

## JISC update Apr – May 2020

### High risk assessment rooms

A Liaison Psychiatrist has asked about College guidelines (safety standards) for rooms that patients are seen in - outward opening doors etc. 'I know such guidance exists but I can't find it.'

**Response:** PLAN requirements are as follows: The liaison team has access to facilities and equipment for conducting high risk assessments

*Note: facilities suitable for high risk assessments must ensure the safety of staff and service users. They should:*

- *Be located close to or in part of the main Emergency Department or Acute Medical Unit;*
- *Have a door which opens both ways and is not lockable from the inside;*
- *Have an observation panel or window;*
- *Have a panic button or alarm system (unless the staff carry alarms at all times);*
- *Only include furniture, fittings and equipment which are unlikely to be used to cause harm;*
- *Ideally, the facilities should also include two doors.*

*Important! If a team is unable to meet all of the points above, staff **must** be able to satisfy the peer review team and Accreditation Committee that facilities and procedures ensure the safety of service users and staff.*

### Discussion about managing the treatment of tuberculosis and psychosis

TB becomes non-infectious very quickly once started on Anti-Cox treatment. Be aware that isoniazid can precipitate exacerbate mania due to its similarity to tricyclic antidepressants.

### What is a useful dashboard for Liaison Psychiatry?

From Worthing 'our MH trust data which looks at who we see and our response times' – what do others measure?

**Response one:** *Numbers week by week of MH presentations to the ED, to see if these are increasing, to see if numbers of people waiting to be seen by psych is increasing, if breaches are increasing, waits for beds increasing – are obvious candidates. You could add in use of MHA; and police related presentations.*

**Response two:** 'I suppose if we had a reliable coding system we would be able to characterise this group as they range from very low level primary care needs to complex; and neither clustering the current MH data set is not discerning enough for liaison. Is this something we could look/ or is already being looked at in the Faculty?'

## C&R

'Life in the general hospital setting is getting more risky for our service – and I expect for others. Our liaison team is trained in breakaway – not C&R – which seems appropriate as our numbers are small; and even if we could do C&R we could not safely implement it – but sometimes just running away isn't an option

However when there is a need to restrain my experience (today as it happens) is that helping to coordinate this is tricky – no-one feels experienced, skilled, confident – of course the will to do the right thing in a kind compassionate way sees us through - but it feels as if we are muddling through rather awkwardly Is there a middle ground? Liaison/general hospital training in C&R in a way to involve the general hospital staff?'

**Response from London team:** After years of trying to change this we finally have some progress. The acute trust board have just signed off a policy for restraint. The new bit is that they have committed to train about 40 ED nurses, all the security staff and the nurses from our team in "medication holds". It's a two day course and trains teams to hold people in order to give sedation. The idea is that at any one time there will be enough people around who are confident and competent to do this.'

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Worthing