

Adult Mental Health Intensive Care Networks

Summary This Policy Directive sets out the NSW Mental Health Intensive Care Unit (MHICU) Referral Networks. It defines the referral pathway for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to access more intensive care for patients experiencing highly acute mental illnesses, within an integrated model of care.

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ADULT MENTAL HEALTH INTENSIVE CARE NETWORKS

PURPOSE

This Policy Directive sets out the NSW Mental Health Intensive Care Unit (MHICU) Referral Networks. It defines the referral pathway for Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to access more intensive care for patients experiencing high acuity mental illness and complex needs, within an integrated model of care.

MHICUs are centres of specialist expertise in the management of people presenting with highly acute and complex mental illness. MHICUs operate as supra LHD services, and are state-wide referral facilities. Referral to a MHICU occurs from an inpatient mental health facility as the least restrictive option when the patient can no longer be safely cared for due to the risk that their behaviour poses to themselves or others

Each MHICU is a part of a local clinical referral Network and the state wide integrated Network of clinical services that provide timely access to appropriate care.

This Policy Directive also sets out the principles and procedures each LHD should develop and monitor for the care of consumers requiring mental health intensive care.

MANDATORY REQUIREMENTS

- All options for consumer placement to other mental health facilities should be explored before seeking a referral to a MHICU.
- LHDs to admit consumers with the highest acuity or most complex clinical needs from their designated zone into the MHICU
- MHICUs only provide care to those consumers with the highest acuity or most complex clinical needs.
- Referral and transfer to a MHICU is a time-limited episode of care. On stabilisation of symptoms and/or reduction in the level of clinical risk, consumers will be repatriated to the referring LHD.
- The referring LHD will facilitate the transfer to the MHICU.
- The MHICU will facilitate return transfer back to the referring LHD.
- LHDs must inform relevant clinical staff of this policy directive.

IMPLEMENTATION

- This Policy Directive applies to all adult mental health inpatient facilities.
- LHDs/SHNs must have local policies and procedures in place that are consistent with the principles and procedures identified in this policy by August 2019

Local Health District/Network Chief Executives are responsible for:

- Ensuring implementation of the Policy Directive, with the Chief Executive as the final point of arbitration and escalation.
- Documenting and implementing local governance and escalation plans to ensure the appropriate accommodation of patients who need to access a MHICU bed. This must include procedures for clinicians to obtain timely clinical advice and/or support to expedite the review. Escalation plans must include procedures for clinicians to follow in instances where an appropriate bed is not available within the zone or difficulties are experienced with patient acceptance and placement.
- Meeting the MHICU needs of their LHD and linked LHDs including the provision of clinical advice and ensuring access to appropriate treatment.

Local Health District/Network Mental Health Directors are responsible for:

- Ensuring clinical advice and/or support, escalation and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe.
- Ensuring that all options for placement of the referring LHD's patient within the originating LHD have been explored, and that transfer to a MHICU is clinically appropriate.
- Engaging relevant clinicians and ensuring that consistent local protocols or operating procedures are developed and distributed to relevant clinical areas.
- Ensuring timely repatriation. On stabilisation of symptoms and/or reduction in the level of clinical risk, MHICU patients must be repatriated to the referring LHD. Repatriation is the responsibility of the referring LHD.
- Ensuring that compliance with this policy is audited and regularly monitored in collaboration with intra and inter-LHD stakeholders.

Mental Health Intensive Care Units are responsible for:

- Ensuring information in the Patient Flow Portal and/or Emergency Access View is current and correct at each shift handover

Patient Flow Units/Bed/ After Hours Managers are responsible for:

- Facilitating referrals for Statewide MHICU transfers in consultation with the local MHICU

REVISION HISTORY

Version	Approved by	Amendment notes
June-2019 (PD2019_024)	Dr Nigel Lyons, Deputy Secretary, Strategy & Resources	Updated to reflect change process
April 2017		New Policy

ATTACHMENTS

1. Adult Mental Health Intensive Care Networks: Procedures.

Adult Mental Health Intensive Care Networks



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1 BACKGROUND

1.1 About this document

This policy provides guidance to ensure that patients with high acuity mental illness and complex clinical needs receive timely treatment in the most appropriate setting.

Mental Health Intensive Care Units (MHICUs) are specialty units with a small number of beds and high staff to patient ratios that provide a highly specialist and intensive multidisciplinary mental health care to patients who present with clinical complexity and risks that cannot be safely and effectively managed in an acute mental health inpatient unit.

In NSW there are six MHICUs that currently provide tertiary level intensive mental health care and operate as part of a state wide Network.

