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How to Establish Local Beds in a Non-Specialist Environment

NSW Eating Disorders Network Forum
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Aims of the Workshop

To discuss the importance of local access to inpatient care for people with an eating disorder.

To facilitate discussion around the key elements of setting up eating disorders inpatient programs.

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Outline of the Workshop

- Background information (10 minutes)
- Our local experience (15 minutes)
- Key elements of setting up inpatient programs (10 minutes)
- Group work (30 minutes)
- Feedback and close (15 minutes)

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Background to the Workshop

Why are inpatient admissions important for patients with an eating disorder?

Why have local access to inpatient care?

What is the Evidence Base?

Types of admissions

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Why are Inpatient Admissions Important?

- Community-based care - preferred treatment option.
- A necessity and life-saving treatment option.
- The necessity will continue and will not be completely removed by LHD hospital avoidance strategies.
- Required - imminent serious risk of medical or mental health complications; ineffective outpatient treatment.

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Why Have Local Access to Inpatient Care?

- Specialist inpatient beds – scarce & can be difficult to access.
- Alternative model:
  - admission to general medical/psychiatric beds
  - addressing medical & mental health needs
  - integrated care - support to generalist clinicians by mental health/medical staff and specialist eating disorders services.

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Acute Medical Complications

- Malnutrition
- Dehydration
- Electrolyte disturbances
- Cardiac compromise
- Hypothermia
- Bradycardia
- Hypotension
- Renal problems
- Gastrointestinal changes

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Acute Mental Health Issues

- Increased agitation
- Self-harm
- Suicidality
- Co-morbid issues

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The Evidence Base for Inpatient Treatment

- Limited evidence to support inpatient care.
- Need to manage physiological complications of starvation, semi-starvation and purging behaviour.
- Need to manage risks associated with refeeding.
- Combinations of medical, nutritional and psychological interventions.
- Evidence supporting best way of achieving and maintaining appropriate nutritional status and eating behaviour is scarce.

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Barriers and risks

1. Medical or mental illness – fall between gaps
2. High illness mortality and morbidity
3. Access to, and treatment in, LHD hospitals can be inconsistent
4. ?depend on physician interest and willingness to admit, rather than on clinical need or current admission guidelines
5. Lack of understanding of the illness and illness-driven behaviour

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Types of Admissions

- Brief medical stabilisation versus nutritional rehabilitation
- Specialist versus non-specialist
- Medical versus Mental Health

It is about the patient journey and patient needs.

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The HNE LHD Experience

- Have implemented inpatient C&A ED programs in different settings in non specialised units.
- Set up programs on mental health and medical wards.
- Have learnt (and still learning) from these experiences.

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NEXUS Overview

- 12 bed C&A general mental health ward
- Locked ward environment
- Holistic view of patient needs
- MST provided with patients eating with all those in ward
- Strong therapeutic approach
- Emphasis on staff training and support

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J2 overview

- Collaboration between medical & mental health services
- Up to 4 beds available on medical ward
- Open ward
- Three levels: medical stabilisation, re-establishing eating patterns, community re-integration
- Reliance on range of departments
- Meal support for those with eating disorders
- Staff training and support

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Creating the J2 Eating Disorder Program

- Phase One: Development of agreements
- Phase Two: Development of protocols
- Phase Three: Implementation
- Phase Four: Evaluation

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Phase One: Development of Agreements

- Agreement on
  - Need for program
  - Overarching model of care
  - Roles and Responsibilities
  - Staffing / Dept involvement & designated time
  - Executive involvement
  - Developing a working party

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Phase Two: Development of Protocols

Developing processes surrounding:

Meal Support	Intake
Non Negotiables vs guidelines	Discharge
Safety	Family Meetings
Phases of treatment	Staff Support and Training
Containing ED behaviours	Team Meeting
Food Service	Evaluation
Schooling	Communication

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Phase Three: Implementation

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Phase Four: Evaluation

- Clinical / Service Outcomes
- Parent / Client Satisfaction
- Staff Satisfaction

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Service Data …

Table 1: Comparison of Key Patient Outcomes

Item	Year Pre-Program Implementation (Median, n=13)	Year 1 of Program Implementation (Median, n=19)	Year 2 of Program Implementation (Median, n=19)	*p*-value
% Without NGF	18	61	49	0.17
Change %EBW	9	9	9	0.26
ALOS (days)	35	26	30	0.47

Note: % Without NGF denotes the percentage of days without naso-gastric feeding;%EBW denotes percentage expected body weight; a Kruskall-Wallis one-way analysis of variance was used to assess difference between the 3 groups.

