Psychiatry Handbook for Junior Doctors

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Contents

Disclaimer: This is not an official policy document. For official policies, procedures and guidelines please check with your Consultant and/or consult appropriate trust documentation.

Humber NHS Foundation Trust

Welcome to Humber NHS Foundation Trust.

We aim to be a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff and known as a great employer and valued partner.

Our Mission

Humber NHS Foundation Trust - *A multi-specialty health and social care teaching provider* committed to Caring, Learning, Growing.

Our Vision

We aim to be a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff and known as a great employer and a valued partner.

Our Values

Caring - Caring for people while ensuring they are always at the heart of everything we do.

Learning - Learning and using proven research as a basis for delivering safe, effective, integrated care.

Growing - Growing our reputation for being a provider of high-quality services and a great place to work.

These values shape the behaviour of our staff and are the foundation of our determination to:

- Foster a culture in which safe, high-quality care is tailored to each person's needs and which guarantees their dignity and respect;
- Achieve excellent results for people and communities;
- Improve expertise while stimulating innovation, raising morale and supporting good decision-making;
- Unify and focus our services on early intervention, recovery and rehabilitation;
- Engage with and listen to our patients, carers, families and partners so they can help shape the development and delivery of our healthcare;

- Work with accountability, integrity and honesty; nurture close and productive working relationships with other providers and our partners.

Strategic Goals

- Innovating quality and patient safety
- Enhancing prevention, wellbeing and recovery
- Fostering integration, partnership and alliances
- Developing an effective and empowered workforce
- Maximising an efficient and sustainable organization
- Promoting people, communities and social values

About us

We are a provider of mental health, learning disabilities and community health services across Hull, East Riding & parts of north Lincolnshire (specifically Grimsby & Scunthorpe).

Our health care services cover all ages. We also offer hospital based mental health care and some specialist learning disabilities support for people too unwell to be treated at home.

Our health care staff includes:

- Mental health nurses
- Psychiatrists
- Healthcare support workers
- District nurses
- Health visitors
- Allied health professionals (for example, psychologists, occupational therapists)

In the Link below you will find all the Care Groups and associated directors within the Trust.
https://intranet.humber.nhs.uk/care-groups.htm

The Board: http://www.humber.nhs.uk/about-our-trust/meet-the-board.htm

A Message from Us

We are delighted to have you joining us

A statement from the Chief Executive, Michele Moran

I would like to take this opportunity in extending to you a warm welcome to Humber NHS Foundation Trust. We are pleased to have you as part of our valued work force, to continue with the delivery of patient focused care, professional education and quality improvement that are central to us all.

Our corporal units and clinical staff all work together to produce quality services that we all can be proud of. We have a long-standing heritage of commitment to excellence, leadership and innovation; principles that are woven all through our strategy, vision and value, those of 'Caring, learning and growing'. We hope to offer you a inspiring career here at Humber Foundation Trust.

I trust as new recruits you will find your work home here a happy one, and that our committed employees make all newcomers feel welcome. You have my gratitude for your contribution. I always welcome any new ideas for the betterment of the Trust, do don't be shy in sharing your invaluable experience with the board.

A statement from the Medical Director, Dr John Byrne

Welcome to Humber. I am delighted that we will have the opportunity to work with you during your placement and I am sure that your overall experience will be a positive one. We have a strong track record in terms of training support and we are hoping to enhance this with a refresh of the training program in order to place a greater emphasis on Quality Improvement, Patient Safety and Medical Leadership. I hope you find this booklet helpful, not just part of your induction but also as an aide memoir. It's the first time we have done this so hopefully you can help us build on it over time. I look forward to the opportunity to meeting you over the coming months.

A statement from Royal College Tutor, Dr Douglas Ma

It gives me great pleasure to welcome you most warmly to the Humber NHS Foundation Trust (HFT). I trust that you will find Hull & East Riding to be a very friendly and highly supportive place in which to live and work. I am exhilarated to have you with us - so set your sights high and have confidence that you can achieve your ambitions, as so many of your predecessors have done throughout the Trust's strive for improved care.

In the meantime we shall do all we can to ensure your time here is as happy and as rewarding as possible. My role as Royal College Tutor is to ensure the smooth running of your time at Humber Foundation Trust. I look forward to working together and getting your

placements off to a strong start. I wish to offer you an environment that enables you to realise your full potential.

Don't ever hesitate to get in touch! I am a great believer in meeting with people not just at times of grievances, but also when things are going well to better build relations. See you soon!

Foreword

This handbook is aimed at helping you to become familiar with your placements and:

- ease any anxiety about psychiatric practices;
- reassure you that your mentors are accessible, approachable, and personable;
- set the stage for continued, positive interactions between you and your supervisors
- save you time by compiling all the most FAQs and relevant information

General Points and Information

- Psychiatry is different from other specialities. Your focus is more on the mental health and wellbeing of the patient. Nonetheless, our patients often have physical co-morbidities and the medication we have can often impact on that. Hence, it is important for us to interface with other disciplines and offer advice when appropriate.

- At the start of your rotation, you will be given a mobile phone, which allows the staff at your base to contact you. It also serves as your on-call phone. Your phone will need to be switched on during the hours of work.

- All doctors in an in-patient unit should be given a personal alarm and Entry badges before they commence their shift.

- ID badges are obtained from HR department at Trust Head Quarters, Willerby Hill.

- You can apply for a parking permit via Lisa Arnold or Diane Jones in Medical Staffing at Trust HQ

- Inform your Consultant and base ward (if you are based in an inpatient unit) when you know you are on annual leave/study leave and on a set of 'nights'.

- If you are due to take leave or take study leave, this will require authorisation by your Consultant. This form can be found on the intranet under 'Policies, Procedures and Guidelines': **Medical Staff Leave Policy Incorporating Study Leave** .

- When you are allocated to be '1st' day oncall (9am-5pm; please refer to 'rotas, oncalls and handovers'), please let your base ward know. If you are based in an outpatient setting, ensure you do not have any patient's booked in on that day.

- Castle Hill Hospital has a library with internet access. It is used by other specialities but there is a generous selection of psychiatry books there. All Humber NHS Foundation Trust staff are entitled to support in evidence based practice, research and CPD through:

- NHS Athens password
- membership to local health library/knowledge services
- access to library resources catalogue
- membership of University of Hull - Brynmor Jones library (take staff id badge when enrolling)
- access to electronic resources including full text journals, evidence based reviews, e-books, images and guidance
- training and advice on how to get the best out of electronic resources
- mediated literature searches
- document supply (journal articles)
- copyright advice
- current awareness including Netvibes

Other Important Contact Numbers

- **Lisa Arnold, HR and Medical Staffing Officer**: 01482 389 300. It may be easier contacting her through email. Lisa.arnold2@nhs.net Lisa is supportive and approachable and should be the first port of call when it comes to swapping oncalls, arranging annual leave and study leave etc.
- **Sally Morrell-Witty, Postgraduate secretary**, 01482 344 556. Sally circulates the teaching programme. If you want to swap your case conference, journal club presentation, let Sally know. Again, Sally is also very helpful and approachable

In-patient wards at Humber NHS Foundation Trust [HFT], as per August 2017

At HFT we have numerous in-patient units which are spread throughout Hull.

