# The Junior Doctor's Handbook In Psychiatry

## "The Rough Guide"

Dr Leanne Tozer

Dr Ishaan Gosai

Dr Maung Oakarr

**Version 1/ November 2017**

# Contents


| | | Page |
|---|---|---|
| **Chapter 1**: The Essentials | Pay and Banding | 3 |
| | On Call & Out of Hours Arrangements | 3 – 5 |
| | Teaching and Training | 5 – 6 |
| | Info for Psych Core Trainees | 6 |
| **Chapter 2**: The Structure of Services in Plymouth | The Organisation and its structure | 7 – 9 |
| **Chapter 3**: What you need to know | Admissions to Hospital | 9 – 10 |
| | Mental State Examination | 10 – 11 |
| | Physical Exam and Investigations | 11 – 13 |
| | Formulation and Observations | 13 |
| | Emergency Dept. Assessments | 14 – 16 |
| | Risk Assessment | 16 – 17 |
| | CAMHS | 17 – 18 |
| | OPMHS (Old Age Psychiatry) | 18 – 20 |
| **Chapter 4**: On the Wards | ECT | 20 – 21 |
| | Management Acute Disturbed Patient | 22 |
| | Rapid Tranquilisation | 23 |
| | Therapeutic Issues and Emergencies | 23 – 26 |
| **Chapter 5**: Discharge from Hospital | Discharge summaries and Follow Up | 26 |
| | Requests to leave hospital | 26 – 27 |
| **Chapter 6**: The Law | Mental Health Act & Mental Capacity Act | 27 – 30 |
| | Confidentiality | 30 |
| **Chapter 7**: | Maps | 30 – 35 |
| **Chapter 8**: | Useful Contacts and Telephone Numbers | 36 |

# Welcome to Psychiatry…

Welcome to Psychiatry, a specialty we hope you will find incredibly interesting and rewarding! Working in psychiatry can be challenging, and this guide book includes tips on how you can keep yourself healthy and happy, and keep your career on track.

This guide book should be used in conjunction with induction programmer.

My main massage is to have a balance in your professional and personal life. If you have any difficulty in any of these areas, do speak to your friends, family, educational/clinical supervisor or college tutor.

We are here to support you!!

Best Wishes,

Dr Maung Oakarr

Consultant Psychiatrist

College Tutor

# Chapter 1: The Essentials

## Pay and Banding

**Pay details:** Please contact the Medical Staffing Department

**Annual Leave Entitlements:** You are entitled to 13.5 days per six month rotation if you are up to Pt 2 on Salary Scale. This rises to 16 days once you are Pt 3 on the Salary Scale.

Annual Leave must be requested six weeks in advance and any Full Shift Commitments must be covered by the doctor prospectively.

**Study Leave:** You receive 15 days per six months whilst in post- if you attend MRCPsych or GPVTS these are counted as study leave. For psychiatric trainees, 5 days private study is allowed per exam.

**Expenses:** You are entitled to travel expenses for any mileage or journeys made during your work day (although not home-to-duty expenses). You will need to contact Medical Staffing to arrange access to the e-expenses system. Claims will only be processed within a three month deadline.

## On – Call Arrangements & Out of Hours Cover

**Junior Doctor On Call "Duty Doc":** 24 hour doctor cover is required at the Glenbourne Unit. This is staffed by a full shift rota.

In hours 9am-5pm: Core Trainee and F2 Doctors (minimum one on site at all times).

Out of Hours: Twilight Shift 4pm-9:30pm Night Shift 9pm-9:30am

Shifts overlap to allow handover between doctors, psychiatric liaison and to allow follow-up arrangements to be made.

During full shifts, you must remain on the Derriford Site. You cover:

1. The Glenbourne Unit: Acute Adult Inpatient
2. Derriford Hospital (Incl. Emergency Department)
3. Plymbridge House: CAMHS Inpatient Unit

Cover for full shift rota is prospective and it is your responsibility to arrange swaps in order to facilitate any leave. Please discuss with your consultant and medical staffing prior to any swaps.

**Speciality Doctor Twilight Rota:**

5pm- 10pm Monday to Friday
9am – 9pm Saturday and Sunday

Primarily duties are to assess emergency referrals not requiring Mental Health Act Assessment, to provide cover and clerk admissions for psychiatric inpatient units aside from those covered by the “Duty Doc”.

## Supervision On – Call

1. **Consultant On-Call:**
   - Available from 5pm to 9am on Weekdays
   - Available from 5am Friday to 9am Monday at weekends

The rota is available from Medical Staffing and details available out of hours via Mount Gould or Derriford Switchboards. The on-call consultant can be contacted via switchboard. The on-call consultant can be busy on the wards or completing Mental Health Act Assessments in the Place of Safety Suite, Police Cells or someone’s home so don’t be shy of leaving a message for them to call you back when they are available.

It is encouraged that you make contact with the Consultant On-call between 9-10pm to introduce yourself. This aims to overcome historical trainee concerns regarding making contact with the consultant as needed overnight, particularly early in the rotation.

2. **Home Treatment Team:**

Overnight, you will be working with a member of the Home treatment Team nursing staff. They should attend patients of working age and Plymouth GP in the Emergency Department with you and can be a useful source of information overnight. The HTT gate keep in the inpatient beds in Plymouth.

3. **Liaison Supervision:**

Wednesdays 10-11am LCC Meeting Rm

## Out of Hours Information Sources

A. **Plymouth Patient:** Information via SystmOne

B. **Devon Partnership Patients:** Information held via CareNotes available from CRS during office hours. Out of Hours: Night Nurse Practitioner at Torbay Hospital available via Torbay Hospital Switchboard

C. **Cornwall Patients:** Before 8pm East Cornwall Home Treatment Team can provide background information. They are based at Trevillis House. Overnight, countywide information can be obtained from the Home Treatment Team based at Bodmin Hospital

**Mental Health paper records are held separately from physical health notes. They are stored at Hatfield House and can be requested via your secretary.**

SystmOne access is available via SmartCard which will be issued once you have completed the mandatory training (usually done as a part of induction). SystmOne issues can be dealt with by calling 35000 for the SystmOne Helpdesk.

## Teaching and Training

**Weekly Teaching:** Wednesdays 9am- 1pm LCC Meeting Rm, MGH

| | |
|---|---|
| **9am:** | Balint Group- Facilitated by Dr Adams and ST4 – 6 (TBC)<br><br>Once monthly, DBT Theory with Dr Diamond in this slot |
| **10am:** | Liaison Supervision- Facilitated Dr Gosai/Dr Clifford (2nd & 4th Wednesday of each month)<br><br>First Wednesday of the Month- Clinical Practice<br><br>Trainee Committee Meeting 3rd Wednesday of Month |
| **11am – 1pm**: | CPD Programme<br><br>Rolling rota including Journal Club & Case Conference |

**MRCPsych Course**

Module based Peninsula Deanery-wide teaching programme designed to support psychiatric trainees with their learning and progress through their College Membership Examinations.

Course Administrator: Becki Flower (Devon Partnership Trust)

Scheduled Fridays 10am – 4pm at various venues

Details are emailed to Core Trainees and posted on the course Facebook Group page: "Peninsula Psychiatry Trainees and Consultants".

It is compulsory for Psychiatric Trainees to attend an approved course and attendance is monitored.

## Courses and Mandatory Training

Psychotherapy Training:

CT1

- Basic Counselling Skills Course
- 2x Short Counselling Patients
- Supervisor: Shahin Popple
- WPBA's- SAPE
- CBDGA completed at Balint Group

CT2/3

- Psychodynamic Psychotherapy
- Series of Theoretical Seminars
- Long Case Individual Therapy patient for 30 sessions
- Fortnightly Clinical Supervision
- Supervisor: Deena Northover
- WPBA's- SAPE and PACE

Mandatory Corporate Training is facilitated in the Training and Professional Development Team, located on the top floor of the Beauchamp Centre, Mount Gould Hospital. **Tel: (4)35150**

**Breakaway Training:** This course teaches you to safely break away should a patient attempt to attack or restrain you. It is mandatory for all patient facing roles. It is different to Physical Intervention Training (undertaken by ward staff) which teaches team restraint of disturbed patients.

**Child Protection Training**: Level 2 is the minimum requirement in psychiatry. Level 3 Child Protection Training is required if you are working directly with children i.e. in a CAMHS setting.

## Information for Core Psychiatry Trainees

Clinical progress in Psychiatry Training is assessed yearly at the Annual Review Clinical Progress (ARCP) panel, as in other specialities, held in June.

Throughout the year, you are expected to build an online Royal College of Psychiatrists Portfolio for review at ARCP. This is available through the RCPsych Website. As a part of your assessments you are expected to complete Work Place Based Assessments in the following minimum numbers:

**CT1:**

- Case based discussions: x4
- Mini- ACE: x4
- ACE: x2
- CBD- Group Assessment (Balint): x2
- Multi-Source Feedback: x2

**CT2/3:**

- Case Based Discussions: x4
- Mini-ACE: x4
- ACE: x4
- Multi-Source Feedback: x2

Additionally, per placement (six months) you should be writing a minimum of two reflective pieces, completing an audit and undertaking either a case presentation or journal club presentation (both are required for each ARCP). A case log of Out of Hours Contacts should be maintained with a minimum of 50 out of hours cases logged.

