Collaborative care for alcohol-related liver disease

Kieran J Moriarty, Helen Platt, Sandra Crompton, Wendy Darling, Martin Blakemore, Sue Hutchinson, David Proctor, Malcolm Brown, Burt Burtun, George Lipscomb, Kadukkavil Padmakumar

ABSTRACT – By implementing collaborative care for patients with alcohol misuse and alcohol-related liver disease, the Royal Bolton Hospital aimed to improve and coordinate their care by recruiting a multidisciplinary team and placing the patient at the centre of all efforts. There has been a marked improvement in the accuracy of the drinking histories taken, detoxification, dietary documentation, and patient and staff attitudes and confidence, with enhanced satisfaction in patients, their families and staff and improved accessibility and communication. We observed a considerable increase in the number of inpatient and outpatient referrals and believe that it is more effective to work together in a joint gastroenterology/psychiatry team. There is a critical national need to establish steering groups of key clinical, managerial and commissioning personnel to address the growing problem of alcohol misuse. The appointment of dedicated alcohol health workers is central to this strategy.

KEY WORDS: alcohol, collaborative care, liver disease

Background

Alcohol misuse, particularly binge drinking in young people, and alcoholic liver disease (ALD) are major public health concerns.[1] Since the 1970s, alcohol consumption has increased by 50%, due to a number of factors, including falling prices, the aggressive marketing of drinks towards young people, growing affluence and more widespread availability. Already, alcohol-related diseases are costing the NHS about £1.7 billion every year. Around 17 million working days are lost annually because of alcohol misuse, costing our economy £6.4 billion. Seventy per cent of all weekend night time admissions to accident and emergency (A&E) departments are linked to alcohol. More than half of all violent crime is related to drink.[2]

Britain is one of the worst countries in Europe for binge drinking – a third of all teenagers aged just 15 say they have been drunk at least once, compared to only one in ten in France and Italy.[3] Cirrhosis of the liver has risen tenfold since the 1970s, and is now an increasingly frequent cause of death.[1] Not only is cirrhosis getting more common, it is presenting at a younger age, and patients in their twenties and thirties with end-stage ALD are now being seen by liver specialists around the UK. The Chief Medical Officer highlighted the problem in Bolton, particularly with regards to bed occupancy, in his 2001 Annual Report.[1]

Previous service offered

The Royal Bolton Hospital appointed its first consultant gastroenterologist in 1990. Before this appointment, the care of patients with alcohol misuse was fragmented, due to a poorly developed liaison psychiatry service, only being equipped to manage presenting disease rather than concentrate on disease prevention or health promotion, and the lack of dedicated alcohol workers. Typically, patients were admitted under the care of a consultant, had a brief detoxification and were discharged, or self-discharged, with no continuing care or follow up. There was also a large number of recurrent admissions with alcohol misuse, and deaths, particularly in young women. These multi-faceted problems required a collaborative multidisciplinary approach to care.

New service offered

Since 1990, we have pioneered multidisciplinary, holistic care for all patients, especially those with ALD. The multidisciplinary team meets weekly to discuss every inpatient. This team includes the consultant psychiatrist specialising in substance abuse (appointed 1993) and the psychiatric liaison nurse (PLN), thus facilitating care of physical and psychiatric needs. The gastroenterologists, psychiatrist and PLN hold a twice-monthly liver clinic, thus ensuring that medical, psychiatric and counselling needs are met at one attendance, with a reduction in did not attend rates. This provided the foundation for our project.

Collaborative care is a multidisciplinary team approach to assessing, planning, implementing and evaluating care, in collaboration with the patient,

Kieran J Moriarty CBE MD FRCP, Consultant Gastroenterologist

Helen Platt RGN, Project Nurse

Sandra Crompton RGN, Lead Nurse in Liver Disease

Wendy Darling MB ChB MRCPsych, Consultant Psychiatrist in Substance Abuse

Martin Blakemore RGN, Charge Nurse

Sue Hutchinson RGN, Sister

David Proctor RMN MSc, Alcohol Liaison Nurse

Malcolm Brown MB FRCGP, General Practitioner

Burt Burtun RGN, Director of Nurse Training

George Lipscomb MD FRCP, Consultant Gastroenterologist

Kadukkavil Padmakumar FRCP, Consultant Gastroenterologist

Royal Bolton Hospital, Bolton

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and is developed around an anticipated length of stay or episode of care. This contrasts with the more traditional approach, where each discipline plans care in partial or total isolation from others.[4] Collaborative care places the patient at the centre and could well be a model for all nursing and medical care in the future.

