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Care plans in community mental health: an audit focusing on people with recent hospital admissions

Keywords: Community Mental Health Services; mental disorders; patient care planning; consumer participation; clinical audit.

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Abstract

Care planning is a key requirement for recovery-focused mental health care. Audit tools are available so that services can assess their alignment with accepted care planning standards but few benchmarks are available, especially for health services outside the United Kingdom. To assess implementation of recommended care planning in an Australian mental health setting for people recently hospitalised, a sample of service user records was audited against care plan requirements. Of 164 eligible records, 113 (69%) showed a care plan. Of the 113 care plans, 40 (35%) contained a risk assessment and 1 (1%) a crisis management plan. Thirty five (31%) contained some social needs assessment, 1 (1%) contained a physical health assessment, and 53 (47%) identified a primary healthcare physician. This audit indicated a large gap between recommendations and actual practice. Similar audits in other health services are required. Action is needed to integrate care planning into behavioural health practice.

Introduction

Care planning is a key requirement for recovery-focused mental health care.^{1,2} with care plans widely regarded as crucial, fundamental and largely successful guides in managing the complex problems of people with mental illnesses.^{3,4} Various mental health policies internationally mandate that care plans must be created for all people using mental health services. As well, care planning approaches have been developed worldwide to provide comprehensive assessment and holistic management of the person's illnesses and social needs using a multidisciplinary approach and involvement of the service user. Care planning generally begins with assessment of mental, social and physical needs, and then care activities and coordinating services are formulated to address the identified needs.

The Care Programme Approach (CPA) of the Department of Health in the United Kingdom (UK)⁴⁻⁶ is an internationally acknowledged care planning framework, consistent with a recovery model of care and accompanied by an associated care plan audit tool.⁷ A similar approach, the Mental Health Care Plan was introduced in 2010 in South Australia (SA). The SA health authority affirmed the requirement that services adopt the care plan with procedural documents containing the “directive that all consumers of mental health services must have a current care plan that can be accessed on [the IT system]”. An information booklet⁸ was also distributed with the intention that the Mental Health Care Plan “will be implemented in all regions as tools for consistent and transparent care”.

Benefits from such initiatives are seen only if people with mental illnesses actually receive care planning and the care plans are created and enacted as intended. It is known that various categories of care delivery fall short of best practice in mental health⁹⁻¹³ and that care planning and coordination are often poorly delivered in health care generally.¹⁴⁻¹⁷ It is therefore important to assess whether mandated mental health care planning is actually being delivered in health services. Quality audits using samples of documented care plans can be

used to indicate how well care planning is delivered by services, and use of standard audit tools facilitates quality improvement and benchmarking.

Study aim: The study aim was therefore to assess a sample of mental health care plans in an area of metropolitan SA against accepted quality standards, to recommend on improvements where necessary, and to contribute to national and international benchmarking and quality improvement in care planning.^{4,5,18,19} The focus population was people assigned to community care but who also had mental health-related hospital admissions, a priority group because an important aim of care planning is to reduce hospitalisations. As assessment of mental, social and physical needs is the important first care planning step and must be conducted thoroughly as the basis to identify needs and develop planned action, this preliminary study focused primarily on this step of care planning.

Methods

Ethical issues

This audit was classified as low risk and was approved by Southern Adelaide Clinical Human Research Ethics Committee (Application 42.14, approved 12/03/2014).

Setting

Australian state governments deliver the public sector mental health care used by most people with severe mental illness. Specialist acute care and outpatient consultations are delivered by public hospitals, and community care by community and residential mental health care services. This audit was conducted by sampling records for all adults who were mental health inpatients in an acute facility in Southern Adelaide, SA during a specific time period, 1st October 2013 to 31st December 2013. Eligible records related to those patients who had also been service users of community mental health services (where care plans are developed and recorded in the shared IT system) for at least 12 months prior to the inpatient admission.

