

Monitoring the Implementation of the Mental Health Acute Admission and Discharge ICP

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Overview



- Lanarkshire Context

Mental Health Admission and Discharge ICP:

- Audit Findings
- Variance Analysis

ICPs in Lanarkshire



- **1995:** Lanarkshire – surgical procedures at Law Hospital (now Wishaw General)
- **1996 – 1999:** 3-year Scottish Executive funded joint project (Lanarkshire and Glasgow) over 120 ICPs developed
- **1995 – 2007:** ICPs developed in acute hospitals, mental health, paediatrics, learning disabilities, community hospitals, NHS Lanarkshire-wide ICPs.
- **Currently 156 ICPs** in use or being developed

A screenshot of an NHS Integrated Care Pathway (ICP) form for 'Hip Fracture'. The form is blue and contains various fields for patient information, clinical observations, and care plans.A screenshot of an NHS Integrated Care Pathway (ICP) form for 'Hip Fracture'. The form is orange and contains various fields for patient information, clinical observations, and care plans.A screenshot of an NHS Integrated Care Pathway (ICP) form for 'Hip Fracture'. The form is green and contains various fields for patient information, clinical observations, and care plans.A screenshot of an NHS Integrated Care Pathway (ICP) form for 'Hip Fracture'. The form is yellow and contains various fields for patient information, clinical observations, and care plans.A screenshot of an NHS Integrated Care Pathway (ICP) form for 'Hip Fracture'. The form is pink and contains various fields for patient information, clinical observations, and care plans.

What do our ICPs consist of?

- A clear plan of the patient journey based on best practice
- An explicit statement of **who** carries out **what** tasks and **when** in the course of delivering care
- A form of clinical record integrating all disciplines in a single record
- Deviations from planned care can be analysed to see what **actually** happens in comparison to what is **expected** to happen

Why Develop this Mental Health ICP?



- **Lack of consistency** across services with similar / same function
- **Different documentation and procedures** for admissions and discharges across Inpatient Mental Health Services in NHS Lanarkshire
- **Need to standardise** high quality documentation across areas and ensure it meets local and national standards

Mental Health Acute Admission and Discharge ICP Development



- **March 2004** - ICP Development Group formed
- **April 2004** - Stakeholder events held
- **March 2005** - Version 1 ICP Pilot launched
- **June to Nov 2005** - Review of Version 1
- **Dec 2005** - Version 2 ICP launched
- **Jan 2007** - Version 2 ICP audited

Mental Health Acute Admission ICP



- Generic ICP for all patients admitted to Lanarkshire's 13 acute MH admission wards
- Details expected care from admission through to discharge
- Complete record of patient's current inpatient care
- Includes ALL medical, nursing and legal documentation and a record of all AHP and partner agency involvement

Inpatient Mental Health Services Integrated Care Pathway Nursing Admission Assessment		Patient Name: PIMS number: P <i>(or affix patient label)</i>
1 Hospital and Ward:		
Name and designation of Admitting Nurse: Information obtained from (please specify):	2 Admission date: 7 Admission time: <i>(24 hour clock)</i>	
Preferred name: Address: Postcode: <i>(Attach patient label)</i>	Source of Admission (e.g. GP, A&E, CPN): Admission Method: (please tick one only) From Home <input type="checkbox"/> <input checked="" type="checkbox"/> Inpatient Transfer Previous psychiatric admission in Lanarkshire? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, are previous case notes currently on the ward? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Phone number: Date of Birth: Age:	3 Consultant: 4 Named nurse: 5 Discharge Date: Date Discharge Date was set: (Clinical readiness date - applicable to Old Age Psychiatry)	
Legal Status on Admission? (Please tick one only) Informal <input type="checkbox"/> Formal <input type="checkbox"/> Please note: Legal status may change. For most up to date legal status, please refer to Legal Section of the ICP.		
General Practitioner: Name: Address: Phone number:	Referrer: Name of referrer and referring agency: Address: Phone number:	
Named Person: <i>(Mental Health (Care & Treatment) (Scotland) Act (2003))</i> Name and relationship: Address (include postcode): Telephone No: Consent to inform of admission? Yes <input type="checkbox"/> No <input type="checkbox"/>	Family Contact Name: <i>(Next of Kin)</i> Name and relationship: Address (include postcode): Telephone No: Consent to inform of admission? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Known Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please specify)	Physical Health Alerts: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please specify)	

ICP Audit January 2007

Why Audit the ICP?

- Fits with the programme of quality improvement within clinical governance
- Identify good practice
- Identify areas that require change
- To evaluate the ICP process which guides the order of clinical care to improve quality within resources available

Aim of Audit



To identify if the ICP documentation was in place and examine how well the process was being used by the multi-disciplinary team.