In 1994, we made a successful bid to North West Region for the salary to support a collaborative care project nurse for 12 months. A steering group was formed, consisting of the Regional Nurse Alcohol Manager, the Head of Medical Nursing, the Director of Nurse Training, a senior research nurse, a general practitioner (GP), the project nurse, the consultant psychiatrist (substance abuse) and consultant gastroenterologist. A task group was also set up, consisting of the project nurse, ward nurses, dietitian, pharmacist, psychologist, physiotherapist, occupational therapist, social worker, Asian link worker, alcohol counsellor, community psychiatric nurse and health promotion representative.

Our aim was to develop a joint care initiative involving hospital, community, voluntary and social services to meet the holistic needs of our patients with alcohol-related liver disease. There was a clear need to improve documentation relating to issues such as nutritional assessment and the early identification of patients' functional abilities. It was also recognised that duplication and repetition of patient records across the professions was common. We therefore developed a multidisciplinary care assessment booklet, which included a detailed alcohol history as well as guidelines for alcohol detoxification, the management of ascites, portosystemic encephalopathy and bleeding oesophageal varices.[5] All healthcare professionals made their entries in this booklet.

Our alcohol counsellor and project nurse gave brief interventions to our patients. Brief intervention, consisting of information and advice, is effective in reducing alcohol consumption in patients with alcohol misuse.[6–9]

Key measures for improvement

These were assessed by how successful we were in achieving our aims in the two gastroenterology wards of Royal Bolton Hospital. Our key aims were:

- to create a climate that promotes collaboration and cooperation, for the benefit of the patient
- to involve patients and staff in the planning and provision of care
- to promote a learning culture among the various healthcare professionals
- to improve admission and discharge procedures
- to improve channels of communication, staff development and expertise
- to make data available for clinical audit, research, contracting and business planning
- to apply and disseminate good practice and extend lessons learnt to other areas of healthcare.

Effects of change

Patient attitudes

Primarily, patients and their families appreciated the removal of the stigma associated with alcohol misuse. Patients welcomed the opportunity for a brief intervention and education by the PLN. The PLN saw 88% of patients included in the project, whereas only 6% had the opportunity before.

Patients also generally availed of the opportunity for joint gastroenterological/psychiatric outpatient follow up. Outpatient appointments were offered to 84% of patients, compared to only 12% prior to the introduction of collaborative care. Thirty-five per cent of patients were reviewed at home and this was particularly appreciated.

Our patients and families feel confident that we will do everything possible for them. They, and their GPs, know that we are non-judgemental. We never turn our backs on anyone, even if it is their thirtieth admission. GPs in neighbouring districts often refer patients to us, especially the more difficult cases. We try to address all aspects of care, physical, psychiatric and social, both in hospital, on discharge and during follow up. Our patients and families know they can contact our secretaries or wards at any time, and they will be seen or admitted as soon as possible.

Staff attitudes

All staff are valued and supported and all contribute to the department. The unified collaborative care, joint clinics and multidisciplinary meetings emphasise our focus on the patient and their families.

Attitudes are generally very positive. During the collaborative care project, 96% of staff felt that they were more aware of alcohol-related liver disease; 83% felt more confident in caring for a patient; 87% felt more knowledgeable; 87% felt they had a greater understanding of the roles of other professionals involved in the care of patients; 83% felt our project had facilitated a multidisciplinary approach to care; 74% felt patients were referred to the appropriate members of the team without delay; 83% felt the collaboration had helped them to recognise signs and symptoms of alcohol-related liver disease; 83% felt more confident in giving information to patients and their families; and 91% felt more aware of the procedures and investigations to be carried out.

The success of this approach was shown by:

- the increase in the numbers of patients with alcohol misuse referred to us, especially those who were most ill (660% increase in the two years following the project)
- the increase in the number of patients attending the liver/alcohol clinic (we needed to run two clinics rather than one per month).

Both increases have continued over subsequent years, during which virtually 100% of medical patients with alcohol-related liver disease are referred to our care.

The staff, patients and their families have generally found the experience very positive. Working together has been very

stimulating for all. Teaching and training initiatives have been facilitated and the nurses now run their own gastroenterology/liver disease courses.

Adherence to guidelines

General

Following our project, considerable improvement was noted in the documentation of investigations and results, communication with relatives, and discharge planning. There has been improved risk assessment and management, with less behavioural disturbance and violence and improved staff retention. There is close liaison between our service and primary care, the community alcohol services, mental health team, A&E staff and all healthcare professionals. Some patients complete detoxification at home. We have made special efforts to include patients from the Asian community, who suffer a special stigma. We provide booklets on alcohol in Urdu, Gujarati, Punjabi and other languages.

