“THE BLUE BOOK”

Seventeenth Edition
August 2015

Guidelines for the Management of Common/Selected Psychiatric Emergencies and Certain Trust Policies and Procedures

Dr Niruj Agrawal
Editor

© The ‘Blue Book’ 2015 is copyright of South West London and St. Georges Mental Health NHS Trust. All rights reserved.
INTRODUCTION

I am delighted to present the revised seventeenth edition of The Blue Book. The Blue Book was first published in 2001. Since the second edition in July 2004, when I took over as editor, new editions were initially published every six months. Its demand has constantly grown over the years and despite printing ever increasing numbers we always ran out of the printed copies.

In 2010 we took the decision to produce new editions on a yearly basis as trainees now start once a year in August. This has allowed us to print a substantially larger number of copies so that the Blue Book would be distributed more widely to the trust staff. Electronic copies of the Blue Book can now be found more easily on the intranet (InSite) either through a quick search or by looking under the policy section. Individual chapters now have a separate link on InSite to make it easier to find information.

The aim of the Blue Book from the outset has been to orientate and inform junior medical trainees and nursing staff, particularly those who are new to this Trust. Its focus has been on clinical governance issues and to introduce individuals to local working practices and relevant clinical policies & procedures. The content of the Blue Book has constantly evolved, based on feedback from readers and emergence of information. Whilst adding new chapters, attempts have been made to keep different sections concise and some of the information had to be deleted so that the Blue Book remains compact and easy to carry. A lot of the information has been presented as flow charts or tables to make it easier for the reader to follow the information.

Seventeenth edition comes after a gap of two years and doesn’t include any new chapters. However, all the chapters have been reviewed by the link authors for accuracy and have been updated if necessary to ensure the information is as up-to-date as possible. With constantly and rapidly changing world, it is possible that as months pass the information on print version is not most up-to-date but the electronic version is updated more often. Please contact the link person for the chapter if you spot something that needs modifying on any chapter.

The Mental Capacity Act 2005, Mental Health Act 2007 and DoLS have been around for a while now. More recent case law particularly following Cheshire west case and its implications have been added to the relevant chapter. All qualified staff including trainees and nursing staff need to be aware of their implications. Section on medico-legal issues provides only a basic summary. Readers should also look at the guidance at DoH and BMA websites and ensure that they have attended the mandatory training.

During editing and production, attempts have been made to ensure that the contents of this book are fully compatible with local policies, advice given by the British National Formulary, various professional bodies and the available clinical evidence. The Blue Book cannot and does not replace the role of clinical supervision and advice from senior clinical staff. Trainees and nurses are advised to seek senior clinical opinion / advice whenever in doubt and consult full copies of relevant trust guidelines or procedures. These are available on InSite or through relevant departments. All trust employees are required to familiarise themselves with these. It is not possible or practical to include all these policies or guidelines in full.
Whilst the focus of the Blue Book remains on new members of staff, it is hoped that it will prove to be a useful quick reference guide to all clinicians of various disciplines. Your comments, suggestions, criticisms and contributions will be extremely helpful in fulfilling the aim of keeping the Blue Book relevant and focused and are greatly appreciated. Can you please direct these to either the link person named at the beginning of the section concerned or to me through email at niruj.agrawal@swlstg-tr.nhs.uk

I would like to take this opportunity to thank all the link persons / authors for their contributions and for keeping their chapters constantly up-to-date. I shall also thank clinical governance department and in particular Maggie Conway for her hard work in liaising with all the link persons / authors and facilitating the publication of this edition.

Dr Niruj Agrawal
Editor
July 2015
## CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>Contents</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Psychopharmacology</td>
<td>Protocol and Guidelines for the Use of Medicines for Rapid Tranquillisation in Adults (age 18-65)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidelines for Rapid Tranquillisation for Young People (6-17)</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidelines for Rapid Tranquillisation for Frail Older Adults (age 65+)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Roles and responsibilities for patient monitoring following rapid tranquillisation</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicines Requiring Special Precautions</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidelines for the Management of Acute Dystonia</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guidelines for the Management of Neuroleptic Malignant Syndrome (NMS)</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lithium Therapy Summary</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Use of Flumazenil for Reversal of Benzodiazepine Overdosage</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anaphylactic Reactions Treatment Algorithm</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anticoagulant summary</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prescribing opiates for addiction on admission to inpatient psychiatric – Flowchart</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clozapine - out of hours</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Basic Life Support</td>
<td>Medical Emergency and Cardiopulmonary Resuscitation</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Activating Medical Emergency Procedures within Hospitals and the Community</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-hospital Adult Basic Life Support and Automated Defibrillation</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Choking: Assessment and Treatment Flowchart</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What To Do In Case Of Hanging or Strangulation Algorithm</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Naso-Gastric Feeding using Restraint Policy</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest Pain Protocol</td>
<td>32</td>
</tr>
<tr>
<td>4</td>
<td>Procedures for Out of Hours, Out of Area and Emergency Team</td>
<td>Core Trainee On-call Duties</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cross Cover – Springfield</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overview of Out of Hours Support Structure</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoiding out of area admissions</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Procedure flowchart for children brought to 136 Suite – within hours</td>
<td>45</td>
</tr>
</tbody>
</table>
4.5i Procedure flowchart for children brought to 136 Suite – out of hours

4.6 Protocol for the Management of People Presenting at Hospital Sites without referral

5 Information and Records

5.1 Information Governance

5.2 Confidentiality and Data Protection

5.3 Recording Patient Information and Contacts

5.4 Information Security

5.5 Information Quality

5.6 Information Sharing

5.7 Copying Correspondence to Patients

5.8 Payment by results and clustering

5.9 Inpatient discharge summary

6 Observation and Seclusion Policies

6.1 General Considerations in the Application and Management of Observation and Intensive Engagement

6.2 Overview of Seclusion

7 Medico-Legal issues

7.1 Mental Health Act 1983 and Revised Mental Health Act 2007

7.2 Giving Treatment for Mental Disorder: The Mental Health Act, Consent and Capacity

7.3 Assessing Adult Patients’ Capacity to Consent to Psychiatric Medical and Surgical Treatment

7.4 Deprivation of Liberty Safeguards (DoLS)

8 Reassessments and Second Opinions

9 Risk Management and Self-Harm

9.1 Risk Management

9.2 Guidelines for the Assessment and Management of adults patients following self-harm

9.3 Guidelines for the Assessment and Management of children and young people following self-harm

10 Physical Health

10.1 Introduction to Medical Problems in Psychiatric Patients

10.2 RiO documentation for new admissions

11 Management of Alcohol Problems in Psychiatric Wards

11.1 Guidelines for the management of alcohol problems in psychiatric wards

11.2 Alcohol withdrawal treatment for inpatient psychiatric wards
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12</strong></td>
<td>Incident Management</td>
<td></td>
</tr>
<tr>
<td>12.1</td>
<td>Incident Management and Reporting</td>
<td>99</td>
</tr>
<tr>
<td>12.2</td>
<td>Flowchart for Reporting Serious Incidents</td>
<td>100</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>Safeguarding Children and Adults</td>
<td></td>
</tr>
<tr>
<td>13.1</td>
<td>Safeguarding Children</td>
<td>101</td>
</tr>
<tr>
<td>13.2</td>
<td>Safeguarding Adults</td>
<td>102</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>Crisis and Home Treatment</td>
<td></td>
</tr>
<tr>
<td>14.1</td>
<td>Crisis and Home Treatment Teams</td>
<td>104</td>
</tr>
<tr>
<td>14.2</td>
<td>Gatekeeping and Bed Management Flowcharts</td>
<td>105</td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>Infection Control</td>
<td></td>
</tr>
<tr>
<td>15.1</td>
<td>Infection Control Principles and Practice</td>
<td>106</td>
</tr>
<tr>
<td>15.2</td>
<td>Outbreak Action Plan</td>
<td>112</td>
</tr>
<tr>
<td>15.3</td>
<td>MRSA Screening in Mental Health</td>
<td>113</td>
</tr>
<tr>
<td><strong>16</strong></td>
<td>Smoking Cessation</td>
<td></td>
</tr>
<tr>
<td>16.1</td>
<td>Smoking Care Pathways – Inpatient</td>
<td>114</td>
</tr>
<tr>
<td>16.2</td>
<td>Smoking Care Pathways – Community</td>
<td>115</td>
</tr>
<tr>
<td>16.3</td>
<td>Pharmacologic smoking cessation interventions</td>
<td>116</td>
</tr>
</tbody>
</table>

**Appendixes**

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Library Services</td>
<td>117</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Searching for Evidence</td>
<td>119</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Emergency Telephone Numbers for Springfield Site</td>
<td>120</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Emergency Telephone Numbers for Tolworth Site</td>
<td>121</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Emergency Telephone Numbers for Barnes Site</td>
<td>122</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Mandatory Training</td>
<td>123</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Abbreviations</td>
<td>125</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Trust-wide Clinical Policies</td>
<td>127</td>
</tr>
</tbody>
</table>
2.1 RAPID TRANQUILLISATION IN ADULTS (AGE 18-65)

**Consider non-drug approaches to de-escalate the situation**
Try talking to the patient, use of distraction, negotiation, review observation level, move to quiet area, discussion with PICU staff etc..

If measures in Step 1 prove ineffective, move preferably to step 2, or in extreme cases straight to step 3 below.
At all times the intervention chosen must be a proportionate and reasonable response to the risk posed by the patient.
Contact a senior Dr or Pharmacist if rapid tranquillisation is repeated or poor clinical response or if there are any other concerns.

No known history of antipsychotic exposure; history of cardiac disease
Confirmed previous antipsychotic treatment and tolerated
Jump to ‘step 3’ in severe cases

**Step 1**
- Consider non-drug approaches to de-escalate the situation
  
**Step 2**
- **Oral medication**
  - Lorazepam 1–2mg
  - OR promethazine 25–50mg

**Step 3**
- **Intra-muscular medication**
  - Lorazepam 1–2mg
  - OR promethazine 25-50mg

**Step 4**
- **Intra-muscular medication** (gluteal only, using retractable syringes)
  - 1st line: Lorazepam 1-2mg OR promethazine 25-50mg
  - 2nd line: Lorazepam1-2mg + promethazine 25-50mg
  - OR haloperidol 5mg + (lorazepam 1-2mg OR promethazine 25-50mg)
  - 3rd line:
    - Aripiprazole 5.25-9.75mg + (lorazepam 1mg-2mg OR promethazine 25-50mg)

**Step 5**
- Speak to a senior Dr or a Pharmacist. See guidance on the use of Accuphase® (Zuclopentixol acetate) in ‘Treatment with antipsychotics policy’
Monitoring of patients following the use of medicines for rapid tranquillisation

After medication had been given, the following must be monitored & recorded by a qualified nurse every 15 minutes or as requested by the MDT:

If the patient is undergoing control & restraint, or has his/her posture otherwise affected, vital signs will need more frequent monitoring:

- Blood pressure, Pulse, Temperature
- Oxygen saturation level via pulse oximeter
- Respiratory rate
- Extra-pyramidal movement side effects
- Use the NEWS generate a score
- Hydration status (initial assessment)
- Level of consciousness

(If the patient’s level of arousal prevents these measurements being made, the reason must be recorded in the patient’s notes, and the patient must be regularly reviewed in an attempt to make the necessary physical observations).

Use of flumazenil:

- A doctor must administer flumazenil if the respiration rate falls to <10/minute after a benzodiazepine.
- Give flumazenil 200micrograms intravenously over 15 seconds. If the desired level of consciousness is not obtained within 60 seconds, a further 100micrograms can be injected and repeated at 60-second intervals to a maximum total dose of 1mg (1000micrograms) in 24 hours (initial dose plus 8 further doses). Monitor respiration rate continuously until it returns to the baseline level.

N.B. the effect of flumazenil may wear-off and respiratory depression can return – monitoring must continue beyond the initial recovery of the patient.

Use of anticholinergics:

- Procyclidine for an acute dystonic or parkinsonian reaction.
- Procyclidine 5-10mg by IM, IV or oral (tablet/liquid). Max 30mg/24hrs. IV is fastest for symptom relief (Only Dr administer IV).

Maximum recommended doses (healthy adult patients with no known confounding factors):

- The other medicines prescribed for the patient must also be considered (especially regular prescriptions for antipsychotics or benzodiazepines).
- Use your clinical judgement and tailor the dose of medicine to a patient, using higher than the max doses recommended should be discussed with a senior colleague or a pharmacist.
- The maximum daily dose should include both regular medication as well as “PRN” doses given in response to disturbed behaviour.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Max oral in 24 hours</th>
<th>Max injectable in 24 hours</th>
<th>Maximum dose (oral and IM) in one 24 hour period (PRN and regular)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>4mg</td>
<td>4mg IM</td>
<td>4mg (higher doses may be required, contact senior colleagues)</td>
</tr>
<tr>
<td>Promethazine</td>
<td>100mg</td>
<td>100mg</td>
<td>100mg</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>20mg</td>
<td>NA (no injection available)</td>
<td>No injection available</td>
</tr>
<tr>
<td>Risperidone</td>
<td>4mg as PRN doses for RT</td>
<td>N/A (no injection available)</td>
<td>No injection available</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>30mg</td>
<td>30mg IM (max 3 injections)</td>
<td>30mg (manufacturer recommends a 2nd IM dose 5.25-15mg)</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>20mg*</td>
<td>10mg* IM</td>
<td>20mg (oral equivalent) 10mg oral = 6mg IM</td>
</tr>
</tbody>
</table>

*Above BNF max on consultant approval
Explanatory notes to accompany the algorithm:

1. **Lorazepam is the first-line medicine option.**
   Where lorazepam is not contra-indicated (see bullet point 2 below), lorazepam is a safer option than using an antipsychotic.

2. **Lorazepam may be used up to 4mg in 24 hours**
   At times up to 8mg may be required.

3. **Where a benzodiazepine is contra-indicated promethazine or an antipsychotic may be a suitable option.**
   E.g. where there is a history of dependence, tolerance to benzodiazepines or history of disinhibition or paradoxical aggression caused by benzodiazepines.

4. **Antipsychotics are NOT recommended as first line or monotherapy in RT.**
   This is due to the following adverse effects: extrapyramidal symptoms, cardiac arrhythmia and potential cardio-respiratory collapse, and the potentially life-threatening and unpredictable risk of neuroleptic malignant syndrome (NMS). They are not more effective than lorazepam monotherapy.

5. **Where an antipsychotic is needed, they should be used in combination with a benzodiazepine (lorazepam) or promethazine.**
   This is to increase effectiveness, minimise the dose of antipsychotic and reduce the risk of adverse effects from the antipsychotic.

6. **An ECG is required before prescribing haloperidol.**
   If haloperidol is prescribed without a satisfactory ECG having been obtained pre-treatment, the liability for the prescription lies with the prescriber. Reasoning behind the decision (including risk/benefit) to give haloperidol without a pre-treatment ECG must be clearly documented in the patient’s notes. An alternative antipsychotic, lorazepam or promethazine is preferred to haloperidol where a pre-treatment ECG cannot be obtained.

7. **Medicines prescribed PRN for RT should be reviewed weekly.**
   Medicines not used in the past week should be stopped. Antipsychotics should be time limited on the ‘when required side’ and preferably written on the ‘once only’ section.

8. **Ensure RT medicines are included on MHA Forms T2 or T3, as a section 61 or 62 may be needed.**

9. **If you have any concerns or doubts about prescribing, discuss with a senior colleague or contact the pharmacist.**
   These guidelines do not replace the need to exercise clinical judgement in the treatment decisions for an individual patient.

10. **Where possible avoid high dose and combination antipsychotics when prescribing PRN antipsychotics for RT.**
## 2.2 RAPID TRANQUILLISATION FOR YOUNG PEOPLE (AGE 6-17)

<table>
<thead>
<tr>
<th>Psychotic Illness</th>
<th>Non-psychotic or unknown illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam tablet or Promethazine tablet/liquid&lt;br&gt;<strong>&lt;12 years or weight below 30kg: 0.5-1mg&lt;br&gt;30kg: 5-10mg (max 25mg/day)&lt;br&gt;</strong>&gt;12 years: 1-2mg (Max. 4mg/day)&lt;br&gt;(Max. doses include any regular prescription)<strong>&lt;br&gt;</strong></td>
<td>Lorazepam tablet&lt;br&gt;&lt;br&gt;<strong>&lt;12 years or weight below 30kg: 0.5-1mg&lt;br&gt;30kg: 1mg-25mg (max 10mg/day)&lt;br&gt;</strong>&gt;12 years: 10mg/day&lt;br&gt;**</td>
</tr>
</tbody>
</table>
| **| Olanzapine tablet/velotab<br><br>**<12 years: N/A<br>12 years: 5mg<br>**| Promethazine tablet/liquid<br>**<12 years or weight below 30kg: 5-10mg (max 25mg/day)<br>**>12 years: 10mg-25mg (max 50mg/day)<br>**<br>Max. doses include any regular prescription<br>**<br>**<br>**<br>
| OR<br>** | | Max. >12 yrs: 50mg/day<br>Max. <12 yrs: 25mg/day<br>**<br>**<br>**<br>**<br>**

Little or no response 30-45 minutes, consider repeating oral therapy or use intramuscular glucose injections as below. Request medical assessment before proceeding. Use retractable syringes.

### In extreme circumstances consider lorazepam IM AND promethazine IM

- Flumazenil must be given if respiration rate falls to <10/minute after lorazepam has been given as follows by a doctor: <12 years: 150microgram IV injection over 15 seconds; >12 years: 250microgram IV injection over 15 seconds. If the desired effect is not achieved in 1 minute, repeat with half the initial dose at 1 minute intervals until recovering or a maximum of 5 doses. N.B. the effect of flumazenil may wear off & respiratory depression can return – monitoring must therefore continue beyond initial recovery.
- Use where oral therapy fails or severe episodes
- Use where oral therapy fails or severe episodes
- Use where oral therapy fails or severe episodes

- Lorazepam intramuscular<br><br>**<12 years or weight below 30kg: 0.5-1mg<br>30kg: 5-10mg (max 25mg/day)<br>**>12 years: 1-2mg (Max. 4mg/day)<br>**<br>**<br>**<br>

- Haloperidol intramuscular<br><br>(Pre-treatment ECG required)<br>**<br>12 years: discuss with CAMHS consultant or SpR<br>**>12 years: 2-5mg (Max. >12 years: 10mg/day)<br>**<br>

- Aripiprazole: 5.25mg-9.75mg**<br>**<br>(Max 15mg/day)<br>**<br>

In extreme circumstances consider either lorazepam IM or promethazine IM AND haloperidol IM or aripiprazole IM together (given in separate syringes) but discuss with CAMHS consultant or SpR before proceeding.
Try talking to the patient, use of distraction, seclusion etc. Consider environmental factors that could be modified. Consider medical / physical causes of disturbance.

Dementia with Lewy Bodies present / cannot be excluded

- Consider oral medication lorazepam 500micrograms – 1mg
- Repeat oral medication lorazepam 500micrograms – 1mg
- Consider alternative oral medication e.g. quetiapine 12.5–50mg

Dementia with Lewy Bodies has been ruled-out

- Consider oral medication lorazepam 500micrograms – 1mg or haloperidol 500micrograms – 2mg
- Repeat the same oral medication lorazepam 500micrograms – 1mg or haloperidol 500micrograms – 2mg
- Alternate oral medication haloperidol 500micrograms – 1mg or lorazepam 500micrograms – 1mg

Little or no effect after 30 mins

If no response, seek advice from more experienced doctor

Intra-muscular injection in severe cases ONLY
lorazepam 500micrograms–2mg IM OR haloperidol 500micrograms-1mg IM
- Give by gluteal route only with a retractable syringe.
- Procyclidine 2.5–5mg IM for acute dystonic reaction to haloperidol.
- Only use haloperidol if Dementia with Lewy Bodies has been ruled-out.
- ECG must be taken before giving haloperidol

These guidelines apply where a frail patient over 65 years of age is behaving in a disturbed or violent manner that is unusual for him/her and that cannot be modified by interventions already in their care-plan. For physically fit patients & those currently/previously treated with higher doses of antipsychotics, the protocol for younger adults may be more appropriate. Details of the clinical situation & all interventions must be recorded in the patient’s medical notes.

- Medication should be the last resort in older people. If required, medication must be used cautiously.
- Take in to consideration the Mental Health Act status of the patient.
- Monitoring must be performed & recorded according to the guidelines overleaf after any injection is given.
- Procyclidine 2.5-5mg can be given by IV or IM injection for acute dystonic / parkinsonian reactions to haloperidol.
- *There is concern with all atypical antipsychotics (in particular olanzapine & risperidone) about their use for disturbed behaviour in dementia and the risk of CVA, but for occasional “PRN” use the risk is minimal.
- Flumazenil (a benzodiazepine antagonist) must be given if the respiration rate falls to <10 breaths/minute after lorazepam has been used (see flumazenil flow chart).

Flumazenil must be given if respiration rate falls to <10/minute after lorazepam has been given as follows by a doctor:
<12 years: 150microgram IV injection over 15 seconds;
>12 years: 200microgram IV injection over 15 seconds
If the desired effect is not achieved in 1 minute, repeat with half the initial dose at 1 minute intervals until recovering or a maximum of 5 doses.
N.B. the effect of flumazenil may wear-off & respiratory depression can return – monitoring must therefore continue beyond initial recovery.
2.4 ROLES AND RESPONSIBILITIES FOLLOWING RAPID TRANQUILLISATION

(Link Committee: Drugs and Therapeutic Committee)

1. After RT is administered the following monitoring schedule must be followed unless stated elsewhere in the patient’s immediate care plan or there are patient/staff safety reasons.

2. Take vital signs *as soon as possible* including (by generating NEWS score):
   - Pulse and respiration, every 15 minutes or sooner if necessary for 1 hour.
   - Temperature (use tempadots) when possible every 15 minutes or sooner if necessary.
   - Oxygen saturation levels when possible every 15 minutes or sooner if necessary (use pulse oximeter).
   - Levels of consciousness every 15 minutes for the 1 hour, then under nurse’s discretion.

3. All observations must be recorded on Modified Early Warning System (MEWS)

4. The patient’s mental state and actions taken regarding physical observations must be entered in the patient records under progress notes.

5. **Role of the Doctor**
   - Document any monitoring requirements additional to the above standard and any subsequent action to be taken by the nursing staff.
   - Must attend RT intervention or assessment post incident promptly upon request of Nurse in Charge and debrief review
   - Prescribe physical intervention including physical observation checks
   - Review patients current notes and care management plan
   - Participate on patient incident and debrief review
   - Must be in attendance at RT intervention whenever possible

6. **Role of the Nurse in charge**
   - Informing ward or Duty Doctor of an RT intervention, liaising with Doctor if there is any deterioration in the patient’s mental or physical state.
   - Deploy Registered Nurse on Level 2 Observations of patient following RT assessment (standard to be reviewed).
   - Ensure the rationale of administering RT is recorded in the progress notes on RIO each time a dose is administered.
   - Ensure that a registered nurse performs the patient monitoring and is allocated to the patient.
   - Ensure all physical observations are entered on to MEWS chart and a summary of actions clearly into progress notes on RIO.
   - Ensure adequate support is in place for this i.e. more than one nurse may be required, i.e. consider gender issues.
   - Ensure that medical emergency equipment is easily accessible.
   - Ensure adequate relief is provided as per Observation Policy / as required.
• Decide in consultation with the Doctor if necessary, whether the next dose of regular medication should be omitted, in the light of the response to rapid tranquilisation.
• Deciding after 60 minutes in consultation with a doctor the appropriate levels of observation to be followed.
• Participate in Post Incident / debrief review & joint Management Review Care Plan
• Ensure that for each episode of rapid tranquilisation a Trust incident form is completed, (see Appendix 3 of TWC22).
• Document the observations and debrief accurately.

7. **Role of registered Nurse**
• Remain with patient at all times (Level 2 Observations)
• Carry out and record observations as per this protocol or as prescribed by a doctor
• Ensure all physical observations are entered on to MEWS chart and a summary of actions entered into progress notes on RIO.
• Ensure MEWS chart is scanned on to RIO once complete.
• Promptly report any untoward signs/symptoms or any other concerns to the Doctor or Nurse in charge
• E.g weakening of pulse, low oxygen saturation levels, decreased respiratory rate
• Promptly inform Nurse in Charge of any variation as per Management Care Plan
• Activate local alarm system plan in an emergency as per policy
• Activate Medical Emergency system as per policy
• Re-establish rapport with patient and document physical and mental health needs
• Complete incident form
• Participate in patients post incident review / debriefing.

8. **Role of Responsible Clinician and MDT**
• Review all RT incidents
• Must review current risk and medium term management care plan to prevent re-occurrence of RT
2.5 MEDICINES REQUIRING SPECIAL PRECAUTIONS

There are a number of non psychiatric medicines for which special precautions are required for prescribing, dispensing, administration and monitoring. Reference should be made to the Quick intranet for guidance:

- Oral Anti-Cancer Medicines (Inc Methotrexate) TWC21d
- VTE & Anticoagulants guidance on assessing, dispensing and monitoring (Summary in Blue book) TWC21u
- Drug Dependence Prescribing policy (Inc Opiates) TWC21f

USEFUL RESOURCES FOR MEDICINES INFORMATION

- [BNF & BNFc](http://www.bnf.org) (BNFs are provided to medical posts twice yearly)
- [Pharmacy Services mini site](http://www.c至尊.org) on ‘InSite’
- Local Mental Health Pharmacist or Mental Health Medicines Information 020 3513 6829.
2.6 GUIDELINES FOR THE MANAGEMENT OF ACUTE DYSTONIA
(Link Committee: Drugs & Therapeutics Committee)

Definition
A neurological movement disorder characterised by sustained muscle contractions, resulting in repetitive, involuntary, twisting or writhing movements and unusual postures or positioning.

Presentation
Muscle spasm in any part of the body
[e.g.:
- eyes rolling upward (oculogyric crisis)
- head and neck twisted to the side (torticollis)
- patient unable to swallow or speak clearly
- in extreme cases, back may arch or jaw dislocate]

can occur within hours of starting antipsychotics or within minutes if IV or IM injection; and can be both painful and very frightening.

NB: If concomitant high temperature consider possibility of neuroleptic malignant syndrome –

Risk factors
More common in
- Young males
- Neuroleptic naive patients
- Patients prescribed “high potency” drugs (e.g. haloperidol)
- Rare in the elderly.

Treatment
Anticholinergic drugs given orally, IM or IV depending on severity of symptoms.
- Remember that patient may be unable to swallow
- Response to IV administration will be seen within 5 minutes and IM in about 20 minutes
e.g.: procyclidine 5-10mg by IM or IV injection
procyclidine 5-10mg orally (tablet or liquid) (BNF maximum 30mg daily)
orphenadrine 50-100mg orally (tablet or liquid) (BNF maximum 400mg daily)
trihexyphenidyl (benzhexol) 1-2mg orally (tablet or liquid) (BNF max. 20mg daily arrived at slowly)

If there is no response, consider repeating the anticholinergic (note maximum dose including regular medication) or discussing with a senior colleague or pharmacist.

Monitoring of the patient should continue, particularly where the dystonic reaction was caused by a long-acting injection of an antipsychotic.
Consider whether the antipsychotic medication should be changed in order to reduce the risk of the dystonic reaction occurring again.

