FINAL REPORT TO

NSW MINISTRY OF HEALTH

External Review of Psychiatric Emergency Care Centres in NSW

From

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DEFINITIONS

Consumer	A person who uses or has used a mental health service.*(4th National Mental Health Plan)*
Carer	A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent and may vary over time according to the needs of the consumer and carer. *(4th National Mental Health Plan)*
Patient	Any recipient of health care services.

EXECUTIVE SUMMARY

The Mental Health Drug & Alcohol Office of the NSW Ministry of Health undertook this external review of the Psychiatric Emergency Care Centres (PECC) to review the operations of each PECC against the Operational Model of Care Guideline and to review the appropriateness of the Operational Model of Care Guideline in the clinical environment. The review involved site visits to the 13 PECC units, stakeholder interviews and review of data.

The PECC service model is intended to facilitate timely access to specialised mental health care for people with mental health problems who present to the Emergency Department (ED). The PECC Operational Model of Care Guideline (2008) provides guidance on the operational implementation of PECC services in Local Health Districts. Local Health Districts are responsible for ensuring that local services are organised so that they meet the aims of PECC service model.

The Operational Model of Care Guideline states that the 'PECCs are functionally integrated into the mainstream ED service' and that they operate 'as an extension to the mental health triage and assessment service offered by the existing Consultation Liaison psychiatry services and mental health CNC ED services'. During the review it was found that the application of the Operational Model of Care Guideline varies across the 13 sites and gaps in the Model were also identified.

The model appears to best meet the needs of the ED and mental health staff as well as the patient and carers when there is a collaborative approach between the ED and PECC service and the mental health CNC is seen as a member of the ED team. In the majority of the hospitals the ED staff spoke highly of the value of the CNC and their role in assessment and managing the care of patients presenting to the ED with mental health problems.

However a number of PECCs, while physically located nearby the ED, are functionally part of the mental health inpatient service and do not operate as an integrated component of the ED. The PECC Operational Model of Care Guideline states that the PECC provides (i) 24/7 mental health staff presence in the ED and (ii) the provision of capacity for observation / immediate care in the ED for up to 48 hours (this refers to the provision of inpatient care in co-located PECC units). There was less agreement about the value of the PECC service, in particular the availability of beds, where the PECC service was not integrated with the ED. In many of these sites the PECC service is more closely aligned to the mental health service and operates in a consulting manner to the ED.

The specific findings and recommendations relating to each key area of the review are described below.

Assessment

At each PECC systems have been established to meet the needs of the patients and to enhance patient flow and efficiency in the ED and PECC. The timely assessment, management and transfer of care of patients presenting to an ED with a mental health problem is critical to achieving responsive care and efficient

patient flow. Some sites have developed screening tools for use by the ED triage staff. A number of issues, such as availability of drug & alcohol services, especially after hours; the variability of access to mental health assessments on a 24 hour basis; the lack of timely transfer of care of patients from the ED and access to mental health acute inpatient beds were identified as some of the challenges to providing efficient and effective management of patients in the ED.

The timeliness of mental health assessments was not identified as a major problem. However, the location for undertaking mental health assessments is an issue needing further clarification. The Guideline states that assessments of patients in triage category 3, 4 and 5 will be undertaken in the PECC. This was found to rarely occur.

The physical assessment of patients in the ED with a mental health issue is an area of tension between the ED and PECC staff.

The PECC Operational Model of Care Guideline provides for the fast tracking of people to the PECC who are already in care and who do not have a confounding medical condition. Access to specialised mental health care should not be unduly delayed, for instance while the person waits for a comprehensive physical assessment in the ED, where this is clearly not indicated.

Mental health patients account for 7% of all presentations to EDs in NSW. Opportunities exist to enhance timely transfer of care of patients from the ED. With the introduction of the National Emergency Access Target (NEAT) the need for streamlined assessment and management planning is required to assist with the throughput of mental health patients presenting to the ED.

> ***Recommendation 1****: That MH and ED staff work together to ensure the appropriate identification of mental health problems in patients presenting to the ED. This may include the development of screening tools for use by ED triage staff.*
>
> ***Recommendation 2****: That the Operational Model of Care Guideline be reviewed to clarify that the key principles in determining the location of mental health assessments (be it in the ED or PECC), are: site, practicality and the safety of patients and staff. That the Operational Model of Care Guideline be reviewed to clarify that patients with low level triage or existing clients of the mental health service with no medical issues be considered for direct referral to the PECC.*
>
> ***Recommendation 3****: That the Operational Model of Care Guideline be reviewed to clarify that pathways to care should meet the clinical needs of the patient. Local services should have processes in place to ensure that where indicated, patients receive a comprehensive physical assessment in the ED. Where there are no acute medical issues requiring immediate treatment or stabilisation in the ED or where there is no confounding medical condition, patients should be fast tracked to the PECC (or mental health unit). There should be protocols in place which ensure an appropriate medical response*

is available to the PECC should a medical condition be identified after the patient has been referred to the PECC.

That the Guideline refer to relevant NSW Health policies and guidelines regarding the physical assessment of mental health patients.

That immediate consideration is given to the adoption of the NSW Emergency Care Institute's rationale for and use of their physical assessment of mental health patients form.

***Recommendation 4**: That the Operational Model of Care Guideline include a statement about the requirement to meet the NEAT and that guidance be provided regarding timely transfer of care and physical flow of patients from the ED in accordance with the NEAT.*

***Recommendation 5**: That data is routinely captured regarding people being seen in ED by mental health/PECC staff who are not admitted to the PECC or a mental health unit.*

Admission to the PECC inpatient unit

Admission and discharge criteria are available for all PECCs and generally guide practice. Recent data shows that the majority of all PECC admissions are via the ED, the average length of stay for all PECCs is 3.9 days and the average occupancy rate is 62.1%*. (*Note: This figure includes PECC beds being commissioned, closed beds and services becoming operational during the time period being reported. The adjusted PECC occupancy rate, taking into account the impact of closed or partially commissioned beds, is estimated by InforMH to be 75-78%).

The population groups being managed in the PECC units varies, depending upon availability of inpatient beds and other services. Adolescents comprise a large number of the patients admitted to the PECC, especially in certain locations. The patient profile impacts on the occupancy and service provision.

***Recommendation 6:** That the Operational Model of Care Guideline is reviewed to clarify that the admission criteria and processes are in line with the operational guiding principles and key functions of the PECC model and assist in meeting patient and hospital needs.*

***Recommendation 7:** That the Operational Model of Care Guideline is reviewed to clarify that the admission criteria include consideration of the PECC inpatient population at the time and should still meet other key admission criteria, such as short-stay admission and non-violent.*

Management and systems

The PECC Operational Model of Care Guideline provides guidance on management processes to support the shared care approach to managing the care of mental health patients in the ED or PECC. Local Health Districts are responsible for establishing these management processes and ensuring that appropriate supports are in place to sustain them.

While staff in the ED and PECC aim to work collaboratively in the management of mental health consumers the philosophies, practices and priorities of the two specialities are, at times, at odds. There is value in having regular, at least monthly, meetings between ED and PECC managers to discuss clinical and operational issues. These meetings should be formal and include quality review, issues that impact on patient care and/or safety. There should be tangible evidence about the effectiveness of these meetings such as the development of shared protocols and outcomes of clinical reviews.

The staffing in the PECC units is comparable across hospitals though there are variations in allied health numbers, the availability of mental health staff onsite to work in the ED 24/7, and the location of the CNC.

Recommendation 8: *That the Operational Model of Care Guideline stipulate that at each site ED:PECC meetings are held at least once every two months to discuss clinical and operational matters. These meetings should include drug & alcohol services and specialist mental health services (CAMHS and SMHSOP), where relevant. These meetings are not to be part of the MOU or interagency meetings involving Ambulance and Police.*

Recommendation 9: *That the Operational Model of Care Guideline stipulate that ED and PECC services (and drug & alcohol services, where relevant) develop agreed systems and processes for the shared care approach to providing care for mental health consumers in the ED or the PECC and to managing the care of patients with challenging behaviours in the ED. These processes should then be used to review and, as appropriate, revise the clinical pathways for mental health consumers.*

Recommendation 10: *That each PECC reviews the availability of mental health staff on-site in the ED 24/7 to undertake assessments and to assist in managing the care of mental health consumers in the ED. That each PECC reviews the availability of medical staff on-site 24/7 to facilitate the timely transfer of care and physical flow of mental health consumers from the ED, in accordance with NEAT principles.*

Recommendation 11: *That the mental health CNCs are located within the ED to promote an integrated model of care and to ensure mental health staff are on-site to assist ED staff to manage the care of people presenting with challenging behaviours.*

Recommendation 12: *That each PECC reviews the staffing mix to ensure the staff possess the skills and knowledge to meet the casemix of patients, for example, nursing staff with skills in meeting the physical health needs of patients. This also includes the availability of allied health staff, in particular social workers.*

<u>Consumer and carer perspective</u>

Anecdotally information was provided regarding the experience of consumers and carers in the ED and PECC. The need for health services to obtain feedback in a more formal and consistent manner was identified.

Recommendation 13: *That the PECC and mental health managers institute processes to enhance mental health consumer and carer engagement in PECC services including:*

- *routine dissemination of MH-CoPES to all patients discharged from the PECC unit (e.g. include in discharge procedure);*
- *promoting the use of the community MH-CoPES for patients who are assessed in the ED and are not admitted to the PECC or inpatient unit;*
- *the inclusion of feedback from consumers and carers be considered as a standing item on the agenda of the ED:PECC meetings;*
- *seeking advice from the Consumer Sub-Committee regarding strategies for consumers and carers to provide feedback to PECC services on an ongoing basis.*

<u>Managing intoxicated, overdosed or patients with challenging behaviours</u>

An area of tension identified during this Review was the management of people who present to the ED who are intoxicated/overdosed and/or behaviourally disturbed. There is a disconnect between EDs and mental health services about the responsibilities for managing this group of patients. The availability of drug & alcohol staff especially after hours and the availability of mental health staff on site in the ED on a 24 hour basis were identified as some of the challenges to managing the care of these patients. ED and mental health staff recognise that the provision of care to this patient group is beyond the current capacity of both services, given the increasing numbers and level of complexity and dangerousness of these presentations. The resolution of this issue is not easy and will require local corporate and clinical leadership, collaborative care and clinical review to determine the best pathways to managing the care of this patient group.

Recommendation 14: *That the hospital executive in conjunction with ED, mental health and drug & alcohol staff, , develop agreed systems and processes to manage the care of patients who are intoxicated, overdosed or with challenging behaviours who present with a mental health issue and to determine the most appropriate clinical pathways for these patients. This may include, for example, consideration of a short-term medical admission for intoxicants where these patients can be assessed and cleared by ward based teams.*

Recommendation 15: *That ED clinicians and mental health clinicians working in the ED and PECC receive education on managing the care of patients with drug and alcohol issues.*

Recommendation 16: *That ED clinicians and mental health clinicians working in the ED and PECC receive education, in line with NSW Health policies, on preventing and minimising aggression and on managing the care of patients with challenging or disturbed behaviour.*

During this Review a number of other issues were identified that impact on the delivery of mental health assessment and care in the ED and length of stay in PECC units. The recommendations relating to these are outlined below.

Recommendation 17: *That each site reviews areas available for mental health assessments in the ED and PECC and identifies safe and private locations for assessments of patients at different triage categories.*

Recommendation 18: *That mental health services continue to review demand and implement strategies to meet the needs of the population and the hospital.*

Recommendation 19: *That ED clinicians and mental health clinicians working in ED and PECC receive education on managing the care of younger people with mental health issues who present to the ED.*

Recommendation 20: *That the Ministry of Health identifies opportunities to support networking and information sharing between the PECCs, including supporting all PECCs to be part of the PECC Network.*

Recommendation 21: *That the Ministry of Health considers the proposal to bring ED and PECC staff from the 13 hospitals with PECCs to discuss the Operational Model of Care Guideline and other system matters on an annual basis to support networking and information sharing between the PECCs and EDs.*

During this Review many staff requested information regarding the outcomes of the Review. The review findings and recommendations should be made available to all hospitals with PECC services to enable staff to review and action the recommendations.

Recommendation 22: *That the report from this External Review be made available to the PECC and ED staff and consumer and carer groups who participated in the review to facilitate networking between the PECCs and EDs.*

1. PURPOSE OF THE REPORT

This report details results of an external review of the Psychiatric Emergency Care Centres (PECC) undertaken by JulieAnne Anderson of JA Projects Pty Ltd. The report describes the findings regarding the implementation of the PECC Operational Model of Care Guideline and makes recommendations for ongoing enhancement to the services for people requiring mental health assessment who present to the Emergency Department. The report also outlines some of the lessons learnt in the establishment and operating of the PECCs.

2. BACKGROUND

In 2005, as part of the NSW Mental Health Emergency Care Program, the establishment of nine PECCs was announced. PECCs were designed as an extension to the mental health triage and assessment service in the Emergency Department (ED). Since 2005, a further four PECCs have been established.

In 2006 an evaluation of the five functioning PECCs was conducted which confirmed the viability of the PECC model of care and indicated improved outcomes both in terms of consumer access to mental health care and satisfaction with the service provided for consumers, emergency staff and PECC staff.

At a meeting of the Ministerial Taskforce for Emergency Care (MTEC) in 2011 members expressed concern that some PECCs operate outside the scope of the PECC Model of Care Guideline which impacts on the interface between emergency departments and mental health services. It has been noted that both ED and PECC staff report challenges in the provision of appropriate medical and mental health treatment of mental health consumers in the ED.

The Mental Health Drug and Alcohol Office (MHDAO) identified the need to review the operations of each PECC against the Operational Model of Care Guideline and to review the appropriateness of the Operational Model of Care Guideline in the clinical environment.

Key components of the PECC model

A PECC Operational Model of Care Guideline was developed in collaboration with representatives from PECC services and EDs and was released in 2008.

The Guideline describes the two key functions of PECCs as:

- 24 hour provision of timely mental health assessment on-site in the ED and
- observation / immediate care in co-located PECC units for patients requiring short-term mental health care (up to 48 hours).