Drinking histories

Seventy-six per cent of booklets contained a detailed history and in 50% of booklets, consumption was converted into units. Prior to the project, 59% of records documented some form of alcohol history. This was usually descriptive, and rarely in units.

Detoxification

The guidelines for detoxification were adhered to in 94% of cases.

Dietary documentation

Fifty-three per cent of booklets contained detailed dietary advice in the relevant section. Prior to the project, detailed nutritional assessment had only been included in 12%.

Lessons learnt

It was evident that a restructuring of the service and care offered to patients was paramount. With collaborative care, the key strategy was to recruit all healthcare professionals, clinical and managerial, especially the multidisciplinary team, patients and their families. It was also necessary to place patients at the centre of all our planning and to empower them to make fundamental lifestyle decisions, especially regarding alcohol consumption.

Our collaborative work in alcohol has had a knock-on effect on every aspect of our work, especially nutritional support. Our approach has been disseminated throughout our trust and nationally. The Royal College of Physicians (RCP) used our evidence about best practice and two of our care protocols were included in their Working Party publication.[10] We have received commendations from the Audit Commission, the Improving Working Lives Accreditation Team and the Modernisation Agency.

We have learnt how much more effective and enjoyable it is to work together in a team, rather than in isolation. We appreciate that we are all there for the patient and families, who are at the centre of all our care. Our approach is mainly qualitative rather than quantitative. Our colleagues in general practice and in hospitals now refer virtually all patients with ALD and other alcohol-related problems for our specialist care.

Our project and continuing work have helped us to put in place the key recommendations made by the RCP for local care by acute hospitals receiving unselected medical admissions.[10] These include:

- a screening strategy for early detection of harmful/coincidental hazardous drinkers
- early assessment of dependence severity by appropriately trained staff
- widely available protocols for the pharmacotherapy of detoxification
- readily available 'acute response' from liaison or specialised alcohol psychiatry services for the management of patients undergoing 'complicated' alcohol withdrawal
- assessment of the need for referral to ongoing support services by appropriately trained staff with knowledge of local services
- provision of brief interventions for coincidental hazardous drinkers
- provision of general staff education
- occupational policies for alcohol for all healthcare workers, for example with respect to drinking at work
- close liaison with GPs on discharge.

The trust's strategy should include the identification of:

- a senior member of medical staff and a senior member of nursing staff to act as a focus for alcohol strategy and to support more junior members of staff
- a senior psychiatric colleague with an interest in the management of alcohol problems to act as the primary link between the acute hospital trust and local mental health services, who may or may not be employed by the acute trust
- one or more dedicated alcohol health workers employed by and answerable to the acute trust.

In 1999, the Royal Bolton Hospital won the Hospital Doctor Gastroenterology Team of the Year and Doctor of the Year awards for our innovative, collaborative, holistic care. The judges' citation highlighted our unit's mission statement, 'We never give up on anybody, even when they have given up on themselves'.

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References

1 Department of Health. *The annual report of the Chief Medical Officer of the Department of Health, 2001*. London: DH, 2001. www.dh.gov.uk/assetRoot/04/08/22/73/04082273.pdf
2 Strategy Unit Alcohol Harm Reduction Project. *Interim analytical report*. London: Strategy Unit, 2003. www.pm.gov.uk/files/pdf/SU%20interim_report2.pdf
3 European School Survey Project on Alcohol and Other Drugs. www.espad.org (accessed 20 February 2007).
4 Finnegan E. Collaborative care planning pilot study report April 1991. West Midlands Health Region Resource Management Support Unit.
5 Williams C, George L, Lowry M. A framework for patient assessment. *Nurs Stand* 1994;8:29–33.
6 Wallace P, Cutler S. Haines A. Randomized controlled trial of general practitioner intervention in patients with excessive alcohol consumption. *BMJ* 1988;297:663–8.
7 Anderson P, Scott E. The effect of general practitioners' advice to heavy drinking men. *Br J Addictions* 1992;87:891–900.
8 Chick J, Lloyd G, Crombie E. Counselling problem drinkers in medical wards: a controlled study. *BMJ* 1985;290:965–7.
9 Scott E, Anderson P. Randomized controlled trial of general practitioner intervention in women with excessive alcohol consumption. *Drug Alcohol Review* 1990;10:313–21.
10 Royal College of Physicians. *Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals*. Report of a Working Party: RCP, 2001.