This procedure describes key processes of MHICUs as follows

- Inclusion and exclusion criteria for referral
- Referral processes
- Transfer of patients between MHICUs and LHD inpatient mental health units
- Roles and responsibilities of MHICUs and referring inpatient mental health units in relation to the transfer and return transfer of patients
- Roles and responsibilities of referring inpatient mental health units during a patient's admission to a MHICU

1.2 Key definitions

Complex clinical needs: Complex clinical needs refers to the care that a patient requires to manage their acute mental health presentation. Complex needs require significant intervention and ongoing support in a range of biomedical, psychological, social and occupational domains.

High acuity: a high acuity patient is a patient that is acutely unstable in their clinical presentation and require increased multidisciplinary review, intervention and care.

Acute severe behavioural disturbance (ASBD): Behaviour that puts the patient or others at immediate risk of serious harm and may include threatening or aggressive behaviour, extreme distress, and serious self-harm which could cause major injury or death. It is important to note that for the purposes of this policy, ASBD related to dementias, intellectual disability and intoxication are excluded.

MHA: *Mental Health Act 2007*

Patient: It is noted that the preferred terminology for people with a lived experience of mental distress and/or mental illness is “consumer”, however for the purposes of this document “patient” has been used to refer to this population.

This term is used to identify that the patient is an admitted inpatient and is accessing mental health intensive care services

Referring inpatient mental health unit: A LHD/SHN based public inpatient mental health unit that has referred a patient to a MHICU for intensive management or stabilisation.

1.3 Legal and legislative framework

This policy refers to the care of people who are subject to the restrictions and directions of the *NSW Mental Health Act, 2007*. In cases where this policy and the MHA are in conflict, the directions of the MHA are to be followed in the first instance. Transfer procedures, detainment of patients and communication with designated carers are all included in the MHA.

1.4 Relevant Information

This policy directive has been informed by, and is designed to be read in conjunction with the following NSW Health Policy Directives and frameworks:

Australian Health Ministers' Advisory Council (2003). *A National Framework for Recovery- Oriented Mental Health Services*. Author, Canberra

Blue Knot Foundation (2012). *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. Author, Sydney

Mental Health Commission of NSW (2014). *Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report*. Author, Sydney

NSW Health (2018). *NSW Ministry of Health Demand Escalation Framework*.

NSW Health PD2018_011: *NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*

NSW Health PD2017_025: *Engagement and Observation in Mental Health Inpatient Units*

NSW Health PD2016_056: *Transfer of Care from Mental Health Inpatient Services*

NSW Health PD2016_007: *Clinical Care of People Who May Be Suicidal*

NSW Health PD2014_025 - [Departure of Emergency Department Patients](#)

NSW Health PD2012_035: *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW*.

NSW Health PD2011_015: *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals*

NSW Health PD2009_060: *Clinical Handover- Standard Key Principles*

NSW Health (2006). *Aboriginal Mental Health and Wellbeing Policy 2006- 2010*. Author, Sydney

2 ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

The Adult Mental Health Intensive Care Network defines the links between LHDs/ SHNs and MHICUs. The Networks take into account established clinical referral relationships which may include referral patterns across LHD boundaries.

There are six (6) local mental health intensive care Networks (Networks), each served by one MHICU.

In addition, the Forensic Hospital acts as a second tier referral facility when the patient has been trialled in a tier 1 MHICU and continues to require a higher level of care or security than is available in the tier one MHICU.

Table 1: State Wide Adult Mental Health Intensive Care Network

MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent’s Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs

3 OVERARCHING PRINCIPLES OF CARE

3.1 Guiding principles for the Adult MHICU Network

The operation of the Adult MHICU Network, and arrangements for patient referral and transfer between referring inpatient mental health units and MHICUs is to be guided by the following principles:

1. The care of the patient is to be collaborative, recovery oriented, trauma informed and person centred, respecting the patient's human rights and dignity whilst being provided in the least restrictive environment alongside input from the patient's family and support people.
2. Referral and transfer to a MHICU is a time-limited episode of care for the intensive management of high acuity and complex symptoms. On the stabilisation of symptoms and/or reduction in the need for intensive care, the patient is returned to the referring inpatient mental health unit as soon as practicable.
3. Admissions are determined with consideration to the existing patient mix in each Network, and then within the broader Adult MHICU Network.
4. In cases of significant distance between the referring inpatient mental health unit and the MHICU, the benefits of admission to the MHICU must outweigh the risks associated with transferring the patient and their separation from family, carers and identified support people.
5. Determination and coordination of safe and timely patient transfer relies on current and accurate clinical handover between senior clinicians at each site. Relevant service executives and patient flow units should be included in all communication.
6. All processes must comply with the Adult Mental Health Intensive Care Network Policy (PD 2019_ 024).