An entry should be made on RIO in the `Allergies and Adverse Reactions Summary` section and relevant allergy sections of patient medication charts to indicate the antipsychotic responsible for acute dystonia.
2.7 GUIDELINES FOR THE MANAGEMENT OF NEUROLEPTIC MALIGNANT SYNDROME (NMS)
(Linked Committee: Drugs & Therapeutics Committee)

Presentation: NMS can present with any, or many, of the following symptoms:

- Fever, diaphoresis, rigidity, confusion, fluctuating consciousness
- Fluctuating blood pressure, tachycardia
- Elevated creatinine kinase, leukocytosis, altered liver function tests.

NB: the presentation varies greatly, with a wide spectrum of both symptoms and severity, and so it is prudent to consider NMS if a patient on an antipsychotic becomes pyrexial.

Risk Factors

- High potency typical antipsychotic drugs, recent or rapid dose increase, rapid dose reduction, abrupt withdrawal of anticholinergics
- Psychosis, organic brain disease, alcoholism, Parkinson's disease, hyperthyroidism
- Agitation, dehydration.

Treatment

If NMS is suspected, probable, or you have cause for concern alert the on-call senior doctor and treat as a medical emergency:

- Transfer the patient to a medical/A&E unit
- Withhold antipsychotics
- Monitor temperature, pulse, BP very frequently
- Check CPK, WBC, LFTs
- Ensure adequate hydration.
- Consider benzodiazepines if not already prescribed – IM lorazepam has been used.

At the medical/A&E unit:

- Treatment may include in addition to the above:
  - Rehydration, bromocriptine and dantrolene, sedation with benzodiazepines
  - Artificial ventilation if required.
  - L-dopa, apomorphine and carbamazepine have also been used.

Restarting Antipsychotics

- Antipsychotic treatment will be required in most instances and rechallenge is associated with acceptable risk.
- Withhold antipsychotics for at least 5 days, preferably longer. Allow time for symptoms and signs of NMS to resolve completely.
- Consider using an antipsychotic structurally unrelated to the drug associated with NMS, or a drug with low affinity for dopamine receptors, e.g. clozapine or quetiapine. Aripiprazole may also be considered.
- Avoid depots (of any kind) and high-potency conventional antipsychotics.
- Begin with a very small dose and increase very slowly with close monitoring of temperature, pulse and blood pressure. CK monitoring may be useful.
2.8 LITHIUM THERAPY SUMMARY

(Link Committee: Drugs and Therapeutic Committee)

**Psychiatrist & Care Co-ordinator**

- Prescribe: Dose in milligrams (NOT mmol/L)
  - Lithium citrate (Li-Liquid®) or lithium carbonate MR (e.g. Priadel®)
  - 1.018g/5mL liquid & mL when used
- A lithium care plan is to be opened in Rio (found in the care plan library)
- Purple lithium booklet to be given to the patient and attached to the chart if and inpatient (available from Pharmacy)
- Service users must be informed of the side-effects, interactions and other important prescribing details as mentioned in the lithium booklet.
- Check on going monitoring of lithium and document in Rio (send shared care to GP where appropriate)
- Patients who have the capacity to refuse monitoring must be given a copy of the standard letter from the trust policy.

**Pharmacist**

- To ensure Rio care plans are opened for dispensed prescriptions
- Ensure the patient has had required blood tests before dispensing lithium.
- Only dispense a 14 day supply if a lithium level is >3 months old, unless otherwise agreed.
- Contact the prescriber or care coordinator if the required monitoring is not completed.
- To ensure the patient has been given a purple booklet and the patient has received appropriate advice on their lithium treatment.
- Only supply 1.018g/5mL of lithium, if prescribed as liquid.
- Document the lithium level and date on the prescription once checked.

**Drug Interactions**

<table>
<thead>
<tr>
<th>Lower serum levels</th>
<th>Increase lithium levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antacids or urinary alkalinising agents</td>
<td>NSAIDs, COX-2 inhibitors, ACE-inhibitors &amp; angiotensin II inhibitors</td>
</tr>
</tbody>
</table>

The above list is not exhaustive, check BNF or contact your team pharmacist or Medicines Information on 020 8682 6829 for further information.

**Summary of lithium therapy monitoring**

<table>
<thead>
<tr>
<th>Baseline monitoring</th>
<th>Lithium levels:</th>
<th>Follow-up monitoring &amp; annual check up:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid function tests</td>
<td>Acceptable: 0.4-1mmol/L</td>
<td>3 monthly: Lithium levels</td>
</tr>
<tr>
<td>Renal function tests (RF)</td>
<td>Maintenance BPAD: 0.6-0.8 mmol/L</td>
<td>6 monthly: TFTs &amp; RF</td>
</tr>
<tr>
<td>Weight (or BMI)</td>
<td>Mania or treatment resistant BPAD: 0.8-1.0mmol/L</td>
<td>Annual:</td>
</tr>
<tr>
<td>Serum Calcium</td>
<td>Check level:</td>
<td>- Weight (or BMI)</td>
</tr>
<tr>
<td>FBC (if indicated)</td>
<td>- 1 week after initiation,</td>
<td>- Serum Calcium</td>
</tr>
<tr>
<td>ECG where there are risk factors such as cardiac disease</td>
<td>- 1 week after every dose</td>
<td>To be monitored once after initiation:</td>
</tr>
<tr>
<td></td>
<td>change until levels stable, then</td>
<td>- at 3 months: Weight/BMI</td>
</tr>
<tr>
<td></td>
<td>- every 3 months and</td>
<td>where there has been</td>
</tr>
<tr>
<td></td>
<td>- more frequently in the elderly &amp;/or prescribed interacting drugs</td>
<td>rapid weight gain</td>
</tr>
<tr>
<td></td>
<td>Sampling time: 12 hrs post dose</td>
<td></td>
</tr>
</tbody>
</table>

**Signs of lithium toxicity when >1.2 mmol/L**

<table>
<thead>
<tr>
<th>High serum lithium</th>
<th>Very high serum lithium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea/ diarrhoea</td>
<td>Impaired consciousness &amp; increased confusion</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Muscle twitches</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>Hyperreflexia</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Nystagmus</td>
</tr>
<tr>
<td>Severe hand tremor</td>
<td>Oliguria, anuria</td>
</tr>
<tr>
<td>Lack of coordination</td>
<td>Convulsions/ Seizures</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>Cardiac arrhythmias</td>
</tr>
<tr>
<td>Sluggishness</td>
<td>Coma</td>
</tr>
<tr>
<td>Sleepiness</td>
<td></td>
</tr>
<tr>
<td>/Light-headedness</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment of Toxicity**

1. A level greater than 1.5mmol/l is associated with a risk of coma which may be fatal. A level greater than 2.0mmol/l warrants emergency treatment.
2. Withhold lithium and repeat levels & monitor ECG.
3. Ensure adequate hydration (e.g. give sodium chloride 0.9%) and correct any electrolyte abnormalities.
4. Forced diuresis and diuretics are contraindicated.
5. Correct hypotension by raising the foot of the bed or in severe cases by expanding the intravascular volume.
6. Control convulsions with benzodiazepines.
7. Haemodialysis is the treatment of choice for chronic lithium accumulation with a lithium concentration of >2.0mmol/L or in those patients with clinical evidence of severe lithium toxicity (e.g. neurological features or renal failure).
### 2.9 FLUMAZENIL FOR REVERSAL OF BENZODIAZEPINE OVERDOSE

(Link Committee: Drugs and Therapeutic Committee)

****May only administered by a Doctor***

<table>
<thead>
<tr>
<th>Adults &amp; older people</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial dose over 15 second IV 200micrograms (2ml)</td>
<td>Initial dose over 15 second IV</td>
</tr>
<tr>
<td>If desired level of consciousness is not obtained within 60 seconds: 100micrograms (1ml) over 15 seconds</td>
<td>&gt;1 month – 12 years 10 micrograms / kg (max 200micrograms per dose)</td>
</tr>
<tr>
<td>Desired level of consciousness not obtained within 60 seconds: Repeat 100micrograms (1ml) at 60-second intervals as required Maximum total dose of 1mg¹</td>
<td>12-18 years 200 micrograms</td>
</tr>
<tr>
<td>Give over 15 seconds</td>
<td>Desired level of consciousness not obtained within 60 seconds: Repeat dose at 60-second intervals as required Maximum total dose of 40micrograms/kg or 1mg¹</td>
</tr>
<tr>
<td>Keep patient under close observation for several hours²</td>
<td>Give doses over 15 seconds</td>
</tr>
<tr>
<td></td>
<td>Keep patient under close observation for several hours²</td>
</tr>
</tbody>
</table>

1. Flumazenil is in the Green ILS (immediate life support) bag & must be available when giving IM benzodiazepines
2. Administer by slow IV injection over 15 seconds
3. Flumazenil presents as 500microgram in 5ml ampoules
4. If a significant improvement in consciousness or respiratory function is not obtained after repeated doses of flumazenil, a cause other than benzodiazepine overdose must be assumed. Flumazenil is much shorter acting (short half-life) than other benzodiazepines commonly encountered. Patients must therefore be kept under close observation for several hours in case toxicity recurs.
2.10 ANAPHYLACTIC REACTIONS TREATMENT ALGORITHM
(Link Person: Resuscitation Training Officer)

Anaphylactic reaction?

Airway, Breathing, Circulation, Disability, Exposure

Diagnosis – look for:
- acute onset of illness
- life-threatening airway and/or breathing and/or circulation problems¹
- and usually skin changes

- Call for help
- Lie patient flat
- Raise patient’s legs

Adrenaline²

When skills and equipment available:
- Establish airway
- High flow oxygen
- IV fluid challenge³
- Chlorphenamine⁴
- Hydrocortisone⁵
- Monitor:
  - Pulse oximetry
  - E.C.G.
  - Blood pressure

¹ Life-threatening problems:
**Airway:** swelling, hoarseness, stridor
**Breathing:** rapid breathing, wheeze, fatigue, cyanosis, SpO₂<92%, confusion
**Circulation:** pale, clammy, low blood pressure, faintness, drowsy/coma

² Adrenaline (give IM unless experienced with IV adrenaline)
IM doses of 1:1000 adrenaline (repeat after 5min if no better)
- Adult: 500 micrograms IM (0.5ml)
- Child more than 12 years: 500 micrograms IM (0.5ml)
- Child 6-12 years: 300 micrograms IM (0.3ml)
- Child less than 6 years: 150 micrograms IM (0.15ml)

³ IV fluid challenge:
- Adult: 500-1000ml
- Child: crystalloid 20ml/kg
- Stop IV colloid
- if this might be the cause of anaphylaxis

⁴ Chlorphenamine (IM or slow IV)
- Adult or child more than 12 years: 10mg 200mg
- Child 6-12 years: 5mg 100mg
- Child 6 months to 6 years: 2.5mg 50mg
- Child less than 6 months: 250microgram / kg 25mg

⁵ Hydrocortisone (IM or slow IV)
2.11 ASSESSING VTE, TREATING, ADMINISTERING AND DISPENSING ANTICOAGULANTS

(Link: Drugs and Therapeutic Committee)

<table>
<thead>
<tr>
<th>VTE risk factors</th>
<th>Bleeding risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age over 60 years</td>
<td>Active bleeding</td>
</tr>
<tr>
<td>Obesity (BMI over 30 kg/m²)</td>
<td>Acquired bleeding disorders (e.g. acute liver failure)</td>
</tr>
<tr>
<td>Dehydration</td>
<td>anticoagulants, NSAIDs prescribed</td>
</tr>
<tr>
<td>One or more significant medical co morbidities (e.g. heart disease, cerebrovascular disease)</td>
<td>Acute stroke</td>
</tr>
<tr>
<td>Critical care admission</td>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td>Personal history or family with a history of VTE</td>
<td>Uncontrolled systolic hypertension (230/120 mmHg or higher)</td>
</tr>
<tr>
<td>Critical care admission</td>
<td>Untreated inherited bleeding disorders</td>
</tr>
<tr>
<td>Personal history or family with a history of VTE</td>
<td>Procedures with high risk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor</th>
</tr>
</thead>
</table>

All patients initiated on antipsychotics or admitted to inpatients should have a VTE risk assessment carried out:
- Document clearly in the patient’s medical record:
  - details of VTE assessment (see RiO risk assessment template),
  - treatment and monitoring plans (e.g. indication, dose, duration and target INR if prescribed an oral anticoagulant)
  - blood results (including frequency of ongoing monitoring).
- Prescribing advice and monitoring requirements can be obtained/confirmed with a specialist clinic (see below).
- Prescribe heparins SUBCUTANEOUSLY ONLY (see the full policy for prescribing information)
- Prescribe oral anticoagulants in mg and heparin in mg or ‘units’ (where appropriate)
- Document indication, Target INR, INR results and patients weight on the drug chart.
- Monitor U&E, LFT and INR.
- Discuss treatment with patient; provide adequate information regarding their treatment (inc adverse effects, monitoring and blood test arrangements) to enable them to make informed choices
- Ensure that patient have a ‘yellow book’ if prescribed oral anticoagulants (from specialist clinic)
- Ensure nursing staff are given adequate information on how to monitor the patient while on anticoagulants or receiving mechanical intervention (TED stockings).
- On discharge: document on-going arrangements for supply of medicines/interventions and monitoring, the ‘yellow anticoagulant book’ is completed and recent blood results are recorded.

<table>
<thead>
<tr>
<th>Haematology Results</th>
<th>Anticoagulant clinic/ Haematology</th>
<th>Monitor for adverse effects. Notify a doctor immediately if any occur.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low platelets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Bruising</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Nosebleeds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Bleeding mouth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Rashes (pinpoint red spots)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signs of bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-prolonged nosebleed (more than 10 minutes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-painful nosebleed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-severe or spontaneous bruising</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-for women, heavy or increased bleeding during their period or any other vaginal bleeding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward Nurse</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer heparins subcutaneously ONLY</td>
<td></td>
</tr>
</tbody>
</table>
- Monitor the patient for adverse effects.
- Ensure the required monitoring has been done before administering.
- Ensure adequately informed/trained in use of these meds
| |
| Check: |
- Assessment, treatment, monitoring (i.e. U&E, LFTs) & discharge plans (inc anticoag. book completion)
- Patient has been given adequate info regarding their anticoagulant.
Complete the anticoagulant check list and file in Pharmacy.

<table>
<thead>
<tr>
<th>Care coordinators</th>
</tr>
</thead>
</table>
- Highlight where VTE risk assessments have not been undertaken on initiation of antipsychotics or there are high risk factors, and report to medical staff.
2.12 PRESCRIBING OPIATES FOR ADDICTION ON ADMISSION TO INPATIENT PSYCHIATRIC
(see guideline and SmPC for full advice) v2.0 (Link: DTC)

<table>
<thead>
<tr>
<th>Obtain accurate drug history</th>
<th>Consider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm the dose of any opiate dependence treatment from a reputable source. Confirm: dose, prescriber and clinic details, dispensing pharmacy including last date picked up.</td>
<td>- Use of heroin, diamorphine, methadone, other opiates (dihydrocodeine &amp; buprenorphine), benzodiazepines &amp; alcohol.</td>
</tr>
<tr>
<td>Does the person have opiate treatment from an NHS or publicly funded institution?</td>
<td>- UDS must be completed.</td>
</tr>
<tr>
<td>Yes</td>
<td>- Give written information on methadone treatment (e.g. methadone handbook).</td>
</tr>
<tr>
<td>Continue on same maintenance dose. Let the relevant agency know the patient has been admitted.</td>
<td>- Physical examination: examine injection sites, BP, pulse, BM and ECG, full blood count, urea and electrolytes, liver function tests with gamma glutamyl transferase (GGT), offer Hepatitis C testing and Hepatitis B vaccination, advise on blood borne viruses. Consider referral for HIV screening.</td>
</tr>
<tr>
<td>No</td>
<td>- Do not prescribe to those clearly intoxicated.</td>
</tr>
<tr>
<td>Methadone --use PRN regimen below</td>
<td></td>
</tr>
<tr>
<td>Refer to Community Drug and Alcohol Teams if the patient is interested, as soon as practicable Use the PRN regimen for private patients.</td>
<td></td>
</tr>
</tbody>
</table>

PRN Methadone Regimen

**DAY 1** -Prescribe: “10mg (10mL) methadone liquid, 1mg/mL PRN max 40mg/24hurs
When OOWS score 4 double ticks or more give a dose (see appendix 4). Dr Review after 40mg given”
- Monitor the patient **hourly** using the opiate objective withdrawal scale (OOWS) for the first **4 hours**, or until there are no further symptoms. Once signs of withdrawal have stopped monitor **4 hourly**.
- If signs of withdrawal persist after 40mg has been given and 4 hours has passed since the last dose, 10mg doses may be given four hours apart. Max total dose: 60mg in 24hurs. Reasons for further doses must be documented in the notes.
- Most cases will be managed with 40mg in the first 24 hours, severe cases may need 60mg. Contact a specialist should more than 60mg be needed.

**DAY 2 onward**
- STOP PRN dosing and give the total dose given on day 1.
Further dose increases should be no more than 5-10mg on one day and no more than 30mg in the first week. Contact drug and alcohol services for advice.

Other supportive treatment:
- Diarrhoea: Loperamide 4mg immediately followed by 2mg after each loose stool for up to 5 days. Usual dose 6-8mg maximum dose 16mg/24hours.
- Nausea/vomiting: metoclopramide 10mg tds or prochlorperazine 5mg tds.
- Stomach cramps: mebeverine 135mg tds or hyoscine butylbromide 20mg qds
- Agitation /insomnia: promethazine 25-50mg, max 100mg/24hrs, at night for hypnotic effect. Z-drugs and benzodiazepines should be avoided for insomnia, if given short courses of 3 days should be prescribed along with good sleep hygiene advice.
- Muscular pain/headaches: paracetamol or NSAIDS

On discharge: Inform the relevant agency. Opiates are not routinely dispensed.
2.13 CLOZAPINE – OUT OF HOURS
(Link: Drugs and Therapeutic Committee)

Please refer to the Trust Clozapine guide for full guidance

Advice should be sought from a senior colleague where required.

The on-call pharmacist should always be contacted when new patients are admitted on clozapine. The on-call pharmacist is available for advice has access to the clozapine monitoring systems to check for valid FBC results.

New patients should not be commenced on clozapine out of hours.

Treatment with clozapine requires mandatory haematological monitoring and all patients taking clozapine are registered with the relevant clozapine monitoring system.

The risk of neutropenia and agranulocytosis is greatest during the first 18 weeks of treatment so weekly full blood counts are required. Monitoring is then fortnightly until 52 weeks of treatment and then as long as counts are stable, 4 weekly thereafter.

A ‘traffic light’ classification system for results is used, which is applied to WBC and neutrophil counts:

- Amber – continue clozapine treatment. Twice weekly FBC monitoring until the result is green. See “Management of amber results”.
- Red – stop clozapine treatment immediately. Follow “Management of Red Results” procedure.

Contact pharmacy to upload FBCs onto the monitoring system to confirm the validity of the FBC.

Missed Doses and Treatment Breaks of <48hrs

If there is any doubt as to the exact duration of a patient’s treatment break it is advisable to re-titratre clozapine.

If a patient misses one or more doses, but less than 48 hours have lapsed since they last took clozapine, their clozapine can be recommenced or continued at the same dose. If the missed doses occurred during a titration however, the titration should be restarted at a logical point.

A repeat FBC is not required if the patient still has a valid green FBC result. Contact pharmacy for further advice if needed.

Treatment breaks > 48hrs

If clozapine has not been taken for more than 48 hours patients must have their clozapine re-titrated. This is due to the increased risks of cardiac complications when restarting clozapine (e.g. postural hypotension, tachycardia or bradycardia). Large increases in doses following treatment breaks have caused death in patients that had already been taking clozapine.
If there is any doubt as to the exact duration of a patient's treatment break it is advisable to re-titrate clozapine.

If the treatment break is more than 3 days then the patient needs to have a valid FBC, taken within 7 days, prior to re-commencing the clozapine.

The re-titration must commence at a dose of no more than 12.5mg - 25mg. The dose can then be increased according to patient tolerability. A more rapid titration e.g. increasing by 50mg-100mg per day may be appropriate if the patient has previously tolerated initiation of clozapine, there are no significant co-morbidities and they’re physically fit and well.

ZTAS/DMS must be informed of any treatment breaks in excess of 72 hours, and the blood monitoring frequency may also change depending on the duration of the treatment break.

Management of adverse effects
Please refer to the Trust Clozapine guide for full advice.

Seizures
Seizures tend to be dose related and are more common with plasma clozapine levels above 0.6mg/L. Myoclonic jerks are particularly common. Seizure prophylaxis medication should be considered for patients who require high plasma clozapine levels

If seizure develops, withhold clozapine for 1 day, restart at a reduced dose and give sodium valproate.
EEG abnormalities are common in those on clozapine.

Tachycardia
Tachycardia is a common adverse effect in the early stages of treatment, and is usually benign. If however, tachycardia is persistent at rest and associated with fever, hypotension or chest pain, this may be an indication of myocarditis or cardiomyopathy. In this situation, stop the clozapine and refer to a cardiologist immediately.

Benign tachycardia may be treated with atenolol, but other causes must first be excluded. This would usually include an ECHO and a referral to a cardiologist. An ECG is not sufficient.

Constipation
Constipation is a very common side effect and has resulted in a large number of serious complications such as intestinal peristalsis, intestinal obstruction, faecal impaction and paralytic ileus. On rare occasions these cases have been fatal. Particular care is necessary in patients who are receiving concomitant medications known to cause constipation (e.g. those with anticholinergic properties such as some antipsychotics, antidepressants and antiparkinsonian treatments), have a history of colonic disease or a history of lower abdominal surgery, as these may exacerbate the situation.

It is vital that constipation is recognised, actively treated and monitored by using the Bristol Stool Chart. Bulk forming and stimulant laxatives can be used in combination.

Constipation may also inhibit the absorption of clozapine in the gut. Plasma clozapine levels may be reduced when a patient is constipated and increased as the constipation resolves.
3.1 MEDICAL EMERGENCY & CARDIOPULMONARY RESUSCITATION
(Link Person: Director of Nursing)

The South West London & St. George’s Mental Health NHS Trust conducts all resuscitation and medical emergency procedures in accordance with the current Resuscitation Council Guidelines (UK).

Medical and nursing staff must be familiar with the Trust’s Medical Emergency & Cardiopulmonary Resuscitation policy, location and use of medical emergency equipment and local procedures for activating and responding to medical emergency and cardiac arrest calls.

The Trust has a comprehensive training programme in basic and intermediate life support procedures and the use of an automated external defibrillator. Annual mandatory training can be accessed via the Training and Development Department at Springfield Hospital.

The Trust conducts unannounced simulated medical emergencies through the various hospital sites within the Trust. Your participation and cooperation in these exercises are expected.

Simulations are viewed as a positive learning tool and are followed up immediately by a debriefing and a written report for team members and appropriate personnel.

The Trust’s Medical Emergency and Resuscitation Committee meet on a regular basis to review and update evidence-based practice.
3.2 ACTIVATING MEDICAL EMERGENCY PROCEDURES WITHIN HOSPITALS AND THE COMMUNITY
(Link Person: Director of Nursing)

Remember: if in any doubt regarding the physical well being of an individual it is safer to activate the medical emergency system and obtain help. The trust accepts false alarm calls are inevitable. All medical emergency procedures within the hospital and community setting must be reported using the appropriate documentation and sent to the Trust’s Resuscitation Officer at Springfield Hospital c/o the Nursing Directorate.

Suspected Medical Emergency

Activate the appropriate medical emergency system within your hospital (see Appendices).

Community care services will activate ‘999’

When phoning, ensure that the operator has understood and acknowledged the nature and location of the medical emergency.

Example Call in trust sites with medical emergency teams:

- Caller: ‘that is correct’

For 999 calls provide all information as fully as possible as asked for by the operator

Ensure that the medical emergency team and/ or ‘999’ services can gain immediate access to the site of the emergency.

Bring all emergency medical bags and defibrillator to the scene

If a second person is available they must be allocated to meet and guide the emergency team/paramedics to the site of the medical emergency.

Commence the appropriate medical emergency/ basic life support care whilst awaiting the arrival of the medical emergency team and/or ‘999’ ambulance.
3.3 IN-HOSPITAL ADULT BASIC LIFE SUPPORT AND AUTOMATED DEFIBRILLATION
(Link Person: Director of Nursing)

Patient Collapsed - Ensure it is safe to approach

Assess responsiveness & shout for help

Not responsive

Responsive

Assess breathing, and any signs of life

No breathing or abnormal breathing - Or Unsure!
- Call medical emergency team.
- Obtain defibrillator, orange BLS bag and Green ILS Bag.
- Commence CPR if defibrillator not immediately available.

On arrival of defibrillator:
- Switch on.
- Follow audible instructions provided.
- Perform CPR unless audible instructions indicate otherwise.

CPR
- Oxygenate at 15 litres per minute
- Ventilate/Chest Compressions 2:30
- Await arrival of '999' ambulance.
- Find patients notes.
- Inform next of kin.
- Ensure documentation has been completed for transfer to A/E Dept.

Definite breathing and pulse
- Call medical emergency team.
- Oxygen 2-4 litres.
- Assess BP, pulse, and respiration.
- Oxygen saturation.
- Blood glucose.
- Intravenous access.
- Keep warm.
- Assess: airway, breathing and pulse every minute.
- If in any doubt concerning presence of breathing or abnormal breathing, commence CPR.
3.4 ADULT CHOKING ASSESSMENT AND TREATMENT
(Link Person: Director of Nursing)

ASSESS SEVERITY

SEVERE AIRWAY OBSTRUCTION
(Ineffective cough)

MILD AIRWAY OBSTRUCTION
(Effective cough)

UNCONSCIOUS
START CPR

CONSCIOUS
5 BACK BLOWS
5 ABDOMINAL THRUSTS

ENCOURAGE COUGH
CONTINUE TO CHECK FOR DETERIORATION TO INEFFECTIVE COUGH OR RELIEF OF OBSTRUCTION
WHAT TO DO IN A CASE OF A HANGING OR STRANGULATION

3.5 WHAT TO DO IN CASE OF HANGING OR STRANGULATION

- Put out Medical Emergency call
- Get all emergency equipment
- Call 999 ambulance
- Support body while ligature is cut. Use the scissors from the Blue airway/breathing Bag (Don't cut through the knot)
- Lay patient flat on the floor. Ensure you have enough space to get behind the head
- Assess patient's response: Tap & Shout

PATIENT UNRESPONSIVE
Open airway and check for breathing

- NOT BREATHING OR BREATHING ABNORMALLY
COMMENCE BASIC LIFE SUPPORT
- 30 Chest compressions to 2 rescue breaths with Bag valve mask device
- Attach Defibrillator as soon as it is available
- If non shockable rhythm detected follow the non shockable side of Advanced Life Support algorithm
- If a shockable rhythm detected follow the shockable side of the Advanced Life Support algorithm
- Ensure oxygen is attached to the Bag valve mask device with a flow rate of 15 litres/min

- BREATHING NORMALLY
Assess Patient fully using ABCDE approach
- Give Oxygen via high volume mask with reservoir bag with a flow rate of 15 litres/min
- Attach Pulse oximeter and monitor saturation aim to maintain between 94-98%
- Obtain I.V access with the largest venflon you can put in. Keep the line open with I.V fluid at the slowest rate possible
- Perform & Record observations of Pulse, Respirations, BP, O₂ Sat. Temperature & AVPU. Record on NEWS Chart
- Check patient, their clothing, & property for other signs of self harm, such as O.D or cutting
- If time allows before arrival of emergency services record a 12 lead ECG

PATIENT RESPONSIVE
AssessPatient fully using ABCDE approach

Hence do not cut through the knot.

If the patient does not survive, the police will investigate. They will want to see the ligature used, and what knot was used to tie it. Hence do not cut through the knot.

