Eastern Mental Health Service Coordination Alliance Audit Results 2015

Introduction/ Background

System audits is a method of inspection or examination, which enables an assessment of procedures or processes. An audit can compare how things actually are at a given time to how we think they are and how they ought to be in accordance with accepted service principles or quality standards. The EMHSCA 'Client file audit' process in 2014 sought to collect baseline data regarding shared care practices for people with mental health and co-occurring concerns in the Eastern Metropolitan Region (EMR). Key recommendations and actions from the 2014 findings include:

- Development and Implementation of a strategy guide to support the implementation of the Shared Care Practices and Collaborative Planning Protocol for EMHSCA member services.
- Continued work with the Workforce Development Committee to build capacity of organisations regarding Shared Care planning and associated activities.
- Support establishment of Service Coordination Champion role in the EMR and provide specific Service Coordination Champion activities to enable the development of the role.

A second audit conducted in 2015 aimed to assess changes or improvements in member holistic and shared care practices. Diagram 1 represents the EMHSCA audit process and cycle for 2014 to 2015.

Diagram 1: EMHSCA Audit process cycle 2014-15

Vision

"All participating agencies offer opportunities for people to participate in a person centered, integrated, shared care planning process with a recovery focus."

Purpose

The purpose of the 2015 audit process aims to contribute to EMHSCA member knowledge of service provider shared care practices and behaviours occurring in the EMR for people with mental health and co-occurring concerns. EMHSCA audits are viewed as a systematic mechanism for assessing and identifying areas for learning and continuous improvement.

Objective

To assess and ascertain the level of holistic health screening and changes in shared care practice activity and approach in the EMR, using results from the 2014 (baseline data) and 2015 (post data) EMHSCA client file audits.

Audit Execution

Sample

- **Client target group:** N=1008

  The client group for the audit review was purposively selected (non-probability sample). Client participants were self-selected so those sampled were relevant to the audit purpose. The file audit was completed for all consumers/clients registered for service in the month of February 2015.

- ***Participating member organisations:*** *N= 14*

  In all, seven of the 14 organisations (50%) participated in the 2014 (baseline) and 2015 (post) audits (see table 1).

New Participants, 2015	Participants, 2014 & 2015
Box Hill Mental Health Mobile Support and Treatment Service (BHMSTS)	Canterbury Road Community Care Unit (CCCU)
Chandler House Continuing Care Team (CCT)	EACH Social and Community Health
Lilydale Continuing Care Team (CCT)	Mental Illness Fellowship -Partners in Recovery (MIF PIR)
Linwood Prevention and Recovery Care (PARC)	Maroondah Community Care Units (MCCU), Eastern Health.
Maroondah Mobile Support and Treatment Service (MSTS)	MIND Nunawading
Maroondah Prevention and Recovery Care (PARC)	Murnong Continuing Care Team (CCT)
Prahran Mission	NEAMI Eastern Region

Table 1: EMHSCA Member organisation participants

Audit data collection method and procedure

The audit method used was clinician/ service provider self-report, using a common audit guide and Microsoft Excel and/or survey monkey tools to collect 'client file audit' information. Each service provider used their current caseload list and completed the audit for clients/consumers who were registered for service on the 1st February to 28 February 2015.

Additional criteria in relation to physical health screening practice and carer involvement in the care planning process were added to the 2015 audit tool.

Analysis and Reporting

- Mean scores were used to determine the average organisational performance for audit criteria.
- Mean scores were then converted to percentages so show general comparisons between 2014 to 2015 data.
- Data was grouped and interpreted according to key audit criteria components
- This report will seek to highlight changes in key outcomes for 2014-15. Icons below will be used throughout the report to highlight if there has been an improvement (increase in performance); decrease in performance; same performance or if criterion was new for 2015 (see key limitations and considerations).

Increase/ Improvement in performance	*Decrease/decrease in performance*	*Same/ equal performance (no change)*	*New 2015 criteria*
☺	☹	😐	☯

- Audit results will be disseminated via the EMHSCA meetings and locally via participating organisations.
    - The report will be available via the EMHSCA website.
    - Individual summary reports will be made available to participating member organisations.
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Key Findings

Of the files audited (n=1008):

☺ Overall 86% of consumers who accessed a service had an **identified general practitioner**, with majority of services (n=7) reporting 90-100%, five services 80-89% and two services reporting 71% and 70% respectively (see diagram 1 for an organisation/service breakdown[1]).

