Psychiatric Intensive Care Unit (PICU) Operational Policy

Lead executive	Director of Nursing, Therapies Patient Partnership
Authors details	PICU Ward Manager (Brooklands) - 0151 482 7638 PICU Ward Manager (Wiilow) - 01244 397301 Advanced Practitioner for PICU - 0151 482 7638

Type of document	Policy
Target audience	All clinical staff
Document purpose	The purpose of this document is to outline the function and operational procedures relating to the Psychiatric Intensive Care Unit service within Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Approving meeting	Wirral Locality Governance and Risk Meeting	Date 17-Feb-14
Implementation date	17-Feb-14	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
CP12	The searching of patients and environments (including the use of Police dogs)
CP25	Therapeutic observation policy for in patients.
CP36	Securing or locking of access doors to inpatient areas
CP38	Seclusion policy
CP40	Safeguarding children policy
GR1	Incident reporting and management review policy
GR3	Risk management policy
GR4	Policy for the recording, investigation and management of complaints / concerns
GR8	Security policy (incorporating lock down procedure)
GR25	Crisis Support Team policy
HR14	Guidance on accessing staff support and psychological wellbeing service.
HR22	Supervision policy
MP1	Medicine policy
MP10	Rapid tranquilisation policy
MP12	Antidepressant Treatment pathway for adults (over 18) with moderate to severe depression
MP18	High dose antipsychotic therapy (HDAT) guideline
MP22	Policy for prescribing antipsychotic medications in psychotic conditions (excluding Bipolar Disorder)
NCG82	Schizophrenia
NCG90	Depression
NCG185	Bipolar disorder
NCG78	Borderline personality disorder
NCG16	Self harm and suicide
NCG10	Short term management of aggression and violence

Document change history	
What is different?	
Appendices / electronic forms	Have appendices been added, or changed since the last issue, if so explain the reasons why?
What is the impact of change?	Will this new document change the way we do things currently

Training requirements	Select - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Who within this service have you spoken to
Corporate services	Who within this service have you spoken to
External agencies	Who within this service have you spoken to

Financial resource implications	Select

External references	
1.	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	Select	
- Ethnic origins (including gypsies and travellers)	Select	
- Nationality	Select	
- Gender	Select	
- Culture	Select	
- Religion or belief	Select	
- Sexual orientation including lesbian, gay and bisexual people	Select	
- Age	Select	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Select	
Is there any evidence that some groups are affected differently?	Select	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? Select		
Is the impact of the document likely to be negative?	Select	
- If so can the impact be avoided?	Select	
- What alternatives are there to achieving the document without the impact?	Select	
- Can we reduce the impact by taking different action?	Select	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department. | | |
| Was a full impact assessment required? | Select | |
| What is the level of impact? | Select | |

Contents

1. Introduction

PICU is a specialty, within mental health inpatient services, for adult patients who are experiencing an acutely disturbed phase of a serious mental disorder (Department of Health 2002) and require rapid assessment and stabilization. This is done through active engagement and treatment and is for patients aged 18 and over with a range of diagnoses including mental disorder and mild to moderate learning disabilities in association with mental illness. Patients who are under 18, over 65 or have a diagnosis of dementia can still experience symptoms which would benefit from an intensive assessment and PICU advice should be sought in these cases if felt appropriate by clinicians.

Our emphasis is intensive treatment combined with a range of physical, procedural and relational security measures that are designed to reduce risk, disturbance and vulnerability. By providing transparent, collaborative and timely assessments the ensuing treatment plan enables PICU staff to focus on promoting recovery and assist in planning the next step for patients.

2. Definitions

The Mental Health Policy Implementation Guide (2003) defines PICU as:

"Psychiatric intensive care is for patients who are compulsorily detained, usually within secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self- control, with a corresponding increase in risk which does not enable safe, therapeutic management and treatment in a general open acute ward."

