

JISC update Oct - Nov 2018

Health Care Assistants in Liaison teams

What is the best use of this potentially valuable resource?

Response one: Was from a team who have had Band 3s for some years now.
Main roles:

1. Adjunctive therapy and 'problem-free talk' on the wards.
2. Reminiscence therapy and assisting in encouraging oral intake in depressed/dementia patients.
3. One is community-based and has a caseload of patients with long term conditions with who he works through psychoeducation and CBT-based work. This is supervised by a more senior nurse.

These HCAs have no role in the ED. If a patient requires close observation, then this is facilitated by ED staff/agency MH staff.

Response two: This service has a HCA group. They are active within the 3 pathways we provide within the Acute Trust – The Acute Care Pathway (ACP), In-patients (I/P) & Acute Care of the Elderly (ACE). They are an integral part of our team and managed as such governance wise. Like the first respondent, the 'specialling' role is only occasional; until an agency or other can be obtained by the Acute Trust.

We have also done a piece of work with one of our Acute Trusts where they have now employed a group of HCA's (5 in total) specifically for 'specialling' (called them the "Specialist Wellbeing and Observation team") in order to save on agency costs. We are planning to be part of their induction and they will be invited along to our teaching sessions and offered any supervision required via Liaison. See appendix 1 for HCA job plan.

Zopiclone

A clinician describes a patient who has used large amounts of zopiclone daily for several years; and who has presented in a confusional state. Does anyone have any up to date literature to share or anecdotal clinical experience regarding z drugs and withdrawals?

Respondent 1: Has done a lot of reading on this in the past and came away fairly convinced that benzos and z drugs have similar harm profiles.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3657020/>

I would treat as for benzodiazepine dependence *if* your patient is motivated to change.

Response 2: Has seen similar cases (including a delirium that lasted weeks); with patients improving after a detox (gradual reduction regimen like with medium half-life benzos) - the long-term outcomes are likely to be related to appropriate support for dealing with addiction (12 step programme like Narcotics Anonymous).

Role of Liaison in Section 136

I would be interested in what people think is the **role of liaison** when a 136 patient is brought into A&E on s136 with police?

We are a bit divided in our team – some staff thinking we have no role. I think we do, in terms of *supporting A&E and the police with high risk patients* – at least performing some form of *risk assessment* – particularly as MHAct requests are taking longer and longer to happen.

Two similar responses: Whose views were that as S12 psychiatrists on the ground we would be approached regarding assessment, in the first instance (especially given the availability of S12 doctors, the time constraints with the policing and crime act, etc). We (the whole team) already have a role *with respect to advice about management anyway if mentally disordered*. We also have a role in offering *an opinion on whether a full MHA is required* and will liaise with relevant services re this.

If there is no medical need we will do our best to *facilitate transfer to our local POS* but when this can't happen we go ahead and *do what we can to speed up the process*.

Delirium Pathway

I was wondering if other liaison psychiatry teams have a discharge planning process for patients with delirium. If there is a pathway for patients with protracted delirium, who is this pathway co-ordinated by e.g. geriatricians, liaison psychiatry, discharge planning? What support is involved on discharge e.g. live in carer/ interim bed? Does liaison psychiatry offer any follow up? Are there any criteria for patients to access this pathway? Are there any exclusion criteria? What are the outcomes? Does the pathway include any training - both within the hospital and/or with the care agency/ care home used?

Response 1: We have a delirium recovery pathway in Watford in conjunction with geriatricians and an OT and with social services that focus on getting the patient home with a living in carer.

Response 2: Luton has a 'delirium steering group' and it is jointly owned by liaison psychiatry, geriatricians, the discharge team, social services and CCGs. Although it is very much focused on the elderly, the remit of this group is also to develop strategies to manage delirium in all ages.

The remit is to improve delirium diagnosis and management; along with teaching and then to have a joint social care and health discharge pathway. It's useful to have a shared voice. The plan is to have interim care beds for 12 weeks and reassess.

