

# THE ROLE OF A PSYCHIATRIC CONSULTATION LIAISON NURSE IN A GENERAL HOSPITAL: A CASE STUDY APPROACH

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*Accepted for publication February 2002*

**Key words:** case study, consultation-liaison, general hospital, mental health problems, mental health nurses, psychiatric nurses

## ABSTRACT

Growing support for the role of the psychiatric consultation-liaison nurse in assisting general nurses in caring for patients experiencing mental health problems in the general hospital environment is evident from the relevant literature. However, there remains a paucity of research which examines the process of this nursing role or its impact on outcomes for nurses and patients. This paper seeks to contribute to the literature in articulating the role of the psychiatric consultation-liaison nurse using a case study approach to describe the role of the nurse in assessing the needs of, and, planning and providing care to two general hospital patients experiencing mental health problems, and the general nurses caring for them.

## INTRODUCTION

There is a growing body of evidence to suggest that nurses working in general hospital settings do not generally consider themselves adequately prepared, skilled or experienced to care for patients with mental health problems (Sharrock 2000; Bailey 1998; Gillette et al 1996; Bailey 1994; Whitehead and Mayou 1989). This issue is not always restricted to the question of skill and knowledge but also relates to the scope of practice. A study of emergency nurses found that they questioned their role in the care of patients with mental health problems and did not see it as part of their 'real' work (Gillette et al 1996). In giving priority to the physical needs of patients, emergency nurses often actively avoid patients with mental health problems (Gillette and Bucknell 1996). A lack of resources and difficulty in accessing psychiatric expertise have been identified as compounding the nurses' perception of their inadequacy in meeting the mental health needs of patients (Bailey 1998; Gillette et al 1996).

There has been considerable anecdotal evidence to suggest the availability of skilled psychiatric nurses to health professionals working in non-psychiatric services has been shown to positively influence the care of patients with mental health problems in that setting. However, there has been little systematic research or evaluation to substantiate such claims.

Roberts (1998) undertook a qualitative study of nursing staff on an haematology ward in Britain. The nurses found the regular services provided by the Psychiatric Consultation Liaison Nurse (PCLN) to be highly valuable, particularly his psychiatric knowledge and expertise, objectivity and counselling skills. The availability and accessibility of the PCLN were considered very important in the provision of this service. However, this study was limited in that it was small (n=3) and the group interview was conducted by the PCLN providing service to the

participants, which may have impacted upon the honesty and reliability of the comments made by participants.

In Canada, a satisfaction survey was undertaken of nurses using the PCLN service within a general hospital. The evaluation was based on 75 referrals over a three-month period (Newton and Wilson 1990). The findings of this study also highlighted the importance of accessibility, availability and clinical expertise of the PCLN as valued aspects of that service.

Attempts at demonstrating cost-effectiveness of the PCLN have been made. An American study estimated that the provision of family therapy within a community hospital contributed to savings of \$65,000 over an eight-month period (Ragaisis 1996). The effect of PCLN contact on the care of patients who required 'sitters' (lay people employed to provide constant observation of patients considered at risk) in a large general hospital in the USA was also undertaken (Talley et al 1990). The hypothesis was that PCLN contact with staff would improve documentation of mental status of patients and reduce resource utilisation and untoward incidents in relation to patients requiring 'sitters'. This was not found to be the case. A limitation of this study was that the subjects were considered too 'heterogenous' and that many variables other than PCLN intervention influenced the decisions about the use and discontinuation of 'sitters'. In contrast, another American study (Mallory et al 1993) demonstrated a significant decrease in general nursing resource utilisation in the majority of patients who were referred to the consultation-liaison service and received consultation by both consultation-liaison nursing and consultation-liaison medical staff.

An Australian project evaluated the role and function of the psychiatric nurse consultant within the emergency department (Gillette et al 1996). The consultants in this study were found to undertake a role and function similar to the PCLN in the USA. Improved access and decreased length of stay for patients experiencing mental health problems in the emergency department and improved patient satisfaction were significant findings. Emergency department staff reported increased confidence and improvements in staff attitudes, knowledge and skills in relation to this group of patients. Since the completion of this project the number of psychiatric nurses employed within emergency departments in Victorian hospitals has increased significantly. It must be noted that models of service delivery vary (Mental Health Branch Victoria 2000) and there is, to some degree, a lack of clarity between the triage role of mental health clinicians based in emergency departments or crisis teams, and psychiatric consultation-liaison nursing.

