# Psychiatric Emergency Care Centre Model of Care Guideline

**Summary** This Model of Care Guideline provides high level set of guiding principles and basic components from which each service can develop and monitor their own detailed operating procedures and governance processes. These processes will contribute to best patient care and to the structure of each services' model of care.

**Document type** Guideline
**Document number** GL2015_009
**Publication date** 03 September 2015
**Author branch** Mental Health
**Branch contact**
**Review date** 30 September 2025
**Policy manual** Not applicable
**File number** H15/68974
**Previous reference** N/A
**Status** Review
**Functional group** Clinical/Patient Services - Mental Health, Nursing and Midwifery
**Applies to** Local Health Districts, Board Governed Statutory Health Corporations, Ministry of Health
**Distributed to** Public Health System, Ministry of Health
**Audience** Mental Health services;Emergency Departments;Drug & Alcohol services

NSW GOVERNMENT Health

GUIDELINE SUMMARY

# PSYCHIATRIC EMERGENCEY CARE CENTRE MODEL OF CARE GUIDELINE

## PURPOSE

Psychiatric Emergency Care Centres (PECCs) were introduced in NSW from 2005 as one component of a series of strategies designed to enhance Mental Health (MH) Emergency Care services alongside community mental health teams, Emergency Department mental health clinicians, consultation liaison psychiatry services, psychiatry registrars and consultant psychiatrists.

The earlier version of the PECC Operational Model of Care Guideline attempted to articulate a consensus regarding detailed aspects of PECC operations. The facilities in which PECCs operate differ from each other including with regards to governance, overall mental health resources and how these resources are configured and managed and the physical location and design of the PECC and it has become apparent that it is neither desirable nor possible to standardise resourcing or service delivery arrangements for managing the care of people with mental health problems including those presenting to Emergency Departments (ED).

This updated PECC Model of Care Guideline provides high level guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services' model of care.

## KEY PRINCIPLES

MH care in the ED is a collaborative process, with shared responsibility between Emergency Department and MH clinicians and managers and other specialities (e.g. Toxicology, Drug and Alcohol), where relevant. The relative portion of this shared responsibility varies according to individual patient needs and local service arrangements.

PECCs are integrated with a range of community-based and inpatient care options and represent the least restrictive hospital-based inpatient care option. It is intended to be utilised by consumers with low to medium acuity mental health problems for whom less restrictive care (e.g. community based care), is considered inappropriate and unsafe and who are likely to require only a brief (up to 48 hours) period of time in hospital.

The guiding principles for PECCs are:

1. Collaborative decision-making
2. Least restrictive, short-term inpatient care
3. Outcome based monitoring.

## USE OF THE GUIDELINE

It is the intention of this guideline that individual PECCs represent a locally determined service collaboration and configuration, based on the guided principles contained within this document. Services should monitor, evaluate and if necessary re-design these

agreements by way of carefully chosen outcome and process data reflective of important aspects of mental health emergency care.

This document will assist in the process of establishing, monitoring or reviewing PECC services, their role in the emergency space and in relation to the remainder of community - inpatient MH services.

## REVISION HISTORY

| Version | Approved by | Amendment notes |
|---|---|---|
| September 2015 (PD2015_009) | Deputy Secretary, Strategy and Resources | New guideline |

## ATTACHMENTS

1. Psychiatric Emergency Care Centre Model of Care Guideline.

# Psychiatric Emergency Care Centre Model of Care Guideline

NSW GOVERNMENT Health

GUIDELINE

**Issue date:** September-2015

GL2015_009

# CONTENTS

**1 INTRODUCTION ..... 1**

**2 GOVERNANCE AND MANAGEMENT ..... 2**

**3 CORE FEATURES OF A PECC SERVICE ..... 3**

3.1 Collaborative Care ..... 3

3.2 Mental Health Assessment ..... 4

3.3 PECC Inpatient Admission ..... 4

3.4 Service components ..... 5

3.5 Staffing ..... 5

3.6 Discharge Planning / Transfer of Care ..... 6

**4 MONITORING PECC PERFORMANCE ..... 6**

**5 SUPPORTING POLICIES ..... 6**

# 1 INTRODUCTION

Psychiatric Emergency Care Centres (PECCs) were introduced in NSW from 2005 as one component of a series of comprehensive strategies designed to enhance Mental Health (MH) Emergency services.

