



High Dependency Unit Guidelines

Introduction

Increased levels of intervention are sometimes necessary in a mental health inpatient unit for the management of severely behaviourally disturbed patients, and may take a number of forms. A High Dependency Unit (HDU) is an environment providing a higher level of individual care and monitoring to some patients, and is identified in the *Acute Psychiatric Inpatient Unit - 25 beds Generic Brief 95/0229* as an essential component of the unit.

Other interventions in the management of a severely disturbed patient may include one-on-one nursing ('specialling'), or the use of seclusion. Intensive care interventions are used when there is potential for physical harm to the patient themselves or to others around them, or when a patient is likely to abscond where this would carry a significant degree of risk to the patient or to others. Specialling or the use of a high dependency area may also provide an increased level of observation for a person whose mental condition is unstable, especially where there are concerns for the person's physical health.

A high dependency area is a separate area within a mental health inpatient unit, which has the potential to be locked. It usually has an increased staff-to-patient ratio and facilitates a more intensive level of observation of the patients and staff in the unit. Nearly all mental health facilities have a HDU, and Clinical Reviews of services have revealed varying practice in their use, indicating the need for guidelines to assist in the implementation of best practice standards.

Purpose

This guideline, one of a planned series on the use of more intensive interventions, focuses on the use of a high dependency area on an inpatient unit. These guidelines:

- Define the principles of psychiatric intensive care management
- Provide a framework for the development of local policies and procedures around psychiatric intensive care
- Are adaptable across the child and adolescent, adult and aged persons' psychiatric care settings.

Principles and Aims

The overriding principle of inpatient care is the provision of effective care within a minimally restrictive environment, in accordance with the *Mental Health Act*. The decision to utilise more restrictive interventions should be based on an assessment of the person, their risk factors, mental state and physical condition, rather than service or staffing issues, although it is recognised that in extreme situations these issues may become relevant.

The Chief Psychiatrist's guideline: *Access to Beds* (April 1997), states, "High dependency beds are inpatient beds that facilitate more intensive observation, treatment and safety. High dependency beds form part of the mental health service overall capacity and are not recorded as discrete beds in the system. The decision to nurse a patient in a high dependency bed is a local clinical decision made by staff of the receiving inpatient unit."

Physical Layout of HDUs

A High Dependency Unit should be a separate environment, situated in an area of the ward that is quiet and readily accessible by staff. There should be adequate comfortable seating for patients and staff, with ready access to toileting, bathing and dining facilities, and access at staff discretion to telephone services. A secure outdoor area with shade from the weather should be available.

The potential to lock the HDU should exist, but the area should also be amenable to use as an unlocked facility for increased levels of observation.

The placement of seclusion facilities within a high dependency unit may aid in the provision of a continuum of care, where a patient may be observed after seclusion in a less restrictive environment, facilitating appropriate risk assessment prior to return to the open ward.

Voluntary Patients in HDUs

The issue of placing voluntarily admitted patients in a locked environment is potentially problematic. Situations where this may be appropriate include circumstances where impulse control is impaired despite the presence of insight and consent, for instance in diagnostic categories such as personality disorder or acquired brain injury. Voluntarily admitted patients may also request to be placed in a locked area if they feel that they cannot trust themselves to control destructive impulses in a less restrictive environment. In these situations, the circumstances surrounding the decision should be documented in the notes, and patient consent to placement in HDU should be documented where appropriate.

Some of these situations may be addressed under the duty of care held by the service toward the person, and others may be appropriately addressed under the Guardianship Act. If informal patients do require placement in HDU, consideration should be given to their status under the Mental Health Act.

Entry to HDUs

Decision process

The decision to place a person in a HDU may be made at any time during an admission. Ideally, this should be a team decision, although in situations of immediate risk the nurse in charge will make the decision, informing the treating doctor of this as soon as feasible. The decision, and the underlying reasons, should be clearly documented in the clinical record and communicated to the patient at the time, if practicable, or otherwise in a timely manner.

Reasons for placing a person in a HDU may include:

- Significant risk of harm to others
- Significant risk of harm to self
- Significant risk of absconding where this would be likely to lead to a deterioration in the person's mental and/or physical condition
- Significant disruption to the ward environment, adversely affecting the mental status of other patients
- Patient request, if deemed appropriate

At all times, the decision to place a person in HDU should be made in the context of a management plan which identifies the person's primary diagnosis, clinical needs, treatment goals and expected outcomes. It is not appropriate to routinely admit persons to a high dependency area without consideration of individual needs.

The number of patients admitted to the high dependency area should be consistent with the number of available beds, other than in exceptional circumstances.