In regards to the timely mental health assessment on-site the key components of the PECC model are:

- 24/7 mental health service on-site

- Fast tracking mental health assessments of ED presentations
- Safe care and environment, including appropriate use of sedation and restraint, in line with local; policies and protocols
- Consultancy service to the ED
- Collaborative working relationship between ED and the mental health service.

The key components of the model to enable observation / immediate care in co-located PECC units for patients requiring short-term mental health care are:

- Short term mental health treatment and observation for patients admitted to the PECC
- Short stay of less than 48 hours
- Safe care and environment, including appropriate use of sedation and restraint, in line with local; policies and protocols
- Seclusion not a PECC unit intervention
- Access to consumer advocate
- Collaborative working relationship between ED and the mental health service.

The Objectives of the Review

The objectives of the review were for the consultant to document variations to the PECC Model of Care Guideline and comment on its performance in relation to the interface with local Emergency Departments, with particular emphasis on:

1. timeliness of mental health assessments in emergency departments, including out of hours assessments
2. location of mental health assessments
3. timeliness of medical assessment of consumers with a mental health issue in the ED
4. local criteria for admission and discharge from PECC
5. local protocols for collaborative care between ED and PECC
6. the clinical pathways of mental health consumers in the PECC and in the ED
7. the definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit
8. population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)
9. audit of mental health staffing in the ED and PECC and their function
10. any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.

The Deliverables from the review include:

- Stakeholder meetings
- Draft final Report for review and feedback by the Project Advisory Committee
- Final Report

A Project Advisory Committee was established to oversee the project. Its members comprised nursing and medical representatives from emergency departments, PECCs and mental health, consumer representatives and Ministry of Health staff. A list of members is provided at Appendix 1.

3. PROJECT METHODOLOGY

The project was undertaken from April – June 2012. The project involved:

- site visits to the 13 PECC services to conduct interviews, review facilities, systems and review data
- gathering of data from consumer and carer representatives and other stakeholders
- data analysis
- report preparation.

3.1 Stakeholder consultations

The consultant undertook site visits in May and June 2012. A timetable for each site visit was developed by the individual PECC. It was recommend that at each site a tour of the PECC and ED occurred, and interviews were held with medical and nursing representatives from the PECC and ED, along with time with the consumer representative/s. At some sites additional people were interviewed, such as social workers, managers of mental health services and community mental health team members. Interviews were held by telephone with individuals who were unavailable on the day of the site visit.

A set of questions was developed and used to guide the interviews. The interviews sought to explore the key areas of the review: access and timeliness to mental health assessments, medical clearance, management of co-morbidities, admission criteria to the PECC and management of the PECC. The stakeholders interviewed for the project are outlined in Appendix 2.

3.2 Review of the data

Recent reports on PECC activity were reviewed by the consultant as part of this Review. Activity data was sourced from InforMH and data was also gathered in relation to consumer and carer experiences with the ED and PECC.

3.3 Final report

The initial report was sent to the Project Advisory Group members for feedback. Feedback was reviewed and incorporated as required. A final report was provided.

4. FINDINGS AND DISCUSSION

The Operational Model of Care Guideline for the PECCs was developed in 2008 to guide the operations of the PECC services. This Review was established to examine the application of the Model of Care Guideline. Variations were found across the 13 PECCs in the application of the Guideline.

The Model of Care Guideline covers both the assessment process for people presenting to the ED with a mental health problem and the processes for admission to a PECC inpatient unit. During this Review it was apparent that when people refer to 'the PECC' they are referring to the inpatient unit and do not necessarily include the assessment or ambulatory component of the PECC service. This is important in considering the findings and recommendations of this Review.

The findings of the Review are described below in six main areas:

1. Assessment
2. Admission to the PECC inpatient unit
3. Management and systems
4. Consumer and carer perspective
5. Managing intoxicated, overdosed or patients with challenging behaviours
6. Other issues

The key issues from the Operational Model of Care Guideline for each area is outlined along with the findings, discussion and recommendations.

When considering the findings and discussion it is important to note the limitations associated with the quantitative and qualitative data that was obtained during the Review. These limitations include:

- the data is from patient administrative data which is reported manually and therefore may be under-reported
- gaps in data such as poor ambulatory activity data relating to mental health
- the, at times, conflicting information and views obtained from site interviews.

4.1 Assessment

The Operational Model of Care Guideline describes the assessment processes for people with mental health problems including:

- ED presentation and the option of direct referral from the ED to the PECC
- ED triage and initial screening. ATS triage category 3 and below are provided with screening and recording of key observations
- The decision regarding location of assessment, be it the ED or PECC.
- Assessment and immediate care to be provided in the ED to people triaged as ATS category 1 and 2. Mental health staff may undertake mental health triage and assessment to assist ED staff

- For people with ATS triage category 3 and below the mental health assessment should occur in the PECC
- PECC staff may request ED staff to provide a physical assessment and immediate medical care in the PECC unit.
- Registered nurse with mental health experience presence 24/7 *(from Staffing section)*
- Psychiatrist registrar for patient review including capacity for onsite attendance 24/7*(from Staffing section)*

In addition to reviewing the assessment components from the Guideline, the objectives of the Review sought consideration of the following issues relating to access and assessment:

- timeliness of mental health assessments including out of hours assessments
- timeliness of medical assessment of consumers with a mental health issue in the ED
- "medical clearance" (physical assessment of the mental health patient), and
- the clinical pathways of mental health consumers in the ED.

Review findings

Presentation and triage

All presentations to the ED are triaged. If the ED Triage Nurse identifies a mental health presentation, it is usual practice for the Mental Health CNC to be notified and the assessment process commences. There are tools available in some EDs to assist with the rapid assessment at triage of a mental health consumer. In most hospitals the CNC will be paged by the Triage Nurse to alert them to the patient's arrival. In a few sites the Triage Nurse notifies the PECC Nurse Manager and the patient is logged into the PECC computer system and then seen by the CNC.

At most PECC sites there is no difference in the process if the patient is voluntary or involuntary. At times and in some locations, the Police, Ambulance Service or community mental health team may call ahead to inform the ED that they are bringing a patient who will require mental health assessment. The ED then alerts the Mental Health CNC and in a few locations these patients are taken directly to the PECC for assessment.

Location of mental health assessments

In the majority of hospitals the mental health assessment takes place in the ED despite the Guideline stating that people triaged as Category 3, 4 or 5 be assessed in the PECC. Safety and security for staff is one of the major drivers of the location of the assessment. A safe and private location to conduct the assessment is a challenge in many EDs.

In some EDs, there are designated Safe Assessment Rooms, interview rooms or other areas for assessments. In a number of EDs the patient may be assessed in the waiting room or other location where some privacy may be afforded to the patient.

In one facility, all patients with a triage category of 3 or below are assessed in the PECC during the hours that security staff are available. After hours these assessments take place in the ED. In three other centres, ED staff prefer that patients are assessed in the PECC. In these hospitals the PECC is not co-located with the ED and staff in the PECC are reluctant to undertake assessments outside the ED. Staff in a number of PECC units also report reluctance to undertake assessments in the PECC unit as it is difficult to return the patient to the ED if further physical health assessments and/or management is required.

In many hospitals PECC and ED staff recognise that there are limited places for an appropriate assessment of a mental health patient to be undertaken, especially if the patient does not require a bed in the ED.

Timeliness of mental health assessments including out of hours assessments
Most hospitals reported that they aim for the initial assessment undertaken by the Mental Health CNC to occur in a parallel fashion, dependent upon the triage category and patient physical health status. For example, if a patient is unable to be interviewed due to intoxication and/or overdose, the CNC would note the referral for assessment and wait until a time when the patient is "fit for interview" to commence the assessment. All sites agreed that patients who were triaged into Category 1 or 2 required medical management in the ED prior to being deemed suitable for admission or transfer. Many of these patients are admitted with co-morbidities and may also be managed by the Drug & Alcohol team, Consultant Liaison or medical/surgical teams.

In some circumstances, while waiting to assess the patient, the CNC will locate old notes and seek the patient history, though this was not identified as the process in all sites.

The mental health teams at all PECCs noted that at the times when a CNC is available, there would be little delay in undertaking a mental health assessment. In some EDs the CNCs require the medical clearance to be provided prior to commencing their assessments. ED staff report delays for mental health assessments due to other mental health patients being seen, the need for the CNC to support staff in the PECC, limited access to assessments after-hours as mental health staff were not on-site and differences in opinion as to the whether a patient who is intoxicated being fit for interview.

Timeliness of physical health assessment of consumers with a mental health issue in the ED
The timeliness of the physical health assessment of consumers with a mental health issue in the ED is undertaken in accordance with the triage category times. Patients in categories 1 and 2 are more likely to have a physical health assessment prior to mental health assessment. Other patients may have either assessment first, with many hospitals favouring a parallel assessment process.

In one ED an Emergency Department Mental Health Screen process and form has been jointly prepared and is used to assist in determining whether the patient should be seen by ED medical staff or mental health staff first.

Prior to discharge from the ED or admission to the PECC all mental health services require a physical assessment for any patient who presents to the ED. In 11 of the PECCs this assessment needs to be completed by an ED medical officer, while in one site, the PECC JMO undertakes the physical health assessment which is then signed off by an ED medical officer and in the other the PECC CMO may complete the physical health assessment for people being admitted to the PECC.

This requirement that all patients require a physical assessment prior to admission to the PECC is at odds with NSW Ministry of Health Policy (http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_016.pdf [page 13]) which states that all admissions to inpatient settings should have a physical examination at least within 24 hours of admission if it has not occurred at the time of admission. This occurs at one PECC where the physical health assessment will be undertaken within 24 hours for any patient who is admitted to the PECC directly following their assessment in the PECC. PECC and ED staff report satisfaction with this approach.

Further policies and guidelines for use by the ED and PECC services include:

- Mental Health Clinical Documentation – Redesigned; Document Number GL2008_016
  http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_016.pdf

- Physical Health Care Within Mental Health Services, May 2009
  http://www.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_027.pdf

- NSW Health Guidelines for the Physical Health Care of Mental Health Consumers - GL2009_007
  http://www.health.nsw.gov.au/policies/gl/2009/pdf/GL2009_007.pdf

Medical clearance

The definition of and responsibility for 'medical clearance' of people presenting with a mental health issue was considered as part of this Review.

The majority of ED clinicians understood the term 'medical clearance' to mean that there were no acute medical issues requiring immediate treatment or stabilisation in the ED or medical ward and which would preclude admission to the PECC or a mental health inpatient unit. The ED staff report that the PECC staff prefer a thorough medical assessment, and hence 'clearance', for all patients, even those where it is apparent there is no acute illness.

One hospital assigns senior medical officers in the ED to all mental health patients to allow for thorough physical assessment and medical clearance to be provided in a timely fashion. In some sites the term 'fit for interview' is used to signify that the patient has no acute medical problems that would prevent the mental health team from assessing them and developing a management plan.

An area of tension between the ED and mental health services regarding medical clearance is the apparent need for an ED medical officer to provide the medical clearance. ED staff suggest that the Psychiatrist Registrars should be able to provide a medical clearance for patients, especially those in triage categories 3, 4 and 5. Mental health services do not believe that the Psychiatrist Registrar has the breadth of skill to undertake the physical assessment.

The term 'physical assessment' is recognised as the preferred term in EDs both locally and internationally and more appropriately describes the assessment required of mental health patients.. All patients are assessed at triage and for most patients with a mental health presentation, a record of normal vital signs and triage assessment is all that is required. Further physical assessment is not required for mental health patients without risks identified on initial screen in the ED. The NSW Emergency Care Institute has developed a physical assessment of mental health patients form for use by ED clinicians to determine whether the person's presentation is caused by a physical illness or injury and to assist with planning relevant management and transfer of care from the ED. The Assessment Form is available at: http://www.ecinsw.com.au/mental-health-assessment

The clinical pathways of mental health consumers in the ED

The clinical pathways of mental health consumers fall into a few categories:

- those requiring acute medical assessment and monitoring, who may or may not need the specialised services of an ED
- those requiring mental health assessment and admission to a mental health bed, who may or may not need the specialised services of an ED
- those requiring mental health assessment and management and are then discharged from the ED.

Some mental health patients will require medical management for a period of time. These patients may receive initial management in the ED and then be transferred to the PECC or mental health inpatient unit. Alternately they may require ongoing medical management and may be admitted to a medical ward. Only one hospital has dedicated toxicology beds where patients may be admitted. In all sites, if a mental health consumer is admitted to a medical or surgical ward, they are managed by the Consultant Liaison mental health team. If the patient is then requiring transfer to a PECC the care is assumed by the PECC consultant.

The admission criteria for the PECC is used to determine whether a patient requiring admission is suitable to be admitted to the PECC or an in-patient unit. The pathways for their management to the PECC are clearly documented and known by staff. As stated earlier, acute physical health needs of patients may be met by PECC staff or staff from the ED or other wards. Many PECC staff report minimal competence in managing acute physical health problems. In two PECC services, recruitment of nursing staff has attempted to address this and staff who are competent in managing acute physical health issues are being employed. In one PECC all nursing staff are seeking IV credentialing.

For those mental health consumers who have their mental health assessments completed in the ED and are assessed as not requiring admission, clear pathways exist for their referral to their GP, the community mental health team or other services such as psychology clinics or private practitioners. As required, the ED social workers work with the mental health CNCs to organise the discharge plans for these consumers.

The Operational Model of Care Guideline for the PECC promotes timely assessments of people who present to the ED with mental health problems. There is nothing specific in the Guideline promoting timely transfer of care of patients from the ED.

During the Review the timely transfer of care of patients from the ED was identified by ED staff as a gap in the Guideline and current practice. ED staff report that the length of stay in the ED of patients with mental health problems does not assist in meeting agreed targets for transfer from the ED. Further, it was proposed that the CNC assessment prior to the Psychiatrist Registrar assessment may be seen as inefficient or not contributing to the care pathway as it adds to delays in decision making. A further issue raised by ED staff is the inefficiency created by the multi-layered process required to gain acceptance of a patient for admission. While mental health CNCs report that they liaise directly with the PECC consultant to arrange admission, it appears that the usual practice involves the mental health CNC assessing the patient, then the Psychiatrist Registrar assessing the patient and then agreeing the admission with the PECC Consultant.

