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Triage in mental health – a new model for acute in-patient psychiatry

AIMS AND METHOD
In-patient psychiatric care needs urgent improvement and development. A new model of psychiatric care (triage) has been used for 6 months across an adult psychiatric service covering a London borough.

RESULTS
Preliminary results show that the new model has reduced bed occupancy, leading to more-efficient throughput, with positive feedback from patients and staff. Important factors contributing to these positive changes include a whole-systems approach, senior medical input 6 days a week, creative use of information technology and a highly skilled multidisciplinary team.

CLINICAL IMPLICATIONS
The introduction of the new model has resulted in a more-efficient use of beds. Further evaluation will enable us to assess the impact on other parts of the service. As with all innovations, the improvements must be sustained once the initial enthusiasm has passed.

In-patient care is an essential component of mental health services, but has been described as ineffective, inefficient and poorly organised (Muijen, 1999). Many services find it difficult to provide effective high-quality care as part of an integrated mental healthcare system. There is a need to transform in-patient care and address increasing user dissatisfaction, the number of adverse incidents and the loss of high-quality staff. Despite these perceived failings, in-patient care consumes the greatest proportion of the mental health budget and employs the greatest number of staff (Department of Health, 2002).

Improving the quality of acute adult in-patient care is a key challenge to mental health services. This priority is reflected in current mental health policy. Although progress is being made in ward environments, the improvement needs to be combined with changes in operational practices (Royal College of Psychiatrists, 1998).

The recent guidance from the Department of Health (2002) highlights many of the difficulties of acute in-patient care. This was previously lacking from the National Health Service (NHS) plan (Department of Health, 2000) and the National Service Framework (Department of Health, 1999). However, the guidance concentrates on improving existing services rather than considering service innovation as a means of solving problems. There is a need to develop new ways of delivering acute in-patient care as well as making it more efficient. Patients in the UK have longer hospital stays, well above international best standards (Sainsbury Centre for Mental Health, 2002).

In many in-patient units there are significant problems with the provision and delivery of care and unacceptably high bed occupancy levels (Greengross *et al*, 2000), which are often well over 100%. This is particularly a problem in the inner cities (Powell *et al*, 1995), leading to high levels of stress for staff and a poor quality of care for patients. Although recommendations for smaller, locally based units (Royal College of Psychiatrists, 1998) are recognised, they do not address the issue of pressure on beds and the implications for logistics and resources. This often leads to a paralysis in service development (Griffiths, 2002).

Crisis can lead to innovation. Here we describe such an innovation. The South London and Maudsley NHS Trust provides mental health services to the London Borough of Lewisham. In-patient care is provided in the Ladywell Unit, located within the grounds of the University Hospital Lewisham, and run by a separate acute NHS trust. Lewisham is a relatively deprived inner-city London borough and has an ethnically diverse population, with 30% belonging to a Black or minority ethnic group.

In Lewisham, a new model has been developed in an effort to improve the experience of in-patient care for patients and staff. We have tried to adopt many of the principles described in the Department of Health guidance, taking into account the views of users and staff. We are unaware of any other UK unit currently using this model of care. Essential to the model is the recognition that there are now alternatives to in-patient care – it is no longer assumed that hospital is the only option. In order to create a coherent whole, we have adopted a

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'whole-system approach' and have tried to link the community mental health teams (CMHTs), home treatment teams (HTTs) and other components of the service.

The mental health unit at Lewisham previously consisted of three acute admission wards each serving an area of the borough (a locality ward), with two wards of 23 beds and one of 24 beds. Under the new system the number of beds on each of the locality wards has been decreased to 18. In addition, an 8-bedded pre-discharge unit was closed. Thus 8 low-intensity beds have been lost with the opening of the new 16-bedded triage ward. The number of acute beds (70) has remained unchanged, but the density of patients on each ward has been reduced.