Care and treatment offered must be patient – centred, multi disciplinary, intensive, comprehensive, and collaborative and have an immediacy of response to critical situations. Length of stay must be appropriate to clinical need and assessment of risk, but would ordinarily not exceed eight weeks in duration.

Psychiatric intensive care is delivered by qualified staff according to an agreed philosophy of unit operation underpinned by principles of risk assessment and management.

3. Procedure

PICU by its nature is a more restrictive environment, and referrers are asked to consider the following criteria:

Patients who are:
- Experiencing acute behavioural disturbance that seriously compromises the physical / psychological well being of themselves and / or others;
- At notable risk of aggression, suicide and / or serious self harm;
- At risk of increased vulnerability because of sexual disinhibition or over activity in the context of mental disorder;
- Posing a level of risk which means they are unable to be safely managed within an open ward setting;
- Likely to be detained under the Mental Health Act. Some patients will be subject to additional restrictions or be prisoners / detainee's transferred under Section 47 or 48;
- Presenting with a high risk of absconding associated with increased risks of aggression or self injurious behaviour.

3.1 Service model of care

The provision of full risk history / events by the referring service can contribute to the formulation of a robust risk management plan. This plan is based on thorough assessment, identification of potential risks and encouraging positive risk taking when developing clear risk management plans. This incorporates de-escalation and seclusion as a last resort. Seclusion will be for the shortest, clinically, appropriate period and will be monitored according to Mental Health Act Guidelines and Trust policy.

- The provision of a full assessment of both mental and physical health with subsequent care planning, involving service users and their carers at each step.

- A robust treatment plan, developed using a multi-disciplinary approach, will be formulated, promoting effective links with referring service. This will also promote ongoing treatment and transfer back to the referrer or to another appropriate environment.
- Fostering effective relationships with referring services which are facilitated by regular attendance at CPA and MDT by care coordinators in order to formulate plan for discharge / transfer. (This is to be weekly unless agreed otherwise by care team)
- These relationships are supported by PICU In-reach both formally, through daily attendance at open wards, and informally by regular communications with the respective units / referring services.

4.   PICU standards

a)   Admission Criteria

Rationale: Detention in a locked environment constitutes a fundamental loss of freedom for an individual. PICU staff need to work collaboratively with referring services to ensure that admission is appropriate to the individual's needs. There should be no more restrictions on a person's freedom than is warranted by his or her clinical condition. If an informal patient agrees they can also be admitted to the PICU.

All patients admitted to the PICU environment can have behavioural difficulties which seriously compromise their physical and psychological well-being or the wellbeing of others. These difficulties will not be able to be safely assessed or treated in an open acute inpatient facility.

All patients will be admitted if they display a significant risk of aggression, absconding with associated serious risk, suicide or vulnerability (e.g. due to sexual disinhibition or over-activity) within the context of a serious mental disorder.

All admissions to PICU must be due to a new episode or to an acute exacerbation of the patient's condition. There must be an assessment from PICU and a subsequent discussion with the referring team incorporating the positive therapeutic benefits expected to be gained from the time limited admission and to include a clear rationale for assessment and treatment.

Nursing staff should also feel able to negotiate admission to PICU for patients who may not satisfy the above criteria, but would benefit from Intensive Care.

PICU, in line with DH guidance, provide intensive care for people with a primary presenting problem of acute mental illness but the individual may also have a secondary diagnosis.

There are other groups of patients who present in acute crisis whose mental distress is not due to mental illness but may be due to organic causes. For patients of CWP we work collaboratively with other teams offering advice, in-reach and support. There may be occasions when internally the best clinical option is to admit patients who do not meet our core criteria as it is the best clinical option. However this needs to be carefully risk assessed and agreement is required from PICU alongside support from the clinical team caring for patient.

Externally, we need to be clear that we are not commissioned to provide intensive care facilities for people with cognitive dysfunction e.g. dementia, ABI, alcohol and PICU staff do not necessarily have the expertise. The environment of care is designed for people with acute mental illness and we may need specialist services and sometimes bespoke packages to meet other patient's needs.

