Evaluation Report

Review of Nurse Practitioner Role in Clutha

Nurse Practitioner Position in Clutha Community Mental Health Team: Evaluation Nine-months on.

Introduction

The following report provides a brief outline of the development and progress of the Nurse Practitioner (NP) position within the Clutha Community Mental Health Team (CCMHT).

The establishment of an NP role within a rural CMHT team was a new initiative and was implemented for a variety of reasons. The following were the key objectives for implementing of the position:

- Explore how the NP role could complement the consultant psychiatrists limited time within the team.
- Assess whether the implementation of an NP role would reduce EPS assessments, crisis hospital admissions and length of stay of admissions (LOS).
- Strengthen the alignment between the CCMHT and PACT (primary NGO in the region) by developing a collaborative partnership aimed at improving mental health services/support to consumers.
- Provide clinical leadership and assist with service development to a team with recognized staff conflict
- Explore whether the implementation of an NP role could minimise the impact of a longstanding clinical psychology vacancy.

Evaluation and Outcomes

The NP time has been used predominantly for clinical work with a smaller component being focused on leadership/quality service development.

Clinical Evaluation:

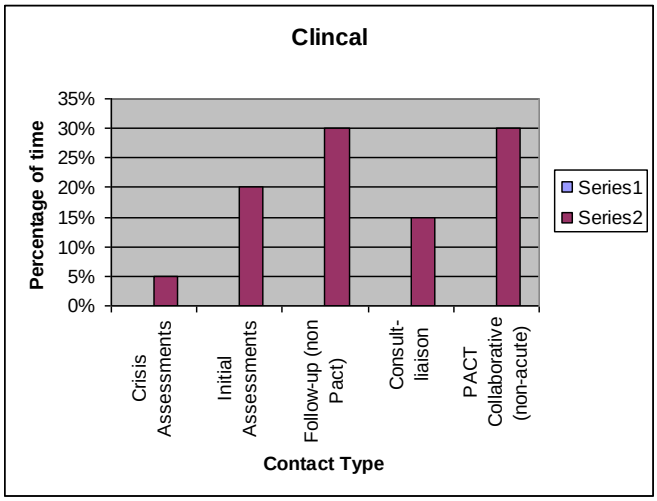
Approximately 80% of the NP role/time has been used for clinical work and of that time it can be roughly divided into the following five clinical categories

1. **Crisis Assessments**: Conducting crisis assessments which occur on the NP working days – Monday and Thursday.
2. **Initial Assessments**: Doing initial psychiatric assessments. Some of these come from the weekly MDT and some come as urgent assessments which are referred into the NP clinic between the weekly MDT/referral meetings.
3. **Follow-up out-patient appointments:** This covers the follow-up assessment and/or treatment that occurs subsequent to the initial assessment. After assessment some clients are referred onto other MDT members for follow-up with a plan for consult-liaison/ back to the NP as required. Some continue on for

short-term NP follow-up, whilst others are referred back to the GP with recommendations. A small few are triaged to the consultant psychiatrist's clinic. Diagnostic assessments for aspergers are referred directly to the NP clinic.

4. **Consultation-liaison with MDT members**: These are one-off advisory assessments with team members, sometimes they include a brief assessment of the client, but mostly they require clinical advice or a prescription. Medication requests are usually for; an adjustment to their regular medications (often due to the recurrence of EWS ie preventing an exacerbation of mental illness); short term supply of medication to enhance sleep or reduce anxiety until they can be seen by their regular doctor.
5. **PACT Collaborative Work**: This time is being used to slowly work through the group of PACT clients. The focus of this work is developing Mental Health Wellness Plans and clinical reviews. At the start of this project it was identified that the PACT services did not have treatment plans or EWS/RPPs for joint clients.

Percentage of time (approximate) to each clinical category



Impact on Consultant Psychiatrist

The consultant psychiatrist position within the CCMHT is a 0.2 position. The allocation of 0.2 to the CCMHT had resulted in the psychiatrist's clinic being chronically fully booked with longer than optimal waiting times for assessment and insufficient time for attendance to clinical notes. Acute and new assessments took priority over follow-up appointments, with longer than optimal waiting times for follow-up appointments at times.

The NP role has allowed a portion of new assessments to go directly to the NP clinic. This has resulted in:

- Reduced waiting time for psychiatric assessments
- Reduced waiting time for follow-up assessments with psychiatrist,
- Sufficient time for consultant psychiatrist to attend to clinical notes, admin etc.
- Significantly reduced out-of-hours contacts with the consultant psychiatrist (i.e. contacts made to psychiatrist on non CCMHT working day)

Impact on EPS Assessments & Admission

Whilst it is beyond the ability of this report to evaluate the specific data on this it is known that at times NP crisis and urgent assessments have resulted in interventions (usually medication) that have clearly reduced EWS that would have resulted in EPS assessments (the need for a review with a doctor) and possible admission. Clinical data was kept for the first two months but because of the time involved in continuing to collect this data it did not continue – see document attached in table 1 in the last section of this report. A comparative evaluation from the DHB admission and discharge data could further assess this. Data on overtime and on-call work could also be obtained and evaluated by CCMHT unit manager.

A rough look at the NP clinic shows that there are on average:

- Four to five urgent assessments or consult-liaisons with other MDT members per month where crisis medication is prescribed to a person decompensating/ showing EWs or in crisis. It is likely that in all these assessments the absence of the NP would have resulted in an EPS contact.

Strengthen the Collaboration with PACT

As shown in the graph above a large portion of the NP clinical time has been working on developing a collaborative partnership with the sole NGO in the region – PACT. This project aims to have one clinician (NP at this stage) within the team who will primarily case-manage the PACT clients. This project is closely aligned to the government's priorities for mental health - Te Kokiri and Te Tahuhu: *Improving Mental Health 2005-2015*, which emphasises all providers of mental health services working across boundaries and "more closely together". There is a strong emphasis on strengthening the alignment between the delivery of provider-arm health services and NGOs thereby maximising the capacity and capability of NGOs. It highlights the need to "build linkages between providers to ensure integrated and responsive services which promote mental wellbeing and prevent mental ill health". There is a body of evidence to show that the NP role is effective at bridging provider-arm/community splits, along with being effective and bridging the physical-mental health split which we know leads to disparities in health for people with enduring mental illness.

The current NP/PACT project is grounded in the concept of "working together" and aims to provide a more responsive and integrated service with greater continuity of care via a collaborative, partnership model. To date the NP has picked up a portion of the shared clients with a plan to slowly build on this. Other MDT members will provide "back-up" or crisis work as needed. Specific disciplines will provide specific interventions as required. This project has to be managed carefully and sensitively as many of the clients have been on the case-load of other clinicians for some time. To date ten clients have been reviewed by the NP.

The NP has developed a "Mental Health Wellness Plan" which not only incorporates the MHS requirements of an EWS/RPP and Treatment Plan, but also includes a consumer focused section based on the WRAP document and a clinical advisory section which gives clear guidelines to the NGO team on how to best manage specific symptoms and/or behaviours. The development of such plans within a collaborative model is allowing for discharge of long term clients that didn't really require much input with an agreed annual review or review "as required" and for realistic time frames for follow-up

reviews. For example, some people only require reviews if there is a specific concern about their mental health. This type of situation doesn't require a three month review, but can have reviews when initiated by the persons support staff i.e. PRN review based on occurrence of specific symptoms or behaviours.

Clinical Leadership & Service Development

Project	
NGO/PACT project as outlined above. As well as the clinical work described above this project has required several meetings with PACT staff. • Attached is the one month evaluation of consult-liaison contacts with other members of the team for January	One month evaluation of consult-liaison data
PHO project – to implement a collaborative model of community mental health between the CCMHT and the Primary Mental Health Service. • Attended meetings with PMH BIT Coordinator • Proposal for single point of entry and co-location of services written.	Proposal
Mental Health Seminar Series/Teaching • Provided to PACT and IDEA Services	

Filling the psychology gap:
• instigation of training session for the CCMHT with Kumari Fernando
• Development of training for interested staff in 1A programme. Five staff attending ward training focused on developing programmes.
• Supporting the development of groups within the team.
  • Discussion and encouragement of interested staff.
  • Development of resources for group work
 	
Summary:
Whilst it would be possible to use the NP role for psychological work as the current NP has CBT and psychodynamic training there isn't the capacity within the 0.4 NP time to provide this. The lack of a psychologist continues to leave a major gap in service provision in the CCMHT. This is a serious gap as it leaves a gap in what the service is contracted to provide and this gap occurs within a geographic location where there is limited alternatives in the community and also within a community with low socio-economic demographics, therefore making private work unaffordable for most. Having a psychologist within the team should be a high priority.
	To date there has been one anxiety management group run

Leadership: • Providing support to the UM with quality service improvement initiatives within the team. • Bringing a leadership voice to team meetings	Feedback can be obtained from UM
Evaluation Feedback: • PACT • Consultant psychiatrist	Attached

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Updated Report February 2013

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- Explore whether the implementation of an NP role could minimise the impact of not having a clinical psychologist within the team.

Evaluation and Outcomes

The NP time has been used predominantly for clinical work with a smaller component being focused on leadership/quality service development.

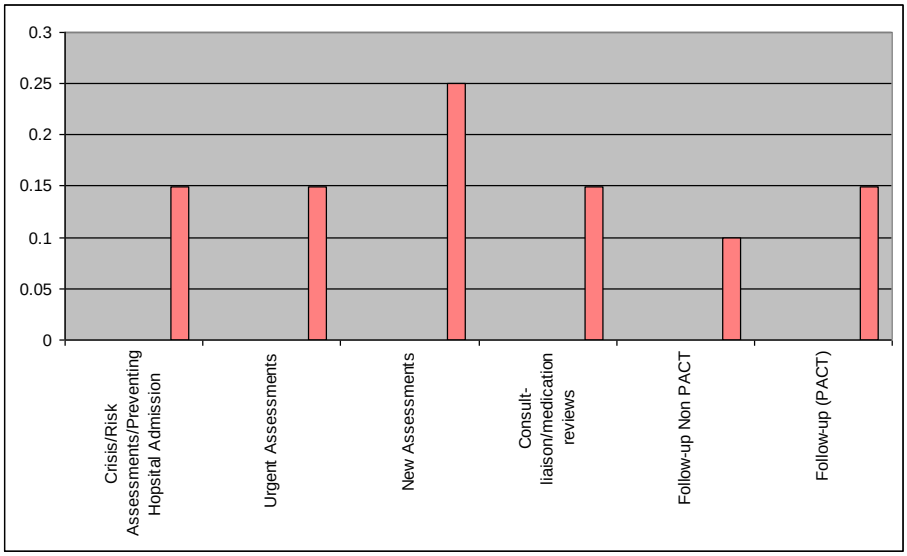
Clinical Evaluation:

Approximately 90% of the NP role/time has been used for clinical work and of that time it can be roughly divided into the following five clinical categories

6. **Crisis/Risk Assessments aimed at Preventing Admission**: Duty staff member able to triage high risk presentations assessments to the NP (on the NP working days – Monday and Thursday) to conduct urgent assessments/risk assessments. These assessments would otherwise have to go to EPS.
7. **Urgent Assessments**: Conducting urgent assessments that come via the GP and between the weekly MDT. Triaged up to NP clinic by duty staff member.

8. **Initial Assessments**: Following the weekly MDT complex new referrals are split between psychiatrist and NP clinics. Diagnostic assessments for aspergers are referred directly to the NP clinic.
9. **Follow-up out-patient appointments:** This covers the follow-up assessment and/or treatment that occurs subsequent to the initial assessment. After assessment some clients are referred onto other MDT members for follow-up with a plan for consult-liaison/ back to the NP as required. Some continue on for short-term NP follow-up, whilst others are referred back to the GP with recommendations. A small number of very complex presentations are referred to the consultant psychiatrist's clinic.
10. **Consultation-liaison/medication reviews with MDT members**: These are one-off advisory assessments with team members, sometimes they include a brief assessment of the client, but mostly they require clinical advice or a prescription. Medication requests are usually for; an adjustment to their regular medications (often due to the recurrence of EWS ie preventing an exacerbation of mental illness/preventing admission); short term supply of medication to enhance sleep or reduce anxiety until they can be seen by their regular doctor.
11. **PACT Collaborative Work**: Time with clients who are also supported by PACT ie shared-care clients. This part of the role is highly responsive being available at short notice if there is a need for review. The focus of this work has also been on developing Mental Health Wellness Plans and joint clinical reviews. At the start of this project it was identified that the PACT services did not have treatment plans or EWS/RPPs for joint clients.

Percentage of time (approximate) to each clinical category



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Impact on EPS Assessments & Admission

Whilst there no hard evidence has been gathered it is clear that the NP role – particularly in doing crisis/urgent assessments/risk assessments has reduced the contact with EPS and reduced hospital admissions. The NP can provide the level of risk assessment and pharmacotherapy necessary to prevent admissions

Clinical data was kept for the first two months but because of the time involved in continuing to collect this data it has not continued – see document attached in table 1 in the last section of this report. A comparative evaluation from the DHB admission and discharge data could further assess this. Data on overtime and on-call work could also be obtained and evaluated by CCMHT unit manager.

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