Guidelines for the Management of National Specialised Rehabilitation Unit (SRU) Placements

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Contents

1. Introduction 3

2. Purpose 3

3. Oversight for Referrals 3

4. Referral & Transition Process for SRU Placements (Appendix A) 4

5. Care Coordinator 5

6. Service User's Deterioration during SRU placement 6

7. Discharge Process for SRU Placement (Appendix E) 7

8. Data Protection 8

Appendix A: Service User Referral & Transition process from an Acute Inpatient Unit to a Specialised Rehabilitation Unit (SRU) 1

Appendix B: Specialised Rehabilitation Unit Criteria for Referral 5

Appendix C: Mental Health Deterioration during SRU Placement 6

Appendix D: Physical Health Deterioration during SRU Placement 8

Appendix E: Discharge Process from SRU Placement 10

1. Introduction

Over the last number of years the majority of western countries have closed down their large psychiatric hospitals, embarking on a process known as 'deinstitutionalisation'. In Ireland this process involved opening smaller acute inpatient units within general hospitals and the development of community based mental health services.

Overall deinstitutionalisation has improved outcomes for many service users, with many successfully moving from large psychiatric hospitals to the community, and several progressing onto independent living. However, following the closure of long stay institutions, it has become apparent that this new system is not suitable for some service users with complex needs as they are often unable to be discharged to the care of the community resulting in them remaining in acute units for long periods of time.

The HSE Community Mental Health Services recognise the issue of service users with complex needs remaining in acute units for long periods of time and a model of care that describes a care pathway for people with severe and enduring mental illness and complex needs has been developed.

A significant component of this care pathway is the Specialised Rehabilitation Unit (SRU). The National Community Mental Health Management Team have established national SRU placements, provided by two external mental healthcare providers for service users who require specialised inpatient rehabilitation and recovery.

The National Community Mental Health Management Team acknowledges the need for a robust governance structure around the management and provision of national placements in SRUs and as a result, this guideline has been developed.

2. Purpose

The purpose of this guideline is to ensure all referrals made from local Community Healthcare Organisations (CHOs) to External National Specialised Rehabilitation Units (SRUs) are appropriate and allocation of placements are based on greatest clinical need.

3. Oversight for Referrals

3.1 The National Community Mental Health Management team will have overall financial accountability for the Service Level Agreement and financing of external National SRU placements. In practice, financial responsibility is devolved to local Community Healthcare Organisations (CHOs) who manage their own allocated revenue. However, where an

external National SRU bed is being provided, the National Community Mental Health Management Team will maintain centralised overview of funding.

3.2 All referrals for SRU placements require a level of scrutiny beyond that of the referring team making the request. A National Referral Committee will provide governance on behalf of the National Community Mental Health Management Team. It will review, screen and consider all SRU applications prior to any referrals being sent to the National SRU provider's clinical team for assessment.

The membership of the national referral committee will consist of nominated representatives from within Mental Health Services and will include a:

- Clinical Director
- Consultant in Rehabilitation Psychiatry
- Senior Occupational Therapist
- Senior Social Worker
- Senior Clinical Psychologist
- Mental Health Nurse Manager
- CHO Senior Management Representative
- National Community Mental Health Management Representative

3.3 The National Referral Committee will make the final decision regarding SRU assessments. If demands for National SRU placements outweigh supply, a waiting list will be established. The National Referral Committee will prioritise assessments which will ensure people on the waiting list are weighted according to their clinical needs. This waiting list will be reviewed at least three monthly by the National Referral Committee.

4. Referral & Transition Process for SRU Placements (Appendix A)

- SRU referral eligibility should be established prior to a referral being made (**see appendix B)** and agreed with the Clinical Director of the referring service
- Referrals should be made by the Community Rehabilitation Team (CRT) using the standardised SRU referral form. In the absences of a CRT, the General Adult CMHT can make the referral
- From the outset, the Mental Health Head of Service (or nominee) of each CHO must give a written guarantee that a suitable step down community rehabilitation placement under the care of the community rehabilitation team will be available for the service user on discharge from the SRU

- A care coordinator from the referring Community Rehabilitation Team/ General Adult CMHT must be identified prior to a referral being made
- *Completed referral forms can be submitted at any time and should be forwarded to the National Referral Committee via email to terence.smith@hse.ie
- Referrals will be reviewed, screened and assessed by the National Referral Committee every three months
- If a referral is deemed appropriate by the National Referral Committee, it will be forwarded onto one of the National SRU provider's clinical teams for assessment
- If demand for SRU placements outweighs supply, there will be a need for the National Referral Committee to triage referrals based on greatest clinical need and a waiting list for assessment will be established. This waiting list will be reviewed by the National Referral Committee at least every three months
- Once a referral is forwarded onto the National SRU provider's multidisciplinary team, a nominated SRU clinician will complete a full assessment of the service user in their current location in collaboration with the referring team
- If both the service user and the National SRU clinical team agree to admission, the transition process will commence

