Evaluation of the Camberwell Assessment of Need for the Elderly and a critical appraisal of the evidence relating to meeting a patient's communication needs.

Tracey Collins

Case Study

Aadi is a 69 year old man, originally from India but moved to the UK ten years ago. Aadi's next of kin is his niece Rima and Aadi has communicated to the liaison mental health nurse that he would like Rima to be involved with decisions that are made on his behalf.

Aadi has been admitted to a General Hospital in the South West of England to an Elderly Care Ward primarily with chest pain and has a history of physical health problems of a respiratory and cardiovascular nature. A referral was made from the ward for a liaison assessment as staff were concerned about his recent low mood and his fixation with his catheter. Anti-depressants were prescribed and upon a follow up assessment, Aadi was in a good mood however appeared to be suffering with delirium. Staff were querying a Urinary Tract Infection (UTI).

Discharge planning was being discussed with a best interest meeting involving his niece and staff involved in Aadi's care. The mental health liaison nurse will perform a mental state examination once the infection has cleared to determine if Aadi has dementia. Upon discharge from the ward, it was discussed that the liaison nurse will visit Aadi once he is back in the community.

Please note that Aadi and Rima are pseudonyms in line with the NMC Code (2008).

Abstract

This paper is an evaluation of a mental health liaison nursing assessment using the Camberwell Assessment of needs for the elderly (CANE) (Reynolds et al 2000) and a critical appraisal of the evidence relating to meeting communication needs of an individual patient. Whilst this paper acknowledges that the MMSE forms part of a liaison assessment (Johnston and Cowman 2008), it is an individual nursing assessment and therefore the focus of this paper is solely on the CANE assessment as used in liaison nursing. This paper will start by addressing the benefits and limitations of holistic nursing, evaluate whether liaison nursing is holistic, discuss whether the CANE assessment is a holistic assessment, and will then go on to appraise the evidence related to communication needs in the context of liaison nursing using the CANE assessment. This paper will then end by discussing the future directions for the CANE assessment in liaison nursing.

Introduction

Holistic nursing is a patient-centred care approach that considers all aspects of the individual patient including the psychological, physical, social and spiritual care needs (Bradshaw and Coleman 2007). The American Holistic Nurses Association (AHNA) was developed in the 1980's to advance nursing to emphasise the need for holistic nursing with attention to caring for the whole patient and significant others (Dossey et al 1998). In holistic nursing, the nursing assessment becomes a way of being rather than a strict set of prescribed interventions which focuses on the whole individual to create a therapeutic environment, recognises alternative and complementary frameworks and implements self-care (Davis and Eschiti 2005). A holistic nursing assessment involves assessment, planning, implementation and evaluation of an individual patient to prevent, maintain, restore and support functions of the physical, emotional, mental and spiritual aspects of care. Aadi's nurse focused on treating all of Aadi's needs as the nurse was aware that his physical, social and psychological needs would be related to his mental health needs. Care should be planned with the patient and their family and include their cultural beliefs, values and preferences. Holistic nursing should acknowledge the aging process from birth to death, understanding the psychology of the lifespan to see the person beyond their illness (Eschiti and Struthers 2004).

Kolcaba (2003) suggests holistic nursing is a way of encompassing physical, environmental, psychospiritual and sociocul-

Author details
Tracey Collins
1st year student of Post Graduate Mental Health Nursing
University of Southampton
tc2r13@soton.ac.uk