MIRANDA HOUSE (home of switchboard and ECT)

Telephone number: 01482 216 624

Avondale Assessment Unit:

Telephone number: 01482 617565

Avondale provides a residential, assessment, treatment and triage service to adults of working age.

The unit has 14 individual bedrooms and provides services to males and females who have been assessed as requiring admission due to mental disorder. The team works closely with the Rapid Response Team who manages its admissions. It also liaises with other residential inpatient services for patients who need to stay in hospital for longer than seven days.

Psychiatric Intensive Care Unit (PICU)

PICU is a 14 bedded, mixed sex, ward. Psychiatric Intensive Care is offered to service users who require treatment during an acutely disturbed phase of serious mental disorder that cannot be managed in a traditional, inpatient environment owing to serious risks to themselves, to other patients and to staff.

MILLVIEW COURT AND MILLVIEW LODGE: both located at Castle Hill Hospital

Millview Court

Telephone number: 01482 344530

A 10 bedded, male and female working adult (18-65 years) unit that cares for and treats people experiencing acute mental health problems that require a period of assessment within a hospital environment.

Millview Lodge

Telephone number: 01482 344537

A 9 bedded unit for male and female patients experiencing functional mental health problems (such as depression) and those with memory impairment above the age of 65.

Humber Centre for Forensic Psychiatry

Telephone number: 01482 336200 (this will put you through to the central desk, please ask for the ward you require).

A medium-secure hospital for patients suffering from mental disorders.

All patients at the Humber Centre are detained under the Mental Health Act 1983 (amended 2007) and due to the nature of the unit some limitations are placed on patients, staff and visitors for clinical, health and safety reasons.

The Humber Centre consists of the following units:

- Darley House - low secure unit
- Swale – specifically patients with personality disorder
- Derwent – Assessment unit
- Ouse – Rehabilitation ward
- Ullswater - learning disability
- Greentrees - long stay
- South West Lodge - low secure community preparation unit

TIP: Rota One doctors called to the Humber Centre, will have to leave their oncall phones at reception. If you can give switchboard a call, and let them know you're at the Humber Centre, any calls can be directed to you via the receptionist working at the main desk.

Hawthorne Court

Telephone number: 01482 336830

An 18-bedded, male and female rehabilitation unit for people experiencing severe and enduring mental illnesses.

The aim of the service is to restore people to their optimal level of functioning following a breakdown caused by a mental disorder

Westlands

Telephone number: 01482 335647

A 16 bedded, in-patient unit for females between the ages of 18-65 experiencing mental health problems, often requiring a longer period of assessment and treatment.

Townend Court

Telephone number: 01482 336740

A 20 bedded unit, for the assessment and treatment of people with learning disabilities. Those who are admitted to Townend Court are often struggling to be supported in their community placement and require a safe and therapeutic environment. Townend Court comprises:

- Willow Unit: Assessment services
- Lilac Unit: Treatment services
- Beech Unit: Enablement services

Newbridges

Telephone number: 01482 335829

An inpatient unit for male patients between the ages of 18-65, suffering from any form of mental illness and need to be in hospital, usually for a longer period of assessment and treatment.

Maister Lodge:

Telephone number: 01482 303775

A 16-bedded, inpatient unit for older people. This male and female unit caters to those who are experiencing predominantly organic mental Health Problems.

ROTAS, ONCALLS & HANDOVER

It is only FY2, CT and GPST doctors that undertake oncalls.

The oncall rotas can be found on the 'V-Drive':

Computer > Shares (V:) > HMHTT > Medical Directorate > Medical Business > Rotas

At present, there are three rotas

1) **Day Rota: 9am-5pm**.
    a. Applicable to FY2s, CTs and GPSTs. There are two doctors: a '1st oncall' and a '2nd oncall'. The '2nd oncall' is put to duty if the 1st oncall doctor is unwell. You will be called to provide cover if a doctor has called in sick or is on annual leave. **Please note the dates you are the 'day oncall' and if you have clinics, ensure no patients are booked in to see you & your Consultant is aware of this.**

    b. **DUTIES:** as day oncall, you are meant to be called out for "urgent jobs". However, you can imagine jobs will accumulate if a doctor is on annual leave or on nights, in which case re-writing drug charts, doing TTOs will be necessary. If you do have concerns over the appropriateness of jobs and are feeling inundated, do as much as you can, make a detailed note of the jobs asked of you and bring any concerns you have to our **monthly Guardian of Safe Working & Junior Doctor's Forum. Dr. Lucy Williamson (Consultant Forensic Psychiatrist) is the appointed Guardian of Safe Working.**

2) **Evening rota: 17:00-22:00:** Applicable to FY2s, CTs and GPSTs
    - **ROTA ONE**: HRI, Castle Hill Hospital, Millview Court and Lodge, Humber Centre, Westlands & Hawthorne Court
    - **ROTA TWO**: Avondale, PICU, Maister Lodge, Townend Court & Newbridges

Handover is between 21:30-22:00 and is done via our confidential email: 'jnrdoctors'. You will be given access to this in due course.

We do have non-trust, locum doctors who help out with our oncalls. They may not have access to our email handover. Hence, a telephone handover is necessary. Nonetheless, we encourage an email handover be done too, to ensure that future oncall doctors have access to information if certain patients continue to be unwell.

3) **HYBRID ROTA: 22:00-09:00:** Applicable to FY2s, CTs and GPSTs:

The hybrid doctor is on call in 2 separate work patterns, you will carry out at least one of each whilst on your placement.

1) Monday / Tuesday / Wednesday / Thursday. **Friday plus the weekend is rest, and you will return to work at 9am Monday morning.**

2) Friday/ Saturday / Sunday. **Monday & Tuesday will be your rest days and you will return to work at 9am on Wednesday morning.**

WEEKEND ONCALLS: 09:00-22:00: Applicable to FY2s, CTs and GPSTs:

Similar to the evening oncall, there is a rota one and rota two doctor. Handover is at 21:30 via email, unless there are any emergencies requiring your immediate attention.

TEACHING

We have a weekly psychiatry teaching programme, held every **Wednesday morning at the lecture theatre in Castle Hill Hospital**. This involves external speakers, Consultant teaching as well as presentations by junior doctors. You will have been given a timetable for the teaching programme over the next 6 months. Please keep a note of what you have been allocated to

CASE CONFERENCE

These involve trainees (FY2+) presenting a patient whom them have been involved in the care of during their placement. You will present a full psychiatric history and then present on an aspect of the case you found interesting or something that you feel may be a useful teaching point. There will be a case chair who will usually be (but not always) your Consultant Supervisor. Nonetheless, your supervisor should be present to aid you with questions you may be asked. It is your duty to inform your supervisor of the date of your presentation.

GUIDELINES for CASE CONFERENCE

- Trainee to identify case with consultant supervisor (4 weeks)
- The case is one that, ideally, you know well. It needn't be complicated, rather anything you (and your Consultant Supervisor) feel has an educational value
- Please ensure that first slide has name and date of presentation
- As a guidance the usual format is the history (see under history taking), mental state examination, current management and presentation & a useful teaching point from the case
- Discuss case presentation with consultant supervisor (~3 weeks)
- Case presentation should be sent to Consultant supervisor, chair and Sally Morell-Witty (1 week before)

- Arrive early on the day of the presentation to ensure IT equipment is working

- Ideally, your Consultant supervisor will be in attendance to support you during presentation. If they can't attend, discuss the details of your case with the chairing Consultant

After case conference

- Verbal/written feedback from the chairing Consultant
- Meeting with consultant supervisor to discuss how the conference went
- Request chair or consultant supervisor to complete a Work Place Based Assessment

If you are unable to present on your allocated date, swap with another trainee and Sally. If case conference is cancelled this MUST be discussed with college tutor and consultant supervisor who will make entry into trainee education portfolio.