The facilities in which PECCs operate differ significantly from each other with regards to governance, the overall mental health resources (community based and hospital), how those resources are configured and managed, the policies and procedures that create a framework for provision of mental health assessment and treatment planning services and the physical design and layout of the PECC; for instance, whether there is physical co-location with the Emergency Department (ED) or local arrangements for different triage points between MH and the ED.

It is neither desirable nor possible to standardise resourcing, service delivery arrangements or facilities for managing the care of persons with mental health problems. Earlier versions of the PECC Model of Care Guideline have attempted to articulate a consensus regarding detailed aspects of PECC operations. However it has become apparent that the preferred approach is that this Model of Care Guideline provide a relatively high level set of guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services' model of care.

The guiding principles for PECCs are:

1. Collaborative decision-making
2. Least restrictive, short-term inpatient care
3. Outcome based monitoring.

These principle-based guidelines are not intended to be prescriptive and lack the detail to describe all aspects of PECC operations given that there are significant individual differences between existing PECCs and that there is no convincing evidence to support a 'preferred' or 'best practice' model.

This document will assist in the process of establishing, monitoring or reviewing PECC services, their role in the emergency space and in relation to the remainder of community- inpatient MH services.

It is the intention of this guideline that individual PECCs should represent a locally determined service collaboration and configuration, based on the guided principles contained within this document. Services should monitor, evaluate and if necessary re-design these agreements by way of carefully chosen outcome and process data reflective of important aspects of mental health emergency care.

MH care in the ED is a collaborative process, with shared responsibility between ED and MH clinicians and managers and other specialities (e.g. Toxicology, Drug & Alcohol (D&A)), where relevant. The relative portion of this shared responsibility varies according to individual patient needs and local service arrangements.

It is quite clear from reviewing the performance of existing PECCs that the better outcomes for patient care, including the need to manage the physical health needs of

mental health consumers, occur where there is true collaboration and shared responsibility between MH and ED services from the point of entry to the ED to the point of discharge from the PECC.

By way of contrast, there are also some characteristic traits of those services performing less well when compared through measures such as the National Emergency Access Target (NEAT), Length of Stay (LOS), and incident or complaint reports. These traits include a reluctance of MH services to assess consumers in the ED until they have been 'medically cleared'; and a reluctance of ED services to provide further medical review of consumers transferred to the PECC whose physical health has deteriorated. What can develop in these services is an unhelpful 'zone of demarcation' between the ED and the PECC that interferes with timely assessment, care coordination and review by both parties and which restricts the seamless flow of services between the ED and the PECC leading to prolonged patient journeys and poorer patient outcomes.

PECCs are one component of the Mental Health Emergency Service, alongside community mental health teams, Emergency Department mental health clinicians, consultation liaison psychiatry services, psychiatry registrars and consultant psychiatrists. The PECC, in turn, is integrated with a range of community-based and inpatient care options and represents the least restrictive hospital-based inpatient care option. It is intended to be utilised by consumers with low to medium acuity mental health problems for whom less restrictive care (e.g. community based care), is considered inappropriate and unsafe and who are likely to require only a brief (up to 48 hours) period of time in hospital.

The remainder of this guideline describes aspects of the model of care for PECCs which may assist those services that are establishing, reviewing or redesigning their PECC. It is expected that services will develop local operating procedures and policies through reference to this document which ensure the quality of care for the consumer, the safety of everyone involved and consideration of available resources through a shared and collaborative planning, monitoring and evaluation process which includes senior MH and ED clinicians and managers.