# The Organisation and The structure of Services

The service is provided by Livewell SW (formerly Plymouth Community Healthcare) which incorporates Mental Health, Care of the Elderly and Rehabilitation Medicine under its umbrella.

Psychiatric Services are divided into:

1) **Child and Adolescent Mental Health Service (CAMHS)**
   This service is largely based at MGH with 'The Terraces' being the base for the neurodevelopment team, the Young Persons Centre and 'Revive' which houses outpatients and therapy space. There is a Tier 4 inpatient unit, Plymbridge House, and Under 18's Place of Safety Suite near the Derriford Site.

2) **Older Persons Mental Health Service (OPMHS)**
   Outpatient services are based on the MGH site at patients are cared for by either the Functional Team or the Memory Pathway.

   Inpatient Services are similarly broken down into Cotehele Ward (Functional) and Edgecumbe Ward (Memory/Organic). These wards are both sited at Mount Gould Hospital.

3) **Learning Disability**
   This service is based at Westbourne Hospital and provides care to adults with Intellectual Disability.

4) **General Adult Psychiatry**

   **Community Mental Health Teams –** Plymouth is covered by four geographically orientated teams with allocation being determined by the patients registered GP surgery. If patients are not registered with a GP, a weekly rota for allocation is maintained and can be accessed via CMHT managers.

| **South CMHT at Avon House, MGH** | **East CMHT at Plympton Clinic** |
|---|---|
| Main 01752 435382 | Main 01752 435212 |
| Duty 01752 435389 | Duty 01752 434459 |
| Fax 01752 314744 | Fax 01752 314465 |
| **West CMHT at Avon House, MGH** | **North CMHT at Southway Clinic** |
| Main 01752 435249 | Main 01752 434447 |
| Duty 01752 434691 | Duty 01752 434457 |
| Fax 01752 314744 | Fax 01752 315882 |

**Adult Inpatient Services at the Glenbourne Unit**

Acutely unwell adults are nursed on single sex wards at the Glenbourne Unit, which is on the Derriford Hospital Site.

Plymouth patients are admitted via the Home Treatment Team. There are beds available for use by Devon Partnership Trust's Crisis Resolution Service (CRS) and the Assertive Outreach Service with the patients under these teams being managed by the respective teams psychiatrists rather than those on the ward. The junior doctor cover relates to the ward rather than a specific consultant.

Glenbourne houses the ECT suite with treatments occurring on Monday and Thursday mornings for both in and outpatients.

The Adult Place of Safety Suite is also at the Glenbourne Unit. It is located on the lower level to the right of the main entrance or via a door next to the entrance to Bridford Ward. The majority of S136 arrests will be taken here although a small minority will be held at Charles Cross Police Station due to level of aggression.

**Home Treatment Team**

Provide intensive short term support for people at times of particular need as an alternative to hospital admission. The team works 24 hours a day, 365 days a year available via switchboard out of hours for staff and patients. HTT gate keep admissions to Glenbourne. Tel No:

A member of HTT staff is based at Glenbourne overnight and works with the Duty SHO to see Plymouth patients of working age in the Emergency Department. HTT staff can also visit patients on their caseload at home overnight with their 2nd on call.

**Assertive Outreach Service (AOS)**

Manage patients with severe and enduring mental illness that struggle to engage with traditional CMHT settings. They provide intensive long term support for people with complex needs. The AOS is based on the top floor of Riverview, Mount Gould Hospital

**Insight (Early Intervention Service)**

Provide assessment within two weeks of referral and, if taken on, provide support and treatment of people with emerging psychotic illness for a period of up to three years.

Insight is based at The Zone, Union St, Plymouth. 01752 206626

**Icebreak (Emerging Personality Disorder Service**)

Provide support for young people with emerging personality disorder. Also based at The Zone.

**Personality Disorder Service**

Outpatient DBT Model of Care for people with Personality Disorder. Based at Riverview, Mount Gould Hospital.

**Psychotherapy Services @ Centre Court, Exeter Street**

Provide CBT, EMDR, family therapy, psychodynamic psychotherapy, narrative therapy and music/art therapy. There is a New Horizons group for those whom have suffered sexual abuse. Plymouth Options (IAPT) is also based here.

**Recovery Services**

Inpatient Recovery beds are situated:

- Greenfields Unit, MGH: 9 bed inpatient recovery unit
- Syrena House, Plymstock: 9 bed male recovery unit

Community Recovery Team provides support once people have completed their inpatients recovery stay to support the transition back to community living.

Lee Mill Low Secure Hospital also sits within recovery services and provides inpatient care for 10 male patients. This is on a separate site near in Lee Mill, near Ivybridge.

**Harbour Community Drug and Alcohol Service**

This multi-disciplinary team is for people with substance abuse difficulties. People may be open to both mental health services and Harbour. There is a Complex Needs Team based within Harbour for patients with Dual Diagnosis. There is psychiatric medical input available at Harbour for reviews and prescribing.

There are multiple other wards based on the Mount Gould Site that provide physical healthcare and rehabilitation to patients. There should not be a requirement for you to attend these wards whilst working in psychiatry.

There are Psychiatric Liaison Nurses at both Derriford and Mount Gould Hospitals whom manage referrals from inpatient services to psychiatry.

# What you need to know

## Admissions to Glenbourne

Most patients admitted will have been seen by the Home Treatment Team or had a Mental Health Act Assessment. There may also be information about patients on SystmOne. You need to complete a unified assessment, complete a physical examination, blood tests and an ECG for all new admissions. If the patient refuses any part of the admission, this needs to be documented and handed over to the next doctor to follow up.

The Unified Assessment Proforma is available on SystmOne under the ‘Glenbourne Unit’ tab of the Blue Star Icon.

<u>How to Complete a Unified Assessment</u>

Basic information is auto-populating. Add Mental Health Act status as appropriate in the top dialogue box.

- Reason for Referral: A brief summary of the concerns raised by community staff, MHAA Team, relative or patient
- Presenting Complaint: Patient view of reason for admission
- History of Presenting Complaint:
  - Circumstances leading up to admission
  - Duration and course of this episode
  - Psychopathology
  - Associated symptoms
  - Recent life events/triggers
  - Patients explanation of symptoms
  - Specific risks

Examples are really useful in explaining the specifics of any psychopathology or situational events.

- Past Psychiatric History
  - Previous / Established diagnosis
  - Chronological list of admissions
  - Current service involvement
  - Previous episodes managed outside secondary care
- Medical History
  - Current and significant physical illness
  - Previous surgeries
  - Medical sequelae of mental illness
- Medications
  - Names and doses including over the counter
  - Concordance prior to admission
  - Previous drug reactions or allergies
  - Previous successful/failed psychotropic medications
  - Recreational drug and alcohol history- including risk of withdrawal or potential impact on mental state
- Family History
  - Genogram and mental illness in family members
  - Dependants
- Personal and Social History
  - Developmental history, education and employment
  - Social support network and intimate relationships
  - Current accommodation and finances
  - Activities of daily living
  - Life stressors
  - Carers or professional input
- Forensic History
  - Arrests/ Charges / Convictions/ Custodial Sentences
  - Outstanding matters or pending court cases
  - Risk to others

Collateral history is extremely helpful in assessing patients

## Mental State Examination

**Appearance:**

- Biological age, physical condition, self-care. Abnormal involuntary movements I.e. grimaces or tics, dyskinetic movements to tremors. Eye contact. Facial expressions.

**Behaviour:**

- Appropriateness of behaviour, level of motor activity, rapport, apparent anxiety.
- Distractibility, responding to unseen stimuli. Agitation or aggression. General manner and engagement.

**Speech:**

- Rate, rhythm, fluency, tone and volume. Content. Quantity of speech and amounts spontaneous speech

**Mood:**

- Mood- Like the climate occurring over a period of time
- Affect- Like the weather- how they are now
- Comment upon **subjective** (their opinion) and **objective** (your opinion). Include range, depth, congruent and appropriateness
- Anxiety or panic symptoms. Suicidal ideation.

**Thoughts:**

- **Content**- abnormal beliefs, pre-occupations, obsessions, impulses
- Delusions- fixed false culturally inappropriate beliefs
- **Formation**- Formal Thought Disorder, Passivity phenomena, thought insertion/withdrawal/ broadcasting

**Perceptions:**

- Hallucinations (see assessment of perceptions), Illusions, flashbacks, depersonalisation or derealisation.

**Cognition**:

- Attention, concentration. Orientation. Level understanding. Short term and other type's memory. Capacity ?

**Insight:**

- Have they noticed anything wrong? Attribution to illness? Accepting treatment? Willing to remain in hospital?

