Guidance notes on the role and function of Organic Old Age Psychiatry wards (NHS Lanarkshire)

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(Revised by Dr R Routh, Clinical Director Old Age Psychiatry - August 2020 Review August 2023)

This document is principally written to inform colleagues working in general hospital sites of the nature and function of the following organic old age psychiatry wards:

- Ward 24, University Hospital Monklands
- Brandon Ward, Udston Hospital, Hamilton

Current model of care regarding admission

The Old Age Psychiatry model of care is based on the Mental Health Strategy; we aim to support people to live independently at home, and to avoid admissions where possible. The majority of both work and sources of admissions for Old Age Psychiatrists are from the community. The final decision to admit to our beds from this setting is limited to consultant psychiatrists but will always follow a multidisciplinary assessment and ruling out any acute physical health issues. We are often able to find a better alternative to hospital admission. Admission would be only sought once all other sources have been exhausted, not least because an avoidable admission can often be detrimental to a person's wellbeing.

The same multidisciplinary approach must be taken when considering admission from general hospital beds, as a bed in an organic old age psychiatry ward may not be the best option for a person. This process will usually involve the team currently looking after the patient, the liaison team, and the organic psychiatry ward team.

The purpose of an Organic Old Age Psychiatry ward is to reduce the Stress and Distress experienced by a patient (and thus the signs such as agitation and aggression that result from this) to a level where they can be managed out with a hospital environment. It is usually not possible to remove all symptoms completely. Further treatment can then take place if necessary in the Community (for example a patient's home, nursing home etc).

When the decision to admit is being considered a number of factors must be taken into account:

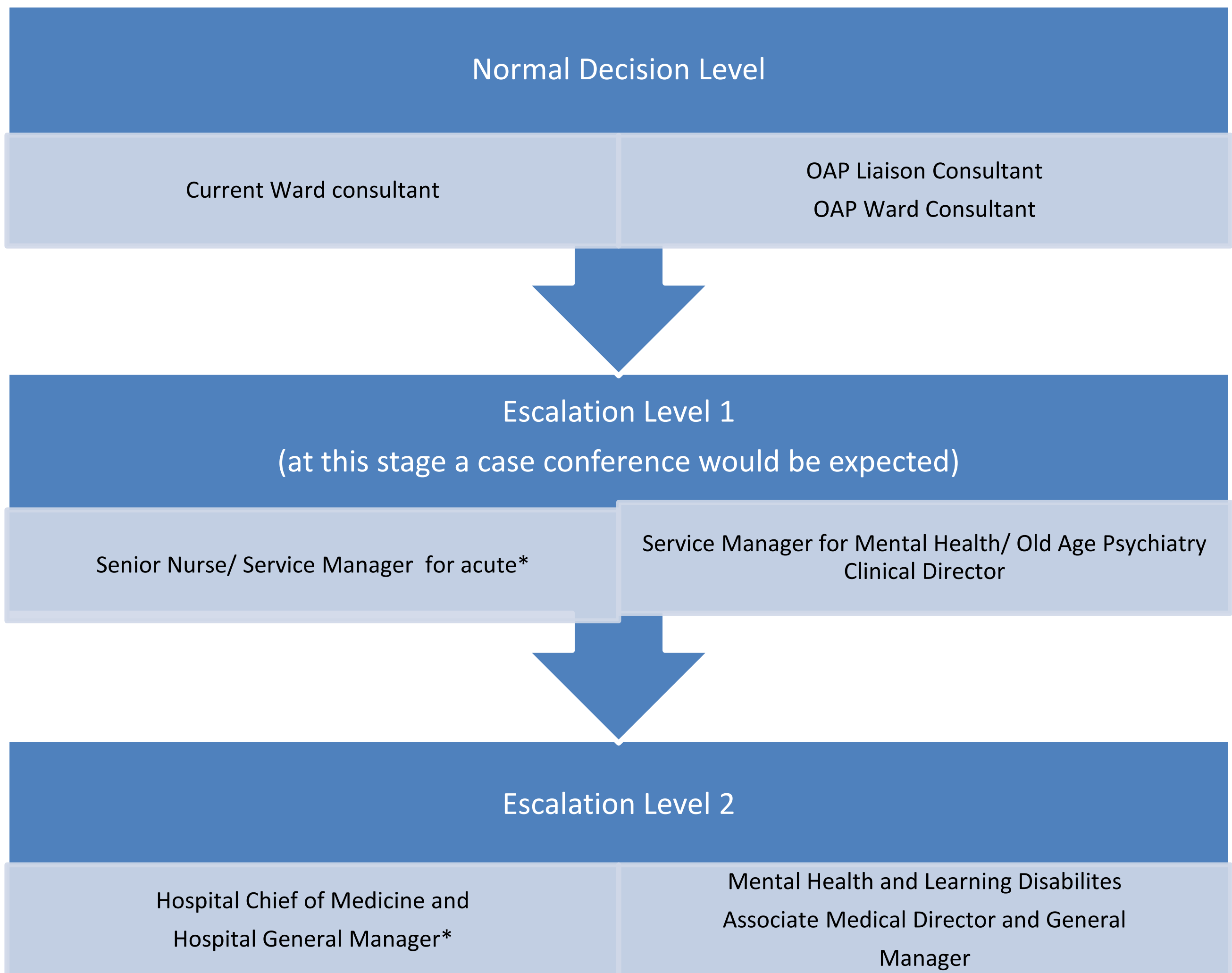
- **Symptoms:** The nursing, medical, clinical psychology and AHPs' expertise in our organic psychiatry wards relate to managing severe and recurrent stress and distress symptoms, chiefly those resulting in high levels of aggression.
- **Ward dynamics/ environment:** Our organic psychiatry wards aim to provide a therapeutic environment for individual needs which can vary from high levels of stress and distressed behaviours and end of life care. The current therapeutic milieu of the ward will be considered to identify the benefit to be gained from admission or any detriment that admission could pose.
- **Alternatives:** If a patient can be managed in an alternative setting (for example a care home) then this would be our preference, as it is likely to reduce the risk the patient is exposed to on the ward and the number of moves the patients will have overall. We have nursing led care home liaison team who can provide expertise and support to care home staffs and patients placed within care homes.
- **Person Centred Care**: Decisions should benefit the patient and be the least restrictive alternative. Patient, family and any legally empowered decision makers' opinion, or any information within an advanced statement or anticipatory care plan must be considered.