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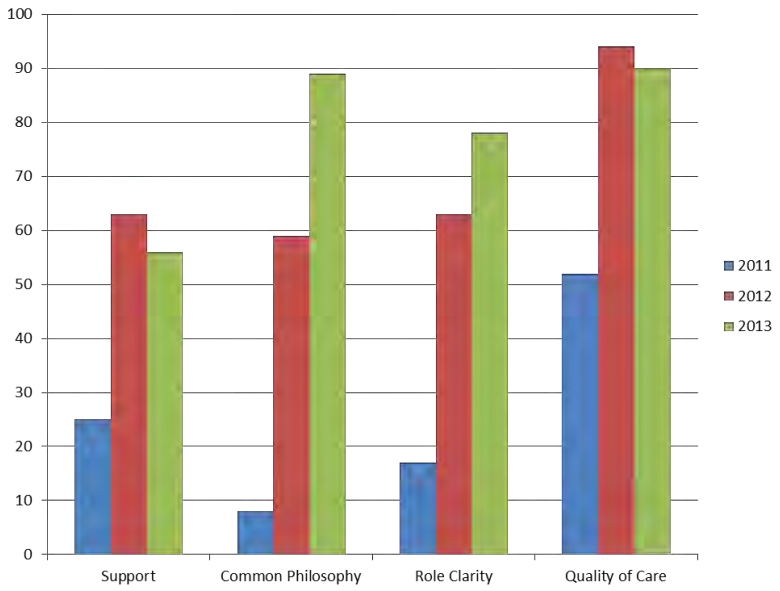
Changing Staff Perceptions …

Table 2: Comparison of Staff Perception of Care Provided and Self-Attributes Between the Year Before Program Implementation, Year One and Year Two of Program Implementation

Item	Year Pre-Program Implementation (n=12) Frequency (%)	Year 1 of Program (n=16) Frequency (%)	Year 2 of Program (n=10) Frequency (%)	p-value
Care Satisfaction	7 (58)	15 (94)	9 (90)	0.04
Role Clarity	2 (17)	10 (63)	7 (78)	0.01
Shared Philosophy	1 (8)	11 (69)	8 (89)	<0.01
Supported in Role	3 (25)	10 (63)	5 (56)	0.13
Level of Comfort	10 (83)	12 (75)	9 (100)	0.27
Level of Confident	9 (75)	14 (88)	8 (89)	0.60
Level of Knowledge	9 (75)	13 (81)	9 (100)	0.29
Level of Skill	9 (75)	14 (88)	8 (89)	0.60
Level of Willingness	9 (75)	14 (88)	9 (100)	0.25

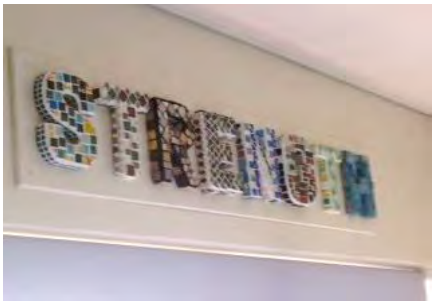
Note: % denotes percent; a Chi-Square Test was used to assess difference between the 3 groups; where multiple comparisons were found to be significant a Fisher's Exact test was used to assess difference between the year before program implementation and each year of program implementation.

Changing Staff perceptions …



Patient and Parent/Carer Feedback:

- CSQ Atkinson 2008
- Score out of 100



- Parent Score 84.21 Mean, 84 Median
- Patient Score: 73.68 Mean, 75 Median

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What are the Key Elements?

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Learning from experience

- Ensuring organisational support/agreement overarches the program
- That medical AND mental health services view eating disorders as a shared core business
- That roles and responsibilities are clearly defined, agreed upon and accountable
- That clear protocols are developed and consistently applied (for both medical, mental health and ward issues)
- Supported staff = supported clients

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Group Work

1. What is your current model of inpatient treatment (where do patients go and what will they be offered)?
2. Are there any gaps?
3. What would be key elements in ensuring timely access to appropriate inpatient care (within or external to the LHD)?

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Conclusions

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