Mental Health Services 2010

Care Pathways Report

EXECUTIVE CATCHMENT AREA	Limerick, Clare, North Tipperary
HSE AREA	West
MENTAL HEALTH SERVICE	Approved Centre
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	10 September 2010

INTRODUCTION

In 2010, the Mental Health Commission examined the clinical files of two residents in two different approved centres in order to assess their care pathways. Two services, one in the East of the country and one in the West, were chosen.

Care pathways track residents' experience from time of referral through all aspects of the service received. They have been identified as a way of facilitating integration and continuity of care and multidisciplinary working (HSE Corporate Plan 2005-2008). Best practice in terms of care pathways was outlined in *A Vision for Change* (Department of Health and Children, 2006) and The Quality Framework (Mental Health Commission, 2007) which recommended the provision of a seamless range of community and hospital based services for people with mental ill-health.

PROFILE OF SERVICE

The acute unit was situated in a general hospital in the Health Service Executive West region.

The admission teams had access to multidisciplinary teams, although these were under-resourced in relation to the recommendations of *A Vision for Change*.

REFERRAL

The clinical files of two residents were examined.

Resident 1: The first resident was a single, middle aged male living alone who was diagnosed with depression and alcohol dependence. This resident's second admission was facilitated following a report from a concerned neighbour who felt the resident was not well. This concerned person had contacted the out-of-hours nursing service who gave advice on how to manage the situation. The gentleman was referred to the Emergency Department and was subsequently admitted. This was documented on a computer system, which allowed brief notes of resident contacts to be entered by staff working in different parts of the service. The resident was willing to return to hospital as he was afraid his condition would worsen if he did not. The resident complained that he had been anxious after his discharge and afraid of relapse. He was admitted on a voluntary basis.

This resident had first been admitted following referral by his general practitioner (GP).

Resident 2: was an elderly married woman with a diagnosis of schizophrenia who was admitted on an involuntary basis under section 14 and 15 of the Mental Health Act 2001. This followed an application being made by a family member to the resident's general practitioner. The family member was concerned that her relative was suffering a relapse of her psychosis and felt the family could not cope with her at home. The resident was unwilling to go to hospital on a voluntary basis.

She had been admitted on five occasions in the past, two of which were involuntary, for the treatment of schizophrenia.

ADMISSION

Resident 1: This gentleman's second admission was just four days prior to the day of inspection. According to his clinical file, a mental health assessment was completed by a non consultant hospital doctor (NCHD). A nursing assessment form had been completed by a student nurse.

There was no evidence in the clinical file that these assessments had been completed on first admission. During that admission he had been given a diagnosis of alcohol dependence and depression and had been seen by his consultant psychiatrist and social worker.

On his second admission, personal issues were identified and flagged for further investigation, although responsibility for this was not clear from the clinical file. A nurse had spent time talking to him and had provided education on alcohol abuse. The nurse had discussed the support group Alcoholics Anonymous (AA) with him and provided him with a leaflet about the organisation.

Resident 2: On admission, a mental health assessment form was completed by the non consultant hospital doctor and a nursing assessment form was completed by nursing staff.

Three days after her admission, issues with regard to the resident's safety were documented and a recommendation was made that there would be a referral be made to the social worker for elder abuse. Responsibility for this was not documented. Similar recommendations were made the following week. The reason for the delay was not documented. Reference was made to the family being distressed, but there was no plan documented for dealing with this. There was no reference to family education or ongoing support services for any family members in the clinical file.

A plan was discussed to contact the elder abuse social work service to address safety issues. A report was documented in the clinical file of the staff being threatened by the resident's family. An Garda Síochána were contacted. On a previous admission, a number of social services including An Garda Síochána had attended a pre-discharge case conference because of concern for the resident's safety.

The appropriate statutory form was completed indicating that the resident's involuntary status was confirmed by a Mental Health Tribunal.

There was evidence in the clinical file that the doctor on call attended for investigation of a physical complaint. There was evidence in the clinical file of laboratory investigations.

There was evidence that clinical staff listened to her family. Following a complaint about the resident's adverse reaction to medication, this was changed.

