The Royal London Hospital Long-stayers Project

Albert, R., Osborne, H., McKinnon, S., Smyth, R.,

Royal London Hospital, London Borough of Tower Hamlets

Background

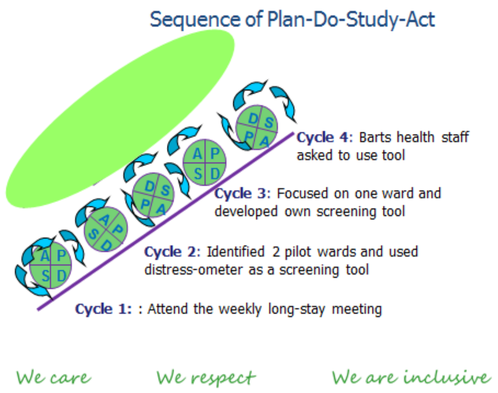
- 250-270 long stay patients in the Royal London Hospital a week.
- The long stay ranges from 10 – XX days (some outliers of 200+ admission days)
- Long term health conditions – increased likelihood of co-morbid mental health problems
- 40-60% of patients in an acute general hospital have mental health problems
- Research into long-stay patients factors look at the complexities within specialities but does not look at mental health factors

Project Aims

Methodology -
The project was set up in 2014 using the Qualitative Improvement methodology and ran to Oct 2015

- **Aim -** to create an effective way of identifying long-stay patients who has mental health problems. The target group was people who had been in 29+ days
- **Measure -** increase the number of long stay patients referred to the liaison team by June 2015 to 2 per week.
- **Changes –**
  Presence on the ward -attending multi-disciplinary meetings
  Mental Health Awareness – teaching
  Referrals - screening tool

Methods - Activity



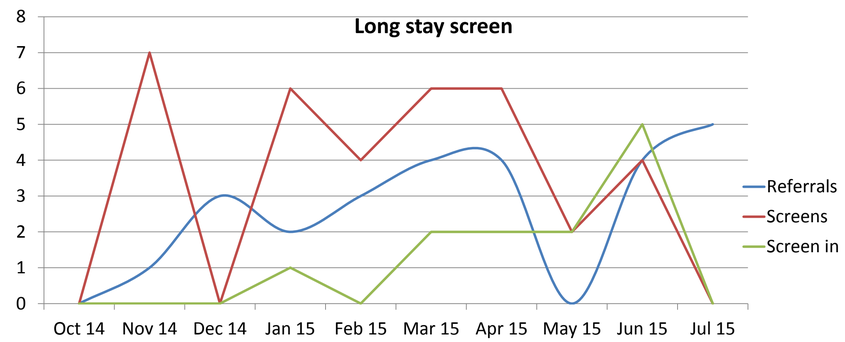
Methods- Activity

- Development and testing of screening tool
- Affinity diagram – exercise with acute staff to identify areas which might identify unmet needs to be included in screening tool
- Full biopsychosocial assessment of patients identified
- Care planning and intervention including aftercare discharge
- Audit of all long-stayers to identify who is known to mental health services
- Monthly training sessions on conditions and management of presentations
- Weekly MDT meetings

Audit- snapshot Feb 2016

- 60 (58%) of 104 Long-stayers had never been seen by MH services. Of these:
- Total number of days was 3, 201
- Average length of stay for LSs was 55 days

Results



The discrepancy between patients screened in and actual referrals to the team is an example of the cultural barriers to the project. Therapy staff would identify patients who may have unmet needs but would ask doctors to refer to RAID. Instead other patients who had a briefer period of admission got referred.

Case Scenario

- Mohammed was admitted following a complication from his diabetes. He had his left foot amputated. He was admitted for 30 days before being screen in for assessment
- Prior to this admission he had had a heart attack and cancer of the bowels.
- He was avoiding his rehab and was due to be discharged home without mobilising
- Full biopsychosocial assessment found Mohammed to be depressed as well as struggling with adjustment to his recent deterioration in health.

Outcome

- Family meeting to look at coping at home and ways for Mohammed to regain some of his previous purpose.
- Mohammed was a proud man who did not talk about his feelings so helping him explain what was happening helped him and the family
- Medication for his depression and planning with community team on how to engage him in his rehabilitation.

Discussion

- The QI methodology allowed the team to develop ways of identifying unmet mental health needs
- The affinity diagram was useful to engage Acute Trust in project
- The screening tool was aimed at non-mental health staff but cultural practices has meant a slow uptake
- The biggest impact was attending the wards and discussing patient presentation

Future Directions

- Business case put into local Vanguard Project to develop screening tool and support a change of culture
- Validation of the screening tool