



Sir Charles  
Gairdner Hospital

## **NURSE PRACTITIONER CLINICAL PROTOCOLS**

**For**

**Mental Health Consultation – Liaison Services**

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## **STATEMENT OF INTENT OF THESE CLINICAL PROTOCOLS AND DISCLAIMER**

The information provided in these Clinical Protocols is intended for information purposes only. Clinical Protocols are designed to improve the quality of health care and decrease the use of unnecessary or harmful interventions. These Clinical Protocols have been developed by clinicians and researchers for use within Sir Charles Gairdner Hospital. They provide advice regarding the care and management of patients presenting with mental illnesses or mental health issues by the Nurse Practitioner – Mental Health.

While every reasonable effort has been made to ensure the accuracy of these Clinical Protocols, no guarantee can be given that the information is free from error or omission. The recommendations do not indicate an exclusive course of action or serve as a definitive mode of patient care. Variations which takes into account individual circumstances, clinical judgement and patient choice may also be appropriate. Users are strongly recommended to confirm by way of independent sources that the information contained within the Clinical Protocol is correct.

The information contained in these Clinical Protocols is NOT a substitute for clinical judgement whereby appropriate diagnosis, treatment and advice are taken into account.

These Clinical Protocols may also include references to the quality of evidence used in their formulation. Where this has not been located, the Clinical Protocols include references to support the recommended care. Providing a reference does not constitute an endorsement or approval of that source or any information, products or services through that source.

The Minister for Health, the State of Western Australia, and their Employees and Agents will accept no liability for any act or omission occurring in as a consequence of relying on these Protocols in clinical use or as a result of the use of these Protocols

**MENTAL HEALTH NURSE PRACTITIONER CLINICAL  
PROTOCOLS  
FOR  
THE ASSESSMENT AND MANAGEMENT OF PATIENTS WITH  
A MENTAL ILLNESS OR MENTAL HEALTH ISSUES**

**CLINICAL PROTOCOL 1: MENTAL STATE ASSESSMENT**

The assessment of a patient's mental state will depend on the circumstances and the type of presentation. Sufficient information needs to be elicited to achieve a comprehensible picture of all factors which may have a bearing on the patient's mental state.

Set formats for the assessment of mental state are intended to be guidelines only and should not be followed rigidly. Interviews to elicit a patient's mental state should be adapted to the clinical situation whereby the interviewer's approach should take into account the patient's presentation and reaction to the interviewer. Flexibility to adapt the approach remains an essential component of the process. Mental State Assessment is therefore not merely eliciting information but also about engaging the patient.

Engagement refers to "the ongoing development of a sense of safety and respect from which patients feel increasingly free to share their problems, while gaining an increased confidence in the clinician's potential to understand them" (Shea, 1998, pg 10)

Goals of Assessment:

- To establish a therapeutic alliance with the patient
- To collect valid data pertaining to the patient's mental state from which a formulation can be made.
- To develop an understanding of the patient's problems
- To develop a treatment or management plan in collaboration with the patient if possible
- To decrease the impact of psychiatric symptoms for the patient and reduce suffering.