## 2 GOVERNANCE AND MANAGEMENT

PECCs are one of a suite of MH service options providing for short-term admission of people with low to medium acuity mental health problems who present to the ED or other established access points; and who do not require admission to an acute MH inpatient unit.

MH staff provide ambulatory in-reach to the ED for MH assessment, immediate care coordination, assistance with behaviour management and in managing the care of consumers in the ED requiring MH and D&A support (where there are no D&A specialist staff available).

A high level of collaboration and shared responsibility is necessary to safely manage the care of people with mental health issues who present to the ED and has proven to facilitate better outcomes for consumer care. Strong clinical leadership from both the ED and the MH service is required to support the collaborative process. It is essential that mechanisms to maintain the relationship between the parties are established and supported.

A local governance committee comprising senior clinicians and managers from ED, MH service (including PECC), D&A, should meet regularly as this is seen as an essential means of supporting the collaborative relationship between the services. These meetings should be used as a forum to examine and discuss clinical and operational matters including but not limited to:

- Emergency Treatment Performance data
- Critical incidents
- Length of stay
- Case reviews
- Contentious cases
- Joint Quality Improvement initiatives
- Joint policy and procedural requirements / development
- Clinical staff shared educational needs.

Consumer and carer representative participation would be beneficial in an evolving model of care.

Sub-specialty services like Child & Adolescent Mental Health Services (CAMHS) and Specialist Mental Health Services for Older People (SMHSOP) and other services should be involved in these meetings where relevant.

Representatives from security should also be involved where relevant.

These discussions and review of data will influence the development of local processes and resource allocation with a view to improving patient care.

These meetings may be a separate meeting to the local MOU or Interagency meeting involving Ambulance and Police, but not necessarily so.

# 3 CORE FEATURES OF A PECC SERVICE

The PECC provides the least restrictive hospital-based inpatient care. It is suitable for mental health consumers with low to medium acuity mental health problems who are likely to require a brief admission.

PECCs are declared as mental health facilities to provide for the involuntary care and treatment of patients under the Mental Health Act (NSW) 2007.

## 3.1 Collaborative Care

The early engagement of the MH service will facilitate a timely determination of appropriate patient disposition. This may include referral to MH from point of triage or referral from ED, so that the collaborative process can begin at the earliest possible time.

Where an inpatient (including PECC) admission is deemed likely, all barriers should be removed to ensure the admission occurs at the earliest possible time.

For more complex presentations, the involvement of relevant specialties, e.g. D&A and sub-specialties e.g. CAMHS and SMHSOP, should be sought at the earliest opportunity if assistance is required with assessment or to manage the care of the

consumer. Specialty consultations should not unnecessarily delay assessment and disposition planning.

The consumer does not need to be 'medically cleared' in order for other specialties to be involved or consulted. The term 'medically cleared' is misleading and considered unhelpful and should be replaced with consideration of the medical needs of the patient, i.e. low risk medical care versus high risk medical care.

## 3.2 Mental Health Assessment

The purpose of assessment in relation to PECCs is to determine the level of acuity and to ensure that a PECC admission is the most appropriate, least restrictive care option.

The MH service is to be informed of the likely mental health referral at the earliest opportunity, preferably at triage, so that the collaborative process can begin at the earliest possible time. This may include conducting parallel assessments where indicated. The early engagement of the MH service will also assist to direct MH presentations to the ED into appropriate mental health care in a timely manner.

Within the constraints of the individual PECC facility design, it may be the case that the assessment occurs in the PECC. Consideration may also be given to direct referral to the PECC of low acuity / low medical risk consumers who have been referred for admission by the Community MH team or other locally agreed service providers.

Wherever possible, information should be sought from family and carers and other service providers directly involved in the presentation as this information can aid in assessment of risk and influence care and discharge planning.

## 3.3 PECC Inpatient Admission

Consumers most likely to be considered for a PECC admission are those:

- With low to medium acuity
- Who are low risk of behavioural disturbance and aggression
- With low medical risk
- Who are likely to require a brief admission of up to 48 hours.

