the columns

correspondence

In-patient care – staff training

Lelliott *et al* highlight some real and urgent problems in acute mental health services (*Psychiatric Bulletin*, October 2006, **30**, 361–363). As the Psychology Lead on adult acute in-patient services in Lambeth I have a long experience of working on acute in-patient wards and agree with all the problems described: focus has been on community services; the environment is often not therapeutic; there is always a staffing crisis and the bed management system governing the functioning of the services is there to meet the needs of the service rather than the needs of the service users.

As Lelliott *et al* point out there is no shortage of guidelines, but they are not always easily implemented. In-patient care is overshadowed by the focus on community care, which, although important, cannot remove the need for a safe and therapeutic environment for those who require hospitalisation. To improve the quality of care and the therapeutic environment on the wards we need to focus on the ward itself. Some fundamental changes are needed to support frontline staff. This is where I see a role for my profession – psychology.

Apart from organisational and systemic needs, there is also the issue of staff training. The accreditation of acute in-patient mental health services as described by Lelliott *et al* would be an important development. For this to work, frontline staff would need to perceive any training as something which supports and helps them in their work, rather than yet another bureaucratic demand. In South London and Maudsley NHS Foundation Trust we have developed a 1-day training course on implementing the recommendations of the Department of Health guidelines on adult acute mental health care provision (Department of Health, 2002). One of the objectives was to train staff in skills conducive to developing a therapeutic environment on acute wards. The courses were well attended and well received, suggesting that frontline staff might welcome such initiatives. Details of the course are available from the author.

DEPARTMENT OF HEALTH (2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. Department of Health.

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'Do not resuscitate' decisions – need for objective measures

Chakraborty & Creaney (*Psychiatric Bulletin*, October 2006, **30**, 376–378) described the understanding of 'do not resuscitate' (DNR) orders among staff in continuing care psychiatric wards. Many nursing staff and many psychiatric trainees connect DNR orders not only with cardiopulmonary resuscitation (CPR) but also with the intensity of medical intervention for physical illness. Deterioration of physical health is more common than cardiac arrest on old age continuing care psychiatric wards and requires a decision on whether or not to transfer to a medical facility. In the absence of clear guidelines, the role of DNR orders is debatable.

The argument for a DNR order is clear. In advanced dementia complicated by physical debilitation, CPR is unlikely to be successful. If successful, residual brain damage worsens the prognosis, contributing to an even poorer quality of life. Such information is understood by relatives. However, reasons given for not transferring to a medical ward appear vague and at worst inhumane to relatives. A common explanation from a medical registrar on duty is that further intervention is unlikely to improve quality of life. This is viewed by many relatives as evidence of ageism in an era of scarce resources. Indeed, transferring such patients may improve their quality of life by relieving pain and discomfort caused by reversible conditions such as pneumonia, septicaemia and bowel obstruction.

Perhaps the answer lies with clear and transparent guidelines supported by objective means of measuring quality of life. Old age psychiatrists need training in palliative care so that they can justify their treatment choices in those with terminal illness.

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We recently conducted an audit of the documentation of cardiopulmonary resuscitation (CPR) status in patients on a 20-bed dementia assessment ward (all with a diagnosis of dementia and lacking mental capacity to discuss resuscitation) and found that only a quarter had their CPR status documented. Following discussions with staff to draw their attention to trust policy on CPR, re-audit showed only modest improvement: CPR status was documented in half of the patients' notes. An educational programme was arranged to address the potential barriers to optimal CPR documentation. Subsequent audit showed documentation of CPR status in three-quarters of patients.

Poor quality of life and futility of CPR are often cited as the reasons behind the decision not to resuscitate. Despite the advanced age and diagnosis of dementia in our patients, judgements on patients' quality of life can be complex and emotive, and the critical factor seemed to be a lack of readiness among staff to initiate discussion of issues surrounding death.

We agree that relatives should be involved in discussions on resuscitation. However, this has to be done with sensitivity so that a decision not to resuscitate does not add to the relatives' sense of guilt. Often this can be achieved by presenting such decisions as a considered opinion of the team before seeking the relatives' view.

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Standard template for letters to general practitioners

Dinniss *et al* (*Psychiatric Bulletin*, September 2006, **30**, 334–336)