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Adult Mental Health Guidance in Relation to Outlying

Introduction and Aim

In the event of bed shortages outlying patients to another ward (or the ward designated to provide their assessment and/or treatment) into a different clinical area within the service may be required. This may include Rehabilitation and Recovery Services, Addictions, Admissions, Low Secure and Locality Wards.

The guidance will relate only to outlying arrangements due to bed capacity issues and not transfers due to clinical need or other clearly defined reason (e.g. mobility issues, risk management, conflict between 2 individuals etc)

This document is not in support of a policy. It should achieve consistency across the service in relation to the process of identifying suitable patients for outlying to other clinical areas.

Objectives

- *To ensure that, if patients are required to move to another clinical area patient safety and wellbeing are at the forefront of the decision-making process.*
- *To ensure that all staff follow the same guidance when identifying which patients are suitable for outlying to an alternative clinical area.*
- *To ensure that no patient is disadvantaged in terms of the care that they receive in the event of outlying to another ward. An equitable service is to be provided regardless of where the patient is.*
- *To ensure that patients are moved in a timely manner and are adequately informed and have given consent. Please see guidance below.*
- *To ensure that the outlying arrangements have been clearly documented and a risk assessment has been carefully considered, updated and communicated to the receiving clinical area.*
- *To ensure that all outlying arrangements have been discussed with the on-duty shift coordinator.*

Scope

This guidance applies to all staff within Adult Mental Health Services.

Equality Health Impact Assessment	*An Equality Health Impact Assessment has not been completed as this guidance is in support of:* *Crisis Assessment Ward Operating Policy*
Documents to read alongside this Controlled Document	*Crisis Assessment Ward Operating Policy* *Locality Ward Operational Policy* *Out of Area Bed Procedure*

	Mental Health (Wales) Measure *Mental Health Clinical Risk Assessment and Management Policy*
Approved by	*Controlled Document Oversight Group* *Mental Health Clinical Board*

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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*13/08/2015*	*07/04/2016*	*New document*
2	*July 2023*	*July 2023*	*This is a revised document to replace Adult Inpatient Sleeping Out Guidance. Reference no. UHB 294 Version 1.*

Contents

1. Definition & Overview

1.1 The term *'outlying'* is used to describe a situation whereby a clinical area is at capacity and no longer able to accommodate patients associated with the Wards locality and/or specialty. As a result, it may be necessary to arrange for another ward to accommodate one (or more) of their patients. For example, this situation may occur when there is a clinical need to create an admission bed on Cedar Ward.

1.2 For the purpose of this guidance, the ward where the patient ordinarily receives their assessment/care/treatment is referred to as the '**parent ward'** and the ward that temporarily accommodates the patient under an outlying arrangement is referred to as the '**host ward'**.

1.3 The outlying arrangement is usually temporary but may be prolonged over a number of days and in some cases a number of weeks; it may include more than one patient.

1.4 This practise has previously been referred to as "sleeping out" and is not to be used in the situation of a formal transfer of care which requires cross speciality referral and acceptance.

1.5 Once outlying, further moves should be kept to a minimum and priority given to returning the individual to their parent ward when possible.

2. Guidance

2.1 The guiding principle should be to identify any need for outlying at the earliest possibility. The decision for outlying patients should be made within day time hours 07:00-19:00. Outside of these hours should be considered exceptional and avoided where possible. If it is to occur a discussion with the shift coordinator would be required and rationale recorded. Consideration should be afforded to the requirement of a Datix form.

2.2 All ward teams need to assess their bed capacity and report any bed requirements that can't be met to the shift coordinator as soon as it is realised. It is the responsibility of the Nurse in Charge of the ward to notify the shift coordinator of bed capacity issues and the possible requirement for outlying patients.

2.3 This is to be complemented by the Shift Coordinator assessing the likelihood of having to use outlying guidance at the beginning of the early shift.