Information for the audit was extracted from the electronic patient records system, which integrates community and hospital records and which specifically provides a mental health care plan template.

Audit questions

The CPA (CPA-BAT) was used as the basis for the audit.⁷ This tool provides for assessment of the following components of care planning: systematic assessment of the health and social care needs of the service user, design of a package of care agreed with members of the multi-disciplinary team, GPs, service users and their carers, and regular review and monitoring. It has been used previously for similar auditing purposes.¹⁹ The full CPA-BAT consists of two parts: an audit of the care plan in the service user's case notes, and an interview with the service user.

This study focused on care plans recorded in case notes. In identifying a care plan, the study used the criterion from the CPA-BAT that the care plan "should be easily accessible". The clinician researcher searched fields in the shared electronic record designated for care planning.

For this study, care plan audit items were selected corresponding to published recommendations for SA.⁸ Presence or absence of the following was therefore recorded for each care plan identified.

1. Mental health needs
 - a. An assessment of the current risk
 - b. A clear contingency and crisis management plan
2. Social health needs
 - a. An assessment of the smoking/alcohol/substance abuse
 - b. An assessment of the housing/living needs
 - c. An assessment of the family/relationship needs

- d. An assessment of the employment/financial needs
 - e. An assessment of activities of daily living (ADL)
3. Physical health needs
- a. A physical health assessment
 - b. Details of the person's general practitioner (GP) or primary care physician
4. Need for action

The proportion of assessments meeting pre-defined criteria indicating need for planned action was noted. The criteria were based on existing risk scoring for mental and social health and physical health measures shown in the case notes. Case note scoring for mental health and social health used a 1 to 4 scale with higher scores indicating greater risk. Mental health risk included suicide or self-harm, violence or aggression, absconding, and vulnerability to harm. Social health risk included substance abuse, housing and living needs, relationship assessment, work and financial needs, and needs associated with activities of daily living. Risk scores of 3 on the 4-point scale for any two risks or 4 for any one risk met audit criteria as needing action. Social health scores of 2 or more met audit criteria as needing action. Physical health assessments recorded in case notes met audit criteria as needing action if measures showed blood pressure >140/90 mmHg, or pulse >100 BPM, or body mass index >25 kg/m², or waist circumference >90 cm or random blood sugar level >7 mmol/L.

Data recording and analysis

Data was recorded on MS Excel 2010 (Microsoft, USA). Statistical analyses were performed using MS Excel 2010 (Microsoft, USA) and SPSS Statistics 19 (IBM, USA).

Results

Care plans in patient records

A total of 177 adult patients were admitted and discharged to the sampled facility during the inclusion period. Of these, 7 were readmitted and therefore not assigned to community mental health services in the audit period. Records for the remaining 170 patients included 6 with no existing care plan and with refusal or unwillingness on the part of the person with mental illness recorded as the reason, 51 with no existing care plan and without a reason provided, and 113 with a care plan. Discounting the records for those not wanting to have care plans, 113 of 164 eligible records therefor showed a care plan (69%) at the time of audit.

Patient profile for records with care plans

The main characteristics of the sample population are listed in Table 1. Fifty eight percent of the patients were male. Records showed 80.5% of patients as non-Indigenous, 3.5 % as Indigenous Australians, and 16% without ethnicity adequately described.

Primary diagnoses, as noted in case notes or care plan were mainly psychoses (schizophrenia, schizoaffective disorder, psychosis not specified, and psychosis.)

The mean age of patients was 39 years (standard deviation (SD) 12).

Table 1

Information extracted for records with care plan

Assessment, crisis plan and GP (primary care physician) information recorded in the 113 care plans which were found is summarised in Table 2.

In relation to risk assessment and crisis planning, current risk assessment was shown in 40 plans (35%) and a clear crisis management plan, including the details of who to contact in the event of acute crisis, was shown for 1 (1%).