[1] Organisations have been de-identified and allocated a random number in order to show some metadata

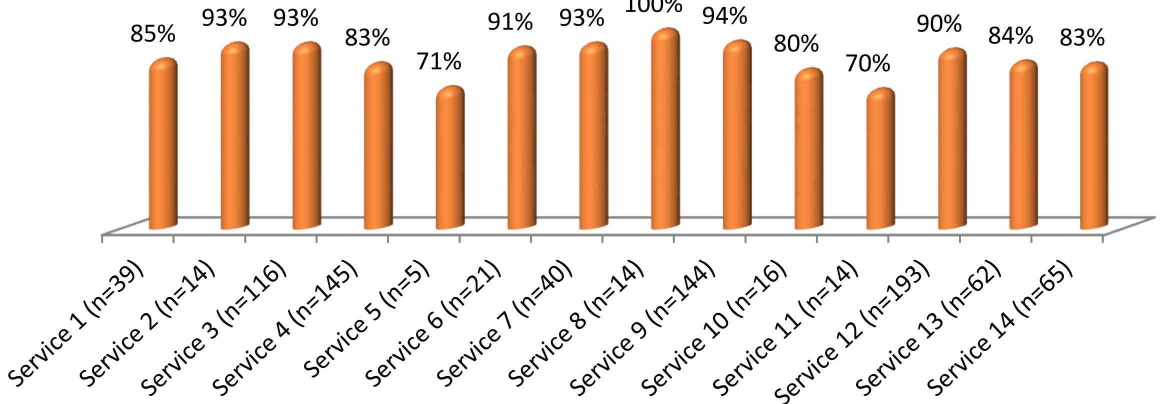


Diagram 1: Organisation/ service breakdown-consumers with an identified GP

- 70% clients were asked the six **(6) general questions as part of a physical health screen** and of those clients, 57% of clients had physical health needs identified. It was interesting to note, six services identified physical health needs when consumers were not asked the formal six questions (see diagram 2).

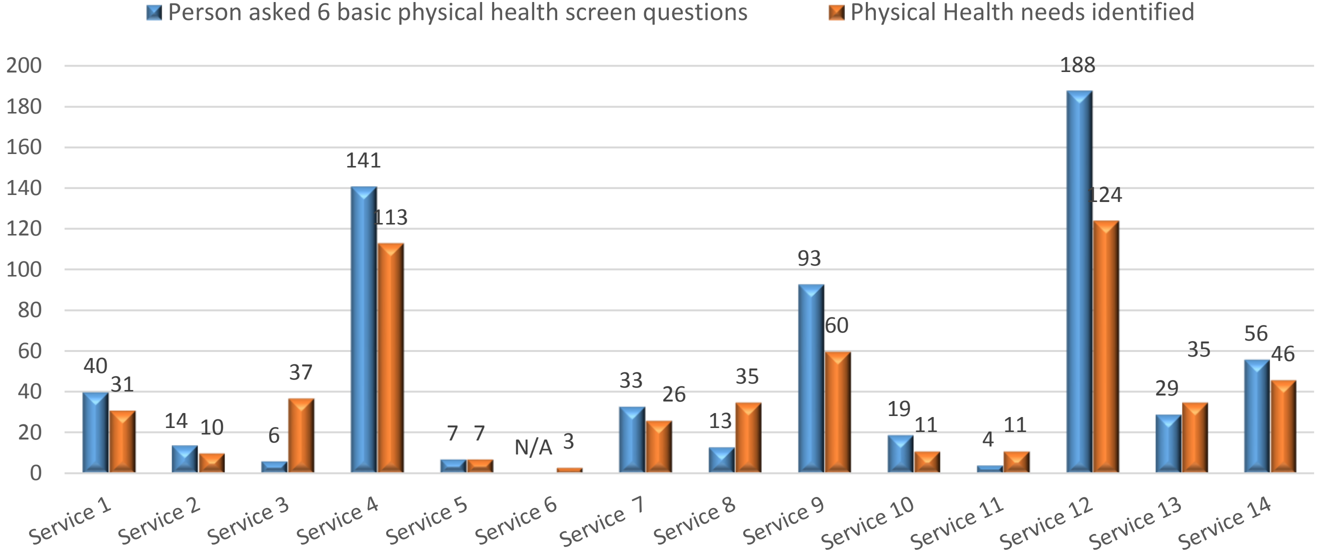
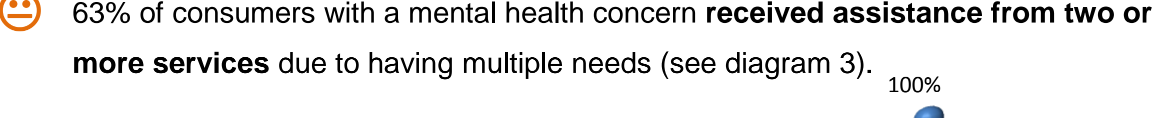


Diagram 2: Service breakdown-consumers asked 6 health screen questions; identification of physical health needs



63% of consumers with a mental health concern **received assistance from two or more services** due to having multiple needs (see diagram 3).