Further studies that evaluate the role of the PCLN and how it may effect outcomes are clearly needed. The clients of the PCLN include both staff and patients (Newton and Wilson 1990), and evaluation of the PCLN role ideally should therefore include both client groups. The impact of

the PCLN on nurses and other health professionals, patients and their families in a broad range of settings must be considered. Evaluative research to identify the level of satisfaction with PCLN services on the part of patients, families, nurses and other health care professionals is undoubtedly an important approach to research that must be followed through. Equally important, however, is an in-depth understanding of how the PCLN works with individual patients, nurses and treating teams, and how the outcomes of interventions make a difference to the patients concerned.

## AIM OF THE STUDY

The primary aim of this study was to provide a more detailed knowledge of and greater insight into the role and function of the PCLN. The use of a case-study approach allows a detailed exploration of how the PCLN's interventions are developed and delivered in direct response to the presenting problems of the patient. The specific research question addressed in this paper is: 'what specific skills and interventions are used by the PCLN in providing care for patients experiencing mental health problems?'

## THE RESEARCH SETTING

This research was undertaken at the Austin and Repatriation Medical Centre (A&RMC), an 800-bed tertiary teaching hospital in north-eastern metropolitan Melbourne, Victoria, Australia. The A&RMC campuses provide general and specialist medical-surgical inpatient, day and outpatient care. Specialist services include cardiothoracic, spinal cord injury, neurology, oncology, urology, renal and aged care. Liver, renal and bone marrow transplant, cardiovascular, neurological and orthopaedic surgery is also provided. The Royal Talbot Rehabilitation Centre (RTRC) operates on a third site and offers specialist services for patients with a range of disabilities arising from spinal cord injury, orthopaedic and arthritic conditions, amputation, head injury, stroke and various other neurological conditions. The A&RMC and RTRC currently provide services to 66,700 inpatients and 120,000 outpatients a year.

The PCLN provides psychiatric nursing consultation to nurses and other health care professionals working within non-psychiatric general hospital services in order to achieve integrated and holistic care of patients with mental health problems. Each consultation aims at facilitating effective staff interventions when a patient presents with a mental health problem. Staff are provided with advice, guidance and education in relation to the mental health needs of patients. A consultation could include working directly with the patient and his or her relatives. It also includes working indirectly by providing assistance to the primary treating team in the development of a plan of care for the patient. In addition, the PCLN acted as a resource

to the A&RMC for educational and policy development purposes on mental health care issues and as a link between general and psychiatric services.

The Consultation-Liaison Psychiatry Service operates in conjunction with the non-psychiatric services of the A&RMC and RTRC to provide psychiatric and mental health care to the patients using these services. In addition to the nurse position, the Consultation-Liaison psychiatry team consists of part-time consultant psychiatrists, psychiatric registrars and one family medicine practitioner. Links are established with clinical psychologists who provide consultation-liaison psychology services to A&RMC patients.

## METHODOLOGY

### Research design

This study was conducted as part of a larger evaluation of the role of the PCLN as a nurse practitioner. Ethics approval was granted from the A&RMC to conduct the study including the collection of case studies to describe the role of the PCLN. The section of the study described in this paper used a case study approach to provide detailed information on the role of the PCLN in relation to two clients experiencing mental health problems within a general hospital environment. The advantage of the case study approach is that it enables the collection and reporting of in-depth information that is difficult to obtain by any other method (Wilson 1989). While acknowledging the limitation of lack of generalisability, this process enabled a greater understanding of the PCLN role and its potential contribution to the health care outcomes of general hospital patients experiencing mental health problems.

The case study approach is more concerned with what can be learned from an individual situation than in comparing this situation to others (Stake 1994). Although we cannot establish a single or definitive approach to the PCLN role, we are able to increase understanding of the complexities of the role and how it may be used in a supportive manner within the general hospital environment.

### Population and sample

The two case studies presented in this paper were patients of the A&RMC. They were selected on the basis of the diversity of their histories and presenting problems, which enabled a broad range of the skills, knowledge and interventions of the PCLN to be described.

### Data collection and analysis

The routine collection of data is an integral part of the role of the PCLN. Information collected at each referral includes medical surgical history, psychiatric history, reasons underlying referral to PCLN and, presenting problems (as observed by PCLN, where relevant).

Documentation of the PCLN intervention, follow up and evaluation were also made.