tural contexts into nursing care. Kolcaba investigated Benners (2001) novice to expert theory to understand how nurses utilise holistic care and found that using the concept of comfort, Benner's theory could be used as a framework. Boswell et al (2013) interprets Benner's (2001) theory with the rationale that individual nurses that become the expert nurse are able to understand situations as a whole rather than individual parts. Aadi's nurse was able to understand the wider perspective on Aadi's situation. Learning from previous experiences, these nurses are able to adapt current decisions which leads to a profoundly more holistic approach to nursing. Nurses that reach the expert phase no longer need to rely on principles, rules and guidelines but use their experience to determine clinical decisions. Boswell et al (2013) suggests to develop competent clinical knowledge and decision making, it is necessary to include holistic nursing care, religion, listening and communication. This gives the perspective that a nursing assessment becomes holistic from the experienced nurse that conducts the assessment. Holistic nursing assessments have the benefit of involving the patient in their care. The 'no decision about me without me' is about keeping nursing values and behaviours at the heart of nursing assessments, allowing patients to become the expert in their care by including patients in decisions that are made about their care. This should lead to good communication and shared decision making (DOH 2012). Aadi's nurse involved Aadi into his care by always asking what he wanted.

According to Davis and Eschitti (2005) holistic nursing assessments provide interventions that are based on research findings. Coombs et al (2013) suggests that there is not a clear understanding of what makes an assessment holistic as there is little research on how an assessment is undertaken in practice. It was evident that Aadi's nurse was practicing holistic nursing, but there is not any known evidence underpinning the assessment. Regardless of the philosophy, school of thought or model that informs mental health nursing practice, the assessment should contain content that reflects the practice. Coombs et al (2011) systemic review did not find any journal articles that were able to describe the content and process of a mental health assessment and therefore it is unknown how many of these nursing assessments are effective given that there is little evidence on these assessments' methodology. However Boyer (1986) describes mental health assessments as an empty category, a complex activity based on external factors where there is a shared agreed meaning. This leads to the perspective that nurses need to understand the context of the interventions in practice. Less variability of assessments may give a clear understanding of how an assessment is undertaken.

Liaison mental health nursing, an area of mental health nursing that considers the psychosocial aspect of physical health is beginning to grow in interest with the nursing research and has the potential to give an understanding of what makes a holistic assessment. Liaison nursing integrates the psychological, sociological and biological perspectives to provide holistic care (Roberts 1997). The mental health liaison nursing role includes consultation with nursing staff, education to patient care teams, direct psychological care to patients and their families, understanding the relationship between physical and psychological states, expertise in psychiatric illnesses, and liaison between disciplines. The mental health liaison nurses' main concern is the psychological problems and issues in general healthcare settings with the focus on initial assessment and brief therapies (Roberts 1997).

In the physically ill, psychosocial problems are common, psychological factors influence physical illness and psychosocial interventions improve psychological and physical outcomes (Roberts 1997). Comorbidity is common, especially with older people in general hospitals. In the UK, two-thirds of NHS in-patients are aged over 65 in general hospital wards, generally unwell and their complex needs may be hard to assess (Holmes 2005). In this case study, Aadi had a history of physical comorbidity with cardiovascular and respiratory problems, was admitted with severe chest pain, became depressed whilst in hospital and later become delirious. This is an example of complex physical and psychiatric comorbidity in a general hospital setting. One theory of comorbidity is that comorbidity alters the patient's perceptions of their symptoms and that there is a coexisting relationship between the physical and psychiatric comorbidity (Lyketsos et al 2002). Older people with mental illness have complex needs due to re-occurring co-existing disability, social economic problems and physical illness. Assessment of such needs can be difficult without an assessment that is holistic (Reynolds et al, 2000).

There are several models and theoretical frameworks that underpin the application of mental health liaison assessments such as the holistic theoretical model by Lewis and Levy (1982 cited in Roberts 1997) that is developed on the basis of nursing theory, psychodynamic theories of personality development, systems theory, adult learning theory and stress theory. Dulaney and Crawford (1988) created a relief behaviour model of anxiety management derived from Maslow's hierarchy of needs and suggest that liaison nurses develop a core of conventional wisdom when conducting assessments. Regardless of the model that is used in liaison nursing, assessments are based on a biopsychosocial approach and therefore seen to an area that practices holistic nursing (Roberts 1997).

