Introduction/ Background

System audits is a method of inspection or examination that enables an assessment of procedures or processes. The EMHSCA client file audit 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). The 2016 audit aimed to assess changes or improvements in member holistic and shared care practices from previous years (2014 and 2015). Diagram 1, represents the EMHSCA audit process cycle.

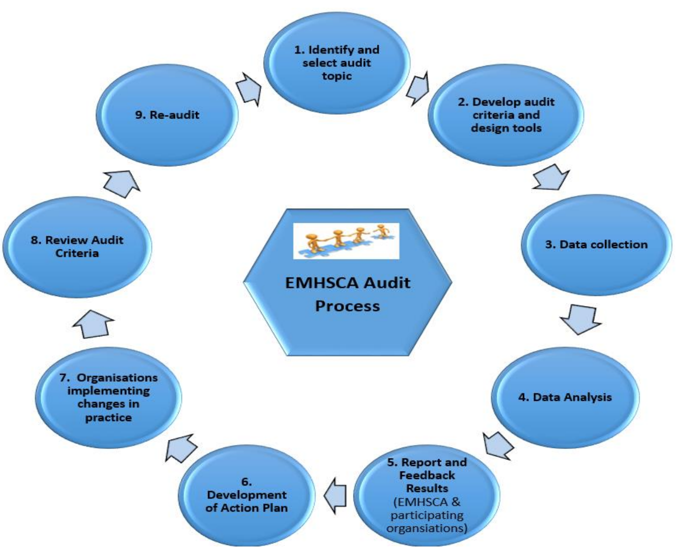


Diagram 1: EMHSCA Audit process cycle

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 2016 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 2014/15 and 2016 EMHSCA client file audits.

Audit Execution

Sample

- **Consumer target group:** N=1763

  The consumer group for the audit review was purposively selected; I.e. consumer participants were self-selected so those sampled were relevant to the audit purpose.

- ***Participating member organisations[1]:*** *N= 6*

Audit data collection method and procedure

- The audit method used a common audit guide and Microsoft Excel tool to collect 'client file audit' information. Data was gathered by organisations over a four-week period.

[1] Anglicare, Eastern Health, Mental Illness Fellowship, NEAMI Eastern Region, MIND, Prahran Mission

- Additional criterion in relation to the person having an Advanced Statement was added to the 2016 audit tool.

See Appendix 1: Data Summary, 2014-16

Analysis and Reporting

- Frequency scores were converted to percentages so show general comparisons between previous years data.
- Data was grouped and interpreted according to key audit criteria components
- This report will seek to highlight changes in key outcomes for 2014-16. Icons below will be used throughout the report to highlight if there has been an increase or improvement; decrease or decrease in performance; same or equal performance or if criterion was new for 2016.

Increase or Improvement in performance	*Decrease or decrease in performance*	*Same/ equal performance (no change)*	*New 2016 criterion*
☺+	☹ –	😐 =	☯

See 'Key limitations and considerations' section of this report, for identified analysis issues.

- 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.

Key Findings

Of the files audited (n=1763):

- 89% of consumers who accessed a service had an **identified general practitioner**
  2016: ☺+1 % 2015: ☺+1 %

- 82% consumers were asked the six **(6) general questions as part of a physical health screen** and of those consumers, 54% had physical health needs identified.
  2016: ☺+13 %

- 63% of consumers with a mental health concern **received assistance from two or more services** due to having multiple needs
  2016: ☹ -1% 2015: ☺+1 %

Of those consumers with an identified mental health illness and receiving services from multiple (two or more) services (n=1104):

- 66 % had a **Wellness plan** documented.
  2016: ☺ +12 2015: ☹ -27%

- 86% had a documented **Safety assessment and management plan** — 2016: ☺ +19 — 2015: ☺ +15

- 73% of consumer service activity was translated into **receiving shared care from a group or team of service professionals working together** to deliver coordinated care (n=802). — 2016: ☹ -5%

Consumers receiving shared care:

- 64% had evidence of a documented shared care plan. — 2016: ☹ -12% — 2015: ☺ +21
- 10% (n=50) had an Advanced Statement — 2016

Document 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.

Advanced Statement: An advance statement sets out a person's treatment preferences in case they become unwell and need compulsory mental health treatment.

Diagram 2, provides a visual breakdown of planning documentation percentages per individual organisation/ service.