Data were therefore already available for the two selected patients. However, after their selection, the PCLN sought and documented more detailed information which was collected under the following headings: Mode of referral; Assessment; Interventions (for the patient, family and significant others, and the treating team); and, Outcomes. This process occurred according to routine practice but with more detailed documentation of follow up and outcomes. This approach enabled a degree of consistency in the collection of data, while allowing for the individuality of each participant to be included. This is congruent with the use of a case study approach (Stake 1994).

The method of data collection used provided the framework for the analysis of data. Data are presented in the manner in which they were collected. An overview of the two case studies will now be presented. Identifying features of the individuals and their presentation have been altered to protect their identity.

## THE CASE STUDIES

### Tina

Tina was a 26-year-old married woman who was referred to the PCLN three days post surgery for removal of an ovarian tumour. Tina began experiencing episodes of anxiety on her first post-operative day. The results of the pathology had not been obtained because of external difficulties. There was a slim chance the tumour was malignant.

### Referral

The referral was made by the nurse caring for Tina. The PCLN was requested to see Tina to help her with the anxiety episodes. The referring nurse also sought advice as to what she could do to help Tina. The referring nurse had raised the idea of a PCLN referral with Tina and the latter indicated she was keen for some assistance.

### Assessment

The initial assessment of the request took place with the general nurse initiating the referral. The PCLN decided to interview Tina directly given that she was receptive to the idea of assistance and there were likely to be some straightforward and useful interventions that could readily be put into place. The fact the referral was made on a Friday afternoon, with the possibility Tina would be discharged at the weekend, meant there was limited time to liaise with the Consultation-Liaison registrar. Tina was interviewed in the presence of her husband Keith (with Tina's permission).

Tina presented as an articulate, intelligent woman deeply distressed by her recent operation. In particular, Tina was upset by the unexpected wait for her results and

that her recovery was hindered by a wound infection. She was extremely cooperative at interview and there was obvious openness and caring between Tina and Keith. Keith was also distressed about Tina's anxiety and was keen to assist if he could.

Tina described experiencing her first 'anxiety attack' one day post operatively. She described 'funny feelings all over', dizziness, weakness in the legs, feelings of fear and loss of control. She had used some relaxation strategies she had learned once, mainly trying to imagine herself elsewhere, but had limited success as frightening thoughts of dying came into her mind. She was tearful when describing her symptoms and clearly anxious about her prognosis. She described herself as a 'high achiever' and 'perfectionist', a view Keith supported.

Her past medical history was uneventful. She did not smoke or use drugs but did drink alcohol, sometimes to calm herself down at the end of a busy day. She had an aunt on her father's side who had 'problems', possibly panic attacks. No other psychiatric history in her family was noted. Upon questioning Tina did recall having similar episodes as a teenager but they were fleeting in comparison, 'not as bad as this' and they 'went away of their own accord'.

The staff reported that Tina was recovering quite well but became very uptight once the results were delayed. Her anxiety was worse at night and she was having difficulty sleeping. No sedative had been ordered because Tina had initially been reluctant to use medication but was now reconsidering this.

### **Interventions**

Although Tina's situation may appear routine and less involved than would be the case where a variety of florid symptoms of psychosis was involved, a number of interventions were initiated by the PCLN. Each intervention is briefly described:

**Direct care of the patient:** Tina was assessed drawing on information from herself, her family, the staff and the clinical file. She was provided with supportive counselling and education. Supportive counselling refers to providing Tina with the opportunity to verbalise her concerns, to which the PCLN responds with understanding and compassion. The support provided extends further to working with Tina to identify the strengths she possessed and how these might be used to overcome her current state of anxiety. Education included alternative relaxation techniques, supported by written material for future reference. Tina was given an opportunity to practise relaxation techniques in the presence of the PCLN.

Tina was provided with the telephone number of the PCLN so she could make contact after discharge to discuss how things were going. She was also provided with information on community resources that she could choose to access.

**Direct care of the family:** The PCLN provided Keith and Tina's mother with information as to the anxiety state Tina was experiencing. They were encouraged to continue to be available to and supportive of Tina, and provided with some approaches and strategies they could use to assist Tina at times of distress.

**Advice and guidance to the treating team:** Feedback was given to the team about the PCLN's assessment and Tina's suggested management plan. Guidance was also provided to the medical officer who agreed to prescribe night sedation.

**Education:** Information (written and oral) was provided to the staff so that they could support Tina through her periods of anxiety and talk her through her relaxation techniques as required.