Implementation Process

Once the decision has been made, sufficient staff with appropriate levels of training and experience should be assembled to safely place the person in the high dependency area. Explanation of the decision and negotiation with the person to voluntarily enter HDU maintains patient dignity and should be attempted. Where this is not possible, a planned and co-ordinated restraint may be required. The use of appropriately trained security personnel under the guidance and direction of the senior clinician may be necessary, and should follow local policy and procedures.

Potentially dangerous items, such as sharp objects, lighters, belts and shoelaces, may need to be removed from the custody of the person prior to placing them in HDU, to reduce the likelihood of these items being used to self-harm or harm others, either by the patient concerned or by others in HDU. This confiscation should be voluntary if possible, and accompanied by an explanation. The items removed should be clearly documented, and stored in a safe place for return to the person on leaving HDU.

The patient's rights should be explained to them, and access to complaints procedures facilitated where this is feasible. Patient consent should be sought before informing callers or visitors about the person's admissions to HDU, however the reactions of carers or visitors to the patient's placement in HDU should be taken into account, and reassurance given if appropriate.

Management of HDU stay

The main purpose of a high dependency area is the provision of an increased level of supervision and intervention in a safe environment, facilitated by a higher nurse-to-patient ratio. ***It is expected that placement in HDU should be as brief as possible in the circumstances of the case.*** Interaction with the patient should be an active, therapeutic process, with frequent verbal contacts to assist in ongoing assessment of the patient, rather than a custodial and passive one. The use of casual or agency staff within this environment should be minimised. Structured activities may be useful in the provision of a therapeutic environment. If the person is a smoker, reasonable access to purchase and smoking of cigarettes should be provided, consistent with safety and health regulations.

Telephone calls

In general, the making and receiving of telephone calls should be permitted. Telephone calls may be restricted in the instance of a patient causing harm to themselves or others, such as by giving instructions to a financial agent while unwell, or where the patient has been making threats.

Visitors

Patients should be given access to visits from relatives, friends, and others whom they might request, such as religious counsellors or community agents. Visitors may be restricted where there are safety concerns. Provision of privacy for a visit needs to be considered in the context of the person's mental state and the nature of

the visit, however staff should be readily available at all times. Special consideration may need to be given to the requirements of children visiting a person in HDU, including monitoring their reactions for evidence of distress.

Attire

While in HDU, a patient should have access to appropriate clothing to maintain their dignity. It is not acceptable to routinely clothe patients in the high dependency area in sleeping attire or hospital gowns during the day.

Review Process

During a person's time in HDU, ongoing monitoring and regular reviews should be conducted. **Formal mental, physical and risk assessment by a medical practitioner should be documented at least once a day.** Identification and implementation of strategies to reduce the risks that this person may represent to themselves or to others will minimise the time spent in HDU, and should be a focus for the team.

Persons with Special Needs

Persons in a high dependency area may require attention for a range of special needs. Those from a non-English speaking background may require an interpreter for interactions such as the assessment of their mental state, the provision of information about their rights, and the opportunity to make other needs known. Persons in a state of delirium may be unable to make their anxieties or needs known, and it is important to remember their vulnerabilities and the fluctuating nature of this problem. Attention should be given to persons who may be sedated or withdrawing from substances while in HDU, and their physical state should be closely monitored and managed as appropriate. Other special needs should be managed as clinically indicated.

Exit from HDU

Assessment of the point at which a person may safely exit a high dependency area to a lower level of dependency is a clinical decision to be made by the treating team, and is based on a comprehensive assessment of risk. Options such as a trial out of HDU, possibly with a special nurse in attendance, should be considered to decrease the person's time in HDU.

Debriefing may be considered at the time of exit from HDU. Where this is appropriate, patients should be encouraged to ventilate their concerns with a senior staff member.

Self Assessment Tool

The following indicators are provided to assist services in the internal quality monitoring of practices, and link with the guidelines forming the basis for the Chief Psychiatrist's Clinical Review of mental health services.

- Services have established policy and procedures for the management of critical incidents, restraint, and placement in a high dependency unit.
- Services have established policy and procedures for the management of persons in a high dependency unit, consistent with the 'least restrictive environment' principle articulated under the *Mental Health Act* 1986.
- Patients who remain in a high dependency unit for more than one week are the subject of automatic review by the treating team.
- Clinical staff are able to identify the key principles of management of persons in a high dependency unit.
- Each person in a high dependency unit has a documented management plan outlining primary diagnosis, risk assessment, strategies for managing these risks and anticipated outcomes.
- There is documentation in the clinical file of mental state, physical assessment and risk assessment on at least a daily basis.