Whilst it is clear that mental health liaison nursing is based on psychological theories of nursing that do address that it is holistic, there is little evidence to prove the effectiveness of the assessments that practice holistic nursing (Holmes 2005). One meta-review of high quality systematic reviews of liaison nursing assessments found only 14 reviews that could be included in their meta-analysis out of 64 studies due to a lack of high quality evidence, suggesting that research is not implemented into practice for mental health nursing (Ruddy and House 2005). There was a systematic review conducted by Wood and Wand (2014) which evaluated the effectiveness of mental health liaison services in the general hospital settings and found that there is some evidence to suggest liaison services reduce length of stay when referred early and are cost effective, however many studies were methodologically flawed and had conflicting results.

Methodology

Research has suggested liaison nursing becomes holistic based on how the assessment is conducted by the nurse's experience and from the holistic

theoretical models that liaison nursing is based on (Roberts 1997). It is therefore important to evaluate a holistic nursing assessment that is used in liaison mental health nursing to determine whether there is scope for the future to practice holistic liaison nursing based on evidence. Given that psychosocial functioning is the most appreciated aspect to assess effectiveness of assessments (Wood and Wand 2014) it is important to evaluate an assessment that incorporates all of the patient's physical and psychiatric needs. One liaison assessment gives insights in the complexity of comorbidity and patient needs, the Camberwell assessment of Need for the Elderly (CANE) (Reynolds et al 2000). The CANE assessment examines 24 psychological, social and physical domains such as psychological distress, physical health, psychotic symptoms, drugs, alcohol, daytime activities and included two items for carers, therefore records staff, carer and patient views. Reynolds et al (2000) study shows that the CANE has good content, construct and consensual validity and demonstrated high reliability which means the assessment does examine the above holistic domains and is trustworthy of providing holistic care.

For the purposes of implementing a holistic nursing assessment into practice, universally using the CANE as a routine assessment in mental health liaison services could provide a standardised holistic assessment of needs as there is yet no standardised assessment used (Crome and Phillipson 2000). Greaves et al (2006) suggests that the CANE assessment addresses the complex social, psychiatric and physical needs of those that are referred to liaison services, that it highlights the met and unmet needs of the patient that might go unnoticed, reduces the likelihood of readmission to hospital, provides a tool for measuring outcome of care plans and care packages, identifies areas where resources are needed such as training, supports discharge planning and improves quality of life. This shows that the CANE is capable of reducing the devastating effects of disease and illness, assists the nurse and the patient towards wholeness and recovery on their person-centred journey indicating that the CANE is a holistic nursing assessment (Sharoff 2008).

There is no research to examine whether the CANE assessment is a holistic assessment or how the CANE is implemented in practice such as Reynolds et al's (2000) study provides no information on how the CANE was used, only to say that the CANE was carried out. The CANE assessment can only be interpreted as holistic based on what is known about what a holistic nursing assessment is and could therefore be seen as a subjective assessment. The CANE focuses on all aspects of care and holistic nursing focuses on all aspects of care (Eschiti and Struthers 2004). It can therefore be considered that the CANE is a holistic assessment but research needs to confirm this by for example looking at health status measurements and providing qualitative studies with liaison nurses and patients to understand how the assessments become holistic.

Critical review of the literature

This part of the paper will now critically evaluate the CANE assessment in relation to the research on the essential care need, communication and identify if the CANE is a holistic assessment. Aadi's most important need is communication, as the CANE needs require good communication in order to be met. Aadi's nurse needed excellent communication in order to help Aadi on his personal journey to recovery. Communication is defined by the DOH (2010) as a process that includes a meaningful exchange between at least two people to share needs, facts, feelings, opinions, thoughts and other information via both verbal and nonverbal interactions, which can involve face-to-face exchanges and/or written words. Roper, Logan and Tierney's model of nursing (Roper et al, 2000) is a nursing model of care based upon activities of living which promotes independence, considers the patient's lifespan development and incorporates holism by including aspects of biological, psychological, sociocultural and environmental care. It is a model that should be used consistently through a patient's admission right through to discharge. With consistent engagement it is a tool to provide support and assist recovery. It is important to assess the CANE assessment regarding communication needs as communication is one of the activities of daily living in this model and an essential need for patients to have met (Roper et al, 2000). In this case study, it was fundamental for Aadi to receive this essential care need during the CANE liaison assessment as unmet communication needs would have left Aadi with unmet holistic needs such as religion and physical needs.

