Metabolic Monitoring in a Regional Community Adult Mental Health Setting

South Cairns Continuing Care Team (SCCT)

Cairns and Hinterland Hospital Health Service

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HRT 1712 Mental Health Improvement Group

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Key Problem

An overall lack of routine metabolic monitoring (MM) which was noted to be due to a number of factors:

- Organisation wide culture that MM was the sole responsibility of the GP
- No clear, consistent and longitudinal way to track the metabolic health of our consumers resulting in less than optimal (or totally unknown!) improvements in this area
- No leadership or MM “champion”
- Lack of correctly documented MM – even if the MM was done, trying to find this data in a maze of clinical notes was near impossible
- Clinicians not prioritising the MM of consumer
- SCCT culture that MM was traditionally seen as a nursing role, not necessarily a role that everyone (consumer, family, allied health, medical, nursing etc.) can contribute to – therefore the buy-in not being there

Aim of this innovation

- An organisation wide culture shift in acknowledging MM is a key part of Mental Health service delivery
- An overall improvement in the metabolic outcomes for consumers
- Early detection and treatment, at a local level, and within GP shared care arrangement

Key Changes Implemented

How were we going to achieve this?:

- Designated Nurse to coordinate, oversee and champion the program.
  - Has direct clinical contact with each consumer in order to complete MM requirements
  - Will follow up with Case Managers (C/Ms) directly if information is still missing (e.g. if pathology has not been completed)
  - Specialist level access to online pathology results, to obtain pathology results in a timely manner and to also ensure tests are not completed twice (e.g. by GP)
  - Enters the data into the approved forms on the consumer integrated mental health application CIMHA (Clinical notes)
  - Keeps a comprehensive database of all consumers and their MM status in order to easily access salient information and keep track of outcomes
  - Embedded into the SCCT team, has a desk in the same office and designated days dedicated solely to MM that correspond with medical clinic days in order to access
  - Yarrabah (Indigenous community) - Identified a champion (RN)- champion trained the Indigenous Liaison Officers (ILO's) to monitor for MM

- Introduction of routine metabolic monitoring practices, as dictated by evidence base, completed every 6 months for all SCCT clients
  - Pathology (Fasting glucose etc.) - minimum 6 monthly
  - Observations (Height, Weight, Waist circumference, BP, BMI) - minimum 6 monthly
  - Relevant health & demographic information (Family history, cultural background , tobacco intake, alcohol intake)

Key Changes Implemented

How were we going to achieve this?:

- All results documented in CIMHA on the approved forms
- Generation of a comprehensive database that monitors and keeps track of each SCCT consumer on their MM status
- MM status discussed and documented at weekly case review meeting
- MM nurse aligns work hours with regular scheduled medical reviews at the clinic
- Culture change around the importance of metabolic monitoring for consumers, families and staff
  - Designated “wellness room” where consumers are seen for their MM consult
  - Encouraging other staff members to take initiative around arranging MM in the absence of the MM nurse

- A feasible, sustainable, generalisable and easy to implement community-based program
  - Meeting with other community teams in the area around the SCCT MM program in order to support them in implementing a similar program in their catchment area

Baseline Data

- Review of the evidence base in order to ensure the most salient and evidence based observations and monitoring is being conducted and at the appropriate time intervals:
  - Utilisation of Positive Cardio-metabolic Health Algorithm (Curtis J, Newall H, Samaras K.)
  - Pathology (Fasting glucose etc.) - minimum 6 monthly
  - Observations (Height, Weight, Waist circumference, BP, BMI) - minimum 6 monthly
  - Relevant health & demographic information (Family history, cultural background, tobacco intake, alcohol intake)
- Prior project implementation, an audit of consumers MM was conducted and baseline data gathered – including % of those with full MM completion
- Presenting the proposal to the team and asking for feedback and suggestions
- Setting up of a wellness room – comfortable, non-mental health focussed space with all required provisions (e.g. obs machine, pathology slips, computer for direct documentation, comfortable chair for consumers, fresh fruit for a snack, algorithm on wall to support in education and rationale for consumers)
- Generation of a data base to store the monitoring data for each consumer as well as to track their MM status and outcomes
- Once baseline measures taken, aim to repeat every 6 months unless otherwise indicated

Outcomes so far

- Improved metabolic profile, especially in the Indigenous consumers
- Motivation to change – consumers see the results themselves and get motivated to change by improving diet and exercise
- Increased enthusiasm within team members
- Improved communication with the GPs
- Able to detect early metabolic changes and commence evidence informed treatment
- Exploring further options:
  - linking up with exercise physiologist - commenced talks with PCYC Gym
  - Dietician involvement
  - Linking in with ATLAS project (Depot GP shared care)
  - Formation of psycho-education group
  - Linking in a consumer rep
  - Quit program with NRT readily available
  - Exploration of the feasibility of a service-wide MM coordinator position

Lessons Learnt

- Culture change is both imperative and possible!
- Having “champions” to drive and co-ordinate a program, plus keeping it on the agenda for all staff to have ongoing input and buy-in, is central to success
- Putting in place clear protocols and procedures is crucial
- Would recommend to other services, in fact, other CCT’s in Cairns have started the process of setting up their own MM program based on this model