## Physical Examination

**You know how to do this!**

A baseline physical examination needs to include CVS/Respiratory/Abdominal/Neuro including Cranial nerves/ Musculoskeletal and should be documented like in any other medical job. A set of physical observations is also required. An annual physical should be completed for any patient in hospital over a year.

Make a special note of physical symptoms of mental illness:

- Alcohol or drug dependence
- Eating Disorder
- Metabolic Syndrome
- Neglect
- Hypo/hyperthyroidism
- Extra-pyramidal side effects (Parkinsonian Symptoms)

**Useful signs in Psychiatry:**

- Self-harm injuries
- Parkinsonian Symptoms
- Pupil size (opiates)
- Parotid Enlargement (bulimia)
- Clozapine hyper salivation
- Goitre
- Piloerection
- Needle tracks
- Checkerboard Abdomen (Somatisation)
- Gynecomastia or galactorrhoea
- Lanugo hair (anorexia)
- Russell's Sign (Bulimia)

**ECGs in Psychiatry:**

You will be familiar with ECG's in your usual practice and those in Psychiatry should be examined with no less rigour that you would usually use. All patients should have an ECG on admission and prior to starting any antipsychotic medication

The QTc is the ECG parameter likely to be least familiar to you from your previous practice and is of key interest in psychiatry.
The QT interval is the time between Q and T waves and the QTc is this measure corrected for heart rate. Prolongation of this measure can lead to ventricular arrhythmia and sudden death.

| | **Men** | **Women** |
|---|---|---|
| **Normal** | **<440** | **<470** |
| **Borderline** | **440-500** | **470-500** |
| **Prolonged** | **>500** | **>500** |

A QTc above 500 milliseconds represents a significant risk of Torsades de Pointes. 1 in 10 people with Torsades de Pontes suffer sudden death. Recommended actions for prolonged QTc:

| **QTc** | **Action** | **Refer Cardiology?** |
|---|---|---|
| Normal | None if T wave normal | Consider if concerned |
| Borderline | Consider reduce dose or antipsychotic switch. Repeat ECG. | Consider |
| Prolonged | Stop causative agent and switch medication | Immediately |
| Abnormal T Wave Morphology | Review treatment and consider switch | Immediately |

**Initial Investigations**

- Bloods: FBC/ Renal/ Liver/ Bone /TFT/ Glucose/ Lipids
- If concerned regarding alcohol abuse GGT and haematinics
- Consider re-feeding bloods as required.
- Urinary dipstick and urinary drug screen (kits on the wards)
- Pregnancy test (if any concerns/risk of pregnancy)
- ECG
- Any concerns raised on examination should be investigated as required and referrals can be made to Derriford specialities in the same way as for Derriford inpts: Redtop Referral, Phone or SALUS
- S17 leave is required to attend physical health appointments at Derriford with the exception of emergency situations.
- If you have undertaken a physical assessment and had no concerns, it is helpful to complete a Gym Clearance Form to allow patient access to the onsite gym with Occupational Therapy.

**Risk Assessment of Inpatients**
Consider:

- Intentional risk to self on the ward
- Risks to staff/ other patients
- Risk of harm from other patients
- Triggers for escalation of behaviour
- Vulnerability
- Drug and alcohol withdrawal
- Physical health
- Oral intake- food and fluid charts are available
- Absconding/ AWOL

## Formulation

A succinct summary of the case highlighting key points within the history. The formulation should include predisposing, precipitating and perpetuating factors as well as protective factors across biological, social and psychological domains.

A differential diagnosis should be considered for all patients which can then be reviewed with the consultant in MDT ward round. This provides an opportunity to highlight both psychiatric, physical and social problems currently arising for the patient.

## Supportive Observations

Level 1: Constant Observations

This is usually on a 1:1 basis at either ‘Arms Length’ or ‘Line of Sight’. Usually used for the most high risk patients on the open wards. Higher staff ratios are occasionally used but this should prompt consideration of escalation of care to Psychiatric Intensive Care at the earliest opportunity.

Level 2: (X) minutes intermittent observations

There are intermittent observations where staff check on the patient at pre-determined intervals from 5 minutes upwards. Usual intervals include 5/10/15/30 minutes and vary according to risks around the particular individual at the time.

Level 3: General Observations

Baseline level intervention where checked hourly and whereabouts should be always known i.e. coffee shop, OT etc.

## Assessment in the Emergency Department

We have considered the in depth assessment required on admission but you are also required to assess presentations to the Emergency Department and on the wards of Derriford Hospital.

You should not routinely see Under 18's and they should be admitted for review by the CAMHS Outreach team (COT) when they are next available (usually the next working day but they do work some weekends). However, you may be asked to review CAMHS patients if they are attempting to leave hospital or on request by, and with support from, the CAMHS Consultant on call.

When assessing crisis presentations, collateral and background information is invaluable (see page 5 for sources).

A proforma for Psychiatric Liaison Assessments is available in the induction pack, on SystmOne or in the PLN Office.

The assessment in the Emergency Department requires much of the same information as the admission clerking process. However, the focus of assessment is the current presentation and risk assessment of the situation. Management plans made in the Emergency Department tend to be focused on management of acute risk and arranging appropriate follow up for the patients.

It is highly unusual to start medication in the ED and the focus is more triage for admission and signposting for onward care. A validating experience in the ED may be enough in the crisis situation but follow up by CMHT, CRS, HTT or admission can be arranged. Admission is arranged by referral to the HTT.

**Assessing Anxiety**

- When did the symptoms begin?
- Were there any precipitants, triggers or trauma?
- Are the symptoms constant or fluctuating?
- Are there any particular situations that make it worse?
    - Social events?
    - Enclosed spaces or leaving the house
    - Meeting new people
    - Reminders of trauma
- How is anxiety experienced for the patient?
    - Physical or somatic symptoms, Thoughts and Emotions
- Have they ever had a panic attack?
- Do they have intrusive thoughts that keep coming even if they try to push them away?
- Any repetitive behaviours or rituals?

- Experience flashbacks or nightmare?

**Assessing Mood**

- Is the mood low, elated or irritable?
- Is mood stable or labile?
- Do they get enjoyment out of activities?
- Do they have plans or hopes for the future?
- Do they have special powers or gifts?
- Biological symptoms of depression:
    - Early morning waking/ late somnolence
    - Subjective appetite change or weight change
    - Libido
    - Concentration and memory
- Ask about energy levels- both increased and decreased
- Ask about suicidality and passive thoughts about death
    - See (INSERT PAGE) for details suicide risk assessment

**Assessing Overdose**

- Have they been medically assessed and deemed medically fit for discharge?
- Are they intoxicated or under the influence of any substances?
- What did they take? Where did they get it from?
- Did they take everything they had available to them?
- How were they found?
- Did they alert anyone to their actions or seek help?
- Were drugs or alcohol involved?
- Did they think that the quantity would be lethal?
- Did they regret their actions? At the time? Now?
- Did they have a plan to do this today? Or was it impulsive?
- How long have they been considering suicide?
- Was this their first attempt? What else had they tried?
- Was there a trigger to action today?
- Was there anyone else involved? Was it a pact?
- What efforts did they go to not to be found?
- What preparations did they make? Note? Finances? Will?

Assess for underlying mental disorder

Ongoing thoughts and risk assessment

Suicidal ideation or thoughts of self-harm without action consider:

- Frequency, prominence and intensity of thoughts
- Methods considered and access to means
- Making of plans and/or preparations
- Previous attempts or DSH.

FULL RISK ASSESSMENT OF INDIVIDUAL CASE REQUIRED

**Assessing Psychotic Phenomena**

<u>Assessing Abnormal Beliefs:</u>

- Do you have any particular worries or concerns at the moment?
- Has anything unusual happened to you recently?
- Do you ever feel people are watching you or following you?
- Is anyone conspiring or plotting about you?
- Do you hear people talking about you in the street?
- Does the TV or radio make special reference to you?
- Are you to blame for any recent events or incidents in the media?
- Do you worry about there being anything wrong with your body?
- Do you receive or hear special messages?

Assessing Perceptual Abnormalities

- Do you see or hear anything that others around you do not?
- Do you hear people speaking to you when no one is around?
- Have you searched for the source of noises to no avail?
- Do you have visions or flashbacks?
- Do you notice tastes or smells that others aren't aware of?
- Have you ever experiences a sensation that you are not real or the world around you is not real or a dream?

Other psychotic phenomena

- Do you ever hear voices commenting on what you are doing? (2nd person) or talking amongst themselves (3rd person)?
- Do you ever hear voices repeating your own thoughts back?
- Does anyone steal or extract thoughts from your mind?
- Does anyone interfere with or insert thoughts into your head?
- Are your thoughts transmitted?
- Are you in control of your thoughts and actions?
- Are your thoughts or feelings being forced on you by anyone?