3.2 Defining patients appropriate for MHICU care

A MHICU patient is an existing patient of a mental health facility, who requires a high level of multidisciplinary care, observation and review to remain safe in the acute inpatient environment. A patient appropriate for a MHICU may demonstrate the following risks or behaviours

- Significant risk or continued attempts to harm themselves, with the intent of self-harm and/or suicide.
- Significant risk or actions of acute and severe behavioural difficulties, which seriously compromise the patient's physical wellbeing, psychological wellbeing, the physical wellbeing of others or the psychological wellbeing of others.
- Deterioration of mental health, or increasing symptoms of mental illness including disinhibition, disorganisation, disruption of others and/or significant distressing symptoms of psychosis leading to increased vulnerability
- Repeated attempts to leave the unit without authorisation, if detained under the MHA.

Patients admitted to MHICU demonstrate the highest level of risk, are at the most risk and/or whose symptoms are not resolving to a lower level of acuity in acute inpatient wards. These are patients for whom accessing a higher level of care will provide the resources, observation and structure to contain their experience of distress.

4 REFERRAL TO MHICUS

4.1 Referral to a MHICU

4.1.1 Referral Documentation

The referring inpatient unit will provide a comprehensive clinical handover and package of clinical documentation to the MHICU at the time of referral and transfer.

Referral documentation will include:

- Referral form
- Current assessment by psychiatrist
- A care plan, including the expected goals for admission and a plan for return transfer to the referring inpatient unit
- MHA documentation, including designated carer form
- Contact details of family/ carers and support people
- Medication charts
- Risk Assessment
- 7 days of progress notes
- Details of management and medication strategies trialled and outcomes of these

4.1.2 Assessment

Each LHD must have documented and implemented escalation plans to ensure the appropriate accommodation of the highest acuity patients. Escalation plans must also include procedures for clinicians to follow in instances where an appropriate bed is not available within the Network or difficulties are experienced with patient acceptance and placement.

It is the responsibility of the receiving MHICU to assess whether a referral is appropriate or not, considering the inclusion and exclusion criteria and the current patient population. The receiving MHICU will confirm receipt of referral documentation to the referring inpatient unit, and will assess referrals and respond to referrals within six hours of referral, or next day in business hours if the referral is received after 11am.

If a referral is not accepted for admission, the MHICU will provide a rationale for this. The MHICU clinical team will also be available to provide clinical consultancy to the referring inpatient unit as required to enable safe care and management of the patient.

4.1.3 Inclusion Criteria

Patients admitted to MHICU are:

- Aged 18 or over
- Detained under the NSW Mental Health Act 2007
- Requiring an intensive level of observation and care to manage deterioration of mental health, increased acuity of mental health symptoms and significant risk of ASBD, suicide or vulnerability
- Presenting with behaviour that severely compromises the patient's or another person's physical or psychological wellbeing and safety
- Medically stable

4.1.4 Exclusion Criteria

Patients not appropriate for admission have:

- A diagnosis of dementia, intellectual disability, substance misuse or intoxication in the absence of a primary diagnosis of a mental illness
- Physical frailty that affects the patient's care in an intensive care environment
- Medical conditions, including intoxication or detoxification from alcohol or other substances that cannot be safely managed in a MHICU

4.1.5 High Risk Presentations from Emergency Departments or Community

A MHICU admission from an Emergency Department or a community mental health team, may occur after a psychiatrist's assessment in the following exceptional circumstances:

- To avoid further deterioration and in cases of significant and ongoing risk of ASBD and aggression, patients should not progress through the usual admission pathway of trialling acute unit care.

Where a patient is referred to a MHICU from an Emergency Department the mental health service linked to the Emergency Department has a responsibility to assist the Emergency Department in the proactive management of the patient until the patient is able to be transferred.

4.1.6 Local referral

Referrals from inpatient units will be made to the MHICU in their Local Network in the first instance (Table 1). If a referral is considered appropriate, every effort is to be made by the receiving MHICU to facilitate timely access. This may require a patient with less intensive health care needs in the MHICU to be repatriated to the patient's referring inpatient unit, or another bed in the referring LHD.

4.1.7 State Wide referral

State Wide referrals will only occur when a local MHICU bed is unavailable, and following an assessment of MHICU and referring LHD resources to ensure that only patients

meeting the inclusion criteria at the time of assessment are receiving MHICU care. In this case, all patients currently being treated in the Local MHICU will have higher health care needs than the patient being referred.

Following consultation with the referring LHD, the Local MHICU liaises with the relevant hospital patient flow processes and State Wide MHICU to identify a bed, and forwards the referral to the State Wide MHICU. The Local MHICU will inform the referring inpatient unit of the State Wide referral, and will provide the contact details of the State Wide MHICU.

Once a bed is identified in the state wide Network, the referring inpatient unit will contact the State Wide MHICU and liaise for the transfer of clinical care. The referring inpatient unit remains responsible for the transfer of the patient to a MHICU.