Risk assessments were not documented for either resident. Staff reported these were only done for the residents admitted by the rehabilitation team.

INDIVIDUAL CARE PLAN

Multidisciplinary care plans were in use in the approved centre. These incorporated residents' views about their individual care plans which were to be completed by the key worker prior to the multidisciplinary meeting. However, an examination of the clinical files for both residents showed that these individual care plans were being completed in a haphazard fashion. In particular the section on discharge had not being completed. On several occasions they were not signed, the key worker was not identified, or responsibility for goals and tasks was too generalised to be useful.

DISCHARGE GROUP

Neither resident attended a discharge group. The staff reported that discharge was discussed with residents on an individual basis.

Resident 1: During his first admission resident 1 was seen by his consultant psychiatrist and social worker. His discharge was discussed at the multidisciplinary team meeting. He was assigned a key worker and referred to a community mental health nurse and the medical outpatient department. There was no evidence in the clinical file that he had been referred to addiction services and no reason documented as to why this was not done. It was documented in the clinical file that the resident was anxious following discharge. He was discharged four days prior to readmission.

Resident 2: There was evidence of pre-discharge planning during her last admission; this resident's discharge was discussed at a multidisciplinary team meeting. A case conference was organised with community services to address issues of resident safety. Copies of discharge summaries to the resident's GP were in the clinical file. Referral had been made to the outpatients department and the community mental health nurses as well as the outreach service. Referral had been made to the elder abuse social work service and An Garda Síochána.

This family were unco-operative with the mental health team. This may have been the reason that no ongoing supportive services for the family were documented. However, it was not clear from the clinical files whether absence of support was cause or effect for their lack of co-operation.

VOCATIONAL PATHWAY

On a previous admission, resident 2 had been referred to the day hospital on discharge.

OTHER SERVICES

Resident 1: Attendance at Alcoholics Anonymous had been discussed with the resident on his second admission. No referral to the addiction counsellor was documented in his clinical file. No referrals to general community support services were documented. Reasons for this were not documented. Referral was made to the community mental health nurse, who had not had an opportunity to see him prior to re-referral.

Resident 2: General medical services were available to the resident. An Garda Síochána had been contacted when staff reported a threat made to them by a family member. A number of social and medical services had been involved in a case conference at the time of her previous admission.

PATIENT EXPERIENCE COMMENTS

Both residents were interviewed and stated they were happy with the service. They reported the staff were kind and the food was good. The female resident said she did not think previous admissions had helped her. With her permission, an attempt was made by the Inspectorate to speak by phone to her relatives, but they were not available.

OVERALL CONCLUSIONS

This was the first report of a mental health care pathway which had been undertaken by the Mental Health Commission Inspectorate. To facilitate this, two clinical files were reviewed. The review highlighted good referral and contact systems, with appropriate use of an information technology based resident contact system. Multidisciplinary care plans were in use by the service, but in many instances, they were incomplete. Discharge sections of the individual care plans often had no entries.

A gentleman with identified alcohol abuse and depression issues was admitted voluntarily to hospital. He was not referred to an appropriate counselling service on first admission. His addiction and other issues were identified on second admission. The reason for non referral was not documented.

A woman with enduring mental illness was admitted involuntarily on application by her family. There was no documentation to the effect that her family was aware that application could be made by an authorised officer under section 9 (1) (b) of the Mental Health Act 2001, thus relieving the family of the stress of having to make the application. When safety issues arose for the resident on a previous admission, there was good evidence that medical and social safety networks in the community were mobilised. However, there was no documentation of psycho-education or mental health support services provided family members and no reason for this was documented.

RECOMMENDATIONS 2010

1. Individual care plans should be completed.

2. A proactive out-reach service should be provided for families of people with enduring mental disorder. Steps should be taken to assess and address the needs of families through the provision of education, support and specialised services where necessary. This should be documented in the clinical file and where it does not happen, reasons should be documented.

3. Care should be taken to specify responsibility for identified interventions in the clinical notes.

4. Once need is identified, specialised services should be contacted as soon as possible.

5. Risk assessments should be completed on admission for all residents.

6. Addiction counsellors should be available to services users if indicated.