Communication should be used to encourage the importance of caring for the psychological well-being of patients that are physically unwell (Priest 2010). In this case study, the mental health nurse was using communication skills to promote psychological well-being. On another visit to the general hospital, Aadi had become depressed and it was important for the nurse to use good communication with Aadi to recognise that he was depressed and understand why. Non-verbal communication was also important, there was a change in Aadi's normal behaviour and his body language, and the lack of spoken words when he communicated with the nurse, led the nurse to be aware of addressing Aadi's psychological needs. Psychiatric disorders in medical wards is most common in the elderly. One of the needs that patient's over 65 most of the time feel are not being met is psychotic symptoms and psychological distress but feel that their physical needs are met more frequently on the CANE questionnaire, suggesting that nurses need to make sure they communicate and deliver care in correspondence with their psychological needs (Greaves et al, 2006).

Mental health nurses must practice in a non-judgemental, holistic, sensitive and caring approach that recognises and acknowledges diversity and individual choice. Mental health nurses must use effective, safe, passionate communication and interpersonal skills to promote recovery and practice therapeutic use of self (NMC 2010). It is important for mental health nurses to deliver effective communication with the patient and the patient's family. Research that evaluated the role of a liaison nurse in a surgical ward found that good communication with family decreased stress and anxiety about the patients stay in hospital and increased family and patient satisfaction (Herd and Rieben 2014). In this case study, the liaison nurse updated Aadi's niece Rima, about Aadi's care, often communicating by phone and involving her to CPA meetings so Rima could communicate her thoughts and opinions about Aadi's care.

Communication with members of a multidisciplinary team for a mental health liaison nurse is vital, to create a positive

nursing environment which is known to enhance patient outcomes (Apker et al 2006). Nurses frequently have to routinely collaborate with physicians, allied health caregivers, and communicate with nursing staff within multidisciplinary teams in order to provide therapeutic relationships and to successfully share important information. Professionalism is maintained by speaking credibly, communicating with compassion to demonstrate other team member's concerns, and communicating with professionalism when the nurse advocates for staff members when situations warrant action (Apker et al 2006). In this case study, it was important for the liaison nurse to communicate updates to the occupational therapist about Aadi's mobility and educate staff members about psychiatric illnesses.

Communicating to educate and train team members is important for early intervention and reduce re-occurring illness (Roberts 1997). The most unmet needs in Hoogendijk et al's (2014) study using the CANE assessment was 'company' and 'daytime activities', communicating these unmet needs may improve the patient's lifespan development. Aadi had been in a side room for several weeks and it was important that the liaison nurse communicated that Aadi had become lonely and to make the team aware of keeping communication with Aadi in order to meet these CANE needs. A Cochrane review of 43 studies, including 29 randomised clinical trials using person-centred interventions found that using person-centred assessments can improve communication problems that can arise between the patient and the team and that when healthcare providers focus on disease and management, they do not see the patient beyond the illness leading to more unresolved psychological problems. This review has a small sample size and the review does not detail the interventions used, therefore more research is needed on communication and specific holistic assessments. This review does however imply that there is a relationship between communication needs being met and holistic nursing assessments (Dwamena et al 2012).