This is based on the handover from the previous night's coordinator which will include the midnight bed status, the outlying patients record and general activity on the wards, Crisis Resolution Home Treatment Teams (CRHTTs) and especially Cedar Ward.

2.4 The decision for outlying may not be as a result of capacity issues alone. Examples of the need for outlying are:

- Patient to patient conflict
- Safeguarding concerns
- Condemned bed space
- Safe management of enhanced observations.

These examples are not exhaustive and the parent wards rationale must be discussed with the Shift Co-Ordinator with the same being recorded in the Paris record.

Patients must be carefully risk assessed prior to outlying. If it is disruptive and harmful to move a patient to back to the parent ward during the day this must be prevented- do no harm. Equally, there may also be reasons (such as infection control or workforce capacity issues) that prevent patients moving across wards during day from host to parent ward. There may be situations when outlying is an immediate safeguarding action. In all these cases a further risk assessment is required. This will include a review of any changes in risk which have resulted from outlying the patient from their parent ward. A detailed intervention plan will need to be put in place including measures taken to mitigate any risks. A member of the MDT from the parent ward or senior nurse will be required to support and guide this assessment and care plan.

2.5 Cedar ward should maintain consistent capacity to accept admissions. This is not always the case and there will be times when patients will require outlying to other clinical areas.

2.6 When the initial capacity issue is identified, all options to alleviate this must be considered e.g. reviews by MDT regarding alternative options to hospital stay. Consideration should be given to referral for Early Discharge Assessment for Home Treatment. If all options are exhausted and a need for outlying has been confirmed, the clinical team would need to establish which patient(s) are most suitable. Wherever possible this should be an MDT discussion and always based upon an up to date risk assessment. The Shift Coordinator should be used as a resource to assist decision making.

2.7 There could be occasions when there are no beds available within the service provision and an out of area bed would be required. OOA bed procurement is to be actioned as outlined in the OOA Bed procedure.

2.8 Patient involvement is required prior to any decision being made and should be discussed with the Shift Coordinator and the host ward.

2.9 This policy/procedure acknowledges the possible impact outlying may have on patients in that they may feel that they do not have the support of the staff and fellow patients they have built a rapport with, or feel they are not valued as individuals. For this reason, every attempt must be made to support the patient when outlying, by engaging with them to establish a rapport and provide reassurance that their care and treatment is important, and that any disruption to their care is minimised as much as possible during any outlying. The intention being to reduce the possible negative impact of outlying.

The following should be discussed with the identified patient and documented accordingly:

- An explanation and rationale as to why they are required to outlie.
- Where they will be outlying
- What will happen with their personal possessions
- Mitigation for any implications to their care
- The patients consent to be moved.
- The patients consent to inform family/carers if they wish to do so

2.10 Criteria for consideration when deciding who is appropriate for outlying will include as a minimum:

- Mental state/ current presentation
- Level of Observations
- Leave status
- WARRN Risk formulation
- Upcoming Mental Health Tribunal
- Ongoing suicide mitigation work and assessment
- Status of discharge plans
- Patient consent
- Mental Health Act status
- Adequate staffing Levels
- Any existing conflict within the patient population within the host ward

This above information should be handed over to the nurse in charge each time a patient is moved from one ward to another.

Every attempt should be made to return the patient to their parent ward at the nearest opportunity to reduce any disruption or risk to their care.

Consideration should be given in the decision-making process of balancing the safe management of the hospital against the individual clinical risk of outlying a patient to another ward, particularly if it is not the specialty they require (see section 4 for more guidance).

3. Clinical Responsibility

3.1 There is the need to discern between different categories of outlying:

Adult Acute/Rehab to Adult Acute/Rehab

3.2 this describes the situation where the parent ward and host ward are of the same speciality. For example, the patient moves from one locality ward onto another locality ward.