Cutting down the patient must be done as quickly as practicable. Ensure enough staff are available to prevent injury to both patient and staff.
As most drops are small, it is unlikely that any cervical spine injury will have occurred, but try and support the head and neck as best you can.

If the patient does not survive, the police will investigate. They will want to see the ligature used, and what knot was used to tie it. Hence do not cut through the knot.

If time allows before arrival of emergency services record a 12 lead ECG.

CC/MERC. 2013
### 3.6 NASO-GASTRIC TUBE FEEDING IN ANOREXIA NERVOSA PATIENTS

*(Link Person: Director of Therapies)*

This policy refers to the naso-gastric feeding of a patient with anorexia nervosa against their will and using a Proactive Physical Intervention (PPI) technique. It should be read in conjunction with the full policy on enteral feeding including procedures for the insertion of naso-gastric tubes.

#### Assessment Process:
- This procedure can only be carried out against a patient’s will, without consent and using a PPI technique if the patient is detained on a Section 3 of the Mental Health Act 1983 or with parental consent under the Children’s Act (1989).
- This procedure should only be carried out if there is a recent (in the last 2 weeks), agreed multi-disciplinary team care plan in place, which is clearly documented in the patient’s notes.

#### People involved:
- Senior Nurse/shift coordinator on duty to co-ordinate.
- Medical Officer to monitor patient – usually Ward Doctor. If out of hours, Duty Doctor.
- Nursing team from the eating disorder service, with current PPI certificate (where possible).
- Nursing team from the eating disorder service, trained and competent in administering a naso-gastric tube.

#### Preparation
- This procedure will always be risk assessed, planned and reviewed by the MDT. The following people should be notified of the plan beforehand:
  - **IN HOURS** – the ward manager/modern matron should be informed of the plan to initiate restraint to feed
  - **OUT OF HOURS** – The onsite nurse advisor and on call manager should only be informed if an injury occurs or incident happens during the intervention.
  - The rationale for implementing naso-gastric feeding will be explained to the patient. The procedure will be explained to the patient.
  - In the case of a young person, the procedure will be discussed with the parent/guardian/carer beforehand.
  - Clear documentation and record-keeping to be carried out by Senior Nurse shift coordinator
  - Follow-up observations to be delegated beforehand.
  - Clear documentation and record-keeping to be carried out by shift co-ordinator/nurse leading the feeding procedure.
- Equipment to be prepared in advance.
- The security team on site at Springfield Hospital must not be involved in the PPI intervention. If planned support is requested from other areas, security may be asked to provide support to patients and staff. NB. This is not a psychiatric emergency. The nurse in charge may consider that the presence of security staff on the ward (e.g. on the adolescent unit) may be unnecessarily distressing for patients and can therefore decide that their presence is not required.
- Ensure that there is sufficient staffing to safely undertake this procedure.
**Naso-gastric tube placement:**
- An appropriately trained and competent qualified nurse should be identified to pass the NG tube prior to commencing the procedure.
- Naso-gastric equipment and feed to be prepared in advance by the designated nurse.

**INTERVENTION:**
1. The procedure should be explained to the patient, and the reasons for undertaking it clearly outlined. The patient should be given every opportunity to accept the feed without the use of restraint.
2. IM medication should be given prior to the procedure if necessary.
3. The team must use a seated position (please see NG/PPI care plan supplement) in accordance with the Trust’s therapeutic management of violence and aggression policy. The team will be made up of nurses from the eating disorders service. **POSSIBLY ADD A LINK TO THE NG/PPI CARE PLAN SUPPLEMENT AND ADD THAT INFO TO THE mva POLICY**
4. One nurse FEEDING THE TUBE should be allocated to speak to the patient DURING the procedure, offering support, reassurance and explanation whilst it happens.
5. The designated nurse should pass the Naso-Gastric tube, and ensure that it is placed correctly using the procedure described in the Enteral Feeding guidelines.
6. Staff must have the competence and confidence to assess when the intervention is causing unnecessary distress and when the restraint is prolonged. In this instance staff should halt the procedure and review the plan.
7. The nursing team should at all times monitor the patient’s level of consciousness, pallor, breathing, whilst continuing to observe that the tube is correctly placed.
8. After the feed has been administered, the lead communicator should hand over the responsibility of the intervention to one of the staff holding the arms. This person would then commence a seated de-escalation procedure.
9. One nurse should remain with the patient offering support and reassurance. There may be a risk of vomiting which needs to be observed. This nurse should carry out observations of Pulse and Blood Pressure regularly for as long as is considered necessary, but most importantly directly after the procedure. This nurse should continue to offer to help the patient discuss their anxieties.

**Physical Observation Monitoring:**
- Pulse should be monitored during the restraint by a nurse holding an arm
- Follow-up observations to be delegated beforehand.
- A doctor should be aware that the procedure is taking place and available present during this procedure. The ward doctor or duty doctor should therefore be alerted depending on the time of day.
- Physical observations to be documented on a NEWS chart.

1. The procedure must be documented in the notes including a rationale for initiating the NG replacement plan using PPI.
2. Complete an Incident Form for all naso-gastric tubes passed using PPI.

3. The team involved in the procedure must conduct a post incident review after the event.

4. The Nurses involved should discuss the procedure and the rationale for why with the patient as soon as is appropriate after the event.

5. Other patients on the ward to be checked and offered support if needed.

6. Ward doctor/Duty Doctor to be aware of risk of physical complications and monitor accordingly. There may be a possible drop in serum phosphate levels and bloods to be taken if necessary.

7. If the patient wishes, then a nurse from the team should offer support, explanation and reassurance to the family/carers where appropriate.

8. If the patient’s agitation and resistance to feeding is extreme, consideration should be given to the use of sedation. In low weight patients this should be done cautiously, with close monitoring of physical observations. The aim of sedation is to calm the patient. Care should be taken to ensure that the patient remains awake for the procedure.

9. If the patient’s physical state is concerning e.g. abnormal ECG, grossly abnormal electrolytes, such that they require additional medical intervention e.g. intravenous supplementation or cardiac monitoring, then the patient MUST be transferred to the care of physicians at St. George’s Hospital.
3.7 CHEST PAIN PROTOCOL

Cardiac sounding – consider:

1) Nature of pain (Site, Onset, Character, Radiation, Alleviating, Timing, Exacerbating, Severity)
2) Cardiovascular risk factors (diabetes, smoking, total cholesterol >6.47mmol)
3) History of ischemic heart disease
4) Previous investigations for chest pain

If yes to any of the above then use protocol otherwise consider other diagnosis.

Suspected Acute Coronary Syndrome (ACS) – consider:

1) Pain in chest/arm/back/jaw >15 minutes OR collapse
2) Nausea and vomiting
3) Shortness of breath
4) Haemodynamically unstable
5) New onset of pain or sudden worsening of stable angina on minimal exertion producing pain >15 minutes duration

If yes to 1) or 5) then suspect ACS

Suspected ACS?

Yes

No

Consider alternative diagnosis:
1) Pulmonary embolus
2) Aortic dissection
3) Pneumonia
4) Gastro-oesophageal reflux
5) Musculoskeletal

Timing of chest pain

Perform 12 lead ECG. If unsure about findings discuss with cardiology registrar on call

Abnormal ECG?

Yes

No

Emergency admission
while waiting for ambulance
1) Use Basic Life Protocol
2) 12 lead ECG
3) Aspirin 300mg chewable
4) GTN spray
5) Give oxygen if sats below 94% or 88-92% if COPD

Same day assessment in A&E
Discuss urgency of referral with medical registrar on call

Further assessment
1) Troponin level
2) 12 lead ECG
3) Consider referral to Rapid Access Chest pain clinic or cardiology clinic

Complications e.g. pulmonary oedema

Yes

No

Now

<12 hours ago

12-72 hours ago

>72 hours ago
4.1 CORE TRAINEE ON-CALL DUTIES
(Link Person: Core Trainee representative)

Overview
Four Core Trainee (CT) rotas cover the Trust’s five boroughs: Wandsworth and Merton (Springfield), Kingston and Richmond (Tolworth/Queen Mary’s/Kingston hospital) and Sutton. (St Helier’s hospital). Although broadly similar, differences exist between their on-call duties.

Daytime on-call
Core Trainees should try to arrange team admissions and routine work for when they are on site or get the ward to wait when possible, for example if at a morning clinic. The majority of Core Trainees are paired and when their daytime duties cannot be performed, their named pair should do them. Paired Core Trainees should not be on leave at the same time and are not expected to cover ward rounds or clinics, but rather see new admissions and trouble-shoot specific problems. For simple tasks (such as prescribing), if the team registrar is around they should assist.

Cross Cover
Springfield Hospital has a Cross Cover arrangement which is a separate document in this book. This is organised by different wards clustering together to provide cover for each other. In circumstances where neither the team Core Trainee nor the cross cover team is available, duties fall to the on-call Doctor. Tolworth, Queen Mary’s and Springfield Hospitals have daytime (9am–5pm) on-call rotas, and all 4 rotas, including Sutton rota (St Helier’s hospital) have a rota for evening cover (5pm–9pm).

The on-call duty doctor is the nominated deputy for the purposes of the Mental Health Act, 1983 and therefore is the Duty Doctor responsible for applying Section 5.2 on-site should it be required. The team doctors cannot apply Section 5.2 to their patients unless they are the duty doctor.

At all sites, CMHTs should assess their patients prior to admission and put a full account into the RiO Progress Notes. Any GP referrals which reach the Duty Core Trainees directly should be directed to the appropriate team.

All sites have Liaison teams that cover A&E during working hours and the duty core trainees should only be contacted in very exceptional circumstances.

Evening on-calls are from 5pm until 9pm. Sutton Core Trainees cover St. Helier A&E during this period. Core trainees on the Queen Mary/Tolworth rota cover either Queen Mary’s Hospital or Tolworth Hospital. Queen Mary’s core trainee also provide cover to Kingston A&E should a child present or lack of cover of the Kingston Liaison Team between 5pm and 9pm. If the QMH core trainee has to cover Kingston Hospital, then the Tolworth Core Trainee would then cover both Tolworth and Queen Mary’s.

Springfield duty doctors do not cover St Georges A+E as this is covered by the Liaison team on a 24 hour basis. Night shifts start at 8.30pm to allow time for handover with the person on evening on-call who leaves at 9pm.
Though a full assessment and note taking in A&E usually takes well over an hour, Core Trainees should accept referrals and start their assessment at the earliest rather than pass them on directly to their night colleagues. Getting corroborative history and liaising with other agencies can be done before the doctor for the next shift comes on.

Nights on-call
All sites are full shift (resident), with the day off preceding and following a night shift. All four rota (Queen Mary’s, Sutton, Tolworth and Springfield) split this into four weekday nights and three weekend nights.

Out of hours GP referrals
As below, the Crisis and Home Treatment Teams (contact details) can and should be involved and the GP deputising services are encouraged to phone the Crisis 0800 number rather than bleeping the duty doctor. The Crisis Team will take the referral details; arrange a visit in a safe place.

In most instances, this may be A&E, especially if a physical workup is indicated. Where calls come directly to the Core Trainees, they should take the referral details, liaise with Crisis and Home Treatment Team, and hand over to their colleague covering A&E.

In some instances, it may be considered preferable to exercise discretion and assess the patient on the ward. Such occurrences are not common and should be with the agreement of all concerned, such as the assessing ward and duty senior nurse, as well as the Crisis and Home Treatment team, above. An example of where this might occur would be with a patient very well known to the ward, with a very clear cut presentation, perhaps shortly after a recent discharge. Tolworth and Queen Mary’s will take patients under 65 directly onto the appropriate ward for assessment, unless concerns exist about potential organic causes of illness.

As well as covering A&E, Core Trainees will cover the relevant hospital’s wards in the case of emergency only. Most requests for ward assessments can wait for referral to the local Liaison Psychiatry service within hours. An exception is the Medical Assessment unit in Kingston hospital, which is expected to be covered by on-call Core Trainee.

Please note with regards to Kingston A+E DSH patients do not need to medically cleared before they are referred to you. If the patient is to be admitted to the acute trust you are expected to provide a risk assessment on transfer to the medical ward.

For patients with previous involvement with mental health services, it is invaluable to speak to the ward(s) involved and to use the RiO database. RiO should contain a Care Plan, Risk assessment, and copies of previous correspondence (in “Clinical Documentation”) as well as the most recent Progress Notes.

For patients who present at A&E out of hours who genuinely have no fixed abode the responsibility and NFA rota consultant borough will be determined by where they present.

Home Treatment Team (HTT) Gatekeeping and Bed Management (see flowcharts)
Gatekeeping adult beds is a vital function of HTT both in hours and out of hours. In essence adult admission cannot occur without the involvement and agreement of the
locally Home Treatment Team (identified according to current CMHT or the address of the patient not their GP).

Everybody (including people in need of mental health act assessments) requiring emergency access to acute mental health services (CRHT and In-patient) go through the gatekeeping process. This requires:

- The HTT to provide a mobile 24 hour, seven day week response to requests for assessments.
- The HT team actively involved in all requests for admission for adult beds
- The HT team being notified of the impending mental health act (MHA) assessments.
- The HT team assessing all these cases before admission happens.
- The HT team being central to the decision making process in conjunction with the rest of the multi-disciplinary team.

(Guidance Statement on Fidelity and Best Practice for Crisis Services DH 2006)

Currently the full HT teams work until 11pm seven days a week and then operate night cover for gatekeeping assessments. Referrals should be made direct to borough home treatment team numbers (see Home Treatment Section in Blue Book 14.1.) Teams may also be contacted via the 0800 028 8000 Crisis Line out of hours only.

Teams are required to be actively involved in all admissions to hospital with a 95% face to face gate keeping standard.

If assessment by the Home Treatment Team is in favour of admission, the relevant ward needs to be contacted to arrange this. It is not the core trainee’s job to find an adult bed should none be available but rather the primary responsibility of the Home Treatment Teams in Wandsworth, Merton, Kingston or Richmond supported by the locality wards. The principles of the bed management protocol are that acute patients should be admitted to their locality ward and this may necessitate early discharge to Home treatment of a Green Zone patient, or transfer to a neighbouring locality ward of a green zone patient, to facilitate this. Moving existing patients after 9pm is to be avoided. Utilising beds of patients on leave is accepted practice. In extreme cases vacancies on older peoples wards can be utilised. The use of external private beds does not occur for acute admission. The senior manager on call can be contacted in complex cases via switchboard.

More recently a trial protocol for Consultant Gatekeeping in addition to the processes above has been implemented. Therefore if one does have a potential informal admission then liaise with the on-call team and/or Home Treatment Team.

**A&E**

It is important to be aware when performing a review at A&E’s that the patient remains the responsibility of the acute Trust where they presented. Such review does not lead to the patient becoming the responsibility of the Core Trainees or Crisis Team unless admittance to the Mental Health Trust’s ward is agreed.

Therefore, in transfers to other Trusts, responsibility ultimately lies with A&E. However, cooperation and helpful liaison with the Charge Nurse in A&E are the most useful assets in such occasionally difficult episodes.
If patients are sent home from A&E, but the Core Trainee wishes to alert the RST, GP, or arrange follow up, the practice is for them to fax or post such referrals on themselves. Patients should be given the Trust Crisis Line free phone number. Core Trainees do not provide cover for physical problems at Burntwood Villas and, should this be required, they should contact the out of hours GP service, or, if needed, send the patient to A&E.

The Core Trainee on duty from 17.00 until 21:00 will have to obtain the on-call mobile and/or pager and/or radio. There will be a formal face-face handover at 20.30 between the finishing and starting Core Trainees. The handover occurs in the Liaison office at St Helier and Kingston, Doctors Mess at Springfield and on-call room at Tolworth for the Tolworth/Queen Mary on-call.

Taxis will only be provided by the Trust between hospitals.

**Section 136 patients**

Patients may be brought by Police under Section 136 of the Mental Health Act to a place of safety. Currently all S136 assessments are done in the Section 136 suite at Springfield Hospital. It is the Core Trainees responsibility to perform a physical examination, including a drug and alcohol screen, and a brief mental state examination, prior to assessment by the duty Specialist Registrar. The aim of this is to check suitability for further assessment. Naturally, the Core Trainee must be satisfied that it is safe to do so first.

**Specialist services**

None of the sites provide acute detoxification facilities for drugs or alcohol. If a patient requires urgent treatment for either of these, they should be seen and treated accordingly by the duty physicians. However, patients may at times be admitted with co-morbid drug and alcohol dependency. Advice on detoxification regimes is given in this book. Patients who do not require admission can be referred to the local Community Drugs and Alcohol Team, usually through their GP. Similarly, there is no provision for acute admission of patients with eating disorders.

In emergencies, they should be admitted under the physicians. The Eating Disorder wards at Springfield Hospital may be able to provide advice on specific patients should concerns remain.

All sites have specific wards for Psychogeriatric patients. Some wards have policies of contacting the catchment area Consultant prior to any admission and this should be checked with the ward.

The duty core trainee also covers children and adolescents out of hours. Core trainees should assess these patients and discuss ALL patients with the CAMHS SpR. Usually; episodes of Deliberate Self Harm or overdose are admitted to the Paediatric ward, with follow up the next day, by CAMHS. At weekends the on-call SpR for CAMHS/LD will review CAMHS patients admitted to the paediatric ward during the day.
CONTACT DETAILS

Disclaimer: attempts have been made to keep all details on this list as up to date as possible. However, it is possible that some sites have been omitted. In cases of concern, please discuss with the Trust Site Coordinator.

Duty Core Trainee Mobiles
Kingston Hospital – 07702 719636
Queen Mary’s Hospital – 07970 523784
Tolworth Hospital – 07590 961699
St Helier Hospital - 07875 722811
Springfield Pager - 0844 822 2888

Crisis and Home Treatment Teams
Crisis Line and Wandsworth HTT 0800 028 8000
Merton HTT (Day) 07525 671483
Sutton HTT (Day) 07595 400880
Sutton and Merton HTT Night Phone 07803 624158
Kingston HTT 07912 071848
Richmond HTT 07900 681305

Hospital Sites
Springfield Switchboard 020 3513 5000
Tolworth Switchboard 020 3513 5000
Queen Mary’s Hospital 020 8487 6000
Kingston Hospital 020 8546 7711
St. George’s Hospital 020 8672 1255
Medical Staffing 020 8682 6843/6423/6759
St. Helier Hospital 020 8296 2000
Wilson Hospital 020 3458 5580
Jubilee Health Centre 020 3513 3950

MHA ASSESSMENT REFERRAL
Merton, Sutton, Kingston, Richmond 020 8744 2442
Wandsworth 020 8871 6000
4.2 CROSS COVER - SPRINGFIELD
(Link Person: Core Trainee representative)

The following is the current cross cover arrangements at Springfield Hospital. Cross cover should be used in the absence of the ward doctor prior to contacting the duty doctor. This cross cover will place no restrictions on leave and there is no requirement to coordinate leave with other wards as due to the current functioning of the rota this is very difficult.

If there is no cross cover doctor available then the ward would have to contact the duty doctor who should perform the duty. The duties which should be covered are those which need to be performed on the day and could not wait for the normal clinical team to come back. Examples of this work would include reviewing unwell patients, updating drug charts etc… It would always be the responsibility of the duty doctor to perform duties such as attending medical and psychiatric emergencies and providing cover out of hours.

Cluster A – Ward 1, Ward 2 and Ward 3

Therefore in the model shown below Ward 1 would always call Ward 2 initially and if there was no doctor to cross cover on Ward 2, they would call Ward 3. If there was no doctor to cross cover on either ward it would be the responsibility of the duty doctor.
**Cluster B – Jupiter, Crocus and Avalon**

Therefore in the model shown below Jupiter would always call Crocus initially and if there was no doctor to cross cover on Crocus, they would call Avalon. If there was no doctor to cross cover on either ward it would be the responsibility of the duty doctor.
Cluster C – Halswell, Turner, Ruby and Hume

Therefore in the model shown below Halswell would always call Hume initially and if there was no doctor to cross cover on Hume, they would call Turner. If there was no doctor to cross cover on Turner ward, then Ruby would cover. If no ward were able to cross cover then it would be the responsibility of the duty doctor.
Cluster D – Wisteria and Aquarius

Therefore in the model shown below Wisteria would always call Aquarius initially and if there was no doctor to cross cover on Aquarius, it would be the responsibility of the duty doctor.
Cluster E – Phoenix, Seacole, Bluebell

Therefore in the model shown below Phoenix would always call Seacole initially and if there was no doctor to cross cover on Seacole, they would call Bluebell. If there was no doctor to cross cover on either ward it would be the responsibility of the duty doctor.
4.3 OVERVIEW OF OUT OF HOURS SUPPORT STRUCTURE

During the ‘out of hours’ period day-to-day operational issues will be managed by the On-Site Nurse Advisor, where escalation is required they will contact the Manager On-Call. Should it be necessary, the Manager On-Call will escalate issues to the Director and, if required, clinical queries will be escalated to the medical on-call team. The exception to this is where a doctor phones in sick/unable to cover their on-call shift. The Manager On-Call will be required to arrange rota coverage by initially telephoning the junior doctors from the contact list. If after calling around and no-one is available then the doctors agency [Pulse] can be contacted to fill the shift.

In addition the medical team will provide on-call support to the Springfield, Tolworth, Queen Mary’s, Richmond and Barnes Hospital sites. A&E support is also provided to Kingston, St Helier and St George’s Hospitals. There are three levels of medical cover [Core Trainee 1-3, Core Trainee 4-5 and Consultant].

The On Site Nurse Advisor (OSNA) will act as the first point of contact for staff who need management support across the Trust out of hours. The aim of the role was to provide a consultation service to the other ward nurses across the Trust and the on-call manager. The service operates from 20.30 to 07.30 Monday to Sunday and during 09.00 to 17.00 Saturday and Sunday.

The Manager On-Call (MOC) is the second point of contact, they need to be available during the on-call times to support the OSNA should senior support be required. However from 17.00-20.30hrs and 07.30-09.00hrs (Monday – Friday) and also 17.00-20.30hrs (Saturday and Sunday) the MOC will be the first point of contact. The MOC will be notified if medical cover is required and they will need to arrange cover, either internally or through a locum agency. The on-call manager will have access to the on-call directors via pager or mobile to escalate concerns or to verify actions.

The Director On-Call is the third point of contact. They are to be contacted for all media enquiries, an unexpected death of a patient, all major incident queries including IM&T technology queries having an impact of more than ten staff. A summary of the responsibilities for the on-call Director can be found within the Major Incident Plan (reviewed 2014).
4.4 AVOIDING OUT OF AREA ADMISSIONS

Avoiding out of area acute admissions to Trust beds

Final 25/7/11

Request for admission
Establish residency/ current treatment team/GP status as below options.
To check catchment area hospital for an address ring the 24hr. Emergency Bed Number line 0207 407 7181 and ask for ‘psychiatric catchment area enquiry’

Current patient of our services

New patient and Permanent resident of Kingston Richmond, Merton, Sutton, or Wandsworth.

No Fixed abode

Is the person open to another mental health service?

GP in another Borough to where resides?

YES

NO

If NFA but is registered to a GP outside our area but not open to a mental health service in that area then admission is where they are presenting

NO or don’t know

Last known address outside Trust area?

YES

NO

GP registration outside our area in the locality of last known address adds weight to a case that the patient is not usually resident here

Yes

Are they open to another Trusts team or placed in temp accommodation by another local authority?

YES

No or don’t know

Admission to SWLSTG Trust bed according to Borough of residence

If NFA but is registered to a GP outside our area but not open to a mental health service in that area then admission is where they are presenting

New patient and not ‘usually resident’ in Kingston Richmond, Merton, Sutton, or Wandsworth.

Includes temporary address, students staying with parents

Are they open to another Trusts team or placed in temp accommodation by another local authority?

YES

No or don’t know

Negotiate admission to responsible NHS provider bed

Next Door

See gatekeeping and bed management algorithms (blue book)

Page 9 of ‘Who pays? Establishing the responsible commissioner’ defined.
Where a patient has ‘no fixed abode’ and no GP registration the ‘usually resident’ test applies (see Annex A).
The patient is the final arbiter. If the patient considers themselves to be resident at an address, which is for example a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, then the address at which they were last resident will establish the PCT of residence. Holiday or second homes are not considered as “usual” residences.
4.5 PROCEDURE FLOWCHART FOR CHILDREN BROUGHT TO 136 SUITE

Within Hours (Monday to Friday, 9-5)

(Link person: Nurse Consultant)

Brought by Police to 136 Suite

Check RiO and contact Aquarius Ward if known.

Check GP and if known to the trust or out of area mental health services.

Contact CAMHS approved Doctor.

**Mon/ Tues/ Fri** – Aquarius

**Wed** – Wisteria

**Thurs** – Corner House

Contact CAMHS Modern Matron for advice and consultation.

Assess

Admit to other provision

Local Borough follow up

Admit to Aquarius Ward

Complete 24hour notification

Inform Wandsworth General Management
4.5i PROCEDURE FLOWCHART FOR CHILDREN Brought to 136 Suite

Out of Hours

(Link person: Nurse Consultant)

- Brought by Police to 136 Suite
- Confirm any demographic and other information with the police. E.g family details, contact numbers.

- Check RiO and contact Aquarius Ward if known.
- Check GP and if known to the trust or out of area mental health services.

- Contact Aquarius re:
  - Any known details
  - Alert to possible admission.

- Contact On-Site Nurse
- Discuss contact with family with the young person

- Contact on call CAMHS SPR, via Switchboard
- Contact on call AMPH
- Contact on call manager to update.

- Assess. If possible this should include parent/carer.

- Admit to other provision after discussion with on call CAMHS consultant.
- Admit to Aquarius after discussion with on call CAMHS consultant.
- Discharge home with local Borough follow up

- Complete 24hour notification as an alert. Copy to Named Nurse for Safeguarding and CAMHS Modern Matron.
PROTOCOL FOR THE MANAGEMENT OF PEOPLE PRESENTING AT HOSPITAL SITES WITHOUT REFERRAL

Ensure existing patients have a crisis card which details how to get help routinely and in a psychiatric emergency.

Recommended access routes for known patients are:
- Working hours – contact their community team
- Out of Hours – Crisis Line 0800028800 for psychiatric emergencies.

If you are not currently a Trust patient contact your GP who can provide routine and emergency care access.

**Link Person** - Service Development Lead Community

**Patient presents without referral at hospital site in crisis or asking for help.**

- **Crisis Home Treatment Team (CHTT) carry out initial screen unless patient is able to give current care co-ordinator/team.** Check name address, GP, DOB and verify responsible catchment area service. Check RiO if known and alerts.

**Presentation indicates need for urgent psychiatric assistance / and or associated social vulnerability**

- **Not sure (e.g. intoxicated)**
  - Facilitate initial TRIAGE ONLY in a safe place.