The term triage was chosen because it means, 'assort according to need'. Initially, all patients from the Lewisham catchment area are admitted to the triage ward to assess the most-appropriate intervention. Patients are either discharged to the HTTs, CMHTs, or primary care, or admitted to one of the three locality admission wards. Patients needing a longer hospital stay are transferred to the locality ward, whereas those requiring assessment or short-term interventions remain on the triage ward. The length of stay on the triage ward is limited to a maximum of 7 days, with discharge or transfer to a locality ward as soon as appropriate.

Our hypothesis is that the assessment procedure can be made more efficient, with management decisions taken quickly as a result of the daily consultant input. In this way care can be delivered in a more timely manner. Such a system allows staff on locality wards to focus more on delivering care and to spend less time freeing-up beds. Furthermore, daily input of senior medical staff has the advantage that patients are informed about their care, which appears to reduce the level of uncertainty among both patients and staff.

Principles of 'triage' care at Lewisham

Focused purposeful admissions

Planned admissions are discussed daily by the multidisciplinary team during the ward round before the patient arrives on the ward. This allows for clarity regarding the purpose of the admission and further information to be sought if necessary. On admission to the ward, each patient receives a comprehensive nursing and medical assessment as well as review by a senior psychiatrist.

Planning for discharge starts on the day of admission. Where appropriate, we involve the CMHT or the HTT as soon as possible. We recognise the importance of the involvement of the patient's community care coordinator in the assessment procedure and planning for discharge. It is important to maintain contact with the CMHT and the locality wards. The locality consultants visit the triage ward when necessary to assist with assessment.

Ward environment

The ward environment is comfortable, relaxed and safe. Male and female areas are separate. In order to preserve their dignity and privacy, all patients have their own room. The ward has been specifically designed as an assessment ward (within the limitations of the existing building space), with staff involved in all stages of refurbishment and design of the wards. Particular attention has been paid to the layout of the ward, as well as the use of high-quality furnishings and fittings. In this way, not only are good hotel services provided, but a safer ward is also created. The ward environment has undoubtedly had a positive effect on the morale of patients and staff.

Information technology

The ward uses the latest technology – CCS (the trust-wide information technology (IT) system) – during the daily ward round, with the patient's information being projected onto a wall using a networked personal computer and LCD projector. This enables the team to review details of contact with the CMHT, past discharge summaries and care programme approach and risk assessment documentation, allowing staff to assimilate the information accurately and efficiently (no searching or waiting for case notes). A 'running entry' is made during the ward round which serves as a summary of the patient's progress on the ward. This forms the basis for the discharge summary and allows the whole team to be involved. E-mail is also used to clarify details with others involved in the patient's care, for example, the community consultant's advice on management may be sought. Answers to e-mails are often received during the ward round, allowing the plan to be implemented without delay.

Medical input

The medical input consists of one whole-time equivalent consultant, a specialist registrar (SpR) and a senior house officer (SHO). The SpR and SHO have no clinical duties other than providing medical input to the triage ward. The consultant is present at the daily review and assesses patients on the ward as required. There is normally consultant input 6 days per week. This means involving the senior member of the medical staff at the time of admission, one of the key points in the patient's journey. Therefore, all patients admitted to the ward normally have senior input within 24 h.

Funding for the consultant comes from no longer using private beds. Previously, decisions were often delayed until the consultant reviewed the patient on the weekly ward round. Treatment can be initiated at an early stage, minimising the patient's distress and potentially decreasing the length of in-patient stay. A consultant performs a ward review on a Saturday morning, which is important because the peak time for admission to the ward is Friday afternoon/evening. This allows for rapid review of patients and for decisions regarding bed management.