**ASSESSMENT AND INVESTIGATION**

PROCESS	ACTION	REFERENCES	LEVEL OF EVIDENCE - GUIDANCE
Mental State Assessment	<ul style="list-style-type: none"> <li>• <u>Appearance and Behaviour</u> – general appearance and dress. Self-care and cleanliness. Attitude to situation / manner of relating. Motor Behaviour</li> <li>• <u>Speech</u> – Rate, Volume, Pitch, Tone, Fluency, Quality of Articulation and Information.</li> <li>• <u>Mood and Affect</u> – Mood – depressed, euphoric, suspicious, irritable. Affect – restricted, flattened, blunted, incongruous, perplexed.</li> <li>• <u>Form of Thought</u> – Amount of thought and rate of production, continuity of ideas, disturbances in language and/or meaning.</li> <li>• <u>Content of Thought</u> – Delusions, Suicidal Thoughts, Obsessions, Phobias, pre-occupations, Anti-social urges.</li> <li>• <u>Perception</u> – Hallucinations, Other perceptual disturbances (de-realisation, de-personalisation, heightened or dulled perception)</li> <li>• <u>Insight</u> – Extent of the patient’s awareness of problem and current situation</li> <li>• <u>Cognition</u> – Level of consciousness, memory (immediate, recent, remote), orientation (time, place, person) concentration, abstract thinking.</li> </ul>	<p>Davis, 1997;</p> <p>IGDA Workgroup, WPA, 2003;</p> <p>Henshall, 1999.</p> <p>Laws &amp; Rouse, 1996</p> <p>New Zealand Guidelines Group, 2003</p> <p>Orygen Research Centre, 2004</p> <p>Brockington, 2004</p> <p>Gomez, 1987</p> <p>American Psychiatric Association, 1995</p> <p>Muggli, E, 2002.</p> <p>Sompradit et al, 2002</p> <p>Brown et al, 2004</p> <p>Petersen et al, 2001</p>	<p>G</p> <p>G</p> <p>G</p> <p>F</p> <p>A, B, C, D</p> <p>F, G</p> <p>A</p> <p>G</p> <p>E</p> <p>E</p> <p>A</p> <p>A</p> <p>E</p>
Patient History, Formulation and	<ul style="list-style-type: none"> <li>• Presentation – The mode of referral or admission</li> <li>• Presenting medical illness and current mental</li> </ul>	<p>Davis, 1997;</p>	<p>G</p>

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Presentation	<ul style="list-style-type: none"> <li>• health problem</li> <li>• Physical findings – significant findings on physical assessment</li> <li>• History of mental health problem – When did the problem start? Did any events precede the problem? How did it develop? What effect does the problem have on the patient’s day-to-day functioning and ability to participate in their recovery?</li> <li>• Past Psychiatric History – A record of previous mental health problems and treatment and services involved previously in their care.</li> <li>• Medications – Current medications including alternative medicines. Recent changes to medications. Side – effects to current and past medications. Allergies. Compliance with medications.</li> <li>• Personal background – Family and personal history.</li> <li>• Alcohol and Other Drugs – type of alcohol / drugs and pattern of use. Amount and frequency of use. Psychological and social impact of drug use.</li> <li>• Sexual Health – Lifestyle and risk factors. Previous history of abuse, sexually transmitted diseases, sexual dysfunction and / or sexual orientation.</li> <li>• Medical History – Previous and current physical illnesses.</li> <li>• Forensic History – Previous and current offences and convictions. Bail or Parole Conditions. Pending legal matters.</li> <li>• Formulation – summary of presenting psychiatric signs and symptoms, historical data and significant physical illnesses.</li> <li>• Management – Liaison with other health care team members to discuss risk factors and further</li> </ul>	<p>IGDA Workgroup, WPA, 2003;</p> <p>Henshall, 1999.</p> <p>Laws &amp; Rouse, 1996</p> <p>New Zealand Guidelines Group, 2003</p> <p>Orygen Research Centre, 2004</p> <p>Brockington, 2004</p> <p>Gomez, 1987</p>	<p>G</p> <p>G</p> <p>F</p> <p>A, B, C, D</p> <p>F, G</p> <p>A</p> <p>G</p>
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	<p>information needed, investigations required and consultations with other services needed to plan comprehensive care. A psycho-social framework should be utilised to address such factors such as:</p> <ul style="list-style-type: none"> <li>- psychiatric and / or physical phenomena</li> <li>- Functional performance</li> <li>- Relationships with family and significant others and the wider social environment</li> <li>- Interpersonal communication</li> <li>- Social resources</li> </ul>		
Collaborative History and referral data	<p>Wherever possible additional information should be sought. Liaison with the patient's</p> <ul style="list-style-type: none"> <li>• General Practitioner</li> <li>• Case manager</li> <li>• Community Mental Health Nurse</li> <li>• Psychiatrist</li> <li>• Family Members or significant others</li> </ul> <p>To ensure clarification of the patient's history and reduce duplication of investigation and treatment.</p>	<p>Davis, 1997; IGDA Workgroup, WPA, 2003; Henshall, 1999. Laws &amp; Rouse, 1996 New Zealand Guidelines Group, 2003 Orygen Research Centre, 2004 Brockington, 2004 Gomez, 1987</p>	<p>G G G F A, B, C, D F, G A G</p>
Risk Assessment	<p>For</p> <ol style="list-style-type: none"> <li>1. Self-harm / suicide Using risk assessment tool</li> <li>2. Aggression / harm to others Using the Broset Violence Checklist</li> </ol>	<p>American Psychiatric Association, 2003 U.S. Preventative Services, 1996</p>	<p>D, E, F, G D, E</p>

