Cornwall Partnership
NHS Foundation Trust

The Impact of Introducing a Psychiatric Liaison Nurse to the RCHT Multi-agency discharge team

Complex Care and Dementia Psychiatric Liaison Team RCHT Cornwall

Find us online at cornwallft

DELIVERING HIGH QUALITY CARE · EMPOWERING PEOPLE · COMPASSIONATE SERVICES · ACHIEVING HIGH STANDARDS · RESPECTING INDIVIDUALS

Who are we

- Specialist Older Adults Psych liaison team
- People living with dementia, Suspected dementia and those over the age of 75 years living with functional mental illness.
- January 2015 - investment as part of the winter pressures resilience plan

Discharge Psych liaison nurse role

1 Mental health Nurse

Based with psych liaison

Weekly MDT’s with multi professions

Information sharing sessions

Discharge to Assess

Patients Hospital Discharge

Form small groups of 4 to 5

Consider as a group your current team involvement in the discharge process for your patients.

You have 5 minutes

What did it look like……….

30 hrs per week over four days

Three days hospital based

One day based within the community providing follow-up for patients case managed and discharge from hospital

Additional admin support

Four Consultant sessions per week – split over two days

Cornwall Partnership NHS Foundation Trust

Key Performance Indicators

To Provide expert assessment, risk assessment and treatment where needed for people living with dementia.

To increase patient flow, by case managing people living with dementia out of RCHT to other safe, appropriate environments, where their needs could be met more effectively.

To case manage patients once discharged from RCHT in the community, to reduce readmission to acute hospital settings, with the benchmark being that they are not readmitted within 28 days of discharge.

To have an understanding of the training needs of the Onward Care team, in relation to their understanding of the needs of people living with dementia.

NHS
Cornwall Partnership
NHS Foundation Trust

The Impact of the pilot

Case managed 44 people with dementia *out of the hospital* providing community follow up. None of whom were readmitted to acute hospital.

Increased recordable diagnosis of dementia – 25 out of the 44 being currently unknown to Complex care and dementia service, 22 with no recorded diagnosis of dementia, the role has facilitated signposting or diagnosis.

Specialist risk assessments and knowledge have proven particularly effective when considering if a person can return home.

Limited information sharing. Increased training was required.

Increased quality of care home assessments - The terminology used to describe a person's experiences or behaviours lacks clear evidence of triggers and has most certainly delayed patients discharge when seeking care environment to accommodate them.

Average length of stay (LOS) from referral to Specialist Nurse to discharge = 7.64 days

Find us online at cornwallft

Discharge focus – Ability to focus on discharge solely.

Continuity of care and a seamless provision, from hospital to home.

Enabling Focus - the Psychiatric Liaison team to prioritise acute assessments.

Increased availability within the team increased ability provide to support , triage and daily MDT attendance.

Patient and carer feedback was benefited from the continuity of seeing the same clinician within hospital and at home.

What did we learn

- Home visits were not required for all
- Office base was important
- Education was needed
- Where possible to attend all care home assessments
- Triage was important, providing signposting

Where we are in 2018

- Substantive post in place
- Weekly MDT's with multi professions
- Information sharing sessions
- LoS Increased – lack of community resources
- Discharge to Assess
- Prompting avoidable hospital admissions
- 68 patients referred (Aug 17-Jan 18) 6 patients readmitted

What are the barriers to complex discharge?

Information – Detailed and accurate, meaningfully interpreted, sharing	**Risk Assessment – positive risk management, sharing**
Exploring Options	Care planning

DELIVERING HIGH QUALITY CARE
EMPOWERING PEOPLE • COMPASSIONATE SERVICES • ACHIEVING HIGH STANDARDS • RESPECTING INDIVIDUALS

Case study - Patient 1
70 year old lady with comorbidities.