If the PICU service is approached with referral from a service user outside of our core service user group then we will individually assess the service user as to whether PICU is the best clinical option, if PICU can meet their holistic needs and formulate a bespoke package if necessary.

b)   Additional Criteria – Exclusion

The following criteria would result in a patient being excluded from PICU admission but current mental health presentation will be taken into account at the point of referral:

- The patient is assessed as presenting too high a degree of risk for PICU and may require admission to a greater level of security or forensic services. Restricted patients should not be accepted unless there is provision to transfer them to an open ward if warranted by their clinical condition.
- The patient has a primary diagnosis of substance misuse.
- The patient's behaviour is as a direct result of substance misuse and they are not suffering from an exacerbation of their mental disorder at the time of referral.

- The patient's physical condition is too frail to allow their safe management in a PICU.

c)   Assessment

While historical factors will play an important part in assessment, current symptoms will be the prime consideration in determining if admission is appropriate. However, this emphasis may be different for low secure environments.

d)   Follow up Support

If admission is not thought to be appropriate, PICU staff may offer advice and guidance on the management of the patient. PICU follow-up contact should occur within 24 hours to assess whether the situation has changed.

The needs of young people should be identified and met through a comprehensive assessment and the provision of an appropriate environment.

e)   Assessment Protocol

The need may arise for PICU staff to complete joint assessments (with acute and medical staff) on patients presenting with initial high risk behaviour prior to ward admission. In such cases PICU will discuss with the accepting ward prior to any assessment taking place. On occasions a Consultant may liaise with PICU directly regarding bed availability.

The referring ward will contact PICU, during office hours, and fax a completed Side 1 of the Referral Form, and recent risk review.   If out of hours, then referral form to be faxed to Brooklands and Willow Ward, followed by discussion with 2nd tier, on call, manager for complex cases.

On receipt of referral, wherever possible, an RMN will visit the referring ward to undertake an assessment, using the appropriate tool.

After completion of the assessment and relevant documentation, the assessing nurse will discuss the outcome with the referrer. An entry will be made in the patient's notes by the assessing nurse describing the outcome of the assessment and what action is to be taken.

If PICU admission is felt to be appropriate but there are no beds available or transfer cannot be arranged immediately, then a PICU Nurse will liaise with the referring team regarding on-going management and care, until transfer can be arranged.

If admission is not felt to be appropriate, then PICU staff will offer advice on future management and care of the presenting mental health needs.

If, post-assessment, PICU admission is felt to be appropriate but there are circumstances where the patients presentation or PICU environment indicates reduced safety then referral for assessment should be facilitated to a service with a higher level of security (i.e. low secure or medium secure services). Joint assessment should be carried out by staff from the two disciplines.

f)   Admission protocol

The PICU assessing nurse, if admission is required, will discuss which PICU ward will provide the safe management of risk prior to allocation of bed.

The PICU assessing nurse will liaise with the PICU shift leader to ensure relevant resources are available.

All relevant documentation will be brought by the assessing nurse to prepare for admission (where appropriate, the admission nurse will be the assessing nurse).

The shift leader will allocate a named nurse in accordance with the Trust Policy.

The admitting nurse will meet the patient (ensuring other staff are available for support, if necessary).

The initial care will be in response to the current presentation.

The admitting nurse will complete the Trust risk assessment tool. Level of observations will be determined by the outcome of this.

A full search of a patient and their property should be made and an inventory of items removed completed using the guidelines from the appropriate policy.

The admitting nurse will complete the initial intervention care plan and all relevant documentation.

Assessment of the patient's care needs will be a continual, collaborative, process utilising nursing interactions and the patient's perceptions of their needs.

The named nurse will review the care plan which will reflect progress made or changes to individual care needs. The overall aims of the care plan being to reduce the problems that precipitated the crisis and subsequent PICU admission, to stabilize the patient's mental health and ultimately to return the patient to their locality ward (where possible).