JOURNAL CLUB

Trainees, FY2s+, will be allocated to 'type' of journal to be studied. These can include:

- Randomised Control Trials
- Qualitative Studies
- Case-Control Studies
- Cohort Studies

Sometimes it may be specified what type of study you have been allocated to. If not (it reads just 'JC' by your name) contact Sally and ask her is there a specific type of study you have been allocated to.

The following website:

http://www.casp-uk.net/

has been very useful in breaking down how to appraise a paper, and you can use it as a framework for your presentations.

Balint Group

Balint group takes place every Wednesday, 11:15, after teaching in the lecture theatre at Castle Hill Hospital. This is attended by FY doctors, GPSTs & CTs.

This is a case-based discussion on psychodynamic principles. Attendance by all training doctors is mandatory. It is a requirement of training and for completion of competences for psychiatry trainees. CTs are able to obtain a CBDGA from this and it can suffice as a Case Based Discussion (CBD) for FYs and GPSTs.

NOTE: Balint group starts sharply at 11:15 and is for one hour

NOTE: You may not wish to attend if you are the oncall day doctor. Phones are to be turned off during Balint group.

If you are unable to attend teaching and Balint group, please let Sally know. A register is taken at Balint group and sent to Rosemary Jones, whom is the Medical Secretary working at Rank House, Victoria House in the Specialist Psychotherapy Services.

Audits

Your Consultant supervisor is the first point of contact when it comes to audits: it is easier to pursue an audit (particularly something new you feel may be worthy of auditing) with the backing of your Consultant Supervisor. Hence, do get them to co-sign emails and proposal forms you put forward. You can gain access to the audit department's webpage via the intranet:

- **Home> Directorates> Nursing and Service Delivery> Clinical Audit**

It is advised that you contact the clinical audit department as soon as possible by email HNF-TR.clinicalaudit@nhs.net or telephone 01482 301728**.** Thereafter, you will need to submit an audit proposal. The link to this is available via the trust intranet page (as above).

The two main points of contact within the audit department are Jane Foster and Allyson Kent. Jane's contact details are as follows:

Jane Foster (Information Officer) 01482 301728

janefoster3@nhs.net

The Trust is currently in the process of promoting Quality Improvement Projects across its services. The guidance and template for this kind of endeavour is still being fined tuned but this should not be a deterrent for those keen to push the QI agenda. Any trainees with a QI idea in mind is welcomed to approach their consultants, the audit department, and Tom Phillips (Deputy Director of Nursing) for support.

Foundation Year 1 Guidelines

FY1 doctors: What they can do:

- FY1s, based on an inpatient unit, can clerk in new patient admitted on to the ward and undertake physical examinations, bloods and an ECG. FY1s can attempt to formulate a management plan (and it'd be encouraged that that they do so!) and run it past a senior doctor (Consultant Supervisor and/or Oncall SpR & Consultant)

- Undertake reviews on the ward (both physical and mental health) in between ward reviews.

- Rewrite drug charts and re-writing medication on drug charts

- Prescribing medications that would normally be prescribed on the medical / surgical wards in their FY1 roles (includes simple analgesia, antibiotics etc.)

- Dealing with physical health issues on the ward, appropriate referrals to other specialties, provided this has been discussed with a more senior trainee / Consultant colleague first (where appropriate)

- Getting familiar with what other disciplines within mental health offers (such as psychologists, Occupational therapists, Support workers..etc)

FY1 Doctors what they cannot do:

- See patients on their own in the community.

- Emergency assessments in A&E or medical wards unless there is direct observation and supervision from Clinical Supervisor.

- Detaining patients in hospital under Sec 5(2) of the mental health act.

- On Call duties in Psychiatry. **However, please do handover and jobs that will need to completed after 17:00 via the email handover system/**

Also, for FYs

- Discuss ALL new admissions or unplanned discharges with Consultant, (including on call consultant). Unplanned discharges (including INFORMAL patients) should be dealt ONLY by FY2+ doctors following appropriate discussion with consultant clinical supervisor or oncall Consultant.

Foundation Year 2 Guidelines

FY2 doctors: What they can do:

- They can do all that an FY1 doctor can.

- In addition, where applicable, they can see patients on home visits in conjunction with other staff (more appropriate in psychiatry of the elderly) as long as issues of risk and safety have been assessed by the supervisor and the trainee is aware of how to deal with risk in an emergency situation.

- On Call duties: Includes Emergency assessments in A&E, detaining patients under Sec 5(2) of the MHA where appropriate – however must discuss with Consultant.

- Although they are able to initiate psychiatric medication, they should consult a senior trainee / Consultant if they do not feel competent enough to do so.

FY2 Doctors: What they cannot do

- As an FY2 unless you are part of the psychiatric liaison team, you will not and should not be asked to provide a psychiatric assessment of an inpatient on a medical ward, during normal working hours.

Also, for FYs

- Discuss ALL new admissions or unplanned discharges with Consultant, (including on call consultant). Unplanned discharges (including INFORMAL patients) should be

dealt ONLY by FY2 doctors following appropriate discussion with consultant clinical supervisor (including on call consultant)

- Junior doctors on call are strongly encouraged to ring the on call consultant (or Higher trainee) for advice.

This is not an exhaustive list so if you do have any queries, please liaise with your Consultant Supervisors

Child and Adolescent Mental Health Services

- CAMHS covers all patients up to the age of 18.
- From 9am-5pm all calls should go to the CAMHS day team.
- After 5pm, for CAMHS patients (including overdoses, self-harm, attempts at suicide) presenting to A&E, you will be contacted if an assessment is required (usually 'Rota One' doctor as they cover HRI). There is an A&E Hospital Liaison team present, who finish around 8-10 pm. The CAMHS Crisis Team are available 24/7.
- There is no CAMHS inpatient unit in Hull, at present. If a patient does require admission, 'Form 1' needs to be completed (Crisis Team are aware of the form and do know how to complete it). CAMHS patients are usually sent to York.

******YOU MUST ALWAYS RING THE SENIOR CAMHS DOCTOR (via switchboard) TO CONFIRM A MANAGEMENT PLAN AFTER YOUR ASSESSMENT*****

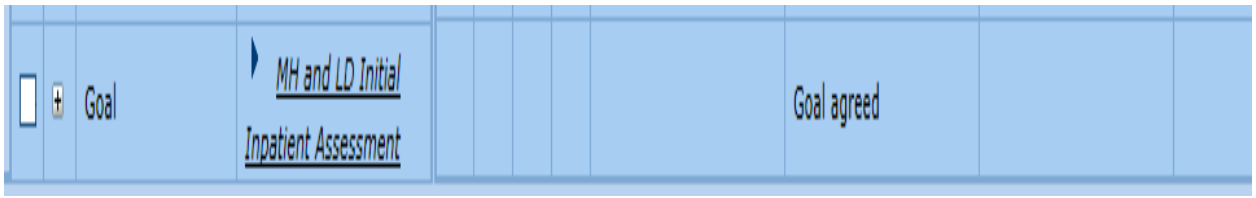
Admissions

- Patients can be admitted to the inpatient wards from clinic, A&E, medical/surgical wards (usually after being seen by the liaison team), Rapid Response & the Crisis Team.
- New patients require a physical examination, baseline ECG (psychotropic medications impact on the heart) and a range of bloods: FBC, BCP (inc. LFTS, Calcium and Phosphate), TFTs, Prolactin, HDL/Cholesterol ratio, HBA_1C.