In addition patients with co-morbidities, such as substance abuse, may have lengthy stays in the ED.

Data regarding presentation to and transfer from the Emergency Department
ED data showing to state-wide mental health ED activity, covering the period July 2010 – December 2011, was accessed from InforMH.

This data included information from 11 hospitals with a PECC. Manly PECC was not included as it was not operational when the data collection commenced and data from the ED at Calvary Mater Hospital Newcastle and the Hunter New England PECC is reported through a different administrative dataset. Data for length of stay in the ED is measured using the benchmark of an eight hour target. Data is not yet available which shows patient length of stay in ED in relation to the National Emergency Access Target (NEAT) of four hours.

The state-wide data is broken down into a number of tables to enable comparisons.

Table 1: State-wide mental health ED data

ED DATA						INPATIENT DATA	
All ED Visits	**MH ED visits**	**MH as a % of all ED**	**MH probs admitted**	**Adm < 8 hours (%)**	**MH in ED > 24 hrs (%)**	**Inpatient Seps**	**Adm via ED (%)**
1,957,469	128,045	7%	13,429	9,113 (68%)	655 (4.9%)	29,540	15,944 (54%)

Table 2: Facilities with PECC units (Note: excludes Manly and Calvary Mater/HNE)

ED DATA						INPATIENT DATA	
All ED Visits	**MH ED visits**	**MH as a % of all ED**	**MH probs admitted**	**Adm < 8 hours (%)**	**MH in ED > 24 hrs (%)**	**Inpatient Seps**	**Adm via ED (%)**
491,367	41,167	8%	7,859	5,144 (65%)	429 (5.5%)	11,340	8,992 (79%)

Data was also obtained for facilities with mental health inpatient units, where there is no PECC. This data is shown below.

Table 3: Metropolitan facilities with MH units, no PECC

ED DATA						INPATIENT DATA	
All ED Visits	**MH ED visits**	**MH as a % of all ED**	**MH probs admitted**	**Adm < 8 hours (%)**	**MH in ED > 24 hrs (%)**	**Inpatient Seps**	**Adm via ED (%)**
475,287	33,269	7%	2,581	1,731 (67%)	135 (5.2%)	10,516	3,248 (31%)

Table 4: Metropolitan facilities without a mental health unit

ED DATA		
All ED Visits	**MH ED visits**	**MH as a % of all ED**
199,893	12,758	6%

Mental health patients account for 7% of all presentations to EDs in NSW. For hospitals with a PECC unit, mental health presentations account for 8% of presentations, 1% higher than metropolitan hospitals with a mental health unit without a PECC unit.

Across NSW 68% of all mental health patients presenting to the ED are separated in less than 8 hours. This percentage is a little lower for hospitals with a PECC unit (65%).

The percentage of mental health patients remain in the ED for greater than 24 hours is 4.9% across NSW, while 5.5% of patients at hospitals with a PECC and 5.2% of patients at hospitals with a mental health unit but no PECC remain in the ED for greater than 24 hours.

Specific data for each hospital with a PECC is provided in Appendix 3.

Discussion and recommendations

The timely assessment, management and transfer of care of patients presenting to an Emergency Department with a mental health problem is critical to achieving responsive care and efficient patient flow.

Processes for triage in the ED and accessing mental health assessments are well developed and, on most occasions, appear to work efficiently. Some sites have developed screening tools for use by the triage staff and this assists in determining whether the patient should be seen by ED medical staff or mental health staff first. In some sites ongoing education is provided by the PECC staff to assist ED staff working in triage.

> ***Recommendation 1****: That MH and ED staff work together to ensure the appropriate identification of mental health problems in patients presenting to the ED. This may include the development of screening tools for use by ED triage staff.*

The location of mental health assessments appears to be based upon availability of space and traditional practice. Mental health services have a strong preference for mental health assessments to be conducted in the ED due to:

- Unsuitability of the PECC environment with respect to safety of staff and patient
- Impact on safety where the PECC is not adjacent to the ED
- Issues with flowing back patients to the ED if required.

ED staff support the assessment of patients who are triaged as Category 3 or below to occur in the PECC as per the Operational Model of Care Guideline. This approach only occurs routinely in one PECC, and only during certain hours. In three other hospitals there is a significant push from the ED for this to occur.

> ***Recommendation 2:*** *That the Operational Model of Care Guideline be reviewed to clarify that the key principles in determining the location of mental health assessments (be it in the ED or PECC), are: site, practicality and the safety of patients and staff. That the Operational Model of Care Guideline be reviewed to clarify that patients with low level triage or existing clients of the mental health service with no medical issues, be considered for direct referral to the PECC.*

In most hospitals mental health assessments are undertaken in a timely manner during the hours when a mental health CNC is onsite. There may be some delays due to other patients being seen but this does not appear to cause unnecessary delays in mental health assessment by the CNC.

Timeliness of mental health assessments may vary after hours due to mental health staff not being available on-site, the need for the CNC to support staff in the PECC inpatient unit and patients being determined as not being fit for interview due to intoxication or overdose.

The need for further assessment by the psychiatrist registrar prior to liaison with the PECC Medical Officer is a process that could be streamlined. Further information about staffing levels and roles is described in section 4.3.

The physical assessment of patients in the ED with a mental health issue is an area of tension between the ED and PECC staff. The need for an ED medical officer to provide "medical clearance" was challenged when all patients are also seen by a psychiatrist registrar. The mental health services support the completion of a physical assessment by an ED medical officer rather than the psychiatrist registrar citing expertise of ED clinicians in physical health.

However, if not clinically indicated, an ED medical officer should not have to complete a comprehensive physical assessment when all patients are also required to be seen by a psychiatrist registrar. To counter concerns about the skill set of psychiatric registrars to competently complete a physical assessment, it is suggested that ED medical officers could provide supervision and/or mentoring of psychiatrist registrars in completing physical assessments.

The NSW Ministry of Health policies and guidelines regarding the physical health assessment of mental health patients and documents developed by the NSW Emergency Care Institute should be used at all sites to guide physical assessments of mental health consumers and to support local systems and processes which have been established for undertaking physical assessments.

> ***Recommendation 3****: That the Operational Model of Care Guideline be reviewed to clarify that pathways to care should meet the clinical needs of the patient. Local services should have processes in place to ensure that where indicated, patients receive a comprehensive physical assessment in the ED. Where there are no acute medical issues requiring immediate treatment or stabilisation in the ED, or where there is no confounding medical condition, patients should be fast tracked to the PECC (or mental health unit). There should be protocols in place which ensure an appropriate medical response is available to the PECC should a medical condition be identified after the patient has been referred to the PECC.*
>
> *That the Guideline refer to relevant NSW Health policies and guidelines regarding the physical assessment of mental health patients.*
>
> *That immediate consideration is given to the adoption of the NSW Emergency Care Institute's rationale for and use of their physical assessment of mental health patients form.*

Data regarding presentations to ED and admissions from ED does not support the position that having a PECC unit on-site encourages presentations and assists with timely admission.

There needs to be a very strong emphasis on time critical decisions by PECC and the mental health services regarding the outcome of assessments, a decision about the transfer of care of patients from the ED and any plans for further care.

With the introduction of the NEAT the need for streamlined assessment and management planning is required to assist with the throughput of mental health patients presenting to the ED.

> ***Recommendation 4****: That the Operational Model of Care Guideline include a statement about the requirement to meet the NEAT and that guidance be provided regarding timely transfer of care of patients from the ED in accordance with the NEAT.*

Ambulatory care data is not readily available that describes the population groups receiving care in the ED by the mental health CNCs who are not admitted.

> ***Recommendation 5****: That data is routinely captured regarding people being seen in ED by mental health/PECC staff who are not admitted to the PECC or a mental health unit.*

4.2 PECC Unit Inpatient Admission

The Operational Model of Care Guideline provides information relating to admission to the PECC unit including:

- people suitable for PECC admission as inpatients are those:
  - assessed as having a mental health illness or disorder, and
  - likely to require care for less than 48 hours, and
  - who have been medically stabilised, and who may
  - require further observation and short term care to allow determination of appropriate clinical pathways, and who may
  - be at risk of absconding, and
  - where the risks can be contained and managed safely in the PECC, relative to the general ED
- people not suitable for PECC admission as inpatients are those:
  - that require immediate medical management
  - that are screened to be at risk of an organic illness
  - whose age profile is not appropriate
  - who require community care or admission to a mental health unit
  - with serious co-morbid medical or surgical illness
- admission to the PECC inpatient unit must be preceded by an assessment
- the decision to accept the referral for admission lies with the mental health medical officer responsible for the PECC

Review findings

Admission to and discharge from the PECC
Each PECC has documented admission and discharge criteria that guide the practice locally. The units all identify that PECC admission is most suitable for short stay patients and that the discharge plan should be clear prior to their admission to the PECC. The PECC inpatient staff report that PECC inpatients need to be medically stabilised and be low risk in regards to violence.

Admission to the PECC unit may be direct, either through referral from the community mental health team, general practitioner (GP) or Police. Anecdotally, direct admissions to the PECC accounted for less than 5% of all admissions in the majority of hospitals. At some hospitals, direct admissions of some patients to the PECC created further delays for patients waiting in the ED for an inpatient bed.

The PECC unit beds are frequently used to meet the needs of particular patient groups such as adolescents and hospital staff members. Also, the PECCs use the beds to backflow patients from in-patient wards so that a more acute patient can be admitted to the acute facility.

There is some disagreement between the ED and PECCs regarding the admission criteria and strict adherence to the criteria. ED staff report that there are more exclusion criteria than admission criteria and that frequently the people who are being excluded are the people who could benefit from not being in the ED, such as intoxicated patients and those with other challenging behaviours. Of particular concern to ED staff is the lengthy stay in the ED required for intoxicated and/or overdose patients who do not need acute medical care prior to them being managed by the mental health team. One hospital is endeavouring to access funding to establish a dedicated area within the ED for the management of these patients where adequate medical, mental health and drug & alcohol/toxicology services can be provided.

While strictly adhering to the PECC admission criteria ED staff note the availability of beds within the PECC which are not being used while patients requiring observation and/or admission remain in the, often over-crowded, ED. Some EDs report little support from the PECC staff to use PECC waiting areas for patients requiring admission when a bed will become available in the next few hours. One PECC does use sofa beds within the PECC unit interview rooms to accommodate additional patients though this is not the usual practice. However, there was some support for the strict adherence to the admission criteria as the beds would then not be available for the patients they are designed to manage. This is the case in a few hospitals where the beds are used for mental health in-patient admissions when a bed in a more suitable location cannot be found.

Admission and activity data for all PECC inpatient units has been obtained from the Adult Acute Inpatient Benchmarking Data from InforMH.

It is important to note that this data has been collated from patient administrative data which is reported manually and therefore, may be under-reported. The data may also differ from other data provided in this report as the data sets are different as too are the timeframes. Of note too is the impact on occupancy of PECC beds being commissioned, closed beds or services becoming operational during the time period being reported. The data is provided to give an indication of performance against the Operational Model of Care Guideline in the relevant areas.

Some relevant data is shown below. During the period July – December 2011:

- 98% of PECC admissions were via the ED
- The average length of stay across all PECC units was 3.9 days
- 10.3% of patients were involuntary patients at the time of admission
- The average occupancy rate was 62.1%*

*Note: The PECC occupancy rate adjusted to take into account the impact of closed or partially commissioned beds is estimated by InforMH to be 75 - 78%.

Population groups receiving care in PECC
The Benchmarking Data from InforMH covering the periods July – December 2011. Data definitions to assist in reviewing this data are provided at Appendix 4.

Data relating to population groups served by the PECCs during July – December 2011 is shown below. Specific data for each PECC facility is provided at Appendix 5.

- The major age groups for patients across all PECCS are aged between 18-30 years (34.4%), 31-44 years (31.2%) and 45-64 years (22.3%)
- While the average separations of adolescents account for 8.9% of admissions these groups account for 38.4% of all separations at Wyong PECC and 25% at Hornsby PECC
- The average percent separations for older people (65 – 85+ years) is 3.2%. However, older people account for 7.9% of separations at Campbelltown PECC.
- The major primary diagnosis groups for all PECCs are: anxiety (27.6%), affective disorder (19.6%), psychoses (12.7%) and substance use (8.1%)
- Comorbid diagnoses for all PECCs are: substance use (28%), anxiety (24.6%), affective disorder (19.3%) and personality disorders (14.2%)

HoNOS data shows that, at admission:

  - 71% of all patients had clinically significant scores for depression
  - 45% of all patients had clinically significant scores for self-injury
  - 40% of all patients had clinically significant scores for substance issues.

The information relating to age groups of patients within the PECC was supported during the stakeholder consultations. The management of adolescents appeared to be a major challenge for all PECCs, even when there were effective mechanisms for the Child & Adolescent Mental Health Services to support the patient in the paediatric ward. Some sites report challenges in providing services to older people with mental health issues and that these patients are then admitted to the PECC.

Data covering the period July 2011 – June 2012 was also obtained from InforMH. The data regarding length of stay in the PECC units is shown below.

Table 5: Length of stay in the PECC

	Percent of separations
Length of stay of 1 – 3 days	70%
Length of stay of 4 – 7 days	14%
Length of stay > 8 days	2%

The age range of people admitted to all PECCs during this period is shown in the following table.

Table 6: Age range of people admitted to all PECCs admitted during 2011/12

Age	**Total**	**Percent of total admissions**
10-14 years	76	1
15-19 years	720	12
20-24 years	685	12
25-29 years	764	13
30-34 years	638	11
35-39 years	689	12
40-44 years	595	10
45-49 years	545	9
50-54 years	424	7
55-59 years	289	5
60-64 years	209	4
65-69 years	102	2
70-74 years	69	1
75-79 years	29	0
80-84 years	22	0
85 +years	17	0
TOTAL	**5,873**	**100%**

For the 12 months July 2011 – June 2012 data on discharges from all PECC units shows:

Total stays in PECC	Discharged from PECC	Not discharged from PECC	Percent of PECC stays admitted to a mental health unit
5,873	4,485	1,388	24%

Discussion and recommendations

The PECC inpatient units were initially established to provide capacity for observation and immediate care for people who are seen as benefitting from a short stay of up to 48 hours. However, as the units have developed they are generally seen as a short-stay unit of the mental health services and not part of the ED. This view impacts on policies and practices within the ED and PECC.