4.1.8 Clinical Handover

The referring inpatient unit will provide a comprehensive clinical handover and package of care documentation to the MHICU at time of transfer. The package of documents will include

- Original MHA documentation, including a signed Section 78
- Medication Charts (including current PRN medication)
- Contact details of family and carers

If no access to the referred patient's electronic medical records are available by the MHICU, the package of documents will also include:

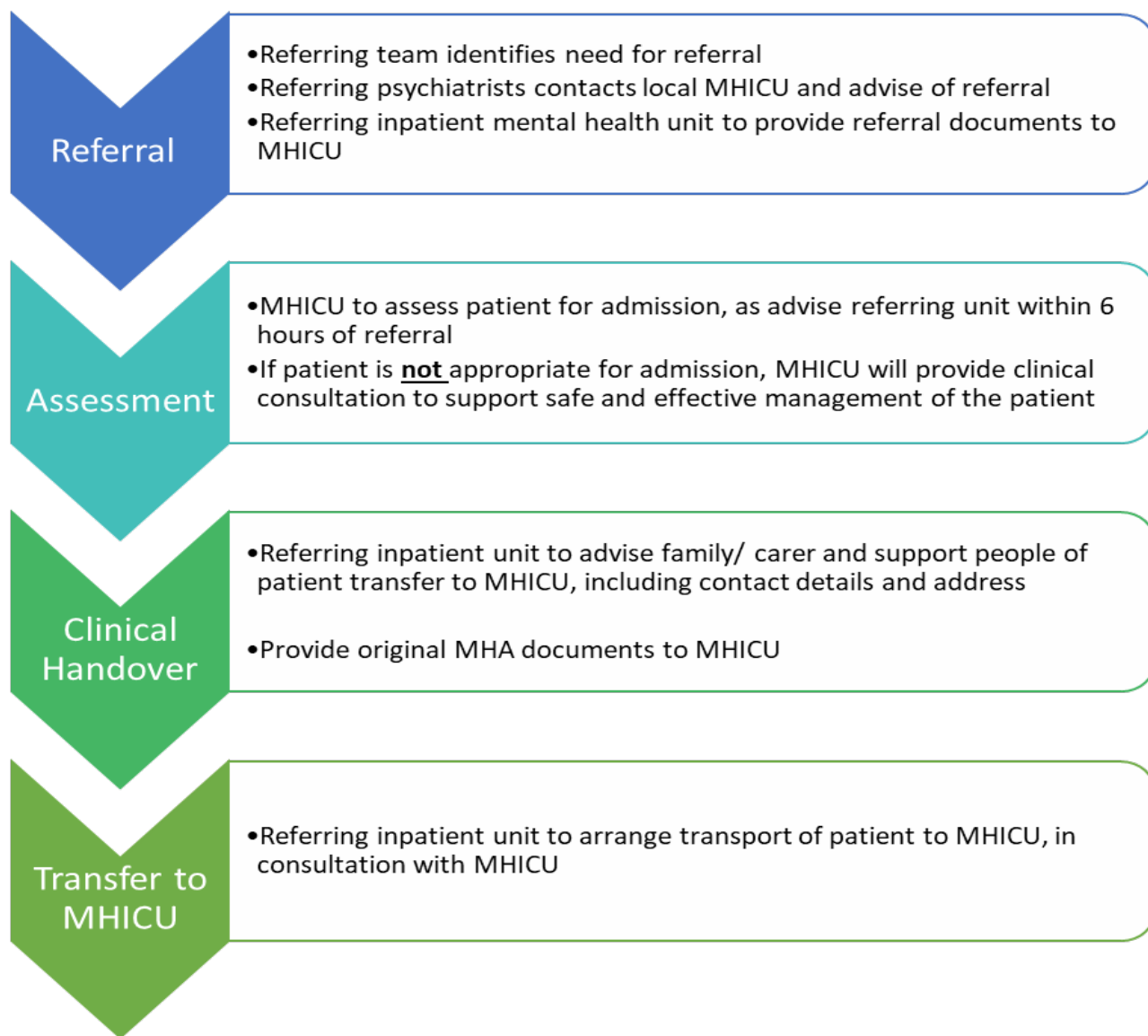
- Current assessment by treating psychiatrist
- A current physical health examination
- Patient History
- Risk Assessment
- 7 days of progress notes
- Details of management strategies trialled and outcomes of these
- Any available allied health assessments and reports

4.2 Transfer to a Mental Health Intensive Care Unit

It is the responsibility of the referring inpatient unit in consultation with MHICU to arrange for the timely and safe transfer of a patient. Transport arrangements should be in accordance with local policy and resources, and may require coordination with hospital security services, the NSW Ambulance Service and NSW Police consistent with the NSW Health- NSW Police Memorandum of Understanding 2018.

Family, carers and designated support people should be involved in any care planning and informed of any referral. *PD 2016_056 Transfer of Care from Mental Health Inpatient Services* details the principles and requirements for the safe transfer of a patient's care across settings. The referring inpatient unit must ensure the continued involvement of family and carers by providing information about options for contact and visits.

