

## JISC update April – May 2017

### Overall clinical responsibility in the general hospital – is it ever liaison?

**Question:** 'I am not sure why this issue has arisen for the first time now – I have been in this post for well over a decade. If a patient is referred to our team and is 'medically fit' who has overall responsibility for this patient? This particularly seems to be a problem with our relationship with A&E and its associated ward. I have found my name put down as consultant in charge of care. Is that reasonable? I wonder if the expansion of liaison services in the medical setting has resulted in a greater expectation from the acute trust of our remit and responsibility. We are not core-24 here – we work 7-9 seven days per week. By way of contrast, in our hospital we don't have neurology beds – the neurologists come and see patients and advise as required on a daily rota – the patient being under the care of a named inpatient physician. The acute trust physician would accept consultant responsibility despite say the presentation being epilepsy. Is there a logical sensible way to approach this question? Is it best thought through clinically and/or legally? Is it merely a matter of the local service level agreement between trusts with no overarching legal rationale?'

**1. Cambridge:** My understanding is that if the contract is for a *consultation service* which does not have admitting rights then the patient remains under the care of the treating team for the duration of the admission even if they are deemed 'medically fit' and their only ongoing need is a mental health one. This would apply for patients being admitted for a primary mental health need e.g. care home not managing someone with dementia. They would need to come in under a medical (or other appropriate) team. This is how it is in our service (and my understanding is that that would be the same for most liaison services). That doesn't stop us having similar request now and again to take over care though.

**2. Dublin:** Here is some local experience. The admitting consultant physician, or surgeon, or ED physician, has *formal responsibility* (Medical Practitioners Act here specifies that hospital patients are in the care of a named consultant), with a *consultation service* provided by Psychological Medicine-Liaison Psychiatry, locally here and in many (even most?) places. The corollary is that the admitting consultant can disregard any advice (and discharge a patient) if he / she wishes / sees fit, from a consulting service (e.g. liaison psychiatry) – this is rare to never, locally. More junior team members sometimes confuse 'does not need surgery acutely' with 'discharged from surgery team' – but a more senior colleague (e.g. consultant surgeon) will understand that decompensation of dementia or similar can be a rare adverse event post-op etc, requiring more time before discharge, and work collaboratively to make an onward plan. Quid pro quo, we try to make onward plans short, simple, quick, clear and effective, with frequent review etc. In ED, where the patients are not admitted, the ED team would like psychiatry to take over care of all consult patients – which many specialties will do, and discharge directly. However, Dublin liaison has declined this and the patients remain in ED team care for them to discharge. This is because they are not an admitting service, among other reasons. 'This does not stop new staff or even old ones just looking for a solution from asking the same question / presenting the same misapprehension every so often. Measured and repeated simple messages have begun to get through, after some years'.

**3. Cosham:** 'The responsibility for the patient should lie with the admitting team, not the liaison psychiatrist. Generally, we are visiting experts. If the person did not have physical health needs they would not need to be in a general hospital in the first place. In that case, the appropriate place would be a mental health unit. This is how it's been everywhere I've ever worked'.

**4.** This has likely come from a position statement which the RCEM wrote in Nov 2016. It states that once they have referred to a specialty they have effectively handed over responsibility for the patient, any subsequent referrals to other teams are to be made by the team referred to and a team referred to cannot decline referrals. This is enormously convenient for the ED but doubtful that it was negotiated with other colleges. '*On a local level I explain that as I do not have admitting rights to the hospital there remains a need for a named clinician from the general hospital and in ED this will be the referring consultant*'.

#### FCEM Position Statement: Clinical Responsibility for a Patient

**5. Papworth:** There are local variations and will also depend on who is employing LPS staff. In our area, staff are employed by the mental health Trust and are considered to provide consultation only. This is agreed but it occasionally crops up - often after hours. The term "medically fit" is a questionable term – as if the patient needs a psychiatric assessment then arguably they are not medically fit.

**6. Hampshire:** For the "take over" patient we (LP) are like endocrine and palliative care. I have no beds and only provide a consult-liaison service to the primary attending physician and therefore unable to take over the care of a patient. I also think there is a scope for ensuring our acute colleagues know our role as one gets less of those requests once they understand Liaison and what we do.

**7. Stoke Mandeville:** is in agreement with some of the views already mentioned for considering psychiatric patients as exceptions.

## How do liaison psychiatrists manage RC responsibilities for patients detained in the acute hospital?

E.g. severe Eating disorder cases requiring medical treatment/nutritional support before they could move to ED unit.

**A clinician in Stoke Mandeville** asks - do people take RC roles or do medics take that role? What happens for OOH cover? If on call psychiatrists cover this, are they legally covered via SLAs or via honorary contracts?

**Response from Hampshire:** My colleagues and I are RC for all patients detained in the hospital, covered by SLA and our consult role. OOH cover is by consultant on call for the whole locality as the CCG agreement is that on call covers everywhere...for emergencies and that includes the hospital.

## Guidance for the assessment and management of concerns about the risk of self-harm, by the physios and pain nurses

**Oldham:** As part of the integrated pain service in Oldham we were asked to develop guidance for the assessment and management of concerns about the risk of self-harm, by the physiotherapists and pain nurses who have been doing bio-psychosocial assessments which have involved questions about suicidal thoughts and mental health etc. We developed a flow chart to help support this, which they seem to have found useful, as well as training and case discussion groups. The pain nurses also do *acute pain in IP settings in the acute trust and are asking for similar guidance as they are now detecting more people about whom they have concerns about MH and risk*, and want to know the pathways for IP settings. This isn't guidance for people who have been admitted with an episode of self-harm, but for IP's in whom general hospital staff has concerns and are often not under/ in any contact with mental health services. I am sure others may have developed similar, and wonder if you could share any protocols that have been developed, so that we are not reinventing the wheel. The guidance we developed for the pain service was done in haste and we now have a bit more time to reflect on this and improve things.