**Link with Consultation-Liaison psychiatry:** Telephone contact was made with the Consultation-Liaison Psychiatrist who agreed that Tina's symptoms were suggestive of panic attacks. It was planned to offer Tina an outpatient consultation-liaison psychiatry appointment for further assessment. Tina was given the contact number of the outpatients department to arrange an appointment directly with them if she wished.

### **Outcome**

Tina was discharged on the Sunday as planned after receiving the pathology results that revealed a benign tumour. She contacted the PCLN the next week saying that the anxiety had settled and she did not want to pursue the consultation-liaison psychiatric outpatients appointment. Tina was encouraged to be mindful of her vulnerability to anxiety and to seek help early if the anxiety attacks returned. Tina resolved to look further at her anxiety and purchased a self-help book and relaxation tape recommended by the PCLN.

### **Adam**

The nurse unit manager of the Rehabilitation Unit requested the input of the PCLN in the care of a man admitted for rehabilitation after sustaining significant injuries as a result of a motorbike accident. Almost simultaneously, the Consultation-Liaison psychiatrist requested the input of the PCLN because he had identified significant potential issues when discussing the case with the psychiatric registrar.

### **Background**

Adam was a 30-year-old single man who was transferred to the rehabilitation unit from an orthopaedic unit of a general hospital where he had been admitted three months earlier. In the motorbike accident he had sustained multiple fractures to his lower limbs that had resulted in an above knee amputation of his right leg. His left leg had also been fractured and had multiple skin grafts applied. This leg was healing well. He had a permanent colostomy as a result of abdominal injuries.

### **Assessment by the psychiatric registrar**

The Consultation-Liaison Psychiatric Registrar had seen Adam when he was first admitted to the rehabilitation unit. The registrar managed to obtain a comprehensive history from Adam, his family and the referring hospital. She offered Adam ongoing psychiatric support which he refused. He stated that he was 'not a nutcase' and refused further contact with her. The Consultation-Liaison psychiatric registrar's assessment was that Adam was a man with significant narcissistic and antisocial personality traits who was having difficulty adjusting to the disability resulting from his injury.

Adam had a history of marijuana and alcohol use since his teens. He had used heroin occasionally in the past. Prior to the accident, Adam described having periods of depression that he managed to get over himself. He had one accidental heroin overdose in the past and on reflection, he felt that he knew he was taking too much but did not care. He had been in contact with a community drug and alcohol service for assistance with some degree of success in decreasing his heroin use.

Adam's hospitalisation in the orthopaedic unit was marked with episodes of anger and verbal aggression usually directed at the treating team and his family. His relationship with his previous employer and colleagues was strained leading to ongoing tension in his job and the trend that fights seemed to 'follow Adam where ever he went'. While his colleagues had rallied together to raise funds to support Adam, they rarely visited. This further angered Adam because he believed that they were responsible for the accident.

Since Adam's arrival on the ward, five days earlier, he had left the ward on one occasion without informing staff. He became intoxicated and was returned to the unit by the police after creating a disturbance at the local hotel. On return to the unit his blood alcohol level was high and he had evidence of cannabis use from his urine drug screen. This incident had resulted in conflict with the staff about alcohol and drug use, compliance with treatment and leaving the ward without informing staff.

### **Interventions**

Given Adam's refusal to allow psychiatry to have direct involvement, the PCLN was unable to provide care directly to Adam. The PCLN was nevertheless able to assess and provide support to the care of Adam via the following means:

**Assessment and monitoring of the patient via the staff:** Details of the patient's history were obtained through discussion with staff and through a review of the clinical file. Adam's progress was monitored through regular contact with the staff.

**Direct care of the family:** Adam's family were accepting of support from the PCLN and the psychiatric registrar even though Adam was steadfast in his refusal to see the 'psychs' as he called them.

**Development of a care plan:** The PCLN initiated a meeting with the treating team to ascertain their concerns, identify the care issues and develop a care plan. A supportive behavioural approach was taken to Adam's care. Part of the care plan included a rehabilitation agreement that was signed by the staff and Adam.

**Education:** Regular formal education sessions were initiated. These included an opportunity for staff to discuss and problem-solve the care issues in relation to Adam. Nursing, allied and medical staff attended these sessions. Theoretical information on personality disorder and its management, depression, suicide, drug and alcohol abuse, and adjustment to disability and illness was provided through formal education sessions. Written material was also provided.

**Advice and guidance:** The PCLN was available during business hours to discuss issues of concern with staff. All the staff used this opportunity. It greatly assisted staff to keep the goals of rehabilitation in focus and maintain a consistent approach to Adam.

