ROLES AND RESPONSIBILITIES OF DOCTORS ON CONTINUING CARE WARDS

• Doctors should set a tone in line with the philosophy of care of the ward which enables patients to be treated with respect, avoids stereotyping and treats people as individuals.

• Have developed a clear and open policy defining eligibility for continuing care services.

• Have an understanding of the difficulties presented to the nursing and care staff by patients with behavioural and psychiatric disturbance in dementia. Be particularly sensitive to the psychological demands placed on staff who spend a lot of time working directly with this patient group.

• Have an understanding of the difficulties and anxieties faced by relatives and friends of the patient.

• Be aware of the potential for many types of abuse of dependent and difficult patients and be involved in plans and training for prevention, recognition and management of abuse.

• Visit regularly and frequently. Have a regular time for reviews and make other frequent ad hoc visits to provide opportunities to discuss problems and successes.

• Psychiatric: understand the complex psychiatric needs and treatment issues of patients with dementia. Recognise and be able to manage comorbid psychiatric conditions.
Medical: treat physical conditions within the competence of the psychiatrist. Have
developed liaison plans with robust arrangements in place to manage the interface
between old age psychiatry services and old age medicine.

Understand the use and misuse of psychotropic medication in dementia. Develop a
ward policy for the prescription and monitoring of psychotropics.

Have individual and ward treatment policies available and accessible for out of hours
medical cover.

The patient’s GP will be contacted at the beginning of the admission so that all
aspects of the physical and medication history may be understood.

Different wards will develop different resuscitation policies depending on the location
of the ward and accessibility to a cardiac arrest team. However, any policy needs to
take into account individual differences between patients and the wishes of their
families. The doctor will be aware that the best course of action is not always to
attempt resuscitation and that in most patients it will be unsuccessful and traumatic
also for the staff involved.

Adopt a multidisciplinary, multiagency approach to assessment and management and
develop collaborative working relationships to include some joint training initiatives.

Be cognisant of the interrelationship of biological, psychological and social factors in
the aetiology, presentation and management of mental disorder. Have an
understanding of psychosocial aspects of dementia and a willingness to use non-
medical treatments.

Support mechanisms for patient representation and advocacy.
• Have a detailed understanding of issues of consent and capacity in relation to dementia and the appropriate use of legislation. For those who lack capacity the doctor will at all times act in the patient’s best interests.

• Patient information will be treated as confidential. Information about patients without capacity to agree to disclosure may nevertheless be shared with close family if it is considered to be in the patient’s best interests. Sensitive judgements may be required if the patient and/or family are in conflict.

• Have a consistent emphasis on staff support, supervision, education and training.

• Develop a critical self-awareness of emotional responses to disabled and dependent patients.

• Have a basic understanding of group/team dynamics.

• Ensure that systems are in place for the support of patients’ families and friends. Recognise that the needs and wishes of patients and their families although often the same do not always coincide.

• Be able to consider moral and ethical dilemmas at the end of life and be able to discuss these where appropriate with patients and families.

• Develop a scheme for ward reviews which encompasses all aspects of a patient’s life. Each ward and team will develop their own scheme. Some will prefer the use of standardised rating scales, others free discussion. Each long stay patient will be reviewed by the ward doctor three monthly and at a ward review with a senior doctor six monthly or more frequently if there are problems.
The multidisciplinary team will know who is scheduled for review and be ready to
discuss the patient.

The ward doctor will have examined the patient beforehand and results of any
appropriate investigations will be to hand for the review.

Family members, partner or close friend may be invited to discuss aspects of the
patient’s care and particularly contribute to drawing up a plan of action for when/if
the patient becomes physically unwell.

Areas for presentation and discussion may include the patient’s -

• Current cognitive and psychiatric condition
• Current physical condition
• Medication review
• Resuscitation and treatment plans for the future
• Functional abilities
• Behaviour
• Care needs
• Communication skills
• Activities
• Pleasures and preferences
• Cultural and religious needs
• Family
• Finances and possessions
• Strengths

• Ensure that complete, understandable and legible records are kept of clinical
  assessments and decisions.
• Actively continue to learn and develop professionally and be aware of contemporary clinical advances.

• Develop an understanding of how services are planned and managed within the NHS, in collaboration with other partner agencies, e.g. social services.

Units which are entirely within the NHS and those which are private but treating NHS patients present similar but different issues and responsibilities for doctors. Each catchment area should have some NHS beds, staffed and managed entirely by NHS personnel.

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