3.3 In instances of outlying; to ensure continuity of care for the patient, best practice would be for the responsible clinician and allied health professionals of the parent ward to continue to regularly review the patient whilst outlying. However, all day to day clinical involvement, with respect to management of risk and nursing is to be managed by the nursing team on the host ward. The patient should not be disadvantaged in any way or their admission prolonged from delayed care as a result of outlying. The host ward's responsibility will be as follows:

- Allocate primary nurse
- Complete Nursing 1:1s
- Discharge planning
- Risk management
- All day to day clinical involvement.

3.4 Each clinical area is required to keep a record on their office board of those individuals outlying to ensure MDT awareness and will improve ability to return individuals to their parent ward at the nearest appropriate opportunity.

3.5 If a patient is outlying on one of the rehabilitation wards, the Rehabilitation & Recovery Waiting List needs to be consulted in order to inform the decision about the most appropriate person for outlying into a Rehab area. Ideally, it should be the person who is top of this list. If Park Road or Phoenix are being

considered as an option for outlying, the guidance for this ***must*** be followed (**Appendix 1**).

3.6 If a patient is placed on long term leave by their clinical team whilst outlying to another ward, then the patient should be placed on the bed state of the parent ward with the aim of returning to the parent ward for reviews, discharge planning meetings and TTH medications.

4. Outlying to Addictions Services and Neuropsychiatry

4.0 This describes the situation where the parent ward and host ward are from different specialities. For example, the patient outlying from a locality ward to Neuropsychiatry ward; or inpatient adult acute setting to the addictions service.

4.1 In instances whereby an adult acute patient is outlying to alternate specialties such as Addictions or Neuropsychiatry it will remain the responsibility of the parent ward to facilitate discharge planning, daily nursing 1:1's, completion of paperwork under the Mental Health Measure and WARRN Risk formulation. Patients who are outlying should be included in the routine handovers on the parent and host ward and their name should be kept on the office board patient list to ensure that they are discussed at each handover.

4.2 During the daytime the patient should remain on the host ward, however on occasions it may be appropriate for the patient to return to the parent ward for a review or a therapeutic activity. To ensure continued standard please see guide below outlining responsibilities.

Responsibilities of the parent ward –

- Completion of paperwork under the Mental Health Measure and WARRN risk formulation.
- Allocate an appropriate qualified nurse to complete a daily face to face 1:1 interaction with the patient.
- Request a daily handover from the host ward.
- Review appropriateness of outlying.
- Ensuring attendance at ward round and other appointments.
- All aspects of discharge planning e.g TTH, follow up appointments and liaising with CMHT.

Responsibilities of the host ward –

- To record a daily case note capturing presentation and level of risk with acknowledgement that the patient is outlying.
- To handover any updated information to the parent ward each day.
- To record any change in context of risk and to review or report appropriateness of outlying.

4.3 Referrals within the Adult Acute, Crisis and Rehabilitation will remain open when outlying to these areas.

4.4 On occasions whereby an individual is already outlying from their parent ward to a host ward; prior to further outlying to a speciality ward; the responsibility outlined in 4.1 needs to be agreed between the parent ward and host ward prior to outlying to the speciality ward. Length of time on the host ward and original rationale for their outlying should be factors considered when making this decision. This should be recorded clearly in the patients Paris notes.

4.5 Ash Ward is a specialist tertiary service funded by WHCCS (Welsh Health Specialist Services Committee). Therefore, these beds are designated for patients with acquired brain injury and associated mental health conditions. Due to the nature of WHCCS funding, Ash ward beds must only be used as a last resort. Prior to Ash acting as a host ward, a discussion must take place with Neuropsychiatry/Directorate management/Silver on Call. Part of the agreement to act as a host ward will require a detailed plan including timescales for transfer back to the parent ward.

5. MHSOP

5.0 Outlying to MHSOP bed provision should be considered a last resort and approached as a rarity. In the unlikely event this is needed then consideration as to the most appropriate client and associated risks need to be considered. A discussion will be required between the parent ward, shift co-ordinator and appropriate manager within MHSOP.