In relation to social health assessments, some social needs assessment was shown in 35 care plans (31%) and the full audited range of assessments was shown for 34 (30%).

In relation to physical health assessment, physical health assessment was shown in one care plan (1%) and a GP (primary care physician) identified in 53 (47%).

Table 2

Where care plans showed assessments, these were classified as requiring action in 14 of 40 risk assessments (35%), 13 of 35 substance abuse assessments (37%), 9 of 35 housing assessments (26%), 18 of 34 relationship assessments (53%), 12 of 34 financial assessments (35%) and 10 of ADL assessments (29%). A single assessment of physical health was also classified as requiring action.

Discussion

Summary

The aim for this study was to make an initial evaluation of community mental health care plans in an area of Australia, for people with recent hospitalizations and focusing particularly on recorded assessment of the person's needs. This audit indicates a large implementation gap between care planning recommendations and what occurs in practice. Excluding records for those who refused care planning, only 69% of sampled records had a mental health care plan available at the time of the audit. Where care plans were available, individual recommended assessments were more often missing than present. As well, a crisis plan was found in only one plan and a GP (primary care physician) identified in less than half. For care plans that were available, actions frequently appeared necessary for audited assessments, indicating that it would be worthwhile to extend auditing to sections of the care plan which record actions and referrals.

Relationship to other evidence

This study is the first formal audit of mental health care planning in Australia to authors' knowledge but findings are consistent with shortfalls noted in mental health care plan audits from the UK^{5,19} and care planning in other fields,^{20,21} especially in initial audits. While broad care planning in mental health is under-studied, there have been several studies focusing particularly on monitoring for physical health care needs. The need for this has been repeatedly highlighted^{13,22-24} but findings of the study reported here mirror other findings in Australia and internationally of suboptimal in-practice physical health screening and monitoring in people with mental illness.^{25,26}

Limitations

This audit was conducted using a sample and in one inpatient service only. It is possible that case records for patients hospitalised for the sampled period were not representative of these mental health patients more generally in the service. Though it may not reflect mental health care planning more generally in Australia, there is nothing to suggest that this service was atypical in the quality of care planning. Other audits are needed for further benchmarking and to underpin collaborative efforts in implementation.

This study used care plans provided in patient records as proxies for the existence and quality of actual of care planning. It may be that care plans were created but not formally recorded or were stored elsewhere. However, plans need to be easily accessible in the designated location to all providers especially including the patient as a basis for coordinated care provision in line with plans. Unrecorded or inaccessible plans do not meet the needs of care planning.

This study assessed only part of the care planning process; the assessment of needs. Further studies to audit the quality of care plans are planned, based on the outcomes of this preliminary study. Assessment is the first necessary step in development of a care plan and if

this information is lacking, as demonstrated in this study, effective planned action is arguably unlikely and extended auditing unlikely to yield useful information.

Interpretation

The most obvious inference from this audit is the need for targeted action to better implement care planning guidelines and recommendations. Producing broad guidelines and mandating their use has not ensured that all service users have an accessible care plan, or, for those who do have an accessible plan, plans which are consistent with guidelines. In the setting for this study, there appeared to be no formal organisational plans, supports or checks to facilitate implementation. Health service implementation frameworks confirm that guidelines and recommendations alone are insufficient. A defined implementable care planning intervention, supportive service settings, staff ready and able to perform care planning, and a deliberate implementation process are also needed.^{27,28} Care planning interventions are available for use in mental health.^{29,30}

Other studies indicate barriers to practice-change for recovery-oriented care which the implementation plans should target. While creating and updating care plans collaboratively with patients may seem straightforward, complex barriers to shared decision-making have been identified within mental health care.^{31,32} Barriers include the accepted norms of clinical practice and lack of organisational supports for practice-change, therefore training and clinician involvement in identifying barriers and in explicit organisational support are suggested implementation strategies.^{33,34}