The named nurse will be supported by local Nursing Team Management arrangements.

The named nurse on PICU will complete reports as requested by the Hospital Managers and the Mental Health Review Tribunal.

The associate nurse may be involved in the initial assessment and planning of care, but the named nurse maintains responsibility to assess, implement and evaluate nursing care. The associate nurse will deputise for the named nurse in their absence and work under the guidance of the named nurse.

The co-workers will be involved in the holistic patients' care. They will communicate back to the named or associate nurse regarding any progress, deterioration and relevant incidents. The co-worker is a vital resource in the process of implementing and evaluating care.

When it is agreed that the patient no longer requires PICU intervention then the named / associate nurse or shift coordinator will liaise with the referring ward.

If patients, who following a period of assessment, are identified as requiring a higher level of security than PICU can offer, the MDT will consider referral to the appropriate facilities e.g. Low Secure Unit, Regional Secure Unit.

Carer assessment should be facilitated, if indicated, as per Trust Policy.

Overnight leave from the PICU may be granted as part of therapeutic risk taking measure followed by planned transfer to the open ward of their locality or direct discharge with CRHT and CMHT follow up.

g)   Admission / transfer process

If admission to PICU is considered appropriate, and a bed is available, transfer should take place as quickly as possible.

The referring ward will seek the patient's consent and, with permission, will contact the carer / relative, to inform them of transfer to PICU.

The Multi-disciplinary Team will be involved as early as possible, following transfer.

Following transfer to the PICU, the objectives, previously agreed with the referring ward, will be clearly reflected in the intervention plan.

This will include a commitment to returning the patient, where possible, to their locality ward, when they are beyond the crisis in their mental health.

Following admission, regular contact will be maintained with the locality ward to ensure continuity of care.

4.1   Core interventions

a)   Rationale

The PICU should ensure that patients are provided with an intensive, multidisciplinary, therapeutic program and evidence-based interventions whilst admitted to the Unit.

b)   Standard

All patients will receive an intensive therapeutic program, appropriate to their needs and underpinned by:

c)   Biological Interventions

All patients will receive the necessary physical investigations whilst an in-patient on the unit.

Polypharmacy and high doses of medication will, as far as possible, be avoided. However, when used, Royal College of Psychiatrists guidelines (CR26), CWP High Dose Antipsychotic Treatment (HDAT) guideline (MP18) and current best practice will be adhered to. A clear rationale will also be outlined to patient and carers.

All patients will be informed of pharmacological treatments and should, whenever possible, be included in the decision making as regard to their prescribed medication.

All patients and carers will be provided with both written and verbal information on medications and provision of such will be documented on the electronic patient record system.

Side-effects of medication will be closely monitored. As far as practicable, the best tolerated medications should be prescribed. Evidence based assessment tools to assess the prevalence of side effects will be used, following discussion with pharmacy as to the most appropriate tool to use.

Rapid tranquilisation can be safely used to control disturbed or violent behaviour when all other methods of de-escalation have proved ineffective. This will be in line with the rapid tranquilisation policy.

Electroconvulsive therapy (ECT), if clinically indicated, can be given and would be given in line with Royal College of Psychiatrists guidelines (CR39).

d)   Psychological and other interventions

Psychological and other interventions which may be available includes:

- Counselling / therapy (individual and group)
- Cognitive behavioural interventions.
- Psychosocial interventions for patients and their families/carers.
- Recreational activities such as therapeutic, diversional, interventions that can include engaging in creative work, hobbies and special interests.
- Life skills training incorporating psycho-education on topics relating to activities of daily living such as interpersonal communication, relationships, coping with stigma and stress management.
- Health promotion activities; including diet, exercise, substance misuse and smoking cessation.
- Boundary setting within the context of physical and psychological containment. This may include: contracting, de-escalation, restraint, time-out, and / or seclusion.

e)   Social Interventions

Staff should foster a therapeutic milieu for patients whilst on the PICU e.g. through use of milieu therapy. Social skills training, including anger management, should be provided where appropriate.