Response 3: In CUH we have a specific delirium discharge planning pathway '4Q' which stands for 'four questions'. They are a brief assessment of function and need. It identifies people with delirium who have some potential for cognitive and functional improvement but not ready for home. They have an

interim placement and then reassessment of needs after 6 weeks. The 4Q pathway is led by our discharge planning team; but liaison psychiatry are often involved in advising on whether we think the pathway is appropriate.

Response 4: This service has a post discharge team which essentially act a bit like a crisis team, providing support at home 2-3 times a day, OT led with nurses and support workers to get people home whilst still delirious; and often that resolves the delirium. Obviously not all patients are suitable for this and so we have 'time to think' beds (essentially rehab) to see how good people can get – rehab wards tend to be much better at resolving delirium than acute medical wards and also the care home option. But we would be involved in these discharge planning meetings via the ward 'huddles' so that we can get as many home as possible.

Clozapine and chemotherapy

This is a gentleman in his 50s with a diagnosis of schizophrenia on clozapine who has started urgent chemotherapy (Cisplatin, Etoposide and Bleomycin) and his blood counts are expected to drop in 7-10 days' time. His CMHT consultant was concerned about relapse and wishes to keep him on Clozapine if possible. *The oncologist has asked whether we would recommend prescribing both, and if the neutropenic risk with both is additive.* The team have checked with CPMS pharmacist and is it possible to prescribe clozapine off-label with a reduction in red limits (to zero if necessary) for the duration of chemotherapy.

Response 1: This clinician needed to sign a waiver from the CPMS so that he took on the responsibility for medication treatment; and his patient's neutrophils did indeed plummet. It is difficult to know whether the effects are additive or not. This patient was given G-CSF (granulocyte colony stimulating factor) and gradually things picked up. His experience was that there was very limited published information to guide the decision, just one or two case reports. The decision will come down to a risk-benefit analysis. In this case if there was a psychotic relapse then the one window for chemo would be missed. He adds: The patient may well have a view on this. Most patients undergoing chemo understand that the stakes are high, and (as in my case) support the decision that you have proposed. He would also ask for an opinion from a psychiatric colleague, or at least talk the case through with a consultant colleague.

Response 2: This clinician was reminded of a very challenging scenario in an acute hospital in Sussex. This was a clozapine patient with metastatic malignancy. The patient presented with bowel obstruction of unknown cause and clozapine was stopped prior to and subsequent to emergency surgery / HDU stay. Despite using an alternative anti-psychotic for cover this patient relapsed and the patient died of complications of widespread cancer about 6 weeks later; requiring being 'nursed' by security because of his risk to others. This reminds us that the risk of relapse can be catastrophic for some patients. This clinician now finds out as much as possible about a patient's relapse profile before making decisions about ceasing clozapine.

Response 3: Another clinician successfully managed this situation; a collaborative approach with the haematologist worked and for 4 weeks this patient received G-CSF's twice weekly and for every cycle of chemo. Neutrophils

reduced to make it amber but we avoided the red in monitoring. She advises getting the clozapine pharmacist and Haematologist in a case conference with the patient.

Cyclical Vomiting Syndrome

This clinician is asking for experience and expertise in the clinical management of this condition?

First response - 'has gastroenterology diagnosed it after excluding other causes'? I think migraine prophylaxis and amitriptyline have the best evidence base. She points to American and paediatric websites.

<https://www.aboutgimotility.org/disorders-of-the-stomach/cyclic-vomiting-syndrome/cvs-in-adults.html>

<http://www.cvsa.org.uk/downloads/Fleisherguidlines.pdf>

Oesophageal Manometry can help if the diagnosis not clear and lots of other eating disorder like/regurgitation/rumination features? Admission would be to the gastroenterologists surely if unmanageable unless the vomiting is stress/ anxiety induced and you were thinking it was the only place to sedate and or try behavioural techniques.

Response 2: This experienced clinician has treated CVS with CBT with mixed results.