    - **There can be difficulties, particularly overnight, with delivering blood samples to the pathology lab at HRI owing to fewer staff being available at night time; this may not be an issue at Avondale which is, in very close proximity to HRI. Hence, it is easier for bloods to be taken in the morning. However, if you are concerned about the patient's physical health (not severe enough to warrant a review in A&E) and feel it can't wait until the morning, do take the bloods and ask the ward staff to ring for a taxi for them to be delivered to HRI pathology.**
- It will fall on you, at times, to chase blood results. As these are processed at HRI, they will go up on the 'Hull and East Yorkshire' (HEYH) Lorenzo. It can be laborious to call up the lab to chase up blood results. Hence, if you contact Gary Walton at gary.walton1@nhs.net , with the details of your full name, grade/level of training, the name of your Consultant Supervisor, site where you work and your smart card number he will be able to allow you to access blood results via the HEYH website.
    - However, as many of us have do not have laptops (therefore unable to work remotely from homes) it may fall to you to chase these bloods, whilst oncall, but not on a trust site. In which case, you have to call up HRI switchboard (01482 875 875) and ask to be put through to the pathology lab (01482 607777). **Do not forget to hand these blood results over via email if you are not on the ward.**
- Medication charts should be completed. Current medication can be accessed via Summary Care Record on Lorenzo. Don't forget to ask patients what medication they're on and whether they have brought it with them; their family may be able to help with this too
- Ideally, bloods, ECG & physical examination should be done at the time of admission. However this may not always be possible (patient declines). In this case **please handover to the next oncall doctor what needs to be completed.**
- A capacitous patient consenting to admission is called an 'informal' patient. Otherwise a patient will be detained under a section of mental health act (rarely some people will be in hospital under the mental capacity act).

Admission Checklist

- Log into Lorenzo (you will be given your login details after Lorenzo training)
- You will be taken to the home screen: on the upper left aspect of the screen is a box entitled 'My Work': if you scroll down in it you will see 'Inpatient'. Click on this.
- Under 'Options' on the left, click 'Wards'
- Tick the box next to the required ward, then click 'OK' down below
- A list of patients should come up on the centre of the screen (lime-green in colour)
- Select the patient you want be clicking on their name (sometimes you'll have to wait until the patient has been "admitted onto Lorenzo"
- There will be some tabs along the right hand side. Click 'Structured Care'
- Your screen should then come up with a bar, that says 'Adult MH Inpatient Pathway Care Plan'
- On the left will be tab that says 'List'
- There will be various options about the 'care plan'. Click on evaluate Care plan
- On the left side of the screen will be a need panel. In most cases, you will select 'Adult Mental Health Admission Upto 4 hours'
- This will open up various goals: yours will be **'MH & LD Initial Inpatient Assessment'. Click on the '+' tab.**



- This will open up all that you will need to do during an admission including:
    - Complete Medical Assessment and Mental State Examination
    - Complete Physical examination on admission
    - Complete Supportive observations: incorporates risk assessment & level of supportive observations (CONSTANT, with the patient close by at all times, CONSTANT in sight, intermittent and General) which **needs** to be discussed

with nursing staff. If in doubt, call the oncall SpR or oncall Consultant whom will be more than happy to discuss this with you.

- Complete initial impression and management plan
- Complete VTE risk assessment (this will need to be reassessed at 24 hours and there is a separate tab for this)
- Complete VTE decision pathway

History Taking

PRESENTING COMPLAINT

HISTORY OF PRESENTAING COMPLAINT

PAST PSYCHIATRIC HISTORY

CURRENT MEDICATIONS (INC. ALLERGIES)

PAST MEDICAL HISTORY

FAMILY HISTORY (of both physical and mental health problems)

PERSONAL HISTORY

CURRENT SOCIAL CIRCUMSTANCES

DRUGS / ALCOHOL / SMOKING

FORENSIC HISTORY

PERSONALITY TYPE – PRE-MORBID PERSONALITY

Mental State Examination (MSE)

Mental State Examination

APPEARANCE (e.g. well-kempt or unkempt, signs of self-neglect,)

BEHAVIOUR (e.g. initiating and sustaining eye contact, responding to unseen stimuli, rapport, agitation level, posturing)

SPEECH (e.g. fluency, rate, volume) Also the content of what they are saying, does it make sense? Are they using words in the correct context? Have they made up words [neologisms, seen in Schizophrenia]?)

***MOOD* & AFFECT** (e.g. subjective: what the patient says about their mood. Objective- what you observe about their mood. Affect- the emotional state prevailing in a patient at the time of seeing them)

RISKS: not a definitive list and worth discussing with your Consultant Supervisor (includes risk of self-harm, risk of suicide and risk of harm to others. Also, risk of self-neglect, risk of harm from others [not only physical abuse. Other elements include sexual & emotional abuse, risk of financial and risk of sexual exploitation] Other risks include risk of arson, risk of damage to property, risk of non-concordance with medication, risk of illicit substance misuse and risk related to others in their care esp. if they are carers).

THOUGHT

- ***THOUGHT FORM*** (e.g. loosened associations, flight of ideas, tangentiality)
- ***THOUGHT CONTENT*** (e.g. delusions, persecutory, grandiose, guilt)

[FIRST RANK SYMPTOMS (e.g. passivity, thought withdrawal, thought echo)**]**

PERCEPTIONS (e.g. auditory/visual hallucinations)

COGNITION (consider MMSE)

INSIGHT (e.g. do they consider themselves unwell, willing to take treatment & capacity to consent to admission and/or treatment)

Physical Examination

GENERAL OBSERVATIONS (e.g. weight, height, ataxia, nystagmus, tremor, sweating, anaemia, cyanosis, oedema, clubbing)

RESPIRATORY SYSTEM

CARDIOVASCULAR SYSTEM

ABDOMINAL/GI SYSTEM (including stigmata of CLD)

NEUROLOGICAL SYSTEM (gait, EPSEs, peripheral nervous system- tone/power/reflexes, relevant cranial nerves, pupillary reflexes)

OTHER (anything not covered above but you find clinically important)

VTE RISK (complete relevant section on Lorenzo)

CONSENT TO ADMISSION & TREATMENT

CHAPERONE

Investigations

BLOODS: FBC, U+E'S, LFT'S, TFT'S, LIPIDS, PROLACTIN, GLUCOSE/HbA1C

Additional bloods: Gamma-GT & haematinincs, B12, Folate level for patients with a history of alcohol dependence or harmful alcohol use. You may also want to consider Refeeding bloods for this patient group, as well patients being admitted with eating disorders (Mg^{2+}, adjusted Calcium, Phosphate, U&Es and Vitamin D).