The MDT should obtain details of the family and social circumstances prior to admission.

Care coordinators should be actively involved in the provision of assessments, CPA meetings and links with the MDT on PICU and they also have a role in helping longer-term patients maintain social ties to the wider community by encouraging appropriate visits and activities.

f)   Environmental Interventions

All patients, including those who are acutely disturbed, should have access to fresh air and/or secure external space for regular exercise with appropriate supervision.

g)   Good Practice Guidance

All of the above should be based on comprehensive, needs based, assessment need and may also inform further interventions following transfer from PICU. Interventions must aim to:

- Meet the individuals needs;
- Be adapted to the PICU environment;
- Promote functioning where this may have become impaired, thus maximizing the patients' opportunities of optimum functioning and independence in the community.

Staff have an important role in promoting optimum engagement with the treatment program through encouragement, negotiation, education and patient involvement in their own care planning.

It is desirable that the MDT considers the role of complementary therapies on the unit.

4.2   MDT Working

a)   Rationale

Multidisciplinary working is at the heart of PICU practice. Good teamwork enables the provision of effective, comprehensive, care. Meeting the patient's needs is the primary task of the multidisciplinary team (MDT). All relevant professionals should be able to contribute to this task while maintaining effective inter-professional relationships.

b)   Standard

The nursing team aim to liaise with all members of the MDT in the provision of care to their patients and aim to have the following in place:

The PICU will have a 6 monthly forum for meeting with all stakeholders to consider important topics such as referrals, service developments, issues of concern and to re-affirm good practice.

Shared, in-house, MDT training, education and practice development activities will occur on the unit on at least a monthly basis.

There will be shared documentation e.g. MDT electronic patient record.

Patients will receive multidisciplinary care planning.

Care coordinators and nursing staff from locality wards will attend weekly meetings, as agreed with the PICU MDT.

c) Good practice guidance

In order to work intensively, there must be a shared vision and cohesion among team members. This is enhanced by:

- MDT involvement in the selection and recruitment of team members;
- Inclusion of multidisciplinary working in job descriptions;
- Joint and specialist training.

The qualities identified for a successful team are:

- Clear goals;
- Clear roles;
- Right skill mix to deliver the results;
- A good process for involving all members;
- Trust between team members;
- It works for the individuals in the team.

4.3 Physical Environment

a) Rationale

The physical environment of a PICU is one of its defining aspects. The design of the unit maximises the primary functions of safety, therapy and security, whilst working within local policies, procedures and building constraints.

Both PICU wards are AIMS accredited and have environments that are conducive to effective risk management. Seclusion and safe care facilities are available within both PICU wards and are supported by local policy relating to same.

4.4 Patient Involvement

a) Rationale

In order to create a genuine patient-centred service several processes should be created to enable patients to contribute to the design and delivery of care. The aim is to promote a non-judgmental, inclusive, collaborative approach to care. Each patient is encouraged to participate in the assessment and care planning process and care plans are signed by patients at point of review.

b) Standard

Patients will be involved at managerial and monitoring levels of service provision as part of the Trust's commitment to patient users' involvement.

4.5 Carer Involvement

a) Rationale

Carer's should be involved in every appropriate aspect of the patient's care and treatment in order to maximise positive experiences and reduce stigma. All PICU environments should respond to carer's concerns regarding treatment in a secure environment.

b) Standard

Carers will be involved at the beginning of care through the Care Co-ordination (CCO) process. Each PICU will provide written information about all aspects of the local PICU environment and will be given within 24 hours of admission, when possible.

All identified carers or relatives will be informed within 24 hours of admitting or discharging patient to / from PICU.

With the consent of the patient, carers will be invited to express their concerns and views to the MDT in the appropriate forum. Alongside this, carer views of the care and treatment process (including transfer to and from PICUs) can also be expressed in person with any member of the unit team.

Crisis plans, in particular when there is a risk of absconding, will include carers and any specific persons who may be at risk.