Process Followed

- Audit sub-group formed from ICP development group
- Piloted in one ward
- 13 inpatient wards involved - Adult/Old Age Psychiatry
- Sample size comprised of 50% of the bed occupancy at the start date of audit
- Only patients who had been in for more than 24 hours were eligible for the audit due to the requirement for mandatory assessments to be completed within specific timescales.
- Carried out by peer review. Person should have a working knowledge of the ICP documentation.

Structure of Audit

8 sections of ICP folder audited:

1. Front Section (3 sheets)
2. Admission Pathway (6 sheets)
3. Legal Section (1 sheet)
4. MDT Notes/Careplan (2 sheets)
5. Nursing/AHP Notes (1 sheet)
6. Medical Section (4 sheets)
7. Results Section (1 sheet)
8. Variance Analysis (1 sheet)
(Discharge omitted)

96

**QUESTIONS
IN TOTAL!**

(19 sheets audited)

Results

1. Number of sections in place
2. Mandatory assessments completed within timeframe
3. Discretionary assessments used
4. Multi-disciplinary team meeting details recorded
5. Variance recording completed
6. Supplementary documentation used

1. All sections of the ICP in place?

Percentage of sections in place	Adult MH	Old Age MH
100%	5 (26%)	10 (53%)
90+%	15 (79%)	16 (84%)

n = 19

2a. Mandatory assessments completed within timeframe?

Mandatory Nursing Assessments	Adult MH		Old Age MH	
	Completed	In Timeframe	Completed	In Timeframe
Weighted Risk Indicator (24 hours)	100%	96%	95%	77%
MH Presentation Checklist (24 hours)	99%	96%	93%	73%
Nursing Admission Checklist (6 hours)	97%	94%	93%	77%
Urinalysis (24 hours)	94%	77%	77%	59%
Waterlow Score (6 hrs)	94%	91%	98%	73%
Nutritional Assessment (24 hours)	76%	63%	84%	68%

n = 78 (Adult), 44 (Old Age)

2b. Mandatory assessments completed within timeframe?

Mandatory Medical Assessments	Adult MH		Old Age MH	
	Completed	In Timeframe	Completed	In Timeframe
Medical Clerk-in (6 hours)	94%	92%	100%	91%
Doctor's physical examination (12 hours)	91%	88%	100%	84%
Routine bloods taken (24 hours)	92%	85%	84%	68%

n = 78 (Adult), 44 (Old Age)

3. Top 5 Discretionary Assessments Used

Adult:

1. Alcohol Screening Questionnaire (FAST) – 33%
2. ZUNG Self Rating Depression Scale – 29%
3. Symptom Rating Scale – 28%
4. Mini Mental Health Examination (MMSE) – 15%
5. Hospital Anxiety and Depression Scale (HADS) – 14%

Old Age:

1. Moving and Handling Risk Assessment – 80%
2. Mini Mental Health Examination (MMSE) – 57%
3. Revised Elderly Persons Disability Scale (REPDS) – 50%
4. Falls Risk Assessment Score for the Elderly – 48%
5. Geriatric Depression Scale (GDS) – 43%

4. Multidisciplinary Team Meeting details

recorded? (Average of date of admission against date of first MDT meeting)

Adult Ward	Mean no. of days	Old Age Ward	Mean no. of days
1	4	1	6
2	6	2	6
3	3	3	5
4	3	4	5
5	5	5	6
6	3	6	5
7	7		

n = 78 (Adult), 44 (Old Age)

5. Variance Recording Completion



Results showed that variance recording tool was being used at the end of the process.

6. Supplementary Documents Used

Adult:

1. Weight Chart
2. Disclaimer Form
3. TPR Chart
4. BP Chart
5. Beck Inventory
6. Care Programme Approach
7. 3-day Asses. Care Plan
8. Clinical Global Impression Scale
9. CIWA Scale
10. Volition Questionnaire Form

Old Age:

1. Patient Activity Recording Sheet
2. Dem Tect Rating Scale
3. PAINAID
4. Diabetic Chart
5. Clinical Global Impression Scale

Summary of Results



- Snapshot from 50% of admissions
- Good compliance and engagement with process
- Room for improvement
- Some areas of process need further explanation to staff

Next Steps

Develop Version 3 of the ICP based on the results of the audit:

- Main changes required to process not content
- Need to reach 100% on Contents Section
- Need to amend documentation to aid mandatory assessment completion within timeframes
- Refine some assessments in use
- Education for staff on Variance completion

Variance Analysis 2006

Outcomes Based Variance Analysis



- Variations recorded on the pathway
- Part of the care provision
- Outcomes chosen by the ICP development group – based on guidelines, standards, local best practice
- Outcomes highlighted in bold and numbered throughout the pathway