N.B. We are having difficulties with access to blood results (which are processed at Hull Royal Infirmary and hence require a HEYH login) and often have to call the pathology lab for results. This can be laborious**. Hence, it is possible to gain access to HEHY Lorenzo by emailing Gary Walton (gary.walton1@nhs.net)**

Please be aware of your patients who are on Clozapine or Lithium as they require extra monitoring.

- Patients on lithium:
  - Before starting lithium it's essential that you have checked U+Es and TFTs
  - Check lithium levels 5 days after starting lithium or changing the dose
  - Repeat lithium levels as guided by your consultant/pharmacists

- Patients on Clozapine:
  - Patients require ECG and FBC within 7 days before starting Clozapine. After starting Clozapine the CPMS require weekly FBC for the first 18 weeks

URINE – dipstick for infection, urine drug screen

ECG – If a patient is unwell, do ECG immediately. On Avondale, there is no access to the ECG machine out of hours. If you are concerned that they have cardiac sounding chest pain, send them to A&E.

You have to sign paper copies of ECG/blood results for your patients that are kept on the ward. Ask nurses where these are.

- **DRUG CHART** (see Rapid Tranquilisation Guidelines) – Routine prescribing of 'PRN' is NOT encouraged. You may have to check Summary Care Record (get consent from patient) for more information on current medications/allergies. When this isn't available, a fax request to the patient's GP may have to be sent in the morning.

HAVE YOU CONSIDERED ANY OF THE FOLLOWING WHEN ADMITTING A PATIENT?

ALCOHOL DEPENDANCE / WITHDRAWAL / DT's / WERNICKE'S/ SMOKER

(See 'Management of Alcohol Problems on Psychiatric Ward' guidelines available on the trust intranet [under policies, procedures and guidelines]. Beware of Ataxia, Nystagmus/Ophthalmoplegia & confusion: the rare but important triad of Wernicke's encephalopathy)

NEUROLEPTIC MALIGNANT SYNDROME (NMS) – Particularly if pyrexic, on psychotropic medications, labile blood pressure, incontinence, tachycardia, raised white cell count and

raised creatine kinase. **SEROTONIN SYNDROME** (fever, tremor, hyperreflexia, confusion, on SSRIs)

CATATONIA (stupor, immobile, mutism, rigidity, abnormal posturing)

Ring the oncall registrar or consultant on call if you need any help and/or are unsure

Syndromes and Side Effects to know

Prolactin

Patients on Antipsychotics often have raised Prolactin, therefore monitor every 2-3 weeks to ensure they are not having side effects and the levels of Prolactin are below 2000. Prolactin levels over 2000 require assessment:

- Check when depot was given (If recent then most likely due to depot)
- Complete a neurological examination/visual fields (rule out prolactinoma)
- Enquire regarding symptoms of raised Prolactin (galactorrhoea, amenorrhoea etc)
- Contact the medical registrar for advice

Neuroleptic malignant syndrome

Neuroleptic malignant syndrome (NMS) is a rare but potentially fatal neurological complication of treatment with antipsychotic drugs. There is no specific test for NMS and diagnosis is primarily symptom-based. NMS is associated with four classic symptoms: altered mental status, pyrexia, muscle rigidity and autonomic dysfunction. Symptoms of NMS progress rapidly and reach peak intensity about 72 hours after onset.

Biochemical changes

Raised creatine kinase> usually in excess of 1,000 IU/L.

Leucocytosis

Iron deficiency

Liver function abnormalities

Complications

Rhabdomyolysis

Renal failure & Respiratory failure

Seizures

Deterioration of psychiatric disease

Disseminated intravascular coagulation

Management

If you think the patient has NMS then contact the consultant as in the majority of cases you will need to stop the offending drug. Supportive measures are the mainstay of treatment.

Lithium Toxicity

Serum lithium levels should be checked 1 week after starting and 1 week after every dose change and until the levels are stable. The aim should be to maintain serum lithium levels between 0.6 and 0.8 mmol per litre in people being prescribed it for the first time.

For people who have relapsed previously while taking lithium or who still have sub-threshold symptoms with functional impairment while receiving lithium, a trial of at least 6 months with serum Lithium levels between 0.8 and 1.0 mmol per litre should be considered.

Monitoring lithium

Monitor serum lithium levels normally every 3 months.

Monitor older adults carefully for symptoms of lithium toxicity, because they may develop high serum levels of lithium at doses

Monitor weight, especially in patients with rapid weight gain.

Undertake more frequent tests if there is evidence of clinical deterioration, abnormal results, a change in sodium intake, or symptoms suggesting abnormal renal or thyroid function such as unexplained fatigue, or other risk factors, for example, if the patient is starting medication such as ACE inhibitors, non-steroidal anti-inflammatory drugs, or diuretics.

Arrange thyroid and renal function tests every 6 months and more often if there is evidence of impaired renal function.

Initiate closer monitoring of lithium dose and blood serum levels if urea and creatinine levels become elevated, and assess the rate of deterioration of renal function.

Monitor for symptoms of neurotoxicity, including paraesthesia, ataxia, tremor and cognitive impairment, which can occur at therapeutic levels.

Lithium should be stopped gradually over at least 4 weeks, and preferably over a period of up 3 months.

Patients taking lithium should be warned not to take over-the-counter non-steroidal anti-inflammatory drugs. Prescribing non-steroidal anti-inflammatory drugs for such patients should be avoided if possible, and if they are prescribed the patient should be closely monitored.

Clozapine

Prior to starting Clozapine, patients require Baseline ECG and bloods within 10 days of administering the first dose of Clozapine. The next sample must then be taken within 10 days of the initial blood sample. Thereafter weekly blood tests are required for the patient for a period of 6 months, then subsequently fortnightly for a period of 6 months. If Clozapine is stopped, patients will require weekly bloods for a month to monitor for any haematological changes.

Metabolic Syndrome

Metabolic Syndrome is a clustering of closely related medical conditions which increase the risk of developing heart disease and diabetes.

The following features comprise metabolic syndrome that increases risk of future adult diabetes and future heart disease:

- Increased blood triglyceride levels
- Decreased HDL cholesterol levels
- Overweight particularly around the abdomen
- Increased blood pressure
- Increased blood glucose level

If a person has been diagnosed with three of the above features they have metabolic syndrome. Check all patients for this using the assessment criteria, as both atypical and second generation antipsychotics can result in metabolic syndrome.

Agitated Patient

- Verbal de-escalation is considered the ideal way to manage patient's agitation but this doesn't always work.
- Oral PRN medications should be offered first (see pharmacy guidelines in doctor's room/wards) for which medications should be used.
- **Please refer to the rapid tranquilisation policy**!
- You can try and familiarise yourself with BNF limits of drugs – some patients are on very high doses of medications. When prescribing please use following for more help:

- Maudsley's prescribing guidelines
- BNF

} Available on the trust's intranet

- Pharmacy guideline

- Pharmacists (they are very knowledgeable and helpful)

Ward Reviews/Rounds & Care Programme Approach (CPAs)

Ward reviews (usually) occur once/week. Any changes in patient's mental state, leave status and medication are commonly discussed. CPA meetings are arranged with the patient's family and other staff involved in the care of the patient. As the junior doctor you may be expected to document the discussion. The Structure of notes varies from person to person but a good example is described below in Table 1.