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		National Collaborating centre for Nursing and Supportive care, 2005	D, E, F, G
Legal Considerations	<p>Awareness of the legal implications of caring for patients within a general hospital setting.</p> <ol style="list-style-type: none"> <li>1. <u>Duty of care</u> – The premise that all health professionals owe patients and other staff a duty of care is well accepted. It involves both <i>acts and omissions</i> meaning that liability can arise from a failure to act as it can from doing it and doing it badly. The justification for medical treatment against the patients wishes is the common law duty of clinicians to provide whatever care is required to preserve life. The justification of treatment against the patient’s will in an emergency is known as the concept of urgent necessity. Health professionals must balance need for emergency treatment against the patient’s right for self autonomy.</li> <li>2. <u>Capacity to Consent</u> – A competent person has the right to consent or not to consent to examination, investigation and treatment even if their decisions are likely to result in death. The following three factors must be met to achieve competence; <ul style="list-style-type: none"> <li>- The patient understands the information on the proposed treatment and is able to retain this information and understands the consequences of no treatment.</li> <li>- The patient believes the information</li> <li>- The patient is able to weigh up that information and make a choice.</li> </ul> <p>Decisions regarding capacity to refuse treatment should be made with an experienced medical practitioner and must take into account the effect of physical and mental illness,</p> </li> </ol>	<p>Office of the Chief Psychiatrist (1997)</p> <p>Office of the Chief Psychiatrist (2006)</p>	<p>G</p> <p>G</p>

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	<p>alcohol and other drugs which may have been consumed by the patient. Consideration of the effect of drugs on the patient's capacity should be urgently considered.</p> <p>3. The WA Mental Health Act (1996) – The WA Mental Health Act provides treatment for patients suffering from a mental illness utilising the concept of the least restrictive treatment option. It places particular emphasis on the maintenance of the patients, dignity and respect and is specifically aimed at mode of referral and admission of patients to and the treatment of patients in authorised mental health facilities.</p> <p>3. <u>The Occupational Health and Safety Legislation of WA</u> – This act is aimed at promoting the health, safety and welfare of employees and overrides all legal statutes and regulations. All staff need to consider their own safety as a priority and not subject themselves to undue risk. No staff member should feel they must restrain a patient who is absconding from the hospital prior to receiving appropriate care in the absence of a coordinated response team. Restraining a patient without adequate resources or a planned response places the safety of the patient and other staff members in jeopardy.</p>		
Medical Assessment	<p>Medical assessment is a multi-disciplinary and ultimately it is the treating medical team who determines the assessment and medical management of patients referred to the Mental Health Nurse Practitioner. The purpose of such an assessment is aimed at identifying the role of any underlying medical illness which may explain the patient's symptoms and to identify any medical factors which may render the admission to a specialised mental health facility inappropriate.</p> <p>Indicators which suggest organic pathology and which require further medical investigation include:</p> <ul style="list-style-type: none"> <li>• Clouding of consciousness</li> <li>• Disorientation</li> </ul>	<p>Lukens TW et al, 2006</p> <p>Robinson, 1999</p> <p>Phelan, 2001</p>	<p>A, B C, D</p> <p>G</p> <p>F, G</p>