## Risk Assessment

Areas of Potential Risk to Consider:

- Risk of deliberate self-harm or suicide attempt
- Risk of harm to others
- Risk of offending
- Risk of self-neglect
- Vulnerability from others
- Risk of inciting harm from others
- Risk of Substance misuse
- Physical health concerns
- Driving
- Falls
- Engagement with Treatment and Support
- Access to basic needs- Shelter, Food, Utilities etc.
- Financial abuse or Exploitation
- Domestic Violence

- Sexual Abuse or Exploitation

Protective or mitigating factors:

- What would stop them acting?
- What has prevented them from acting so far?
- Children/Family/Pets
- Engagement in treatment plan
- Hope or ambition for the future

## Suicide Risk Assessment

The most sensitive tool for assessing risk is your own judgement!

The Tool for Assessment of Suicide Risk suggests the inclusion of the following factors in your decision:

√ Gender (M>F)
√ Age 15-35 or >65
√ FHx suicide
√ Chronic medical illness or chronic pain
√ Psychiatric Illness
√ Poor social support/ social isolation
√ Substance Misuse
√ Depressive or psychotic symptoms
√ Hopelessness
√ Worthlessness
√ Anhedonia
√ Anxiety/Agitation/Panic
√ Anger
√ Impulsivity
√ Planning or preparation for attempt
√ Measures not to be discovered
√ Access to lethal means
√ Command hallucinations
√ Current problems insurmountable
√ Previous suicide attempts
√ Grief and recent loss

**CAMHS Extras**

The threshold for CAMHS is 18 years old unlike the paediatric 16 year old cut off. You should not be routinely seeing CAMHS patients in the Emergency Department. Patients should be admitted to the Children's Ward on Level 12 (<16yo) or CDU (16+) at Derriford Out of Hours to be reviewed by the CAMHS Outreach Team the next working day. You may be asked to support if there are any concerns regarding the patients distress or behaviour on the ward or if a young person is unwilling to wait and attempting to leave. Should any situation arise regarding assessment or advice for young people, the CAMHS Consultant on call should be involved prior to your seeing the patient and before any decision making. They are friendly and happy to support you as needed!

At Plymbridge House inpatient unit, you may be asked to provide medical and psychiatric support out of hours. The CAMHS consultant is available via switchboard to support you in this role. There are different management approaches and prescribing practices within CAMHS services so it is always worth consulting with the CAMHS consultant rather than just treating them as you would an adult. Unit nursing staff are available to you for support and a happy to support your consultation and act as chaperones as needed.

Any calls that you receive whilst on call should be referred to the CAMHS Outreach Team or CAMHS Consultant on-call in the first instance if the referrer is unhappy with the standard practice of admission until the next working day.

**OPMHS Extras**

**Dementia:** Generalised impairment of intellect, memory and personality with no impairment of consciousness.

Screening questions should be undertaken in all >65 year olds:

Memory:

- Do you feel you have any memory problems?
- Do you forget appointments or plans you have made?
- Do you remember to take your medications?
- Do others ever tell you are repeating yourself?
- Do you seem to be asking the same questions repeatedly?
- Do you sometimes struggle to find the right word?
- Do you frequently lose things?
- How is your long term memory?
- Tell me about your childhood, work, life events
- Can people understand what you are trying to tell them?

Attention and Concentration

- How do you spend your time?
- Can you focus on things that interest you?
- Can you manage your grocery shopping?
- What help do you need when shopping?
- Do you manage your own finances?

Language

- Have you noticed any change in your ability to write?
- Do you struggle to find the words you want to use?
- Is it the same when speaking?

Self-care

- Are you able to get up and dressed in the morning?
- How do you manage with household chores?
- Has anyone ever raised concerns with your safety cooking or using kitchen appliances?
- Do you have any help around the home?
- Do you feel you need any extra help or support?

Visual Perceptions

- Do you ever struggle to recognise family members?
- Can you recognise objects and colours?

Social Conduct
- How would you describe your personality?
- How would others describe you?
- Are there any situations you try and avoid?
- Have you or anyone else noted change in your behaviour?
- How you relate to and understand the emotions of others?

Orientation and Route Finding
- Do you drive? Car? Mobility scooter?
- Can you remember familiar routes?
- Can you successfully navigate unfamiliar locations?

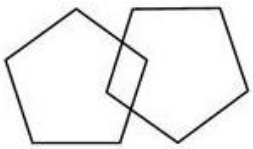
Eating
- How is your appetite? Do you enjoy your food?
- How often do you eat during the day?
- Has anyone mentioned deterioration in table manners?
- Has your weight changed at all?

Mood
- How would you describe your mood? Recent changes?
- How would others describe your mood?
- General assessment for depression

Delusions and hallucinations
- Any worries or concerns currently?
- Anybody out to get you or conspiring against you?
- Unusual experiences that others don't have?
- How do you feel when others don't understand these?
- Perform full psychosis screen

**Mini Mental State Examination**

Patient _____ Examiner _____ Date _____

| *Maximum* | *Score* | |
|---|---|---|
| 5 | | **Orientation**<br>• What is the (year) (season) (date) (day) (month)? |
| 5 | | • Where are we (state) (country) (town) (hospital) (floor)? |
| 3 | | **Registration**<br>• Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat until he/she learns all 3. Count trials and record. Trials _____ |
| 5 | | **Attention and Calculation**<br>• Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward. |
| 3 | | **Recall**<br>• Ask for the 3 objects repeated above. Give 1 point for each correct answer. |
| 2 | | **Language**<br>• Name a pencil and watch. |
| 1 | | • Repeat the following "No ifs, ands or buts." |
| 3 | | • Follow a 3-stage command:<br>"Take a paper in your hand, fold it in half and put it on the floor." |
| 1 | | • Read and obey the following CLOSE YOUR EYES. |
| 1 | | • Write a sentence. |
| 1 | | • Copy the design shown.<br>  |

_____ **Total Score**

# On the Wards

## ECT

If asked to complete ECT paperwork, this is available on the inpatient wards. It is a good idea to know about the procedure and to have seen it so you can explain it to patients/carers. ECT takes place Monday and Thursday mornings at Glenbourne.

**What is ECT?** It is used as a treatment for a small number of severe psychiatric illnesses. It was previously widely used since its development in the 1930's but has been developed and refined since then. It is very different to patient's experiences via television and film but they need to be reassured about this.

ECT consists of electric current being passed through the brain to produce an epileptic fit- research suggests the effect is due to the fit rather than the current but exact mechanism of action is not known. It is theorised that ECT triggers release of neurotransmitters and increases their activity/ability to function. It is thought to stimulate growth of new blood vessels.

An anaesthetic and a muscle relaxant are given to reduce seizure movements that may cause damage to the tissues. Therefore fitness for anaesthetic is a key part of treatment work up.

**Indications for ECT:**

- Severe or refractory depression
- Catatonia
- Mania associated with life threatening physical exhaustion
- Fourth line in Schizophrenia where clozapine failed

Pre- ECT Investigations:

- FBC, U&E,LFT,TFT, Glucose, Lipids
- ECG
- Sickle Test (In high risk groups)
- CXR if clinically indicated
- Lung Function Tests if patient has COPD

Contraindications

- Uncontrolled cardiac failure
- DVT until coagulated
- Acute infection
- Recent MI (within 3/12) or CVE (within 1/12)
- Raised ICP
- Unstable major fracture
- Untreated phaeochromocytoma

**Adverse Effects**- Mortality rate same as baseline GA for minor op

**Post ECT Symptoms:**

- Headaches, muscular aches, drowsiness, nausea, anorexia
- Adverse psychological reactions are rare
- Can produce deficits in autobiographical and impersonal memory which improve on completion of course of treatment but some residual deficits can persist.

**ECT under the MHA:**

Emergency treatment can be given under Section 62 of the Act
SOAD required for non-consenting patients detained under MHA in non-emergency situations.

Things to consider:

- Steroids, anticholinergics, insulin and benzodiazepines should be omitted on the morning of treatment
- Many psychotropic drugs lower seizure threshold

A junior doctor should never prescribe ECT- Consultants only!

## Management of the Acutely Disturbed Patient

- Be able to get out of the room where assessment takes place
- Remove potential weapons and missiles
- It is inadvisable to sit face to face with an aggressive patient
- In a confronting or eyeball to eyeball position.
- Don't intimidate patient, e.g. standing over him
- Encourage patient to sit but don't push the point
- Note that many paranoid and agitated people feel more
- Comfortable with a wall behind them.
- Have colleagues present with you or readily accessible. Do not interview in an isolated room where no one can hear you if problems arise.
- Don't dismiss patient. If dismissive attitude or annoyance with patient demonstrated then disturbed behaviour more likely.
- Gather as much information as possible from collateral
- Introduce yourself to patients. Tell them what you are doing and why
- Recognise signs of increasing agitation, anger. Observe body language.
- Don't be afraid of terminating an interview if you feel you are losing control of the situation.
- Agitated patients are best nursed in a quiet low stimulating environment by people whom they have trust for
- Distraction techniques can be helpful
- Explain that it is the behaviour that is the problem and offer opportunity for them to speak to you about their distress
- Glenbourne does not use seclusion, Plymbridge House does use a seclusion suite- there is a policy available on the intranet
- Rapid Tranquilisation should be considered in the context of risk
- Physical intervention should always be a last resort
- Transfer to Psychiatric ICU may be required.