Cornwall Partnership
NHS Foundation Trust

Admission – Jan 2017 with chest sepsis – discharged home Aug 2017

Presentation - Decline in mental state, fluctuating confusion with acute agitation, aggression and paranoia, believing that staff were attempting to kill her. She was refusing all medical intervention and was placed on a Section 2 MHA in April with differential diagnosis of psychotic depression/delirium and transferred to Acute Psychiatric Hospital.

Referred to the Adult Psychiatric team on 3 separate occasions. The last occasion being 23rd June for discharge planning. She was seen a total of 15+ times and remained in RCH with no clear discharge plans.

On the 04/07/17 patient was discharged home without a safe discharge plan or contingency plan regarding any further readmission.

Readmitted 05/07/17 – found to have a UTI, carers reported that patient was at home on visit presenting with a knife to carers (later it was established she was making a salad for lunch). Also the patient had not been told she was having carers, so was shocked to see people entering her home.

Referral 20/7/18 – 21/7/17 Multi agency discharge meet arranged. Patient, Community Matron, Nephrology Consultant, care agency and South Western Ambulance Service), ward staff and MH.

Cornwall Partnership
NHS Foundation Trust

Find us online at cornwallft

Cornwall Partnership
NHS Foundation Trust

Proactive discharge interventions

- CA introduce themselves, so patient feels comfortable and familiar with them. Robust introductions on each visit with name badges to identify their role.
- An appropriate lifeline to be arrange with falls sensor
- SWAST to be informed of complex discharge and high risk of falls.
- Consider nutritional intake – Wilshire farm foods. Family to provide shopping.
- Consideration prophylactic dose of Antibiotics to manage risk of recurrent UTI's
- UTI screen prior to discharge.
- Morning discharge.
- Night time checks – night sittings had previously failed.
- Social support – referral to Age UK
- QDS POC - personal care, domestic chores and shopping.
- Community Matron to monitor Mrs Richards Psychical health needs whilst in the community
- Medication administered into a blister pack.
- The cinnamon trust to support Mrs Richards, continue to walk Cally and introduce slowly.
- Care agency staff to monitor Mrs Richards mood and behaviour to ensure they are aware of any changes (possible UTI) and act accordingly
- Janet to offer some education to carers re- UTI and early identification and management.

4th August Mrs x discharge plans were given to her in writing with a discharge date 7th August.

Mrs X length of stay in a acute hospital bed was 212 days just over 8 months.

Case study - Patient 2
80 year old gentleman with diagnosis of vascular dementia

- Mr X was admitted 09/03/17 following fall down the stairs.
- He was accepted by a EMI N/H and discharged 30/03/17.
- Mr X was readmitted with a fractured left NOF following a fall 4 days later.
- The home had reported that Mr X had grabbed a knife and threatened staff.
- EMI N/H did not feel they would be able to manage Mr X long term needs due to level of aggression.
- Mr X history followed him from the home and he was deemed to be extremely unpredictable aggressive man on the ward.
- Mr X was nursed with male HCA's who stood over him with crossed arms.
- When ask why ? They responded he is quick and aggressive he needs to sit there.
- A number of N/H has declined Mr X due to his presentation/history.

A Bio-Psycho Social approach

- The home confirmed that Mr X had picked up butter knife and wanted his dinner.
- A ‘Know me’ was completed with the Family.
- Information sharing and education was offered to staff re- behaviours that challenge.
- The staff were introduced to the ‘Know me’
- HCA’s saw Mr X differently and knew and understood why he presented as he did.
- They developed skills and began to recognise that Mr X response was to a unmet need.
- The ward introduced a calmer environment and used music to reduce Mr X agitation.
- Mr X was excepted by a EMI N/H 2/06/17.

Group activities

Consider a discharge you have been involved in recently.

Could you have worked differently?

How?

Are there changes your team could make?

DELIVERING HIGH QUALITY CARE
EMPOWERING PEOPLE • COMPASSIONATE SERVICES • ACHIEVING HIGH STANDARDS • RESPECTING INDIVIDUALS