Admission and discharge criteria are available for all PECCs and generally guide practice. The most recently available data from InforMH shows that the majority of all PECC admissions are via the ED and that the average length of stay for all PECCs is 3.9 days which is longer than the suggested length of stay in the Guideline. The average occupancy rate across all the PECCs in the time period reported is 62.1%. It is to be noted that this includes data from one service which was closed for part of the time, one being established and one with two beds being commissioned but not occupied. InforMH estimate the PECC occupancy rate to be closer to 75-78% when adjusted for these closed or partially commissioned beds. Further, it is to be noted that the occupancy rate does not include same day admissions which may impact further on the utilisation of PECC beds.

There are opportunities to improve the admission processes to the PECC, including:

- consideration of direct admission to the PECC, especially when referred by the community mental health team,
- review of admission criteria to ensure maximum occupancy, and
- review of the need for the patient to be assessed by both the CNC and the Psychiatrist Registrar prior to liaising with the PECC Consultant to admit the patient.

The major age groups of patients admitted to the PECC units range from the ages of 18 – 64 years. While the PECCs have not been established to meet the needs of adolescents, admissions of adolescents account for an average of 8.9% of total admissions. This figure is much higher in Wyong (38.4%) and Hornsby PECC (25%) where there are no specialist child & adolescent inpatient beds. The difficulty in accessing child and adolescent in-patient beds was raised at all sites. While older people may also be admitted to the PECC people aged over 65 years account for 3.2% of all admissions. A number of PECC staff raised the issue of managing older people in the PECC and the challenge of finding appropriate units to admit them.

In line with the admission criteria the major primary diagnosis groups for admissions to all PECCs are anxiety, affective disorder, psychoses and substance use. The specific patient profile varies across sites.

> ***Recommendation 6****: That the Operational Model of Care Guideline is reviewed to clarify that the admission criteria and processes are in line with the operational guiding principles and key functions of the PECC model and assist in meeting patient and hospital needs.*
>
> ***Recommendation 7****: That the Operational Model of Care Guideline is reviewed to clarify that the admission criteria include consideration of the PECC inpatient population at the time and should still meet other key admission criteria, such as short-stay admission and non-violent.*

4.3 PECC management and systems

The Operational Model of Care Guideline provides the following information relevant to PECC management and systems:

- Clinical Governance:
  - Mental health presentations to the ED remain the responsibility of the ED until they are discharged, transferred or admitted
  - Mental health patients admitted to the PECC unit will be under the overall responsibility of the admitting PECC medical officer or psychiatrist
  - Shared responsibility may be agreed for PECC inpatients who also require a level of medical intervention

- Management:
  - PECC unit staff are responsible to the Mental Health Service
  - Agreed local work processes and lines of responsibility need to be developed
  - Agreed policies and procedures, including on issues such as patient flow, sedation, prevention and management of aggression, restraint and care documentation
  - Regular ED: PECC management meetings
  - Joint ED: Mental Health clinical review
  - Service agreements between ED, Mental Health and Drug & Alcohol services
  - MOU between ED, Mental Health Services, Police and Ambulance which incorporates the PECC service

- Staffing: the minimum staffing for the PECC service described in the Guidelines is:
  - Registered nurse, with mental health experience, presence 24/7
  - CNC during peak demand periods
  - Access to consultant psychiatrist advice 24/7 (and daily visit Monday – Friday)
  - Psychiatrist registrar for patient review including capacity for on-site attendance 24/7

- Access to Health Security Assistants 24/7

- The PECC facility:
  - The PECC unit should be part of the ED building or immediately attached to it
  - Close proximity to the ED Triage and Ambulance/Police vehicle area
  - Beds in open bays or in combination with a minority of single rooms
  - Sufficient interview rooms to enable PECC assessment function
  - Appropriate waiting area for use by PECC

Review findings

Clinical Governance
Staff at all sites are aware of the clinical governance responsibilities for people with mental health problems in the ED and the PECC unit. The clinical governance responsibility of the ED was frequently cited by PECC staff in support of the need to undertake mental health assessments within the ED.

PECC management and systems
PECC units have documented Operational Manuals, based on the Operational Model of Care Guideline. These manuals include policies and procedures on issues such as patient flow, sedation, prevention and management of aggression, restraint and care documentation. At some sites these documents have been developed in collaboration with ED staff but in others they have been done in isolation.

All hospitals report that they hold ED: Mental Health management meetings to assist in the effective and efficient delivery of services to mental health consumers. The frequency of these meetings varies from fortnightly, monthly, quarterly to an 'ad hoc' basis. In some hospitals the meetings are part of the overall MOU meeting and may include Ambulance and Police representatives. In other hospitals they are an ED:PECC meeting exclusively.

The meetings enable discussion of management systems and processes. To a lesser extent the meetings involve some clinical case review. Staff also report that discussions are held between meetings to address specific clinical matters that may arise.

Joint ED: PECC meetings were used at one hospital to develop a process for undertaking physical assessment of mental health patients presenting to the ED. The process also outlines the required documentation to be completed. As a result of the clinical review undertaken by staff it was reported that a more thorough physical assessment was required by ED staff prior to patients being discharged or admitted. As a result of implementation of the new physical assessment processes staff have demonstrated a reduction in MET calls within 24 hours post discharge from the ED.

Local protocols for collaborative care between ED and PECC

The collaborative care approaches in the ED are most apparent where mental health and ED staff, and at times staff from other services, jointly manage patients. The processes for parallel assessments have been described earlier. The mental health CNCs report that they assist the ED staff with the management of patients with challenging behaviours, whether they are mental health consumers or not. However in many sites there is little evidence of a team approach between ED and the PECC in jointly managing mental health patients.

There are fewer examples of shared care models which involve the ED staff working with the mental health staff within the PECC unit. The example was cited earlier where medical assessments were undertaken in the PECC for some patients. Where a patient of the PECC may require some ongoing assistance with a physical health problem, such as wound management, then protocols have been established at some sites where staff from the ED or short stay unit staff assist in the delivery of patient care in the PECC.

PECC staff report that, once a patient is admitted to the PECC, it is very difficult to get assistance from the ED for any physical health problems. If a medical emergency occurs, PECC staff utilise the local procedures to get assistance for the patient, which may or may not involve support from ED. ED staff report that this is in line with procedures for other short stay unit who manage their own patients.

Audit of mental health staffing in the ED and their function

The mental health staffing profiles in the ED were similar across all 13 PECCs. The mental health CNCs provide the ongoing presence in the ED. Two hospitals employ Nurse Practitioners who work in the ED as part of the mental health team. Psychiatrist registrars are on-site to participate in patient assessment in the ED.

The exception to this model for mental health staff in the ED is at one hospital, where the mental health staffing within the ED comprises a Junior Medical Officer, a CNC and an endorsed Enrolled Nurse.

The ED staff report high levels of satisfaction with the skills of the mental health CNCs and report that they are considered to be part of the ED team. This is particularly the case where the CNCs are physically based in the ED. In hospitals where the CNCs are based within the PECC there appears to be less rapport with the ED staff. Some CNCs report that their constant presence within the ED may result in decreasing the skills of the ED staff in managing mental health consumers. This was not substantiated by ED staff, though ED staff support the presence of mental health CNCs in the ED.

In all hospitals the mental health CNC has a role in education of nurses and medical staff within the ED. There is variability between the hospitals as to whether this education takes place.

The mental health CNCs, especially after hours, frequently assume other roles which support the mental health service activities. This may include the bed manager role, support for clinical care in other mental health units and cover for staff having breaks in the PECC. In some sites the CNCs work in more than one ED and have to travel between locations to assess patients.

In 12 of the PECC units, the mental health CNCs working in the ED are part of the inpatient mental health establishment; in the other hospital the CNCs are part of the community mental health team establishment.

Not all services have mental health staff onsite 24 hours a day available to undertake assessments of patients who present to the ED. All hospitals have at least two shifts a day with onsite staff and the overnight shift may use Psychiatrist Registrars who are onsite but covering wards including the ED or there is only an on-call service. Anecdotally, the presence of onsite staff 24 hours a day is reported by all hospitals as being more beneficial in the timely assessment, management and throughput of mental health patients.

Audit of mental health staffing in the PECC and their function

The PECC inpatient service uses a combination of registered nurses, enrolled nurses and assistants-in-nursing. The staffing profile is at times dependent upon success of recruitment strategies. The role of the nursing staff varies a little from PECC to PECC, partly related to the therapeutic program available and partly related to availability of social work services. In the PECCs without a social worker, nursing staff assist in finding accommodation, arranging for Centrelink services, arranging family meetings and work with patients on goal setting and other therapeutic activities. In others they support the management plan for the patients.

The medical staff generally comprise a 0.5FTE Psychiatrist Registrar and also a 0.5FTE Consultant. In some hospitals the Psychiatrist Registrar is 1.0FTE covering the ED and PECC.

Social workers are employed in 11 services. These positions are 0.5FTE except in one service where the service is employed as a 1.4FTE. As required and available, social workers, psychologists and occupational therapists from the inpatient mental health service may participate in the delivery of patient care to the PECC.

PECC units generally have a 0.5FTE administration clerk to assist with patient and general administration tasks such as data collection.

PECC unit facilities

The layout and design of the PECCs varies from site to site, partly based on the recency of the establishment of the PECC and on the space and location available in or near the ED. The first PECC unit to be established resembles an acute observation area within an ED while the more recently established units are comprised of predominantly single rooms and resemble an inpatient area.

There is at least one interview room in each PECC unit and the availability of a waiting room varies from non-existent to an area that can be monitored from the nurses' station. Some sites are co-located within the ED and others are further away. Access to all PECC units is via locked doors.

The layout, facilities and location impact on the accessibility of the PECC for mental health assessments to be undertaken in the PECC rather than the ED and the ease with which staff from can move between services.

Discussion and recommendations

Staff in the ED and PECC work collaboratively in the management of mental health consumers. At times though, the philosophies, practices and priorities of the two specialities are at odds. Systems and processes need to be developed and agreed for the shared care approach to managing the care of mental health consumers in the ED or the PECC and to managing the care of patients with challenging behaviours in the ED. These systems and processes also need to include other services, in particular the drug & alcohol services. Focussing on the outcomes to be achieved will assist in the development of processes and increase the team approach to the management of the consumers. The clinical pathways for mental health consumers in the ED and PECC would then be developed as part of this process.

The Operational Model of Care Guideline suggests that a regular ED:PECC meeting be held and that joint case reviews are also undertaken. Meetings between the ED and mental health services are held at each site. These meetings may have a particular focus on the ED:PECC operations but more often they form just one element of the meeting which includes Ambulance, Police and other stakeholders. Staff reported in a few sites that joint clinical review meetings occurred between ED and PECC staff.

There is value in having regular, at least monthly, meetings between ED and PECC managers to discuss clinical and operational issues. These meetings should be formal and include quality review, issues that impact on patient care and/or safety. There should be tangible evidence about the effectiveness of these meetings such as the development of shared protocols and outcomes of clinical reviews.

> ***Recommendation 8****: That the Operational Model of Care Guideline stipulate that at each site ED:PECC meetings are held at least once every two months to discuss clinical and operational matters. These meetings should include drug & alcohol services and specialist mental health services (CAMHS and SMHSOP), where relevant. These meetings are not to be part of the MOU or interagency meetings involving Ambulance and Police.*
>
> ***Recommendation 9****: That the Operational Model of Care Guideline stipulate that ED and PECC services (and drug & alcohol services where relevant), develop agreed systems and processes for the shared care approach to providing care for mental health consumers in the ED or the*

PECC and to managing the care of patients with challenging behaviours in the ED. These processes should then be used to review and, as appropriate, revise the clinical pathways for mental health consumers.

The staffing in the PECC units is comparable across hospitals although there are variations in allied health numbers and the availability of mental health staff onsite to work in the ED 24/7. The delay in assessing and developing management plans for patients by not having staff onsite for 24 hours exacerbates length of stay within the ED.

The PECC Operational Model of Care Guideline states that there should be mental health staff onsite 24/7 to undertake assessments but this is not the case in all hospitals. At one hospital there has been a recent improvement noted with the introduction of onsite staff overnight rather than on-call staff.

The majority of patients admitted to the PECC are experiencing situational crises. They benefit from accessing the skills and knowledge of allied health staff, such as social workers. Social workers are not available at all sites and, while nursing staff may undertake some of this work, it would be more beneficial to patients and their families to have access to a social worker.

Many PECC managers identified that the skills and competencies of staff, in particular nursing staff, is different in the short-stay PECC environment than for many inpatient mental health units. Some hospitals are recruiting staff with greater skills in managing the care of patients with more acute physical health needs. To meet the needs of the patients and to support patient flow this approach could be considered by all PECC units.

The location and layout of the PECCs varies from site to site and is most often dictated to by the space available and any redevelopment plans being undertaken. In the Operational Model of Care Guideline the PECC is considered to be part of the ED, both physically and functionally. Where there is a strong presence of the mental health CNCs within the ED the actual location of the PECC inpatient beds does not appear to have a significant effect on the length of stay and delivery of mental health assessments and care in the ED. However, when the CNCs are based in the PECC with less interaction in the ED, the location does impact on service delivery.

***Recommendation 10**: That each PECC reviews the availability of mental health staff on-site in the ED 24/7 to undertake assessments and to assist in managing the care of mental health consumers in the ED. That each PECC reviews the availability of medical staff on-site 24/7 to facilitate the timely transfer of care and physical flow of mental health consumers from the ED in accordance with NEAT principles.*

***Recommendation 11**: That the mental health CNCs are located within the ED to promote an integrated model of care and to ensure mental health staff are on-site to assist ED staff with patients presenting with challenging behaviours.*

***Recommendation 12**: That each PECC reviews the staffing mix to ensure the staff possess the skills and knowledge to meet the casemix of patients, for example, nursing staff with skills in meeting the physical health needs of patients. This also includes the availability of allied health staff, in particular social workers*

4.4 Consumer and carer perspective

A number of health service consumer representatives were interviewed as part of the Review. Overall, they stated that mental health consumers and carers are satisfied with the services they receive in the PECC. These opinions were mainly anecdotal as each site reported low use of and responses to the MH-COPES surveys.