**Response from NWLondon:** My suggestion would be to consider doing the Connecting with People or STORM "train the trainer" module for suicide awareness or self-harm awareness; and deliver a half-day training session. Probably more useful than a proforma; not a large time commitment for the non-mental health staff and substantially increases the skill base of the department of psychological medicine in terms of training ability.

## Can I ask what other liaison teams are doing around incident reporting presentations of self-harm?

**Exeter:** The context is that we of course see a lot of patients: many are not known to MH services and for many who are it is not a particular change in their presentation. Currently we feel incident reporting should be driven by clinical risk- i.e. if it is self-harm that is different, more risky, indicates a relapse etc. we will incident report it. What do others do?

We are being asked by the Trust to incident report "all self-harm presentations of those known to services" as that is what other (community) MH teams routinely do

Is there a national benchmark for this?

This clinician thinks that useful data can be collected differently (coding in ED for example) and that incident reporting on this scale is going to be a lot of extra paperwork ('I've worked out this may affect about 150 patients a month or about 20 odd extra man hours in form filling for our teams')

**Leeds:** Takes this argument further -

a) The numbers – if you see in 1800 episodes a year in A&E, this represents about 1400 people. The gap is accounted for by repeat episodes, which can run into multiples in any 12 month period. And repetition goes with being known to MH services. So as well as the cost of the basic man hours there's the question of what response will be mounted when there are multiple reports on one person (20-25% repeat within a year), and occasional reports telling them of 5-10 untoward incidents in 12 months related to a single patient of theirs? If the decision is to invest in a specialist service for repeated self-harm you might consider the extra time is worth the effort. If not then you'd have to ask what the risk strategy is – as this group has a high suicide rate

b) And it's a waste of money because as you say they could negotiate a regular report based upon routine data – which have to be collected both for ED attendance and for admission because the figures are used to populate the HES database for NHS Digital. There's a national CQUIN out for the problem of repeat ED attendance for mental health problems so advice could be got on the specifics from other Trusts already looking.

**Avon:** In Avon & Wiltshire Partnership Trust we too have to report on every episode of self-harm by someone under secondary mental health care. There has to be a red rating - investigation for anyone admitted to ICU.

But, it doesn't catch escalating repetition or other potentially useful patterns. 'However it is a must do from the Trust'.

On the paperwork, should the CCO be better placed to do the (required) paperwork?

**Homerton takes an assertive stand:** 'As the liaison team we don't do it - whilst it is trust policy for them to be reported, our view is that it should be the patient's care coordinator or usual clinician that does the paperwork. If my small team had to do the incident report paperwork for every secondary care patient we see who self-harms, I dread to think how little useful clinical work we would get done'.

## CQUIN

A really useful A4 sized summary of the CQUIN timeline for ED and Liaison Psychiatry from NW London. This is for liaison psychiatrists in England, prompted by discussion at the RCPsych liaison psychiatry faculty conference about the national emergency department and mental health commissioning for quality and innovation scheme. 'I've developed the attached one-page timeline to summarise what we're all supposed to be doing for our local depts. - do feel free to adopt & adapt locally'.

[C&NWL ED and Mental Health CQUIN](#)

## Pressure sores were unusual in dissociative / functional disorders

**From North Middlesex:** I have a vague recollection of being taught that pressure sores were unusual in dissociative / functional disorders. Can anyone help me with some actual knowledge on this subject please?

**Avon:** This clinician has seen contractures in clear somatoform disorders - 'more severe than you'd think consequences. I've never seen pressure sores and would think they were unusual but not diagnostic.'

**Leeds:** This clinician has seen contractures and trophic changes but can only recall one patient who went to bed and developed pressure sores. The combination of his demeanour and the rarity of this made them wonder about factitious sores initially; but they decided they were indeed pressure sores.

A medical observation from 1869: "That this apparently absolute paralysis co-exists with perfect sensibility of skin, electro-muscular sensibility, and contractility; *with unimpaired nutrition of the muscles and the skin*; and with no sign of disease in the spinal bones; ..."

[Paralysis and other disorder of motion and sensation dependent on idea](#)

You wouldn't expect it in a recent-onset group so you need chronic cases or longer-term follow-up.

**Also Leeds:** 'a perspective from the inpatient unit' - that this is a general hospital-based specialist inpatient unit (ward) which delivers multidisciplinary care particularly for people with severe and complex medically unexplained symptoms (MUS), presenting in any bodily system. 'All patients are, of course, unique, but of our most severe cases a "typical" patient may have been bedbound for years, fully dependent, perhaps tube-fed and/or catheterised, and taking numerous medications, but of course without organic pathology to explain their illness. Over a 6 year period they have had 12 inpatients with somatoform disorders who have had pressure changes sufficient to be categorised on the Pressure Ulcer scale (European Pressure Ulcer Advisory Panel classification - EPUAP 2014). However, all have been at Category 1 - i.e. "Intact skin but with non-blanchable redness of a localised area, usually over a bony prominence". So none of them have actually broken down to become true ulcers, i.e. Category 2 "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough", or worse. But they have all been judged to be pre-breakdown, have led to input from the Tissue Viability Team in the hospital, and specific care plans to ensure regular movement and positional changes of the patient by our nursing team, plus creams, etc, as well as specialist air mattresses, to prevent true ulcers developing. So, despite the context and nature of this service and the patient group, I have also not seen an actual pressure ulcer in a somatoform case. Although the team here believe that some or all of these cases would have developed ulcerated areas if the plans described were not instituted, because from a clinical perspective it was close to happening'.

Dr Jackie Gordon

Worthing