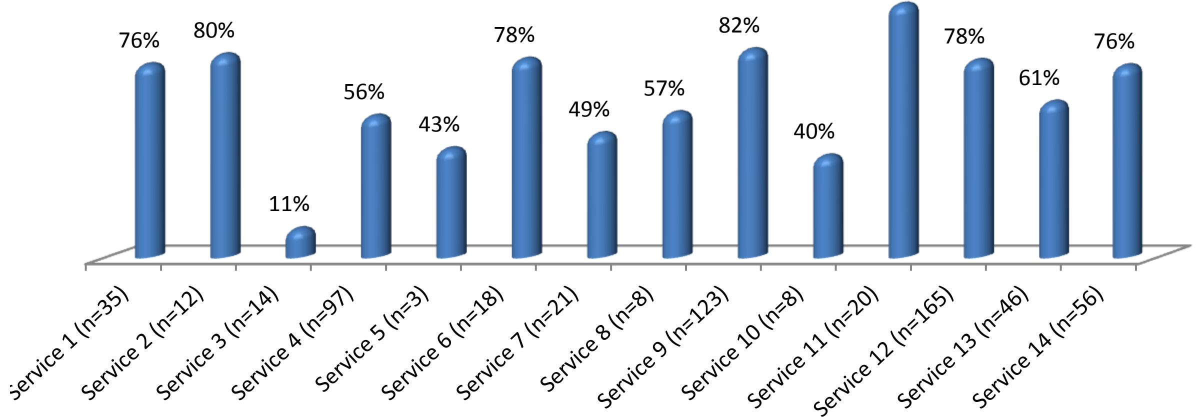


Diagram 3: Consumers receiving assistance from two or more services

Consumers with a mental health concern and receiving services from multiple (two or more) services:

- Of those consumers with an identified mental illness and receiving assistance from two (2) or more services (n=503), 74% consumer service activity was translated into **receiving shared care from a group or team of service professionals working together** to deliver coordinated care (n=370). Consumers receiving shared care:
  - 55 % had a Wellness plan documented ☹
  - 66% had a documented safety assessment and management plan ☺
  - 69% had evidence of a documented shared care plan ☺

Plan Descriptors

Wellness plan: A wellness plan could include the following elements: (a) Overview of the client's key stressors, early warning signs, key self-management strengths, natural supports and effective coping and relapse prevention strategies (b) Support plans pertaining to those who may be dependent upon the client in times of relapse... E.g. children, pets etc.... Advanced directives.

Safety assessment plan: A safety assessment is an ongoing process of observation and critical thinking to ensure the safety of consumers and those who support them. A risk assessment tool may be used to further identify clear management strategies (e.g. CRAM- Clinical Risk Assessment and Management tool).

Shared Care Plan: A shared care plan is a plan of care in which a group or team of health/ service professionals work together with the client, carers to deliver a holistic, coordinated and individualised service response.

Diagram 4 provides a breakdown of planning documentation percentages per individual organisation/ service.