Where care plans were found in this study, there was low compliance with recommendations on assessments of needs. Only 35% of care plans found showed risks assessment. Risk assessments are considered an essential and ongoing element of care plans.⁴ Similarly, with one exception care plans did not list a crisis plan nor provided contact numbers for care coordinators or services. Recommendations for care plan include listing actions to be taken in

order to prevent the development of crisis and actions that to be taken in the event of crisis.⁷ Particularly, contact details of the care coordinator or staff or the services are needed so that the service user can access services as planned in the event of crisis. Researchers noted that the care plan template being used by this service did not have a clear framework for contingency or crisis management plans, creating an immediate barrier to including these plans. About 30% of care plans showed assessments of social health needs. Social health and recovery are interdependent in mental health with recovery unlikely where a person with mental illness has constant struggles with unmet social needs. Guidelines specify social needs assessment in care plans including housing, employment and substance use.⁸ It should be noted that many service users would also have non-government agencies providing additional psychosocial support. It may be that these agencies would have separately recorded assessments of social needs that could be brought into a central care plan. Furthermore, with one exception, care plans did not show physical health assessments in spite of consistent national and international statements. The GP (primary care physician) is often a key provider in taking action on physical health. However only about half of care plans audited identified this provider. While many people with mental illness may not have a regular GP (primary care physician), plans also did not note or plan services to deal with this.

Missing care plans and missing elements in care plan assessments raise questions about consistency of care delivery in relation to risk, social health, and physical health. Further audits could be used to check for recorded action in these areas.

It should also be noted that often many external agencies provide care for service users in community mental health services inclusive of GPs (primary care physicians) and non-government providers. There is no consistent care plan document or care plan framework across these multiple agencies in South Australia, which likely contributes to communication problems and possible unnecessary duplication.

Important care planning requirements not addressed by this audit relate to support for self-management and recovery. Practices, and even guidelines, often do not genuinely provide these supports. For example, while reference is made to inclusion of the consumer, the SA policy and booklet ⁸ direct the clinician to develop the goals and direct that goals and plans deal with the areas identified by the service using a battery of measurement scales.

Requirements for care planning processes that involve the person, and follow up self-management supports that motivate behaviour change, have been clarified.^{35,36} These provide a basis for future work evaluating care planning processes and self-management support.

Conclusion

Consistent with studies in other jurisdictions, a large gap between recommendations and actual practice was seen in this audit of mental health care plans.

Implications for Behavioural Health

Behavioural health services delivering recovery-focused care need to initiate and use care plans. This study suggests that they also need to audit the quality of plans and, if necessary, identify and address barriers to quality care planning.

Conflict of interest: Authors declare no conflict of interest.

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Table 1

Sample demographics for patient records with care plans (N=113)

Patient characteristics		Number	Percent
Sex			
	Male	66	58
	Female	47	42
Ethnicity			0
	Indigenous	4	4
	Non indigenous	91	81
	Not adequately described	18	16
Diagnosis			0
	Psychotic spectrum disorders	62	55
	Bipolar affective	16	14
	Depression	6	5
	Adjustment disorder	13	12
	Other	16	14

Table 2

Information provided in care plans (N=113)

Audit item	Number	Percent of 113 care plans	Percent of 164 eligible records
Mental health risk and crisis plan:			
- current risk	40	35	24
- clear contingency and crisis management plan	1	1	1
Social health needs assessments [‡] :			
- smoking/alcohol/substance abuse	35	31	21
- housing/living needs	35	31	21
- family/relationship needs	34	30	21
- employment/financial needs	34	30	21
- ADL	34	30	21
Physical health needs assessments:			
- physical health assessment*	1	1	1
- details of patient's GP (primary care physician)	53	47	32

[‡] Eg using Health of the Nation's Outcome Scores (HoNOS)

* Eg record of any of blood pressure, pulse, body mass index, waist circumference, blood sugar level