5.1 Patients experiencing mental health conditions may require outlying to organic wards. There may also be patients with organic illness who may require outlying to mental health wards.

5.2 Prior to outlying, where patients have capacity, consent must be sort. If appropriate; family/next of kin/carer must be informed. In cases where patients lack capacity, LPA/family/next of Kin/carer would need to be informed of any outlying arrangements.

6. Low Secure Services

6.1 When considering outlying a male patient on the Low Secure ward it is essential that the patient is made aware of restrictions of this environment. The patient needs to be aware that Low Secure the environment does not allow mobile phones, vapes (e-liquid devices) and there is limited access to the garden. Patients that are identified as appropriate to outlie to these wards must be subject to the Mental Health Act. Outlying an informal patient to Low Secure services should only be considered in extreme circumstances once all other options have been exhausted. Patients with MOJ restrictions attached to their detention cannot be considered for outlying, these include prison transfers and those individuals undergoing court ordered assessments.

6.2 Patients who are outlying to the Low Secure service will be returned to their parent wards as soon as a bed is available. Patients can only subject to outlying to Low Secure Services when an identified risk has highlighted the need for this environment, and transfer has been discussed within an MDT and agreed as appropriate with the Low Secure senior team.

6.3 Careful consideration must also be given and documented regarding the risk to and from others who are outlying to a Low Secure ward from another clinical area. This may carry a specific risk due to the patient population within the Low Secure setting.

7. Further Considerations

7.1 In all circumstances of outlying, it is the individual clinicians in all disciplines of the MDT's responsibility both on the parent and host ward to be informed of the individuals risk assessment through awareness of the Paris record. Any changes to the risk profile are to be reported and responded to by the host ward.

In each instance of a patient outlying to another ward a thorough nursing handover must be facilitated by the transferring ward (parent to host and host

to parent ward). This is to include acknowledgment of clinical risk and any supportive measures that can be implemented to reduce individual disruption to the patient.

7.2 The guiding principle to be followed is that the same level of care and treatment will be provided regardless of where the patient is. No-one should be disadvantaged or feel that they are receiving a lesser service as a result of outlying.

7.3 On outlying to the host ward the patient must be orientated to the ward and informed of the expectations of the ward including any additional restrictions that may be placed upon them. This must be documented in their Paris notes. There must be clear, consistent and timely communication between the patient's parent ward and the host ward. This must include the expectations of the owning clinical team to review care and support the patient's pathway.

7.4 If the patient is unhappy about the outlying arrangements, and bed pressures prevent us from resolving this immediately the patient must be advised of how to escalate their concerns, and offered the support to do this, including the Putting Things Right process.

8. What happens if the bed capacity issue occurs out of office hours?

8.1 Whilst all efforts should be made to pre-empt the outlying decision-making process in order to involve the wider MDT, there will be occasions when the need to do this occurs out of hours, either on the weekend or during the evening etc. When this does happen, the process should be followed as above, but without the considerations of the wider MDT. The Shift Coordinator will need to take a more prominent role to ensure clarity of decision making. If the ward staff are having difficulty in identifying a suitable patient then Shift Coordinator can provide support and assistance. Silver on Call should be informed and in agreement if the decision is to move a patient from a ward to a different specialty.

9. Reviewing outlying

9.1 Generally, this will be a temporary arrangement – the length of time would be determined by the availability of the number of beds on the parent ward. There should be a discussion between the 2 areas about the length of time

outlying is required and should remain line with their discharge plan. This should be reviewed by the MDT on the parent ward on a daily basis.

10. Documentation

10.1 Case notes may be filed under a different PARIS speciality or 'tree' if a patient is outlying on a ward from a different specialism. The nursing team on the host ward may not have access to the required 'tree' and may not have open access to Clinical Information. If any occasion arises on the host ward that require an update in this field then they must ensure that they clearly document this and notify the parent ward so it can be updated by a staff member from the relevant team.