Sufficient basic demographic information must be checked and agreed with carers.

PICU will provide an environment of safety, privacy and dignity during visits.

PICUs will provide training for staff on meeting the needs of carers.

A carer support network or group should exist and be available to carers of patients admitted to PICU units, as per trust directives.

A list of voluntary organisations that provide information and support for carers will be available.

Protocols for carers' assessment will be followed, as per Trust Policy.

All carers providing substantial care will have their needs assessed and a written care plan in line with the National Service Framework by Care coordinators Care co-ordination document).

All information leaflets about PICU for patients and carers will be reviewed every 12 months by a team, including representatives of the local carers support Group.

Risk management plans will include risk to and incorporate views of carers (usually with patient's consent).

c)   Good practice guidance
Clinicians should be aware of the emotional impact on carers, the value of active carer involvement and any potential difficulties that may result as part of this process.

PICU wards have a dedicated carer link that works collaboratively with the carer lead for the trust and ensures dissemination of information within the PICU team.

4.6   Documentation

a)   Rationale
It is important that all PICU environments have an information system that is adequate and effective. Inadequate systems and processes can compound the difficulties around communication. Some of the main tools of communication are the documentation that is used to assess, plan, and evaluate care, as well as inform others.

b)   Standard
Listed below are some of the processes of care that need specific documentation and the types of documents that should be in place in addition to the usual statutory and other legal documents e.g. the Mental Health Act.

We aim to have the following general documents:
- Description of the unit;

- Introduction / induction to the unit for patients and staff;
- Pre-admission documents;
- Referral form;
- Pre-admission assessment form (where appropriate);
- Admission documents;
- Front sheet (Demographics);
- Initial assessment (Individual / MDT);
- Doctor's assessment;
- Physical health check;
- Nurse's assessment;
- 72 hours' assessment;
- Care plan;
- Risk assessment;
- Care Co-Ordination (CCO);
- Property check;
- Property disclaimer;
- During admission documents;
- Level of supervision / observation;
- Section 17 form;
- Mental Health Act Rights Form;
- Seclusion;
- Complaints;
- Pre-discharge documents;
- Care co-ordination (CCO);
- Part 1 discharge summary;
- Post Discharge Documents.

Discharge summary from all disciplines within the multidisciplinary team outlining problems, needs, progress and recommendations specific to each of the disciplines.

Transfer sheet outlining current management plans and treatment details to facilitate smooth handover of care to receiving unit or team.

c)   Discharge / transfer out
Efficient transfer / discharge of patients is essential in providing a dynamic service. It is acknowledged that the efficient use of beds is dependent on an atmosphere of co-operation between PICU and locality wards. Frequently when patients are transferred from PICUs, problematic behaviour returns and the multi-professional team and locality ward should plan for this event, making contingency plans.

PICU provide an in- reach service that enables timely identification and potential solutions as regard to transfer into and out of PICU

The decision to transfer a patient from the PICU will be made by the PICU Team, in conjunction with the receiving ward in the acute service and will be based on their progress towards the agreed goals set in the intervention plan.

The transfer to the acute service will, where possible, be planned with a clear notice period and plans will be discussed both with the patient and the acute service staff. In the case of disagreement, discussion will be held by all parties until a resolution is achieved. The Clinical Service Manager / Modern Matron and Responsible Clinicians may be required to facilitate this process.

A patient may be considered ready for discharge/transfer out, when he/she meets one or more of the following criteria:
- Shows an increased control over high risk behaviour;

- Shows significant decrease in symptoms of mental disorder;
- Has achieved maximum benefit for treatment;
- Shows evidence of potential for extremely dangerous behaviour, which is assessed as requiring a higher level of security, such as that provided by low, medium or high security, secure services or the Criminal Justice system.

If the demand for PICU beds exceeds the number of beds available on the ward, assessments will be made, which may involve transfer of patients from PICU, in order to admit patients regarded as being of higher risk.

