The physical health of residents of long-stay wards in Carlow/Kilkenny

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Abstract

Objectives: This audit is supported by regulations within the Mental Health Act 2001. It is in response to the Mental Health Commission Strategic Priority Number One, Quality Framework, 2002-2008 which aims to promote high standards of physical examination in the care of long-stay residents of psychiatric facilities. It is based on improved awareness of adverse effects of mental illness or its treatment on physical health. This awareness informs better practice.

Method: Physical examination proforma and case notes of all long-stay residents in wards in Carlow and Kilkenny were assessed over a six month period to examine the quality of physical examination. Following departmental meetings and literature review, standards of care as recommended by the Royal College of Psychiatrists in Occasional Paper 67 and Irish statutory documents were agreed to be the appropriate benchmark.

Results: Areas of strength were the examination of 'routine' systems (≥ 92%), ie. cardiovascular, respiratory, alimentary, central nervous, genitourinary and the frequency of clinical review by treating psychiatric team. Areas needing improvement were eye (8%) and ear (3%) examinations, measurements of weight (58%), height (1.6%), body mass index (1.6%), waist circumference (0%), investigating for prostatic specific antigen (50%), discussion of results of physical examination and investigations with the residents (both 0%) and referral to BreastCheck (36%).

Conclusion: A new physical examination form has been created for long-stay residents to correct these deficiencies and a new departmental policy document setting out a standard of practice consistent with recommended practice and general statutory requirements has been put into place.

Key words: Physical health; Long-stay residents; A Vision for Change; HSE Transformation Programme.

Introduction

Fair Deal Campaign and physical health

Physical health evaluation of new admissions into acute mental healthcare is a current standard of good practice.[1] This has become imperative following increasing recognition that physical illnesses can present along with psychiatric symptoms.[2] The Royal College of Psychiatrists in the UK has prioritised the linking of mental and physical health in its Fair Deal campaign to optimise mental health outcomes for all health service users.[3] However, residents in long-stay care are less likely to receive recommended standards of physical healthcare, resulting in failure to detect early disease and subsequent poor health outcomes.[4-6]

This experience of health inequalities may have resulted from their limited access to primary care.[7] Shared care between psychiatrists and primary care providers is advocated for the improvement of this imbalance.[1,8] Also, outcomes are better when psychiatrists who have traditionally busied themselves with understanding of mental illness and its treatments, engage in physical health evaluation as a part of mental health assessments.[9]

Effects of mental illness and treatments on physical health

Psychiatric illness, by itself[6,10,11] and its very treatment contribute to significant morbidity and mortality.[6] Both schizophrenia and depression are associated with cardiovascular disease.[12] Depression is a strong predictor of future myocardial infarction and of poor prognosis following infarction.[12] Service users with schizophrenia are more likely to be overweight and predisposed to developing hypertension, diabetes, dyslipidaemia and some forms of cancer.[13]

Psychotropic medication can induce metabolic changes that contribute to morbidity.[14] Resultant sedentary lifestyle imposes greater metabolic burden resulting in even worse health outcomes.[6] Significant metabolic changes include increases in blood sugar, triglycerides, cholesterol and LDL lipoprotein which induce diabetes and heart disease. An increase in prolactin from antipsychotic medication use affects sexual functioning. Decreases in thyroid hormones occur from lithium use, sodium from antidepressants use. Anticonvulsants may cause iatrogenic hypothyroidism and hyponatraemia which present with various physical and mental state changes. Haematological changes such as agranulocytosis may result from clozapine and carbamazepine use.[13]

Irish mental health policies and physical health

Regulation No. 19, General Health and Care of Residents, of Statutory Instrument No. 551 of the Mental Health Act 2001 requires that long-stay care facilities, as approved centres, ensure high quality general medical healthcare for residents.[15] *A Vision for Change*, the national policy for mental health services in Ireland recommends that "All mental health service users, including those in long-stay wards, should be

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registered with a GP" (Recommendation 7.3 p64).[16] The HSE *Vision For Change Implementation Plan 2009-2013* has translated this recommendation into a prioritised action to be delivered in 2009: "Monitor the extent to which mental health service users (including those in long-stay wards) are registered with a GP and have their physical needs met; and assist and support service users in accessing GMS services for which they are eligible" (p44).[17]