- **Physical Health needs:** The resources in the Old Age Psychiatric wards are limited, particularly out of hours, because the majority of our beds are either not on general hospital sites or do not have OOH on site medical cover. If there is the possibility of significant continued medical needs this needs to be carefully considered.
- **Age:** Younger adults with dementia are managed on either an Old Age Psychiatry Organic Ward or a General Adult Psychiatry ward, depending on the needs of the patient.
- **Risk to others**: The patients admitted to these wards will usually pose a high level of risk to others or, less often, to themselves.
- **Risk to patient:** Owing to the reason that patients are being treated there, there is a high level of risk to patients from other patients. There are a number of mechanisms and procedures in place to reduce the risk but there is still a high risk of injury.
- **Diagnosis:** The ward is chiefly occupied by people who have advanced dementia, i.e. progressive, degenerative neurological disorders that impair daily or social functioning. The staff in the ward are highly skilled at caring for these conditions. People with conditions which will improve, such as delirium (whether a cause has been identified or not) would rarely be better managed on organic old age psychiatry wards, even once causes have been treated/excluded, unless the risk to others is very high. Those who have a cognitive impairment of a static nature (such as a brain injury, however caused) are also not best managed on these wards as the wards are not tailored toward rehabilitation.

It would be the norm that a patient assessed by the Old Age Psychiatric Liaison team remains in their general hospital bed, but with advice on management and expediting discharge when appropriate. If extra staff are required in such a scenario, the ward the patient is currently on is responsible for arranging this.

Escalation Procedure

It has been suggested that an escalation process would be helpful in the rare instance that a decision cannot be reached by the teams involved of how to proceed. (OAP=Old Age Psychiatry)



**Levels of escalation marked have yet to be agreed with general hospital services.*

Out of hours admissions

An admission out of hours should be exceptionally rare, but would need authorisation from the on call consultant psychiatrist.

Revised document discussed with OAP Clinical Governance (August 2020) Review (August 2023)

This document previously was discussed and agreed at the following

- *NHSL Old Age Psychiatry Consultants Group (Nov 2014)*
- *NHSL Old Age Psychiatry Clinical Governance Group (Nov 2014)*
- *NHSL MH&LD Clinical Governance Group (Dec 2014)*