Almost half of patients on medical and surgical wards have either delirium, depression or dementia (Baldwin et al 2004).Delirium is frequently seen in most hospital settings and surprisingly little is known about its epidemiology, outcome, management and prevention. Core features are disturbance of consciousness, rapid onset, change in cognition, fluctuating course and external causation. Communication in assessment is essential because complications in delirium is preventable and assessment can reduce functional decline (Vidan et al 2009). Communication with patients with delirium is vital as delirium has serious effects on mortality, length of stay in hospital, and functional outcomes (Siddiqui et al 2006). In this case study, Aadi developed delirium and communication was essential to recognise the symptoms and treat the delirium.
Dementia is one of the most common diagnosis in the elderly in-patient population with the majority of patients on medical wards (Greaves et al 2006). A study with one hundred and one patients from various care settings were assessed using the CANE assessment (Hancock et al 2003). This study found it is important to identify the needs of dementia patients. Dementia patients rated fewer needs compared to their staff and carers rated whereas patients with functional disorders rated similar numbers of needs to their staff and carers. The underreporting of needs from dementia patients may be due to lack of insight, memory problems, resignation or denial but highlights the importance of communicating needs of dementia patients. Communication is important as dementia patients may not understand all of their needs (Hancock et al 2003). In this case study, it was important to communicate effectively with Aadi to understand the nature of Aadi's confused state and recognise his needs.

Depression in late life is common and has an impact on well-being. Depression has been associated with high levels of unmet needs, and only a minority appear to be adequately treated. Houtjes et al's (2011) study of ninety nine older patients in outpatient liaison services in the Netherlands were interviewed with the CANE assessment and patients with depression scored more unmet needs than staff and carers. This study showed that severe depression is an indicator of a substantial number of CANE items and shows that good communication is essential to understand the perception of needs of older depressed patients. In this case study, the nurse communicated with the patient to understand that Aadi was suffering with depression and to treat the depression with anti-depressants. Communication enabled the nurse to practice person-centred holistic care (Priest 2010).

Communication is a two-way process involving the speaker and the subject, and influences come from the environment. These co-influence outcomes for communication and any barriers to them can result from ineffective communication. Communication barriers can occur that are related to old age and it is important to recognise older patient's perceptions about communication barriers. It is important for nurses to develop communication skills and attitudes in order for nurses to correctly perform holistic assessments and understand the patient's communication needs (Park and Song 2005). In this case study, Aadi's communication barrier was his low mood and the nurse had to communicate with empathy to show understanding of Aadi's psychosocial needs (DOH 2012). Nurse's attitudes towards patients has also shown to effect communication (Armstrong-Esther et al, 1989). Hospital management and problems with physicians can be a communication barrier and staff can problem shift, so the negative attitude transfers from the nurse to the patient (Neivaard 1987).

Holistic nursing is considered holistic nursing when the bio-psycho-social components are met, a body (biological), a mind (psychological) and a social world (Sarafino 2006). These components can include culture, environment and a spiritual component such as religious beliefs (Priest 2010). In this case study, Aadi's religion was important to him and it was important for the nurse to communicate with Aadi so the nurse could understand his religious needs.
Jockemson et al (2006) believes that spiritual care is not embedded into nursing care. Holistic nursing care should include the spiritual care needs for the patient, and nurses need to be knowledgeable about the content of spiritual care and this includes participating in decision making discussions of spiritual care as implemented in practice. The CANE liaison assessment does not assess spirituality as a component, it could be argued that the CANE assessment is not truly holistic by definition and there is a danger of unexperienced nurses not including the spiritual needs of the

patient (Reynolds et al 2000). However, Narayanasamy (2006) suggested that spiritual and cultural needs are the responsibility of the nurse which requires a multidisciplinary and flexible approach in order for holistic care to be integrated into practice. In this case study, the liaison nurse had the experience of understanding the patient's spiritual needs and communicating with the team to provide holistic care.

Interpretation of findings

There is currently no research examining the effective communication in relation to the CANE assessment in liaison nursing, given that communication is one of the most important activities of daily living (Roper et al 1980) and the CANE assessment is commonly used in liaison nursing (Wood and Wand 2014). There is a gap in the research to understand the effectiveness of communication needs being met or unmet when the CANE assessment is used in liaison nursing (Hoogendijk et al 2014). Another gap in the research is looking at communication needs related to the CANE assessment using liaison models such as the Rapid, Assessment, Interface and Discharge (RAID) model which is starting to be implemented into liaison services to provide multidisciplinary holistic care. This could give a better understanding of the communication involved in the planning and implementation of the CANE assessment (Tadros et al (2013).