**All emailed referrals will be followed up with a confirmation email informing sender that the referral has been received. If you do not receive a confirmation email then please contact either Sinead.Reynolds@hse.ie or terence.smith@hse.ie.*

5. Care Coordinator

5.1 Upon admission, the nominated Care Coordinator from the referring Community Rehabilitation Team/ General Adult CMHT will have coordination responsibility for the service user who is in a National SRU placement. They will formally review the service user's care and provide regular progress reports to the referring CRT/ CMHT. The aim of these reviews is to:

- Address problems as they arise
- Collaborate with all stakeholders on rehabilitation plans
- Share clinical information
- Plan for a return to local CHO care

5.2 It is the role of the Care Coordinator to liaise closely with the Multidisciplinary Team of the National SRU provider and to ensure they (the care coordinator) remain involved in the care of the service user. The Care Coordinator will also act as the point of contact for the

service user's family, ensuring that they have good communication links with the National SRU provider's clinical team and that they are made aware of any issues that may arise concerning the placement of their relative.

5.3 During the placement the Care Coordinator must:

- Ensure that the views of the service user, their families and carers are central to the assessment and care planning process.
- Manage a timely review process (minimum three monthly) for service users in National SRU placements.
- Maintain regular contact with the National SRU clinical team and report back to their CRT.
- Have input into clinical reviews and any other relevant meetings as agreed.
- Ensure that the agreed Individual care plan (ICP) reflects the actions to achieve effective discharge for the Service User.

6. Service User's Deterioration during SRU placement

6.1 Mental Health Deterioration during SRU Placement (appendix C)

- If a service user is showing early signs of mental health deterioration, the SRU Multidisciplinary Team will review and adjust the treatment plan as necessary
- In the event that the service user's mental health continues to deteriorate the SRU Multidisciplinary Team will arrange transfer to an acute unit within the SRU or repatriate to the service user's local acute unit
- Regular updates regarding the service user's condition will take place between the SRU Multidisciplinary Team/ keyworker, acute services, care coordinator and national community mental health management team.
- If the service user's condition has improved (within a six weeks timeframe) then the SRU Multidisciplinary Team will complete an assessment of suitability for readmission back to the SRU
- If the service user is deemed suitable for readmission, the SRU Multidisciplinary Team/ keyworker will liaise with acute services to arrange transfer back to the SRU
- If the services user's condition does not improve within the six week timeframe then they will be transferred back to the care of the local mental health services where, if appropriate, a re- referral can be made to the national referral committee at a later date

6.2 Physical Health Deterioration during SRU placement (appendix D)

- If a service user is showing signs of becoming physically unwell the SRU Multidisciplinary Team will request the GP to review.
- The GP will decide if the service user can be treated locally or if a transfer to a general hospital is required
- The SRU Multidisciplinary Team/ key worker will inform the care coordinator and key stakeholders if the service user is admitted to a general hospital
- Regular updates regarding the service user's condition will take place between the SRU Multidisciplinary Team / key worker, general hospital, care coordinator and national community mental health management team.
- Once the service user's condition improves , they can be transferred back to the SRU
- If the service user's condition does not improve within the agreed time frame (*2 weeks) then they will be transferred back to relevant local services when treatment is completed. A re-referral can be made to the national referral committee (if appropriate) at a later date.

**this is a flexible timeframe and can be agreed on a case by case basis*

7. Discharge Process for SRU Placement (Appendix E)

7.1 Discharge planning must commence prior to the allocation of a National SRU placement. Each CHO Senior Management Mental Health Team must ensure that a step down community placement under the care of the community rehabilitation team, incorporating an active rehabilitation programme will be available for service users on discharge from the National SRU. Ideally, this should be close to a service user's own area.

7.2 Following admission to the National SRU as part of the Individual Care Plan (ICP) a comprehensive and structured discharge plan must be drawn up with a provisional discharge date agreed. The service user, care coordinator, key worker and other relevant members of the SRU Multidisciplinary Team, and the service user's family, carer and/or chosen advocate must be involved in this process. This is to ensure that the service user and family member /carer are made fully aware of the transitioning process.