Governments expect a seamless service interaction between different healthcare providers.[15,18] In its Transformation Programme 2007-2010, the HSE has set out a stated purpose to integrate all health and social services to create a seamless patient journey through the health system for all illness and its consequences.[19] The restructuring of health service delivery systems to align the boundaries of primary care teams, community mental health teams and social care networks has been gathering pace in parallel with the implementation of *A Vision for Change,* such that in the future the inequity suffered by mental health service users in respect of general health and social care should hopefully disappear.

Regulation No 20 of the Mental Health Act 2001 requires that information on illness and treatment be provided to residents in a form they can understand as a means of empowering them to participate in their management.[15] This is buttressed by Standard 3.1 of the Quality Framework for Mental Health Services in Ireland which intends that "service users are facilitated to be actively involved in their own care and treatment through the provision of information". [20] This requirement of access to primary care and receipt of health related information have been included in this study.

In Carlow/ Kilkenny Mental Health Service, comprehensive physical health evaluation is carried out on a six monthly basis on residents in facilities in both counties and documented in a standard proforma kept in residents' case notes.

Objectives

Standards

This audit considered the absence of a departmental policy on physical examination as an area of concern. As outcome of serial discussions in departmental meetings and literature review, we accepted as standard the level of care that could be expected to be provided by a well resourced psychiatric team with understanding of physical health issues as relates to our patient group. This standard was as described, at the time, in the report of the Scoping Group of the Royal College of Psychiatrists on Physical Health in Mental Health[21] which has now been presented as a final report in *Occasional Paper 671*.

Information sought

We examined whether residents received a full physical health evaluation regularly. Information sought was age, length of hospital stay, the documentation of medical and psychiatric complaints, examination of physiologic systems, anthropometric measurements relevant to psychiatry: weight, height, body mass index and waist circumference. In line with above stated statutory requirements, we considered the documentation in notes of discussion of results of examination, investigations and relevant required actions with residents and communication of same to primary care providers. This was in a setting where physical health concerns are managed primarily by the psychiatric team with the option of referral to secondary care where necessary. Most of the residents were not registered with a GP.

Methods

The study evaluated care received by long-stay residents over a six month period, January to June 2008. A physical examination proforma in use at the time was evaluated for information as to whether examinations of cardiovascular, respiratory, alimentary, central nervous (CNS), locomotor and genitourinary systems had taken place. Other examinations, whose recording was not provided for in the physical examination proforma, were sought from case notes. These were examinations of the skin, eye, ear, oropharynx and breasts. Also considered were entries of weight, height, body mass index, waist circumference, investigation results and note of discussion of those results with patients in case notes. A check for note entries on discussions about examination, investigations results and communication of same results were extended for a further five month period. Results were analysed using StatsDirect software.

Statistics

Results are expressed as the mean, mean ± standard error of mean, median, range. 95% confidence intervals (CI) are included.

Results

A total of 60 residents were evaluated. Of these, 28 were from St. Luke's Unit, Kilkenny, 32 were resident in Carlow, 19 in St Patrick's, and 13 in St Mary's Wards of St Dymphna's Hospital, Carlow. This represented 29 male and 31 female residents. This was the total population in these care settings. A summary of the results are presented in *Figure 1*. Other results are stated below.

The mean age was 67.38 ± 1.78 years. The median age was 68 years and the range was 29-87 years. The mean age for men was 64.08 years while the mean age for women was 70.42 years. There were 18 male patients above the age of 60 years who required PSA investigation.

The mean hospital stay was for 11.54 ± 1.72 years. The median stay was 7.00 years and the range of stay was from 0.5-45 years.

All (n = 60) of the residents had been seen by a doctor at some point during the study period. These contacts were in form of consultations over physical health complaints made by the resident or nursing staff or as part of six monthly physical health checks. A total of 91.67% (n = 55) of the residents had a record of current psychiatric symptoms/complaints recorded in their case notes, 95% CI of 81.61-97.24%. With 85% (n = 51) of residents, there was a record of current medical complaints in the case notes, 95% CI of 73.43-92.90%. A total of 97% (n = 58) of residents had received physical health examination within the period of study, 95% CI of 88.47-99.59%.

There was no record of results of physical examination which took place during the first six months being discussed with residents when checked over a subsequent five month period after the event. Over the same time frame, there was also no record of results of routine investigations which were carried out being discussed with residents.

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No letter or documented note of phone calls had been made to any primary care provider following the physical health evaluation which had taken place within the first six months when checked five months following the event.

Discussion

Areas of good practice

This study highlights current practice showing areas where good standards are achieved and areas where improvements can be made. All residents are regularly seen in the long-stay wards by the psychiatric team's non-consultant hospital doctor (NCHD) who is considered the responsible ward doctor. Good generic practice, as supported by the Royal College of Psychiatrists[22] is achieved as evidenced by the high level of documentation of physical and psychiatric complaints before conducting physical examination. This suggests an improvement in practice when considered against Osborn and Warner's study of 1998 in which psychiatric trainees considered medical history to be of less importance in the evaluation of physical health, placing more value on only physical examination.[23] In Michael Phelan's review, he stresses the importance of medical history taking in psychiatry as fundamental to the identification and diagnosis of physical illness.[24]

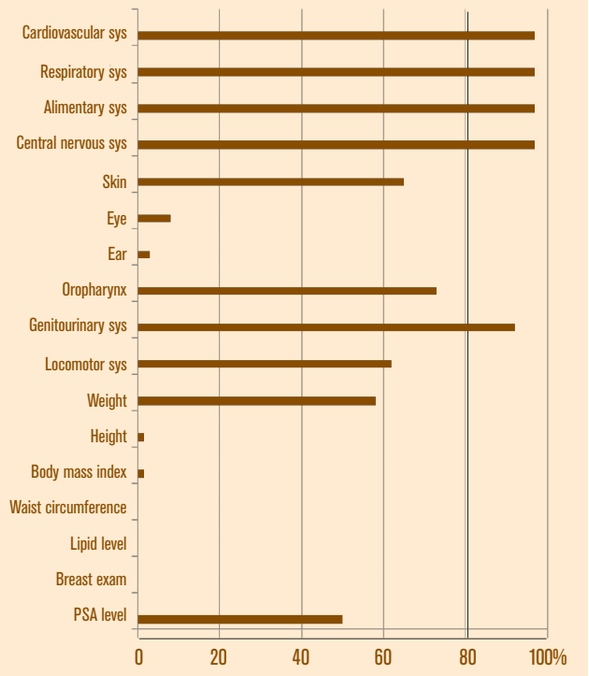
From our survey, it is evident that physiologic systems; cardiovascular, respiratory, alimentary, central nervous and genitourinary are being regularly examined. This is further evidence of good practice which recognises that long-stay residents can have comorbid medical illnesses just as the rest of the general population and be predisposed to medical illness as a consequence of psychotropic medications.[6]

The oral health of long-stay residents had been identified as an important area that is frequently overlooked.[25,26] Our study shows that 73% of our residents had their oropharynx examined and documented. Our experience in clinical practice has been that medical and nursing staff have been effective in responding to early symptoms of poor dental health in long-stay residents. This may have been helped along by the good working relationship between our services and the community dental health practitioners.

Areas for improvement

Our study reveals current areas of concern. Sensory organs; only 8% of residents' eyes and 3% of residents' ears were examined. In Fisher and Roberts' study of primary care service provision in a long-stay psychiatric setting, illnesses affecting these organs are prevalent, with all ocular pathologies necessitating referral to specialist care.[7] This finding was supported by Dixon's study in which visual problems represented the most commonly reported lifetime and current physical illness.[25] Problems with vision such as blurring and glaucoma may result from side effects of antipsychotic medications[13,27] and worsen with limited access to specialist care. Missing important pathology in these areas could represent missed opportunities in improving the quality of life in this service user group which is already likely to be compromised by age related changes. These may then represent new areas where physical examination skill needs to be optimised by responsible doctors. Also, appropriate equipment like otoscopes and auroscopes need to be accessible to doctors attending long-stay facilities.