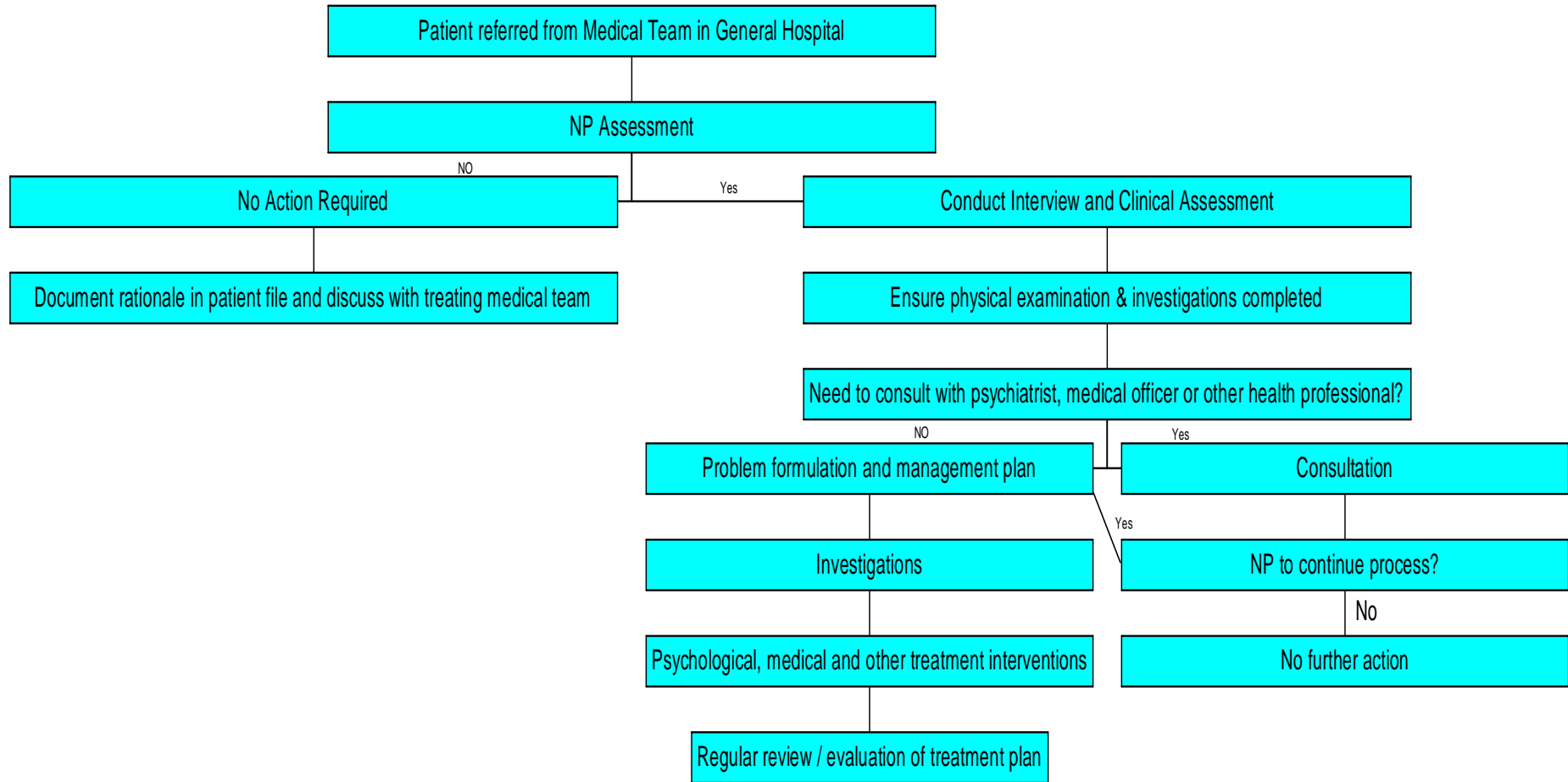
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	<ul style="list-style-type: none"> <li>• Late onset of behavioural symptoms</li> <li>• Abnormal vital signs</li> <li>• Visual hallucinations and illusions.</li> </ul> <p>Common underlying causes for psychiatric symptomatology include:</p> <ul style="list-style-type: none"> <li>• Medications</li> <li>• Drug and alcohol intoxication and withdrawal</li> <li>• Metabolic and endocrine disorders (eg. Thyroid disease)</li> <li>• Cardiac disease.</li> <li>• Delerium</li> <li>• CNS Tumour</li> <li>• Encephalitis</li> <li>• Wernicke's Encephalopathy / Korsakoff psychosis</li> <li>• Non-Epileptic Seizures (Pseudo-seizures).</li> </ul>		
Investigations	<p>The performance of investigations on patients presenting with psychiatric symptoms should be specific to the patient and the presentation. The following investigations will be performed;</p> <p>Alcohol use / abuse</p> <ul style="list-style-type: none"> <li>• Glutamyl transaminase (GGT)</li> <li>• Aspartate aminotransferase ( AST)</li> <li>• Alanine aminotransferase (ALT)</li> <li>• Mean Corpuscular Volume (MCV)</li> </ul> <p>Delerium</p> <ul style="list-style-type: none"> <li>• Electrolytes (especially K+ and Na)</li> <li>• Glucose (fasting BSL)</li> <li>• Drug levels             <ul style="list-style-type: none"> <li><i>Lithium carbonate</i></li> <li><i>Sodium valproate</i></li> <li><i>Carbamazepine</i></li> </ul> </li> </ul> <p>Eating Disorder</p> <ul style="list-style-type: none"> <li>• Electrolytes (especially K+, Ca, Mg, PO4)</li> <li>• FBC, LFT, Albumin/ protein</li> <li>• ECG</li> </ul>	<p>Lukens TW et al, 2006</p> <p>Robinson, 1999</p> <p>Phelan, 2001</p>	<p>A, B C, D</p> <p>G</p> <p>F, G</p>