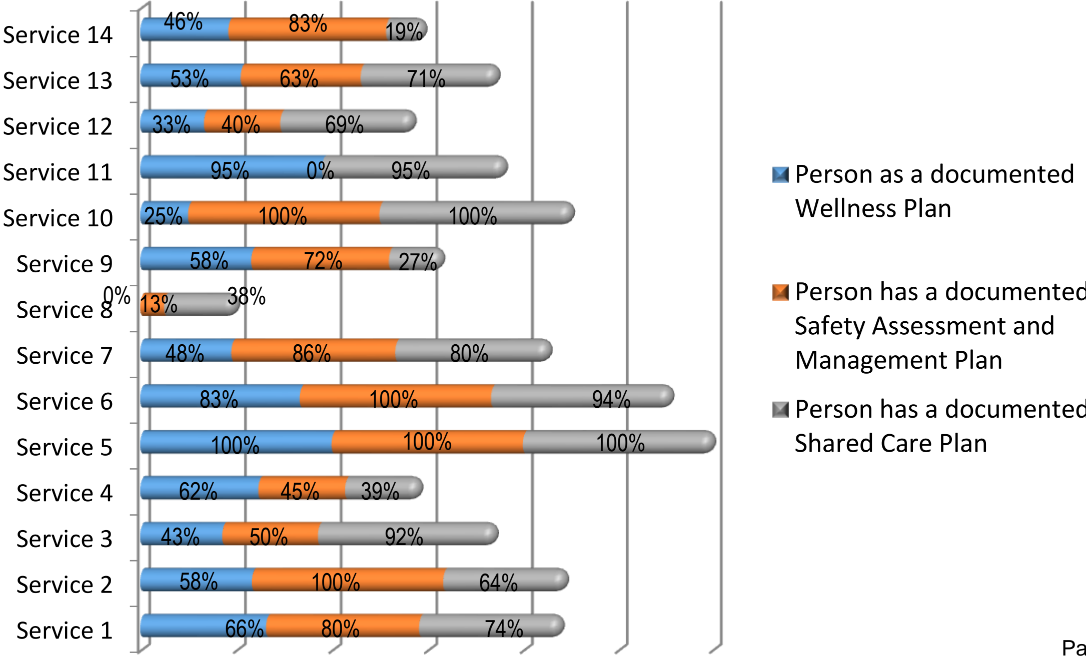


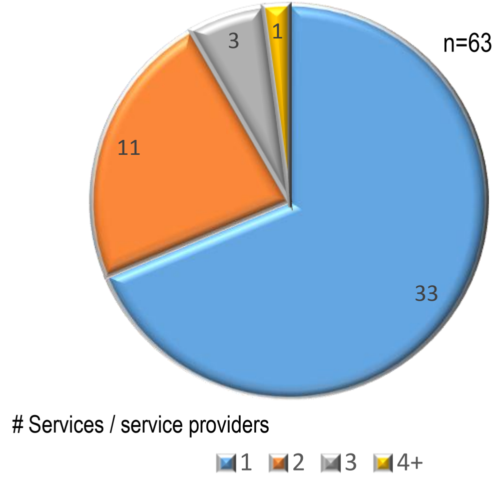
Diagram 4: Documented evidence of plans per service organisation

Shared care and care plan documentation

Shared care participants

Service providers were asked to report the number of participants/ other services that were missing from the person's shared care planning process. Services overall reported that an additional 63 participants were not included on the shared care plans. The total of 63 is made up of:

- 69% single service providers
- 23% two service providers
- 6% three service providers
- 2% four or more service providers



Carer/ significant other: Service providers reported 64% carer/significant other involvement in the care planning process. 14% (n=2) service organisations did not provide a response for this criterion.

Shared care plan fields/elements and information

As reported above, 69% (n=270) files audited across service organisations had evidence of a documented care plan. Of those documented care plans, service providers were asked to indicate if the care plan had evidence of nine different information components or fields completed. Table 1 provides mean scores and percentages for each care plan field criterion.

- 'Consumer goals' and ' Strategies or actions' components rated the highest with 91%, with 'Roles and responsibilities of participants' and 'List of participants involved in the development of the plan' coming a close second with 90%. Other care plan components include 'consumer consent' (87%), planning coordinator or support facilitator identified' (79%), 'Overview of the clients current situation' (79%) and 'Planned review dates' (74%).
- Consumers' with identified physical health needs is a new 2015 audit criterion. Of those identified consumers, 80% had their physical health priorities and actions included in the care plan.

The shared care plan includes the following elements (fields), information									
	(a) Overview of consumer current situation	(b) Consumer goals	(c) Strategies or actions	(d) Roles and responsibilities of all parties involved	(e) List of participants involved in the development of the plan	(f) Planning Coordinator or Support facilitator identified	(g) Planned Review dates and agreed form of communication	(h) Consumer consent document ed	(i) Physical health priorities and actions included in care plan (if identified)
n=	238	270	271	268	267	262	244	251	176
%	79	91	91	90	90	79	74	87	80
	☹	☺	☺	☺	☺	☺	☺	☺	☯

Table 2: Care plan elements and completion rates

Key Limitations and considerations

The Implementation subcommittee recognises certain limitations to the audit procedure when attempting to compare 2014 and 2015 data, these being:

- Different organisational service groups and clinician/ service provider representatives participated, which makes it impossible to make true comparable inferences.
- Sample sizes for data collection are often a compromise between the validity of results and pragmatical issues around data collection. In an ideal situation, audit data should be representative and valid. Some organisational data would not have been representative due to low sample sizes.
- No performance indicators have been defined for the audit criteria, hence unable to draw quantitative conclusions about success or achievement.
- We do not know what changes organisations have made/ implemented as a result of findings in 2014. No specific intervention was undertaken by organisations, but based on the assumption organisations would implement key recommended activities from the 2014 findings.

- Audits take time and organisations must be realistic when coming to undertaking their audit. To be useful organisations must view the activity as a learning and improvement opportunity.