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

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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.

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Carer Engagement and Support in North and West Kent Rehabilitation Services

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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.

To discuss the outcomes with the Carer Champions on each unit, to review what form their support currently takes, and consider how this could link in with the requirements of Standard 5.2.

To re-audit in 1 year.

Prescribing and Monitoring of Pychotropic Medications in a CAMHS Inpatient Service

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Aims. To ensure that there is a clear rationale for commencing service users on psychotropic medications.

To ensure that the prescription of psychotropic medications is evidence-based and that they are in line with the Trusts and NICE guidelines.

Ensure that psychotropic medications are regularly reviewed by the managing team.

To ensure that information about medications is adequately shared with patients and carers.

To ensure that service users are well-monitored for side effects.

Methods. A 2-week retrospective audit on Phoenix ward.

Clinical information from all the current service users on psychotropic medication was reviewed.

The clinical information was collated from all 8 service users' medication cards, ward round documents, MDT reviews, and electronic notes (PARIS), and these were analyzed by the inpatient specialty registrar.

Results.

1. We attained a 100% mark in some areas of our prescribing such as indicating the rationale, the maximum dose for medication, and also prescribing within BNF limits.
2. We however could not evidence proper information sharing with patients (only 40% documented).
3. We could not evidence sufficient information sharing with carers (only 20% documented).
4. PRN medication was mostly prescribed as a range rather than a clear dose, which gave rise to subjective dispensing bias.
5. Side effect monitoring was documented for 85% of patients, meanwhile, the standard for this is 100%.

Conclusion. Clinicians are to ensure that medication information is always shared with service users, and their carers, and this is documented.

Clinicians are to also ensure that PRN medications are prescribed as a single dose rather than as a dose range.

Ward staff are to ensure that they are monitoring side effects and documenting these clearly on electronic notes and ward round documents.

The MDT is to ensure that all regular and PRN medications are reviewed regularly during ward rounds.

Present this audit, share relevant findings with the clinical team, and monitor the implementation of the action plans by doing a reaudit in 6 months.

A Complete Audit Cycle of the Recording of the Baby's and Their Siblings' Age, Date of Births and Due Dates of Pregnant Mothers During the Initial Assessment Process for Patients Presenting to a Community Perinatal Mental Health Services

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Aims.

- To find out the proportion of patients for whom the dates of births of their children, age and their due date were recorded during their initial assessment as a means of reducing risks through safeguarding.
- According to the Royal College of Psychiatrists: Standards for Community Perinatal Mental Health Services 5th Edition (2020), Under Section 5 – Rights, Infant Welfare and Safeguarding: during the initial assessment, the baby's age and date of birth and mother's due date should be recorded as part of the infants' physical and emotional care needs assessment.

Methods.

- All new patients discussed during multidisciplinary team meetings within a 2 month period from 01/08/2023 to 30/09/2023 were identified
- Their clinical records were audited.
- This information was cross-checked with the information provided on their referral letters.
- Patients attending preconception counselling were excluded.
- The initial results were presented in one of the multidisciplinary team meetings.
- The recording of the children's ages, date of birth or due dates of their mothers was re-audited two months later.

Results.

Audit

- A total of 70 new patients were discussed within the initial two months period.
- 25 out of the 70 (36%) did not attend their appointments and two patients (3%) cancelled their appointment.
- 1 patient who attended for preconception counselling was excluded.
- Of the remaining 42 patients that were assessed, 6 (14%) were primigravida while 36 (86%) patients were multiparous patients.
- 15 out of the 42 (36%) had their children's age, dates of birth and due date recorded while 27 out of the 42 (64%) lacked this record.

Re-audit

- A total of 65 patients were identified during the re-audit period
- 18 out of the 65 patients (28%) did not attend their appointment and one patient cancelled her appointment.
- One patient that attended for preconception counselling was excluded from the re-audit process.
- Of the remaining 45 patients that were assessed, 2 (4%) were primigravida and the remaining 43 (96%) were multiparous women.
- The age, dates of birth and the due date were recorded for 26 (58%) out of 45 patients while 19 out of the 45 patients (42%) did not have this record.