation of such a place should be made in consultation with senior medical, nursing, and managerial staff, to ensure clinical care of that patient and all other patients is safe. It is noted that additional beds in wards can in itself bring significant pressures to staff and risks to patients.

It should be recognised that from time-to-time it would be appropriate to find a place for a patient to remain where there is not a designated bed immediately available. Examples of special temporary arrangements would include:

- The patient remaining in an acute hospital; or
- Use of seclusion room, where available/safe to do so. This would necessitate observations to be undertaken by staff from the referring Directorate
- Use of s136 suite where available/safe to do so. This may require support by staff from the referring Directorate
- Use of a quiet room.

It is expected that these measures are used only where there is a requirement to protect the immediate safety of patients and the arrangement will be reviewed by the referring team/service at the earliest opportunity, i.e., next day at the latest. Use of special temporary arrangements should be reported via Datix and where significant clinical risk arises from such management arrangements, then a local incident review should be undertaken to understand why this has occurred and to disseminate learning.

It is recognised that non-working age adults with a functional psychiatric illness, who have the same needs as people of working age, should be treated in a similar way. This means that this protocol applies equally to them. However, patients with dementia should not be included within this protocol and units specifically designed for the treatment of people with dementia should not be considered as being available for people with acute functional illness.

This is the ‘meat’ of the document and should set out what staff should/should not do, when and how. Be clear, succinct, and direct to the point, avoiding long paragraphs or unnecessary information. Use bullet points where possible and flowcharts where this will be helpful to summarise a set of steps with explanatory notes. Include diagrams or pictures if it will help to clarify a process or procedure.

This should also state who they can approach for advice or support, if needed.

4 Appendices

1. Proforma for use of a leave bed
2. Utilisation of beds where no ‘immediately available’ bed is identified
3. Use of s136 suite bed as an emergency, temporary bed

APPENDIX 1.

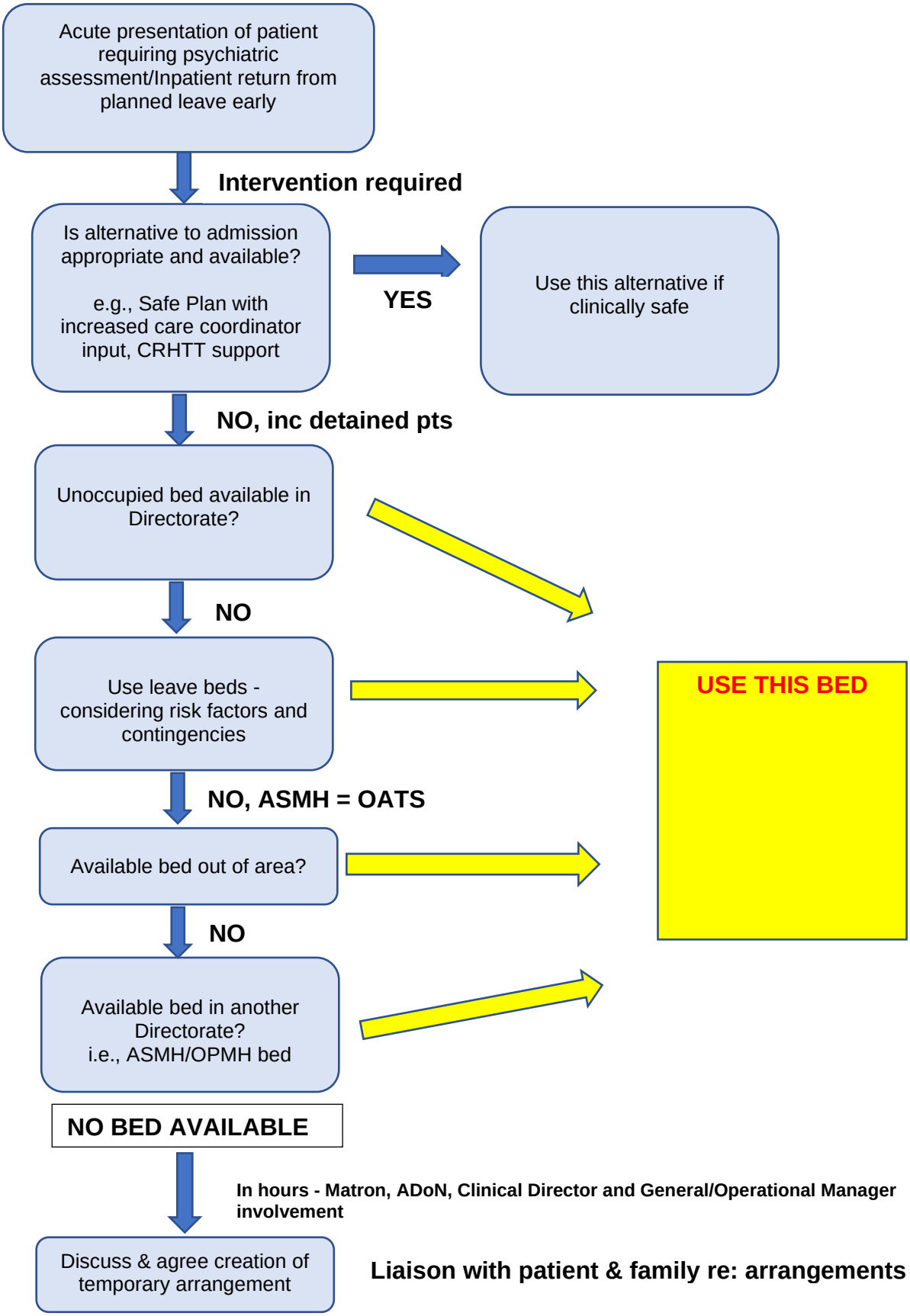
Pro-forma for use of a leave bed:

We need to determine if this is copied and pasted into the patients notes or completed separately and uploaded

Patient Identifier (Name/NHS Number)	
MHA Status:	
Date leave commenced:	
Purpose of the leave: Include if this is first period of leave or if leave has been utilised previously and successfully.	
Expected Duration of leave:	
Intended plan following period of leave: Further leave? Discharge? Has a discharge meeting been arranged?	
Known Risk Factors that may impact upon success of the leave: Substance misuse, level of engagement from support network, medication compliancy,	
Which services are currently supporting: CRHTT, Locality etc.	
Level of input throughout leave: Frequency of CRHTT contact, Ward Contact, Care Coordinator involvement.	
Has the patient been made aware that they may not have a bed to return to? What are their views?	
What would be the contingency plan should the leave break down (refer to Appendix 2): - Increased CRHTT input? - Convene urgent MDT in the community? - Source private bed? - Utilise alternative areas to provide short term place of safety (Seclusion room / 136 Suite) **Senior Manager approval required**	
Who has been involved in agreeing the use of this leave bed:	

APPENDIX 2.

Utilisation of beds where no 'immediately available' bed is identified



APPENDIX 3.

Use of s136 suite bed as an emergency, temporary bed

All Patients requiring **admission** to the 136 Suite will undergo ward admission protocols including a risk assessment, MSE, Physical examination by the nominated CPFT doctor (The Tier 1 on call Fulbourn site) within 4 hrs of the decision to admit to the 136 Suite. **All** patients remaining in the 136 Suite for more than 24 hrs will undergo a physical examination and review of risks and MSE by the nominated CPFT Dr at 24hrs and every 24hr thereafter. Where this is not possible due to the individual's presentation the doctor will document and give recommendations for observations that may be possible/relevant and a timeframe to revisit.	To be added to the 136 SOP. On site Junior doctor cover from the oncall rota (Tier 1 Fulbourn site in hours and OOH). They are expected to liaise with the consultant /RC in hours and the Tier 2 OOH in the first instance. Consultant oversight/RC will be the most appropriately skilled clinician as determined at the point of **admission** according to the patient needs Escalate to inpatient ACD/CD as needed. (On call OOH and by default)
Where ANY patient remains in the 136 Suite for over 24 hours they will be reviewed daily by the responsible clinician/allocated consultant psychiatrist (on call consultant OOH and by default unless otherwise agreed with ACD/C) and an MDT discussion held agreeing further management	

Equality statement

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this policy/guideline. There are no specific adverse impacts for people with 'protected characteristics' or otherwise.

If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the policy development lead.

Document control details

V**ersion Control Page**

Version no.	**Date approved**	**Author**	**Reason for change and details of changes made**
1.0	24.08.22	Denise Hone	This is a new protocol, developed in response to a CQC concern.
2.0			