## Rapid Tranquilisation (18- 64 years old)

Other policies are available for differing age groups via the Intranet

| | |
|---|---|
| 1 | Assess physical state Note drug allergies/sensitivities<br>Review patient's clinical record for previous medical history and recent investigations<br>Consider total antipsychotic dosage prescribed (including PRN and Depots)<br>Continue to use non-pharmacological approaches throughout Rapid Tranquillisation |

| 2 | Offer ORAL medication | |
|---|---|---|
| Lorazepam | 1mg to 2mg orally<br>**Wait** 45-60mins. Repeat up to twice more to **maximum dose of 4mg/24 hours** (6mg in extremis) | **Caution in respiratory depression**<br>**Increased risk of cardio-pulmonary collapse with clozapine** |
| **Consider adding one of the following:** | | |
| Haloperidol | 2mg to 5mg orally<br>**Wait** 45-60 mins. Repeat up to twice more or to **maximum dose of 20 mg/24 hours** | **Caution if no known history of antipsychotic use**<br>**Note: Pre-treatment ECG recommended** |
| **OR atypical antipsychotic orally:** | | |
| Aripiprazole | 10mg to 15mg orally<br>Repeat up to maximum 30mg/24 hours | **Consider if neuroleptic-naïve, or no known history of antipsychotic use, or history of unacceptable side-effects from typical antipsychotics**<br>Unlicensed use – on consultant advice only |
| Olanzapine | 10mg orally<br>Repeat up to maximum 20mg/24 hours | |
| Quetiapine | 50mg to 100mg orally (NOT XL) | |
| Risperidone | 1mg to 2mg orally<br>Repeat up to maximum 6mg/24 hours | |

| 3 | Consider INTRAMUSCULAR treatment if oral medication refused or if risk continues | |
|---|---|---|
| Lorazepam | 1mg to 2mg IM<br>Wait 30mins. Repeat up to twice more or to **maximum dose of 4mg** (6mg in extremis). | Caution in respiratory depression.<br>Increased risk of cardio-pulmonary collapse with clozapine |
| **Where there is a serious risk from prolonged restraint add:** | | |
| Haloperidol | 2- 5mg IM<br>Wait 30 mins and then repeat up to twice more. **Maximum 12mg in 24 hours** | NB: anticholinergic may be required<br>**Note: Pre-treatment ECG recommended** |
| **OR (but see note concerning use with parenteral benzodiazepines)** | | |
| Olanzapine | 10mg (range 5mg to 10mg) IM<br>Wait 2 hours and then repeat up to twice more (3 doses in all). Max. 20mg in 24 hours via any route. | **IMPORTANT: caution with benzodiazepines – see note below*** |
| **OR** | | |
| Aripiprazole | 9.75mg (range 5.25mg to 15mg) IM<br>Wait 2 hours and then repeat up to twice more (3 doses in all). Max. 30mg in 24 hours via any route. | |

*Simultaneous injection of intramuscular olanzapine and parenteral benzodiazepine is not recommended. If the patient is considered to need parenteral benzodiazepine treatment, this should not be given until at least one hour after IM olanzapine administration. If the patient has received parenteral benzodiazepine, IM olanzapine administration should only be considered after careful evaluation of clinical status, and the patient should be closely monitored for excessive sedation and cardiorespiratory depression.

| 4 | Other drugs | |
|---|---|---|
| Promethazine Oral or IM | 50mg IM (25mg to 50mg oral)<br>Wait at least 60 mins Maximum dose 100mg in 24hrs. | Note slow onset of action.<br>May be useful earlier instead of lorazepam in benzodiazepine-tolerant patients. |

## Therapeutic Issues

1. **Akathisia:** Unpleasant side effect of antipsychotic medication. A feeling of inner restlessness associated with increased motor activity, especially in the lower limbs. Movements such as constant pacing, inability to sit still, rocking, inability to sit still. Managed by reducing antipsychotic in the first line. If this fails, specific treatment may be required.

2. **Tardive Dyskinesia:** Involuntary repetitive purposeless movements occurring with long term antipsychotic treatment. Perioral movement's most common but also includes axial trunk twisting, torticollis, shoulder shrugging, and pelvis thrusting or hand movements.
3. **Acute Dystonic Reactions:** Acute reaction following exposure to antipsychotics with sustained and often painless muscle spasms producing abnormal postures, oculogyric crisis or opisthosomas. Can last minutes to hours without treatment. Management: discontinue causative agent, IM/IV ant muscarinic agent (Procyclidine 5mg) which should be continued orally for two weeks then tapered off. Prophylaxis may be required at point of re-challenge.
4. **Extra-pyramidal Side Effects:** Common particularly with older generation typical antipsychotics**.** Characterised by Parkinsonism including bradykinesia, rigidity and hypertonia. Can be objectively illicit on examination. Treatment is Procyclidine 5mg PRN up to TDS in the first instance.

## Emergencies

**Neuroleptic Malignant Syndrome:** Rare life threatening idiosyncratic reaction to antipsychotic medication, often seen when increasing the dose or stopping abruptly. Characterised by:

- Temperature >38C
- Muscular Rigidity
- Confusion/Agitation/Altered Consciousness Level
- Tachycardia
- Tachypnoea
- Labile Blood Pressure
- Diaphoresis
- Tremor
- Urinary incontinence or retention

Investigations should include:

- FBC, Renal profile, Liver Profile, Calcium, Phosphate
- Coagulation screen
- Serum CK
- Urinary myoglobin
- ABG, CXR, ECG and consider excl. Meningitis

Stop causative agents, benzodiazepines manage acute behavioural disturbance. Transfer to general hospital urgently.

Symptoms can last 7-10 days with oral medication after stopped or up to 21 days with depot medication

**Serotonin Syndrome:** Rare, potentially fatal, syndrome occurring in the context of serotonergic agents. Characterised by:

- Altered mental state

- Agitation
- Shivering
- Diarrhoea
- Hyper-reflexia
- Myoclonus
- Ataxia
- Hyperthermia

Associated with SSRIs, MAOIs, TCAs, lithium and amphetamines

**SSRI Withdrawal Discontinuation Syndrome:**

- Dizziness, vertigo or light headedness
- Gait instability
- Nausea
- Fatigue
- Headache
- Insomnia
- Paraesthesia
- Visual Disturbance
- Diarrhoea
- Flu like illness

Typically develops after about 5 days, fluoxetine much longer.

**Severe Hyponatraemia** can be caused by antidepressants

## Emergency Treatment of Poisoning/overdose

All suspected overdoses should be assessed by a doctor and transferred to General Hospital where appropriate (most cases!). In emergency situations, Medical Emergency/Cardiac Arrest Calls are available on 2222/3333 as per Derriford. A 999 call is also required to convey patient to Derriford Emergency Dept. (and often arrives before the medical emergency response team). **Note**: mental health nurses have very little physical health training so do not expect them to respond as nurses would in other healthcare settings you have worked in.

Basic Resuscitation equipment is available on inpatients wards and in the ECT suite. This includes ALS drugs, airway and IV access

**For Opiates:** Naloxone Hydrochloride 400mcg IV repeated 2-3 minutes until response. Max 10mg. (IM/SC only if no IV access)

**Indications:** Bradypnoea or coma secondary to opiate use

**Cautions**:
- Physical dependence on opioids
- Cardiac instability

- Short acting- repeat injections may be needed

**For Benzodiazepines**: Flumazenil 200mcg over 15 seconds, then 100mcg at 60 second intervals. Usual 300-600mcg. Max 1mg.

**Indications**: Reversal of sedative effects of benzodiazepines

**Cautions**:
- Dependence situations
- Prolonged benzodiazepine therapy for epilepsy
- Short acting- repeat doses may be needed

# Discharge from Hospital

## Discharge Summaries and Follow Up

Each patient leaving hospital should have a discharge letter sent to their GP. Unlike at Derriford Hospital, these are often not completed prior to discharge but take the form of a detailed handover of the patient's admission and follow up plans.

There is a specific form available for discharge letters available on SystmOne - this can be found under letters, discharge letter

Most patients whom leave Glenbourne are followed up for a period of time in the community by the Home Treatment Team. This is not automatic and the team need to be contacted and the patient handed over. There are specific teams which follow up certain patients (i.e. AOS) and discharges from the Recovery Units usually involve the Community Recovery Team.

It is important to provide as much detail within discharge letters and possible and the minimum content should include:

- Mental Health Act Status
- Working Diagnosis
- Circumstances leading to admission
- Progress on the Ward- including medications trialled
- Mental State Examination at the time of discharge
- Medications
- Follow up plans
- Circumstances around discharge i.e.? Against advice etc.

## Requests to leave Glenbourne

The request to leave Glenbourne by informal patients is a frequent one and each patient must be assessed by a doctor prior to leaving hospital.

The main reason for this assessment is to assess the risk that the patient poses to themselves or the public and their reasons for leaving.

Often patients which to leave hospital because they are frightened or distressed by something on the unit- explore this, provide reassurance and suggest ways staff can support

them to manage their distress- this will sometimes change their mind regarding their wish to leave hospital.