- **Vulnerable adult without need for urgent clinical treatment**
  - Refer to out of hours social work service

- **Urgent medical problem.** Seek advice from clinician / duty doctor. Facilitate transfer to local walk in clinic or A&E. Inform liaison psychiatry

**Requires full assessment for possible admission**

- **Admitted to ward**
- **Care remains with routine service or signposted/ transferred**
- **Accepted for home treatment**

**Gatekeeping assessment**

- **Contact locality crisis Home Treatment Team (HTT) to request a gatekeeping assessment**

- **Contact catchment area CMHT to request emergency assessment jointly with HTT**

- **If delay or out of hours utilise duty doctor for site,**

- **Gatekeeping** requires full assessment for possible admission

- **Admitted to ward**
- **Care remains with routine service or signposted/ transferred**
- **Accepted for home treatment**

- **Facilitate assessment in a safe place.** See on an appropriate ward at presenting site where it is safe to do so. Avoid transporting patients unnecessarily *

**Record triage, decisions and rationale on RiO**

*Transfer to A&E for assessment only if physically unwell, physically injured, have self harmed or suspected of self harm by poisoning. Utilise emergency team, security and or police if necessary*
Information is a vital asset, in terms of clinical management of service users and the efficient management of services and resources. Information Governance (IG) allows organisations and individuals to ensure that clinical and corporate information is dealt with legally, securely, efficiently and effectively in order to deliver best possible care. IG covers Confidentiality, Data Protection, Freedom of Information, Health Records, Information Security, Information Quality and Information Sharing. It is mandatory for all Trust staff to receive annual Information Governance training. Your induction should include a section on Information Governance. If you are interested in further training, please contact the Training and Development Department.

For further guidance refer to the individual Information Governance Policy [IG1].

[All the policies mentioned in this section can be found in the Information Governance pages under the Policies & Procedures tab on the Intranet (Insite).]
5.2 CONFIDENTIALITY AND DATA PROTECTION

Everyone working in the NHS has an obligation both to protect the privacy of the individual and to be open and accountable to the public.

The Confidentiality: NHS code of practice for all staff can be summarised as a duty to:

- **Protect** patient information
- **Inform** patients about how their information is used
- **Provide** choice to patients about how their information is used
- **Improve** the ways we protect, inform and provide choice about information.

**CALDICOTT PRINCIPLES**

The Caldicott Report was published after a review of how patient information in the NHS was handled. The report recommended that each NHS organisation appoint a Caldicott Guardian (in our Trust this is the Medical Director) and adopt the six Caldicott Principles:

- Justify the purpose of using confidential information
- Only use it when absolutely necessary
- Use the minimum that is required
- Access should be on a strict need-to-know basis
- Everyone must understand their responsibilities to keep information confidential
- Everyone must understand and comply with the law.

A second Caldicott Review in 2013 added a seventh principle:

- The duty to share information can be as important as the duty to protect patient confidentiality

**DATA PROTECTION**

The Data Protection Act 1998 sets standards covering obtaining, recording, holding, using or disposing of personal data (staff or patient) whether electronically or manually held. In brief:

- Tell patients and staff why you are collecting information, what you are going to do with it and with whom you may share it.
- Only use personal identifiable information for the purpose for which it was obtained. If you want to use it for something else, you must obtain consent.
- Never collect information you do not really need.
- Do not just assume that what has been collected before is correct – check details such as spellings, addresses etc.
- Don’t keep information longer than necessary (refer to DoH retention guidelines for further information on retention periods – copy available on the intranet).
- People have a right to access any information held about them and to correct or delete any inaccurate information.
- Always keep personal information secure at all times, whether held electronically or on paper.
- Think before you share any personal information by telephone, fax, e-mail or post – always choose the most secure route and ensure the information reaches the person for whom it is intended.

For further guidance refer to the Data Protection Policy [IG4].
5.3 RECORDING PATIENT INFORMATION AND CONTACTS

Health and social care records consist of any information relating to the physical, mental health or social aspects of an individual made by or on behalf of a professional in connection with the care of that individual. The successful implementation and maintenance of each service user's record depends on the commitment of all involved in providing our mental health services. To enhance client care, all professionals are expected to share integrated records across professional and organisational boundaries (where consent has been obtained or where there is a lawful requirement to do so) to meet clients’ needs. Each service user will therefore have a single, structured, multi professional agency record which supports integrated care. Each person is responsible for any records that they create or use.

RiO (and IAPTus within certain services) is now the standard Trust system for keeping electronic records for service users. The record on RiO is the authentic record; therefore, all information relating to service users must be recorded there. Paper records must not be kept for as an unofficial alternative to RiO. The only exception is specified supplementary paper records as defined in the Health and Social Care Records Policy [IG40].

All records should be contemporaneous and it is the responsibility of each professional to ensure that information is recorded as soon as is practicable.

Health and social care records are legal documents and are replaceable. They should be stored and accessed securely at all times and only accessed or shared in accordance with Caldicott and Data Protection principles.
5.4 INFORMATION SECURITY

Confidentiality: ensure that no member of staff, service user or visitor who is not authorised has access to any confidential information.

Integrity: ensure that it is possible to rely on information generated by every system within the Trust, for instance, information used for treatment is not only recorded but that it is complete and correct.

Availability: ensure that clinical systems within the Trust are able to provide the necessary and appropriate information by recording information in a timely manner.

- Do not use portable storage devices, e.g. floppy disks, CDs, DVDs or USB sticks to save confidential information, including patient information. Only USB sticks provided by the Trust may be used with Trust equipment.
- Always save documents on the Network, never on the hard drive.
- Always log off when away from your desk or use a password protected screen saver.
- Whenever possible use anonymised information.
- Do not send confidential information by email unless it is sent as a password protected document.
- Be careful about where you conduct confidential conversations.
- Ensure that you only fax documents to a safe haven fax machine – and phone to check documents have been received.
5.5 INFORMATION QUALITY

High quality information is vital to safe and effective patient care and for this purpose 100% accuracy 100% of the time must be the goal. In clinical care, poor quality information recorded in the record may:

- result in service users being harmed or distressed
- undermine the trust staff place in recorded information.

The Trust requires all practitioners to make accurate, complete, succinct and up-to-date records in the provision of high quality care to each patient/client. (The Trust recognises the standard abbreviations as acceptable for record keeping [see Appendix 8 at the very end of this book].) Shortcomings in records can have repercussions on service users and can cause serious distress to them and/or their families. The quality of care may be damaged where there has been failure to pass on or to record important information.

Record keeping is an integral part of clinical practice; it is a tool of professional practice and one that should help the care process. Good record keeping is not separate from the care process and it is not an optional extra to be fitted in if circumstances allow.
5.6 INFORMATION SHARING

Information Sharing is an essential part of providing a ‘joined up’ service. The Trust holds huge amounts of information that may be of interest to outside bodies, e.g., the Police, Social Services and regulatory bodies. Such disclosures without consent are made at our own discretion. Before we share any confidential information, we need to ensure that it is lawful to do so.

Many of the legal issues surrounding disclosures or information sharing can be avoided by obtaining the consent of the service user. The aim should be to obtain consent in non-emergency situations – for example, where information may be used for research or staff training. It is lawful to disclose confidential information without consent when protecting vital interests, in helping to prevent or detect crime, for legal purposes, for the fulfilment of statutory functions and for medical purposes.

All requests to see health and social care records whether they are electronically or manually held must be directed to the Information Governance Manager. Under no circumstances must staff give records to the Police, lawyers, service users, or send original records to other hospitals.

If you are unsure about whether or not to share information please contact the Information Governance Manager for guidance.

Sharing information with the Police
The Trust seeks to cooperate with the police at all times but must also ensure that the above requirements are met. The police must submit requests for information in writing to the Information Governance Manager. Out-of-hours requests that cannot wait until the next working day should always be discussed with the on-call Director who is the de facto Caldicott Guardian before a response is made.

For further guidance please refer to the Crime and Disorder Policy [IG2].
5.7 COPYING CORRESPONDENCE TO PATIENTS

All letters written by Trust professionals to other professionals within or outside the Trust should be copied to the person to whom they refer too. Exceptions to this are:

- Letters which contain personal details that would reveal information which related to and identifies another person (for example, that a relative has provided certain information), unless the person has consented to the disclosure, or can be fully anonymised in the letter, or it is reasonable to provide the information without consent (this exception does not apply where the person identified is a health professional), or,

- Where permitting access to the information contained in the letter would be likely to cause serious harm to the physical or mental health or condition of the person to whom the letter relates or any other person (including a health professional).

A person can indicate that they do not wish to receive copies of correspondence relating to their care. Decisions to not copy correspondence to a service user should be recorded on RiO.

All letters sent to the person to whom they refer should be marked ‘private and confidential’. Letters should avoid jargon and be written in language that is understandable to that person.

This policy is relevant only to letters. The Care Programme Approach Policy relates to care plans and risk assessments and indicates that, where possible, these should be shared with the person to whom they refer.
5.8 MENTAL HEALTH TARIFF – CLUSTERING AND CARE PACKAGES

(Link Person: Justin Earl)

Introduction

The government has introduced a new way of funding mental health services. This means mental health service providers will in future receive a payment for each person to whom they provide support, instead of one big payment or block grant to cover their costs. The Department of Health (DoH) produced a document to enable implementation of Mental Health Tariff (previously known as Payment by Result (PbR)):

- Mental Health Clustering Tool booklet

The booklet is available online at:


It will soon be available on a newly developed Mental Health Tariff page on the Trust intranet InSite.

The MHCT consists of the common assessment tool, which is a development of HoNOS (Health of the Nation Outcome Scales) and guidance for allocation to the 20 care clusters. These provide the ability to group people with similar needs and characteristics and to develop a care pathway to address these needs.

A new programme of training is being developed and this will include opportunities for ongoing refresher training to ensure that staff are up-to-date with all the developments with clustering and care packages.
**5.9 INPATIENT DISCHARGE SUMMARY v2.2**

Inpatient Discharge Summary v2.2  
Essential Information for primary care

Editable Letter no. 31 on RiO  
Once completed, the discharge summary should be sent to both the GP and service user within 7 days of discharge and uploaded onto RiO and saved using the approved naming convention:  

| DX1 yymmdd Discharge Summary |

<table>
<thead>
<tr>
<th>Name:</th>
<th>GP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>GP Address:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Carer name (if applicable and service user has given consent to use):</td>
<td></td>
</tr>
<tr>
<td>Ward:</td>
<td>Community team:</td>
</tr>
<tr>
<td>Inpatient consultant:</td>
<td>Community care coordinator:</td>
</tr>
<tr>
<td></td>
<td>Care coordinator tel. no:</td>
</tr>
<tr>
<td>Date of admission:</td>
<td>Date of discharge:</td>
</tr>
<tr>
<td>Cluster on admission:</td>
<td>Cluster on discharge:</td>
</tr>
<tr>
<td>Length of stay:</td>
<td></td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Follow up appointment:</td>
</tr>
<tr>
<td>Physical health comorbidities:</td>
<td></td>
</tr>
<tr>
<td>Allergies/intolerances:</td>
<td></td>
</tr>
</tbody>
</table>

**Circumstances of admission and inpatient progress**

- Brief description of history of symptoms that led to admission and any precipitating factors
- Brief description of how the service user was admitted and if it was under a section of the Mental Health Act
- Brief description of mental state on admission, any significant events or care received during admission and mental state on discharge

**Example**

XXX had not engaged with the CMHT for 3 months. Staff at his hostel reported an increase in agitation, paranoid delusions and he appeared to be responding to auditory hallucinations. He admitted to stopping his oral olanzapine 3 months ago. XXX was admitted following a Mental Health Act assessment at Battersea police station. He had been arrested after causing a disturbance in a local shop. He was shouting and swearing at male members of the public who he accused of trying to sexually assault him. He pulled out a 10cm kitchen knife and threatened to “cut up” anyone who approached him. On assessment at the police station, and on admission, he was found to be agitated, irritable, and thought disordered. He expressed a number of delusional beliefs, focusing on a government conspiracy and a plot to assault and kill him. He showed no insight into his illness. Following admission, Mr Smith required rapid tranquillisation and transfer to the psychiatric intensive care unit as a result of threatening behaviour and damage to ward property. He continues to refuse all medication and was started on depot clopoxil after which his mental state gradually settled. He had a number of successful overnight leaves before discharge. At the point of discharge he was calm, not thought disordered, denied auditory hallucinations and paranoid delusions.
Inpatient medication management (including the rationale for any medication changes)
- Documentation of medication on admission including dose and frequency
- Documentation of changes to medication during admission, including reason for medications being stopped and rationale/purpose of medication started

Example
Prior to admission, XXX was prescribed olanzapine 20mg od. He was not compliant with this prior to, or on, admission as he did not believe he was unwell or that he needed medication. Due to non-compliance with oral medication, on-going positive psychotic symptoms and agitation he was started on Zuclopentixol Decanoate IM gluteal depot which was increased to 400mg weekly.

Inpatient physical health assessment
- Record of observations – BP, pulse, BMI
- Record of blood test results and date
- Record of ECG results and date
- Record of any other investigations, psychical health diagnosis and treatment received during admission

Example
BP 120/60, Pulse 65 reg, BMI 18
Physical examination: unremarkable
Bloods: 8/5/13 – Na 142, K 3.8, Urea 3.6, Creat 79, gfr >90, Bili 15, Alp 95, Alt 15, Albumin 43, Total chol 3.4, Tsh 2.45, Prolactin 170
ECG 8/5/13: Normal sinus rhythm

Risk history/Risk incidents
- Summary of history/incidents of risk to self, risk to others and risk from others
- Documentation of children and adult safeguarding concerns

Example
To self: He has a history of neglecting his self-care and non-compliance with medication.

To others: Prior to admission he was arrested after causing a disturbance in a local shop. He was shouting and swearing at male members of the public who he accused of trying to sexually assault him. Following admission, XXX required rapid tranquillisation and transfer to the Psychiatric Intensive Care Unit as a result of threatening behaviour towards staff and other service users. He also caused damage to ward furniture by using a chair to try to break through the ward office window. Previously when unwell he has become agitated and verbally threatening to public and staff.

From others: Nil

Safeguarding adults and children concerns: Nil

Relapse indicators
- Description of symptoms or signs of relapse

Example
Irritability, suspiciousness, disengagement from the mental health team, increased preoccupation with government conspiracies.
**Crisis plan**
- Possible coping strategies
- Support available to help prevent hospitalisation and information about 24-hour access to services

**Example**
In a crisis, XXX can approach staff at his hostel 24hrs a day. He can also contact his brother and 9-5, Mon-Fri, his CMHT care coordinator on xxxxx xxxxxx. He also has the telephone number for the crisis line.

**Medications on discharge – Please refer to the discharge prescription when updating records of currently prescribed medicines**

**Example**

<table>
<thead>
<tr>
<th>Drug name: Zuclopentixol Decanoate</th>
<th>Dose: 400mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency: Weekly</td>
<td>Route: IM gluteal depot</td>
</tr>
</tbody>
</table>

**Discharge plan**

**Example**
1) Initial 7 day and further follow up by community care coordinator XXX
2) CMHT to administer weekly depot, next due dd/mm/yyyy
3) To attend recovery college

**Actions for GP**

1. **Medication:**
   *Details of medication to be prescribed by GP*

   **Example**
   Depot medication will be administered by the CMHT

2. **Physical health monitoring for psychotropic medication:**
   *Details of physical health monitoring specific medication as per Trust guidelines which can be found on insite*

   **Example**
   Patients taking Clopixol require an annual physical health screen to include P, BP, BMI, and blood screen to include FBC, U+Es, LFTs, fasting blood sugar, lipid profile and prolactin

3. **Physical health comorbidities for follow up:**
   *Request for GP to follow up specific comorbidities*

   **Example**
   You could continue to monitor and manage his asthma

4. **Other:**
   **Example**
   Nil
6.1 GENERAL CONSIDERATIONS IN THE APPLICATION AND MANAGEMENT OF OBSERVATION AND INTENSIVE ENGAGEMENT

(Link Person: Director of Nursing)

Please note this policy is currently under review

A Quick Reference Guide to Levels of Observation

| LEVEL 1: Within Arm’s length | Patients at the highest level of risk of harming themselves or others may need to be intensively managed in close proximity. On rare occasions more than one nurse or member of the team may be necessary. Issues of privacy, dignity and consideration of the gender in allocating staff and the environmental dangers need to be discussed and incorporated into the care plan. The reasons for the observations must always be explained to the patient and include how the patient can support the process and work with staff to reduce the intensity of the observations. |
|LEVEL 2: Within eyesight | is required when the patient could, at any time, make an attempt to harm themselves or others. The patient should be kept within sight at all times, by day and by night and any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the patients and their belongings whilst having due regard for the patients legal rights. The reasons for the observations must always be explained to the patient and include how the patient can support the process and work with staff to reduce the intensity of the observations. |
|LEVEL 3: Intermittent observation | means that the patient’s location must be checked every 5 to 30 minutes (exact times to be specified in the notes and care plan). This level is appropriate when patients are potentially, but not immediately, at risk. Patients with depression, but no immediate plans to harm themselves or patients who have previously been at risk of harm to self or others, but who are in the process of recovery. The patient must be actively involved in the planning and progress of the observations. |
|LEVEL 4: General observation | is the minimum acceptable level of observation for all in-patients. All staff should know the location of all patients, but not all patients need to be kept within sight. At least once a shift a member of the team should sit down and talk with each patient to assess his or her mental state. This interview should always include an evaluation of the patient’s mood and behaviours associated with risk and should be recorded in the notes. |
Indications for the implementation of observation levels

- History of previous suicide attempts, self harm or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the patient believes that other people pose a threat
- Thoughts and ideas that the patient has about harming themselves or others
- Specifically plans or intentions to harm themselves or others
- Past problems with drugs or alcohol
- Recent loss
- Poor adherence to medication programmes.

Who can commence observations?

A 1st Level Registered Nurse followed by a MDT review as soon as is practicable OR

The Multi-Disciplinary Team, to include as a minimum the RMO (or medical representative) and first level registered nurse (DOH 1994).

Who can undertake observations?

A 1st Level or 2nd level Registered Nurse, who is a regular member of staff, or a member of the team who has completed the appropriate competencies and statutory training.

It is important to note that the registered nurse remains accountable for the decision to delegate observation to a support worker or student in training and ensuring they are sufficiently knowledgeable and competent to undertake the role. It is impractical to state exactly who should carry out the above task. It is clearly unacceptable for someone who does not know the ward or the patient to be responsible for observing a patient who is acutely unwell, suicidal, vulnerable or violent.

The following responsibilities should be observed:

- The patient should be well known to the responsible individual, including history, background and specific risk factors.
- The health worker should be familiar with the ward, ward policy for emergency procedures, and potential risks in the environment
- Will have received formal training in responding to emergency situations, risk assessment and in the management of violence, including the observation procedure.

Searches

- Any items considered harmful to the patient or others are to be removed with consent.
- Search procedures should be conducted as indicated by the Mental Health Act Code of Practice (Aug 1998)

Therapeutic Interventions

The responsible individual is expected to engage the patient through the use of communication skills, trust, empathy and diversional activities day and night unless the patient is sleeping (DOH, 1994). Wherever possible, there should be discussion and negotiation with patients regarding observations to develop a safe and collaborative plan.
Length and Level of Observation

- There should be rotation on an hourly basis. Exceptions to this are to be documented and a clear rationale in terms of patient benefit identified. (Levels 1 and 2).
- No period of observation by a member of staff should be longer than 2 hours.
- At the end of each observation period, the responsible individual should have a break from observation of at least half an hour.
- Should there be a need to maintain a patient on more intensive observations, other than general observations, for more than a week, then a full review by the clinical team should be implemented. Advice and consultation can also be sought from the Governance department.
- Part of the process of observations is to consider the ward environment, the mix of patients and the volume of patients who are placed on levels of observations. The number of patients who are on levels of observation should be a factor in the management of the ward and whether it is practically possible to carry out these observations effectively.

Training for Observation:
Observing patients at risk is a highly skilled activity. Team Leaders and Nurse Managers should ensure that all staff engaged in this activity (qualified, unqualified, other clinical staff, including agency) are appropriately trained and supported. The core principles of this training should include:

- Risk Assessment through the trust RATE training.
- Management and engagement of patients at risk of harming self and others.
- The management of emergency situations including basic life support.
- Rapid tranquillisation.
- Factors associated with self harm/harm to others.
- Indications for observation.
- Levels of observation.
- Attitudes to observation.
- Therapeutic opportunities in observation.
- Roles and responsibilities of multi-disciplinary team in relation to observation.
- Making the environment safe.
- Recording observation.
- The use of reviews and audit.

LEVEL 1- LEVEL 2 OBSERVATIONS

Responsibilities
Operational Aspects

- To know the patient well, including their history, background and specific risk factors.
- Be familiar with the ward, ward policy for emergency procedures and potential risk within the environment.
- Have received formal training in the observation procedure, management of violence and risk assessment.
- The patient is not granted leave.
- The patient is not allowed escorted walks in the grounds unless resources are sufficient to minimise the risk of harm to self or others.
- The gender of the responsible individual is to be taken into account, bearing in mind the gender, culture and clinical presentation of the patient.
Self Care
- The patient is allowed to close the toilet door and lock it as long as the door can be opened externally. It is the nurse’s responsibility to carry the means of gaining entry at all times.
- The responsible individual is to wait outside the toilet door and maintain verbal contact. The exception to this is where the patient is deaf.
- The responsible individual can enter the toilet if an increased risk is perceived.
- The patient will require continuous visual observation whilst having a bath.

Administration
- One hourly entries in the clinical notes.
- The responsible individual is expected to document verbal, non-verbal behaviour and current risk on the record form. (Ritter 1989).
- The record form is to be filed in the notes.
- A summary of care / interventions implemented and outcomes at the end of each shift is to be documented in the progress notes by the Named Nurse (1st Level Registered Nurse) or nurse in charge and any other person involved in the observations, and the care plan amended accordingly (DOH 1993) + (UKCC 1993).

Review
- Daily
- A joint daily review (Monday-Friday/ 9.00hrs-17.00hrs) between the named Nurse (1st Level Registered) or Nurse in Charge and the RMO’s ward doctor or duty doctor is to take place and include identification of ongoing risk factors, degree of risk and appropriate interventions. The care plan and medical notes are to be updated accordingly. (DOH 1994).

LEVEL 3 OBSERVATIONS

Responsibilities
Operational Aspects
- Maintain intermittent visual contact every 5 to 30 minutes (exact time to be documented as part of the observation plan).
- Times may be randomised / irregular so as not to allow the patient to become familiar with times of observation (Gardner 1989).
- The patient is not to be granted leave from the hospital.
- The patient is allowed out for escorted walks in the grounds, providing resources are sufficient to minimise the risk of harm to self or others, and/or the risk of absconding can be minimised.
- The gender of the responsible individual is to be taken into account bearing in mind the gender, culture and clinical presentation of the patient.
- The patient is allowed to attend therapeutic activities off the ward providing safety and prevention of absconding can be maintained within existing resources.

Self Care
- The patient is allowed to use the toilet unaccompanied subject to planned visual contact.
- The patient is allowed to bathe unaccompanied but is still subject to planned visual contact.

Administration
- Visual contact is to be documented on the record form every 15 to 30 minutes (exact time to be documented as part of the observation plan).
- Verbal interaction, non-verbal behaviour and current risk factors are to be documented on the record form at least three times per shift. (Ritter 1989).
This record form is to remain in the nursing notes.

A summary of care / interventions implemented and outcomes at the end of each shift is to be documented in the progress notes by the named Nurse (1st Level Registered Nurse) or Nurse in charge, and any other person involved in the observations, and the care plan amended accordingly. (DOH 1993) + (UKCC 1993).

**Review**

- Every 72 hours

**LEVEL 4 OBSERVATIONS**

**Responsibilities**

Operational Aspects

- To observe and interact with the patients on a shift basis documenting this intervention
- Subject to current status and risk, is allowed out for walks in the grounds, providing resources are sufficient to minimise the risk of harm to self or others, and/or the risk of absconding can be minimised.
- The patient is allowed to attend therapeutic activities off the ward providing it is safe and prevention of absconding can be maintained within existing resources.
- Be aware of the patient’s location at all times, i.e. shop, therapy, home visit etc.

**Self Care**

- The patient is allowed to use the toilet unaccompanied subject to plan of care
- The patient is allowed to bathe unaccompanied subject to plan of care.

**Review**

- Weekly by the MDT
- Out of office hours, a review including the duty doctor will only take place if the named nurse/nurse in charge feels a change in the observation level would be appropriate.
- The outcome of the joint review is to be recorded in the clinical records.
- If a joint agreement cannot be reached, the Duty Senior Nurse is to be involved in the review and assist in agreeing an appropriate observation level.
## THE ASSESSMENT PROCESS FOR LEVEL 1 & 2 OBSERVER

<table>
<thead>
<tr>
<th>1. Has knowledge and understanding of the processes of observation and intensive engagement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Has attended mandatory trust risk assessment and management training.</td>
</tr>
<tr>
<td>3. Has good knowledge and understanding of the trust policy on documentation and record keeping.</td>
</tr>
<tr>
<td>4. Has attended the trust training on the management of violence and aggression.</td>
</tr>
<tr>
<td>5. Has access to regular clinical and managerial supervision.</td>
</tr>
<tr>
<td>6. High level of communication, listening and engagement skills.</td>
</tr>
<tr>
<td>7. Able to assess situations and respond to changes.</td>
</tr>
<tr>
<td>8. Able to summon help and support when necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. A 1st or 2nd level registered nurse. RMN/RNLD.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Any permanent member of staff who has completed induction or preceptorship.</td>
</tr>
<tr>
<td>3. Bank and Agency staff that are employed by S.W. London &amp; St George's.</td>
</tr>
</tbody>
</table>
6.2 OVERVIEW OF SECLUSION
(Link Person: Director of Nursing)

The Mental Health Act code of practice (1999) defines seclusion as the 'supervised confinement of a patient in a room that may be locked to prevent others from significant harm'. Seclusion should only be used as a planned, last intervention, where all reasonable steps have been taken by health care staff to avoid its use. It must be framed as quiet time to protect the safety of the patient and others and never as punishment or a response to an “unmanageable” patient.

Only a designated seclusion room should be used. Designated seclusion rooms are located on Shamrocks and Ward1 (PICU) and the Turner Ward spur (Medium Secure Unit). The room must include access to a clock for the person to see, be able to be kept at a comfortable temperature, bathroom facilities and natural daylight together with suitable furnishings and a comfortable sleeping area.

The decision to seclude a patient is usually taken by the Nurse in Charge of the ward or the Doctor both in collaboration with the ward team. If a doctor is not present, arrangements must be made to have one attend as soon as possible and at least within an hour of seclusion commencing. An incident form must be completed as well as seclusion documentation. The physical, emotional and mental health of the patient must be monitored closely; the Doctor should physically examine the patient as soon as it is possible.

Best Practice guidelines when caring for a person who is secluded:

- A suitably competent nurse must continuously observe and engage the patient (see competencies in Observation and Intensive Engagement Policy). Refer to the Rapid Tranquillisation policy [TWC22].
- There must be a care plan drawn up to ensure that the best possible care is given whilst the person is in seclusion, maintaining their dignity at all times. For example a full choice of meals and snacks should still be offered. This must be reviewed and updated regularly.
- A risk assessment and management plan must be undertaken, being mindful not to allow access to items that could be used to harm themselves or others.
- The Seclusion Room door should never be opened without a full Management of Violence and Aggression team being present. Always assess the secluded person’s ability to cooperate with you before opening the seclusion room door.
- Thought should be given to how the person is facilitated back into the ward community without embarrassment or loss of face. This should include discussing with the person their experience of seclusion and what might support them in returning to the general ward environment.
- Families and carers may be an important resource to improve understanding; support de-escalation; help to understand signs and symptoms that the patient presents; support reintegration back to the ward.

Review of Seclusion
This must be undertaken as outlined in the Seclusion Policy.
A review by the shift/team of the process and practice used is recommended.
Increased use of seclusion should be reviewed with the Trust Virtual Risk service.
Advice should also be sought from the trust physical management team

Documentation
As outlined in the Seclusion Policy. More detailed information about Seclusion can be found in the Trust policy [TWC30].
The Mental Health Act 1983 allows for the admission to hospital and treatment, without consent, for those suffering from Mental Disorder, providing the criteria for detention are met. The criteria for detention are:

The presence of ‘Mental Disorder’ of a ‘nature or degree’ that ‘warrants detention for assessment followed by treatment’ (s2) / makes it appropriate for him to receive treatment in hospital (s3), and is ‘necessary for the health or safety of the patient, or for the protection of others.’

