East London NHS
NHS Foundation Trust

Homerton Healthcare
NHS Foundation Trust

High Intensity User Service

Multi-Agency Plan:

Name: **NHS:** **DOB:**

This plan is not a substitute for routine care or clinical judgment. It is the responsibility of the medical team to decide whether it is appropriate to follow this guidance in the context of the presenting situation. This guidance was devised based on third-party information in the context of multi-disciplinary discussions. Please do not share, copy and paste into discharge plans or forward on to others without the explicit consent of our service. This plan is to guide professionals and is not to be shared with the patient

Dated <DATE>

Guidance – Plan for Attendance with an emphasis on consistency within physical & mental health teams & LAS

- Document full set of vital signs at assessment
- Document weight at assessment
- If her presenting symptoms are the same [symptoms listed], she should have an early senior review in ED to try to discharge promptly. ED will not admit unless the doctor-in-charge feels there is a significant risk to her life. She should be reminded that her [site] pain is being investigated by her GP & that she has had 2 normal CT scans.
- Do not prescribe any sedating/anxiolytic medications in ED. She has a history of stockpiling and overdosing is also known to different HIUS and possibly other EDs. Even if we only give her a very small amount, there is a possibility of her storing this up so a very real possibility that we are increasing her risk of harm by prescribing her more medication. It is important we are consistent about this. If she wants to discuss a change to medication, she needs to do this with her CMHT.
- Do not arrange a taxi/transport to take her home.
- If she refuses to leave once senior staff have advised she is discharged, security may be called to escort her out**.** If she is aggressive, threatening or abusive towards staff, consideration should be given to calling the police. She does have a forensic history and has been increasingly aggressive towards health professionals recently, so staff are advised to be cautious even if they feel they know her well.
- If admitted onto East Wing, the Home Treatment Team will endeavour to discharge quickly & follow up by telephone (as face-to-face reviews are taking over an hour each time).
- Reinforce boundaries, she should not be allowed to use facilities, such as shower or be assisted with other personal tasks within the ED unless immediately necessary
- She is aware of how to liaise with Crisis Line, who are allocating 15 minute slots twice a day & she is being encouraged to use this service instead of ED.

- She will often ask to see the mental health team in ED, this should not be encouraged. If there are significant changes and the Senior ED team feel she needs to see HPM, she should be seen by the most senior clinician available. She has an extensive community mental health care package, despite her claims to the contrary and she should be encouraged to use this. She has 24-hour support in her accommodation as well as a mental health care co-ordinator.

- Her GP is in agreement with this plan & has added this to CMC.

- Guidance for LAS is to do observations. If stable and no change to presentation e.g. ongoing [site] pain from earlier call out then LAS will not transfer to ED. They will only convey if significant risk to life.

- LAS should set a time limit for how long to spend at the property. LAS seniors to discuss limiting numbers of allowed callouts to her property

- LAS should not assist with anything that is not emergency medical care, e.g. they should not be assisting with showering, feeding or other activities of daily living

- LAS to liaise with the Crisis Line if bringing her to hospital for psychiatric reasons is being considered

- If Crisis Line are contacted by LAS or police, advice should be given based on the care plan, reiterate the amount of support that is already available and discourage bringing her to ED unless the situation is significantly changed

- She has been referred to the multi-agency local high risk panel for discussion.

Overview of client:

*** is a 49-year old lady whose ED attendances have been increasing a great deal recently. She has been making numerous calls to the Crisis Line and her GP as well as presenting to ED on an almost daily basis complaining mainly of [site] pain. She seems to be in a crisis as a result of stressors at home but she has a considerable amount of support in the community, despite her claims to the contrary. She will often ask to see the mental health team in ED, but it is not clear what she feels she needs from them. For her physical symptoms, she has had a number of investigations recently including blood tests and two CT scans, all of which are reassuring. Her GP is also arranging an endoscopy because of her weight loss.