Figure 1: MHICU Referral Flowchart



Inclusion Criteria	Exclusion Criteria
Aged 18 or over	A diagnosis of dementia, intellectual disability, substance misuse or intoxication without a primary diagnosis of a mental illness
Detained under the <i>NSW Mental Health Act 2007</i>	Physical frailty that affects the patient's care in an intensive care environment
Requires an intensive level of observation and care to manage deterioration in mental health AND significant risk of violence, suicide, absconding or vulnerability	Medical conditions that cannot be safely managed in a MHICU
Presenting with behaviour that severely compromises the patient's or another person's physical or psychological wellbeing or safety	A risk profile requiring a higher level of security than available at a MHICU

If no bed is available, refer to PD2019_024 section 7 for escalation pathways

4.3 MHICU processes

4.3.1 Daily Multi-disciplinary Team (MDT) Handover

Clinical Handover refers to the safe transfer of professional responsibility and accountability for some or all aspects of a patient's care to another person or professional group

Consistent with intensive care practices, MHICU teams are to undertake a daily MDT handover, which provides the opportunity to discuss and review the presentation of each patient.

Handover meetings will review the EDD, care strategies, clinical incidents and care plans for each patient. Handover meetings must include prioritisation of patients for transfer or return transfer in the case of a higher acuity referral and identification of patients ready for return transfer to referring inpatient units. Following the daily handover meeting, MHICU updates Emergency Access View to accurately reflect bed status and vacancies.

Regular (at least weekly) communication must occur between the MHICU clinical team and the referring inpatient unit clinical team of admitted inpatients. Best practice is to invite a member of the referring inpatient unit team to the MDT clinical review, in person or using videoconference or teleconference facilities. This includes where referrals have been referred from a lower acuity ward in the same facility.

If this is not feasible, an identified MHICU clinical team member is to liaise with the referring inpatient team regarding treatment progress, achievement of care plan goals, changes to the EDD and plans for the return transfer of the patient to the referring inpatient unit.

4.3.2 Identification of patients for transfer

Each LHD that hosts a MHICU is responsible for meeting the mental health intensive care needs of that LHD and linked LHDs within their local Network. It is important to note that transfers are collaboratively planned between MHICUs and inpatient units, expected by both facilities and communicated.

It is the responsibility of the MHICU to identify appropriate patients for transfer to LHD inpatient units in order to create capacity for acceptance of higher acuity referrals. Ideally, the identified patient will be transferred to their referring inpatient unit in this instance. If a bed is not available and cannot be made available by the referring inpatient unit, then the patient may be transferred to an available and appropriate bed within the patient's host LHD, in collaboration and consultation with the host LHD, with return transfer to the referring inpatient unit to be expedited.

Patients identified for transfer will be those who:

- Have demonstrated a reduction in the level of clinical risk to themselves and others as assessed by MDT in consultation with the patient
- No longer require intensive supervision and observation

4.4 Transfer of patients to acute mental health units following MHICU care

4.4.1 Roles and responsibilities of MHICU and inpatient units

It is the responsibility of the MHICU senior clinicians, following discussion with the referring LHD senior clinicians, to transfer a patient to less intensive care when the clinical risk has reduced and/ or the exacerbation of mental health symptoms has stabilised. The MHICU is responsible for facilitating the timely and safe transfer of a patient as it is clinically indicated.

The referring inpatient unit will initiate appropriate local patient flow processes to ensure a bed is available to facilitate the transfer of a patient from a MHICU. The referring inpatient unit will advise MHICU of the appropriate timing of transfer (of no more than 24 hours from the time of request). MHICU will arrange transport of the patient and advise the inpatient unit of these arrangements, including the anticipated time of arrival.

If no bed is available for transfer, the MHICU will contact the LHD mental health patient flow manager and identify an alternative bed for transfer within the patient's host LHD. Once the patient has reached an acute inpatient unit, the process for transfer and/or discharge of the patient to the referring inpatient unit and/or community mental health team will progress consistent with existing local policies and procedures.

4.4.2 MHICU Clinical Handover

MHICU will provide a comprehensive clinical handover to the inpatient unit, including the following:

- Successful management strategies
- Outcomes of agreed care goals
- Medication changes
- Therapeutic interventions
- Recommendations for ongoing management

MHICU will provide a package of documents to the inpatient unit, including:

- Original MHA documentation
- Medication Charts
- Care Plan
- Contact details of family and carers

If no access to the referred patient's electronic medical records created by MHICU are available by the inpatient unit, the package of documents will also include:

- Current assessment by treating psychiatrist
- Patient History
- Risk Assessment
- 7 days of progress notes