The MHA 1983 provides both short term and longer term sections

**Short-term detention for assessment**
(To decide about admission under the Mental Health Act)

<table>
<thead>
<tr>
<th>Section</th>
<th>Requirement (Process allowing detention)</th>
<th>Duration</th>
<th>Where can it be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>S4</td>
<td>Emergency Admission for Assessment</td>
<td>1 Medical Recommendation (Med.Rec) + Application by AMHP(or nearest relative.)</td>
<td>Up to 72 hours, a further Med. Rec. in this time converts to a section 2.</td>
</tr>
<tr>
<td>S5(2)</td>
<td>Doctors Holding Power</td>
<td>Medical Recommendation by Doctor in charge of Patient’s Care or Nominated Deputy (Duty Doctor)</td>
<td>Up to 72 hours</td>
</tr>
<tr>
<td>S5(4)</td>
<td>Nurses Holding Power</td>
<td>Recommendation of Registered Mental Health Nurse</td>
<td>6 hours</td>
</tr>
<tr>
<td>S136</td>
<td>Mentally Disordered Persons found In a place to which the public have access</td>
<td>Recommendation of a Police Officer</td>
<td>72 hours</td>
</tr>
<tr>
<td>S135</td>
<td>Warrant to enter property to search for and remove patients</td>
<td>Granted by a Magistrate</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

**Note** – for all the short term sections described above, treatment without consent is not authorised under Part 4 MHA 1983. Consideration should be given to the capacity of the patient, and treatment may be administered to the incapacitated without consent if it is in the individuals best interests, although not for mental disorder if that treatment is actively resisted. Treatment can be given to a mentally disturbed person under **Common Law** if the individual is a manifest danger to himself or others. It is important to consider and accurately record the relevant legal authority relied upon for treatment.
The Longer Term sections

Detention which *allows treatment* under the Mental Health Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Requirement (Process allowing detention)</th>
<th>Duration</th>
<th>Where can it be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2</td>
<td>Admission for Assessment</td>
<td></td>
<td>Hospital or Community</td>
</tr>
<tr>
<td></td>
<td>2 Medical Recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ Application by AMHP (or nearest relative)</td>
<td>Detention for up to 28 days</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>Admission for Treatment</td>
<td></td>
<td>Hospital or Community</td>
</tr>
<tr>
<td></td>
<td>2 Medical Recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ Application by AMHP (or nearest relative) (AMHP must consult nearest relative, who must not object)</td>
<td>Detention for up to 6 months</td>
<td></td>
</tr>
<tr>
<td>S17 E</td>
<td>Community Treatment Order, recall-</td>
<td></td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td>Recall to hospital by the Responsible Clinician</td>
<td>72 hours (from the time the patient gets to the ward)</td>
<td></td>
</tr>
<tr>
<td>S17 F</td>
<td>Community Treatment Order, revoke</td>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Certificate from Responsible Clinician and AMHP</td>
<td>S3 resumes</td>
<td></td>
</tr>
</tbody>
</table>

**Notes on s2 v s3** – the code of practice states it *is appropriate* to admit from the community to hospital under s3 in certain circumstances. These are when the nature and degree of the patient’s mental disorder, the essential elements of the treatment plan to be followed, and the likelihood of the patient accepting treatment on a voluntary basis, are already established.

*Community Treatment Orders, and Recall to Hospital for Treatment*

The Mental Health Act 2007 introduced Supervised Community Treatment (SCT) under Community Treatment Orders (CTOs). A well-known patient on s3, with a pattern of relapse in the community, may be discharged from hospital on a CTO (basically on leave) with conditions to ensure treatment, and health and safety.

The treatment conditions are essentially voluntary (when the CTO is put in place) but the patient may later break them (or relapse) and can be recalled to hospital by the RC, where treatment may be given under Part 4 of the MHA, for up to 72 hours. If the need for treatment under detention goes beyond 72 hours, the CTO can be revoked, with the patient staying in hospital under the original s3 (or otherwise the patient must be discharged back out on the Community Treatment Order again).

Before considering s17 leave of a week or more, the RC is statutorily required to consider a CTO, and record why this is not appropriate.
7.2 GIVING TREATMENT FOR MENTAL DISORDER UNDER THE MENTAL HEALTH ACT

Part 4 of the Mental Health Act 1983 (MHA) governs treating detained patients, including without their consent.

A voluntary patient with capacity can only be treated for mental disorder with full consent (except in very limited emergency circumstances, under common law, noted in 7.2).

Consent is also needed from patients under the short-term “holding” Sections S5(2) and S5(4), s4, s135 and s136. All these Sections “hold” the patient for a MHA assessment, for s2 or s3, and do not allow treatment without consent, nor seclusion.

Treatment able to be given to Detained Patients without Consent

The authority to give treatment is s63: Consent shall not be required for any medical treatment given for mental disorder [not being within s57 or s58, noted below] if given by or under the direction of the Responsible Clinician.

The definition of medical treatment is broad, and ‘includes nursing psychological intervention and specialist mental health habilitation, rehabilitation and care’.

Treatments Requiring Special Precautions

Four treatments for detained patients have restrictions under the MHA. Two of them (defined in s57) are only given in specialist settings: psychosurgery and the implantation of hormones by surgical means to reduce male sex drive. s57 lays down requirements for full consent, consultation, and certification of consent and the need for treatment. You will not meet these in usual practice!

S58: Medication given beyond three months, to detained patients

This will occur in general adult, old age, and forensic psychiatry. The detained patient may give full capable consent. If so, a certificate: Form T2 (by the RC) of capacity and consent must be attached to the current medication card.

If the detained patient does not consent, or is incapable, a Second Opinion Approved Doctor (SOAD) from the CQC must examine, consult (as laid down in S58) and confirm before the treatment can go ahead. (See also “emergency” below). Again, the Second Opinion Form T2 must be attached to the medication charts.

Likely problems when you are prescribing on the wards are that the certificate is not attached to the medicine chart, or does not cover what is being prescribed (e.g. a second antipsychotic or “as required” medication, or a new category of medication) or that the patient clearly no longer has capacity to consent. You should get senior advice.
S58A: ECT given to Detained Patients

The Mental Health Act 2007 further restricted ECT use that it must not be given to a non-consenting detained patient who has capacity. ECT can therefore only be given to consenting patients (whether detained or not), or to detained patients who lack capacity (and have no advanced refusal of ECT, with a second opinion certificate.) The only exception to this is s62 (see below), which provides for ECT to be given in an emergency.

Withdrawal of Consent, and Treatment of Detained Patients in an Emergency (s62)

A detained patient who has given consent may lose capacity or withdraw consent to ECT, or to medication after three months, after consent and capacity have been certified by the RC. This then requires a Second Opinion, but treatment may be given as an emergency in the meantime, defined under s62 as [a] immediately necessary to save the patient’s life, or [b] [not being irreversible] immediately necessary to prevent a serious deterioration or [c] [not being irreversible nor hazardous] immediately necessary to alleviate serious suffering.

Part IVA: Treatment of Community Patients not recalled to hospital (CTOs)

For patients receiving care under SCT outside hospital, medication may be given only with their consent (except to those without capacity in certain emergency situations.) Either certification of capacity and consent by the RC or a SOAD certificate is required after one month.

If the patient is recalled (for up to 72 hours) they may be given treatment without consent, either under Part 4A, if the treatment has been authorised on the Part 4A certificate, or under Part 4 if there is a valid Part 4 certificate from the period of detention prior to application of the CTO. The Code of Practice advises however that it is not good practice to rely on such certificates, even though they are technically valid.
7.3 ASSESSING ADULT PATIENTS’ CAPACITY TO CONSENT TO PSYCHIATRIC, MEDICAL AND SURGICAL TREATMENT

(Link Person: Dr Jim Bolton, Consultant Psychiatrist and Dr Ruth Allen, Director of Social Work)

Introduction
Capacity is the ability to make a decision, including decisions about healthcare. The Mental Capacity Act 2005 (MCA) provides a legal framework for others to make decisions on behalf of adults over 16 years of age who lack the capacity to make specific decisions for themselves.

The Mental Capacity Act makes it clear that a judgement regarding a patient's ability to make decisions can be determined by any professional. Indeed the member of staff implementing a decision made on behalf of a patient has to:
- be certain the patient does lack capacity to make that decision at that time;
- be certain that the action is in the patient's best interests;
- record the above in the notes, saying why the patient lacked capacity and how best interests were determined.

In certain situations, psychiatrists may be asked to assist colleagues in the general hospital with the assessment of patients' capacity to consent to, or refuse, medical and surgical treatment. This is most likely to occur when a patient refuses the suggested treatment. In problematic situations, or where there is uncertainty, junior staff should discuss with senior colleagues.

Principles that guide assessment and decision making, where an individual lacks capacity

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- When decisions are made on behalf of someone who lacks capacity, they must be made in their “best interests”.
- When decisions are made on behalf of someone who lacks capacity, the least restrictive alternative must be considered to attain the goal specified.

Assessing capacity
An adult can only be considered unable to make a particular decision if:
1) They have “an impairment of, or disturbance in, the functioning of the mind or brain”, whether permanent or temporary;
AND
2) They are unable to undertake any of the following steps:
   - Understand the information relevant to the decision;
   - Retain the information;
   - Use or weigh the information as part of the process of making the decision;
   - Communicate the decision made (not necessarily verbal).

An impairment of, or disturbance in, the functioning of the mind or brain
Evidence for this may be an established diagnosis (e.g. dementia, learning disability) or evidence of an abnormal mental state, including transient states (e.g. delirium, psychosis, mood disorder, anxiety, consequences of alcohol or illicit drug use).

**Understanding and retaining the information**
It is the responsibility of the person requiring the decision to be made to provide the information in an appropriate form to optimise understanding. The patient needs to be able to broadly understand the information and retain it long enough to make the necessary decision.

**Using and weighing information**
The following may be helpful in judging whether someone has the ability to understand and weigh up the information:
- Appreciation of the wider consequences of the decision on themselves and others;
- Evidence of reasoning process;
- Consistency between expressed beliefs and decision reached;
- Ability to weigh the risks and benefits of various options;
- The importance to the person of religious and cultural beliefs that may have influenced and/or may account for the decisions taken.

More serious decisions generally require a greater level of understanding.

**Making provision for future incapacity**
Individuals can make provision for a subsequent loss of capacity by two mechanisms under the MCA:
1. Lasting Power of Attorney (LPA): this allows an individual with capacity to nominate someone to make financial, welfare and healthcare decisions on their behalf should they lose capacity.
2. Advance Decision to refuse specified treatment: Providing these are valid and applicable to the particular situation, they have a statutory force. However, if the patient is later admitted under the Mental Health Act (Section 2 or 3) treatment decisions under the MHA will override the Advance Decision (although the Advance Decision would be taken note of in deciding a treatment plan). Patients may make formal or informal statements about preference and wishes on matters other than refusal of treatments in the event of future incapacity (‘Usually termed advance statements or advance directives’). These might include statements about how they want to be treated when detained under the Mental Health Act, for instance, or who they want involved in their care if lose capacity. These should always be considered in an assessment of “best interests”, but are not legally binding.

**Assessing “best interests”**
In determining what is in someone’s best interests when making a decision, the following should be considered:
- Whether and/or when the person is likely to regain capacity and whether the decision or the act to be undertaken can wait;
- How to encourage and optimise the participation of the individual in the decision;
- The past and present wishes, feelings, values and beliefs of the person
- Views of other relevant people, including family and carers;
- The existence of a Lasting Power of Attorney or an Advance Decision.

**Independent Mental Capacity Advocates (IMCAs)**
Where a person lacks the capacity to make decisions about a change in accommodation or about serious medical treatment and has no family or friends, (is ‘unbefriended’) there is a duty to appoint an IMCA to help inform the determination of “best interests”. For contact details, see Trust MCA Guidelines or the appropriate local authority website.

**Court of Protection**
The Court of Protection deals with complex or very significant decision-making for adults who lack capacity to do so. Applications are made to the Court of Protection for particularly difficult decisions or for disagreements that cannot otherwise be resolved. When there is a need for ongoing decision-making powers, the Court may appoint a Deputy to make future decisions.

**Relationship between Capacity and Mental Disorder**
Mental disorder does not automatically make someone incapable of making treatment decisions. Even where a person is detained under the Mental Health Act, it is Trust policy and best practice to ensure every inpatient is involved in treatment decisions as much as possible – through seeking their consent and their views on treatment where they have capacity to participate, with whatever support is appropriate. This capacity to participate in decisions and consent to treatment should be revisited throughout the inpatient stay.

A psychiatric opinion may be helpful when deciding whether mental disorder may be affecting a patient’s decision-making ability regarding their physical healthcare. A psychiatric assessment in such circumstances will usually be carried out together with the responsible physician. **When a patient is judged to lack capacity, the treatment decision will rest with the physician implementing the decision.**

For doctors’ assessments of patients’ specific capacity to consent to the treatment they are proposing, whether they do, in fact, consent and what their views are, the Trust expects all Doctors to use the consent and capacity templates available on the intranet under ‘Forms’ titled: Consent & Mental Capacity - Clinician Templates for Progress Note Recording’ These should be used as the guidance from first admission/treatment and pasted into the progress note on RiO.

**Mental Capacity and decisions not relating to psychiatric treatment**
The Mental Health Act (1983) allows for the medical treatment of a mental disorder in order to alleviate or prevent a worsening of the mental disorder or one of its consequences, including self harm.

Patients detained under the MHA for a mental disorder have the same rights as others regarding decisions about physical health.

Patients with a mental illness detained under the Mental Health Act 1983 cannot be subject to the Mental Capacity Act for their mental health, but can and should be assessed under the Mental Capacity Act should they have a separate physical health issue needing attention.

The Trust has a standard assessment form for assessing mental capacity and determining best interests for inpatients for major decisions other than their core psychiatric treatment regime. This is available on the intranet within ‘Forms’ and is titled ‘MCA - Capacity and Best Interests Form’.
Emergency situations
In emergency medical situations urgent decisions may need to be taken and immediate action taken in the person’s best interests. In these situations, it may not be practical or appropriate to delay treatment while helping the person to make their own decisions or to consult with any known attorneys (under the LPA) or family and carers.

Deprivation of Liberty Safeguards (Also see Blue Book section 7.5)
The Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 as an addition to the MCA. They provide additional legal protection for those over 18 years of age who lack capacity to consent to their care or treatment and who are at risk of being “deprived of their liberty”. The DoLS Code of Practice states that the distinction between deprivation of liberty (which requires authorisation to be made legal) and restriction of liberty (which does not) is one of “degree or intensity”.

If a patient is judged to be deprived of their liberty, application is made to the Local Authority for a DoLS assessment (analogous to a Mental Health Act assessment). This is not generally done as an emergency. Those whose liberty is restricted can be managed under the MCA as previously described

Assessing whether there is deprivation of restriction of liberty is a matter of judgement. Factors which suggest restriction, rather than deprivation, of liberty, and may be relevant to the management of patients in a general hospital, include:
- Benign force (i.e. not being used to overcome resistance) used to take a confused patient to hospital.
- Staff bringing a wandering patient back to the ward.
- The use of restraint or medication in an emergency situation in order to respond to a patient’s disturbed, threatening or self-harming behaviour.

Record Keeping
Capacity issues may be contentious. Keep clear, precise and legible records. Document the assessment of capacity using the criteria above. Remember: under law, if it is not recorded, it did not happen! Record also if other key staff agree.

Further information
- Deprivation of Liberty Safeguards (DOLS) Procedures for Trust Wards on the Trust intranet as above
- Code of Practice for the Mental Capacity Act 2005: available online at: www.dh.gov.uk.
- Mental Capacity Act 2005 Training Sets: available on line at: www.dh.gov.uk/mentalcapacityact. There are sets for Community Care and Primary Care Staff, Acute Hospitals, Mental Health Services, Residential Accommodation
- Code of Practice for the Deprivation of Liberty Safeguards: available online at: www.dh.gov.uk.
What is the purpose of the deprivation of liberty safeguards?

The Deprivation of Liberty Safeguards 2009 (DoLS) are an amendment to the Mental Capacity Act 2005. They arose out of legal challenge to English practice within the European Court of Human Rights (ECtHR). They provide a legal framework to protect those (over 18 years) who lack the capacity to consent to the arrangements for their treatment or care, for example by reason of dementia, learning disability or brain injury. It applies where levels of restriction or restraint used in delivering that care for the purpose of protection from harm/risk are so extensive as to potentially be depriving the person of their liberty. It applies where restraints and restrictions go beyond the actions permitted under section five of the Mental Capacity Act 2005.

The Safeguards cover England and Wales (separate Regulations for Wales)

To whom does DoLS apply?

DoLS only applies to people who lack capacity to consent to the care or treatment they receive, and are over 18 years of age and receiving that care in hospital or a care home setting, and that care deprives them of their liberty, and they are not detained under the Mental Health Act. DoLS provides a framework of rights, review and multiagency, multidisciplinary involvement to ensure the best interests of a person lacking capacity are being pursued through depriving them of choice and liberty.

What is deprivation of liberty and what is it not?

Whether a situations is subject to DoLS or not is specific to the circumstances and the person/s involved.

The ECtHR judgement in the HL v United Kingdom case did not define what was meant by “deprivation of liberty” though it confirmed that it was different from mere restriction of liberty

“To determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance”

- Each case must be considered on its merits and account must be taken of type, duration, effects and manner of implementation of measure in question
- There is unlikely to be any simple definition that can be applied in every case
- It is not possible to say that any single factor alone would always or could never amount to a deprivation of liberty
- DoLS provisions exist only to provide a proper legal process and suitable safeguards in circumstances where deprivation of liberty is an unavoidable necessity in a person’s own best interests
- Every effort should be made to prevent deprivation of liberty
Restrictions on liberty which might be taken into consideration when DoLS might be invoked:

NB If a person is detained under the Mental Health Act (MHA), restrictions and deprivations of liberty and choice are managed through the proper application of the MHA and the other sections of the MCA, not through the specific DoLS provisions.

- The amount and frequency of restraint used, including sedation, to admit a person who was resisting
- Staff exercising complete and effective control over care and movement for a significant period
- Professionals exercising complete control over treatments, contacts and residence choices
- A person would always be prevented from leaving if they made a meaningful attempt to do so
- A request by carers for the person to be discharged from their care is refused
- A person was unable to maintain social contacts because of restrictions placed on access to other people in their best interests
- A person lost all autonomy because they were under continuous supervision and control for a significant period

Practical Steps to reduce the risk of deprivation of liberty and minimise risk of legal challenge

DoLS is an action of last resort. Staff should always be seeking ways to provide care and treatment that, while it may need to place some ‘best interest’ restrictions on a person lacking capacity, does not need to meet the threshold for deprivation of liberty. Relevant areas of practice include:

- Ensuring decisions are taken and reviewed in a structured way and reasons recorded. Protocols for decision making should include consideration on whether deprivation of liberty may arise and how it could be avoided by providing opportunities for people to exercise choice and more freedom of movement etc
- Effective, well-documented care planning that attempts to maximise the person’s participation and offer interventions which are congruent with the person’s wishes, culture, lifestyle and/or feelings
- Proper assessment (and review) of whether the person lacks capacity to decide whether or not to accept the care proposed
- Ensuring admissions to residential care or hospital are fully considered and any restrictions placed on the person kept to a minimum
- Ensuring proper information is given to the person, carer, family and friends regarding the purpose and reason for admission
- Taking proper steps to ensure person retains contact with family, friends and carers
If you think a person lacking capacity might be being deprived of their Liberty

If you think DoLS might apply, and the level of restriction or restraint on a person cannot be quickly stepped down, Ward Managers should take responsibility for starting the DoLS process. This involves applying for an ‘Urgent authorisation’ which provides authorisation for 7 days while full assessment of DoLS is applied for and carried out. The assessment is coordinated by the ‘Best Interest Assessor’. This is specifically trained professional from the local NHS commissioning body who determines whether DoLS applies in this situation.

There are 6 written assessments required to determine whether a person should properly be Deprived of their Liberty for their best interests, in the meaning the of the Act. The assessments are:

- Age assessment
- Mental Health Assessment
- Mental Capacity Assessment
- Best Interests Assessment
- Eligibility Assessment
- No refusals Assessment

Full information on the process to be followed by clinicians and Ward managers can be found in the Trust’s document Deprivation of Liberty Safeguards (DOLS) Procedures for Trust Wards which can be found on the Trust intranet. In this, there is a clear flow diagram of the responsibilities of all involved.

Recent case law and updates based on “Cheshire West”

The MCA permits a person to be deprived of their liberty, as defined by the European Convention on Human Rights, in a hospital or care home but not in their own home (which would require a court order). It should be remembered that a person living in supported accommodation with their own tenancy agreement is living in their own home. The rules known as Deprivation of Liberty Safeguards (DoLS), are complex. They can be summarised as follows:

- The person must be aged 18 or over (the age assessment). This is because a person under 18 may be deprived of their liberty using the authority of the Children Act 1989.
- The deprivation of liberty must not have been refused by a health and welfare attorney or a court (no refusals assessment).
- The person must lack capacity in relation to the decision about the deprivation of liberty (the mental capacity assessment).
- The person must have a disorder or disability of their mind (the mental health assessment). Note that the definition is the same as for the MHA and not the same as for the rest of the MCA.
- The person must not be detained under the MHA at the time or be subject to MHA restrictions that would conflict with the DoLS requirement (the eligibility assessment). It is self-evident that it would be unreasonable, if a person were required to live in a care home under a guardianship order, for example, simultaneously to require them to reside in a care home under a DoLS requirement.
- It must be in the person’s best interests to be deprived of their liberty (the best interests assessment).
The recent Cheshire West case (2014) examined the legal basis for detaining three different people: P, MIG and MEG. It was concluded that because of the extreme vulnerability of people like them, decision makers should err on the side of caution in deciding what constitutes a deprivation of liberty. The case has established the ‘acid test’ for deprivation of liberty being that the person is under continuous supervision and is not free to leave.

In the wake of the Cheshire West case, a key question to consider for social workers and medical practitioners is this: Is the person objectively deprived of their liberty or is there a risk that cannot be sensibly ignored that they are objectively deprived of their liberty?

There are two key questions to ask – the ‘acid test’:

(1) Is the person subject to continuous supervision and control?

All of these factors are necessary. You should seek legal advice if intensive levels of support are being provided to any person as part of a package of care or treatment.

(2) Is the person free to leave?

The focus is not on the person’s ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave.

NB: for a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave.

In all cases, the following are not relevant to the application of the test:

(1) the person’s compliance or lack of objection;

(2) the relative normality of the placement (whatever the comparison made); and

(3) the reason or purpose behind a particular placement.

The factors identified in the guidance given in the Deprivation of Liberty Safeguards Code of Practice at paragraphs 2.1-2.6 must now be read subject to the decision of the Supreme Court in Cheshire West. However, even if a factor identified there is now no longer relevant to the question of whether a deprivation of liberty is occurring, it is likely still to be relevant for the purposes of identifying whether the package of care or treatment is the least restrictive option available for the person, whether it is in their best interests and whether either their rights or those of others under (amongst others) Article 8 ECHR are being infringed. Restrictions upon liberty falling short of a deprivation of liberty must also be necessary and proportionate to the likelihood of the person suffering harming and to the seriousness of that harm.

To come within the scope of Article 5(1) ECHR, the deprivation of liberty must last more than a short period of time – but that period can be very short (even as little as half an hour). Emergency situations are dealt with in below.

NB:

(1) a person who is already subjected to an authorised deprivation of liberty (under the DOLS regime, by virtue of a court order under the MCA 2005 or
under the MHA 1983) can be further deprived of their liberty – e.g. seclusion in a psychiatric hospital. This further deprivation of liberty would need separate authorisation. Legal advice should be sought immediately in such scenarios.

(2) children can be deprived of their liberty just as adults but in the ordinary run of events children cared for at home by their parents without state involvement will not be deprived of their liberty.

**Adults in or being admitted to hospital – emergencies and physical treatment of those detained or detainable under the MHA 1983**

There may be a very few situations where it is not possible to authorise the deprivation of an incapacitated patient’s liberty in hospital under the DOLS regime, where:

(1) a short-term deprivation arises in an emergency situation and an authorisation cannot be sought during the currency if that deprivation of liberty; or

(2) the deprivation of liberty is not sought for purposes of securing the patient’s best interests, but for the protection of others (and the patient does not fall within the scope of the MHA 1983).

In either of these cases, legal advice should be sought as soon as possible, but in neither case should seeking such advice stand in the way of providing immediately necessary care and attention to the person.

There may be rare cases in which it is necessary to get an order under the inherent jurisdiction to authorise a deprivation of liberty where an adult is or could be detained under the MHA 1983 and the deprivation of liberty is required to provide physical treatment to which the adult cannot consent (which could include force-feeding or carrying out of a Caesarean-section).
This process describes the current pathway for requests from primary care for re-assessments or second opinions concerning patients of working age with mental health issues. This is provided in the context of the current stepped care approach in mental health, commissioning arrangements, and the finite capacity of resources. This pathway represents current recommended procedures, which are subject to review.

Re-assessments are broadly defined as requests for a further assessment by the aligned Community and Mental Health Team (CMHT). Requests for reassessments should be directed to the CMHT with a clear exposition of the reasons for the request. These will often include such clinical factors such as:

- The patient not progressing as expected.
- The escalation of symptoms
- The emergence of new symptoms
- The escalation of level of risk

There may additionally be reasons to request that the re-assessment be by a different clinician, such as:

- The patient disclosing rapport issues with the original clinician such that information was not disclosed that might significantly influence the conclusions reached.
- There are specific diagnostic or treatment queries that might merit a fresh perspective, and possibly by a clinician with different expertise.
- Such requests for assessments by a different clinician can usually be accommodated within and should always be discussed with the CMHT, but may prompt requests for a second opinion.

Second opinions are more specifically defined as a request for a further assessment from outside the CMHT.

Following discussion with the CMHT, requests for second opinions should be directed to the appropriate Associate Medical Director with a clear exposition of the reasons for the request.

It is not practicable to offer second opinions on an urgent basis. All urgent matters should be directed to the aligned CMHT.
9.1 RISK MANAGEMENT
The Assessment and Clinical Management of Risk as an Integral Part of Psychiatric Practice
(Link Person: Dr Mark Potter, Associate Medical Director, Wandsworth)

These guidance notes are intended to assist clinicians by providing an ‘aide memoir’ to good clinical practice.

GENERAL PRINCIPLES
1. Risk cannot be eliminated. It can be rigorously assessed and managed but outcomes cannot be guaranteed.
2. Risk is dynamic and may depend on circumstances, which can alter, often over brief periods of time. Therefore, risk assessments need a predominantly short-term perspective and must be subject to frequent reviews.
3. Some risks are general, while other risks are more specific.
4. If possible, information should be gathered from a variety of sources to validate the information.
5. An adequate risk assessment can rarely be done by one person alone. Wider information and discussion are needed.
6. The outcome of the assessment and management plus plan must be shared with others as appropriate.

ASSESSMENT OF RISK
The standard psychiatric assessment should include the following:

**History:**
- Previous violence and/or suicidal behaviour.
- Evidence of poor compliance with treatment or disengagement from psychiatric after care.
- Presence of substance misuse or other potential disinhibiting factors.
- Identification of any precipitants and any changes in mental state or behaviour that have occurred prior to violence and/or relapse in the past.
- Evidence of recent severe stress.
- Evidence of recent discontinuation of medication.