If you feel that the patient poses a risk to themselves or others due to their mental state at the time, you can hold the patient on a Section 5(2) Doctors Holding Power whilst an MHAA is arranged.

The on-call consultant is available for advice and support during these assessments. I would also take a nurse with me to allow MDT decision making in these situations.

Beware of the recently admitted patient that suddenly feels better and wishes to leave hospital- make sure you explore 'What has changed?' with this group.

## Requests to Leave Derriford

You may be contacted about patients at Derriford Hospital with mental health issues that are requesting to leave the hospital. It is not your role to assess these patients but our colleagues are often grateful of some advice in these situations.

Advise them to assess capacity- if the patient does not demonstrate capacity regarding the decision to remain in hospital and/or to receive treatment then the Mental Capacity Act comes into action and the patient can be prevented from leaving in their best interests and Deprivation of Liberty Safeguard Paperwork should be completed. If the patient is providing a rational and capacitous argument for their discharge, the decision making then switches to risk- if the patient is suspected of having a mental health disorder that is impacting upon their decision making and causing the person to be a risk to themselves or others, then the Mental Health Act is required. The consultant in charge of the patients care, or their nominated deputy, can hold the patient under S5 (2) Mental Health Act- paperwork is available from the Derriford Hospital Managers. This allows the staff to prevent the patient from leaving the ward but does not give them the right to give treatment against the patient's wishes.

The Mental Health Act detentions (i.e. S2/3) only give provision for treatment of mental disorder and its direct sequelae. They do not allow treatment for physical health conditions- these would need to be treated in the patient's best interest under the Mental Capacity Act as appropriate.

# The Law

## Mental Health Act

A Responsible Clinician (RC) is the Approved Clinician with overall responsibility for the patient's care- certain decisions can only be undertaken by the RC: Discharge from Section, S17 Leave and Consent to Treatment (T2) are some of these. The Approved Clinician is always a Consultant Psychiatrist locally and has been approved for the purposes of the Mental Health Act by the Secretary of State

Mental Health Tribunals are independent panels that decide whether a detained patient should be discharged or not. They consist of a judge, an independent doctor and a representative lay person.

Second Opinion Appointed Doctor (SOAD) is appointed by the CQC to review treatment plans of patients detained over three months whom do not have the capacity to consent, who are refusing treatment or for ECT.

Mental Health Act Assessment: Arranged by contacting the local (Approved Mental Health Practitioner) Office or Out of Hours Social Services. You can request MHAA if you feel the patient requires admission to hospital due to their mental state and level of risk. Assessments undertaken by AMHP and 2 doctors (one must be Section 12 approved). In order to be detained the doctors must agree that:

a) The patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for a period of assessment or treatment for at least a limited period
b) He or she ought to be detained in the interests of their own health or safety or for the protection or safety of others

## Mental Health Act Sections

**Section 2:** Admission for assessment up to 28 days. Cannot be renewed but can be transferred to a Section 3 if required. Patients can be treated against their wishes, except ECT, but do have the right to appeal.

**Section 3:** Admission for up to 6 months for treatment of known mental health disorder, renewable for 6 months then annually. Appeals to tribunal can be made once per period of detention.

**Section 4:** Emergency admission like Section 2 with only 1 doctor. This is to maintain safety whilst allowing time for second doctor to attend and assess for Section 2. Last up to 72 hours.

**Section 5(2):** Doctors Holding Power of informal patients already admitted within hospital settings. They cannot be used in ED or CDU Lounge as these are classified as outpatient settings. Can only be done by RC or 'Nominated Deputy' which is the ward doctor in hours or Duty Doc OoH. At Derriford, the Medical SpR on-call is the Nominated Deputy Out of Hours. A form must be completed with details of how criteria are met and why informal treatment is no longer appropriate. This must be passed to the Hospital Managers. Lasts 72 hours. Not renewable. The RC or MHAA can discharge from Section 5(2).

**Section 5(4):** Nursing Holding Power for MH nurses which allows them to hold the patient for up to 6 hours to allow time for doctor to arrive and convert to Section 5(2) if appropriate.

**Section 136:** Applicable to mentally disturbed people found in public places and undertaken by police. Maximum 72 hours detention to allow MHAA, person usually taken to Place of Safety Suite or, in certain circumstances, police cells.

**Section 135**: Warrant for search for and removal of patients in private premises. Used if patient suffering from mental disorder and bring ill-treated or neglect; is unable to care for him or herself and lives alone. Magistrates issue this to police officer.

**Community Treatment Order**: The power to discharge a patient detained under Section 3 from hospital subject to them being liable to be recalled to hospital if required. Specifies conditions to which the patient must adhere. If the patient is recalled to hospital, the CTO can be rescinded to a Section 3 if needed.

**Section 17**: Authorised leave from hospital by the RC. In emergency situations, where transfer to general hospital is required- the absence of this form should not prevent transfer.

**Section 117**: Statutory duty on health and social services to provide aftercare for those detained on Sections 3, 37, 47 and 48.

Patients can be discharged from hospital by their RC, Hospital Managers, Mental Health Tribunal or nearest relative (must give notice and can be blocked by the RC via the Hospital Managers)

There are multiple other Sections of the Mental Health Act, largely relating to forensic patients who have specific conditions regarding leave and discharge from hospital

## Mental Capacity Act

**Consent requires:**

- Capacity to consent
- Sufficient information to make the decision
- Consent must be given voluntarily
- Can be withdrawn at any time
- Cannot be given by another unless Power of Attorney

**Capacity to Consent:**

The Patient needs to be able to:

- Understand information
- Retain the information
- Weight up the information
- Communicate their decision

Key principles of the Mental Capacity Act

- Capacity is assumed unless evidence otherwise
- People can make capacious unwise decisions
- Capacity must be assessed for a specific decision
- Capacity is time specific and will vary
- All actions must be taken to support capacity

- Deprivation of Liberty Safeguarding must be considered for anyone lacking capacity whom would be stopped from leaving an inpatient setting should they attempt to and not under other frameworks.

## Confidentiality

Information should not be disclosed to a third party (e.g. relative, partner, police officer or solicitor) without the patients express consent. This does not necessarily need to be in writing but should be clearly documented in the patient's record.

Except where the risk to third parties is so serious that is outweighs the patient's privacy interest.

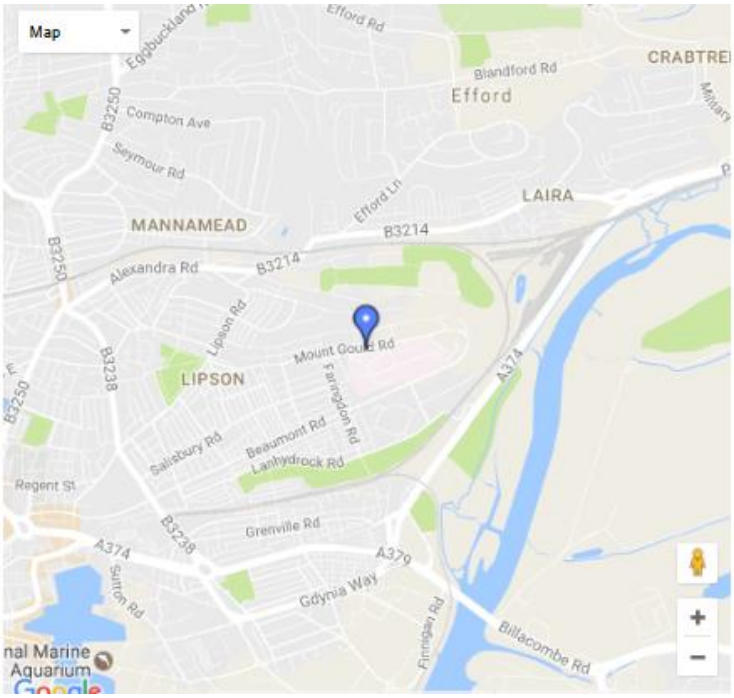
- Prevention or Detection of Serious Crime
- Actions leading to serious harm or death
- Threats of Violence (Tarasoff Case 1969)
- Suspected child abuse

People sometimes think that data protection or confidentiality think that patients relatives or carers should not be spoken to. It is important to explain to people that you are unable to share information with them without the patients consent

However, this does not mean that you cannot speak to them, hear what they wish to say to you and gain information/collateral history FROM them. This is extremely useful in psychiatry and should not be forgone due to misunderstandings regarding confidentiality.