*** has opted not to take her regular prescribed medication for several weeks despite this being available to her. She has been given several doses of [medication names] following ED presentations, which she sometimes refuses and other times returns asking for more. She is not using medication appropriately.

We should not be offering her services which do not constitute appropriate emergency care. In recent weeks she has had showers in ED as she claimed to be homeless, been given [nutritional supplements] to take home and had taxis booked for her when she is able to organise her own transport. We should not offer these things.

It is really important that all of us both in the physical health & mental health team are consistent in our approach.

It is extremely challenging to support ***, she is undoubtedly a very genuine risk to herself in the long term, and to refuse her certain things can feel like 'punishing' her behaviour and can lead to more distress for all concerned. Staff may want to offer measures that may calm her a little and help facilitate her discharge but it is helpful for her care to be led by seniors from the outset as she is a complex, vulnerable and very risky individual all staff need to be supported in managing her.

Typical Presentation in ED:

[PRESENTING COMPLAINTS LISTED]

Typical ED response:

She has had 2 recent CT scans which were unremarkable. She is awaiting a [physical health review appointment] review which her GP is following up.

She has a [speciality] appointment at 10:30am on [date] face-to-face with Dr ***, Homerton Hospital

Engagement: Non engagement with community services

Triggers:

- Possible triggers for repeated presentations recently to the services seem to be that she does not like her placement and her friend *** is currently looking after her parents who are unwell.
- It is of concern that she appears to have lost weight and reports that she has only been eating [nutritional supplements] for the last 2 months.
- She also admits that she does not want to become institutionalised. Apparently, she has expressed her desire to move to [a different borough] and have therapy.
- Triggers for her mood changing are usually interpersonal. It can include facial expressions.
- If she perceives she is not been taken seriously / invalidated emotionally.
- Dissatisfaction with services and a feeling of being “let down” by such.
- Ongoing lack of sleep, feeling depressed, lack of energy and motivation.
- Perceived abandonment, e.g. by [a family member]
- Feelings of loneliness and isolation

Risk: On-going high risk of dangerous behaviour

- Chronic risk to self of impulsive acts of self-harm and suicide. This risk has historically not been mitigated by hospital admission and in fact, has been seen to increase when she is admitted to hospital.
- To health – She has received extensive medical investigations recently, none of which have raised significant concerns. However, she does have some health problems and is placing herself at risk of deteriorating physical and mental health by declining outpatient investigations, stopping all medications and drastically reducing her intake, with associated weight loss. She is also at risk of iatrogenic harm as a result of her increasingly frequent contacts with medical services. This may be through unnecessary investigations and treatments, reinforcing behaviour, or by diagnostic overshadowing. Serious health concerns may be missed because of clinicians’ familiarity with her mental health and recurrent complaints.

- Her [past medical history listed] place her in higher risk group and there is possibility of MI in future.
- Risk of accidental self-harm/death through agitated and acting out behaviour remains high.
- To self – She presents a chronic risk of self-harm/suicide. There is a persistent risk to herself through dangerous behaviours, such as the recent episode of [action described], where she might have easily been injured.
- To others – There are recent reports of threatening/aggressive behaviour towards her CMHT/LAS.
- From others- risk of retaliation. She has a history of significant abuse both in her early life and more recently. She is awaiting a court date due to being a victim of [crime stated]. She may be vulnerable to others. She has, in the past, developed fixations on people in her life and this may place her at risk if her attention is unwanted or exploited.

Past risk history:

She has extensive risk and forensic history.

She has a history of overdoses, suicidal ideation and multiple suicide attempts.

Support:

She is open to [Recovery Team], Community Consultant [name] and Care Coordinator [name]
She also receives support from the Crisis Line.

She has support from the Service User Network Outreach Project.

[Accommodation name] is a supported accommodation which supervises her medication and has 24/7 staff.

She is also supported by her GP at [named surgery].

Care plan discussed with patient: No

Care plan shared with patient: **No**

Care Plan agreed by [List of names & designations]