Conclusion

This paper can conclude that liaison nursing is holistic nursing and that the CANE assessment is holistic but to incorporate the spiritual needs of the individual, the nurse needs to use experience and knowledge to practice holistic nursing care. Holistic nursing should become embedded in nurses just as interventions become embedded (Coombs et al 2013). Experienced nurses practice holistic nursing by seeing that the whole is more than the sum of its parts, and by utilising their experiences to create holistic nursing (Boswell et al 2013). This paper has addressed the evidence for communication needs of the patient, the nurse, the multidisciplinary team and the patient's family (Herd and Rieben (2014). This paper has addressed communication barriers in nursing and the positive attitude towards patients that is needed to overcome communication barriers to provide holistic nursing care (Park and Song 2005). This paper concludes that the CANE assessment in liaison nursing can meet the communication needs of the patient but direct research needs to evidence this. Communication is fundamental for holistic nursing to be achieved (Dwamena et al 2012).

References

Apker J, Propp K, Ford W S and Hofmeister N (2006) Collaboration, credibility, compassion, and coordination: Professional nurse communication skills set in healthcare team interactions. Journal of Professional Nursing 22(3): 180-189

Armstrong-Esther C A, Sandilands M L and Miller D (1989) Attitudes and behaviours of nurses towards the elderly in an acute care setting. Journal of Advanced Nursing 14: 34-41

Baldwin R, Pratt H, Goring H, Marriott A and Roberts C (2004) Does a nurse-led mental health liaison service for older people reduce psychiatric morbidity in acute general medical wards? A randomised controlled trial. Age and Aging 33: 472-478

Boswell C, Cannon S B and Miller J (2013) Students' perceptions of holistic nursing care. Nursing Education Perspective 34(5): 329-333

Boyer P (1986) The 'empty' concept of traditional thinking: A semantic and pragmatic description. Man (New Series) 21: 50-64

Coleman V S and Bradshaw M (2007) Children's and young people's nursing in practice: A problem-based learning approach. Basingstoke: Palgrave Macmillan

Coombs T, Curtis J and Crookes P (2011) What is a comprehensive mental health assessment?: A review of the literature. International Journal of Mental Health Nursing 20: 364-370

Coombs T, Curtis J and Crookes P (2013) A comprehensive mental health nursing assessment: Variability of content in practice. Journal of Psychiatric and Mental Health Nursing 20: 150-155

Crome P and Phillipson C (2000) Assessment of need. Age and Aging 29: 479-480

Department of Health (2010) Essence of care: Benchmarks for communication

Department of Health (2012) Developing the culture of compassionate care: Creating a new vision for nurses, midwives and care-givers

Dossey B, Frisch N, Forker J A and Lavins J (1998) Evolving a blueprint for certification: Inventory of profesional activities and knowledge of a holistic nurse. Journal of Holistic Nursing 16(1): 33-36

Dulaney P E and Crawford G W (1988) Ten years in liaison nursing: Concepts, models, and conventional wisdom. Issues in Mental Health Nursing 9: 425-431

Dwamena F, Holmes-Rovner M, Gaulden C M, Jorgenson S, Sadigh G, Sikorski A, Lewin S, Smith R C, Coffey J, Olomu A and Beasley M (2012) Interventions for providers to promote a patient-centred approach on clinical consultations (Review). The Cochrane Collaboration (12): 1-180

Eschiti V S and Davis L A (2005) Holistic nursing: A way of being. The Oklahoma Nurse: 25-26

Eschiti V S and Struthers R (2004) The experience of indigenious traditional healing and cancer. Integrative Cancer Therapies 3(1): 13-23

Greaves S, Bhat M, Regan C, Qazi A, Miranda-Castillo C and Orrell M (2006) The unmet needs of referrals to old age psychiatry liaison services. Psycho-generiatria Polska 3(4): 175-182

Hancock G A, Reynolds T, Woods B, Thornicroft G and Orrell M (2003) The needs of older people with mental health problems according to the user, the carer, and the staff. International Journal of Geriatric Psychiatry 18: 803-811