**Environment:**
- Does the patient have access to potential victims, particularly individuals identified in mental state abnormalities?

**Mental state:**
- Evidence of any threat control override symptoms associated with increased aggression, e.g. mind feels dominated by forces beyond our control; feelings that thoughts are being put into your head; feelings that there are people who wish you harm; belief that you are being followed (patients reporting TCO symptoms might be twice as likely to engage in assaultive behaviour as those with other psychotic symptoms.
- Emotions related to violence: for example irritability, anger, hostility, suspiciousness, specific threat made by the patient.

**Conclusion:**
A formulation should be made based on these and all other items of history and mental state. The formulation should aim to answer the following questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- What specific treatment and which management plan can best reduce the risk?

**TRUST RISK ASSESSMENT DOCUMENTATION**

All doctors should familiarise themselves with the Trust risk assessment documentation on RIO. The documentation is divided into two parts – a risk history and risk assessment.

(a) **The risk history** aims to provide a comprehensive history of the patient’s risk behaviour acts as a source of information and helps with the completion of the relapse and risk management plan.

(b) **The risk assessment.** Completion of this documentation will provide clear evidence of the current risk, the anticipated risk (i.e., who is at risk, how immediate is that risk, how severe, how ongoing?) and an action plan, including who is responsible for any action with steps to take if the plan breaks down and whom information is shared with.
9.2 GUIDELINES FOR THE ASSESSMENT AND IMMEDIATE MANAGEMENT OF ADULT PATIENTS FOLLOWING SELF-HARM
(Link Person: Dr Jim Bolton, Consultant Psychiatrist)

Principles of management
1) Minimise physical harm from the act
2) Assess the risk of self-harm or suicide
3) Detect any psychiatric disorder
4) Explore the patient’s coping resources and recent stresses

Assessing risk of self-harm or suicide
Assess both the degree of suicidal intent at the time of the self-harm, and the current risk of self-harm or suicide. Remember that some people use self-harm as a coping strategy and have no plans of suicide. Often a patient will be ambivalent or unclear about the suicidal intent associated with an episode of self-harm, particularly if they had consumed alcohol beforehand.

• Patient characteristics associated with high suicidal intent

  Note that these factors describe a stereotype and should be considered as part of an overall risk assessment.

  Male
  Young and middle-aged men, and older people
  Unemployed or retired
  Social isolation
  Poor physical health
  Other mental health problems, including alcohol and substance misuse.

• Factors in the history of the self-harm associated with high suicidal intent

  Evidence of planning
  Final act, e.g. writing a suicide note, making a will
  Act performed alone
  Act unlikely to be discovered
  Precautions to prevent discovery
  No effort to get help
  All available drugs taken
  Expectation of fatal outcome (Ask the patient what they thought the self-harm would achieve)

• Questions to explore current suicidal intent

  There is no evidence that asking a patient about suicidal ideation increases the risk that they will harm themselves. By not asking, there is a danger that risk will be underestimated.

  Do you still feel the same?
  Do you regret what you did?
  Do you still feel hopeless?
  What would make you try again?
  What would you do if you went home now?

  How do you see yourself in a month’s time?

Psychiatric disorder
• Enquire about past psychiatric history, including previous episodes of self-harm.
Examine the patient’s mental state for evidence of an ongoing mental health problem. Remember to enquire specifically about “hopelessness”, which is associated with an increased risk of further self-harm.

Psychiatric disorders commonly associated with self-harm include depression, anxiety, alcohol and substance misuse, and personality disorder. Fifteen percent of patients with schizophrenia and bipolar affective disorder commit suicide.

Stress & coping
- Make an assessment of an individual’s coping resources, their level of social support, and any problems that may have contributed to the self-harm, such as:
  - Relationship difficulties
  - Social isolation
  - Financial problems
  - Housing problems
  - Physical illness
- There is obviously a risk in discharging a patient back to the same situation where self-harm occurred. Consider asking: “Has anything changed as a result of what happened?”

Guidelines for estimating the risk of further self-harm or suicide
Factors to consider include suicidal intent at the time of the act, the ongoing risk of suicide or repetition, background stresses, psychiatric disorder, and the level of social support. The following may help to guide your decision.

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Low risk</th>
<th>Medium risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>65 years or older</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Fleeting but dismissed</td>
<td>Fleeting</td>
<td>Frequent or fixed</td>
</tr>
<tr>
<td>Suicidal plans</td>
<td>None</td>
<td>None</td>
<td>Considered methods or definite plan</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>None</td>
<td>None or transient</td>
<td>Present</td>
</tr>
<tr>
<td>Mental disorder</td>
<td>None or mild</td>
<td>Present</td>
<td>Significant</td>
</tr>
<tr>
<td>Alcohol or drug misuse</td>
<td>None</td>
<td>Present</td>
<td>Significant</td>
</tr>
<tr>
<td>Psychosocial situation</td>
<td>Stable</td>
<td>Unstable, but no impending crisis</td>
<td>Unstable with impending crisis</td>
</tr>
<tr>
<td>Recent dangerous behaviour</td>
<td>None</td>
<td>Infrequent</td>
<td>Escalating</td>
</tr>
</tbody>
</table>

Management
This is guided by your assessment above. Options include:
- Emergency psychiatric admission;
- Referral to home treatment team;
- Referral to community mental health services;
- Referral to drug and alcohol services;
- Giving advice on seeking help from social services or non-statutory services;
- GP follow-up.

For patients judged to be at sufficiently low risk to be discharged home from the Emergency Department (ED), discuss with them contingency plans in the event of thoughts of self-harm recurring. Patients can be helped to consider self-help strategies in a crisis, such as talking to a friend, listening to music or taking a walk. If these are not successful, crisis plans may then include contacting psychiatric services or the Mental Health Crisis Line (if the patient is under psychiatric care), contacting their GP, or returning to ED. Emergency contact numbers include:

**Samaritans**
08457 909090
24-hour service offering confidential emotional support to anyone who is in crisis.

**Mental Health Crisis Line**
0800 028 8000
For patients and carers outside of normal working hours.

**Patients who refuse treatment following self-harm**
In the majority of cases, patients who initially decline assessment and/or treatment following self harm are eventually persuaded to accept intervention. However, use of the Mental Health Act and/or the Mental Capacity Act may be considered if the patient cannot be persuaded to cooperate with the suggested care.

**Mental Health Act (MHA)**
The MHA allows for the medical treatment of the consequences of self harm. However, in an emergency situation when waiting for a MHA assessment may result in serious harm to the patient, treatment under the Mental Capacity Act may be considered.

**Mental Capacity Act (MCA)**
Management in this situation is based upon an assessment of the patient’s capacity to refuse treatment (see section on Capacity). In such a situation there are often grounds for reasonable doubt with respect to a patient’s capacity to make a fully informed and reasoned choice. If the patient lacks capacity it is necessary to proceed in their “best interests”. The case should be discussed with a senior colleague. In the majority of cases the patient is persuaded to accept treatment. Keep careful records of the decisions made and the reasons behind them.
Definition: “Self-poisoning or self-injury, irrespective of the apparent purpose of the act” - NICE GUIDELINES

Children and young people, who self-harm may have different needs and vulnerabilities to adults, are subject to different stressors and to different legislative frameworks. However, the principles of assessment and management are broadly similar to the approach for adults, as outlined in the previous chapter.

**Special issues for children and young people**

- Healthcare Professionals experienced in the assessment of children and adolescents should undertake the assessment. Out of hours this is the SHO or Psychiatric Liaison Nurse
- Assessment should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, including direct contact with the young person’s parent or carer, their social situation and specific consideration of whether there are any child protection/safeguarding issues.

**Legal issues relating to children and young people**

The legal position of children and young people in regard to healthcare, treatment and child protection issues is complex. The following points offer some guidance but should not take the place of seeking senior advice.

**The Children Act 1989**

- Applies to all young people under the age of 18.
- It balances the principle that children’s wishes should be sought and respected whenever possible with professional and parental perceptions of the child’s best interests. *It does not offer an alternative to the Mental Health Act as a mechanism for providing treatment to young people against their will.* It is always advisable to make treatment decisions in conjunction with young people even if they are not competent. Likewise, even if the young person is competent, it is always advisable to involve their parents/carers in treatment decisions, unless there is a specific reason not to.

**Consent and Capacity**

- Young people under 16 have the right to consent, or refuse consent, if they have ‘sufficient understanding and intelligence’ to do so (‘Gillick or Fraser competence’). Although there is no set lower age limit to such competence, it is unlikely it would apply to those under 13. Parents cannot
give consent for their competent children, but can override their valid refusal to give consent.

- Although parents can consent to mental health treatment on behalf of a child under 18 years within the ‘zone of parental consent’ (usual parenting decisions), it is advisable not to rely on this and cannot be used for treatments that restrict a child’s liberty.

<table>
<thead>
<tr>
<th>Consent in young people with Capacity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For Treatment</strong></td>
<td><strong>Refuse Treatment</strong></td>
</tr>
<tr>
<td>Mentally capable young people aged 16 and 17 have the same right to consent to medical treatment as adults.</td>
<td>The refusal of a competent young person, under the age of 18, to receive treatment or to enter hospital, can be overridden by a person or body that has parental responsibility. However, this power to overrule a competent young person’s refusal should be used only in exceptional cases.</td>
</tr>
<tr>
<td>A child under the age of 16 has a right to consent to treatment if he or she is assessed as being mentally competent (‘Gillick competence’).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent in young people without capacity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If a young person under the age of 18 lacks mental capacity, the consent of a person or body that has parental responsibility for that child should be obtained before treatment is given. However, if it is not possible to contact a person with parental responsibility, emergency treatment can be given if it is in the young person’s best interests.</td>
<td></td>
</tr>
</tbody>
</table>

**THIS IS A COMPLEX SITUATION THAT WOULD REQUIRE SENIOR MEDICAL AND LEGAL ADVICE.** Guideline document on ‘The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder’

**Additional risk information relevant to children & adolescents**

<table>
<thead>
<tr>
<th>Age</th>
<th>Completed suicide is very rare before 12.</th>
<th>Risk of suicide increases year on year throughout adolescence to a peak in adulthood.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Although suicides attempts are more common in females (1.6:1), adolescent males are almost 5 times more likely to succeed in killing themselves.</td>
<td></td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Do they have a psychiatric illness?</td>
<td>More than 90% of adolescents who kill themselves have an associated psychiatric disorder at the time of death. The highest risk disorders are mood disorder (increased risk</td>
</tr>
<tr>
<td>Alcohol/Substance Misuse</td>
<td>Are they currently using alcohol/substances?</td>
<td>Substance misuse is one of the strongest predictors of suicide following non-fatal self-harm in young people. Alcohol or other drugs act as a disinhibitor on the behaviour and cognition of vulnerable individuals.</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Past History</td>
<td>Have they made past suicide attempts? How recently &amp; what methods?</td>
<td>12-30% of adolescent suicide attempters report having made a previous attempt. 10% will go on to make another attempt in the next 2 years. Repeat attempts are most common in the 3 months after the initial attempt. 70% used a method similar to their initial attempt. Use of a method other than superficial cutting or ingestion increases the risk although risk of suicide is higher in those who self harm.</td>
</tr>
<tr>
<td>Mental state</td>
<td>What is their current mental state?</td>
<td>Evidence of current mental illness increases the risk of suicide. Ongoing suicidal ideation and intent increases the risk. Evidence of hopelessness increases the risk. Manic, hypomanic, mixed affective, severely anxious and psychotic states increase risk of suicide. A history of impulsivity increases risk.</td>
</tr>
<tr>
<td>Current stressors/life experience</td>
<td>Relationships with friends, family. Safeguarding issues</td>
<td>The lack of an appropriate carer who can ensure the safety of a young person’s environment, by limiting access to both dangerous objects and disinhibiting substances increases risk. The lack of such a person</td>
</tr>
</tbody>
</table>
Access to means of self-harm/suicide | Do they have access to means of suicide? Eg tablets not locked away, sharps around environment, lack of supervision | Limiting access to potential means of committing suicide can reduce risk, especially in young people with a history of impulsive self-harm.

Management

Following assessments of young people ‘Out of Hours’, all cases should be discussed with the On Call CAMHS SpR or Consultant, and if the situation is complex, or admission is potentially required they will need to be directly involved in the assessment process.

As a general guide, all children and young people under the age of 16 years, who present with self-harm, should be admitted to a paediatric ward for a “cooling off period”.

If a young person is discharged following assessment, the following points need to be considered: What is the contingency plan in terms of another similar crisis? Who will be providing a review of the young person (ideally within the following week)? What has been done to ensure the safety of the environment that the young person is going/returning to? An explicit discussion about risk and access to potential means of self-harm needs to occur with carers. Referral needs to be faxed first thing to the local CAMHS by the next working day. Information can be found on the local intranet.

Further References

1) There is no lower age limit to the use of the Mental Health Act (Amended 2007), but there are specific safeguards in relation to its application to young people under the age of 18. Guidance is contained in Chapter 36 of the Code of Practice.

2) Parental responsibility resides with the mother of a child and the birth father if they are named on the child’s birth certificate and in other situations where a court may have awarded it. For children on Care Orders, parental responsibility is shared between the local authority and the parents. In emergency situations where all those who have PR cannot be contacted it is acceptable to obtain the consent of the parent who is the day-to-day carer of the child.
ADULT POPULATION

There are concerns that patients with Serious Mental Illness have poor physical health, high mortality rates from physical illness and often do not access healthcare treatment when it is needed.

Because of this the Trust has developed a Physical Healthcare Policy for adults and older adults, which should be read by medical staff.

The Trust has also appointed Wellbeing Support advisors who can help patients access healthcare and health advice.

Psychiatric illness often co-exists with physical illness, with comorbidity figures quoted at around 30%.

Long-term psychiatric patients suffer from increased morbidity and mortality, with an increased risk of premature death (Brown 1997, Barraclough 1998).

**General principles of assessment and management remain the same as for other patients and a psychiatrist has a duty, which is a requirement of the General Medical Council to be competent in assessment of medical illness (history taking, physical examination and interpretation of routine investigations) and its treatment, including basic life support.**

Factors predisposing include:
- Poverty, unemployment, poor housing
- Poor diet, lack of exercise
- Substance misuse, smoking
- Stigma, low self-esteem, stress
- Psychotropic medication (e.g., weight gain, diabetes, acute neurological syndromes and seizures, abnormal cardiac conduction and autonomic dysfunction…)

Factors preventing detection and delaying treatment include:
- Low rate of self-presentation
- Misattribution of symptoms to psychiatric illness by doctor
- History of abnormal illness behaviour
- Capacity Issues for investigation/treatment
- Erratic compliance

Specific Disorders over-represented are:
- Cardiovascular Disorders, due to unhealthy lifestyle and psychotropic medications
- Respiratory Disease
- Gastrointestinal disorders, excesses attributable to alcohol and obesity
- Neurological Symptoms occur as part of organic psychiatric syndromes, withdrawal states and psychotropic medications
- Endocrine and Musculoskeletal Disorders
- Infectious Diseases, poor oral and sexual health

ELDERLY POPULATION
Physical comorbidity is always important in the elderly with attention to physical examination and investigations where necessary. Presentations can sometimes be non-specific and atypical, hampered by multiple pathology. Careful assessment is necessary, including liaison with the GP and advice from Geriatric Medicine where relevant. Specific attention should be given to mobility and nutrition as predisposing factors for physical illness.

Factors especially relevant to the elderly include:

1. Delirium is a medical emergency and should be managed on a medical ward.
2. Presentation of physical rather than psychological symptoms is common.
3. Sensitivity to the side effects of psychotropic medication is commonplace, so extreme caution is required with doses.
4. Drug interactions are common.
5. Avoid Olanzapine and Risperidone in dementia, which have been recently shown to increase the mortality.

On Old Age Psychiatry wards routine physical assessments are carried out but treatments of physical illness are comparable to those in the community. For example, there are no facilities for intravenous treatments.

DOs

1. keep your general medical knowledge and physical examination skills up to date - it is a statutory requirement.
2. Consider attending an update course regarding general medicine.
3. consider "physical "causes whenever assessing patients presenting with psychiatric symptoms
4. take a good medical history- ask the patients to bring their current medications rather than relying on lists
5. ask help from colleagues from other specialties if needed (contact on-call physicians and other specialists for advice).
6. Ensure patients' have a thorough physical examination on admission (which is documented) and regularly monitor physical symptoms, and signs.

DON'Ts

1. prescribe medication you are not familiar with – the prescriber has legal responsibility
2. accept transfer from general hospitals if you are not sure the physical problems can be managed on your ward.
3. Accept patients from the general hospital or A&E unless you are sure they have had appropriate (and documented) investigations, examination and treatment, and you are confident their medical condition is stable.
4. forget iatrogenic causes of physical symptoms
5. refer patients without assessing them.
This brief document lays out the requirements for recording physical health and consent & capacity assessments on RiO by core trainees for all new admissions.

All service users admitted to inpatient services must receive an initial physical examination within 48 hours of admission and ideally within 24 hours. This must be recorded under the Core assessment* Physical Health Assessment page of RiO. Enter this in the Physical Health Assessment box.

More detailed information if required can be entered in the Physical Examination page of the core assessment in the relevant text boxes.

If the service user refuses or is too distressed to co-operate with having the physical health examination completed within the agreed timeframe this should be documented in the Core Assessment* Physical Health Assessment section and reviewed regularly with the service user.

Draw up care plan to address physical health needs as required.

Consent and capacity issues should also be recorded in the progress notes in line with Trust policy.

The admitting doctor must also enter diagnoses and validate these. Any adverse drug reactions /allergies using the icon on the front page of the patient’s RiO record.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>TIME FRAME</th>
<th>WHO</th>
<th>WHERE TO DOCUMENT</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health Examination</td>
<td>On admission or within 48 hrs of admission</td>
<td>Doctor</td>
<td>Core Assessment Physical health assessment box on the PHA page in Core assessment</td>
<td>Document (even if refused).</td>
</tr>
<tr>
<td>Consent &amp; Capacity</td>
<td>On admission</td>
<td>Doctor</td>
<td>Progress Notes</td>
<td>Use form A1 or A2 (available on Quick)</td>
</tr>
<tr>
<td>Physical Diagnosis</td>
<td>On admission</td>
<td>Doctor</td>
<td>1.Core Assessment - physical health history 2. Diagnosis + Validate</td>
<td></td>
</tr>
<tr>
<td>Learning Disability</td>
<td>On admission</td>
<td>Doctor</td>
<td>1.Core Assessment - physical health history 2. Diagnosis + Validate</td>
<td></td>
</tr>
<tr>
<td>Adverse Reactions/Allergies</td>
<td>On admission</td>
<td>Doctor</td>
<td>Front Page Icon</td>
<td></td>
</tr>
</tbody>
</table>

* the relevant information can also be recorded in the progress notes as well as the stipulated section of RiO
11.1 GUIDELINES FOR THE MANAGEMENT OF ALCOHOL PROBLEMS ON THE PSYCHIATRIC WARD
(Lead Person: Dr Kishore Chawla)

Criteria for In-patient Detoxification
Most patients with an alcohol problem, including withdrawal from alcohol, can be managed in the community but in-patient detoxification is required if a patient:

a) is severely dependent on alcohol, therefore likely to have severe withdrawal symptoms;
b) suffers with a serious or life threatening medical or psychiatric condition
c) is at risk of suicide or homicide;
d) has a current or past history of severe withdrawal symptoms such as delirium tremens (DTs) or epileptiform seizures.

Screening
All patients should be asked about how many units of alcohol they normally consume on a typical day (Table 1). Male patients drinking > 4 units and female patients > 3 units a day should have a more detailed drinking history taken. Other useful short screening questionnaires are the C.A.G.E. (Table 2) and the AUDIT.

TABLE 1

<table>
<thead>
<tr>
<th>ONE UNIT OF ALCOHOL</th>
<th>8g PURE ALCOHOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>=1/2 PINT OF ORDINARY STRENGTH BEER</td>
<td></td>
</tr>
<tr>
<td>=1 GLASS OF TABLE WINE (10-12%)</td>
<td></td>
</tr>
<tr>
<td>=1 PUB MEASURE OF SPIRITS (40%) (1/6 Gill)</td>
<td></td>
</tr>
<tr>
<td>=1 SMALL GLASS OF SHERRY (17.5%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>One can (450 mls) of strong lager</th>
<th>A bottle of table wine (70cl)</th>
<th>A bottle of spirits (70cl)</th>
<th>A bottle of sherry</th>
</tr>
</thead>
<tbody>
<tr>
<td>= 4 units</td>
<td>= 8 units</td>
<td>= 30 units</td>
<td>= 15 units</td>
</tr>
</tbody>
</table>

TABLE 2 - CAGE QUESTIONNAIRE

Have you ever felt you should **Cut** down on your drinking?

Have people ever **Annoyed** you by criticising your drinking?

Have you ever felt bad or **Guilty** about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-opener**)?

Scoring: YES = 1 : NO = 0

Score 3 or 4: almost definitely ‘alcoholic’

Score 2: 90% probability ‘alcoholic’
Score 0 or 1: probably not 'alcoholic' but many have alcohol related problems

Taking a Brief Alcohol History

Units of alcohol per day/week?

Drinking pattern daily/continuous or episodic/binge drinking?

When did the patient have the last drink?

Is there a history of withdrawal symptoms e.g. Sweating, Tremor, Nausea, Vomiting, Anxiety, Insomnia, Convulsions, Hallucinations or Delirium Tremens?

Does the patient report a history of morning/relief drinking, change in tolerance, strong compulsion to drink, continued drinking despite problems, priority of drinking over other important pursuits/activities?

On Examination

Look for tremor, sweating, signs of liver disease, e.g. spider naevi, liver palms, hepatomegaly etc.

Is the patient intoxicated, in withdrawal, confused, psychotic, depressed, suicidal?

Be careful to consider other possible organic causes for the patient's clinical presentation e.g. head injury, hypoglycaemia, concurrent infection, other drugs etc.

INVESTIGATIONS: MCV, LFTs, Gamma GT, and screening of blood/urine for alcohol and other drugs. Other investigations may be necessary depending on differential diagnoses or concurrent conditions.

Alcohol Withdrawal Syndrome

Not all heavy drinkers will experience withdrawal phenomena. However, there is a wide range of severity of withdrawal symptoms and in some cases withdrawal may be life-threatening. You must recognise early clinical features and treat them appropriately.

Early withdrawal symptoms occur up to 12 hours after the last drink (sometimes within a few hours if the patient is severely alcohol dependent). Include tremor, sweating, anorexia, nausea, insomnia and anxiety. In moderate withdrawal the signs are more marked and transient auditory hallucinations in clear consciousness may also occur.

Withdrawal fits can occur at 12 to 48 hours, especially if there is a previous history of withdrawal fits or epilepsy. Fits tend to be generalised (if focal, suspect head injury) and may occur in bouts. 30% of cases are followed by DTs.

Severe withdrawal/delirium tremens usually develops after 72 hours and patients consuming more than 16 units per day (½ to a bottle of spirits per day or equivalent) are particularly at risk. Clinical features include: marked tremor, confusion, disorientation, agitation, restlessness, fearfulness, visual and auditory hallucinations, delusions, autonomic disturbances; tachycardia, sweating, fever and dehydration.
A protracted withdrawal syndrome has been noted in many alcoholics, characterised by irritability, emotional lability, insomnia and anxiety that persists for weeks to months after alcohol withdrawal. It is due to the residual effects of alcohol on neuroadaptation in the central nervous system. It generally clears spontaneously after prolonged abstinence and resorting to benzodiazepines should be avoided.

Measurement of Withdrawal
To manage and make the withdrawal safe and effective the use of benzodiazepines is recommended. Withdrawal symptoms should be monitored twice a day over the first few days. The severity of withdrawal symptoms can be measured by using Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol (CIWA-AR), which is a very sensitive instrument and helps in adjusting the dose of benzodiazepines.

**MANAGEMENT OF ALCOHOL WITHDRAWAL**

Alcohol dependent patients exhibiting withdrawal features or at high risk of developing withdrawal (based on their previous history) should be prescribed benzodiazepines. Dosage should be individually titrated against severity of withdrawal symptoms and signs. Suggested prescribing guidelines are as follows:

<table>
<thead>
<tr>
<th>Daily Consumption</th>
<th>Alcohol 15 – 25 Units</th>
<th>Alcohol 30 - 40 Units</th>
<th>Alcohol 50 - 60 Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of dependence</td>
<td>MODERATE SADQ Score 15-25</td>
<td>SEVERE SADQ Score 30-40</td>
<td>VERY SEVERE SADQ Score 40-60</td>
</tr>
<tr>
<td>Starting doses of Chlordiazepoxide</td>
<td>15 - 25 mg q.d.s.</td>
<td>30 - 40 mg q.d.s.</td>
<td>50 mg q.d.s*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 1 (starting dose)</th>
<th>15 qds</th>
<th>25 qds</th>
<th>30 qds</th>
<th>40 qds*</th>
<th>50qds*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 2</td>
<td>10 qds</td>
<td>20 qds</td>
<td>25 qds</td>
<td>35 qds</td>
<td>45 qds</td>
</tr>
<tr>
<td>Day 3</td>
<td>10 tds</td>
<td>15 qds</td>
<td>20 qds</td>
<td>30 qds</td>
<td>40 qds</td>
</tr>
<tr>
<td>Day 4</td>
<td>5 tds</td>
<td>10 qds</td>
<td>15 qds</td>
<td>25 qds</td>
<td>35 qds</td>
</tr>
<tr>
<td>Day 5</td>
<td>5 bd</td>
<td>10 tds</td>
<td>10 qds</td>
<td>20 qds</td>
<td>30 qds</td>
</tr>
<tr>
<td>Day 6</td>
<td>5 nocte</td>
<td>5 tds</td>
<td>10 tds</td>
<td>15 qds</td>
<td>25 qds</td>
</tr>
<tr>
<td>Day 7</td>
<td>5 bd</td>
<td>5 tds</td>
<td>10 qds</td>
<td>20 qds</td>
<td></td>
</tr>
<tr>
<td>Day 8</td>
<td>5 nocte</td>
<td>5 bd</td>
<td>10 tds</td>
<td>15 qds</td>
<td></td>
</tr>
<tr>
<td>Day 9</td>
<td>5 nocte</td>
<td>5 tds</td>
<td>10 qds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 10</td>
<td>5 bd</td>
<td>10 tds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 11</td>
<td>5 nocte</td>
<td>5 tds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 12</td>
<td>5 bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 13</td>
<td>5 nocte</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*SPECIAL NOTE: DOSES OF CHLORDIAZEPoxide IN EXCESS OF 30mg q.d.s SHOULD ONLY BE PRESCRIBED IN CASES WHERE SEVERE WITHDRAWAL SYMPTOMS ARE EXPECTED AND THE PATIENT’S RESPONSE TO THE TREATMENT SHOULD ALWAYS BE REGULARLY AND CLOSELY MONITORED. DOSES IN EXCESS OF 40mg q.d.s SHOULD ONLY BE PRESCRIBED WHERE THERE IS CLEAR EVIDENCE OF VERY SEVERE ALCOHOL DEPENDENCE. SUCH DOSES ARE RARELY NECESSARY IN WOMEN AND NEVER IN THE ELDERLY OR WHERE THERE IS LIVER IMPAIRMENT

Special caution is necessary in the case of severe liver impairment as the metabolism of benzodiazepines may be reduced and lead to over sedation.