Date & Ward review was undertaken Attendees Handover: Prior to the patient attending the review there is a discussion with all staff members involved in care of the patient. Discussion: Note down everything that is discussed including any relevant behaviour. This can be chronological or you can split it into sub heading to make it more readable. Like medications, leave, physical, social, capacity etc Metal state exam: include an MSE for each patient, comment briefly on each of the following sections: ▪ Appearance ▪ Behaviour ▪ Speech ▪ Mood ▪ Perception

- Thought
- Cognition
- Insight

Risk: Risk to self and others

Consent & Capacity: Whether patient has capacity & consenting to take prescribed treatment

Plan: Documenting the plan is essential as the nursing staff rely on this therefore Include all changes made to leave and medication clearly.

** If you have time during the review, document the patient's current medication as this useful for future reference.

Your Consultant (educational Supervisor) will guide you on any aspect you are unsure of.

A care programme approach (CPA) was developed in 1991. It allows health services and social care services to work together to help with the care those individuals with mental health problems whom have been referred to secondary mental health services. It ensures both services put in place appropriate arrangements for the care and treatment of mentally ill people in the community.

The four main elements of the CPA process are:

1. Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
2. The formation of a care plan, which identifies the health and social care required from a variety of providers;
3. The appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care and;
4. Regular review and, where necessary, agreed changes to the care plan.

CPAs will usually be conducted on the ward, prior to a patient discharge. It is a useful learning opportunity and provides you with an opportunity to witness members of the MDT (in-patient and outpatient) working together to help a patient.

A patient wants to leave the ward…

- This often happens with new patients who have been admitted informally, not yet been reviewed by their team, have become or are usually frustrated/agitated and now want to leave ward/discharge.

- Go and see the patient (MSE, risk assessment), check ward staff's opinion and then discuss with the consultant or on-call consultant.

- They may become agitated or upset if you are not able to give them leave. This may escalate the situation and depending on mental state and risks patient may need assessment for a Section 5(2) (see below).

Assessment for Section 5(2)

- Section 5(2) is doctor's holding power for a patient already admitted in hospital for up to 72h. Any doctor with full GMC registration **(not FY1 doctors)** can use it where they feel patient would be at risk if he/she leaves the ward.

- Always discuss with the consultant before signing the paperwork.

- Legally it is not advisable to write per se 'if patient wants to leave put them on section 5(2)', in patient's notes. Each patient is to be assessed individually if the situation arises.

Important points in filling the section 5(2) form:

- Write your full name (not initials) on section papers
- Write full name and address of ward/building
- Don't forget to sign and date the form

You need to cross out parts of the form that are not applicable. After handing over section papers to ward staff don't forget to make a Lorenzo entry about your assessment.

Mandatory Training

Improving Health and Wellbeing

ORGANISATIONAL MENTAL HEALTH MEDICAL MANDATORY TRAINING MATRIX (including junior doctors)

January 2017

All Face to Face courses can be booked via the Trust Training Department, dates & venues are available on the intranet under Training Diary

Subject	Level	Rationale/comments/Further Reading	Frequency / Refresher Period	Method & E-learning title where applicable
ILS (Immediate Life Support)		All medical staff NHSLA & Resuscitation	Yearly	Face To Face

		Committee		
Control of Substances Hazardous to Health (COSHH)	Awareness	Health & Safety at Work Act	Once on commencement of employment and then every 3 years	338 E-learning H&Y COSH Awareness
Defensible Documentation			Every 3 Years	Face to Face
Display Screen Equipment		All Trust staff who use display screen equipment for more than one hour a day at one given time	Once on commencement of employment and then every 4 years	E-learning
Educational Supervisor Training		This does not relate to all doctors but should be completed by those Consultants who have trainees or who wish to be trainers and where this had been agreed through PDP/appraisal.	Every 5 Years	HEE/Deanery YH
Equality & Diversity		Equality Act 2010 Public sector equality duty	Every 3 years	E learning338 Equality & Diversity(e-learning)
Fire Safety Awareness	Awareness	Regulatory Reform Fire Safety Order 2005. Fire code in the NHS Health techniques memorandum	Alternate refreshers via e-learning (i.e. year 1 face to face, year 2 e-learning, year 3 face to face and so on)	000 Fire Safety Awareness
Health & Safety	Awareness	Health & Safety at Work Act 1974 section 2.2 management of Health & safety at work regulations 1999 regulation 10, 13	Every 3 years	338 Health & Safety Awareness 2010
Infection Prevention & Control Awareness		Also hand hygiene assessments yearly (Infection Control Policy)	Every 3 years	Face to Face then alternating between e-learning & face to face (338 infection prevention & control-level 2
Information Governance standard 112 of IG tool kit		Information Governance policy	Yearly	E-learning

Breakaway Training		All medical staff This includes Conflict Resolution which does not need to be done separately	Every 18 months	Face to Face
Mental Capacity Act & Deprivation of Liberty (MCA)	Awareness	All medical staff	On commencement of employment and refreshed every 3 years	Face to face or E-learning 338 mental capacity Act for clinical staff
Mental Health Act		All medical staff	Section 12 approved medics do not need to attend, but must attend NEAP approved refresher training every 5 years to maintain sec 12 status Those doctors who are not section 12 approved must attend training on commencement and refresh every 3 years.	
Moving & Handling	Basic	Moving & Handling Regulations 1992	Every 3 years	E-learning
Paediatric Resuscitation	Paediatric	All medical staff involved in the care of infants and children	Yearly	Face to Face
Rapid Tranquilisation			On commencement of employment and refreshed every 2 years	Face to Face
Safeguarding Adults at Risk	Level 3 (when available, Level 2 should be	All Trust Staff who have any form of contact with patients or carers regardless of the environment in which they	Every 3 years	Face-to-face

	completed until Level 3 is available)	work NHSLA/CQC		
Safeguarding Children	Level 3 or equivalent in the ERSCB - Working Together to Safeguard Children or HSCB - Working Together Effectively (Both 1 Day) Or six hours training taken from a menu of training opportunities that will be provided from April 2016	Staff who need to contribute to multi- agency working on behalf of children and carers (staff must have completed the intermediate training prior to attending advanced)	Every 3 years	Face-to-Face
Prevent	Level 3	DOH Directive	Every 3 years	Face-to-Face at present not available in the Trust please complete level 2
Seclusion			On commencement of employment and refreshed every 2 years	

How to report and incident: 'Datix'

This is the system employed by our trust to report incidents and 'near misses'.

What is an Incident?

- An event or circumstances that lead to, or could have led to, harm, loss or damage which may be physical or psychological harm to a patient, member of staff, visitor

- A near miss is a situation in which something does not develop to cause actual harm - but did have the actual potential to do so. It serves as a learning opportunity

What should be reported?

