How consultation liaison meetings improved staff knowledge, communication and care

A staff questionnaire at a psychiatric nursing home analysed how the development of a multiprofessional group benefited staff and patients.

**Practical Points**

- Devoting one hour a month to attend a consultation liaison meeting developed:
  - A shared vision that focused on individualised patient care and better patient management;
  - Support for each other between meetings, and effective multiprofessional working;
  - Increased knowledge about: mental illness; skills to manage challenging behaviour; and medication;
  - Improved confidence and collaboration across the team, and better communication;
  - Increased involvement of relatives and carers through regular evening meetings.

- Objective 13 – an informed and effective workforce for people with dementia.

**Aim of the survey**

Here we describe holding multiprofessional consultation liaison meetings in a psychiatric nursing home for older people. These were extremely effective, so a staff questionnaire was designed to find out which components make them successful.

**The setting**

The home provides psychiatric nursing care for up to 30 older people with severe mental illness and challenging behaviours. For 2009 it has a Care Quality Commission “excellent” rating (three stars), the provider type is “voluntary”.

Within a year of starting the consultation liaison meetings, the nursing home gained a reputation for being able to manage challenging behaviours and the problems of the most severely disturbed older people in the borough who could not be managed in other community settings.

The home has three units, each with 10 residents. They have single rooms and communal dining and sitting areas. There is an enclosed garden on the ground floor.

**Staffing**

The care home is owned by the borough PCT, managed by a housing association and staffed by the local mental health trust. Staff are mainly registered mental nurses, nurses with both mental health and general qualifications and care assistants. There are at least two RMNs on duty on every shift.

Other mental health professionals visit on a peripatetic or as needed basis, as do a podiatrist, dietitian, physiotherapist, speech and language therapist, dentist and district nurses. The home-linked GP visits every week for routine reviews and as required for emergencies. Out-of-hours emergencies are covered by the local GP co-operative.

**The consultation liaison meeting**

The meetings came about because the home was experiencing difficulties managing residents with challenging behaviours and new, unexplained symptoms. Residents’ needs and their degree of mental illness had become increasingly complex since the home opened 15 years ago. Referrals were being made to the local community mental health teams on a weekly basis and residents were having frequent hospital admissions.

The consultation manager discussed the situation with the link GP and the community psychiatrist, who decided to meet to consider how to help staff provide the best quality care for residents and make optimum use of local health resources.

The meetings took place at the home every...
three months and lasted for about three hours. The format rapidly evolved into a large meeting attended by 10-12 care home staff and their manager. The link GP and liaison psychiatrist attended all the meetings.

**A typical meeting**

The meetings usually started with general discussion about the care home, any staff or resident changes, local changes in health and social service provisions and any "political" concerns, such as commissioning intentions.

The agenda would be reviewed so new residents, any visitors and any major concerns staff had took priority. The three units decided the order for discussion depending on which staff needed to leave early, but generally all attending staff stayed throughout, with up to 16 cases being discussed per meeting.

Case presentation included: a description of concerns; a review of the resident’s notes, detailing history and diagnoses; a recording of measurements, such as blood pressure, pulse, weight, blood sugar levels; and medication charts. A recent mental state examination would have been done by the unit staff, as well as a cognitive assessment if appropriate. Details of family, visitors, outings, interests and habits were included.

The main concerns were considered and refined by extensive discussion and sharing theoretical and practical knowledge. Management options included further assessment or investigation (often by the GP or psychiatrist), further identification of the problem, for instance by using a behaviour chart (such as A-B-C chart – Antecedents, Behaviour, Consequences) and consideration of management options.

Nursing staff had a number of techniques for managing difficult behaviour and would often choose these before psychotropic drugs. It was always our aim to use as little medication as possible because of the risks of side-effects and drug interactions, which are particularly common in older patients.

Sometimes several options would be agreed in a priority order, so there would be plenty to try before the next meeting in three months’ time. One option might be to phone the psychiatrist and request a short admission of a resident for further assessment if other strategies were not working. Knowing that this option existed was reassuring for staff, who rapidly developed a “Yes it’s difficult but we can do it” attitude to managing residents.

We all learnt from discussing these options and could share our experience, knowledge and any recent research we had found in different journals. Interventions made at previous meetings were also reviewed.

After the meetings, individual patients were seen if needed and the discussions were summarised by one of the doctors.

**THE SURVEY**

After a brief introduction, five questions were presented, with ample space for answers. Eleven staff completed questionnaires and responses were detailed. Table 1 (p20) summarises the main gains.