The timely access to mental health assessments within the ED was noted by consumers as an improvement. The option of being admitted to the PECC and receiving short-stay care was valued.

Some dissatisfaction was expressed regarding waiting times and waiting locations in ED. As stated earlier, there is often no room for interviews and patients who require admission may wait in the waiting room or small isolated area extended periods of time.

Consumers also spoke of the stigma they felt presenting to the ED. As one consumer representative said, “If they (the patients) have the insight and courage to present to the ED they deserve a level of respect”.

Consumer representatives identified the need for increased education on the consumers experience and expectations for ED and PECC staff.

NSW CAG undertook an online survey of their membership to ascertain their views on the ED and PECC. The survey was completed by 77 consumers and carers with consumers accounting for over 70% of responses. Sixty four people nominated an ED that they had attended for a mental health problem. The top four locations, accounting for 78% of presentations were Calvary Mater Newcastle, Royal North Shore, St Vincent’s and Hornsby hospitals. Sixty four per cent of respondents stated that they have been admitted to a PECC.

The following table lists the responses to the NSW CAG survey in regards to their satisfaction with the services the following responses were received.

Table 7: Consumer and Carer satisfaction with ED and PECC services

Question	Satisfied (%)	Dissatisfied (%)	Some improvement needed (%)	Major improvements needed (%)
The information received about their rights and responsibilities	36	64	27	37
Waiting times for a physical health assessment in ED	37	30	30	33
Wait time in the ED to see a mental health clinician	27	32	32	41
Rating the services they received in the ED	31	38		38
Satisfaction with the services they received in the PECC	28	44	44	28
	Agreed	**Disagreed**	**Some improvement needed (%)**	**Major improvements needed (%)**
Felt free to raise concerns with staff if they had a problem:	36	64	n/a	32
Staff were willing to answer questions	42	58		24

An online survey of carers was undertaken by ARAFMI NSW. Twelve responses were received and ten of these people had been to an ED with a person they care for who had a mental health problem. Forty five per cent of the presentations (n = 5) had been the first to the hospital. The major findings were:

- the majority of respondents agreed that staff were friendly and positive and were sensitive to their cultural background.
- 66% of respondents were satisfied with the quality of care delivered in the ED
- 36% were satisfied with the quality of care from the PECC.

Areas requiring major improvements were:

- the need for staff to listen to the information provided by the carer
- provision of information about what to do and who to contact in a crisis
- the wait times in ED to see a doctor for a physical assessment and to see a mental health clinician, and
- involvement in discharge planning.

Discussions were held with and information obtained from the NSW Official Visitors Program. The issues noted by the Official Visitors during the last 12 months in their monthly visits to the 13 PECCs showed:

- 55% of respondents stated that the PECC was not being used for its intended purpose at the time of the site visit. The major reasons for this

was to relieve overcrowding in the acute mental health wards and that adolescents were admitted to the PECC

- 55% of respondents indicated that the working relationship between the PECC and the ED was good or excellent while 39% stated it was satisfactory and a further 14% stated it was unsatisfactory. The reasons for the unsatisfactory rating were due to poor communication and cooperation and differences in opinion regarding management of mental health patients.

Data relating to the site visits over the last 12 months by the NSW Official Visitors to EDs with a PECC was obtained. This data provided information on the quality of physical examinations and management of mental health patients needing a safe area.

The quality of physical examination of patients as rated by the NSW Official Visitors is shown in the table below.

Table 8: Quality of physical examination of patients

Rating	**Number**	**Percentage**
Excellent	2	2
Good	44	48
Satisfactory	29	32
Unsatisfactory	5	5
Unacceptable	0	0
Not applicable	11	12
TOTAL	**91**	**100%**

Official Visitors rated whether mental health patients assessed as needing a safe area or seclusion are 'specialled'. The Official Visitors responses are shown in the table below.

Table 9: Mental health patients assessed as needing a safe area or seclusion are 'specialled'

Rating	**Number**	**Percentage**
Always	19	17
Usually	62	56
Sometimes	15	14
Rarely	3	3
Never	2	2
Not applicable	9	8
TOTAL	**110**	**100%**

Two other areas were reviewed by the Official Visitors:

- When there was a safe assessment room, does it provide a private and dignified environment for patients?

  Yes: 54 No: 38

- Is there are seclusion room available in the ED?

  Yes: 15 No: 136

In discussions, the Principal Official Visitor confirmed the findings from the reports noting that the Official Visitors find a mismatch of expectations between the EDs and PECC and that the lack of agreed processes and policies does not assist with the seamless movement of patients between ED and PECC. The long length of stay for some patients in the PECC was also of concern as the units are not established with appropriate environments or therapeutic programs for patients to stay for longer periods.

Discussion and recommendations

Anecdotally there is generally positive feedback from consumer representatives regarding the experiences of consumers and carers with the mental health staff in the ED and with PECC staff. However, this is not supported in the responses to the surveys undertaken by NSW CAG and ARAFMI in which areas for improvement were noted in wait times in ED for physical and mental health assessments, information provision and service provision.

There is a need for health services to obtain feedback in a more formal and consistent manner through the use of MH-COPES. Responses from these surveys and other consumer and carer feedback could be discussed as part of the ED:PECC meetings.

> ***Recommendation 13:*** *That the PECC and mental health managers institute processes to enhance consumer and carer engagement in PECC services including:*
>
> - *routine dissemination of MH-CoPES to all patients discharged from the PECC unit (e.g. include in discharge procedure)*
> - *promoting the use of the community MH-CoPES for patients who are assessed in the ED and are not admitted to the PECC or inpatient unit*
> - *the inclusion of feedback from consumers and carers be considered as a standing item on the agenda of the ED:PECC meetings*
> - *seeking advice from the Consumer Sub-Committee regarding strategies for consumers and carers to provide feedback to PECC services on an ongoing basis.*

4.5 Managing intoxicated or overdosed or patients with challenging behaviours

An area of tension identified during this Review was the management of people who present to the ED who are intoxicated/overdosed and/or behaviourally disturbed. These patients frequently require a short-stay in hospital and there is a perverse incentive to link them to the mental health service, especially where there is a PECC unit. The lack of drug and alcohol services and beds to manage these patients was identified at all sites.

This group of patients may receive assessment by the mental health team but, these patients do not fit the PECC Operational Model of Care Guideline and are a challenge for the ED to manage. There is a disconnect between EDs and mental health services about the responsibilities for managing this group of patients. ED and mental health staff recognise that the provision of care to this patient group is beyond the current capacity of both services, given the increasing numbers and level of complexity and dangerousness of these presentations. The resolution of this issue is not easy and will require local corporate and clinical leadership, collaborative care and clinical review to determine the best pathways to manage the care of this patient group.

> ***Recommendation 14:*** *That the hospital executive in conjunction with ED, mental health and drug & alcohol staff, develop agreed systems and processes to manage the care of patients who are intoxicated, overdosed or with challenging behaviours who present with a mental health issue and to determine the most appropriate clinical pathways for these patients. This may include, for example, consideration of a short-term medical admission for intoxicants where these patients can be assessed and cleared by ward-based teams.*
>
> ***Recommendation 15****: That ED clinicians and mental health clinicians working in the ED and PECC receive education on managing the care of patients with drug and alcohol issues.*
>
> ***Recommendation 16****: That ED clinicians and mental health clinicians working in the ED and PECC receive education, in line with NSW Health policies, on minimising aggression and on managing the care of patients with challenging or disturbed behaviour.*

4.6 Other issues identified

During this Review a number of other issues were identified that impact on the delivery of mental health assessment and care in the ED and length of stay in PECC units.

Assessment areas

The lack of availability of appropriate assessment areas to enable staff to conduct assessments of mental health patients in a safe and private location

was identified by staff, consumers and carers. The demand for appropriate assessment and treatment areas is a challenge in most EDs.

> ***Recommendation 17****: That each site reviews areas available for mental health assessments in the ED and PECC and identifies safe and private locations for assessments of patients at different triage categories.*

Meeting population demand

In some hospitals the PECC beds are really an extension of the inpatient service. The availability of PECC beds is frequently not seen as making a significant difference to the delivery of care and transfer of care of patients from the ED. The availability of mental health services to adequately meet the populations demand is a challenge across the State. The availability of child and adolescent beds and community services impacts on both the PECC demand and demand for inpatient beds.

> ***Recommendation 18:*** *That mental health services continue to review demand and implement strategies to meet the needs of the population and the hospital.*

> ***Recommendation 19:*** *That ED clinicians and mental health clinicians working in the PECC and ED receive education on managing the care of younger people with mental health issues who present to the ED.*

Promoting cross-service networking

It was noted that, while the PECC Network exists, there are not many opportunities for sharing of information and resources between the PECCs and the EDs where PECCs operate.

There appears to be little networking of the ED and PECC staff between the hospitals with PECCs. While there is a PECC Network not all PECCS participate in this. Further, the PECC Network does not include ED representatives. Opportunities for sharing of systems and processes need to be enhanced.

> ***Recommendation 20****: That the Ministry of Health identifies opportunities to support networking and information sharing between the PECCs, including supporting all PECCs to be part of the PECC Network.*

> ***Recommendation 21****: That the Ministry of Health considers the proposal to bring ED and PECC staff from the 13 hospitals with PECCs to discuss the Operational Model of Care Guideline and other system matters on an annual basis to support networking and information sharing between the PECCs and EDs.*

During this Review many staff requested information regarding the outcomes of the Review. The review findings and recommendations should be made available to all hospitals with PECC services to enable staff to review and action the recommendations.

***Recommendation 22**: That the report from this External Review be made available to the PECC and ED staff and consumer and carer groups who participated in the review to facilitate networking between the PECCs and EDs.*

APPENDIX 1

Advisory Group members

John Allan, Chair	Chief Psychiatrist, NSW Ministry of Health
Jason Bourke	Wyong Hospital
Marcia Fogarty	Hunter New England LHD
Beaver Hudson	St Vincent's Hospital
Sally McCarthy	NSW Emergency Care Institute
Bryan McKee-Hata	Royal North Shore Hospital
Ka Ki Ng	NSW CAG
Marc Reynolds	MHDAO, NSW Ministry of Health
Grant Sara	InforMH
Saleem Sivalingam	St George Hospital
Anne Unicomb	MHDAO, NSW Ministry of Health

APPENDIX 2

Stakeholder groups

Emergency Department, PECC and Mental Health Service staff from the following sites:

Blacktown
Calvary Mater Newcastle/ Hunter New England
Campbelltown
Hornsby
Liverpool
Manly
Nepean
Prince of Wales
Royal North Shore
St George
St Vincent's Hospital
Wollongong
Wyong

Other Stakeholders representing the following organisations:

ARAFMI
InforMH
NSW CAG
NSW Ministry of Health – Mental Health, Drug & Alcohol Office
NSW Official Visitors

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Consultation Draft

APPENDIX 3

Mental Health ED data: 11 PECC sites

NSW Mental Health ED Activity: Estimate of annual activity

	ED Data (from ED data July 2010 - Dec 2011)								Inpatient Data – PECC and inpatient units (based on July-Dec 2011)		
	All ED visits	Mental Health ED visits	MH as % of all ED	MH probs admitted	Adm < 8 hrs	EAP 8 hrs %	MH in ED > 24 hrs	EAP 24 Hrs %	Seps	Admitted via ED	Admitted via ED %
Facilities with PECC units											
St Vincent's Hospital, Darlinghurst	41,836	2,967	7%	1,097	741	68%	23	2.1%	1,340	1,240	93%
Wyong Hospital	48,873	2,456	5%	570	503	88%	1	0.2%	1,244	764	61%
Hornsby and Ku-Ring-Gai Hospital	30,139	1,427	5%	548	463	84%	3	0.6%	804	600	75%
Royal North Shore Hospital	53,298	2,388	4%	505	357	71%	5	0.9%	884	728	82%
Prince of Wales Hospital	39,155	4,111	11%	569	345	61%	18	3.2%	1,214	748	62%
St George Hospital	59,769	6,763	11%	599	473	79%	6	1.0%	700	670	96%
Blacktown Hospital	30,343	2,915	10%	321	157	49%	49	15.1%	630	322	51%
Liverpool Hospital	54,117	5,726	11%	927	461	50%	128	13.8%	1,060	1,010	95%
Nepean Hospital	46,245	3,791	8%	1,073	720	67%	41	3.8%	1,406	1,162	83%
Campbelltown Hospital	40,023	3,954	10%	1,286	690	54%	153	11.9%	1,404	1,266	90%
Wollongong Hospital	47,570	4,669	10%	364	233	64%	3	0.9%	654	482	74%
Total	**491,367**	**41,167**	**8%**	**7,859**	**5,144**	**65%**	**429**	**5.5%**	**11,340**	**8,992**	**79%**

APPENDIX 4

Data definitions - Adult Acute Inpatient Benchmarking Data, InforMH

Primary diagnoses have been grouped into the following categories:

- **Psychosis:**
  Schizophrenia: ICD codes F20 - Schizophrenia.

  Other: Other psychosis. Includes Organic Disorders, Mental and behavioural disorders due to use of substance, Schizotypal disorder, Persistent delusional disorders, Delusional disorder, Acute polymorphic psychotic disorder without symptoms of schizophrenia, Acute schizophrenia-like psychotic disorder, Acute and transient psychotic disorder, Schizoaffective disorders, Other nonorganic psychotic disorders and Unspecified nonorganic psychosis.

- **Anxiety:**
  Adjustment stress: ICD codes F43 - Reaction to severe stress, and adjustment disorders

  Other: ICD Codes F40, F41, F42, F44, F45, F48. Includes Phobic anxiety disorders, Other anxiety disorders, Obsessive-compulsive disorder, Dissociative [conversion] disorders, Somatoform disorders, and Other neurotic disorders

- **Organic:**
  Alzheimer's: ICD codes F00, G30. Includes Dementia in Alzheimer's disease and Alzheimer's disease

  Other dementia: ICD codes F01, F02, F03, G10, G20, G31, G32. Includes Vascular dementia, Dementia in other diseases classified elsewhere, Unspecified dementia, Huntingtons disease, Parkinsons disease, and Other degenerative diseases of nervous system.

  Other: ICD codes F04 – F09. Includes Organic amnesic syndrome, Delirium Other mental disorders due to brain damage and dysfunction and to physical disease, and Personality and behavioural disorders due to brain disease, damage and dysfunction.

- **Substance:**
  Alcohol: ICD codes F10 - Mental and behavioural disorders due to use of alcohol.

  Other: ICD codes F11 – F19. Includes Mental and behavioural disorders due to use of other psychoactive substance.

- **Affective:**
  Depression: ICD codes F31.3, F31.4, F31.5, F32, F33, Includes Bipolar affective disorder (depression), Depressive episode, and Recurrent depressive disorder.

  Mania: ICD codes F30, F31.0 – F31.2. Includes Manic episode and Bipolar affective disorder (current episode hypo-manic or manic with/without psychotic symptoms).

  Other unspecified: ICD codes F31, F31.6 – F31.9, F34, F38, F39. Includes Bipolar affective disorder, Persistent mood [affective] disorders, Other mood [affective] disorders and Unspecified mood [affective] disorder.

- **Behaviour:**
  Eating disorder: ICD codes F50 - Eating disorders.
  Other: ICD codes F5 [1,2,3,5,9] and F6 [3,4,5,6,8,9]. Includes Nonorganic sleep disorders, Sexual dysfunction (not caused by organic disorder or disease), Mental and behavioural disorders associated with the puerperium, Harmful use of non-dependence-producing substances, Unspecified behavioural syndromes associated with physiological disturbances and physical factors, Habit and impulse disorders, Gender identity disorders, Disorders of sexual preference, Psychological and behavioural disorders associated with sexual development and orientation, Other disorders of adult personality and behaviour and Unspecified disorder of adult personality and behaviour.

- **Childhood:**
  Anxiety emotion: ICD codes F93, F94. Includes Emotional disorders specific to childhood and Disorders of social functioning with onset specific to childhood and adolescence.

  Conduct opposition: ICD codes F91, F92. Includes Conduct disorders and Mixed disorders of conduct and emotions.

  Overactive: ICD codes F90 - Hyperkinetic disorders.

  Other: ICD codes F95, F98. Includes Tic disorders, Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

- **Development:**
  Autism spectrum: ICD codes F84 - Pervasive developmental disorders

  Other: ICD codes F70 – F79, F80 – F83, F88, F89. Includes Mental retardation and Specific developmental disorders of speech and language, scholastic skills, motor function, mixed specific developmental disorders and Other/Unspecified disorders of psychological development.

- **Personality:**
  Borderline: ICD codes F60.3, F60.30, F60.31. Includes Emotionally unstable personality disorder - impulsive type/borderline type.

  Other: ICD codes: F60, F60.0 – F60.2, F60.4 – F60.9, F61, F62. Includes Specific personality disorders (Paranoid, Schizoid, Dissocial, Histrionic, Anankastic, Anxious [avoidant], Dependent, Other/Unspecified) and Mixed and other personality disorders.

- **Other:**
  Poisoning and DSH: ICD codes T36 – T50, T71, X60 – X84. Includes Poisoning, Asphyxiation, Intentional self-poisoning and Intentional self-harm.
  Injury: ICD Codes: S00-S99, W00-W99, T00-T07, T11-T35, T90-T98. Includes all injuries, Burns and corrosions, frostbite and Sequelae of injuries, of poisoning and of other consequences of external causes.
  MH Symptoms: ICD codes: F54, F99, R41 – R46. Includes Psychological and behavioural factors associated with disorders or diseases classified elsewhere, Mental disorder not otherwise specified , Other symptoms and signs involving cognitive functions and awareness, Dizziness and giddiness, Disturbances of smell and taste, Other symptoms and signs involving general sensations and perceptions/emotional state/appearance and behaviour.
  Medical Conditions: All other diagnoses not included in above

APPENDIX 5

Individual hospital qualitative and quantitative information

Blacktown Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	Not operational at the time
Occupancy	Not operational at the time
Activity	Not operational at the time
Admission pathways – admissions via ED	n/a
Legal status – involuntary legal status on admission	n/a
Length of Stay – average days per separation	n/a
Staffing levels	
ED:	• CNC - 2 FTE – covering Mt Druitt and Blacktown Hospitals • Psychiatric Registrar - 1 FTE – covering Mt Druitt and Blacktown Hospitals • ED / ASET SW available
PECC:	
Nursing:	• NUM • CNC – as above • RN • EN/ AIN
Medical	• 1 Consultant • Psych Reg - a/a
Allied health	• Nil. (Inpatient unit may provide SW staff as needed)
Administrative	• 1 FTE

PECC beds not operational during the data collection period.

LOS profile	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• CNC in ED covers from 7am – 10pm, working at both Mt Druitt and Blacktown Hospitals. The Psych Reg covers ED overnight and Short Stay unit clinicians assist • Delays in assessments occur when staff are not on-site.
Location of mental health assessments	• Challenge finding a suitable area to undertake the assessment. No SAR. May use resuscitation room for assessments.
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Timeliness not reported as an issue. Patient needs to be 'fit for interview' which may delay timing or patient load may delay assessment.
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• ED role to provide physical assessment and determine that patient is medically clear. • If the patient is to be transferred to Cumberland Hospital a full medical assessment is required.
Local criteria for admission and discharge from PECC	• Guidelines established for short stay unit. Adolescents are transferred to Westmead and, if no bed available, a special is allocated to their care. • Psych Reg liaise with Consultant to arrange admission to PECC
Local protocols for collaborative care between ED and PECC	• Protocols being developed as unit becomes operational again • Mental health staff assist with management of challenging behaviours of patients in the ED regardless of diagnosis • ED / MH meetings schedules for monthly but often cancelled.
The clinical pathways of mental health consumers in the PECC and in the ED	• Patients may be admitted from multiple locations, especially with the Admissions Unit at Cumberland Hospital • Developing agreed protocols, for example, commencing parallel assessment processes • Patients in the PECC may be transferred back to the ED as necessary as it is hard to see a Medical or Surgical registrar in the PECC.
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)

Audit of mental health staffing in the ED and PECC and their function	(See activity table)
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Staff service 2 EDs – Blacktown and Mt Druitt. • Difficulty accessing in-patient beds may see patients remaining in ED for extended periods of time with minimal mental health staffing to provide assistance or supervision of patients • There are no after hours drug & alcohol services available • Need for clarty regarding clinical governance when patient is accepted for admission to MH bed but no bed available and patient remains in ED

Hunter New England Mental Health - PECC – Mater Mental Health Centre (Co-located with Calvary Mater Newcastle)

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of PECC beds	4
Occupied beds	2.5
Occupancy	63.3%
Staffing levels	
ED:	• Liaison Pysch – Calvary Mater employee for Toxicology only in ED during normal hours; CI-Psych service in ED after hours provided by HNEMH • Social Worker - Calvary Mater employee
PECC:	Includes PECC Assessment & PECC Beds
Nursing:	• Nurse Manager – 24/7 for PECC + Bed Management of Mater Mental Health Centre (100 Beds), Mental Health Services District wide (all sites) and service issues after hours (Allocation 5 FTE) reports to NM4 for PES (includes PECC, PICU & Mater Mental Health Centre) normal hours • PECC Assessment - 2 RNs morning and afternoon shifts, 1 RN overnight; • PECC Beds 1 RN each shift
Medical	• Consultant – 1 FTE for PECC & PICU (8 beds) and Medical Superintendent for site • Psych Registrars – 1 Registrar each shift (Allocation 4 FTE on 6 month rotation + After hours service wide roster)
Allied health	• 1.4 FTE Social Workers includes 0.4 FTE weekend coverage working with families project funding
Administrative	• 1 admin officer from 8am-8pm 7 days per week for PECC & PICU (Allocation 2 FTE)
Activity	
Admission pathways – admissions via ED	94.7%
Legal status – involuntary legal status on admission	13.9%
Length of Stay – average days per separation	1.8

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	91.8		6.3		1.4		0.5			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.0	1.4	38.0	35.1	23.6	1.9	0.0	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	5.4	10.8	11.8	54.4	1.5	15.2	1.0	0.0	0.0
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	1.0	**9.8**	**47.5**	**26.5**	**47.1**	**5.9**	**21.6**	**3.9**	**0.5**	**91.2**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Triage conducted by RN in ED and referred to PECC for mental health assessment, patients fast tracked when indicated (discharged from ED) • Direct referrals to PECC triaged by RN in PECC – Local protocol applies • Mental health assessments in ED for (1) Toxicology patients by CMN Cl-Psych; (2) ESSU patents by Cl-Psych; and (3) After hours by HNE Cl-Psych duty MO when indicated, all other MH Assessments are referred to and conducted in PECC • Timeliness depends on when notified by/transferred from ED; May be delay when patients are intoxicated, medically sedated, physically unwell, co-morbid medical conditions, elderly (over 65 yrs), capacity of PECC waiting room/resources or over census/bed management • No mental health presence or PECC staff in ED, no CNC in ED or PECC, limited Cl-Psych cover in ED, PECC and ED co-located with connecting corridor and managed by separate health service organisations
Location of mental health assessments	• Triage and 'pre-assessment' when indicated in ED eg intoxication • Mental health assessments conducted in PECC. • Patient discharged from ED and transferred to PECC. No mental health assessments conducted in ED except for toxicology patients and ESSU
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Physical examination completed in ED for some patients referred to PECC eg medical triage 1 or 2 and when medical condition indicated and identified on triage • There may be delays at times, not undertaken for scheduled patients • No routine medical screening or clearances undertaken or given by ED prior to referral to PECC • Baseline observations completed for some patients referred to PECC • Majority of medical examinations for people with a mental illness/disorder conducted in PECC • Medical examinations routinely done in PECC for all admitted inpatients
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• No routine medical clearance provided or defined in ED • Use of Blood Alcohol Level and clinical judgment to determine if patient is 'fit for interview' – ED staff don't always agree with PECC staff on whether patient ready/appropriate for interview. Scheduled patients are taken straight to PECC and receive no physical examination in ED • Medical examinations routinely done in PECC for all admitted inpatients

Local criteria for admission and discharge from PECC	• Criteria and Local Protocol in place eg. Police and Ambulance presentations direct to PECC, admission to units based on acute mental illness/disorder and residential address, unit specialty (MHUOP/MHSU), situational crisis/adjustment (PECC Bed) • Voluntary and involuntary admissions under the NSW Mental Health Act • Discharge summary, referral and/or follow up for non-admissions and all patients discharged from PECC Beds and inpatient units
Local protocols for collaborative care between ED and PECC	• MOU between HNEMH and CMN, periodically reviewed • Local protocols include: (1) Management of Mental Health Presentations to CMN-ED and HNEMH-PECC; (2) Referral for Medical Consultation for Patients in the Mater MHC; (3) Mater MHC Medical Emergencies (Code Blue) • Regular consultation meetings between respective Nurse/Unit Managers and Clinical Directors • Challenges returning patients to ED once admitted to PECC • No assistance from Calvary Mater for MET calls • Triage/assessment/management of patients with intoxication, medical condition/comorbidities • Mental health and Cl-Psych coverage and presence in ED • Two separate entities working in two different environments
The clinical pathways of mental health consumers in the PECC and in the ED	• Local protocols for direct presentation to PECC, ED triage and fast track • Toxicology service available at Calvary Mater may assist with management of some D&A patients eg DSH/Overdose, but toxicology does not cover intoxicated patients nor D&A • Dual diagnosis service (MHSU) within Mater MHC, but does not cover intoxicated or drug and alcohol patients. Specialist unit for people with dual diagnosis mental illness/disorder and Drug and alcohol dependence. This may cause confusion in ED. • Mental health in older people's pathway cf Medical (delirium); Aged Care (dementia); MHUOP (MI/MD/Delirium with psychol dis/challenging behaviours • Younger persons presented to JHH-ED (location of Nexus Unit)
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED and PECC and their function	(See activity table) • Nurse Manager is also Bed Manager for MH after hours • No presence of MH staff in ED at Calvary Mater

	• No mental health CNC in ED or PECC • Limited CI-Psych cover in ED
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Complex environment as two separate entities provide the ED and PECC services • Liaison Psychiatry is provided by Calvary Mater employees and not associated with the staff from the PECC unit • Consultant Liaison staff won't assess or clear patients on Schedule – must present to PECC or refer. Consult with PECC Clinical Director/Medical Superintendent under the Act • Transfers to PECC/ MH do not get admitted via ED but come straight to the PECC for assessment • Good having the Bed Manager in the PECC • PECC waiting room not working well to meet patient needs – Small/restricted space, risk management factors, patients and family locked in waiting room require staff assistance to exit, no front door/public entrance/exit to PECC, secondary exit to ED clinical/patient occupied area or PECC Bed clinical/patient occupied area, no thoroughfare.

