Quality of Adult Inpatient Discharge Planning and 3 Day Follow Up – a Regional Audit

Dr Tajnin Mitu[1], Dr Anita Pierce[2], Dr Nehad Seddiq[3], Dr Asmaa Elsayed[1] and Dr Ishraq Elahi[1]*

[1]Betsi Cadwaladr University Health Board, Wrexham, United Kingdom; [2]Betsi Cadwaladr University Health Board, Rhyl, United Kingdom and [3]Betsi Cadwaladr University Health Board, Bangor, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.561

Aims. This study aimed to assess the post-discharge follow-up processes for psychiatric patients, specifically focusing on a 72-hour follow-up with documented Mental State Examination (MSE) and the presence of a comprehensive care plan, including up-to-date risk assessments and handover documentation.
Methods. Conducted across three psychiatric units – Heddfan, Ablett, and Hergest – and associated Community Mental Health Team (CMHT) sites within Betsi Cadwaladr University Health Board, the audit spanned eight weeks (14/08/2023 to 16/10/2023). Adhering to NICE guidelines (NG-53) and CCQI Standards for Community-Based Mental Health Services-2017, data collection focused on the specified criteria.
Results. Analysis revealed that 23% of patients did not receive a 72-hour follow-up post-discharge, attributed to reasons such as patient refusal or missed appointments. Only 74% of patients had documented risk assessments, posing challenges to follow-up teams. Despite the hospital's controlled environment, transitioning patients into the community demands updated risk assessments. While 87% of patients had documented mental state examinations during follow-ups, there's room for improvement in this crucial activity.
Conclusion. In summary, the study emphasizes the importance of meticulous documentation and communication in the transition from inpatient psychiatric care to community settings. Challenges in achieving comprehensive follow-up documentation, with only 67% meeting criteria, were identified. The presence of an online Medication Therapy and Electronic Discharge system faced obstacles in printout availability. Designating a responsible individual for care plans pre-discharge and commendable adherence to thorough assessments during inpatient stays (83%) underscore efforts for a holistic approach. Future enhancements should target improving medication information integration and fortifying collaboration between inpatient and community teams. Addressing these aspects not only prevents medication-related errors but also ensures a seamless and patient-focused transition, enhancing the overall quality of mental health care delivery.

Additional Authors: Dr Minahil Junaid, Betsi Cadwaladr University Health Board, Rhyl; Dr Moheet Rahal, Betsi Cadwaladr University Health Board, Rhyl; Dr Aanika Nawr Hoque, Betsi Cadwaladr University Health Board, Wrexham; Raghdah Faisal, Betsi Cadwaladr University Health Board, Bangor, Amin Rezk, Betsi Cadwaladr University Health Board, Wrexham; Mostafa Negm, Betsi Cadwaladr University Health Board, Wrexham.

Carer Engagement and Support in North and West Kent Rehabilitation Services

Dr Ahmed Elshafei*, Dr Martina Heisig and Dr Amanda Fuller

KMPT NHS Trust, Maidstone, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.562

Aims. To compare current practice in local Rehabilitation in audit across North and West Rehab Kent units against standards of 'Triangle of Care'.

Standard 1.3:
Carer's views and knowledge are sought throughout the assessment and treatment process.

Standard 5.2:
An early formal appointment is offered to the carer to hear their story, and history and address the carer's concerns.

Standard 5.10:
The carer is involved in the discharge planning process.

A previous audit was conducted in 2019 using Triangle of Care and AIMS standards. We decided to see whether the standards have been upheld.
Methods. We included all 43 patients admitted over the previous 6-months. No patient had National Opt-Out. The source of information was the RIO system. The data were analysed by 2 investigators.

A data collection form was used:
Question for Standard 1.3: Were the carer's views and knowledge sought throughout the assessment and treatment process? If this was not the case, the reasons were to be specified.

Question for standard Standard 5.2: Was an early formal appointment offered to the carer to hear their story history and address the carer's concerns?

Question for standard Standard 5.10: Was the carer involved in the discharge planning process?
Results.

Standard 1.3:
83.72% had contact with a variety of team members throughout their relative's admission. Reasons for non-involvement included lack of consent, unavailable carers, non-attendance, and carer's preference.

Standard 5.2:
Only 60.53% of carers had an early appointment offer, and the expectation that this should occur in 80% of cases was unmet.

Standard 5.10:
(90%) of the patients had carers involved in the discharge planning process, meeting the required standard.
Conclusion.

Best Practice:
The audit results demonstrate that carers are involved in their relative's care throughout the admission and discharge process.

Lessons learned:
Compared with the previous audit in 2019, when the criteria for Standard 5.2 were met, carers were offered a formal early meeting significantly less often. Possible reasons could be the pandemic and resulting changes in practice have certainly led to a reduction in face-to-face meetings. Offering individual time to all carers is essential, and efforts should be made to integrate this into practice.

Next steps:
To allocate a team member to offer a meeting with the carer.