Variance Analysis Form



Inpatient Mental Health Services
Integrated Care Pathway

Outcomes Based Variance Analysis Tool

PLEASE PRINT IN BLOCK CAPITALS

Q1 Name of Hospital and Ward:	Q2 Admission date: D D M M Y Y Y Y □□/□□/□□□□
Q3 Consultant: (enter full name)	Q4 Named Nurse: (enter full name)
Q5 Discharge date: D D M M Y Y Y Y □□/□□/□□□□	Q6 Ward transfers details for this admission: From: _____ To: _____ Date: _____

Please complete SECTION ONE in the first instance. If any 'no' answers are ticked, please go on to complete the relevant parts of SECTION TWO.

SECTION ONE	Yes	No	SECTION TWO
Q7 (a) Time of admission documented (agreed local best practice)	<input type="checkbox"/>	<input type="checkbox"/>	Q7 b) If no, please specify why not:
Q8 (a) Does the patient have a Named Person? Part 17 Chapter 1 Mental Health (Care and Treatment Scotland) Act 2003	<input type="checkbox"/>	<input type="checkbox"/>	Q8 b) If no, please specify why not: <input type="checkbox"/> Patient does not have a named person <input type="checkbox"/> Patient does not wish to have a named person <input type="checkbox"/> Other (please specify)
Q9 a) Patient's perception of presenting problems/needs recorded? Section 2, Admissions to Adult Mental Health inpatient services NQIS 2004	<input type="checkbox"/>	<input type="checkbox"/>	Q9 b) If no, please specify why not: <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Patient unwilling to co-operate <input type="checkbox"/> Other (please specify)
Q10 a) Carer's perception of presenting problems/needs recorded? Standard 5.2, Clinical Standards Schizophrenia CSBS 2001	<input type="checkbox"/>	<input type="checkbox"/>	Q10 b) If no, please specify why not: <input type="checkbox"/> Patient does not have a carer <input type="checkbox"/> Patient does not wish carer involvement <input type="checkbox"/> Carer not available/not present on admission <input type="checkbox"/> Carer does not wish to be involved <input type="checkbox"/> Other (please specify)
Q11 (a) Does the patient have an Advanced Statement? Section 275-276 Mental (care and Treatment Scotland) Act 2003	<input type="checkbox"/>	<input type="checkbox"/>	Q11 b) If no, please specify why not: <input type="checkbox"/> Patient has not made an advanced statement <input type="checkbox"/> Not applicable <input type="checkbox"/> Other (please specify)
Q12 a) Doctor informed of admission within 3hrs? (agreed local best practice)	<input type="checkbox"/>	<input type="checkbox"/>	Q12 b) If no, please specify why not: <input type="checkbox"/> Doctor unavailable <input type="checkbox"/> Other (please specify)

Please turn over and continue on the other side ➔

SECTION ONE	Yes	No	SECTION TWO
Q14 a) Mental Health Presentation Checklist undertaken within 24hrs of admission? (agreed local best practice)	<input type="checkbox"/>	<input type="checkbox"/>	Q14 b) If no, please specify why not: <input type="checkbox"/> Patient in less than 24 hours <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Other (please specify)
Q15 a) Weighted Risk Indicator undertaken within 24hrs of admission? Observation Policy, Mental Health Services Lanarkshire 2003	<input type="checkbox"/>	<input type="checkbox"/>	Q15 b) If no, please specify why not: <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Other (please specify)
Q16 a) Waterlow Assessment undertaken within 6hrs of admission? Section 2 - Pressure Ulcer Prevention, NMPDU 2002	<input type="checkbox"/>	<input type="checkbox"/>	Q16 b) If no, please specify why not: <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Other (please specify)
Q17 a) Malnutrition Universal Screening Tool (MUST) undertaken within 24hrs of admission Standard 2.1 Food, Fluid & Nutritional Care in Hospitals NQIS 2003	<input type="checkbox"/>	<input type="checkbox"/>	Q17 b) If no, please specify why not: <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Other (please specify)
Q18 a) Initial Care Plan formulated by Nurse, Patient, Carer and Named Person Section 4 Admissions to Adult Mental Health Inpatients Services, NQIS 2004	<input type="checkbox"/>	<input type="checkbox"/>	Q18 b) If no, please specify why not: <input type="checkbox"/> Unable to due to patient condition <input type="checkbox"/> Not all available <input type="checkbox"/> Other (please specify)
Q19 a) Patient given on discharge:- Discharge Summary Discharge Care Plan Risk Management Plan Section 6 - Admissions to Adult Mental Health Inpatients Services, NQIS 2004	<input type="checkbox"/>	<input type="checkbox"/>	Q19 b) If no, please specify why not: <input type="checkbox"/> Patient left the ward Against Medical Advice <input type="checkbox"/> Other (please specify)