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	<ul style="list-style-type: none"> <li>• CXR</li> <li>• Glucose (fasting BSL)</li> </ul> <p>Psychosis</p> <ul style="list-style-type: none"> <li>• Urine drug screen</li> <li>• CT scan if 1<sup>st</sup> presentation</li> </ul> <p>Anxiety or Mood disturbance</p> <ul style="list-style-type: none"> <li>• Thyroid function test</li> <li>• Serum antidepressant levels</li> </ul> <p>Organic conditions</p> <ul style="list-style-type: none"> <li>• Urinalysis</li> </ul>		
Therapeutic Techniques	<p>The essential component of mental health nursing is the nurse – patient relationship (interpersonal relationship between the patient and the nurse. This human contact is often the essence of what patients appreciate from the health professional.</p> <p>Techniques include:</p> <ul style="list-style-type: none"> <li>• Listening skills</li> <li>• Cognitive Behavioural Therapy</li> <li>• Solution Focused Brief Therapy</li> <li>• Motivational Interviewing</li> <li>• Anger Management techniques</li> <li>• Anxiety management techniques</li> </ul> <p>Treatment of patients whose symptoms are likely to respond to the above techniques will take place</p>	<p>Cutcliffe, 2002</p> <p>Peplau, 1994</p> <p>Calvert &amp; Palmer, 2003; Newell, 2000</p> <p>Wales, 1998</p> <p>Chychula &amp; Sciamanna 2002</p> <p>Swaffer &amp; Hollin, 2000</p>	

ASSESSMENT PROCESS PATHWAY



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