In severe withdrawal or the DTs additional doses of chlordiazepoxide orally should be given. For rapid response parental use of benzodiazepines e.g. lorazepam intramuscularly or diazepam intravenously may be necessary initially. On the other hand if the patient is very drowsy or over sedated dosage of chlordiazepoxide may need to be reduced.

Withdrawal fits or status epilepticus: - See respective sections.

Severe behavioural disturbance: Haloperidol should be restricted to only patients who do not respond to benzodiazepines (or experience a paradoxical effect with benzodiazepines) and should not be regarded as a treatment of choice in withdrawal. If rapid tranquillisation becomes necessary then follow the guidelines for rapid tranquillisation.

Vitamin supplements: All heavy drinkers should receive vitamin B1 (Thiamine) 100 mgs orally BD or TDS for three weeks. Severely dependent drinkers and those at a risk of Wernicke’s Encephalopathy (confusion, ataxia, ophthalmoplegia) will require IM/IV. multivitamin (e.g., Pabrinex High Potency) for 5 days followed by oral preparations. Overall the incidence of anaphylaxis is rare but it is a recognised complication. Anaphylactic and serious allergic reactions are most severe and also more likely to occur with the intravenous route. Therefore if the IV route is used then drip infusion using 50-100 mls of normal saline or 5% dextrose for dilution, over a period of 10-30 minutes should be preferred. Also facilities for treating anaphylactoid reactions must be readily available whenever the IV/IM route is used.

Chlormethiazole (Heminevrin): Can be used to treat the alcohol withdrawal syndrome. However, it is no more effective than benzodiazepines, and can lead to respiratory depression especially when taken with other CNS depressants. Its use is therefore not recommended for outpatients.

General Management
During withdrawal patients, especially those with severe withdrawal need close observation and monitoring of vital signs, correction of dehydration or electrolyte imbalance and treatment of concurrent conditions e.g. infection, hypoglycaemia, hepatic failure, GIT bleeding etc. Patients should be orientated and reassured that any distressing symptoms will eventually settle. An explanation of the symptoms and their relationship to excessive consumption should be given.

Directive counselling during the process of detoxification can enhance patient's motivation to continue the treatment.
During withdrawal patients often have alcohol craving and are vulnerable to relapse. Therefore any unaccompanied leave from the ward should be carefully considered and patients should be advised not to go into pubs or places where alcohol is available when on leave.

**Alcohol or drug use in inpatients:** Patients must abstain from alcohol and/or other illicit substances whilst receiving in-patient detoxification. To ensure this, a breath alcohol test or screening of blood/urine for alcohol or other substances should be performed regularly. If a patient does not comply with this, then for the safety of the other patients, an early discharge should be considered. We recommend that each inpatient unit has a written policy on the issue of consumption of alcohol or other non-prescribed drugs which states that a patient may be discharged if found to have consumed such substances, and that breath, blood or urine investigations may be requested at any time during the inpatient stay.

**Planning aftercare:** Well in advance of discharge a plan for further support in the community should be prepared with the patient's full participation and with the involvement of relevant community agencies.

If the patient is discharged prior to completion of detoxification, clear instructions should be given regarding medication on discharge and where necessary arrangements made for ongoing supervision of detoxification (e.g. by the GP).

**ALCOHOL WITHDRAWAL FITS**
(Link Committee: Drugs & Therapeutics Committee)

If a fit/seizure occurs during alcohol withdrawal, it should be treated with diazepam rectal solution as outlined below.

1. Protect the patient from damage during the seizure by making the environment safe (by using padded bed rails / pillows for example). Do not restrain the patient.

2. Call the medical-emergency team.

3. Administer diazepam rectal solution directly from the “rectal tube” container according to the following dosage schedule:
   - Adults of working age – the contents of one 10mg tube
   - Elderly patients – the contents of one 5mg tube

4. If no response is seen after 5 minutes, one further tube containing the same dosage can be administered.

5. If there is still no response, refer to the guidelines for the treatment of status epilepticus.

6. Once the seizure has ceased, place the patient in a semi-prone position with the head down to prevent aspiration and to help maintain the airway. The patient should be kept in this position until full consciousness is restored.

7. Consider obtaining specialist advice regarding the need to start an anticonvulsant drug.
Status epilepticus is defined as a convulsive seizure that continues for a prolonged period (longer than 5 minutes), or when convulsive seizures occur one after the other with no recovery in between. Any patient with a prolonged seizure must be assumed to have status epilepticus unless the history shows otherwise. Convulsive status epilepticus is an emergency and requires immediate medical attention.

General management of Status Epilepticus in the inpatient units:

1. Protect the patient from injury during the seizures by making the environment safe (by using padded bed rolls, release constricting neck wear). Do not restrain the patient.
2. Activate medical emergency procedure with in the hospital
   Alert the on call SHO
3. Initially concentrate on respiratory support. Administer oxygen if possible. Do not attempt to put anything in the patient’s mouth even if the tongue is injured.
4. Measure heart rate, respiratory rate, blood pressure, oxygen saturation and body temperature.
5. Check blood glucose levels with the ward glucometer. If the patient is hypoglycaemic, rapidly infuse a 50% solution of glucose to give 1 to 2 ml per kg body weight.
6. Administer the initial drug treatment as detailed below. If the seizures continue, dial 999 for emergency transfer of the patient to the local A&E.
7. Observe the pattern of seizures as this sometimes gives a clue to their aetiology. Remember the possibility of non epileptic seizures which will be resistant to drug therapy.
8. If the flurry of seizures ceases, place the patient in a semi-prone position with the head down to prevent aspiration and to maintain the airway. The patients should be kept in this position until full consciousness is restored.
9. As soon as the ambulance arrives, transfer the patient to the local casualty department.

Drug treatment of status epilepticus in a psychiatric inpatient setting:

Diazepam 10 mg given rectally, repeated every 5 to 10 minutes for up to 3 times (max 30 mg PR), if status continues to threaten.

For sustained control or if seizures continue, the drug of choice is phenytoin by infusion. As the administration of this drug requires the set up of a continuous intravenous infusion accompanied by continuous monitoring, it will be done once the patient has arrived in Casualty.
11.2 ALCOHOL WITHDRAWAL TREATMENT FOR INPATIENT PSYCHIATRIC WARDS (see full guideline and SmPC for advice)v1.0 Link: DTC

Vitamins
Offer ONE pair IM pabrinex OD for at least 3-5 days to all harmful or dependent drinkers who may possibly be malnourished or have decompensated liver disease.

After parental treatment offer oral thiamine 100mg TDS and vitamin B Co strong 2/day.

Patients showing sign of Wernicke’s Encephalopathy require IV Pabrinex TWO pairs TDS IV at an Acute Hospital for supported treatment.

Severity

<table>
<thead>
<tr>
<th>MODERATE</th>
<th>SEVERE</th>
<th>VERY SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol units/day</td>
<td>15 – 25</td>
<td>30 - 40</td>
</tr>
<tr>
<td>SADQ</td>
<td>15-25</td>
<td>30-40</td>
</tr>
<tr>
<td>CIWA-AR</td>
<td>10-20</td>
<td>&gt;20</td>
</tr>
</tbody>
</table>

Signs of withdrawal
- anxiety/agitation/irritability, nausea/vomiting/diarrhoea, convulsions, tremor of hands, tongue or eyelids, insomnia, hallucinations, sweating, fever with or without infection delirium, tachycardia &hypertension. See rating scale in full policy.

Sign of Delirium Tremens (seen in 5% of severe withdrawals)
- Severe tremor, clouding of consciousness, delusions, confusion and disorientation, tachycardia >100/min, agitation, violent behaviour, delirium, fever with or without infection: temperature > 101°F/38.3°C and severe hallucinations (mainly visual, may be tactile or auditory) often causing extreme fear.

Signs of Werneke’s Encephalopathy (Send patient to an acute hospital for treatment)
- Ataxia (23%), hypothermia and hypotension, confusion (82%), ophthalmoplegia (29%) or nystagmus, memory disturbances, coma or unconsciousness. The ‘classic triad’ of symptoms occurs in only 10% of patients.

Other Notes
- Lorazepam may be required in the elderly or liver impairment.
- 25mg Chlordiazepoxide=10mg diazepam=1mg lorazepam
- Antipsychotics may be used for behavioural disturbance and paradoxical effects of benzodiazepines: haloperidol 2.5/5mg po/IM or olanzapine. Seizure threshold may be lowered and less effective than benzodiazepines for DTs.
- Seizure treatment diazepam 5-10mg PR repeated 5 mins later if needed.
- Chlordiazepoxide should NOT be prescribed on discharge from inpatients.
- Contact senior doctor for advice in difficult cases.
12.1 INCIDENT MANAGEMENT AND REPORTING
(Link Person: Director of Nursing)

All staff have a duty to report incidents and near misses. Currently all staff groups under-report and this means the Trust is losing out on valuable information that could improve Trust learning from incidents.

- All incidents and near misses need to be reported using the Electronic Incident Reporting Form as soon as possible after the incident has occurred (irrespective of the time of day or week). This includes where a serious incident has occurred (homicide, suicide or serious deliberate self-harm, admission of a young person (under 18) to an adult ward, unexpected death or serious injury, actual or attempted sexual offences, serious violent incidents, incidents involving safeguarding children issues, incidents involving safeguarding adults issues, absconds of sectioned in-patients, or where an incident occurs during period of abscond, alleged illegal detentions, (see the Reporting Serious Incident process (pg 12.2))
- Err on the side of caution – it is better to over-report than under-report. Advice can always be obtained from the Nursing and Governance Team (020 3513 6187) or relevant service manager or head of department during office hours.
- Out-of-hours advice on serious incident management can be obtained from the Senior Manager On-call via switchboard.

More detailed information about managing and reporting incidents can be found in the Trust policy on incidents: Accident/incident Reporting (7.8.7) and Serious Incidents (TWC10) on the Trust Intranet under policies and procedures.

**Incident reporting checklist**
The following incidents must *always* be reported within 24 hours of occurrence via the Trust incident report form:

- Absconds (detained patients)
- Absence of signed consent form
- Absence of SOAD forms
- Accidents at work (including near misses)
- Aggression
- All serious incidents, e.g. suicide, homicide
- Arrest by police for a criminal offence
- Breach of confidentiality
- Business Continuity Incident (e.g. IT/Telecoms failure/loss of power)
- Safeguarding Children/Safeguarding Adults issue or concern
- Damage to Trust Property/vandalism
- Fire
- Fraud (e.g. staff found to be working while declared off sick)
- Giving medication unlawfully
- Incomplete or inaccurate Mental Health Act forms
- Incorrect disposal of waste (clinical waste in wrong bag/sharps not in sharps bin, etc)
- Infection (staff or patient)
- Inpatient admission of a minor to an adult ward
- Medical Emergencies (staff or patient)
- Patient injuries sustained on Trust premises
- Patient Injury sustained in PPI
- Patient Intoxication – Alcohol/ drugs
- Patient Self Harm
- Patient/Visitor/Staff possession of illicit drugs
- Malfunction of medical device
- Medication Errors
- Missing or unavailable health records
- Service failures (e.g. closure due to low staffing)
- Staff issues (failure to report for duty/sleeping on duty) etc
- Theft or attempted theft
- Staff injuries sustained on Trust premises
- Staff injury sustained in PPI
- Use of PPI
- Use of Rapid Tranquilisation
- Use of Seclusion
- Verbal abuse, e.g. racist abuse or threats
- Violence
12.2 FLOW CHART FOR REPORTING SERIOUS INCIDENT (Link: SIGG)

**WHAT IS A SERIOUS INCIDENT (SI)?**

A SI requiring investigation is defined as an incident that has occurred resulting in one of the following: unexpected or avoidable death; serious harm or where the outcome requires a life-saving intervention; major/medical surgical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm; a scenario that prevents or threatens to prevent a service to continue to deliver healthcare services; allegations of abuse, adverse media coverage or public concern.

For examples of SIs refer to the SI policy pg. 7

*If a suspected SI has occurred team or ward managers should report it using electronic incident form.*

**IMMEDIATE RESPONSE TO A SERIOUS INCIDENT (SI)**

The relevant General Manager/Service Director/Head of Department (or on-call manager out of hours) will review all reported serious incidents when they happen or as soon as is practicable to ensure appropriate and timely action can be taken. If the incident is of particular gravity with definite media interest it should be reported to Clinical Commissioning Group immediately by SIGG.

**ELECTRONIC INCIDENT NOTIFICATION TO BE COMPLETED WITHIN 24 HOURS**

The SI Lead Investigator will review each incident as a potential serious incident and circulate to the Serious Incident Governance Group as appropriate.

*For Safeguarding Children and Adults refer to sections 10 and 11 for further notification requirements.*

**SERIOUS INCIDENT NOTIFICATION TAKEN TO SERIOUS INCIDENT GOVERNANCE GROUP (SIGG)**

Membership: Director of Nursing, Safeguarding Adults Lead, Nurse Consultant, Head of Quality Governance, Deputy Head of Nursing

A decision is made about the Incident Grade and the Terms of Reference for each investigation confirmed and communicated to the relevant SI lead / Service Director.

- **Grade 0**
  - Not deemed to be a Serious Incident
  - De-escalation request submitted to Clinical Commissioning Group
  - SIGG request an Amber investigation (25 working days)
  - Final report received by Serious Incident Governance Group (Grade 1, Level 1 & 2)

- **Grade 1, Level 1 & 2 Concise & Comprehensive**
  - 45 working days
  - Level 1: No panel
  - Level 2: Panel required
  - Investigated by two senior clinician Managers from outside the team where the incident occurred.
  - Final report received by Trust Board (Grade 2, Level 2 and Grade 2, Level 3)

- **Grade 2, Comprehensive Investigation**
  - 60 working days
  - Director chaired panel, reviewed by senior clinician managers from outside where the incident occurred.
  - Final report received by Trust Board (Grade 2, Level 2 and Grade 2, Level 3)

- **Grade 2, Level 3, Independent Investigation**
  - 6 Months
  - Panel Commissioned by PCT or SHA

**Report and Action Plan to Clinical Commissioning Group**
13.1 SAFEGUARDING CHILDREN
(Link: Named Doctor for Safeguarding Children)

Collect information about children in the home
Assess for Safeguarding Children concerns

Child injured or In immediate danger

Other Safeguarding Children or child in need concerns

*Refer immediately to local safeguarding children team/duty team by telephone, followed by letter.
*Share information with trust Lead Nurse for Safeguarding Children.
*If out of hours contact on call manager.

Discuss with manager/senior colleague/multi-disciplinary team/borough Safeguarding Lead.

Discuss concerns with the parent(s) / carer(s) and agree a Care Plan. Discuss possible Common Assessment Framework referral.

If ongoing concerns.
Consult with Lead Nurse/Doctor for Safeguarding Children.

*Complete either 24 hour report or trust Incident Form

NB:
- Documentation should be completed at all stages
- All cases of suspected Child Sexual Abuse must be referred to Children’s Social Care and clothing or items connected to the case saved for forensic purposes.
- Information about children in the home must be obtained at the initial assessment and any concerns about the care or safety of children discussed with the Safeguarding Children Lead on the team, the consultant, and/or manager and discussed with the Trust Safeguarding named nurse if in doubt.
- If an assessment indicates that a child is at risk of serious harm, then immediate referral must be made to the Local Borough Safeguarding Teams via Children’s Social Care.
- Please refer to London Child Protection Procedures (2007) and the Trusts Safeguarding Children Policy (TWC03) for details located under ‘policies’ on the Trust Intranet Quick
13.2 PROTECTING ADULTS AT RISK
(safeguarding vulnerable adults)
(Link person: Trust Safeguarding Adults Lead)

Aims
The procedures aim to make sure that:
- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all decisions and actions are taken in line with the Mental Capacity Act 2005.

Working together: The policy and procedures are for different agencies and individuals involved in safeguarding adults, including managers, professionals, volunteers and staff working in public, voluntary and private sector organisations. Local authorities have the lead role in coordinating work to safeguard adults, however, responses need multi-agency and multi-disciplinary working.

Definition of an adult at risk/vulnerable adult
An adult aged 18 years or over ‘who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation’ (DH, 2000).

Abuse - definition:
‘a violation of an individual’s human and civil rights by any other person or persons which results in significant harm. (DH, 2000)
Abuse may be:
- a single act or repeated acts
- an act of neglect or a failure to act
- multiple acts, for example, an adult at risk may be neglected and also being financially abused.

Abuse can take place in settings such as the person’s own home, day or residential centres, supported housing, educational establishments, or in nursing homes, clinics or hospitals.

Significant harm – definition:
- ill treatment (including sexual abuse and forms of ill treatment which are not physical)
- the impairment of, or an avoidable deterioration in, physical or mental health and/or
- the impairment of physical, intellectual, emotional, social or behavioural development.
Abuse can be viewed in terms of the following categories:
- physical
- sexual
- psychological/emotional
- financial and material
- neglect and acts of omission
- discriminatory
- institutional
Two of the key Stages in the safeguarding process:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Activity</th>
<th>Responsibility</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Stage One</td>
<td><strong>Raising an alert</strong></td>
<td>Everyone with a duty of care</td>
<td>Immediately, if emergency or within same working day (this should be within four hours)</td>
</tr>
<tr>
<td></td>
<td>• Act to protect adult at risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deal with immediate needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Report to line manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider reporting to the police, if a crime</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision</td>
<td>• Take any immediate management action to identify and address the risk</td>
<td>Alerting manager Safeguarding Adults lead Member of staff if appropriate</td>
<td>Immediately or within 24 hours</td>
</tr>
<tr>
<td></td>
<td>• Decide if a referral is needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If NHS, consider reporting as serious incident (SI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage Two</td>
<td><strong>Making a referral</strong></td>
<td>Adult at risk (carer, friend, relative) Manager Safeguarding Adults lead Other professional Any staff in emergency</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td></td>
<td>• Refer to Safeguarding Adults referral point</td>
<td>Safeguarding Adults Manager and relevant partner organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Report to the police, if a crime</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If NHS, make a report under SI procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Notify CQC if necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gather initial information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clarify facts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision</td>
<td>• Evaluate risk</td>
<td>Safeguarding Adults Manager and relevant partner organisations</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td></td>
<td>• Decide if Safeguarding Adults procedures apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Agree interim protection plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• (Police investigation may have begun)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decide if a strategy meeting or discussion is needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14.1 HOME TREATMENT TEAMS
(Link Person: Home Treatment Team Managers)

Contacts

Wandsworth 0203 513 5445 or Crisis Line out of hours 0800 028 8000:
Wandsworth Recovery Centre, Building 30, Springfield Hospital (Tom Clarke)

Merton 0203 513 6158 (will give a mobile number to call if not answered):
Jasmine Basement, Springfield Hospital (Ann Traynor)

Sutton 0208 296 4235 (will give a mobile number to call if not answered):
Chiltern Wing, Sutton Hospital (Bruce Mamvura)

Kingston 0203 513 5263 9am to 11pm on call from 11pm to 9am via crisis line
0800 028800 ask to be put through to Kingston HTT: Tolworth Hospital
(Lorraine Chademunhu)

Richmond 0208 487 6693: Queen Mary’s Hospital (Emmanuel Aso-Tako)

Team Function

Home Treatment Teams concentrate on people who would normally require
hospital admission and stay involved until the crisis resolves. They provide
intensive, home based treatment on a 24-hour, seven day a week basis for
those in acute crisis. Home Treatment allows an alternative to acute admission
and provides for early discharge to treatment in the least disruptive and
restrictive environment. All adults of working age across the 5 boroughs at risk
of hospital admission will be regarded as possible referrals to the Home
Treatment Team, including those being assessed under the Mental Health Act
1983. The team will act as gatekeeper to acute beds by providing
comprehensive assessment and a home treatment alternative to hospital
admission where appropriate.

On Call

All 5 borough-based home treatment teams have mobile on call arrangements
that operate after extended team hours.

Main referral sources

1. CMHTs and liaison psychiatry.
2. The duty psychiatrist and the duty psychiatrist for the A&E.
3. GPs in boroughs (emergency out of hours only)
4. Emergency Duty Social Work Team for boroughs
5. Ward staff from the in-patients ward for early discharge after discussion at
   the multi-disciplinary ward meeting with the CMHT
6. Other: the teams respond to requests from emergency services, NHS direct,
   etc.

Referral Criteria

The service primarily targets patients with severe and enduring mental health
problems who would meet the threshold for secondary care treatment.
Acceptance will be where the Team has a role in early discharge or acute
alternatives to admission where the crisis is not predominantly social in nature.
The HTT cannot accept referrals for people with exclusively substance misuse
problems, organic brain injury, dementia, or those whose needs can only be met
by highly specialist tertiary services.

Referral Process

Direct to borough home treatment team numbers. Out of Hours the Crisis Line
0800 028 8000 also operates for service users and carers. For appropriate
referrals, assessment will be carried out by HTT within the agreed time scale,
taking into account the urgency and the risks. Wherever possible, the
assessment will be in the patient’s home and with the patient’s care co-ordinator
and involve key members of the supportive network.
All requests for admission to the acute admission wards will be referred to the locality Home Treatment Team for assessment first. 0800 028 8000 or local number

**Features of Gatekeeping** (Guidance Statement on Fidelity and Best Practice for Crisis Services DH 2006)

Everybody (including people in need of mental health act assessments) requiring emergency access to acute mental health services (HHT and In-patient) should go through a full gatekeeping process. This requires:
- The HHT to provide a mobile 24 hour, seven day week response to requests for assessments.
- The HTT team **actively involved in all** requests for admission.
- The HTT team being notified of **all** pending mental health act (MHA) assessments.
- The HTT team assessing all these cases **before** admission happening.
- The HTT team being central to the decision making process in conjunction with the rest of the multi-disciplinary team.

**Flowchart of Gatekeeping**

Link Person: Service Development Lead Community

HTT staff will complete the Home Treatment triage to establish that the referral meets the HTT criteria and that the patient is not the responsibility of another Trust. Active involvement of HTT in gatekeeping means **FACE TO FACE gatekeeping** wherever possible to establish what resources of the HTT can be provided safely to keep the person at home in the acute phase.

In exceptional cases where CHTT unable to offer face to face assessment within a reasonable time period the HTT will agree through meaningful dialogue with the referrer an appropriate community management plan or admission.

**FACE TO FACE Gatekeeping** assessment carried out by CHTT within agreed time jointly with referring agencies where possible.

- Suitable for and service user / family agree to home treatment? (or period of attempted community engagement for home treatment agreed)
  - **NO**
    - Care remains with referring team
  - **ON**
    - Accepted for Home Treatment.
  - **ON**
    - Admitted to Hospital

In patient ward

Discharge Plan see early discharge flowchart

105
15.1 INFECTION CONTROL PRINCIPLES AND PRACTICE

(Link person: Liz Jones, Senior Nurse for Infection Control)

There is often no way of knowing which of your clients is infected; therefore it is essential that Standard Infection Control Practices (see below) are used for all clients on every contact.

The purpose of Infection Control is to minimise the risk of spreading infections. This is helped by informing staff, relatives and clients of the most appropriate methods and practices, which can be used in the treatment and care of people who have contact with our services.

It is very important to request advice from the Senior Nurse Infection Control and Physical Healthcare for this Trust and report any new infections identified immediately. For contact details see below.

This guide is only an introduction to infection control within South West London & St. George’s Mental Health Trust. It is essential that all staff familiarise themselves with the Infection Control policies. It is also essential that all staff receive induction and annual update infection control training.

HOW DOES INFECTION SPREAD?

To enable infection to spread there needs to be four elements:
- A source of infection
- A means of transmission for the infection to get from one place to another
- A means of entry to the body.
- A susceptible host

Sources

There may possibly be a number of sources but usually the source is either people (clients, staff, relatives, visitors) or contaminated hands or objects.

Although invisible, germs, which can cause infection, may sometimes be present in blood, other body fluids (urine, faeces) and secretions (saliva, wound drainage). They are also often present on the skin surface especially hands. A person does not have to look or be sick to be a source of infection.

Contaminated objects can also be a source of infection, such as equipment, dustbins, and dirty laundry.

The five main routes of transmission are:
- Contact

This can occur by direct contact between 2 individuals. More common however is Indirect Contact which occurs when germs are passed from the source’s skin/body fluids to the host’s skin/body fluids via care worker’s hands or contaminated equipment.

- Airborne - Droplet transmission (coughs, sneezes)
This occurs when the source person coughs sneezes or talks close to the susceptible person (host). Droplets do not stay in the air so the risk of transmission is for a very short period.

- **Airborne – Aerosol transmission**
  This can occur over greater distances than droplets because the germs are carried in very small droplets or in the dust. The susceptible host then inhales the tiny particles. The infection is usually passed to someone else in the same room but may, occasionally, be carried on air currents to people further away.

- **Food Water Borne Infections**
  These may occur if Water and Food Safety procedures are not followed.

- **Vectors** (pests and insects)
  This occurs when flies, rats and other insects/animals transmit infections.

**Means of entry**

To be transmitted germs must enter the host’s body through a number of routes, including:

- Breathing in
- Through the mouth, eyes, nose or other openings of the body
- A break in the skin, such as cuts, eczema or dermatitis
- Through a dirty needle or other sharp object.

**Susceptible Host**

All of us are exposed to germs throughout our lives. Our immune systems however often protect us from infection.

Health care patients may be at increased risk of infection if their immune system is impaired. This might be because of:-

- Their age, either very young or old.
- Co-morbidities – patients with underlying physical health disorders are at increased risk. In particular this includes patients who are immuno suppressed and diabetics.
- Invasive Medical Devices and wounds – provide a means of entry for germs
- Some drug treatments affect the immune system. These include Steroids, Cytotoxic Drugs and Clozapine.
STANDARD INFECTION CONTROL PRECAUTIONS

Hand Hygiene

Effective hand hygiene remains the single most important means of reducing the spread of infection. Every health care worker is responsible for maintaining high personal standards of hygiene and hand cleanliness.

It is essential that before and after carrying out any client care activity, hands are safely decontaminated with an appropriate hand wash lotion.

To practice effective hand hygiene staff must follow the Dress Code Policy:-

- Nails should be short, natural (no false, gel acrylic nails) and unvarnished.
- Hand/wrist jewellery should not be worn except plain wedding bands.
- If long sleeves are worn they must be rolled to the elbow before hand washing.

Hand hygiene must be carried out:

- Before starting and ending a shift.
- On entering and leaving a clinical area.
- Before and after direct contact with clients and their equipment.
- Between clinical tasks on the same patient.
- After removing gloves.
- When contaminated with body fluids or organic matter.
- After eating, smoking, using the toilet etc.

Technique:-

1. Hands should be washed with soap and warm water, rinsed and dried thoroughly.
2. See ‘Effective Hand Washing Technique’.
3. It is advised that staff use a moisturiser to protect their hands from drying.
4. Alcohol gel is available in clinical rooms and as personal use bottles.
5. Alcohol gel may be used for the decontamination of CLEAN hands.
6. Alcohol gel should not be used when caring for patients with diarrhoea.

Personal Protective Equipment (PPE)

*Personal Protective Equipment provides a barrier between you and a potential or a definite risk.*

**Latex free gloves:** disposable single use must be worn when in contact with blood; body fluids, chemicals or you have damaged skin. Gloves must be changed between patients and between clinical tasks on the same patient.

Heavy-duty gloves are used by housekeeping staff for cleaning or waste management duties.

**Disposab**le plastic aprons: (suitable protective clothing) must be worn when dealing with blood, body fluids, mucous membranes, clinical waste or non-intact skin and when bed making.
Goggles/visors and masks: are strongly advised when there is a potential for exposure to blood or body fluid ‘splashes’ this is rare

Waste

Clinical waste, which may be produced during client care, must be disposed of in orange clinical waste bags. As the Infection Control Manual states, ‘all bags must be labelled and tagged’.