7.3 In advance of discharge, a discharge meeting must take place (at least 3 months prior to discharge) with the service user, care coordinator, key worker and other relevant members of the SRU Multidisciplinary Team and family member/ chosen advocate. This is to ensure that all issues concerning the discharge process are dealt with and that a step down community placement is available for the service user on discharge from the National SRU.

8. Data Protection

For the Referring Teams

8.1 Prior to a referral being made a copy of the referral must be filed in the service user's records.

8.2 All referrals must be made **electronically** and marked private & confidential. Please note referrals will not be accepted by post.

8.3 It is the responsibility of the referring team to ensure the service user is fully aware and understands that there is the possibility that their personal information could be shared with a third party SRU provider in order for an assessment to be carried out.

8.4 The service users must give written consent (within the referral form) for the sharing of their personal and health information with the external SRU provider for the purpose of assessment.

8.5 All correspondence from either the SRU National Referral Committee and/or SRU provider must be filed in the service user's records.

For the National Community Mental Health Management Team and the SRU National Referral Committee

8.6 All referrals must be stored on a secure HSE network server with restricted access. Where it has been deemed necessary by the information owner to store confidential or personal information on any device other than a HSE network server the information must be encrypted.

8.7 Only HSE desktop or laptop computer devices can be used that have HSE approved encryption software installed. In addition to encryption software the desktop/ laptop must be password protected and have up to date anti-virus software installed.

8.8 HSE approved USB memory sticks must only be used on an exceptional basis where it is essential to store or temporarily transfer confidential or personal data. They must not be used for the long term storage of confidential and personal data.

8.9 Referrals should not be deliberately or inadvertently viewed by uninvolved parties.

8.10 Referrals must never be left unattended where they are visible or may be accessed by unauthorised staff or members of the public.

8.11 Rooms, cabinets or drawers in which referrals are stored should be locked when unattended.

8.12 It is important to ensure that service user's information is not discussed in inappropriate areas where it is likely to be overheard including conversations and telephone calls.

8.13 While appreciating the need for information to be accessible, staff and members of the national referral committee must ensure that personal records are not left on desks or workstations at times when unauthorised access might take place.

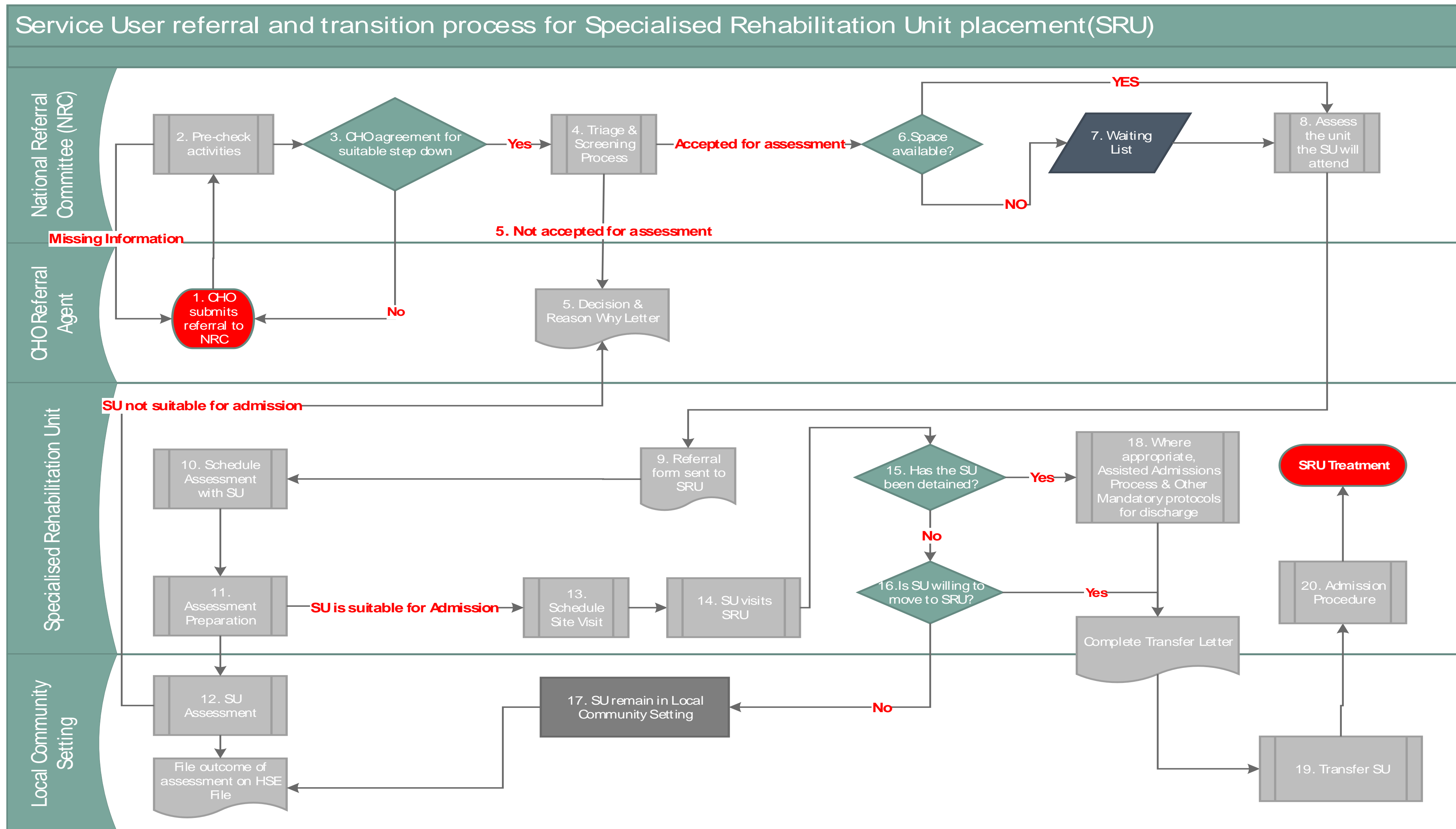
8.14 Staff and members of the national referral committee must only access service user's information on a need to know basis and should only view or share data that is relevant or necessary for them to carry out their duties.