**Question 1: what are the three main things you have learnt from the joint meetings?**

- Increased ability to manage difficult situations holistically to consider family, financial and social issues, and to use new skills (8/11 replies);
- Multiprofessional work and good communication (9/11) – roles of different professionals; realising the importance of nurses in community care; learning from each other; support and direction from medical staff; feeling supported by each other; communicating well with each other; increasing each member’s confidence to manage difficult situations; time for reflection;
- Increased knowledge (6/11) – particularly about recognising signs and symptoms of mental illness, about preventive measures and when medication might help in managing residents’ distress.

**Question 2: what changes have you noticed in your approach to managing residents following the meetings?**

- Improved knowledge to manage “difficult” residents better, such as: holistic and therefore more accurate observation; understand mental states better; individualise care; provide best care; improved skills to manage, monitor and care; managing on a day to day basis with support from the multidisciplinary team (MDT);
- Guidelines and strategies: understand them better; incorporate guidelines and strategies into nursing care more effectively;
- Improved reflection and understanding of own behaviour and approach to patients: “It has encouraged me to reflect on my own behaviour, and my approach and to normalise myself and my clients’ behaviour”; “My approach became more simple and flexible”; more positive approach.

**Question 3: have the meetings resulted in any changes in the way you have organised your service? If so, please describe these.**

All 11 respondents said the meetings had resulted in changes. Examples included:

- Keeping residents at care home rather than referring to hospital for investigations and medication changes;
- Learnt new strategies for managing residents;
- Changed attitude about when to refer to hospital;
- Good referral system means good early intervention and involvement of families for individualised care;
- Preparation of cases ahead of meetings put the focus on individual residents and their problems;
- Learning about how MDTs work and decision making;
- Learning opportunity for support workers;
- Learnt holistic approach;
- Systematic definition of tasks;
- Psychiatrist involved in care plans and...
advise changes to residents’ medication;
- Reflection on each nursing intervention that helped to improve care.

**Question 4: what do you think have been the most important contributions from the meetings?**
- Education;
- Updates in care and high quality care for residents;
- MDT views and networking;
- Opportunity to voice concerns and be heard;
- Able to offer quality service to staff;
- Help to treat each client as an individual;
- Improved communications within MDT and with GP;
- Increased awareness and understanding;
- Case discussion;
- Good relationships with GP and psychiatrist;
- Exchange of ideas;
- Advice and direction;
- Holistic care.

**Question 5: do you have any other comments about the meetings?**

Staff valued the meetings as teaching sessions, for discussion and for improving care. Quotes from this section included:

- “Staff at care home look forward to these meetings and feel they have benefited from the discussion”; 
- “These meetings are important and essential for the high standard and quality of care that is given in the home”; 
- “Able to meet as a multiprofessional team to discuss, plan and implement the best care possible for individual residents who would otherwise not have received this intervention”.

**Summary of the impact**

The meetings seem to have contributed to uniting and motivating staff to provide the best possible care, take pride in their work, and respect each others’ knowledge and skills. Staff enjoyed their new reputation for being able to manage the borough’s most challenging older patients, who often seemed to settle and enjoy an improved quality of life after transfer to this home.

A shared vision evolved throughout the meetings that focused on individualised care, taking a longitudinal view of each resident, including their family, social context and preferences about end of life care. Staff confidence in their skills and strategies to manage difficult situations increased.

Staff were able to support and help each other between meetings and were confident that, if they contacted the GP or psychiatrist for help, a discussion would follow and rapid action be taken.

The link GP said: “From a GP perspective, this regular meeting was hugely supportive. The staff were very well prepared… and there was a real collaboration in planning care. My understanding of dealing with this group of clients has benefited hugely, as has my confidence in dealing with issues that arose between the three monthly meetings.”

Relative support meetings were initiated and took place every three months, usually in the evenings. All relatives and carers were invited and the meetings were well attended. Topics discussed included mental capacity and decision making, end of life care, resuscitation, daily activities and outings and any issues raised by relatives. They often commented they were pleased to hear that a psychiatrist visited and that “residents were being looked after properly”.

We all devoted one hour per month (a three hour meeting every three months) to these meetings and the benefit to both team members and patients seems to have been enormous.

The meetings stopped due to a change in the consultant psychiatrist’s job plan from November 2008. But due to protests from nursing home staff, this work will be reinstated from November 2009.

We recommend that consultation liaison meetings like this one should be considered as a key component of community liaison services.

**REFERENCES**