**Link with drug and alcohol support services:** Adam agreed to the involvement of a local drug and alcohol agency to provide support to him during his admission. He wanted to curb his alcohol intake but was adamant in his desire to continue smoking marijuana.

### **Outcome**

Adam's stay in hospital was marked with a number of crises, usually in response to Adam being in conflict with his friends, family or staff. He had talked about 'topping' himself on occasion, but no attempts at self-harm were made. Adam discharged himself against medical advice after two months in rehabilitation. He was able to mobilise on crutches but was not able to successfully manage a leg prosthesis. The after-hours psychiatric registrar assessed him as competent to make the decision to leave hospital. He denied suicidal ideation at the time of discharge and his mood had been stable over the previous two weeks. He was encouraged to maintain outpatient rehabilitation with the team. He refused ongoing psychiatric support but agreed to continue with counselling for alcohol dependence. The staff were left with concerns for Adam's welfare but recognised that he could not reach his full rehabilitation potential at that point in time because of his difficulty in coming to terms with his disabilities. An offer for readmission for rehabilitation at a later date should he wish to pursue this was made to Adam upon leaving.

## **DISCUSSION**

The presentation of the two case studies enables a greater understanding of the role of the PCLN in relation to patients experiencing mental health problems within a general hospital environment. The diversity of the experiences and presenting problems of the two patients provides some broad insight into the manner in which the PCLN tailors interventions to suit the individual needs of the patient, patients' family and the staff providing care.

This paper demonstrates the potential for autonomous practice despite the complexity of this pivotal role. In caring for these two patients the PCLN performs a number of interventions drawing upon expert skill and knowledge as a psychiatric nurse. These interventions include the assessment and monitoring of the patient's needs either through direct interaction with the patients themselves, or where this is not possible or not relevant, through detailed discussion with staff, family and an extensive review of the clinical file.

Where appropriate, the PCLN provides direct care to the patient, for example through the provision of support and counselling. The PCLN contributes to the development of a patient care plan. This is particularly significant in supporting staff dealing with symptoms or behaviours they find difficult or challenging. The intervention of the PCLN in these cases enabled a more consistent approach to patient management which is likely to reduce the sense of frustration frequently experienced by general hospital staff when they feel unable to cope with patients experiencing mental health problems.

The provision of advice, guidance and education are interventions crucial to the role. Depending on circumstances, these services are offered to the patient, the family and to the treating team. Verbal information is generally supported by written material which remains available for future reference. The expertise of the PCLN is also called upon to provide clarification of patient status in relation to the *Mental Health Act of Victoria (1986)*, and to liaise with relevant services including consultation psychiatry, psychiatric services and drug and alcohol services.

What is clear from this paper is the capacity for the PCLN to make a difference to the lives of patients experiencing mental health problems within the general hospital and their family and the staff who provide care and treatment. There is, as the case studies clearly demonstrate, no magic solution, nor are we guaranteed of a happy ending, but the provision of support and specific psychiatric nursing skills can positively effect the outcomes for these patients and those who care for them.

The case study approach is frequently criticised for its lack of generalisability. However, the more our society moves towards an evidential and outcomes focus, the more research of this type becomes indispensable. Not only does it enable the articulation of specific skills, but it provides a means through which the impact of the PCLN role can be examined and appreciated. The same might not be true for all patients receiving this service, but this does not diminish the potential of the role as demonstrated.

## CONCLUSIONS AND RECOMMENDATIONS

The content of this paper makes a contribution to further articulating, understanding and appreciating the role of the psychiatric consultation-liaison nurse within the general hospital environment. The use of a case study

method enabled a detailed description of the approach taken by the PCLN in response to referrals made on behalf of patients experiencing mental health problems. This has provided a greater understanding of the process of assessment, developing and implementing interventions for staff and patients, and for monitoring the outcomes of intervention. In light of the paucity of research articulating the role of the PCLN, this study has made an important contribution to the development of new nursing knowledge.

While this study has contributed to the body of knowledge, considerably more research is required to more clearly articulate the role of the PCLN and determine the impact of PCLN intervention on patient outcomes. The importance of the PCLN role is largely due to the lack of knowledge, skills and confidence of general nurses in caring for patients experiencing mental health problems. By defining the skills and knowledge of the PCLN, identification of the educational needs of general nurses in relation to caring for patients with mental health problems will become clearer and enable in-service education programs to be developed to address these educational needs.

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