Figure 1: Frequency of examination of different physical health indices expressed in percentage



The low level of documentation of anthropometric measures is a significant area needing improvement. Our study shows that waist circumference had not been documented during the study period and only one resident had height and body mass index documented. These values are important in the early detection and management of obesity and metabolic syndrome which are causes of high morbidity and mortality in this service user group.[28]

Gender based illnesses also represent areas where improvements can be made. Lack of breast examination (0%) and average levels of PSA estimation (50% of male patients above age of 60 years) are worrying. Improvement in these areas are important for the early detection of breast and prostate cancer which usually involve multidisciplinary specialist management input, of which long-stay mental health service users are often denied. Whilst in the UK, cervical screening is available to the community,[29] this is not yet the case in Ireland. Therefore where primary care services are not available to residents, responsibility rests on the psychiatric team to ensure that long-stay residents receive an acceptable level of care in this area.

Generally, there is a need to record results of blood investigations into case notes. While our study shows good practice in the recording of physiologic measurements like blood pressure, there is still poor practice in recording laboratory investigations like lipid levels (0%). Ensuring good practice in this area would help in the early identification of dyslipidaemia, hypothyroidism, and metabolic syndrome in psychiatric long-stay residents.

Even though residents are being examined and blood samples are being taken, the results of these processes are not being communicated to residents or primary care providers where existent. This was seen in a review of case notes

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over a five month period following the six-month study period. This need for communication is a new area which our practice did not previously address. It serves as an example of the systematised institutional discriminatory practices highlighted in *A Vision for Change,* which fail to be person-centred and as a consequence, fail to ensure parity of right of access to all areas of the health system.[16]

Effect of findings on quality improvement

As a result of our findings and as part of a process of continuous quality improvement designed to bring our services into alignment with current best practice, a new physical examination policy, a new physical examination form, and a new laboratory investigation form have come into use in the Carlow/Kilkenny Mental Health Service. The physical health evaluation of long-stay residents has been revised into two stages. Stage 1 is where the doctor, with the collaboration of nursing colleagues, assesses the psychiatric and medical symptoms of residents, recording them in case notes. Physical examination is carried out and recorded, noting any areas that need further attention.

In Stage 2, results of physical examination and investigations are reviewed by the doctor and explained to the resident in simple and clear language, outlining appropriate course of action where required. This is then incorporated into the resident's multidisciplinary care plan. The care plan pro-forma includes a modified version of the Sainsbury Risk Assessment Tool[30] which prompts the formal evaluation of risk as part of the care-planning process. Where the resident has a GP, a letter is sent advising the results. Where warranted, residents are referred to the appropriate specialist service.

The new physical examination form facilitates the delivery of this revised system of physical health management. This new form contains important pieces of information which were not obtainable from the old form. It makes for the recording of BMI, waist circumference, smoking status, extrapyramidal signs and locomotor examination. CNS examination is subdivided into component parts. Space is provided for documentation of dates of last breast, cervical and prostate examinations as well as listing of identified physical health risk factors.

Conclusion

Regardless of the care setting, the comprehensive, regular evaluation of the physical health needs of mental health service users with severe and enduring mental illness will result in the early detection and management of physical illness. This improves quality of life and contributes to better overall functioning and participation in community life.

This study focused on the standard of provision for the physical healthcare to residents of two approved centres by mental health services. It identified areas of good practice and areas for improvement. The most glaring omission identified was organisational blindness to the right of the service user to full and informed participation in their care and attendant choices. A re-audit of case notes against newly developed guidelines is being planned.

Persons with severe and enduring mental health problems deserve equal citizenship with all others. They should have their right to experience a seamless patient journey through an integrated health and social system respected. Reformed Irish mental health law, coupled with policy and quality frameworks, have already produced measurable change. The Irish health system, having established robust standards backed by clear action planning through a national implementation plan, now has this important aspect of fundamental rights for mental health service users well in hand.

Declaration of Interest: None.

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