On discharge please ensure that this form is fully completed and posted in the ICP box on the ward. If you have any questions please contact:

Data Collection

Hospital	2005 Discharges*	2005 Returns	2006 Discharges*	2006 Returns
A (1 ward)	89	42	94	33
B (2 wards)	140	53	139	80
C (2 wards)	692	168	651	239
D (1 ward)	38	10	63	9
E (2 wards)	767	372	674	389
F (2 wards)	215	30	183	86
G (3 wards)	694	408	758	506
TOTAL	2635	1083	2562	1342
		DM=10		DM=1
		1093		1343
% Return Rate		41.5%		52.4%

*Data Source: SMR04 May 2007 (Data are provisional) IS/NHSL

Data Analysis

Category	2005		2006	
	Number	Percentage	Number	Percentage
Time of admission documented	1065	98.7%	1321	98.4%
Patient has Named Person?	414	38.4%	304	22.6%
Patient perception recorded?	981	90.9%	1216	90.5%
Carer perception recorded?	480	44.5%	525	39.1%
Patient has Advanced Statement?	21	1.9%	29	2.2%
Doctor informed within 3hrs?	1063	98.5%	1318	98.1%
MH Checklist completed within 24hrs of admission?	996	92.3%	1284	95.6%
Risk Assessment completed within 24 hrs of admission?	1010	93.6%	1290	96.1%
Waterlow Pressure Ulcer Asses. completed within 6hrs?	989	91.7%	1260	93.8%

Does the Patient have a Named Person? (2006 data)



Yes	No	'No' Reasons (1014):
304 (22.6%)	1014 (75.5%)	<ol style="list-style-type: none">1. Patient does not have/wish a named person (889, 87.7%)2. Informal (1)3. Unknown at admission time (1)4. Patient non-communicative (1)5. Data missing (122, 12.0%)

(Part 17 Chapter 1 Mental Health Care and Treatment Scotland Act 2003)
n=1343, data missing=25 (1.9%)

Carer's perception of presenting problems/ needs recorded? (2006 data)

Yes	No	'No' Reasons (786):
525 (39.1%)	786 (58.5%)	<ol style="list-style-type: none">1. Patient does not have a carer (412, 52.4%)2. Carer not available/present (302, 38.4%)3. Patient does not wish carer involvement (26, 3.3%)4. Carer does not wish involvement (4)5. Carer distressed + needed 'time out' (1)6. Data missing (41, 5.2%)

(Standard 5.2, Clinical Standards Schizophrenia, CSBS 2001)
n=1343, data missing=32 (2.4%)

New for 2006 Data Collection: Nutritional Screening undertaken within 24 hrs?



Yes	No	'No' Reasons (354):
842 (62.7%)	354 (26.4%)	<ol style="list-style-type: none"> 1. Unable to due to patient condition (55) 2. Completed later (2) 3. Short length of stay/patient left AMA before completion (10) 4. Patient declined (11) 5. Scales not suitable (1) 6. Question not on sheet – old sheet used (76) 7. Not completed (1) 8. Not required/applicable (61) 9. Different tool used (31) 10. Tool not available (32) 11. Data missing (74)

*(Standard 2.1 Food, Fluid and Nutritional Care in Hospitals, NHS QIS 2004)
n=1343, data missing=147 (10.9%)*

New for 2006 Data Collection: Discharge Information given to Patient?



Yes	No	
662 (49.3%)	372 (27.7%)	Discharge Summary n = 1343, data missing = 309 (23.0%)
525 (39.1%)	414 (30.8%)	Care Plan n = 1343, data missing = 404 (30.1%)
458 (34.1%)	446 (33.2%)	Risk Management Plan n = 1343, data missing = 439 (32.7%)

(Section 6 Admissions to Adult Mental Health Inpatient Services, NQIS 2004)

Benefits to Date

- Standardisation of practice
- Implementation of guidelines (ongoing)
- Single multidisciplinary record of care
- Increased scrutiny of practice
- Removal of duplication
- Increased knowledge of ICPs and Variance Analysis
- Increased awareness of others roles
- Increased ease of transfer
- Ability to audit practice

Summarise

- **Before the ICP development:**
 - All of the people were doing something
 - Some of the people were doing everything
- **Since the ICP development:**
 - All of the people are doing everything **OR**
 - If they are not, they are documenting why not (apart from all those 'data missings' of course!)

Next Steps

- Report back
- Incorporate amendments required from audit and 2006 variance analysis
- Further define the questions
- Work on the 'data missings' and returns
- Staff education
- Keep improving!