

Treat as One

Bridging the gap between mental and physical healthcare in general hospitals



Principal recommendations

In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand both within working hours and out-of-hours so that they can participate as part of the multidisciplinary team.

All hospital staff who have interaction with patients, including clinical, clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace based continued professional development.

Patients who present with known co-existing mental health conditions should have them documented and assessed

along with any other clinical conditions that have brought them to hospital. And when seen by mental health services (liaison psychiatry) the review should provide clear and concise documented plans in the general hospital notes at the time of assessment.

National guidelines should be developed outlining the expectations of general hospital staff in the management of mental health conditions, such as the point at which a referral to liaison psychiatry should be made and what triggers the referral.

Record sharing (paper or electronic) between mental health hospitals and general hospitals needs to be improved. As a minimum patients should not be transferred between the different hospitals without copies of all relevant notes accompanying the patient.



Summary

This study aimed to identify and explore remediable factors in the quality of mental health and physical health care provided to patients with significant mental health conditions who were admitted to a general hospital with physical illness. This acute care pathway is one important part of the healthcare experienced by those with mental health conditions. Both the clinical aspects and the organisation of care were assessed.

Most of the admissions to hospital (351/552; 63.6%) occurred through the Emergency Department (ED), while 80 (14.5%) patients were referred by their GP and 57 (10.3%) were transferred from a mental health or another general hospital. 164/413 (39.7%) of patients were current smokers, 104/552 (18.8%) had a history of alcohol misuse and 88/552 (15.9%) of substance misuse. Case reviewers were of the opinion that the ED notes should have but did not mention the mental health condition in 47/96 patients at triage and 24/47 patients at a subsequent senior review. Of the patients presenting to the ED, 55 were referred to liaison psychiatry, following which 32 patients were seen by liaison psychiatry in an appropriate time. The lack of liaison psychiatry input in the ED affected the overall quality of care of 20 patients.

The medical clerking on admission to a hospital ward lacked adequate mental health history in 101/471 (21.4%) patients. In addition, medicines reconciliation occurred at this stage in only 206/531 (38.9%) patients and mental health medications were prescribed in only 331/431 (72.2%). Drug interactions are an important aspect of care in this group of patients but were noted in 51/279 (18.3%) patients.

Mental health risk assessments were recorded in only a third of patients, 161/476 (33.8%). An adequate risk management plan should be available to the treating team, but was provided in only 106/224 (47.3%) of these patients. Assessment and management of mental capacity often requires careful attention in this group of patients. However, it was noted in only 66/479 (13.8%) patients during initial assessment. After their initial physical assessment 103/458 (22.5%) patients were referred to the liaison psychiatry team. Of those patients who were not referred, 30/301 (10.0%) should have been at this time and their care was believed to have been impacted as a result.

A liaison psychiatry team reviewed 256/552 (46.4%) patients during their hospital stay. There was room for improvement in the following aspects: mental health risk assessment (22/125; 17.6%), mental capacity assessments (11/53; 20.8%), prescription of medications (11/48; 22.9%) and advice to nursing staff (20/86; 23.3%). However, the first assessment by liaison psychiatry was substantially delayed according to the reviewers in 74/199 (37.2%) patients. This impacted the quality of care in 22/51 patients. The most common reason for the

delay in the liaison psychiatry assessment was that “the liaison psychiatry team would not attend until the patient was declared medically fit” (26/74).

Only a small proportion of patients admitted to a general hospital require detention under mental health legislation. However, appropriate procedures and documentation should be used on each occasion. In this study, 65/541 (12.0%) patients were detained using mental health legislation. In 15/65 of these patients there were issues in the documentation of the process.

The practicalities of ensuring safety saw security staff involved with patients in 23 cases, however in over fifth of those patients was there thought to be room for improvement in this process. A small minority of patients 13/552 required use of physical restraint.

Multidisciplinary discharge planning has an important role to play in patients with complex physical and mental health needs. It took place in 209/423 (49.4%) patients discharged from hospital. Management plans for the patient changed following MDT meetings in 45/107 patients for whom an MDT meeting was documented, demonstrating their value in discharge planning. However, liaison psychiatry were involved in the MDT meeting in only 20/107 (18.7%) of these. Delayed discharges occurred in 65/443 (14.7%) patients.

Each discharge summary should have all relevant medical information, but lacked the mental health diagnosis in 95/343 (27.9%) and details of the mental health medications in 90/308 (29.2%). We found that no discharge summaries were copied to the relevant out of hospital psychiatry consultant.

The overall quality of care was rated by the reviewers as good in 46.0% (252/548) of cases reviewed. Examples of good clinical practice were noted for 17.9% (93/521) of patients in this study. However, 23.7% (130/548) of the case notes reviewed had room for improvement in clinical care and 16.1% (88/548) had room for improvement in the organisation of care. Room for improvement in both clinical and organisational aspects of care was noted in a further 11.7% (64/548) of the cases reviewed. Similar figures were seen when the quality of mental healthcare data was analysed separately.

Good practice in the quality of mental healthcare was demonstrated in 40.8% (20/49) of cases from hospitals with no liaison psychiatry team; in 46.2% (97/210) of cases with non-PLAN accredited liaison psychiatry team and in 59.8% (58/97) of hospitals with a PLAN accredited liaison psychiatry team. The effect of having a liaison psychiatry team, especially one which was PLAN accredited was positively associated with better quality of care.