Black plastic bags should be used for household waste.

Linen

Soiled (body fluids) or infected linen must be placed in red alginate (dissolvable) bags before being placed in a red sunlight bag or a blue plastic bag (patient’s clothing).

Sharps

Needles must be disposed of directly into a rigid sharps container at the bedside.

**DO NOT RESHEATH CONTAMINATED NEEDLES**

Sharps containers must be labelled with a start date and a disposal date and the name of the staff member assembling and closing the bin. Sharps containers must be disposed of when they are two thirds full or have been in use for four weeks, whichever is the sooner.

Spillages of Body Fluids

Spillage of blood and body fluid in the clinical areas must be dealt with by clinical staff; using the appropriate spillage kits and procedures.

Decontamination – See also Infection Control Decontamination Policy

Cleaning: is an essential part of maintaining a safe environment and controlling the spread of infection, by removing the material on which dirt and bacteria can live and grow. Normal and terminal cleaning must be done using hot water and general purpose detergent. Cleaning must also be carried out before using a disinfectant.

Protective clothing must be worn during all cleaning procedures (plastic aprons and heavy-duty gloves). Take care when cleaning under running water to avoid splashing.

Disinfection: is a process that will reduce the number of germs to levels where they are less of a risk. Disinfection is performed using either heat or chemicals.

Chemical disinfection should only be used when heat treatment is impracticable or undesirable.

If chemical disinfectants are to be used:

- Items/equipment must have been thoroughly cleaned with detergent prior to the use of a disinfectant.
• Items/equipment must not be left soaking in disinfectant for longer than recommended.
• Disinfectants must be freshly prepared and used at recommended strength.
• Containers used for disinfectants should not be topped up because contamination will occur.

Extra precautions: which may need to be taken for a particular client will be identified by the Infection Control Specialist and appropriate advice will be given.

Senior Nurses for Infection Control and Physical Healthcare

Contact Details

07739 087333

Or via email

elizabeth.jones@swlstg-tr.nhs.uk
Effective Hand Washing Technique
15.2 OUTBREAK ACTION PLAN
(Lead person: Liz Jones, Senior Nurse for Infection Control)

Outbreaks of infection can cause considerable difficulties for patients, staff and the organisation.

Staff should be aware of the following and ensure they follow this action plan on suspicion of infection outbreak.

Definition: An outbreak is two or more individuals showing the same symptoms and that can be linked by time, location, food/drink or identification of the same micro-organism. A major outbreak is 10 or more people meeting this criteria.

<table>
<thead>
<tr>
<th>1. Identify the problem (Clinician or Nurse in charge of patient[s])</th>
<th>GATHER RELEVANT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Type of infection (same organism, symptoms, numbers, notifiable disease, etc);</td>
</tr>
<tr>
<td></td>
<td>▪ Names of patients/staff affected;</td>
</tr>
<tr>
<td></td>
<td>▪ Current specimens collected; including date of collection and location of laboratory.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Inform Infection Control Team (who will notify the Health Protection Agency if required)</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INFECTION CONTROL NURSE</td>
</tr>
<tr>
<td></td>
<td>IMMEDIATELY</td>
</tr>
<tr>
<td></td>
<td>IF OUT OF HOURS CONTACT SHOULD BE VIA THE ON CALL DUTY MANAGER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Discuss problem with Infection Control Team who will:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Review clinical data;</td>
</tr>
<tr>
<td></td>
<td>▪ Develop case definition;</td>
</tr>
<tr>
<td></td>
<td>▪ Isolate and treat patients/staff as necessary;</td>
</tr>
<tr>
<td></td>
<td>▪ Outbreak Control Committee will be convened if necessary;</td>
</tr>
<tr>
<td></td>
<td>▪ Educate clinical staff on appropriate care and precautions;</td>
</tr>
<tr>
<td></td>
<td>▪ Screen staff if necessary;</td>
</tr>
<tr>
<td></td>
<td>▪ Situation will be discussed with Directorate and Trust managers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Review progress</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Review clinical data;</td>
</tr>
<tr>
<td></td>
<td>▪ Review care plans;</td>
</tr>
<tr>
<td></td>
<td>▪ Review outbreak control measures;</td>
</tr>
<tr>
<td></td>
<td>▪ Attend Outbreak Committee as necessary.</td>
</tr>
</tbody>
</table>

Senior Nurses for Infection Control and Physical Health: Contact Details;

07736 087 333
If the Department of Health directive was followed it would have a major cost implication to the Trust and is not realistic. Therefore based on risk assessment for MH and to be compliant with the recommendations in “Essential Steps” the Trust should screen those patients admitted with

- Any in-dwelling device i.e. a urinary catheter, peg tube or fistula
- If there is recent evidence of an intravenous puncture wound.
- If the patient has a wound i.e. leg ulcer, pressure sore or other chronic wound

This should only equate to less than ten percent of hospital admissions.

Patients moving from the Mental Health Trust to an acute hospital will be routinely screened.

If a patient is due to have elective surgery and is an in-patient within MH we may be asked to screen that patient prior to admission.

Skin eradication treatment should only be prescribed for a patient following discussion with an Infection Control Nurse.
Does the service user smoke?

Yes

Record smoking status on SCF

Provide Brief Intervention and record in Progress Notes on RiO.

Does the service user want to quit smoking and give consent to be referred to a SCA?

Yes

Refer to local Smoking Cessation Advisor via ‘My Caseload’ for assessment and support

Smoking Cessation Advisor to:-
- Assess service user
- Recommend agreed NRT
- Provide intensive support
- Record details on RiO
- Upload Care Plan from RiO library
- Notify all professional staff involved with service user’s care

SHO to:-
- Complete Physical Health Assessment and medication interaction with NRT
- Prescribe recommended NRT based on Smoking Cessation Advisor’s assessment

Smoking Cessation Adviser to:-
- Record on RiO and SCF
- Complete Care Plan and upload onto RiO

Treatment ends or relapse occurs

Smoking Cessation Advisor to inform SHO and staff

A significant dose reduction (of medication) may be necessary when taking NRT

To be reviewed regularly by the SHO and Pharmacist

Psychiatric medication can could cause toxicity if not monitored during the quit attempt:
- Clozapine
- Olanzapine
- Chlorpromazine
- Haloperidol
- Fluphenazine
- Fluvoxamine*
- Duloxetine*
- Benzodiazepines
- Zolpidem*

(NB - * These medicines are non-formulary. This is not an exhaustive list, please refer to BNF)

The Smoking Cessation Advisor and other staff must notify the following:
- Ward Pharmacist
- Responsible Clinician

prior to the service user’s quit attempt as a significant dose reduction may be necessary

If the service user is discharged, the Smoking Cessation Advisor must:-
- Inform the CMHT Care Coordinator / RMO immediately
- Follow up the service user in the community
- Arrange NRT prescription, in conjunction with the SHO, via the Discharge Summary for the GP

Consider taking Bob Joseph’s SC training at level 2 allowing you to support your clients with SC counselling with a focus for people who have serious mental illness.
Robert Joseph at robert.joseph@swlsg-tr.nhs.uk
Smoking Cessation Care Pathway for Service Users aged 16 years + Mental Health Setting - Community

V1.0 - Produced by the Smoking Cessation Project Board (07.12.10)

Record smoking status on the Smoking Cessation Form (SCF) in 'My Caseload'

Does the service user smoke?

Yes

Record smoking status on SCF

Provide Brief Intervention and record in Progress Notes on RiO.

Does the service user want to quit smoking and give consent to be referred to a SCA?

Yes

Record status & Refer to local Smoking Cessation Advisor via 'My Caseload' for assessment and support

No

Begin care pathway again within 6 months

Psychiatric medication can cause toxicity if not monitored during the quit attempt:

- Clozapine
- Olanzapine
- Chlorpromazine
- Haloperidol
- Fluphenazine
- Fluvoxamine *
- Duloxetine *
- Benzodiazepines
- Zolpidem *

(NB - *These medicines are non-formulary.
This is not an exhaustive list, please refer to BNF)

The Smoking Cessation Advisor and other staff must notify the following:
- Pharmacist - 0208 682 6829
- Responsible Clinician
- GP
- Clozapine Clinic

prior to the service user’s quit attempt as a significant dose reduction may be necessary

A significant dose reduction (of medication) may be necessary during the quit attempt

This is to be reviewed regularly by the SCA, Care Coordinator and GP

If the service user is admitted to hospital, Care Coordinator to:

- Inform SCA
- Inform ward staff that the service user is working with the SCA

If relapse occurs, SCA to:

- Inform Care Coordinator / GP for medication to be reviewed and adjust if necessary
- Begin care pathway again at next appointment (within 6 month)

If the service user is discharged back to the CMHT or their GP, the Smoking Cessation Advisor must:

- Follow up the service user in the community
- Arrange NRT prescription, in conjunction with the SHO, via the Discharge Summary for the GP

Consider taking Bob Joseph’s SC training at level 2 allowing you to support your clients with SC counselling with a focus for people who have serious mental illness. Robert Joseph at robert.joseph@swlstg-tr.nhs.uk
16.3 Summary: Pharmacologic smoking cessation interventions (Link Committee: Drugs and Therapeutic Committee)
v2011 (See full guideline, SmPC or contact Medicines Information for further details)

<table>
<thead>
<tr>
<th>Medicine (licensed for use in ages)</th>
<th>Dose</th>
<th>Prescribing advice</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NRT patches</strong> (12yrs+)</td>
<td>7, 14 or 21mg/24hrs, one patch each day</td>
<td>Apply to an area of clean dry skin and rotate position on the trunk or upper arms. Start at 21mg/24hrs if individual smokes more than 20/day. If a 16hr patch is required, use the 24hr patch but remove before bedtime. Initial treatment for 8 weeks, wean on each lower strength patch for 4 weeks. Stop if abstinence not achieved after 9 months, unless motivated to stop.</td>
<td>Skin irritation/redness - discontinue if severe &amp; sleep disturbance</td>
</tr>
<tr>
<td><strong>NRT gum</strong> (12yrs+)</td>
<td>2 or 4mg pieces, maximum 15 pieces/day</td>
<td>Start on 4mg pieces if individual smokes more than 20/day. Chew until taste becomes strong and ‘park’ between the gum and cheek, repeat for 30mins/piece. After 8 weeks gradually reduce the number of pieces used/day.</td>
<td>Throat irritation, wind &amp; hiccups</td>
</tr>
<tr>
<td><strong>NRT inhalator</strong> (12yrs+)</td>
<td>1 cartridge over 40mins, maximum 6 (15mg) cartridges/day</td>
<td>Inhale a cartridge over 40 minutes as required, each cartridge may be used for 8 sessions of 5mins and should be used at room temperature. Inhalations should be for longer than a smoker would inhale a cigarette.</td>
<td>Throat irritation, cough &amp; rhinitis</td>
</tr>
<tr>
<td><strong>Bupropion</strong> (18yrs+)</td>
<td>150mg OD, increase to 150mg BD from day 7 &amp; quit date</td>
<td>Should be used in combination with behavioural smoking cessation support. Treatment is for 7-9 weeks, stop if after week 7 if there is no clinical effect. Maximum dose of 150mg OD in frail elderly.</td>
<td>Manic episodes during a depressive phase of BPAD, depression, suicidal ideation &amp; insomnia. Also dry mouth, GI disturbance, tremor, concentration disturbance, headache, dizziness, fever, pruritus, sweating, drowsiness and hypersensitivity reactions such as urticaria</td>
</tr>
<tr>
<td><strong>Varenicline</strong> (18yrs+)</td>
<td>Day: 1-3 500micrograms OD, 4-7 500micrograms BD, 8 to end of treatment 1mg BD</td>
<td>Start 1-2 weeks before the quit date. Maximum 12 week course. Report all side-effects to the MHRA. Should be used in combination with behavioural smoking cessation support. Check ECG in cardiovascular disease or on using with QTc prolonging medicines.</td>
<td>Abnormal dreams, insomnia, headache, nausea, increased appetite, panic reaction, bradypnea, abnormal thinking, mood swings, somnolence, dizziness, tremor, restlessness, abnormal coordination, depression, dysphoria, decreased libido, lethargy, atrial fibrillation, palpitations, suicidal ideation, aggression, anxiety, psychosis, mood swings and palpitations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Effect</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>TCAs</td>
<td>Be alert for increased adverse effects from these medicines, the dosage may need to be reduced. Advice may need to be sought from GPs or medical Physicians. Decrease dose by 25% one week after stopping for clozapine, olanzapine and haloperidol where clinically appropriate. 7 days after stopping check clozapine levels. Warfarin: recheck INR. Insulin: check blood glucose more frequently. Betablockers &amp; arrhythmics: check BP and HR and review dose accordingly. Theophylline: check level after a week and reduce dose (~50%) accordingly.</td>
</tr>
<tr>
<td>Betablockers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clozapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cinacalcet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flecanide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flupentixol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirtazapine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicines that may need dose reduction on smoking cessation

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Effect</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluphenazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perphenazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flupentixol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melatonin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rivastigmine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sertindole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamoxifen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zuclopenthixol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zotepine*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Non-formulary
Appendix 1: LIBRARY SERVICES
(Link Person: Library Services Manager)

Library services at the Trust support all of the following: evidence-based clinical care; research; service development; journal clubs; case presentations; exam preparation; and any other information needs.

All Library Services are provided in the Libraries and at a distance by email, phone, and post.

Your Librarians:
- Olga Rak, Library Services Manager
  Based at Springfield Hospital full-time
  Location: 1st Floor, Building 30, Storey
  Email: olga.rak@swlstg-tr.nhs.uk Phone: 020 3513 6033

- Olwen Revill, Librarian/Athens Administrator
  Based at Tolworth Hospital part-time
  Location: Room S8, 2nd Floor, Woodroffe House
  Email: olwen.revill@swlstg-tr.nhs.uk Phone: 020 3513 5026

Your Library Services:
- All the library services are free to you and tailored to your needs
- Literature Search Service - we provide you with journal articles, documents, books, websites, and resources relating to a topic you specify;
- Current Awareness Service - we keep you up to date via journal tables of contents, evidence bulletins, saved searches;
- Document Delivery Service – we order journal articles and books from other libraries for you and deliver them, to your desk-top and/or via post;
- Enquiry Service – we answer enquiries by email, phone, and in person;
- Training opportunities – we train you how to use online resources;
- Other Libraries – join St George’s library for full borrowing rights and walk-in access to online resources on site and at Queen Mary’s Hospital.

Your Libraries:
All Trust staff are automatically members of the library service, and can use the two libraries. Facilities at both libraries include:
- Space for quiet study
- Books to borrow
- 4/5 networked PCs
- Printing, photocopying, scanning and shredding facilities

Springfield Library
Room 106, 1st Floor, Building 30, Storey
The library is available 24/7. Please use your ID card to access the library, or please collect and sign out a swipe card from the Gate Lodge at Springfield Hospital each time you wish to use the library and return it when you have finished.
**Tolworth Library**
Room S8, 2nd Floor, Woodroffe House
The library is available 8am-8pm. Please use your swipe card, or please ask the reception staff to let you in. You will need the library door code – please contact your librarians or ask the reception staff.
Appendix 2: SEARCHING FOR EVIDENCE
(Link Person: Library Services Manager)

OpenAthens account registration

You will need your own OpenAthens username and password to be able to access any of our electronic resources from anywhere:

1 Self-Register for an OpenAthens account at: openathens.nice.org.uk/
2 Use the ‘Forgotten password’ option at: openathens.nice.org.uk/Password/Reset
3 To renew your account or for any queries, please email Olwen Revill, your local Athens Administrator at: olwen.revill@swlsg-tr.nhs.uk

Library Services website:
Find us on inSite under Knowledge Base
Then select:
Staff Handbook / Other / Library Services

All of the library resources are available from anywhere, including:

- Maudsley Prescribing Guidelines Online at: www.123library.org
- UpToDate (point of care tool) at: www.uptodate.com
- The Cochrane library at: www.thecochranelibrary.com
- Evidence Search, including NICE guidelines at: www.evidence.nhs.uk
- MyJournals (national and local full-text electronic journals) at: www.library.nhs.uk/booksandjournals/journals/default.aspx
- MyiLibrary (national electronic full-text books) at: www.library.nhs.uk/booksandjournals/ebooks/default.aspx?

Please contact Olga Rak and Olwen Revill for any further information:
olga.rak@swlsg-tr.nhs.uk; olwen.revill@swlsg-tr.nhs.uk

- We can provide a search of the literature and email it to you;
- We can locate references for you;
- We can provide you with full-text journal articles;
- We could demonstrate evidence-based resources at a future team meeting;
- We could train a group of you to use a particular resource;
- All our services can be tailored to your requirements;
- All our services and resources are free to you.
Appendix 3: EMERGENCY TELEPHONE NUMBERS FOR THE SPRINGFIELD SITE OVER THE 24 HOUR PERIOD
(Link Person: Hotel Services Manager)

PSYCHIATRIC AND MEDICAL EMERGENCIES    Telephone 4333
SECURITY    Telephone 6666 (24hr Helpdesk)
FIRE    Telephone 4333/9999

State nature of emergency and the Ward or Area you are phoning from

Deaf Staff    Telephone 43444
Corner House and Hightrees only

Who will come if any of the above emergencies happen?

- Sector Liaison Nurse
- Duty Doctor on Call (except fire)
- A minimum of three emergency response nurses
- Security
- For Fire – fire brigade will attend

UTILITY CRISIS (between 8am and 5pm Monday - Friday)
For Estate Type Emergencies: #6900 or 020 3513 6900
(i.e., burst pipes, electrical failure, blocked toilets etc)

Outside of office hours: dial switchboard ‘0’ who will contact the relevant on-call engineer.

If you are unsure about any non-urgent situation, please contact the On Call Manager via the switchboard dial ‘0’
Appendix 4: EMERGENCY TELEPHONE NUMBERS FOR THE TOLWORTH SITE OVER THE 24 HOUR PERIOD

PSYCHIATRIC AND MEDICAL EMERGENCIES
Use Emergency Bleeps
FIRE Telephone 9999
State nature of emergency and the ward or area you are phoning from

Who will come if any of the above emergencies happen?
A minimum of three emergency response nurses
(three at night)
Security (24hours per day) Mobile number 07967 820786
Duty Doctor on-call when on site via switchboard 020 3513 5000
For Fire – fire brigade will attend dial 9999

UTILITY CRISIS (between 8am and 5pm Monday - Friday)
Maintenance Emergencies – Tel: #6900 or 020 3513 6900
(i.e., burst pipes, electrical failure, blocked toilets etc)
Outside of office hours: dial 020 3513 6667

If you are unsure about any non-urgent situation, please contact the Senior Manager On-call or the Senior Nurse) via switchboard dial 020 3413 6667

121
Appendix 5: EMERGENCY TELEPHONE NUMBERS FOR BARNES SITE OVER THE 24 HOUR PERIOD
(Link Person: Hotel Services Manager)

**PSYCHIATRIC AND MEDICAL EMERGENCIES**

The staff will phone for emergency services – Telephone 9999

**FIRE** – Telephone 9999

State nature of emergency and the ward or area you are phoning from

Who will come if any of the above emergencies happen?

- For Fire – fire brigade will attend dial 9999

---

**UTILITY CRISIS** (between 9am and 3pm)

For Estate Type Emergencies: #6900 or 020 3513 6900
- On-call Estate Manager
  (i.e. Burst pipes, electrical failure, blocked toilets etc)

Outside of office hours: dial 020 8390 6633

If you are unsure about any non-urgent situation, please contact the Senior staff on site contact the Senior Manager On-call via Switchboard at Tolworth dial 020 3513 5000
Appendix 6: MANDATORY & STATUTORY TRAINING

(Link Person: Training Manager)

A key learning priority for the Trust is to deliver education, training and development opportunities for staff to work safely and effectively. This includes health and safety training as well as pre and post qualification education that is specified by regulatory bodies and is mandatory.

The Trust has a programme of mandatory and statutory training that must be considered when deciding an individuals’ development and training specific to service or site which may be related to areas such as local policy, procedure or protocol where the knowledge of these is essential for you to safely carry out your role.

Staff must be compliant with their statutory and mandatory training requirements before CPPD or further training requests will be considered or approved. Individual compliance with statutory and mandatory compliance information can be found on Dashboards.

Information on training currently available can be found on Quick, the Trust’s intranet. Click the Training & Education tab [last on the right] and then select a Training Category from the drop down list.

You can also contact the Training & Development Department (020 3513 5552/5619/5553/5623) with any query you might have.
South West London and St. George’s Mental Health NHS Trust recognises the following abbreviations as acceptable within service users’ records:

1/12 1 month
1/52 1 week
1/7 1 day
A & E Accident and Emergency
ASW Approved Social Worker
AppA Appropriate Adult
AM Morning
Bd Twice Daily
BMI Body Mass Index
BMS Budgetary Management System
BP Blood Pressure
cm Centimetre
CM Care Manager/Management
CMHT Community Mental Health Team
CPA Care Programme Approach
CPN Community Psychiatric Nurse
CPR Cardio Pulmonary Resuscitation
CSSD Central Sterile Supply Dept
CSU Catheter Specimen of Urine
CT Scan Computer tomography
Ctax Council Tax
Dept. Department
DLA Disability Living Allowance
DOB Date of Birth
Dr. Doctor
DSS Department of Social Security
ECG Electro Cardiograph
ECT Electro Convulsive Therapy
EEG Electro Encephalogram
F Female
FAT Financial Assessment Team (Wandsworth)
GP General Practitioner
HB Housing Benefit
HIV Human Immunodeficiency Virus
HT Height
IB Incapacity Benefit
ICA Invalid Care Allowance
IM Intramuscular
IS Income Support
IV Intravenous
JSA Job Seekers Allowance
KG Kilogram
L or Lt Left
lb Pound
m Metre
## Appendix 8: CLINICAL POLICY REVIEW SCHEDULE

<table>
<thead>
<tr>
<th>NO.</th>
<th>POLICY</th>
<th>REVIEW DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>OVERDUE</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Enteral Feeding for Adult and Child Inpatients</td>
<td>01.06.2014</td>
</tr>
<tr>
<td>2</td>
<td>Medical Emergency and Resuscitation Policy</td>
<td>01.06.2014</td>
</tr>
<tr>
<td>3</td>
<td>Supervision Policy</td>
<td>01.06.2014</td>
</tr>
<tr>
<td>4</td>
<td>Seclusion Policy</td>
<td>01.10.2014</td>
</tr>
<tr>
<td></td>
<td><strong>OCTOBER 2014</strong></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Self Harm Policy</td>
<td>24.10.2014</td>
</tr>
<tr>
<td></td>
<td><strong>DECEMBER 2014</strong></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Community Procedure for Handling Service User Money</td>
<td>01.12.2014</td>
</tr>
<tr>
<td>7</td>
<td>Illicit Substances and Alcohol Misuse Policy</td>
<td>01.12.2014</td>
</tr>
<tr>
<td>9</td>
<td>Safeguarding Adults Policy</td>
<td>17.12.2014</td>
</tr>
<tr>
<td>10</td>
<td>Guidance for the transfer of patients between wards and services across Trust sites and with external providers</td>
<td>31.12.2014</td>
</tr>
<tr>
<td></td>
<td><strong>2015</strong></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Safeguarding and Promoting the Welfare of Children</td>
<td>01.01.2015</td>
</tr>
<tr>
<td>12</td>
<td>Ligature Point and Ligature Risks Policy</td>
<td>01.01.2015</td>
</tr>
<tr>
<td>13</td>
<td>Nutrition Food Policy</td>
<td>01.01.2015</td>
</tr>
<tr>
<td>14</td>
<td>IC Aseptic Clean Techniques &amp; Wound Care Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>15</td>
<td>IC Blood Bourne Viruses Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>16</td>
<td>IC Care of the Deceased Person Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>17</td>
<td>IC Collection of Specimens for Microbial Investigations Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>18</td>
<td>IC Decontamination Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>19</td>
<td>IC Ectoparasitic Infection Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>20</td>
<td>IC Isolation to Prevent Cross Infection</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>21</td>
<td>IC Management of Infection in Staff Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>22</td>
<td>IC MRSA Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>23</td>
<td>IC Mycobacterial Infections Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>24</td>
<td>IC Opening Transfer Closure of Wards Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>25</td>
<td>IC Pets in Clinical Practice Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>26</td>
<td>IC Reporting Infectious Disease</td>
<td>01.02.2015</td>
</tr>
<tr>
<td></td>
<td>Policy Title</td>
<td>Date</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>27</td>
<td>IC Safe Handling and Disposal of Sharps Policy</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>28</td>
<td>IC Standard Infection Prevention and Control Precaution and the Infection Control Statement</td>
<td>01.02.2015</td>
</tr>
<tr>
<td>29</td>
<td>Smoking Cessation and NRT Policy</td>
<td>28.02.2015</td>
</tr>
<tr>
<td>30</td>
<td>CPA Policy</td>
<td>01.04.2015</td>
</tr>
<tr>
<td>31</td>
<td>ECT Policy</td>
<td>01.05.2015</td>
</tr>
<tr>
<td>32</td>
<td>Community Teams Medicines Policy</td>
<td>01.05.2015</td>
</tr>
<tr>
<td>33</td>
<td>CAMHS Transition Protocol Policy</td>
<td>01.09.2015</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Physical Healthcare and Disability Policy</td>
<td>01.02.2016</td>
</tr>
<tr>
<td>35</td>
<td>Reporting, Investigation and Learning from Incidents Policy</td>
<td>01.02.2016</td>
</tr>
<tr>
<td>36</td>
<td>Responding to Recommendations following External Visits, Inspections and Accreditations</td>
<td>01.02.2016</td>
</tr>
<tr>
<td>37</td>
<td>Clinical Audit Policy</td>
<td>01.02.2016</td>
</tr>
<tr>
<td>38</td>
<td>Dual Diagnosis Policy</td>
<td>01.03.2016</td>
</tr>
<tr>
<td>39</td>
<td>Searching the Environment, Property and Person Policy</td>
<td>01.04.2016</td>
</tr>
<tr>
<td>40</td>
<td>Complaints Policy</td>
<td>01.04.2016</td>
</tr>
<tr>
<td>41</td>
<td>Clinical Risk Assessment Policy</td>
<td>01.05.2016</td>
</tr>
<tr>
<td>42</td>
<td>Suicide Prevention Strategy Final</td>
<td>02.06.2016</td>
</tr>
<tr>
<td>43</td>
<td>Falls Prevention Policy</td>
<td>01.06.2016</td>
</tr>
<tr>
<td>44</td>
<td>Missing Person and AWOL Policy</td>
<td>01.07.2016</td>
</tr>
<tr>
<td>45</td>
<td>NICE Policy Guidance</td>
<td>01.08.2016</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Support for Staff Involved in a Traumatic Incident</td>
<td>01.07.2017</td>
</tr>
<tr>
<td>47</td>
<td>Being Open with Duty of Candour Policy</td>
<td>01.11.2017</td>
</tr>
</tbody>
</table>

Copyright © 2015 The ‘Blue Book’ is copyright of South West London and St. Georges Mental Health NHS Trust.

All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher, except in the case of brief quotations embodied in critical reviews and certain other non-commercial uses permitted by copyright law. For permission requests, write to the publisher, addressed “Attention: communications team,” at the address below.

Trust HQ. Building 15, 2nd Floor
South West London and St George's Mental Health NHS Trust
Springfield University Hospital
61 Glenburnie Road
London. SW17 7DJ