8.15 In the case of a referral being forwarded to a third party SRU provider for assessment, then the email must be **ENCRYPTED** prior to it being sent and marked private and confidential

8.16 Once referrals are screened by the National Referral Committee and a decision has been made about the referral, then all copies of electronic referrals shold be deleted and paper copies shredded.

8.17 If a waiting list is established, It should only include service users' initals and DOB. Service user's personal information is **not** to be included on the waiting list.

Appendix A: Service User Referral & Transition process from an Acute Inpatient Unit to a Specialised Rehabilitation Unit (SRU)



Step Number	Task	Who is responsible?	By When?	Pre-Requisite
1	CHO submits referrals to National Referral Committee	Referral agent (Community Rehabilitation Teams / General Adult Community Rehab Teams)		
2	**<u>Pre-check activity</u>** - Ensure all the necessary documentation is completed - Care Coordinator is selected	Sinead Reynolds / Terry Smith		
3	CHO commitment to have suitable step-down service once Service User (SU) is ready for discharge from the SRU. If this has not been received the National Office will seek clarification from the referral agent.	Referral agent / Sinead Reynolds / Terry Smith		
4	National Referral Committee will triage and screen each referral received - in advance of this meeting each discipline will have reviewed the referral form content. At this point the referral can either be accepted for assessment or not accepted for assessment.	National Referral Committee		Referral Criteria defined
5	Service User is **<u>not suitable</u>** for assessment to SRU. - Communicate decision and reason why back to referral agent.	National Referral Committee	Within 72 hours of decision being made	

Step Number	Task	Who is responsible?	By When?	Pre-Requisite
6	Service User is suitable for assessment and there is no space available in the SRU facility. The action is to add service user (initials and Date of Birth) to a waiting list. - Communicate decision to accept SU for placement and that the SU is placed on a waiting list to the referral agent.	National Referral Committee	Within 72 hours of decision being made	Restricted access to waiting list database
7	If demands for National SRU placements outweigh supply, then the National Referral Committee will prioritise assessments based on greatest clinical need and a waiting list will be established. This waiting list will be reviewed at least three monthly by the National Referral Committee.	National Referral Committee		
8	Service User is suitable for assessment and there is a place available in the SRU facility. - National Referral Committee will decide SRU placement based on prioritisation criteria	National Referral Committee	Within 24 hours of decision being made	Prioritisation Criteria defined
9	Referral form will be sent to the relevant SRU by encrypted email.	Sinead Reynolds / Terry Smith	Within 72 hours of decision being made	Encryption software
10	Schedule assessment with SU in the acute setting	Rehabilitation Consultant from the selected SRU and Care Coordinator in the acute facility		
11	Assessment Preparation - Pre-meet with relevant stakeholders via telecon and / or face to face meetings - Request local CMHT / Rehab team contact details - Is SU detained under MH Act (renewal)? -	Rehabilitation Consultant Key worker Family Members Acute services Acute Administrator	In advance of scheduled assessment date	Design personal communication plan

Step Number	Task	Who is responsible?	By When?	Pre-Requisite
12	Assessment with the SU - SU consent received - Encourage SU participation - Education via Patient Information Leaflet Following this assessment, two possible outcomes can occur: (a) Service User is not suitable for admission to the SRU facility. Decision and reason why is communicated to the Referral agent, SU and acute facility and documentation filed on HSE notes. (b) Service User is suitable for admission to the SRU facility, refer to step 13	Rehabilitation consultant	1-2 visits may be required	Patient Information Leaflet
13	Service User is suitable for admission to the SRU facility - Communicate decision by letter to the referral agent, SU and acute facility - Schedule site visit to the SRU facility.	Rehabilitation consultant	Within 72 hours of decision being made	
14	SU visits the SRU facility.	Care Co-ordinator, Key Worker SRU, Service User (where appropriate) and Family Member	Within 2-3 weeks post assessment acceptance	Patient Information Leaflet
15	SRU confirms with care coordinator if the SU is currently detained? If yes, proceed to step 18. If no, proceed to Step 16.	SRU Keyworker		
16	SRU keyworker establishes if SU is willing to move to the SRU. In the event the SU is not willing to move to an SRU facility, proceed to step 17. Where the SU is willing to move to an SRU, complete transfer letter from the acute and commence transfer process.	Referring agent / SRU Keyworker / Acute Services	Within 72 hours of decision being made	

Appendix B: Specialised Rehabilitation Unit Criteria for Referral

Inclusion

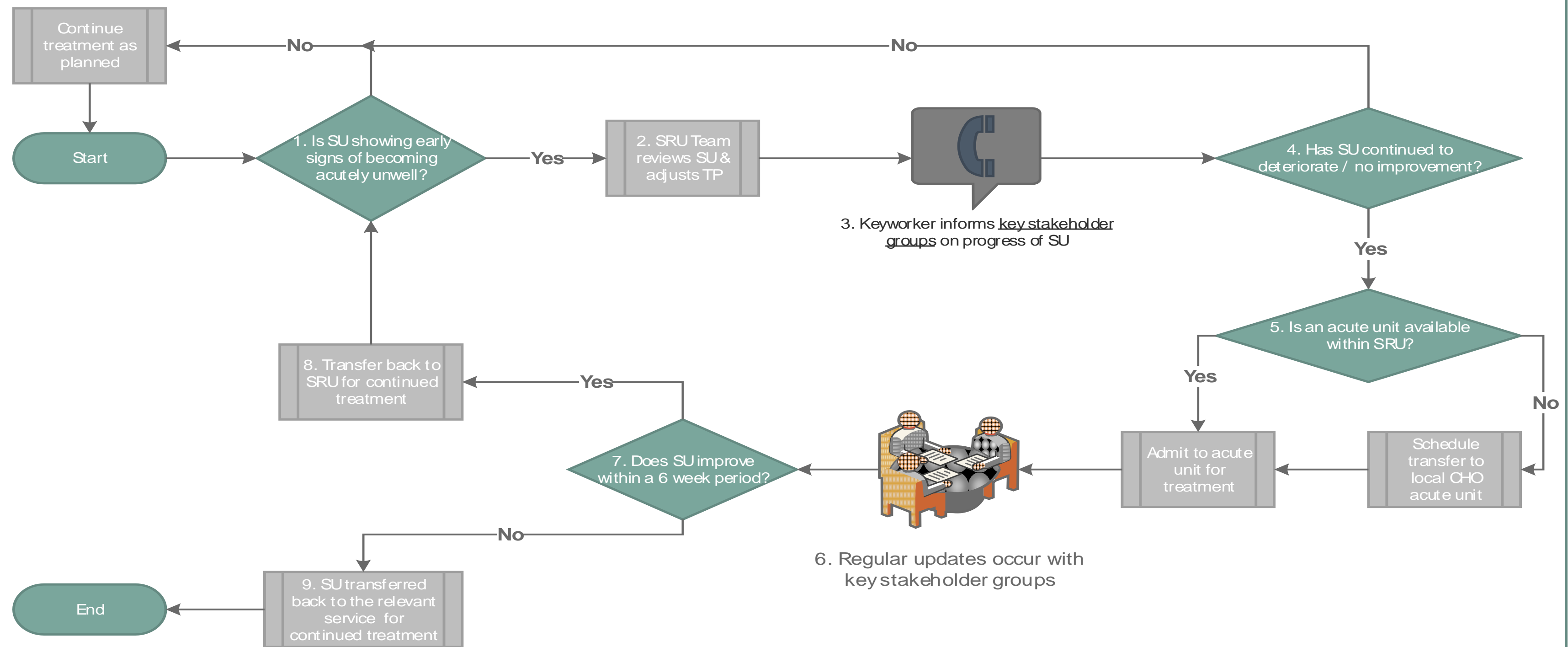
People defined as having severe and enduring mental illness whose needs are not adequately met by the sector of services and who fulfil the following:

- Ongoing symptoms (e.g. hallucinations, delusions, high-levels of anxiety or depression, negative symptoms of psychosis)
- On-going complex needs
- Reduced social functioning (e.g. breakdown of social relationships, reduction in the capacity for economic support)

Exclusion

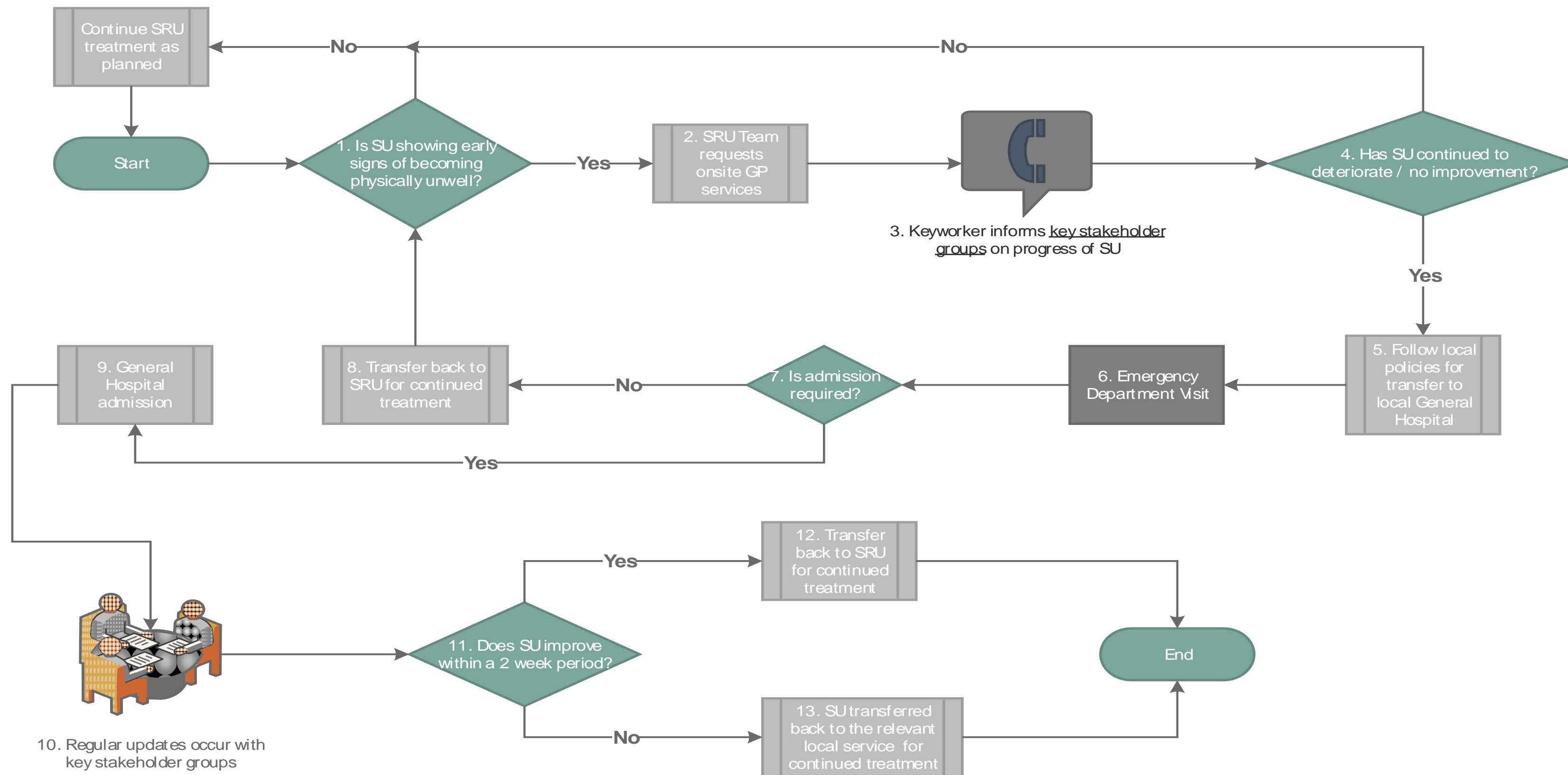
- Under the age of 18 years or over 65 years
- Acutely unwell because of their mental illness
- A primary diagnosis of :
  - Intellectually Disability
  - Autism
  - Acquired Brain Injury
  - Personality Disorder
  - Alzheimer's Disease
- Those who require:
  - A low secure setting only
  - A PICU Placement

Appendix C: Mental Health Deterioration during SRU Placement



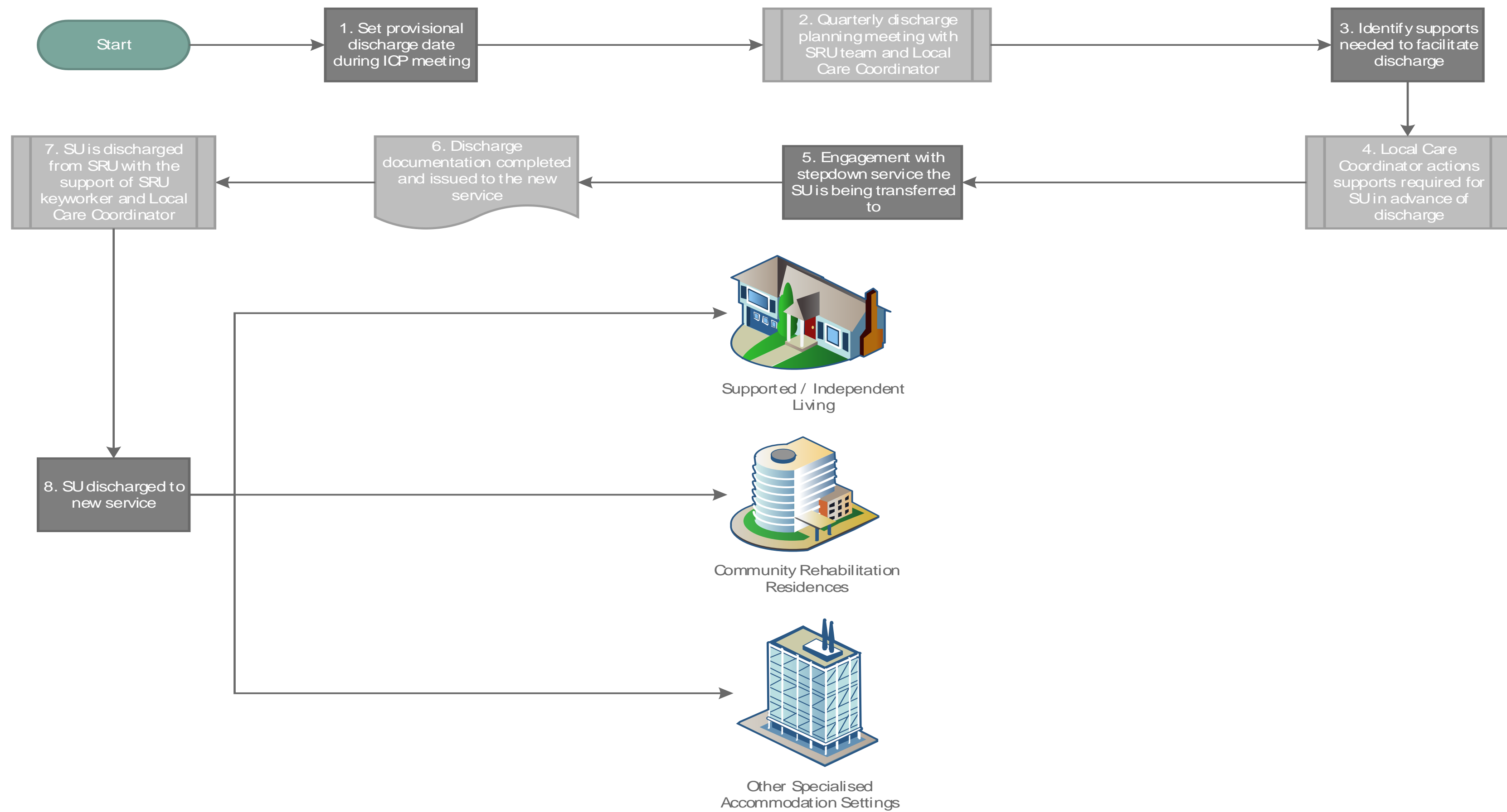
Step Number	Step description
1	Is Service User (SU) showing early signs of becoming acutely unwell? In this scenario, acutely unwell is specific to mental health deterioration only and where a breakdown in placement has occurred. - If no, treatment continues as planned in the SRU facility. - If yes, proceed to step 2.
2	Where the SU is showing early signs of becoming acutely unwell the SRU team will review and adjust treatment plan (TP) as necessary.
3	SRU keyworker will inform the key stakeholder group on the progress of the SU following the adjustment of the TP. Key stakeholders include: - Local Care Coordinator - CHO Head of Service for Mental Health - National SRU point of contact - Clinical Directors from both local services and the SRU
4	Has the SU continued to deteriorate or show no improvement since altering the TP? If no, continue treatment as planned.
5	SU has continued to show increased deterioration/ no signs of improvement, SRU team will consider transfer to an acute unit within SRU or repatriate back to local CHO acute unit where an acute unit is not available onsite. Where no bed is available either onsite or within local acute unit, the SRU team will escalate to the National SRU point of contact for consideration.
6	Daily communication updates take place between the Acute Services and the SRU keyworker to ensure progress is reported in a timely manner to the key stakeholder groups.
7	Does the SU improve within a 6 week timeframe? The admission period for an acute psychiatric admission is 6 weeks. This is a flexible guideline and can be agreed on a case by case basis with the SRU Keyworker, Local Care Coordinator and the National SRU point of contact.
8	The SU has improved within the agreed timeframe and is now in a position to be transferred back to the SRU for continued treatment. The SRU team will review the SU to ensure that he / she is suitable for readmission back to the SRU.
9	The SU has not improved within the agreed timeframe and is transferred back to the relevant local service for continued treatment.

Appendix D: Physical Health Deterioration during SRU Placement



Step Number	Step description
1	Is Service User (SU) showing early signs of becoming physically unwell? - If no, treatment continues as planned in the SRU facility. - If yes, proceed to step 2.
2	Where the SU is showing early signs of becoming physically unwell the SRU team will request onsite GP services who will determine if symptoms can be treated locally or a transfer to a general hospital is required.
3	SRU keyworker will inform the key stakeholder group on the progress of the SU following notification of a physical health deterioration. Key stakeholders include: - Local Care Coordinator - CHO Head of Service for Mental Health - National SRU point of contact - Clinical Directors from both local services and the SRU
4	Has the SU continued to deteriorate or show no improvement since commencing physical health treatment? If no, continue treatment as planned.
5	SU has continued to show increased deterioration/no signs of improvement, SRU team will commence transfer to a local General Hospital.
6	SU attends emergency department for assessment.
7	Following an ED assessment, the decision will be to either (8) Transfer back to SRU for continued treatment or (9) admit SU for further treatment in the General Hospital.
8	SU is transferred back to SRU for continued treatment.
9	SU is admitted for further treatment in the General Hospital.
10	Daily communication updates take place between the Acute Services and the SRU keyworker to ensure progress is reported in a timely manner to the key stakeholder groups.
11	Does the SU improve within a 2 week timeframe? This is a flexible guideline and can be agreed on a case by case basis with the SRU Keyworker, Local Care Coordinator and the National SRU point of contact.
12	The SU has improved within the agreed timeframe and is now in a position to be transferred back to the SRU for continued treatment.
13	The SU has not improved within the agreed timeframe and is transferred back to the relevant local service for continued treatment.

Appendix E: Discharge Process from SRU Placement



Step Number	Step description
1	SRU team agrees a provisional discharge date with the Service User (SU) during the Individual Care Planning process. This typically will range a period between 18 months to 3 years from date of admission to SRU.
2	A case conference meeting takes place between the SRU team and the local care coordinator on a quarterly basis to discuss the progress of the SU. Step 11 Assessment Preparation in the 'Service User transition process from an Acute Inpatient Unit to a Specialised Rehabilitation Unit' (ref Appendix A) will require confirmation of who the care coordinator is and their relevant contact details.
3	During the case conference meeting, supports are identified which will successfully facilitate the discharge of the SU from the SRU facility.
4	The local care coordinator is tasked with ensuring that these supports are in place prior to SU being discharged and will report back on the status of each support identified during the quarterly case conference meeting.
5	SRU keyworker engages with identified discharge service which may be one of the three scenarios identified in step 8.
6	SRU keyworker coordinates the completion of the relevant discharge documentation for the new service.
7	SU is supported by the SRU team and local Care Coordinator in the transition to the new service. The transition period may range between a 2-4 week timeframe.
8	SU is discharged to the new service which may be one of the following three service types: - Supported / Independent Living - Community Rehabilitation Residences - Other Specialised Accommodation Settings which may include Nursing Homes or Continuing Care Placements