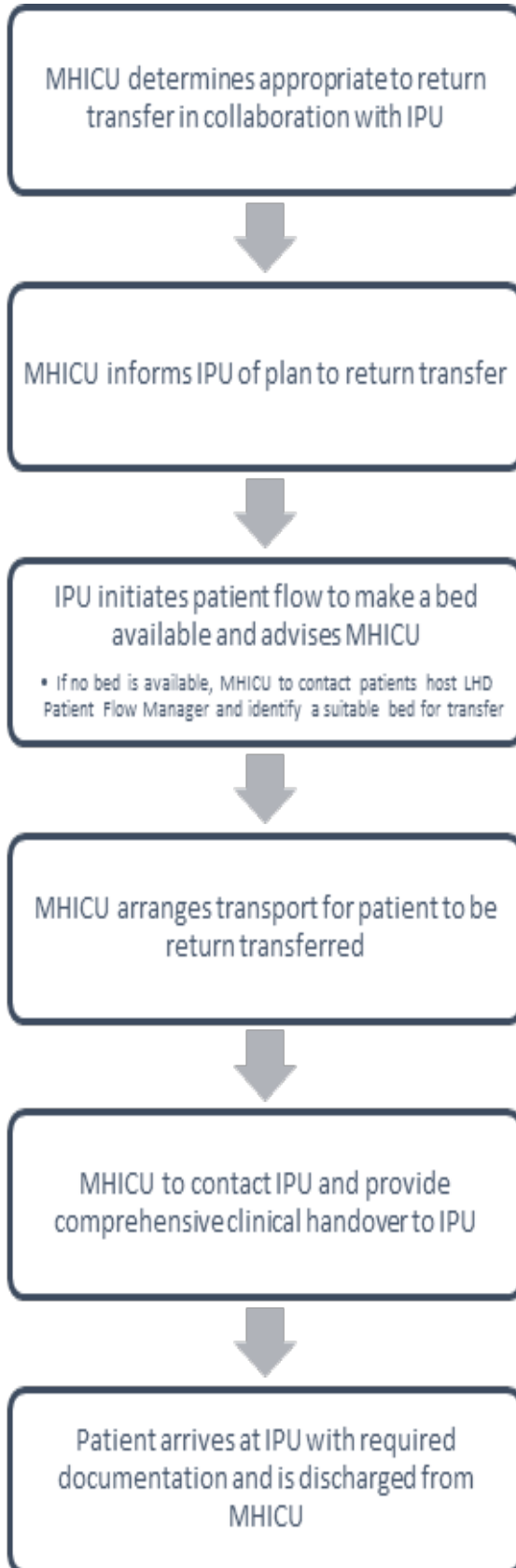
For further information regarding clinical handover, please refer to NSW Health PD2009_060: *Clinical Handover- Standard Key Principles*.

4.4.3 Discharge from MHICU to a community setting

MHICUs do not usually have access to the full range of service resources for each LHD/region to enact and monitor appropriate community referrals in order to facilitate an effective and sustainable discharge to the community.

It is not usually appropriate for a patient to be discharged from a MHICU to the community. However, in rare situations where patients are discharged from a MHICU to a community setting, it will be with the clear collaboration and consent of the relevant accepting community mental health team.

Figure 2: Return transfer of patients from MHICU



5 PATIENT FLOW THROUGH THE ADULT MENTAL HEALTH INTENSIVE CARE NETWORK

5.1 Use of the Patient Flow Portal and Emergency Access View applications

Patient Flow Portal (PFP) and Electronic Patient Journey Boards (EPJB)

The PFP and EPJB are electronic patient flow tools that supports teams to manage their units demand and capacity planning by providing a highly visual tool to facilitate multidisciplinary care, standardising inter-facility transfer processes and supporting the implementation of demand escalation.

It is expected that the EPJB is used by all acute mental health inpatient services, including MHICUs.

At a minimum, each MHICU is required to update the EPJB every four hours, including the Estimated Date of Discharge (EDD) and Waiting for What (W4W) functions. Patients identified as ready for return transfer to their referring inpatient unit will be highlighted using the Inter Ward Transfer (IWT) or Inter Hospital Transfer (IHT) functions.

The MHICU EPJB includes the “MHICU Bed Status tool”, which is used to provide detail of MHICU bed status (staffed and available beds), the on-call details of the MHICU consultant, and patient acuity to assist in the location and access of beds for patients in the greatest need of higher level care.

A daily “MHICU Bed Status” report can be automatically generated and emailed to LHD mental health executive, patient flow managers and clinical directors.

Emergency Access View

The Emergency Access View (EAV) is a real time dashboard displaying the live position against a number of patient demand and patient flow measures. The EAV includes a MHICU Dashboard, and is linked to the PFP to draw information from a single source.

The MHICU Dashboard will support MHICU demand through improved visibility of Network beds, highlighting available beds and the contact details to access these beds. The MHICU Dashboard also provides increased visibility of people in “depart ready” beds, and issues of exit block and delays in transfers.