Herd H A and Rieben M A (2014) Establishing the surgical nurse liaison role to improve patient and family member communication. AORN Journal: 594-599

Holmes J (2005) Liaison old age psychiatry. Psychiatry
4(2): 76-79

Hoogendijk E O, Muntinga M E, Leeuwen K M, Horst H E, Deeg D J, Frijters D H, Hermsen L A, Jansen A P, Nijpels G and Hout H (2014) Self-percieved met and unmet care needs of frail older adults in primary care. Archives of Gerontology and Geriatrics 58: 37-42

Houtjes W, Meijel B V, Deeg D J and Beekman A (2011) Unmet needs of outpatients with late-life depression: A comparison of patient, staff and carer perceptions. Journal of Affective Disorders 134: 242-248

Jochemsen H, Leeuwen R V, Post D and Tiesinga L J (2006) Spritual care: Implications for nurses' professional responsibility. Blackwell publishing Ltd: 875-884

Johnston M L and Cowman S (2008) An examination of the services provided by psychiatric consultation liaison nurses in a general hospital. Journal of Psychiatric and Mental Health Nursing 15: 500-507

Kolcaba K (2003) Comfort theory and practice: A vision for holistic healthcare and research. New York: Springer

Lyketsos C G, Dunn G, Kaminsky M J and Breakey W R (2002) Medical comorbidity in hospital inpatients: Relation to clinical outcomes and hospital length of stay. Psychosomatics 43(1): 24-30

Narayanasamy A (2006) The impact of empirical studies of spirituality and culture on nurse education. Blackwell publishing Ltd: 840-851

Nievaard A C (1987) Communication climate and patient care: Causes and effects of nurses' attitudes to patients. Social Sciences and Medicine 24(9): 777-784

Nursing and Midwifery Council (2008) The code: Standards of conduct, performance and ethics for nurses and midwives.

Nursing and Midwifery Council (2010) Standards for pre-registration nursing education.

Park E and Song M (2005) Communication barriers percieved by older patients and nurses. International Journal of Nursing Studies 42: 159-166

Priest H (2010) Effective psychological care for physically ill patients in hospital. Nursing Standards 24(44): 48-56

Reynolds T, Thornicroft G, Abas M, Woods B, Hoe J, Leese M and Orrell M (2000) Camberwell assessment of need for the elderly (CANE): Development, validity and reliability. The British Journal of Psychiatry 176: 444-452

Roberts D (1997) Liaison mental health nursing: Origins, definition and prospects. Journal of Advanced Nursing 25: 101-108

Roper N, Logan W and Tierney A (2000) The Roper-Logan-Tierney Model of Nursing: Based on activities of living. Edinburgh: Elsevier Health Sciences

Ruddy R and House A (2005) Meta-review of high-quality systematic reviews of interventions in key areas of liaison psychiatry. The British Journal of Psychiatry 187: 109-120

Sarafino E P (2006) Health Psychology: Biopsychosocial Interventions. (Fifth Edition Edition) Hoboken: John Wiley and Sons

Sharoff L (2008) Holistic nursing and medical-surgical nursing: A natural integration. MEDSURG Nursing 17(3): 206-208

Siddiqi N, House A U and Holmes J D (2006) Occurrence and outcome of delirium in medical in-patients: A systematic literature review. Age Aging 35: 350-364

Tadros G, Salama R A, Kingston P, Mustafa N, Johnson E, Pannell R and Hashmi M (2013) Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: The Birmingham RAID model. The Psychiatric Bulletin 37: 4-10

Vidan M T, Sanchez E, Alonso M, Montero B, Ortiz J and Serra J A (2009) An intervention integrated into daily clinical practice reduces the incidence of Delirium during hospitalization in elderly patients. The American Geriatrics Society: 2029-2036

Wood R and Wand A P (2014) The effectiveness of consultation-liaison psychiatry in the general hospital setting: A systematic review. Journal of Psychosomatic Research 76: 175-192