All decisions must be clearly documented in the patients' electronic case notes.

If a patient is to be discharged directly to the community from the PICU, Care Co-ordination (CCO) protocols will be observed, consistent with the CPA process.

The PICU staff will complete a discharge summary in the patient's notes/discharge summary form and all relevant discharge paperwork.

4.7 Ethnicity, culture and gender

a) Rationale
PICU has the responsibility to ensure that all patients receive equality of treatment without prejudice to gender, sexuality, disability, religious beliefs, or ethnicity.

b) Standard
As a minimum, each PICU should have the following:
- A clear policy statement on equal opportunities and racial harassment which all staff and patients are aware of. The policy will cover staff / patient and patient / patient harassment.
- Staff will work within the local strategy.

c) Lone Gender Patients
In the case of a sole male or female patient within the PICU environment, their safety, dignity and integrity will be addressed by appropriate measures within their individual intervention plans.

Where issues are not straight forward there will be discussions between the Ward Managers, Consultant Psychiatrist and Advanced Nurse Practitioner.

4.8 Supervision

a) Rationale
In line with Clinical Governance, it is essential that there is a well-defined and robust system of Clinical Supervision within PICU. Team based clinical discussion; reflective group learning and the existing individual responsibility for Professional Development Reviews (PDR's)/appraisals will be facilitated.

b) Standard
Staff will follow the Trust's Policy and Procedures re: Clinical Supervision. PICU staff all receive line management, clinical and peer supervision. All supervision is recorded and training needs are identified and planned for.

4.9 Liaison with other agencies

a) Rationale
Consistent with the current NHS Plan for interagency working and the agenda for social inclusion, PICU should ensure that mechanisms are in place for rapid access to agencies or services, as per Effective Care Co-ordination.

b)   Standard
Each PICU will have a clearly identified and documented contact / link person in each agency involved with the patient.
PICUs will disseminate information about the unit to all relevant agencies.

PICUs, in liaison with the relevant agencies, will develop clear protocols about shared level of involvement.

In accordance with individual care plans, all possible links to other agencies identified should be passed on to the relevant Mental Health Team, to ensure continuity of care.

Patients will have information on the other agencies involved in their care and the care plan should reflect this.

c)   Good practice guidance
It is the responsibility of all PICUs to develop effective networks with other agencies:
- To maximise the quality of the care package available to individual;
- To maximise engagement and therefore improve quality of life and future well-being for individuals;
- To maximise the available resources and empower the patient to choose what is best suited to their needs;
- To reduce stigma attached to treatment in a secure environment.

Links should be made with agencies under 5 broad categories:
- Social support;
- Patient agencies;
- Legal / judicial;
- Community and Inpatient Mental Health;
- Medical Services – primary and secondary.

4.10   Policies and procedures

a)   Rationale
A Policy can be defined as a statement of the Trust's position and philosophy on key issues, setting out a framework and rules of practice within which managers and staff must operate.

b)   Standard
Staff will work within trust policy and procedures and those specifically relating to PICU.

4.11   Clinical audit and monitoring

a)   Rationale
Clinical Audit is at the heart of clinical governance (NICE 2002) and is an essential tool in raising the quality of care through;
- Assessing the quality of practice against agreed standards.
- Highlighting areas of concern regarding the quality and cost-effectiveness of patient care.
- Improving practice through informed feedback.

Clinical Audit should be an integral part of service culture in order to monitor service responsiveness to the various aspects of patient care.

b)   Standard
All of the standards outlined in this document will be audited.
High risk activities, which are essential to practice, should be accurately documented, audited and reviewed, to ensure good clinical practice and positive learning. These activities could include:
- Restraint;

- Seclusion and other restrictive practices;
- Rapid tranquillisation and high dose medication;
- Adverse incidents and 'near misses'.

A central reporting mechanism should support this process.

At least one individual will be identified as lead, to ensure that Clinical Audit and monitoring is carried out. Patients and carers will be involved in the process of Clinical Audit as far as possible.