11. Property

11.1 Patients are to be reminded that as per the Patients Property Policy, the UHB in general does not take responsibility for the loss or damage of any property, cash and/or valuables that have not been handed in for safe keeping.

The opportunity for handing items in for safe keeping must be offered to anyone outlying to another ward and staff must follow the Patients Property Policy to ensure that the interests of all patients (especially vulnerable patients) are adequately safeguarded.

Appendix 1

Procedural Guidance for sleeping out to Park Road Houses Rehabilitation Unit

Rationale

- Park Road houses and Phoenix are isolated care environments.
- Only 2 staff by night.
- Bedrooms have no viewing panels to observe patients.
- There are numerous exits from the main building and 2 exits from House 11 in Park Road which is separated from the main building.
- No access to 2222 or SIMA trained staff.
- Park Road and Phoenix has many ligature points.
- Knives etc are easily accessible to patients.

Procedure

Outlying a patient to these areas should be made on an individual basis. Decisions around outlying from other inpatient areas to Park Road or Phoenix should be made where possible before 5pm and in consultation with a senior member of Rehabilitation Nursing Staff.

Consideration should be made at all times with regard to:

- Current mental state.
- Risk assessment- this needs to be current and relevant.
- Levels of observation – due to low staffing levels and the environment Park Road and Phoenix staff are unable to observe patients who require more than general observations.
- Patient leave agreements:
- Section 17 leave in place for Phoenix House and Park Road Whitchurch.
- Unescorted leave agreed.
- Risk of absconding.
- Current physical health. (No access to 2222 or Oxygen etc)
- Mobility issues. (All bedrooms and bathrooms are upstairs.)
- Environmental issues and constraints of Park Road Houses and Phoenix

Basic requirements for consideration are:

- Patient must have unescorted leave.
- Is the patient in agreement to outlying at Phoenix or Park Road

- Patient must not be voicing any thoughts of self-harm or current suicidal ideation.
- Patient must be on general observations.
- Risk assessment must be reviewed and updated on Paris prior to consideration.
- TTH is to be provided. Phoenix and Park Road does not carry stock medication.
- All Mental Health Act documentation needs to be in place and up to date

Whilst outlying to Phoenix or Park Road, patients remain the responsibility of their MDT and arrangements with regard to ward round review etc. Which must be communicated to Phoenix or Park road houses.

Appendix 2

Acute/Rehab to Acute/Rehab

- **Responsibilities of parent ward** -
- To ensure continuity of care though regular reviews by RC and allied health professionals.
- If patient is on placed on long term leave whilst outlying, then the patient should be placed on the bed state of the parent ward for further reviews, discharge plannning meetings and TTH medications.
- **Reponisbilities of host ward-**
- All day to day clinical involvement i.e risk management, nursing 1:1s, discharge planning etc.
- The patient should not be disadvantaged in any way as a result of outlying.
- Please refer to appendix 1 if outlying to Park Road or Phoenix.

- *Please refer to outlying guidance for further information*.

Acute/Rehab to Ash or Pine

- **Responsibilities of the parent ward** –
- · Completion of paperwork under the Mental Health Measure and WARRN risk formulation.
- · Allocate an appropriate qualified nurse to complete a daily face to face 1:1 interaction with the patient.
- · Request a daily handover from the host ward.
- · Review appropriateness of outlying.
- · Ensuring attendance at ward round and other appointments.
- · All aspects of discharge planning e.g TTH, follow up appointments and liaising with CMHT.
- **Responsibilities of the host ward** –
- · To record a daily case note capturing presentation and level of risk with acknowledgement that the patient is outlying.
- · To handover any updated information to the parent ward each day.
- · To record any change in context of risk and to review or report appropriateness of outlying.

- *Please refer to outlying guidance for further information*