The MHICU Dashboard will be accessible by LHD executive, Patient Flow Managers and MHICU staff to facilitate the timely access to beds.

5.2 Access to MHICU Beds

MHICUs are tertiary, specialised facilities. MHICUs should not be used to assist in the management of patient flow or clinical capacity for patients who do not meet the criteria for a MHICU admission.

The highest acuity patients in the Network will have access to a MHICU, with lower acuity patients to be transferred from MHICUs to referring inpatient units to facilitate the care of

people who have greater clinical needs. To do this, inpatient units will access the MHICU Bed Status link on the EPJB, to identify the appropriate contact for referral.

Where the local MHICU is full and unable to identify a lower acuity patient to transfer from the MHICU, that MHICU will use EAV to identify an available MHICU bed outside of the local Network, and then link the referring inpatient unit with the receiving MHICU to facilitate the transfer and care of patients.

5.3 Patient Flow Process

Usual MHICU patient flow processes are outlined in Section 4: Common MHICU Processes.

Consistent with the NSW Ministry of Health Demand Escalation Framework, MHICUs will have a demand escalation framework and pathways in place to manage peak variation and changes in patient flow.

As part of a demand escalation framework, MHICUs will require the following plans to be in place to support effective patient flow:

- Short Term Escalation Plan (STEP)
- Facility Demand Escalation Matrix
- Capacity Escalation Plan

These plans will need to interact with facility and LHD demand escalation plans, as well as with regular review by the Local Network.

5.3.1 Estimated Date of Discharge

The Estimated Date of Discharge (EDD) predicts the likely date that a patient will be transferred from MHICU to the referring inpatient unit. It provides everyone involved with the patient's care, including the patient and their family with a projected date to coordinate the patient's care needs. While for some patients the EDD may change due to clinical issues; review of best practice confirms that an accurate EDD can be set for most patients.

The use of an EDD will assist patient flow managers and referring inpatient units to plan the return transfer of patients into appropriate wards, prevent MHICU delays in returning patients to appropriate wards and reduce patients receiving care outside their home mental health service.

5.4 “Depart Ready” and “Good to Go” Identification

5.4.1 Depart Ready

Patients identified as “Depart Ready” will be patients that have been identified for return transfer, have been accepted by the appropriate inpatient unit and have patient transport booked to return the patient to the referring inpatient unit.

Exit block will occur when G2G patients have not been transferred within 24 hours of identification.

5.4.2 Good to Go

Patients identified through the EPJB as “Good to Go” (G2G) are those that have been identified as appropriate for transfer to a lower acuity inpatient unit. These patients should be identified using the G2G cell on the EPJB, and should be flagged with the referring inpatient unit to begin preparing for return transfer, this may include creating appropriate capacity.

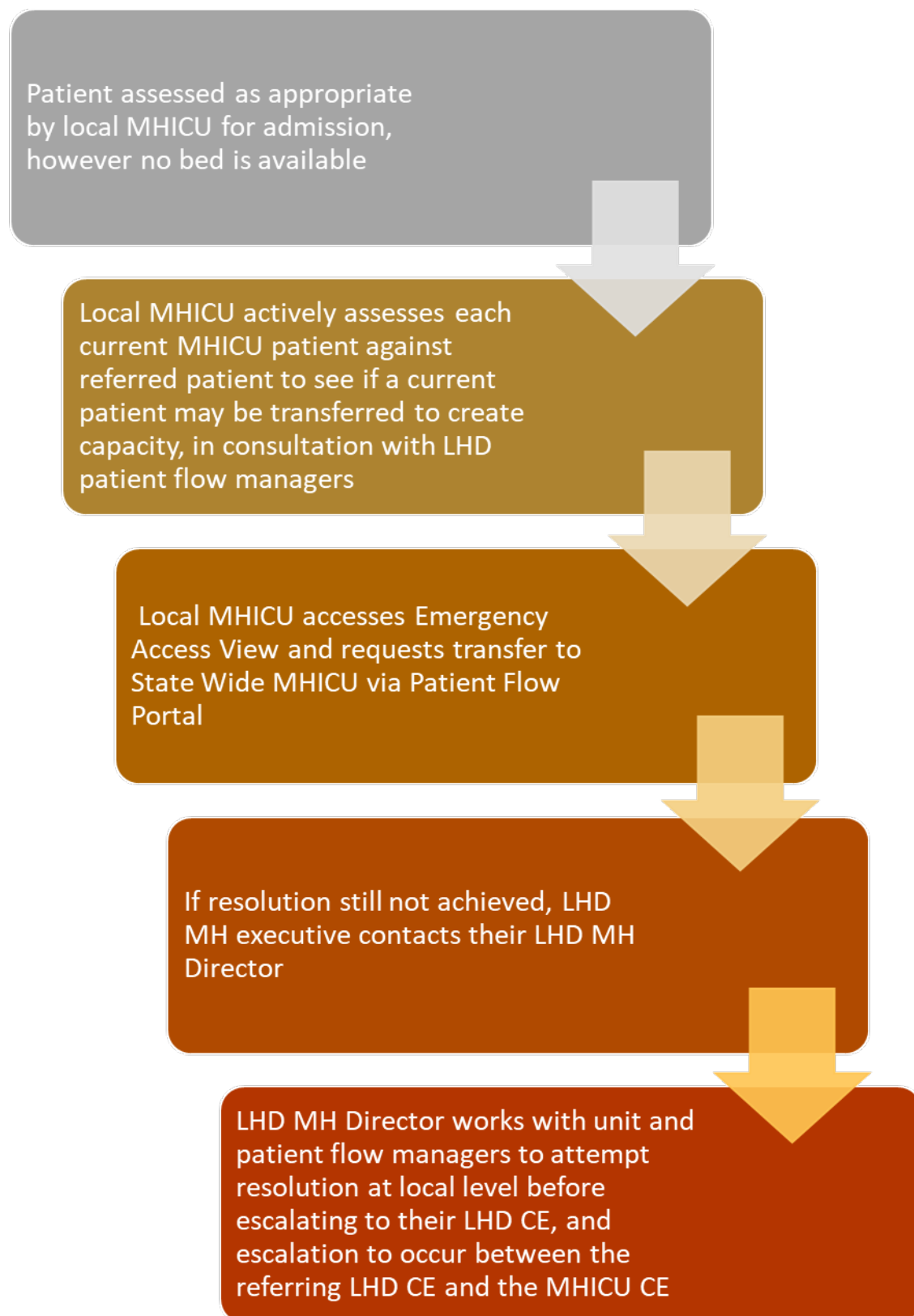
5.5 Network Coordination, Escalation and Management of Delays