Multidisciplinary team-working

Multidisciplinary team-working is central to the model. The team discusses each patient on the ward on a daily

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basis and updates care plans with timely management interventions. The ward is visited daily by a social worker to allow problems about housing, benefits or employment to be addressed. The social worker also provides more-detailed social assessments for the team. There is also input from a dual-diagnosis (substance misuse/mental health) nurse consultant who can provide more-specialist assessment and advise the team of management options in relation to substance misuse. The ward social worker and nurse consultant are precious resources in any in-patient service. Their input at the time of admission and planning for discharge is particularly useful. Their contributions to the patient's assessment enable the most-appropriate care package (which often is not delivered in hospital) to be arranged, and facilitate an early return to the community.

Integrating in-patient care within a whole-system approach

Efforts have been made locally to coordinate service delivery. Investment has been made in alternatives to in-patient care. System coordination eases the pressure on the acute admission ward (triage) and the locality wards by increasing throughput, minimising inappropriate admissions and preventing delayed discharges. Bed management for the borough is based on the ward. The ethos of coordination is at the heart of the operation of the ward. Clear communication allows discharges from the ward to be planned, allowing for a smooth admission to the locality ward or prompt follow-up in the community, delivering the most-appropriate care. Ward staff endeavour to maximise connections with community services and provide information to both patients and carers.

Preliminary results

In the first 6 months since the introduction of the triage ward, 406 patients have been admitted, with 170 discharged home and another 37 transferred back to the borough responsible for their care. By always having beds available for admission, we have been able to provide beds to other boroughs within the trust when they have been unable to accommodate the patient at the time of presentation. As a result of the streamlining of the assessment procedure and the whole-system approach, 42% of patients are discharged home directly from the triage ward, therefore spending less than 7 days in hospital. In the first 6 months since opening, the average bed occupancy on the triage ward has been approximately 70%, although the total number of beds within the in-patient unit as a whole has actually decreased. Patients can now be admitted to an in-patient bed in a timely manner. This has been a major benefit, as less clinical time needs to be spent on bed management.

This system is not only of benefit to the triage ward patients, but also to patients on the locality wards who have more attention from the staff. Staff on the locality wards no longer have to struggle to find beds and deal with the constant disruption of unexpected admissions. We are currently collecting data to determine what (if any) impact the new system has had on the number of adverse incidents in the unit, the use of one-to-one nursing time and levels of sickness among the nursing staff.

Discussion

Admission is the entry point to in-patient care and needs to work well if the whole system is to function optimally. The Lewisham triage model makes the admission procedure and assessment process more efficient and effective. The model integrates the CMHTs and the other mental health services involved in patient care; the use of IT enables most clinical staff (community and in-patient) to access the clinical notes on the ward in real time. The benefits of this are substantial and allow the care to be delivered as part of a whole-system approach. We are fortunate in having a well-developed IT system.

There is a need to gather information about the patient's experience of the change in service provision and to assess the impact the ward has had on the wider service, particularly in relation to the other in-patient wards and CMHTs. Although feedback has generally been favourable, we need to assess the experiences of both patients and staff. We must also ensure that the care of those discharged does not become suboptimal in the drive for increased efficiency.

Our care aims to be patient-centred and highlights the importance of effective communication between mental health professionals, users and carers. There is now a systematic assessment procedure which is delivered by the multidisciplinary team in a timely manner within an integrated care system. Acute in-patient care is considered a brief intensive intervention. Excessively long stays in in-patient units can be unhelpful for patients. As a service we strive to avoid this by providing high-quality alternatives, e.g. HTT, and diverting patients to community services when appropriate.

Although any improvement implies a change, change does not necessarily lead to improvement. The Lewisham model has tried to address local needs and difficulties. However, some aspects of this model may be relevant to other mental health providers. Potential drawbacks include the introduction of another layer of complexity, with some patients having to go to another ward, which could be disruptive. There is the potential for conflict between the triage consultant and other teams, although this can be minimised by clear communication and respecting the views of colleagues who may know the patient better. There is a need to evaluate the model and we are in the process of doing this. Although the early signs are promising, ongoing audit is necessary to determine whether benefits persist or disadvantages emerge.

Declaration of interest

None.

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