# Maps

### Mount Gould Hospital




Mount Gould Hospital,
200 Mount Gould Road,
Plymouth,
PL4 7QD

Swtichboard: 01752 268011

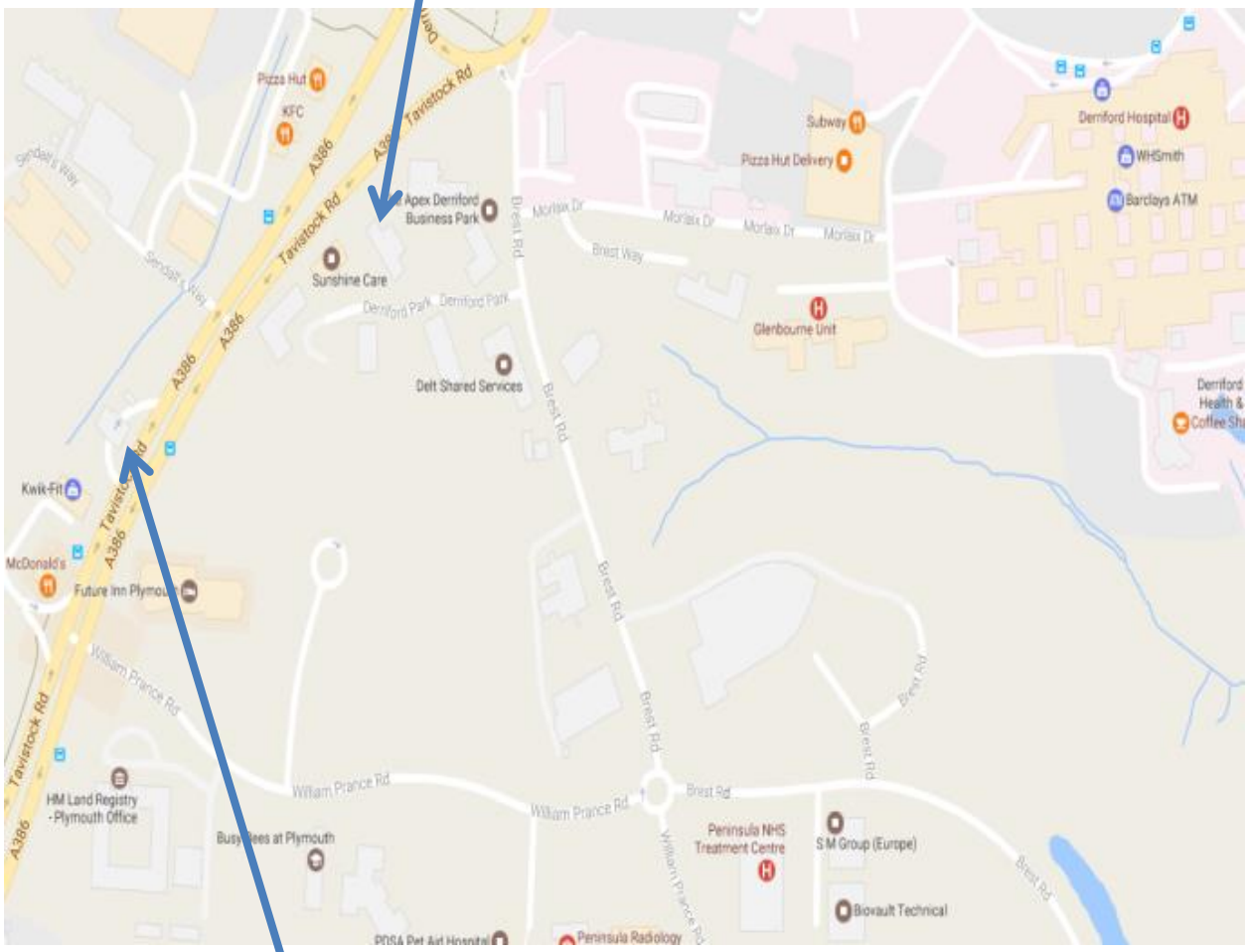
Greenfields: 01752 434145
Cotehele: 35388
Edgcumbe: 35399


Southwest
BEAUMONT ROAD
Local Care Centre
Lower Ground Floor
Terraces
Revive
Erme House
River View
Avon House
Plym
New Heathleigh
Cotehele
Beauchamp Centre
Kingfisher and Skylark
Greenfields
Edgcumbe
The Veranda
Primary Care Centre
Local Care Centre
Outpatients
MOUNT GOULD ROAD
MAIN RECEPTION
Administration
MOUNT GOULD ROAD
3
2
1
Building
Zone
Building
Zone
Building
Zone
Administration
Greenfields
Primary Care Centre
Avon House
Kingfisher
River View
Beauchamp Centre
Local Care Centre
Skylark
Cotehele
New Heathleigh
Terraces
Edgcumbe
Outpatients
The Veranda
Erme House
Plym
Revive
Site Entrance
Bus Stop
Pedestrian Only
One Way Traffic
Building Entrance
Two Way Traffic
Lift
Disabled Parking
Cafe
Parking
Toilets
Information Map