2 articles in Primary Psychiatry, 2009:
Cyclic Vomiting Syndrome Part 1

https://www.researchgate.net/publication/289480382_Cyclic_vomiting_syndrome_part_1

Cyclic Vomiting Syndrome Part 2

https://www.researchgate.net/publication/286494330_Cyclic_vomiting_syndrome_part_2

Response 3: This clinician describes a patient with cyclical vomiting ('rumination syndrome') who was treated with Risperidone and CBT. She responded better to the Risperidone than the CBT; with at most a 20% improvement in symptoms – mostly a greater delay between ingesting food and vomiting.

Response 4: This respondent has worked with a few Gastroenterologists and there is some evidence about the role of venlafaxine and also low dose haloperidol/ olanzapine in cyclical vomiting. 'Cyclical vomiting is a good example of how symptoms can be real yet centrally driven by the brain including emotions. So whilst there might be some peripheral biological vulnerability like in many of our psychosomatic disorders we cannot ignore the primary role of central processes in driving the disorder'.

Dr Jackie Gordon
Worthing Mental Health Liaison Team

Liaison Psychiatry Job Plan for Healthcare Assistants

- To primarily work as part of the inpatient team, to primarily focus on the development of patient care plan and in-patient reviews. To carry out initial assessments if necessary along with a senior member of the team. Any letters of assessment documentation will be checked by your assessing partner.
- HCA's should write review entries - the senior clinician can be approached if needed for a review of the entry and this will be documented at the bottom of the note.
- The HCA will assist with admin tasks to assist the SMHP including GP alerts, social inclusion, family forms. This can also include the administration for accessing private, out of area beds.
- When extra information is required regarding the patients, the HCA will contact GP's, family members, carers etc for collateral history and document this on Care Notes.
- The senior clinician to communicate if a care plan is necessary and to highlight this on the inpatient board. The HCA will ensure that any highlighted inpatients have a care plan. The HCA will spend time with the patient to develop these in order to give the staff on the ward ideas about what the person finds helpful and unhelpful in their care.
- The HCA will complete regular reviews of the inpatients. They are able to do this alone if it is for emotional support, psychosocial interventions, enabling leave from the ward etc. If the HCA has concerns or are asked any questions by the medical team that they are unsure of they should return to the team and ask a senior member of staff to attend or contact the ward.
- The HCA will be expected to read Section 132 rights to patients who are newly detained and offering them an IMHA. Referring them on to IMHA/IMCA services where appropriate and recording this in the appropriate section on care notes.
- Along with other members of the team the HCA will ensure that the whiteboards are up to date (specifically the inpatient board). If a patient's info is out of date the HCA will access Care Notes or seek out the clinician in charge of the patient's care to update it the information.
- Out of Hours the HCA will assist the ACP team in the Emergency Department by either helping with regular reviews of patients waiting for MHAA or a psychiatric bed (and updating the notes). At times this might involve being the second person in an assessment.
- At weekends the HCA will work alongside the ACE nurse to cover the inpatient reviews. Once inpatient work has finished they will help the ACP team with any work they have as well as completing any outstanding work in relation to the HCA role.

Appendix 1

- To attend board round (when on shift) on Monday's and Wednesday's. On other mornings to attend the inpatient meeting in the office at 9am.
- The HCA will cover for the triage worker by holding the referral phone, taking referrals, and updating the new referrals board / open them up on care notes and open a liaison administration form alongside this.
- The HCA should be completing cognitive testing & other mental health rating scales with patients and feedback results to rest of the team.
- They will ensure that the leaflet folders in ED and AMU are up to date with leaflets and info for patients.
- They will ensure the electronic resource file is kept up to date.
- They will attend regular clinical and managerial supervision.
- They will assist with training delivery as and when required.
- They will attend business meetings, staff support and teaching sessions when on shift.
- On occasion the HCA may be asked to support 1:1 with patients, but this should not be a routine occurrence.
- The HCA will assist with the completion of MASH referrals.

Reviewed by Hayley Smith & Andrea Fairclough, August 2018.