Campbelltown Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	6
Occupied beds	6.6
Occupancy	110.1%
Staffing	
ED:	• CNC – 24/7 except Friday and Sat night shift, which is covered by psych reg • Psych Reg in hours – 1.5 FTE for ED and PECC (this varies depending on outpatient clinics and availability – some days 0.5 some days 1.5) • Psych Consultant – 1 FTE ED & PECC • Social worker – PECC and ED • x2 AIN's every shift 24 hours • Variable numbers of Casual security
PECC:	
Nursing:	• NUM – 1 FTE day shift • 2 nursing staff each shift (may be 2 RNs or RN and EN) • If over-census beds open more staff put on.
Medical after hours	• Consultant – a/a • Psych Reg on to 11pm Sunday to Thur covers mainly ED but also wards • Fri and Saturday night Psych Reg on overnight as well as all day
Allied health	• Social Worker – a/a
Administrative	
Activity	
Admission pathways – admissions via ED	99.1%
Legal status – involuntary legal status on admission	0.0% (may be under-reported)
Length of Stay – average days per separation	5.4

Consultation Draft

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	54.6		26.4		11.6		7.4			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.9	4.2	26.9	28.7	31.5	4.2	2.8	0.9
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	7.5	6.1	24.1	17.9	0.0	8.0	0.0	1.9	34.4
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.9	**2.4**	**14.6**	**15.6**	**12.3**	**0.0**	**6.6**	**2.4**	**0.9**	**34.0**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• ED triage staff notify PECC of patient arrival. Referral added to PECC database and then CNC sees pt • Timeliness not noted as an issue
Location of mental health assessments	• Assessments happen usually in ED. Two isolation rooms available for use – not just specific to MH
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Developed a QA project between ED and PECC on physical assessment to reduce MET calls etc • Developed detailed assessment form
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Undertaken by ED staff. Not seen as a significant issue • Agreement as to what constitutes 'medical clearance'
Local criteria for admission and discharge from PECC	• Could have direct admission to PECC but minimal access to beds • Criteria agreed – challenge is access to beds •
Local protocols for collaborative care between ED and PECC	• See above • Staff report collaborative practices and support for mental health patients • ED may undertake assessments in PECC to assist with patient flow from the ED • ED and PECC Executive meeting held
The clinical pathways of mental health consumers in the PECC and in the ED	• PECC team attend ED at 8am each day to facilitate admission and discharge of patients. Followed by a multidisciplinary meeting 8.30 every am to organise staff allocation and prioritise order in which patients are seen. • Policies and agreement on management of patients and beds • ED will take patients back if major physical health matter needs to be addressed
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid	(See activity table) • For adolescents, GKL DT and CNC will develop individualised programs while in PECC.

condition etc)	
Audit of mental health staffing in the ED and PECC and their function	(See activity table)
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• May use fold-out beds in interview rooms to manage patients (hence go over census) • Staff from PECC and ED report satisfaction with the operations of the service

Hornsby Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied Beds	2.5
Occupancy	61.7%
Staffing	
ED:	• CNC – 2 shifts per day • Liaison Pysch • Social worker (part of ED establishment)
PECC:	
Nursing:	• NUM • CNC – a/a • RN / EN – to cover each shift
Medical	• 0.5 FTE Consultant • 1.0 FTE Psych Reg
Allied health	• 0.5 FTE Social Worker
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	99.2%
Legal status – involuntary legal status on admission	1.1%
Length of Stay – average days per separation	2.6

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	75.0		21.7		2.5		0.8			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	10.8	14.2	32.5	18.3	20.8	2.5	0.8	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.8	10.1	8.4	27.7	30.3	0.0	1.7	0.0	0.8	20.2
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.8	**0.0**	**26.1**	**23.5**	**20.0**	**4.2**	**4.2**	**0.0**	**0.8**	**35.3**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Triage staff notify CNC of patient arrival. Assessment timely when CNC is available – 2 shifts a day. • CNC is based in the ED • Timeliness improved over last 12 months with Psych registrar now on-site 24/67
Location of mental health assessments	• Assessments undertaken in interview room, waiting room or at bedside – all in ED
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Screening tool assists in determining if physical or mental health asst should occur first. • No problems reported from MH staff re physical assessments being undertaken
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Recent change in policy allows patients to be admitted to PECC without medical clearance..
Local criteria for admission and discharge from PECC	• Psych Reg liaises with consultant to approve admission to PECC • Criteria for admission established – predominantly the need for a short stay • Frequently used for patients who cannot get access to an inpatient bed
Local protocols for collaborative care between ED and PECC	• Good triage processes using screening tool to determine if patient needs to go to a bed for the physical assessment • ED staff support PECC staff with management of dressings for pts • ED:PECC meetings are held at least quarterly • CNC involved in education to ED staff
The clinical pathways of mental health consumers in the PECC and in the ED	• Psychogeriatric and CAMHS pts are hard to place as there are no specific services available for them • Agreed protocols for the management of short stay patients • Able to transfer patient back to ED if needed from PECC • Long stay patients may be admitted to PECC due to bed access problems in the mental health

	unit
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED and PECC and their function	(See activity table)
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Limited availability of services to address the needs of psychogeriatric patients • ED staff acknowledge the need to medically supervise drug& alcohol patients prior to further management plans being agreed • Clinical governance an issue at times when patient still in ED but being managed by mental health • Hard to observe patients in ED due to location of waiting areas

Liverpool Hospital

Note: Data from Infor MH benchmarking dataset: July – Dec 2011

No. of beds	6 (from 24/11/11) 4 - prior to this
Occupied beds	3.7
Occupancy	62.3%
Staffing	
ED:	• CNC – 24/7 • Psych Reg – 8.30am – 11.00pm M – F; 24/7 on weekends • Psych Consultant • Liaison Pysch • Social worker – part of ED establishment
PECC:	
Nursing:	• NM – covering Liverpool and Campbelltown MH inpt services • CNC – a/a • RN / EN/ AIN – cover shifts
Medical	• Consultant: Currently 0.5FTE • Psych Reg: Currently 0.5FTE (to be reviewed in January 2013 with next rotation).
Allied health	• 0.5 FTE SW
Administrative	• Nil
Activity	
Admission pathways – admissions via ED	100%
Legal status – involuntary legal status on admission	0.6% (May be under-reported)
Length of Stay – average days per separation	3.5

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	65.2		30.9		2.8		1.2			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	2.2	5.5	40.3	30.9	17.1	3.3	0.6	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	26.5	3.5	18.8	12.4	0.0	7.6	1.2	0.6	29.4
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	1.2	**6.5**	**24.1**	**14.7**	**11.8**	**0.0**	**10.6**	**2.9**	**0.6**	**41.2**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Not raised as an issue • After hours the Psych Reg covers the PECC, ED and wards
Location of mental health assessments	• Undertaken in ED – in SAR or patient bay • Pressure from ED for assessments to be undertaken in PECC
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Not identified as an issue
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Checklist used to assess patients physical health
Local criteria for admission and discharge from PECC	• ED pushing for direct admissions from ED Triage • May have direct admission from Community MH team if bed available • Psych Reg approves admission when onsite. CNC managed overnight •
Local protocols for collaborative care between ED and PECC	• Assessments usually undertaken by CNC and ED Registrar at the same time • Difficult returning patient to ED if required • MH/ED meeting held monthly –includes both ED MH issues, community input, D&A and PECC
The clinical pathways of mental health consumers in the PECC and in the ED	• No psychogeriatric services available • While the C&A CNC is not based within the ED/PECC they are located in Park House at Liverpool and attend to all C&A presentations once referred by the PECC CNC (PECC CNC does initial assessment then refers to C&A). • Consultant Liaison service will see patients on medical or surgical wards. CL at Liverpool also review all admitted patients remaining in ED on commencement of shift (0830 hours).

Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table) Adolescents - A recent initiative in Liverpool to introduce groups for young people admitted with the help of C&A CNC
Audit of mental health staffing in the ED and PECC and their function	(See activity table)
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• CNC provides education and orientation to ED staff.

Manly Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	0.7
Occupancy	16.6%
Staffing levels	
ED:	• CNC – covers 8am – 10pm 7/7 • 0.5 FTE Psych Reg • Liaison Pysch available • Social worker provided by ED)
PECC:	
Nursing:	• 1 FTE NUM • CNC – a/a • RN – 2 per shift
Medical	• 0.5 FTE Staff specialist • Psych Reg – a/a
Allied health	• 0.5 FTE Social Worker
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	100%
Legal status – involuntary legal status on admission	2.9%
Length of Stay – average days per separation	2.9

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	77.1		17.1		5.7		0.0			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.0	2.9	40.0	28.6	28.6	0.0	0.0	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	11.4	11.4	20.0	22.9	0.0	0.0	0.0	0.0	34.3
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	2.9	**0.0**	**45.7**	**20.0**	**17.1**	**8.6**	**17.1**	**0.0**	**0.0**	**65.7**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• CNC covers from 8am – 10pm 7 days a week which enable timely assessment for the majority of patients • CNC is based in PECC rather than ED • Service overnight is with on-call staff, not onsite
Location of mental health assessments	• Assessments undertaken in ED, sometimes in SAR. Little privacy for patients • Only 1 assessment room in PECC
Timeliness of medical assessment of consumers with a mental health issue in the ED	• ED physicians see patient first and progress physical assessment • ED staff are not expected to provide physical assessment on every patient known to mental health
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• 'medical clearance' not an issue • Mainly assessing intoxicated patients to ensure they are fit for interview
Local criteria for admission and discharge from PECC	• CNC liaises with Staff Specialist, in hours, to arrange admission to PECC • PECC is a short stay unit to address situational and other crises • Low stimulus environment is good •
Local protocols for collaborative care between ED and PECC	• Nursing staff from ED and EMU assist nursing staff in PECC with meeting the physical health needs of patients, such as wound dressings • Parallel assessment policy in place • Regular meetinsg held with PECC and ED, and CNC involved
The clinical pathways of mental health consumers in the PECC and in the ED	• There is a clear focus on discharge planning from the time the CNC sees the patient in the ED • Other services are called in to assist, such as drug & alcohol
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED	(See activity table)

and PECC and their function	The social worker addresses the housing and welfare needs of patients. The SW has made a resource pack for nursing staff to use when the SW is not available Nursing staff assist in discharge planning, developing consumer wellness plans, relapse plans and developing coping skills
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Nursing staff recruitment includes nurses from ED and other areas of the hospital • PECC nurses are gaining IV competencies to meet pt needs • PECC used sometimes to backflow less acute patients from in-patient unit • May reduce absconding rates if the CNC was available 24/7

Nepean Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	6
Occupied beds	3.4
Occupancy	56.4%
Staffing levels	
ED:	• CNC / Nurse Practitioner / CNS – cover 24/7 • Psych Reg • Social worker (ED establishment)
PECC:	
Nursing:	• NUM • CNC / Nurse Practitioner / CNS – a/a • RN / EN/ AIN – cover each shift
Medical	• Consultant • Psych Reg • CMO – 1 FTE
Allied health	• Nil. Social Worker support from inpt unit if necessary
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	99.7%
Legal status – involuntary legal status on admission	17.9%
Length of Stay – average days per separation	1.9

Consultation Draft

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	95.0		4.0		0.7		0.3			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	2.3	8.3	34.7	34.0	16.8	3.3	0.7	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.7	8.6	6.0	13.9	38.4	0.7	3.3	0.0	0.3	28.1
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	**4.6**	**18.9**	**17.5**	**36.8**	**1.0**	**13.2**	**3.3**	**2.6**	**45.0**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Not identified as an issueas CNC/NP cover 24/7 though Psych Reg is on call AH
Location of mental health assessments	• Triage Cat 3- 5 assessed in PECC during hrs when security is available (7am – 7pm) • Other assessments done in ED. Not many places to assess – only 1 SAR
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Physical health assessments within 24 hours. May be undertaken in PECC for admitted patients
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Psych Reg or CMO may undertake medical clearance for pt to be admitted
Local criteria for admission and discharge from PECC	• Need Psych Reg to agree to admission • Admit adolescents as no other services available
Local protocols for collaborative care between ED and PECC	• Aim for parallel assessment. • Have established a new monthly meeting – 30 minutes for case presentation and 30 mins for management issues
The clinical pathways of mental health consumers in the PECC and in the ED	• May have problems returning pts to ED if need admission in another unit • May admit longer stay pt to PECC bed and commence treatment and transfer to acute bed when available
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)

Audit of mental health staffing in the ED and PECC and their function	(See activity table) • CNC provides education to ED staff, especially re triage • Rely on senior staff skills to assist in patient care with no Social Worker on PECC staff
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• One model could be to have 1 PECC staff member covering all ED patients including intoxicated, delirium, dementia

Prince of Wales Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	3.3
Occupancy	83.0%
Staffing levels	
ED:	• CNC / Nurse Practitioner – 7.30am – 10.30pm • Psych Reg – onsite 24/7 • 0.5 FTE Psych Consultant • Liaison Pysch • (social worker provided by ED)
PECC:	
Nursing:	• NUM • CNC / Nurse Practitioner – a/a • RN / EN – 2 nurses per shift
Medical	• Consultant - a/a • Psych Reg – 0.6 FTE
Allied health	• 0.5 FTE Social Worker
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	92.4%
Legal status – involuntary legal status on admission	0.0%
Length of Stay – average days per separation	6.9

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**		**Note**: 3.5% > 7 wks	
	67.8		14.6		7.0		10.5			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.0	4.1	33.3	33.9	24.6	4.1	0.0	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	11.8	11.2	23.5	23.5	1.8	4.7	0.0	0.0	23.5
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.6	**4.1**	**28.8**	**11.8**	**21.8**	**2.9**	**27.1**	**0.6**	**0.6**	**46.5**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• CNC/Nurse Practitioner notified by phone of pt presence in ED. CNC/NP based in PECC rather than ED • In-hours not too much delay but after hours CNC covers for meal breaks in PECC and covers in-pt unit so may be delays in assessments being undertaken
Location of mental health assessments	• May use PECC interview room but poor access from ED • Usually use triage area of interview room in ED • Having SAR built at the moment
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Aim for parallel assessments. • Delays may occur depending upon availability of space to undertake physical assessments •
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Relevant medical work-up is done by ED for physical health and PECC for mental health
Local criteria for admission and discharge from PECC	• Direct admission is possible to PECC or MH wards. However, this takes priority over a patient already waiting in ED • Completion of discharge plan early is important • Patients being discharged from the PECC are usually referred to the acute care community team • Inefficient system with multiple layers to obtain admission. Limited decision making by CNC
Local protocols for collaborative care between ED and PECC	• CNC/NP assists as needed with management of agitation and other behavioural management issues • Monthly meeting between MH and ED – discussing clinical and operational issues • PECC consultants attend 8am round/handover in ED Mon-Fri
The clinical pathways of mental health	• Patients under 16 years are transferred to Sydney Children's Hospital. Psych Reg assist after-hours with management

consumers in the PECC and in the ED	• Toxicology beds in EMU
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table) • High usage of beds by non-PECC pts
Audit of mental health staffing in the ED and PECC and their function	(See activity table) • Nurse Practitioner role in education to nurses, RMOs, registrars on Mental Health Act, suicide management etc • Social worker position established 6 months ago. SW part of in-pt team. • The Psych registrar covering ED is from PECC 3 days and the remaining cover is provided by Consultant Liaison
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• The PECC unit is more closely aligned with the in-patient MH service rather than the ED • Psych Reg comes to PECC @ 10pm for overnight handover • CNC finishes at 10.30pm and ED shift handover is at 11pm • Improved patient flow from in-patient wards would assist PECC services. PECC seen as a 'consultant' to the ED not part of the team • Application of Model of care varies between staff which results in confusion and frustration

Royal North Shore Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	2.2
Occupancy	55.6%
Staffing levels	
ED:	• CNC – 8am – 12.30am 7/7 • Psych Registrar – onsite 24/7 • Psych Consultant • Liaison Pysch • Social worker – (part of ED establishment)
PECC:	
Nursing:	• NUM – covers PECC and acute in-patient ward • CNC – a/a • RN / EN/ AIN
Medical	• Staff Specialist – 0.8 FTE • Psych Registrar – 1 FTE (for PECC and ED) covering day shift
Allied health	• Nil
Administrative	• 1.0 FTE
Activity	
Admission pathways – admissions via ED	99.1%
Legal status – involuntary legal status on admission	1.7%
Length of Stay – average days per separation	2.1

Consultation Draft

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	88.0		10.2		1.9		0.0			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	1.4	6.9	39.4	34.3	17.6	0.5	0.0	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	8.5	9.9	17.4	25.4	0.9	14.1	0.0	0.5	23.5
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	**5.6**	**19.2**	**21.1**	**23.0**	**2.8**	**10.3**	**0.9**	**1.4**	**38.5**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Differing views as to timeliness of mental health assessments • Availability of Psych Reg 24/7 has assisted in tiemliness
Location of mental health assessments	• Assessments undertaken in ED – no specific location for assessments. May use resuscitation room or relatives waiting room • New ED will have area for mental health patients but not staffing for it
Timeliness of medical assessment of consumers with a mental health issue in the ED	• No problems reported regarding timeliness of physical assessments • ED may assess patient in the PECC unit
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Intoxicated and overdose patients can cause some challenges with medical clearance • Parallel assessment processes assist with 'medical clearance'
Local criteria for admission and discharge from PECC	• Criteria for admission are an area of tension • Admission process requires CNC, Psych Reg and Consultant approval • Patient referred from the Community MH team may have direct admission • No patients with IV in situ are admitted to PECC • More exclusion that inclusion criteria • Support for clearly articulated criteria which are adhered to
Local protocols for collaborative care between ED and PECC	• ED/MH Liaison meeting held every 3 months which includes PECC • CNC sees patients with challenging behaviours • Policies outline responsibilities of all parties

The clinical pathways of mental health consumers in the PECC and in the ED	• Psych Liaison teams assist with MH patients in medical/surgical wards • CAMHS liaises with Paediatric ward to manage children/adolescents on ward • Policies outline responsibilities of all parties
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED and PECC and their function	(See activity table) • CNC provides education to ED staff and new registrars •
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• After hours assessments better since Psych Reg is now onsite 24/7 and not just on-call • Need for more information and education for staff • PECC provides another option for patient management • No Psych Consultant available to PECC or ED after hours

St George Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	6
Occupied beds	4.7
Occupancy	79.1%
Staffing levels	
ED:	• CNC – 24/7 • Psych Reg • Liaison Pysch • Social worker - provided by ED
PECC:	
Nursing:	• NUM 3 – 1 FTE (between 28 bed MHU and PECC) • CNC – a/a • RN / EN/ – cover all shifts
Medical	• Consultant – 0.5FTE • 1 FTE Psych Reg
Allied health	• 0.5 FTE SW Level 3
Administrative	• 0.5 FTE Admin level 2
Activity	
Admission pathways – admissions via ED	98.3%
Legal status – involuntary legal status on admission	27.8%
Length of Stay – average days per separation	11.9

Consultation Draft

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**		**Note**: 8.7% LOS > 7 wks	
	46.6		16.4		13.8		23.3			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.0	2.6	36.2	29.3	29.3	1.7	0.9	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	24.1	6.9	27.6	12.1	0.0	10.3	0.0	0.0	19.0
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	**2.6**	**25.9**	**25.0**	**16.4**	**3.4**	**14.7**	**2.6**	**0.9**	**48.3**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• CNC available in ED 24/7 • ED staff supportive of CNC role • ED reports difficulty in accessing Registrar overnight
Location of mental health assessments	• In ED (PECC currently in demountable building at back of ED)
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Usually undertake physical assessment in parallel, or after CNC assesses patient – if ED is busy there can be delays in getting consumers seen from a medical perspective in ED.
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Senior ED clinical allocated to mental health patients • Not identified as an issue
Local criteria for admission and discharge from PECC	• Documented criteria for admission • Agreed approaches for discharge – link to GP, psychologists and acute care community team
Local protocols for collaborative care between ED and PECC	• Sometimes ED and PECC have different expectations for patient care – work out agreed plan • ED/MH meeting every 2 months. Not specific to PECC • CNCs provide support in ED to patients with challenging behaviours
The clinical pathways of mental health consumers in the PECC and in the ED	• Range of options exist for patient management. • Challenges include managing out-of-District pts brought in by Ambulance and MH patients at Sutherland ED • Delays occur for managing child and adolescent patients
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)

Audit of mental health staffing in the ED and PECC and their function	(See activity table)
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Major challenge is availability of in-patient acute beds. Many patients needing acute bed are admitted while less acute patient is transferred to the PECC • Skills and knowledge of CNC are utilised primarily in the ED and less so in the PECC

St Vincent's Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	6
Occupied beds	3.5
Occupancy	58.3%
Staffing levels	
ED:	• CNS – 24/7 • JMO – 1 FTE • Psych consultant (see below) • EN • Liaison Pysch • Social worker – part of ED establishment (comorbidity ADO/MH CNC recently recruited)
PECC:	
Nursing:	• Clinical Coordinator – 1 FTE • CNS – a/a • RN / EN / AIN (casual pool only – not in FTE) • (Nursing staff 4 nurses from 77am – 10pm and 3 staff overnight)
Medical	• 0.6 FTE Consultant • Psych Reg
Allied health	• 0.6 FTE Social Worker
Administration	
Activity	
Admission pathways – admissions via ED	99%
Legal status – involuntary legal status on admission	36.3%
Length of Stay – average days per separation	3.2

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	84.2		8.2		3.1		4.5			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	0.0	1.0	35.4	37.5	24.4	1.0	0.7	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	20.6	11.7	18.6	16.8	0.0	8.9	0.3	0.0	23.0
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.7	**9.3**	**46.7**	**21.0**	**16.8**	**2.7**	**20.6**	**0.7**	**0.3**	**58.1**

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• JMO, CNC and EN all based in the ED, just near entrance • Rapid assessment form used by MH and ED • Assessment by Psych Reg may be delayed- especially after hours (now have overnight Registrar onsite Monday – Friday)
Location of mental health assessments	• In ED – 2 monitored rooms for use by MH staff or other location as appropriate, such as bay • ED supportive of assessment in ED rather than PECC
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Not identified as an issue – other than for pts who cannot be assessed due to intoxication/sedation. PECC JMO completes physical assessment for patients who arrive involuntarily. Voluntary patients are physically assessed by ED prior to referral.
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• PECC JMO undertakes general physical assessment which is signed off by an ED Medical Officer for patients who arrive involuntarily. Voluntary patients are physically assessed by ED prior to referral. • Good to have physical assessment in ED to assist with management of comorbidities.
Local criteria for admission and discharge from PECC	• Documented criteria in place and adhered to • Require Psych reg approval to admit patient
Local protocols for collaborative care between ED and PECC	• Rapid assessment form developed by PECC and ED staff • Fortnightly meetings held between PECC and ED management • Acknowledge need to assist patient flow from ED • Work together to address the needs of drug & alcohol patients. Will be a challenge when the 4 hr NEAT is introduced
The clinical pathways of mental health consumers in the PECC and in the ED	• Range of pathways exist for patients depending upon age, need for admission, diagnosis
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED	

and PECC and their function	(See activity table) • Nursing staff have range of actions they assist patient with – coping skills, relapse plans – supporting social work intervention • Clinical Coordinators work across shifts
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• PECC staff need to have good skills in acute psychiatric assessment • Could benefit from having fulltime Social Worker • Consultant Liaison staff have admitting rights to the PECC • Are planning for PANDA unit to meet the needs of D & A pts

Wollongong Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	3.2
Occupancy	79.3%
Staffing	
ED:	• On call Consultation / Liaison Psychiatry 24/7 • Social worker part of ED establishment
PECC:	
Nursing:	• NUM 3 (Responsible for Wollongong Hospital 20 bed Acute Mental Health Unit and PECC) • RN and EN cover 24/7
Medical	• CNC – 24/7 • 0.5 FTE Psych Reg • 0.5 Psych consultant
Allied health	• No PECC funding for allied health professionals. However, Wollongong Hospital Acute Mental Health Unit Social Worker, Occupational Therapist and Psychologist provides services to the PECC
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	94.4%
Legal status – involuntary legal status on admission	9.0%
Length of Stay – average days per separation	6.6

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	37.1		33.7		22.5		6.7			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	4.5	6.7	31.5	30.3	27.0	0.0	0.0	0.0
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.0	14.6	2.2	33.7	29.2	0.0	3.4	1.1	0.0	15.7
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	1.1	4.5	27.0	23.6	37.1	4.5	13.5	3.4	1.1	38.2

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• CNC is available 24/7 in the ED • Psych Reg may be at Shellharbour which may cause delays in management planning
Location of mental health assessments	• Assessments undertaken in ED. Quiet room available for use
Timeliness of medical assessment of consumers with a mental health issue in the ED	• ED staff provide physical health assessments. Timeliness not reported as an issue.
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• An area of tension. Psych Reg may request tests be done and results available before travelling from Shellharbour to see patient.
Local criteria for admission and discharge from PECC	• CNC liaises with Psych Reg and/or consultant to arrange admission. • ED staff report little knowledge of admission criteria • No patients with IV infusions
Local protocols for collaborative care between ED and PECC	• An ED/Mental Health MOU meeting is held bi-monthly but it is not specific to PECC • Little collaboration re protocols etc noted
The clinical pathways of mental health consumers in the PECC and in the ED	• Patients assessed in ED and then management plan determined. Maybe transferred to Shellharbour if appropriate. • Unable to transfer CAMHS patients from ED to CAMHS inpatient beds at Shellharbour
Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED and PECC and their function	(See activity table)

Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Clinical governance could be clarified regarding mental health patients in the ED • Access to mental health in-patient beds is a challenge

Wyong Hospital

Note: Data from InforMH benchmarking dataset: July – Dec 2011

No. of beds	4
Occupied beds	2.1
Occupancy	53.4%
Staffing levels	
ED:	• CNC – 24/7 • Social worker (part of ED establishment)
PECC:	
Nursing:	• NUM • CNC – a/a • RN / EN – cover shifts
Medical	• Consultant – 1 FTE • Psych Reg
Allied health	• Nil
Administrative	• 0.5 FTE
Activity	
Admission pathways – admissions via ED	98.6%
Legal status – involuntary legal status on admission	7.4%
Length of Stay – average days per separation	2.8

Consultation Draft

LOS profile - %	**1 – 3 days**		**4 – 7 days**		**8 – 14 days**		**>14 days**			
	74.6		21.0		4.3		0.0			
Age profile - years	**0 – 5 %**	**6 – 12 %**	**13 – 15 %**	**16 – 17 %**	**18 – 30 %**	**31 – 44 %**	**45 – 64 %**	**65 – 74 %**	**75 – 84 %**	**85 + %**
	0.0	0.0	26.8	11.6	24.6	16.7	15.9	1.4	2.2	0.7
Primary Diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.7	5.8	6.6	16.1	40.9	0.0	2.9	0.0	3.6	23.4
Comorbid diagnosis	**Organic %**	**Psychosis %**	**Substance %**	**Affective %**	**Anxiety %**	**Behaviour %**	**Personality %**	**Devel %**	**Childhood %**	**Other %**
	0.7	2.9	17.5	15.3	26.3	2.9	6.6	3.6	0.7	35.8

PECC performance against Review Objectives

Review Objectives	Response
Timeliness of mental health assessments in emergency departments, including out of hours assessments	• Preference for physical health assessment to be undertaken first. • CNC not based in ED • Psych Reg not available 24/7
Location of mental health assessments	• Assessments undertaken in ED though ED staff would prefer them to be undertaken in PECC
Timeliness of medical assessment of consumers with a mental health issue in the ED	• Not noted as a problem
The definition of and responsibility for 'medical clearance' of people in need of mental health treatment in the PECC or mental health inpatient unit	• Use Physical Assessment form from Bankstown Hospital • Use Mini-mental score to assess suitability for interview
Local criteria for admission and discharge from PECC	• Area of tension • Processes for admission to PECC are different than other specialities • All patients discharged from PECC are refrred to the Community MH team
Local protocols for collaborative care between ED and PECC	• Few collaborative processes • Aim for parallel assessments but not happen in practice • Clinical governance not clear • Meetings between ED and PECC every 2 months • Separate databases mean that management plans are not shared
The clinical pathways of mental health consumers in the PECC and in the ED	• Many adolescents present to ED and admitted to PECC • Children managed at Gosford • May be admitted to in-pt unit

Population groups receiving care in PECC (e.g. age, diagnosis, co-morbid condition etc)	(See activity table)
Audit of mental health staffing in the ED and PECC and their function	(See activity table) • CNC part of Assessment Team
Any other issues that impact on the length of stay in PECCs and delivery of mental health assessment and care to emergency departments.	• Tension between PECC and ED staff re the model of care • PECC is not- co-located within ED and it is hard to observe people in the PECC waiting area • Local GPs can't refer direct to Community MH team so patient must present via ED to access the services • Challenge of managing MH presentations to Gosford ED • Difficulty accessing psych services – whether PECC exists or not