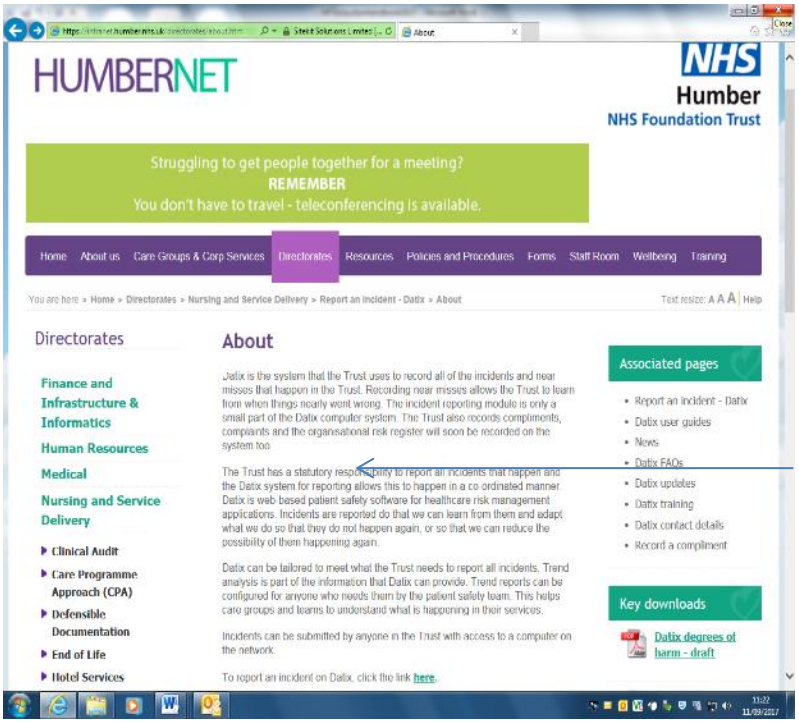
The main types of incidents and near misses that should be reported include:

- Health & Safety incidents, eg slips trips and falls, accidents, fires
- Violence and aggression incidents
- Care pathway & other clinical incidents
- Child protection concerns and incidents
- Confidentiality issues, health records and IT incidents
- Self- harm incidents
- Service user deaths (includes suicide)
- Legal & policy issues, e.g. breaches of policy, MHA issues
- Medication issues and errors
- Security breaches and issues

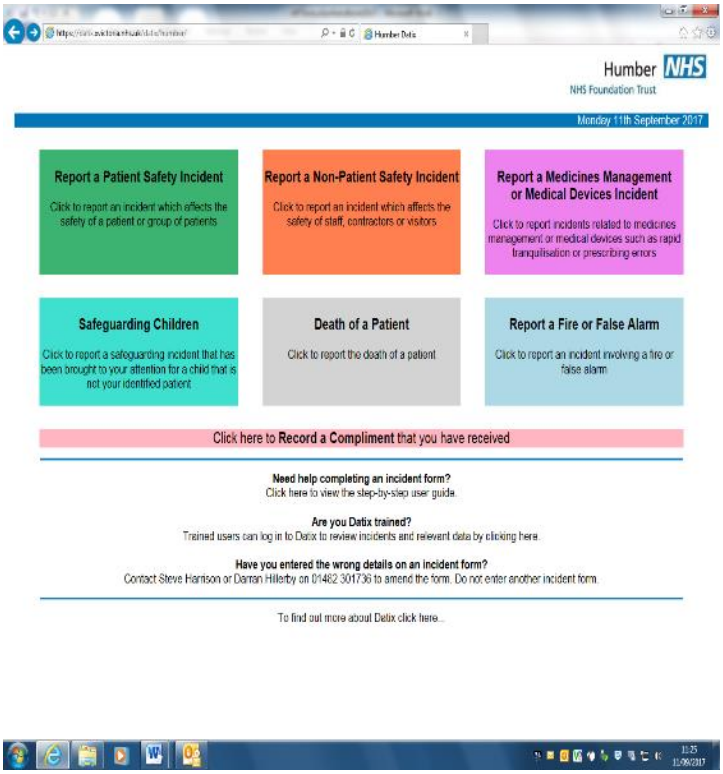
(This list is not exhaustive: always liaise with your Consultant Supervisor)

More information can be obtained via the trust intranet:

- **Home > Directorates > Nursing and Service Delivery > Report an incident - Datix >About**



CLICK HERE



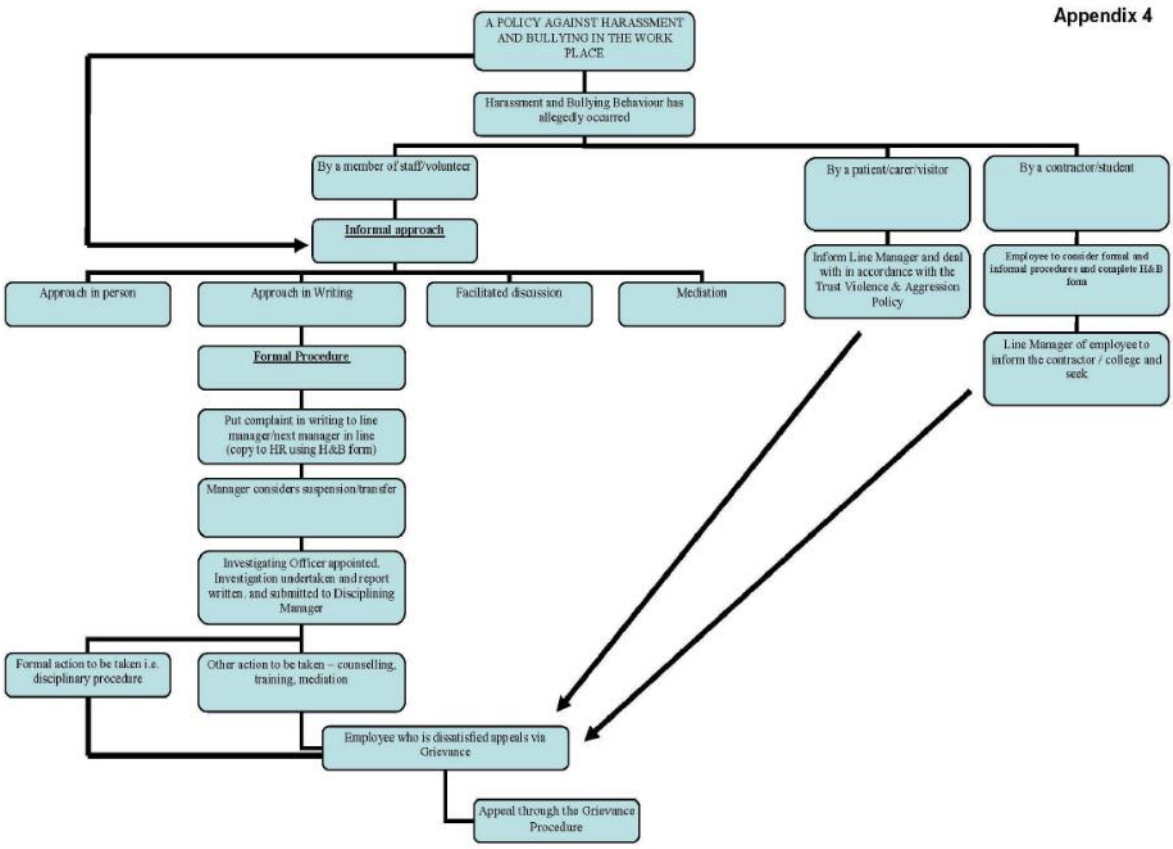
You will be taken to this page. Click on the relevant tile

Policies, procedures & guidelines

A complete collection of the policies are available through Humber NHS Foundation Trust's intranet page. Of particular note are:

- **Seclusion (use of) and long-term segregation**
- **Rapid Tranquilisation (N.B. doses for administered medication aren't given but can be checked via the BNF and/or Oncall Consultants)**
- **Freedom to speak up**
- **Bullying and Harassment Policy**

Appendix 4 - Flowchart



Useful Interactive Links

- Medical Staff Leave Policy Incorporating Study Leave

- ICD 10- For understanding and differentiation of mental illness http://apps.who.int/classifications/icd10/browse/2016/en#/V

- Local Rapid Tranquilisation policy – https://intranet.humber.nhs.uk/policies-procedures-and-guidance2.htm?AccessLetter=R - Please Select the relevant document.

