Transfer of elderly mental health patients

Patients with psychiatric illness are known to be at higher risk of suffering physical problems. The risk is greater still in elderly mental health patients, given their advancing age, underlying physical conditions and polypharmacy. This comorbidity in the elderly is one of the factors making them more susceptible to the side effects of psychotropic medication. It is especially relevant for people with cardiac conditions and metabolic disorders, illnesses which are over represented in this population.

Dr Ishaq Pala North East London NHS Foundation Trust
Dr Shakil Khawaja North East London NHS Foundation Trust
Email isaac_pala@hotmail.com

Mental health units do not have appropriate expertise to manage more complex medical problems. A significant proportion of elderly mental health patients will need to be transferred to a district general hospital (DGH) for assessment and treatment of comorbid physical conditions. Once fit for discharge from the DGH, these patients may continue to have chronic physical problems, which will require specialist medical follow-up. Occasionally such patients need to be urgently re-referred to the DGH. Repeated transfer of patients between hospitals can cause anxiety and distress both to the patient involved but also to staff and carers. It can be detrimental to recovery from mental health problems.

One would hope that the transfer of frail elderly patients between mental health and medical units would follow a seamless care pathway. Our clinical experience suggests that unfortunately this is not always the case. Staff at the DGH may be reluctant to admit elderly psychiatric patients to their wards, fearing that the person may disrupt the normal ward routines because of challenging behaviour such as wandering, physical resistance, non-compliance or simply requiring greater time by staff to sensitively meet their needs. There is no clear or written protocol or procedure locally regarding transfer of such patients between the DGH (Whipps Cross University NHS Hospital, WXUH) and the acute older adult mental health unit (Woodbury Unit). Given our concerns about this vulnerable group of patients, we decided to explore in more detail this aspect of the care pathway.

We performed a literature search on Psychlit and Medline using the keywords transfer, elderly, medical. We were unable to find any national or clear local guidelines for transfer of patients between mental health and medical inpatient wards for physical treatment. A very limited number of Trusts, such as the Berkshire Healthcare NHS Foundation Trust did have protocols covering such transfers. After reviewing relevant literature the audit collaborators (Dr Khawaja and Dr Pala) agreed by consensus five standards for the transfer of mental health patients between medical and psychiatric wards:

1. Each patient should be medically fit before transfer to the mental health unit
2. Each patient must be given a discharge letter with management and follow-up plan
3. Each patient should be given a diagnosis of the medical problem that he or she was treated for
4. Each patient should be assessed by or discussed with the ward psychiatrist or mental health liaison team before transfer back to the mental health unit
5. Transfer should not take place

Box 1: Patients in audit

GROUP A (22 patients) Woodbury inpatients transferred to WXUH for physical treatment		GROUP B (16 patients) Patients admitted to Woodbury unit from WXUH
Medically fit	11	14
Discharge letter	11	3
Diagnosis	18	16
Medical follow up	7	2
Discussed with psychiatrist	9	10
Mental health unit informed	7	8

until the receiving (mental health) unit have confirmed that they are satisfied with the practical arrangements of transfer, eg. timing of transfer, availability of staff etc. and are able to receive the patient.

Method

The audit was conducted with North East London NHS Foundation Trust (NELFT) approval via the Trust Audit Committee. A list was compiled of all patients between June and October 2009 who were either:

A. Admitted initially to an older adult psychiatric inpatient ward (Woodbury Unit) but subsequently required transfer to the DGH (WXUH) for assessment of physical comorbidity; or
B. Admitted to DGH (WXUH) initially for assessment and treatment of medical problems and then were subsequently transferred on discharge to the Woodbury Unit for on-going treatment of a psychiatric condition.

The electronic (RIO) and paper records of all these patients were audited by a member of the audit team. The audit instrument was a semi-structured questionnaire designed by the team incorporating the five standards described above. The consensus was that the five standards should be met in 100% of cases.

Results

The total number of inpatient admissions during the audit period was 65. During this interval 38 patients required transfer between the Woodbury Unit and WXUH and all of these were subject to audit. Of the 38 cases audited, 22 were in group A (transferred from the Woodbury Unit to WXUH for physical treatment and subsequently readmitted to the Woodbury Unit) and 16 were in group B (admitted initially to WXUH and on discharge transferred to the Woodbury Unit). Only one of the five standards was achieved in more than 50% of cases (see box 1). This was standard three (each patient should be given a diagnosis of the medical problem that he or she was treated for) which was achieved in more than 80% of cases.

Group A (22 patients)

60% (13/22) of the patients had been admitted to the Woodbury Unit for more than one week before transfer to the DGH Accident and Emergency (A&E) Unit for assessment of physical problems. 41% (9/22) of patients transferred for physical assessment to A&E were subsequently medically admitted to the DGH. The majority of these patients (5/9) required admission to the DGH for less than 1 week. 66% (6/9) of those admitted to the DGH were reviewed by the psychiatric liaison team during their stay on a medical ward.

