JISC update February – March 2017

ED support from volunteers

A Liaison Consultant consults: 'I'm sure any of you working in a busy ED will be familiar with the challenges of looking after a distressed group faced with long waits and the risks that entails, particularly when you generally have just one liaison psychiatry nurse in the department from 9pm to 7am'

This West London service has been looking at a proposal with a local mental health charity to develop a cohort of volunteers (largely former or current Samaritans) who with training and supervision spend time in ED, particularly out of office hours, offering support to those who need it. The initial focus would be on those presenting with suicidal ideas and self-harm.

'Is anybody was using such a model currently. We would be very interested to know risks, benefits etc.'

Response one: This North London service put a similar proposal in to a bid for the one off liaison money. The main difference is it would be a rota of *paid* peer support workers.

If they win the bid then they will have to get it up and running quickly; and would be interested in what anyone else is doing with volunteers or PSWs. 'If there isn't much like this happening already perhaps we could work together.'

A Cornish Liaison Psychiatrist was cited as someone who may know about the pros and cons of such a set-up.

Also a similar support service has been tried in Bridgend bath Portsmouth and Reading 'so there should be plenty of information out there'.

Transcultural question

From Western Australia: 'I hope someone in this group can help me gain an understanding of the cultural norms of Bolivia.'
This clinician described a situation in which a patient refused a nephrectomy as her cultural beliefs forbid her from having any part of her removed.
A literature search yielded limited information:
'Many Bolivian highlanders believe that if someone is buried without an organ, his or her soul will wander restlessly and not find peace.'
This patient has capacity to make a decision regarding her care.

Response from another part of Australia, who reports that among Islanders there is a very similar belief in needing to be "whole" when buried, to be whole in the next life. 'I have negotiated to have a lower limb embalmed, which was an acceptable compromise, as the patient could be buried with it and thus be OK in the afterlife. Would you patient consider having the kidney in formaldehyde, in a jar, a possible way forward?'

From Yorkshire: A clinician wonders if it is possible to draw an analogy with surgery that is acceptable. For example – if you mangle your leg hopelessly with a crushing accident, is amputation not allowed? Is cancer not cut out, or rotten teeth drawn? Could she think of one kidney as only part of her body's renal organ, so it's like cutting out a bit of something rather than the whole? In his experience, sometimes what you find when you can see family or friends is that there is a cultural background to the ideas but they also have a strong individual twist that dismays those close to them. So a family (or whoever) session can be helpful.

Core 24 model of working

Bristol Liaison is doing a one month pilot of working nights in A&E to review the clinical need and discharge arrangements and was wondering if other teams had a model of working nights, particularly with regards to nurse banding, i.e. use of band 6 or 7 nurses to see, treat and discharge?

Respondent one: 'We have two band 6 nurses work at night, some services run with a lone worker; we feel both the activity and the complexity needs two to share decision making.'

Bristol replies: 'Thanks, so presumably your band 6 nurses can discharge autonomously? Are you employed by the acute or mental health trust?'

Respondent one: yes they can discharge – 'we only have x 3 band 7, 1 team manager and 2 clinical leads, lots of band 6 nurses and some band 5 development posts; we are mental health trust and have honorary contracts with the Acute Trust'.

Respondent Two: At Northwick Park there is a cohort of band 6 nurses who work autonomously out of hours supported by a resident s12 doctor to make a team of three staff (two nurses + one doctor). The band 6 nurses

see, assess and make management plans including discharge. If they need advice they will call the liaison psychiatry doctor, who in turn can call the on-call consultant psychiatrist for advice. They can also contact the on-call senior nurse, manager and director for assistance with progressing admissions/transfers/delays OOH. So they are well supported but most decision-making and management is autonomous.

The team is employed by the mental health trust; with a service level agreement specifying that there is access to the same clinical systems as acute trust employees, and that they abide by acute trust policies for IT, information governance etc. Therefore they don't use honorary contracts.

PLN network

An East London Liaison Psychiatrist is looking for an email group for psychiatric liaison nurses

Respondent 1: 'There is an email list and a meeting held bimonthly in London. The contact is Jackie Waghorn

Respondent 2: (Kate) is about to start and will be chairing an email group in the North East too!

Factitious disorder database

From London: Does anyone have experience of or advice on how to approach a patient who is repeatedly swallowing coins and batteries?
Is there a reliable way to join up and co-ordinate care between hospitals for people who may be having endoscopies for removal of foreign bodies at multiple hospitals over a large geographical region?

Surrey: Following a previous complex case of factitious disorder, I provisionally looked at the possibility of a national database of patients with factitious disorder. However, the confidentiality issues appeared to be a significant stumbling block - despite the fact that many of the severe Munchausen's patients have assumed identifies and a range of false names. In the case I was dealing with we did use an email network for UK pain nurses (analogous to liaison psychiatry on JISC) to track the patient concerned. I wonder if it could be argued that our duty to share information in certain circumstances would allow us to do this in severe cases.

South London: 'Thanks for flagging this up-they are rare cases though familiar cases - so it's good to refresh our thinking and skills. I have recently been involved in several factitious disorder cases complicated by having an underlying long term condition e.g. diabetes or COPD. What I am struggling to understand is that A&E depts. now have red flags for recurrent attenders and some acute trusts have 'complex teams' yet there is less coordination between ambulance and the hospitals that these patients are presenting. Perhaps with all the changes in the NHS structures and increasing specialisms, we have lost the 'common sense' touch (communication) and whether there is a case for RCP, RCPsych, Ambulance Services and RCEM to develop joint guidance-like in the olden days. This would increase awareness, develop clinical and organisational skills in detection and on-the-spot management rather than admission.

One of this clinician's patients had told her "it's not me that gets myself admitted, it's the doctors in A&E who decide to admit me". So we have to start with our colleagues it seems!'

Newcastle: Years ago we had a local network of regional teams (often one man bands) and used to meet regularly - we shared those cases that migrated around the region. E.g. they discovered a young man who was getting Parvolex 7 days/week for 2 months. He was identified and received psychological treatment and improved remarkably. Unfortunately the network eventually folded as people left jobs/Trusts merged teams with crisis. As the framework of national Liaison now exists is there a case for ensuring people get the correct treatment pathway?

Sunderland: In Sunderland where the PLN network is to established the PLN chair hopes that cases like this can be part of discussions; that network could then link with the London Forum where patients may be travelling long distances. The nurses are most likely to come across this client group first in the ED and then can share information with their teams. Invites for the nursing network for the North East, TEWV, NTW and Cumbria will be sent out this week.

Jackie Gordon

Worthing