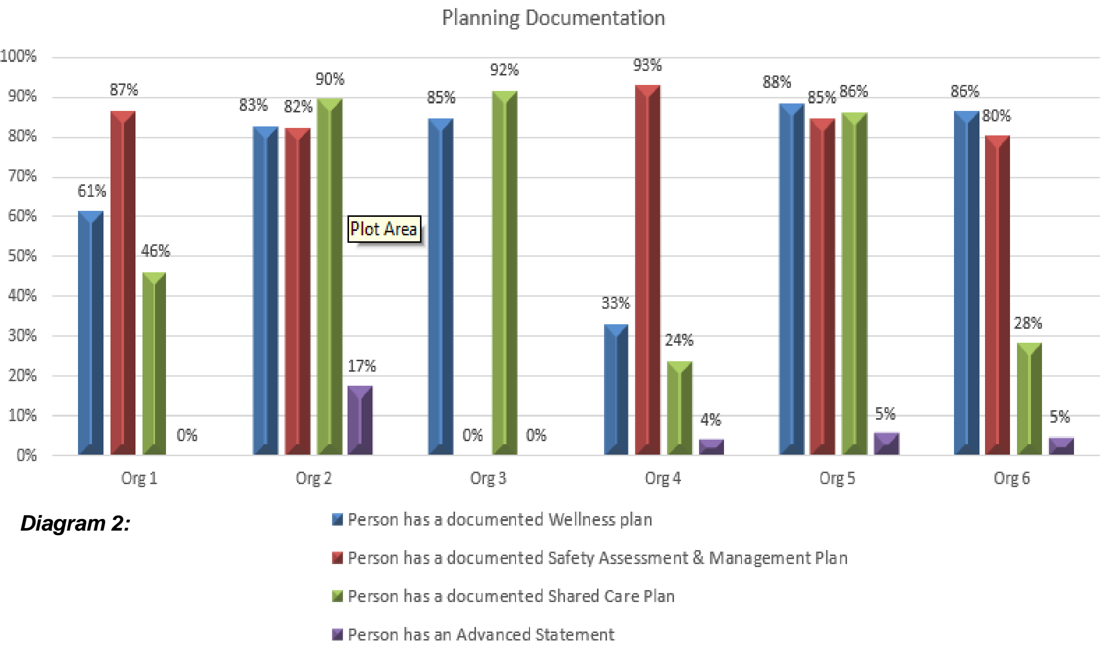


Diagram 2:

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 156 participants were not included on the shared care plans.

Carer/ significant other: Service providers reported 48% carer/significant other involvement in the care planning process.

2016
☹ -17%

Shared care plan fields/elements and information: As reported above, consumers who were receiving shared care, 64% (n=509) 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 eight (8) different information components or fields completed. Table 1 provides scores and percentages for each care plan field criterion. There was an overall improvement for all care plan elements, with the exception of criterion 'Physical health priorities and action being included in the care plan' (71%).

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 documented	(i) Physical health priorities and actions included in care plan (if identified)
n=	**440**	**486**	**498**	**488**	**468**	**459**	**459**	**476**	**268**
%	**86**	**96**	**98**	**96**	**92**	**90**	**90**	**94**	**71**
2016	☺ +8%	☺ +7%	☺ +7%	☺ +7%	☺ +4%	☺ +7%	☺ +12%	☺ +7%	☹ -9%
2015	☹ -3%	☹ -1%	☺ +1%	☺ +8%	☺ +8%	☺ +12%	☺ +7%	☺ +17%	

Table 2: Care plan elements and completion rates

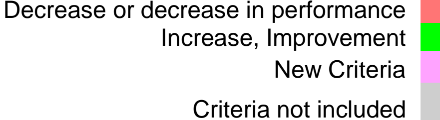
Key Limitations and considerations

The Implementation subcommittee recognise certain limitations to the audit procedure when attempting to compare data, these being:

- Different organisational service groups and clinician/ service provider representatives have participated in each yearly audit, which makes it impossible to make true comparable inferences.
- Self-selection and self-report can unintentionally introduce bias to the audit process.
- 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 or objective outcome measurements have been defined for the audit criteria, hence unable to draw quantitative conclusions about success or significance. This aspect also increases the likelihood of clouding the interpretation of findings.
- We do not know what changes organisations have made/ implemented as a result of findings in 2014/15. No specific intervention was undertaken by organisations, but based on the assumption organisations would implement key recommended activities from the 2014/15 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.

Appendix 1

EMHSCA Audit data	2016		2015		2014	
Sample (N=)	1763		1296		2322	
Questions	n=	%	n=	%	n=	%
1. Person has an identified G.P.?	1556	89%	1014	87%	1026	81%
2. Person has been asked the 6 basic questions as part of a physical health screen	1436	82%	731	69%		
3. Physical Health needs identified	969	55%	625	56%		
4. Person has a mental illness and receiving assistance from two (2) or more services - due to having multiple needs.	1104	63%	710	64%	1378	63%
5. Person has a Wellness plan documented	730	66%	305	54%	1026	81%
6. Person has a Safety assessment and management plan documented	944	86%	462	67%	772	52%
7. Person receiving shared care from a group or team of health professionals who are working together to deliver coordinated care with the client, carer	802	73%	528	78%		
8. Shared care has been formalised into a care plan document (e.g. Individual recovery plan; service/ care coordination plan)	509	64%	326	76%	650	55%
9 (a) Service providers not included on the Shared care plan	156	31%	90	28%	165	25%
9(b) Carer/ significant other involved in the care planning process	179	48%	97	65%		
9 (c) Person have an Advanced Statement	50	10%				
10. If physical health needs were identified- person's physical health priorities and actions have been included in their care plan	268	71%	202	80%		
11. For documented shared care plans-plan included the following elements (fields).						
(a) Overview of the consumer's current situation	440	86%	282	78%	485	81%
(b)Consumer's goals	486	96%	313	89%	600	90%
(c) Strategies or actions	498	98%	318	91%	612	90%
(d) Roles and responsibilities of all parties involved	488	96%	309	89%	477	81%
(e) List of participants involved in the development of the plan	468	92%	305	88%	480	80%
(f) Planning Coordinator or Support Facilitator identified	459	90%	300	78%	351	71%
(g) Planned Review dates and agreed form of communication	459	90%	277	73%	345	54%
(h) Consumer consent documented	476	94%	295	86%	480	69%



Decrease or decrease in performance
Increase, Improvement
New Criteria
Criteria not included