LHDs and SHNs will develop formal specialist clinical referral Network procedures to guide clinicians and facilitate patient flow, ensuring appropriate, safe and timely patient referrals, return transfers and clinical consultancy to the Network. LHDs and SHNs will establish processes including:

- Patient referral and priority of referrals in relation to the existing Network and MHICU patient mix
- Patient assessment by MHICU
- To support the LHD with clinical consultancy and management strategies in circumstances where there is a delay in transfer, where it is unsafe to transport the patient or when no MHICU bed is available
- To ensure the referring inpatient unit maintains active engagement in the care of the patient following referral and transfer, including clinical review and case conferences
- To arrange return transfer and support patient transfers
- For the operational review of processes to improve collaboration between services and the operation of both the local and state-wide Network

Should issues arise in coordinating the care and treatment of a patient within the Network, issues should be escalated to the LHD executive and Chief Executive, following local guidelines. Resolution of issues will occur at this level.

Figure 1: Escalation Pathway



6 LIST OF ATTACHMENTS

1. Implementation Checklist
2. Adult Mental Health Intensive Care Network Flowchart

Attachment 1: Implementation checklist

LHD/Facility:			
Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1. Development and documentation of LHD clinical governance and escalation pathways and demand escalation frameworks to ensure patient flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
2. Development of pathways and communication processes between Networked LHDs and MHICUs to ensure streamlined referral and transfer of MHICU patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
3. Development of local procedures for MHICU referral, care and transfer that are consistent with this policy directive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
4. Appropriate identification and training of clinical and administrative staff in Patient Flow Portal and Emergency Access View applications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
5. Identification of the LHD Chief Executive as the final point of arbitration and decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
6. Audits to review compliance with this document are conducted annually (minimum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		

Attachment 2: Adult Mental Health Intensive Care Network Process



MHICU	Referring LHD
Mental Health Intensive Care Unit, Northern Sydney LHD, Hornsby Hospital, Hornsby	Northern Sydney
	Central Coast
Psychiatric Intensive Care Unit, Hunter New England LHD, Mater Hospital, Waratah (Newcastle)	Hunter New England
	Mid North Coast
	Northern NSW
Orange Lachlan Intensive Care Unit, Western NSW LHD, Bloomfield Hospital, Orange	Western NSW
	Far West
	Murrumbidgee
McKay East Psychiatric Intensive Care Unit, Sydney LHD, Concord Hospital, Concord	Sydney
	South Western Sydney
Yaralla Psychiatric Intensive Care Unit, Western Sydney LHD, Cumberland Hospital, Parramatta	Western Sydney
	Nepean Blue Mountains
	Southern NSW
Mental Health Intensive Care Unit, South Eastern Sydney LHD, Prince of Wales Hospital, Randwick	South Eastern Sydney
	Illawarra Shoalhaven
	St Vincent's Health Network
Forensic Hospital, Justice and Forensic Mental Health Network, Malabar	Second tier referral for all LHDs/SHNs