Mental Health Services 2010

Care Pathways Report 2010

EXECUTIVE CATCHMENT AREA	Dublin South East/Dun Laoghaire/Wicklow
HSE AREA	Dublin Mid-Leinster
MENTAL HEALTH SERVICE	Approved Centre
TYPE OF INSPECTION	Announced
DATE OF INSPECTION	4 November 2010

INTRODUCTION

In 2010, the Mental Health Commission Inspectorate undertook to examine the care pathways of two residents in two different services in order to better understand the service user experience of the mental health services. One service was in the East of the country and one in the West.

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 service was a Psychiatric unit in a General Hospital.

REFERRAL

Resident 1: was admitted about two weeks prior to the inspection. This was done on an involuntary basis with the help of the assisted admission team. He had been referred by his general practitioner (GP) who requested an urgent admission and this was accommodated.

Resident 2: was admitted after referral by her general practitioner (GP) and concern expressed by family members.

ADMISSION

Resident 1: was assessed by a psychiatrist on admission and then reviewed medically every two days. A risk assessment was completed. A nursing care and treatment plan was completed. This included an assessment for holistic needs. Some sections in this holistic needs assessment document were incomplete e.g. the entry opposite the section on ‘social circumstances’ was ‘nil’. There was evidence in the clinical file that nurses spoke to the resident providing support and continuous assessment of need.

Resident 2: was referred by her GP about one month prior to the day of inspection and was admitted through the Emergency Department. Having been assessed there by a triage nurse admission was arranged to the in-patient unit on a voluntary basis. A psychiatric assessment on admission was signed and dated. A risk assessment was not dated. A nursing treatment and care plan was given to the resident who signed it. A falls risk assessment was completed by nursing staff. The resident was seen by the NCHD on duty and reviewed medically daily or more frequently thereafter. The admission followed a letter of concern from the resident’s family, looking for more assistance in addition to that already provided.

INDIVIDUAL CARE PLAN

There were no individual care plans in the clinical files for resident 1.

There was little evidence of multidisciplinary meetings. Although staff informed the Inspectorate that these meetings did happen on a weekly basis, attendance was not recorded in the clinical file. There

was no record of multidisciplinary decision making. A nursing treatment care plan was completed. It was not signed by the resident and there was a written explanation for this.

There were no individual care plans for resident 2. A medical assessment was signed and dated. A risk assessment was signed but not dated. A nursing treatment care plan was given to and signed by the resident. There was reference in the clinical file to team meetings taking place, but attendance was only recorded once. There was an entry from the occupational therapist in the clinical file. There was reference to a meeting with the family by a member of the medical staff and to cognitive behaviour therapy being provided by a staff nurse. Nursing notes in the file referred to the resident's relatives visiting.

DISCHARGE GROUP

The service did not have discharge groups. Staff reported that residents were prepared for discharge on an individual basis. There was evidence of pre-discharge assessments for both residents in their clinical files. There was no evidence that community staff had been involved in the discharge of resident 1 following his previous admission although the GP had been informed within two days. There was no evidence that the family of resident 1 had been notified of his discharge.

There was a note in the clinical file that discharge had been discussed with resident 2. She had been discharged with one hours notice on the previous admission. The clinical reasons for this were documented as was staff contact with the resident's family. Follow-up appointments were given to both residents.

VOCATIONAL PATHWAY

Resident 1: had previously been offered a place at a day centre but did not attend. There was no evidence that he was offered an alternative. Staff reported that where residents refused to attend one centre there was no alternative available to them. At interview the resident‘s preference was not to attend services, but to stay at home.

Resident 2: was referred to the day hospital after a previous admission. There was evidence on the file of communication between the day hospital and GP when she failed to attend.

OTHER SERVICES

Resident 1: lived alone. However, until the time of the previous admission some months previously, he had lived with family. There was no evidence in either the in-patient or outpatient clinical files that family members had benefited from psycho-education or outreach supportive services. A social worker had provided some support some years earlier for a brief period. The handwritten social work notes in the file were densely written and hard to read. It was not possible to locate the community mental health nursing notes in the outpatient clinical file. There was no evidence of occupational therapy involvement at in-patient or outpatient level. Staff reported the resident had refused occupational therapy contact, but this was not documented in the clinical file.

Resident 2: was seen by a dentist and referred for assessment to the DETECT service, which was aimed at early intervention in psychosis. In addition, cognitive behaviour therapy had been offered as well as nutrition and dietetics services.

PATIENT EXPERIENCE COMMENTS

Both residents were offered an opportunity to speak to the Inspectorate.

- Resident 1 reported unhappiness at being in hospital which had not been helpful in the past. He said he did not know the members of his multidisciplinary team. He reported he did not like the day service and had not been offered an alternative.

- Staff reported that resident 2 did not wish to speak to the Inspectorate.

OVERALL CONCLUSIONS

Both residents were admitted to hospital promptly following referral by their GP. The first resident was admitted on an involuntary basis with the aid of the assisted admissions team. The second resident was referred via the Emergency Department following referral by their GP. Both had the benefit of holistic needs assessments by the nursing staff and psychiatric assessment and reviews by the medical staff.

Individual Care Plans as defined in the Mental Health Act 2001 (Approved Centre) Regulations 2006 were not being used for either resident. Staff reported that these Individual Care Plans were being piloted in the service, although they are a legal requirement since 2006. There was little record in the clinical files of multidisciplinary team meetings being held, or who attended them. There was little evidence that the multidisciplinary team contributed to the care of resident 1 either at in-patient or outpatient level. While this resident was offered a day care service following a previous discharge, there was no evidence of an alternative being available to the resident when he did not attend and professed not to like the particular service offered. There was no evidence in the file of supportive services being provided to concerned family members. A recovery based approach was not in evidence.

Resident 2 appeared to have received a wider range of services, which addressed the holistic needs of the resident. There were entries in the clinical files from the occupational therapy department, nutrition and dietetics and cognitive behavioural therapy as well as dentistry. A comprehensive family history had been obtained on a previous admission. Clinical files were well developed for in-resident services, less so for those residents attending the separate outpatient services.

RECOMMENDATIONS 2010

1. Individual care plans should be adopted by services in line with legal requirements.

2. The multidisciplinary team should contribute to residents care and this should be documented.

3. Holistic needs assessments should be meaningful and completed.

4. Care should be taken to ensure that clinical notes are legible. Consideration should be given to having these notes typed.

5. A variety of community services should be developed to facilitate service user's rehabilitation and recovery and this should be documented.

6. Information about family support services should be documented.