**Glenbourne Unit and Plymbridge House**

Glenbourne Unit, Morlaix Drive, Derriford, Plymouth, PL6 5AF

01753 763103




Plymbridge House, 4 William Prance Road, Derriford, Plymouth, PL6 4ZD

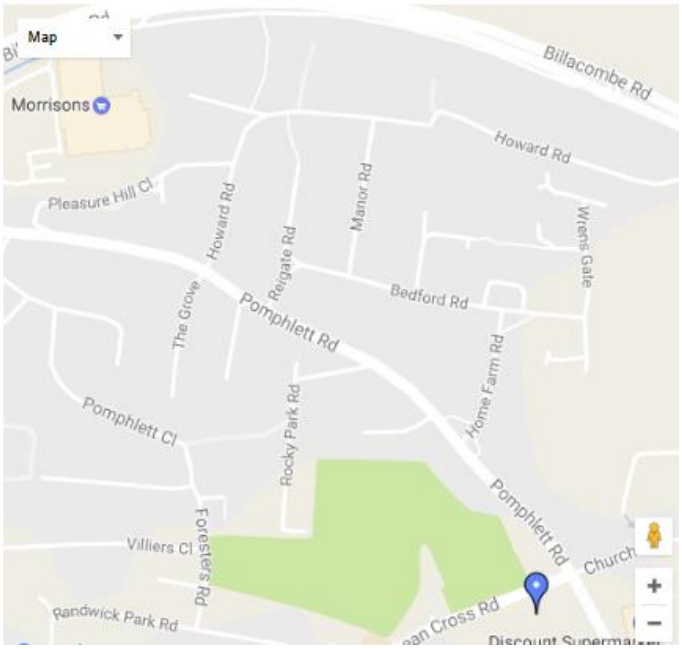
01752 434543

**Lee Mill Hospital**


Beech Road
Lee Mill
Ivybridge
PL21 9HL

01752 314800

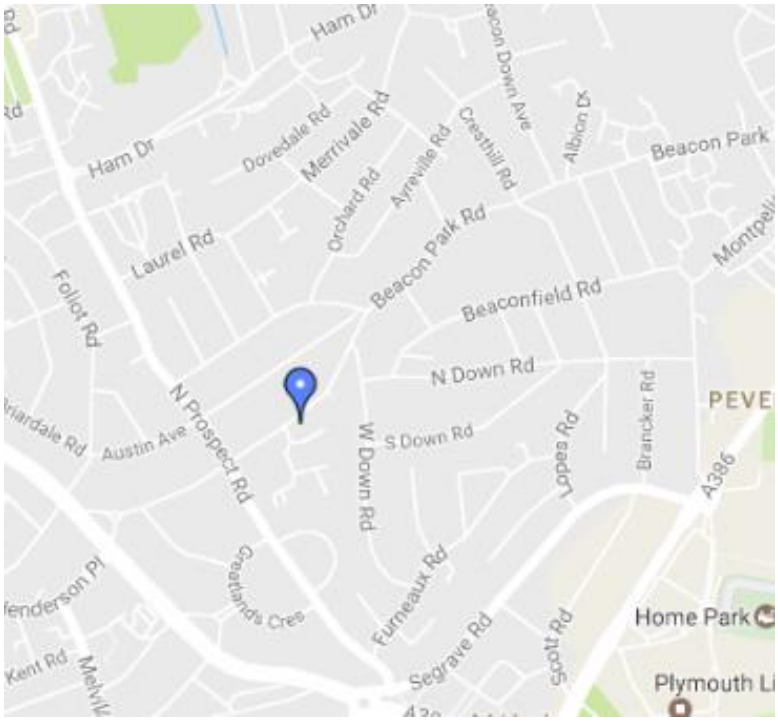
**Syrena House**




284 Dean Cross Road
Plymstock
Plymouth
PL9 7AZ

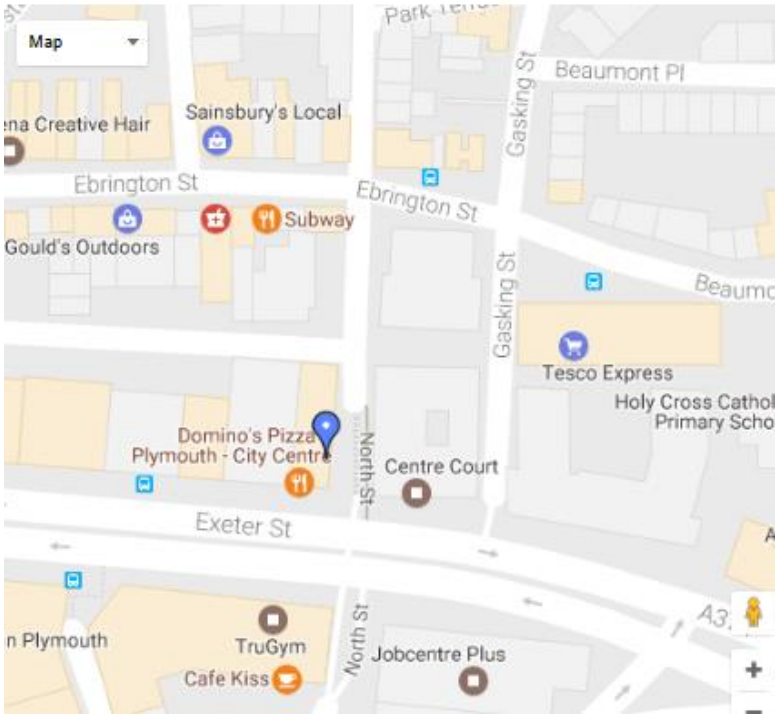
01752 314491

**Westbourne Building, Scott Hospital**



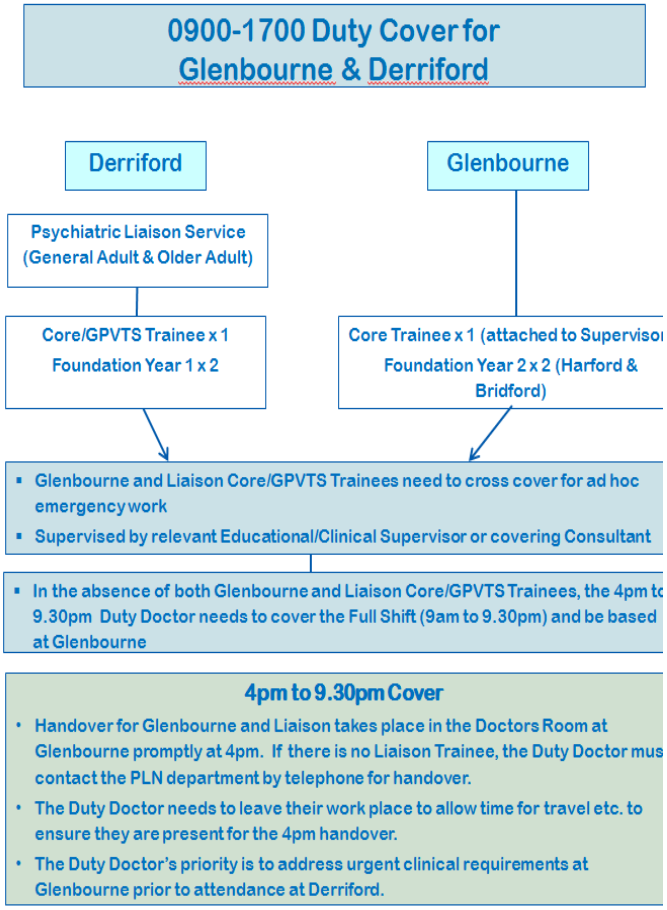

Scott Business Park
Beacon Park Road
Plymouth
PL2 2PQ

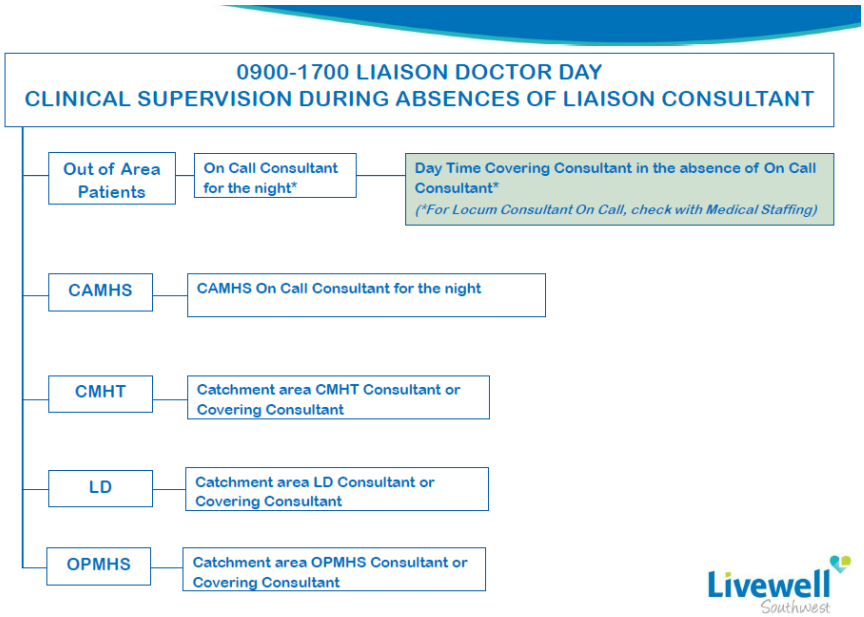
**Centre Court**




Centre Court
73 Exeter Street
Plymouth
PL4 0AH

01752 435419


0900-1700 Duty Cover for
Glenbourne & Derriford
Derriford
Glenbourne
Psychiatric Liaison Service
(General Adult & Older Adult)
Core/GPVTS Trainee x 1
Foundation Year 1 x 2
Core Trainee x 1 (attached to Supervisor
Foundation Year 2 x 2 (Harford &
Bridford)
Glenbourne and Liaison Core/GPVTS Trainees need to cross cover for ad hoc emergency work
Supervised by relevant Educational/Clinical Supervisor or covering Consultant
In the absence of both Glenbourne and Liaison Core/GPVTS Trainees, the 4pm to 9.30pm Duty Doctor needs to cover the Full Shift (9am to 9.30pm) and be based at Glenbourne
4pm to 9.30pm Cover
Handover for Glenbourne and Liaison takes place in the Doctors Room at Glenbourne promptly at 4pm. If there is no Liaison Trainee, the Duty Doctor must contact the PLN department by telephone for handover.
The Duty Doctor needs to leave their work place to allow time for travel etc. to ensure they are present for the 4pm handover.
The Duty Doctor's priority is to address urgent clinical requirements at Glenbourne prior to attendance at Derriford.


0900-1700 LIAISON DOCTOR DAY
CLINICAL SUPERVISION DURING ABSENCES OF LIAISON CONSULTANT
Out of Area Patients
On Call Consultant for the night*
Day Time Covering Consultant in the absence of On Call Consultant*
(*For Locum Consultant On Call, check with Medical Staffing)
CAMHS
CAMHS On Call Consultant for the night
CMHT
Catchment area CMHT Consultant or Covering Consultant
LD
Catchment area LD Consultant or Covering Consultant
OPMHS
Catchment area OPMHS Consultant or Covering Consultant

**Useful Contact Numbers-** For units see maps

**Switchboards**:
**DGH**: 0/ 01752 202082 MGH: 20 **Bodmin**: 01208 251300

**Duty SHO Bleep**: 89855 **Glenbourne Reception**: 53103
**Front Door Code**: 1953
**Harford Ward**: 53121 / 55296
**Bridford Ward**: 53109 / 55291
**Doctors Office**: 53147 / 763147
**POS Suite (Glenbourne**): 53885
**Pharmacy Office**: 39006
**Psychiatry Pharmacist**: 85222 / 85225
**Medical Staffing**: 34609
**Psych Liaison Nurses**: 39297 / 37499 **Bleep**: 89883 **Cotehele:** 35388
**Edgecumbe:** 35399

**ED (DGH**): **Rec**: 52511 / 39745 **Majors**: 52045 / 31322
**Clinical Decision Unit**: 55145 / 57735
**Combined Labs**: 52401 MAU: 39477 /39475
**Clozapine Technician (Derriford):** 39458
**CPMS:** 0845 769 8269
**Tissue Viability: (MGH)** 34757 (**Derriford)** 32717

**Plymouth Home Treatment Team**: 01752 314033 **Fax**: 314022
**Assertive Outreach (AOS**): 01752 435050
**Cornwall Home Treatment Teams**: OoH via Bodmin
**Central:** 0845 230 3900 **West:** 0845 230 3902
**East:** 0845 230 3901 **Fax**: 01872 358743
**CRS (Devon Partnership Trust):**
**Direct**: 692692
**Mobile:** 07772139031 / 07786334418
**Out of Hours:** 0845 6000388
**Fax:** 695043
**Torbay Hospital**: 01803 614567
**Trevillis House**: 01579 373737
**Insight:** 01752 265775
**Icebreak:** 01752 206620
**The Zone:** 01752 206626

**Plymbridge House:** 35278/34639/ 34543
**COT**: 39139
**Devon CAMHS:** 01803 763500 OoH 0845 600 0385
**Cornwall CAMHS**: 0845 2077711

**Duty AMHP:** 306900/308830
**Social Services**: 01752 346984 OoH 01752 668000

**Single Access Referral Centre Cornwall**: 0845 2077711

**DUTY CONSULTANT AVAILABLE VIA MGH SWITCHBOARD**

Notes: