Clinical Utility of NOCC Measures in the Inpatient Setting

"NOCC, NOCC"
Who's There?
HoNOS!

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Introduction

- Morier Ward is a 23 bed acute psychiatric inpatient ward in the Outer Southern area of Adelaide
- 20 beds are open beds
- 3 High Dependency beds
- Currently the average length of stay is 14 days
- The ward is managed by a multi-disciplinary team
- Strong connection to Community Mental Health Team

Collecting HoNOS

- Admission
- 30 Day Review
- Transfer in/out of HDU
- Discharge of admissions greater than 3 days
- Prior to the commencement of ECT
- Weekly whilst having ECT

Who Collects HoNOS

- All members of the multidisciplinary team, including:
  - Medical Staff, Psychiatrists, Registrars, RMO's
  - Nursing Staff, CN, RPN, EN
  - Students, Medical and Nursing
  - Allied Health
  - Community Staff

Where is HoNOS Collected?

- Predominately collected in weekly Ward Rounds by the multi-disciplinary team
- Nursing staff initiated for transfers in/out of HDU
- In the instance of an admission missing Ward Round, patient identified at morning intake meeting and HoNOS completed again by the multi-disciplinary team.

Benefits

- Promotes discussion about clinical care of patients
- Helps identify the goals of the admission i.e. Management plan should reflect any HoNOS scores of 3 or 4
- HoNOS scores help to identify which community team the patient would be best managed in
- Decision for discharge of patients is not just the decision of the Psychiatrist, may be influenced by HoNOS score

Training for Staff

- NOCC Champion on the ward – clinical nurse carrying the portfolio of NOCC
- Annual competencies for nursing staff include outcome measures
- Orientation packs for medical and nursing staff include copies of HoNOS
- Training of new staff by NOCC Champion about outcome measures

Use in Managing Clinical Care

- Case 1 – Management Plan

	Age/Sex:	Female	**Consultant**	Dr Rathjen		
	Diagnosis:	Major Depression 2 recent suicide attempts	**COMMUNITY**	Adaire		
	Treating Date	**1/02/2008**				
	2/04/2008	Ward round with Dr Rathjen, Intern Jan, CNM Terena Slattery, RN Tatjana Butler, Key worker Libby, Social Worker Angela. Continues with course of ECT. Encourage increased fluid intake. Some more reactivity in her mood noted, remains anxious.Needs encouragement with ADL's. Plan, 1. Continue with ECT. 2. E-mail Dr Long re current progress. 3. Continue current community contact. 4.Further 2-3 week admission. 5. ? may need a guardian in the future. 6. Consent until 13/5/08				

Use in Managing Clinical Care

- Case 1:

	HONOS	**admission 1/2/08**	**Discharge aim**	**week 1 6/2/08**	**week 2 12/2/08**	**week 3 19/2/08**	**week 4 27/2/08**	**week 5 5/3/08**	**week 6 12/3/08**	**week 7 19/3/08**	**week 8 26/3/08**	**week 9 2/4/08**
1	overactive, aggressive, agitated	3					3	3		3		
2	self injury	4					0	0		0		
3	drinking and drug taking	0					0	0		0		
4	cognitive problems	3					3	3		3		
5	physical illness and disability vitamin D deficient, ? Cerovascular	0					0	3		3		
6	hallucinations and delusions	1					0	0		0		
7	depression	3					3	3		3		
8	other mental/behavioural problems sleep disturbance	2					0	0		0		
9	relationships	2					2	2		2		
10	ADLs, occupation,recreation	3					2	3		3		
11	living conditions	0					0	2		2		
12	occupation and activities	0					0	0		0		
	total											
	RISK ASSESSMENT											
1	harm to self			3	3	3	3	3	3	3	3	
2	harm to others			2	0	0	0	0	0	0	0	
3	level of problem functioning			3	3	3	3	3	3	3	3	
4	level of support available			0	0	0	0	0	0	0	0	
5	history of response to treatment			2	2	2	2	2	2	2	2	
6	attitude and engagement to treatment			1	2	2	2	2	2	2	2	
	overall risk (low/medium/high/extreme)			high	high	high	high	chronic-high	chronic-high	chronic-high	chronic-high	chronic-high

Use in Managing Clinical Care

- Case 2 – Management Plan

	Age/Sex:	Female	**Consultant**	Dr Rathjen		
	Diagnosis:	Schizo-affective dx	**COMMUNITY**	Adaire		
	Treating Date	**19/03/2008**				
	2/04/2008	Ward round with Dr Rathjen, Intern Jan, CNM Terena				
	26/03/2008	Ward Round Consultant Dr Rathjen, CNM Terena Slattery, Social Worker Angela, EN Phil Collins, Key Worker from Adaire Clinic Jane Transfer from 5J after recent d/c from Morier ward 36 hours previously. Unpredictable in her behaviour, demanding and innapropriate in her behaviour at times. 2 children now in foster care, Julie unable to attend court case yesterday re children's placement. Sleeping better. Plan, 1. Next depot due 31/3/08 2. MAC referral made 3. Strategy 6 package organised. 4. OT assessment to be arranged 5.Neuro-psych testing 6. 2-3 week admission				

Use in Managing Clinical Care

- Case 2:

	HONOS	**Admission 19/3/08**	**Discharge aim**	**week 1 26/3/08**	**week 2 2/4/08**	
1	overactive, aggressive, agitated	3			1	
2	self injury	0			0	
3	drinking and drug taking	0			0	
4	cognitive problems	1			1	
5	physical illness and disability diabetes, obesity, sleep apnoea	2			2	
6	hallucinations and delusions	2			1	
7	depression	0			0	
8	other mental/behavioural problems manic, sleep problems	3			1	
9	relationships	3			3	
10	ADLs, occupation,recreation	3			3	
11	living conditions	0			0	
12	occupation and activities	0			0	
	total					
	RISK ASSESSMENT					
1	harm to self			3	2	
2	harm to others			2	0	
3	level of problem functioning			3	3	
4	level of support available			0	0	
5	history of response to treatment			2	2	
6	attitude and engagement to treatment			1	1	
	overall risk (low/medium/high/extreme)			chronic-high	chronic-medium	

Use in Managing Clinical Care

- Case 3 – Management Plan

	Age/Sex:	Male	**Consultant**	Dr Rathjen		
	Diagnosis:	Poor social skills, social isolation. Poor living conditions	**COMMUNITY**			
	Treating Date	**26/02/2008**				
	12/03/2008	Family meeting at FMC with mother re accomadation. House has an order placed onit that it cant be lived in. Self care have improved. Plan, 1. cease lorazepam 2. Amber Lodge 13/3/08 3. Meeting with mother 12/3/08 4. Southern Junction 18/3/08				
	5/03/2008	Brought to FMC by Southern ACIS with his mother who had both been detained. Living a very isolated life style, spends most of the day watching DVD's, catches a bus to have contact with people. Carer for his mother, mother has schizophrenia currently in Margaret Tobin Centre. Some insight, judgement reasonable.Lack of motivation, poor social skills. No current evidence of psychosis. Plan, 1.Commenced on small dose of lorazepam, slowly reduce. 2.Centrelink benefit to be arranged. 3. To look at support packages and accomadation for d/c 4. Further 1 week admission to look at supports. 5. Organise a meeting with mother and housing options. 6. Make a volentary patient.				

Use in Managing Clinical Care

> Case 3

	HONOS	Admission 26/2/08	Discharge aim	week 1 5/3/08	week 2 12/3/08
1	overactive, aggressive, agitated	1			0
2	self injury	0			0
3	drinking and drug taking	0			0
4	cognitive problems	0			0
5	physical illness and disability	0			0
6	hallucinations and delusions	0			0
7	depression	0			0
8	other mental/behavioural problems	0			0
9	relationships	4			4
10	ADLs, occupation,recreation	3			2
11	living conditions	4			0
12	occupation and activities	0			0
	total				
	RISK ASSESSMENT				
1	harm to self			0	0
2	harm to others			0	0
3	level of problem functioning			3	2
4	level of support available			0	0
5	history of response to treatment			0	0
6	attitude and engagement to treatment			1	0
	overall risk (low/medium/high/extreme)			low	low

Use in Managing Clinical Care

> Case 4 – Management Plan

	Age/Sex:	Female	**Consultant**	Dr Champi on		
	Diagnosis:	Alcohol dependence Emotional distress	**COMMUNITY**			
	Treating Date	**19/01/2008**				
	23/01/2008	Presented intoxicated to the ward, sent to ED. BAL 2.8. Daily heavy use of alcohol.Claims recent sexual and physical assualt. Frequently becomes emotionally distressed on the ward. Distress often relates to the removal of her 5 children. some memory problems.Threatens to harm herself if she is d/c and reports pseudo-hallucinations. Past forensic hx has been in jail. Insight very poor, judgement chronically impaired, difficult to engage with.Seen by Yarrow Place and interviewed by SAPOL.Withdrawn from alcohol. Plan, 1. D/C 23/1/08 2. Visited by Salvation Army alcohol worker 3. Assisted to find accomadation 4.D/C on pericyazine and thiamine.					

Use in Managing Clinical Care

> Case 4

	HONOS	admission 19/1/08	Discharge aim	week 1 23/1/08	week 2	
1	overactive, aggressive, agitated	3		1		
2	self injury	1		1		
3	drinking and drug taking	4		2		
4	cognitive problems	2		2		
5	physical illness and disability bruising on face	1		1		
6	hallucinations and delusions	0		0		
7	depression	0		0		
8	other mental/behavioural problems anti-social and borderline traits	3		3		
9	relationships	3		3		
10	ADLs, occupation,recreation	3		3		
11	living conditions	2		2		
12	occupation and activities	0		0		
	total					
	RISK ASSESSMENT					
1	harm to self			3		
2	harm to others			2		
3	level of problem functioning			3		
4	level of support available			0		
5	history of response to treatment			2		
6	attitude and engagement to treatment			3		
	overall risk (low/medium/high/extreme)			chronic high		

Use in Managing Clinical Care

> Case 5 – Management Plan

	22/01/2008	Presented to ED with multiple physical complaints, ceasing of methadone, speech was pressured and paranoid delusions, being controlled by others. Behaviour disorganised, making little sense in his conversation. Requesting methadone. Urine drug screen positive for methadone, benzodiazepines and THC. Initially in the open area of the ward, transferred to the HDU. Recent move from NSW. Plan, 1. Commenced on Na Valporate. 2. Help to access accomadation. 3.Contact family for more collatoral information 4.Continue management in HDU.

Use in Managing Clinical Care

> Case 5

	HONOS	admission 22/1/08	Discharge aim	week 1 22/1/08	week 2 29/1/08	week 4 5/2/08	week 5 12/2/08	week 6 19/2/08	week 7 26/2/08
1	overactive, aggressive, agitated	3				2			
2	self injury	0				0			
3	drinking and drug taking	4				4			
4	cognitive problems	2				2			
5	physical illness and disability	1				1			
6	hallucinations and delusions	2				1			
7	depression	0				0			
8	other mental/behavioural problems anti-social personality traits	3				3			
9	relationships	3				3			
10	ADLs, occupation,recreation	3				3			
11	living conditions	4				4			
12	occupation and activities	0				0			
	total								
	RISK ASSESSMENT								
1	harm to self			3	3	3	3	3	
2	harm to others			1	1	2	1	1	
3	level of problem functioning			4	4	3	3	3	
4	level of support available			0	0	0	0	0	
5	history of response to treatment			0	0	0	0	0	
6	attitude and engagement to treatment			2	2	2	2	2	
	overall risk (low/medium/high/extreme)			high	high	high	high	high	medium

Issues to Be Worked On

> Directly entering information from ward rounds including patients management plan, HoNOS and risk assessment onto CBIS

> Incorporate medical and allied health staff into annual competencies for outcome measures

> Consider using other parts of the NOCC suite of tools in the ward

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