- Local Segregation Policy - https://intranet.humber.nhs.uk/policies-procedures-and-

guidance2.htm?AccessLetter=S - Please Select the relevant document.

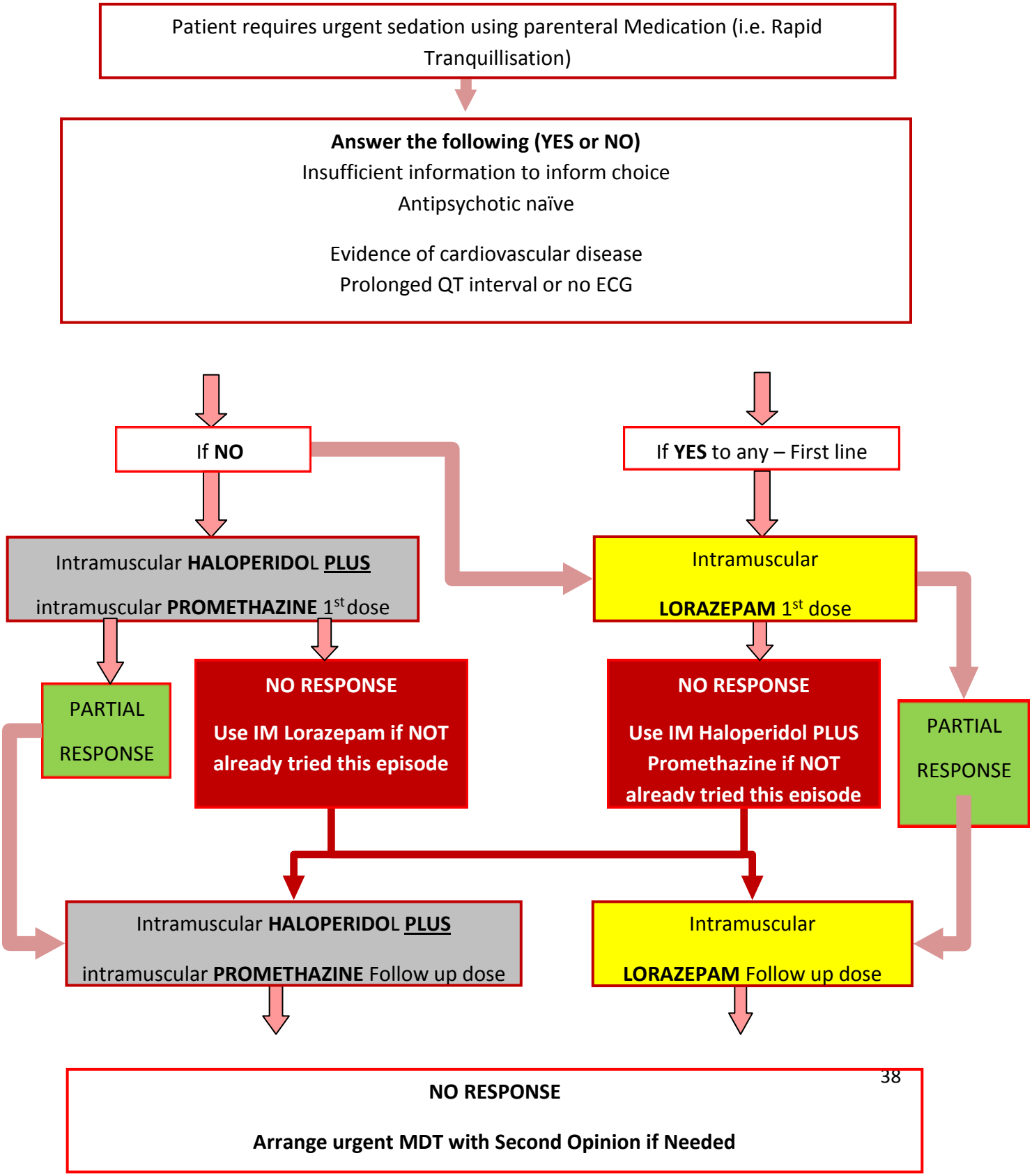
- Local Alcohol and detox management policy https://intranet.humber.nhs.uk/Downloads/Policies%20and%20procedures/Alcohol%20Withdrawal%20on%20Psychiatric%20Wards%20Guideline.pdf

Quick Reference of Antipsychotics and respective BNF max. dose.

ANTIPSYCHOTIC	MAXIMUM LICENSED (Adult) DAILY ORAL DOSES i.e. 100% (daily dose)	MAXIMUM LICENSED (Adult) DAILY INTRAMUSCULAR (IM) DOSES i.e. 100% (daily dose)
Amisulpride	1200 mg	
Aripiprazole	30mg	30mg combined oral and IM. Max 3 injections daily
Chlorpromazine	1000 mg	
Clozapine	900 mg	
Droperidol(disc. 3/01)	120mg	
Flupentixol	18mg	
Fluphenazine	20mg	
Haloperidol	30mg	18mg
Olanzapine	20mg	20mg. Max. course of 3 consecutive days,and a maximum of 3 injections in 24 hours during course.
Oxypertine	300mg	
Pericyazine	300mg	
Perphenazine	24mg	
Pimozide**	20mg	
Pipotiazine		
Prochlorperazine	100mg	
Promazine	800mg	
Quetiapine	750mg or 800mg in mania	
Risperidone	16mg	
Sertindole(named patient)	24mg	
Sulpiride	2400 mg	
Thioridazine	600m	

	g*	
Trifluoperazine	Not stated,45mg suggested	
Zotepine	300mg	
Zuclopenthixol	150mg	max. cumulative dose 400 mg per course and max. 4 injections

Quick Glance: Rapid Tranquilisation Flowchart



Notes to consider:

Caution: Elderly and physical ill or frail patients require lower doses, often between QUARTER to HALF of the standard adult dose (Refer to BNF guidelines for the specific medication). **Remember**: Different dose equivalences for oral and intramuscular medications when calculating concurrent doses.

When prescribing IM haloperidol consider using anticholinergic medication. For first prescriptions of RT write a single dose until effect is reviewed by the doctor. Monitor and record every hour, starting 15minutes after administration. Monitor & record every 15 minutes if: BNF maximum dose exceeded, or, patient appears asleep, or, taken illicit drugs/alcohol, or physical health problems or experienced any restrictive intervention. Record on RT Plan (Appendix 1) and NEWS Chart (See figure 2) **In an Emergency undertake ILS AND dial 9-999.**