Consumers not suitable for a PECC admission are those:

- With ongoing medical instability
- Who require complex acute medical intervention and care
- Who are at medical risk from intoxication
- With higher levels of acuity including with challenging behaviours
- With high clinical risk including at high risk of absconding.

In some services, PECCs have been utilised to provide care for vulnerable patient groups including children and adolescents, older persons and the physically frail. In these circumstances, services should be mindful that these patients meet other admission

criteria for PECC and that the use of the PECC for these purposes does not detract from the PECC's capacity to provide for its targeted patient group. Where the PECC is utilised for these purposes, pre-existing governance and accessibility issues with the relevant specialty should be in place to support the admission and timely transfer of care to the relevant specialty unit.

## 3.4 Service components

PECCs provide:

- Brief (up to 48 hours) admission for short-term mental health treatment, care and observation
- Four to six beds with capacity to admit people detained under the Mental Health Act
- Family and carer engagement
- Discharge planning / transfer of care which commences at the point of initial assessment. This should involve the consumer, their family and carers, their mental health community team, general practitioner and other involved service providers including D&A services, as appropriate.
- Access to consumer consultant or equivalent
- Access to Official Visitors.

## 3.5 Staffing

PECC medical and nursing staffing should be consistent with any other inpatient unit.

There are some important observations to be made from existing PECCs regarding the value of the availability of or access to D&A workers, Social Workers, administrative staff, peer support workers and carer representatives.

Emergency Mental Health is a significant service sub-specialty and support of senior clinicians including Clinical Nurse Consultants and Nurse Practitioners for supervision, clinical skills development and to assist with timely and effective MH care, is highly desirable.

It would be of value to PECC consumers and of benefit to the PECC service for the PECC staffing mix to possess the skills and knowledge to meet the needs of PECC consumers including but is not limited to:

- To respond to substance misuse issues, for example, D&A withdrawal and dangerous intoxication
- Brief interventions / counselling skills
- Trauma informed care
- Young people
- DETECT and Recognising and Responding to the Deteriorating Patient
- Intellectual Disability Mental Health and communication disorders

- Cultural considerations for special needs populations.

### 3.6 Discharge Planning / Transfer of Care

Discharge planning begins at the point of initial assessment. Engagement with the consumer, their family and carers about their discharge plan and follow-up arrangements should begin at the earliest possible time and include the multidisciplinary and multi-skilled staff involved in the care of the person.

## 4 MONITORING PECC PERFORMANCE

The monitoring of PECC performance is a core function of the local governance committee each of which should develop their own outcome and process data.

The committee is encouraged to use existing mental health activity and performance data, influenced by data utilised by the Whole of Health Program initiative, to monitor and evaluate important aspects of mental health emergency care. This data includes but is not limited to:

- Emergency Treatment Performance data
- Length of stay
- Admission and separation data
- ED attendance data
- Incident data
- Complaints.

## 5 SUPPORTING POLICIES

Supporting policies include but are not limited to:

- GL2008_009 Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines.
- GL2008_011 Drug and Alcohol Withdrawal Clinical Practice Guidelines.
- PD2009_027 Physical Health Care within Mental Health Services.
- GL2009_007 Physical Health Care of Mental Health Consumers.
- Mental Health for Emergency Departments – A Reference Guide 2009.
- PD2011_001 Provision of Services to People with an Intellectual Disability & Mental Illness - MOU & Guidelines.
- PD2011_016 Children and Adolescents with Mental Health Problems Requiring Inpatient Care.
- PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW.
- GL2012_005 Aggression, Seclusion & Restraint in Mental Health Facilities - Guideline Focused Upon Older People.

- PD2012_060 Transfer of Care from Mental Health Inpatient Services.
- PD2013_038 Sexual Safety - Responsibilities and Minimum Requirements for Mental Health Services.
- Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies, June 2013.
- PD2015_004 Principles for Safe Management of Disturbed and /or Aggressive Behaviour and the Use of Restraint (for public NSW Health Facilities).