50% (11/22) of patients were found not to be medically fit enough for transfer back to the mental health unit by the psychiatric team (and their transfer was delayed) even though they had been medically cleared for transfer by physicians at the DGH. 81% (18/22) were given a diagnosis of the medical problem requiring treatment. A "discharge sheet" was given to only 50% (11/22) of

patients. There was no mention of any medical follow-up in 68% (15/22) of cases, 73% (11/15) of these patients subsequently needing to be re-referred to the DGH, many of them (5/11) with the same or a related physical problem.

Nearly 60% (13/22) of patients were not assessed by or discussed with a psychiatrist before being transferred back to the mental health unit. 61% (8/13) of these needed to be re-referred to the DGH. Documented evidence was found in 31% (7/22) of cases that the mental health unit was informed the patient was being transferred back to them.

Group B (16 patients)

88% (14/16) of patients were admitted directly from the A&E department of WXUH to the Woodbury Unit. 50% (7/14) of these were actually planned psychiatric admissions but the patient's physical condition necessitated thorough medical assessment, investigation and treatment before the patient could be admitted to the psychiatric ward. A significant proportion of this latter group of individuals had been detained in the community under the mental health act. The mental health liaison service was involved in 50% of these cases.

88% (14/16) of patients were declared medically fit by physicians before transfer to Woodbury and only one of these was re-referred to the DGH. All of the patients were given a diagnosis of the physical problem for which they were assessed and treated. Only 19% (3/16) were given a discharge letter before transfer to Woodbury. The medical team felt that two of these patients required medical follow-up and this was arranged by them prior to transfer to Woodbury.

Only 63% (10/16) of these patients were discussed with the psychiatrist before transfer to the Woodbury Unit. Documentation that the mental health unit was informed of transfer of the patient was found in only 50% (8/16) of cases.

Discussion

The results show that 40% of patients transferred from the Woodbury unit had been psychiatric inpatients for less than a week before they were referred for physical treatment to WXUH. 40% of those transferred to the A&E department required inpatient admission to the DGH, with roughly half being admitted for less than a week. This shows that the majority of patients require short intensive medical interventions at the DGH.

Over half (54%) of the patients deemed by the physicians to be medically fit for transfer, when subsequently assessed by the psychiatric team, were found

to be unsuitable or not medically fit for transfer back to the mental health unit, and their transfer was delayed. This may reflect a lack of understanding by the medical team as to the nature and severity of medical conditions that can be treated within the psychiatric inpatient unit, for example administering intravenous fluids. Registered mental nurses (RMNs) are not trained to manage many of the medical problems registered general nurses (RGNs) regard as routine.

Communication is a vital part of providing successful seamless care. We found that although in the majority of patients a diagnosis of the problem they were treated for was given, other relevant information was often not provided. For example there was no mention of any medical follow-up in 68% of cases, 73% of which had to be re-referred, many with the same or related physical problems. The implication is that if greater attention is paid to providing advice on medical follow-up or a medical contingency plan, the need for re-referral and re-admission may have been avoided.

Due to different methods of documentation (electronic versus paper records) patient information is not easily accessible between the mental health and acute Trusts. There were cases in which the management plan was provided verbally over the telephone to mental health unit staff. Written paper information in the form of a discharge sheet therefore becomes all the more important as an accurate means of conveying important medical information. Verbal discussion with ward staff over the telephone is helpful but can be misinterpreted and some medical information may be incorrectly passed on to doctors. Discharge sheets were only given to half the patients who had been admitted from Woodbury to the DGH. No discharge letters or sheets whatsoever were provided for any of the patients who were seen initially in A&E prior to admission to Woodbury. Such lack of information could lead to suboptimal overall care.

It was also evident that the majority of patients who were not assessed or discussed with the psychiatric team before transfer back to the mental health unit required re-referral to the DGH. Once again, such disjointed care is detrimental to both mental and physical well being.

The audit did show that the situation for patients with psychiatric problems who were admitted from the A&E department of the DGH was much clearer and patient-centred. The vast majority (88%) of such patients who were declared medically fit by physicians were in fact appropriate for transfer, with only one patient requiring re-referral to the DGH. All these patients were given a diagnosis but none of those admitted from A & E department had a discharge letter/sheet. Medical follow-up was more likely to be arranged as needed. The majority (63%) of such patients were discussed with a psychiatrist prior to transfer although the documentation of mental health unit being informed of transfer/admission was found in only half of cases.

Conclusion

This audit shows that there is significant scope for improvement in the management of those psychiatric patients who require transfer to a DGH for assessment, investigation and treatment of comorbid medical conditions. It appears that relatively simple measures could improve the overall care pathway of these individuals. Medical wards still require a better understanding of both the nature and severity of medical conditions that can be treated by psychiatric staff in inpatient units. Similarly a greater provision of psychiatric liaison to our patients admitted to the DGH may assist medical staff in managing challenging behaviours such as wandering or resistance to care interventions. Currently old age services can only provide consultation service which is provided primarily by doctors, advising on diagnosis and treatment. A multidisciplinary old age liaison team would be able to provide a wider range of support and interventions. It is perhaps unsurprising that greater communication, education, mutual understanding and joint working is needed to improve the overall care pathway for these vulnerable patients.

It would certainly be helpful if some ground rules could be agreed between mental health units and medical wards. We felt a transfer protocol would help clarify the situation and improve patient care.

Conflict of interest: none declared.