Adult Inpatient Care Pathway

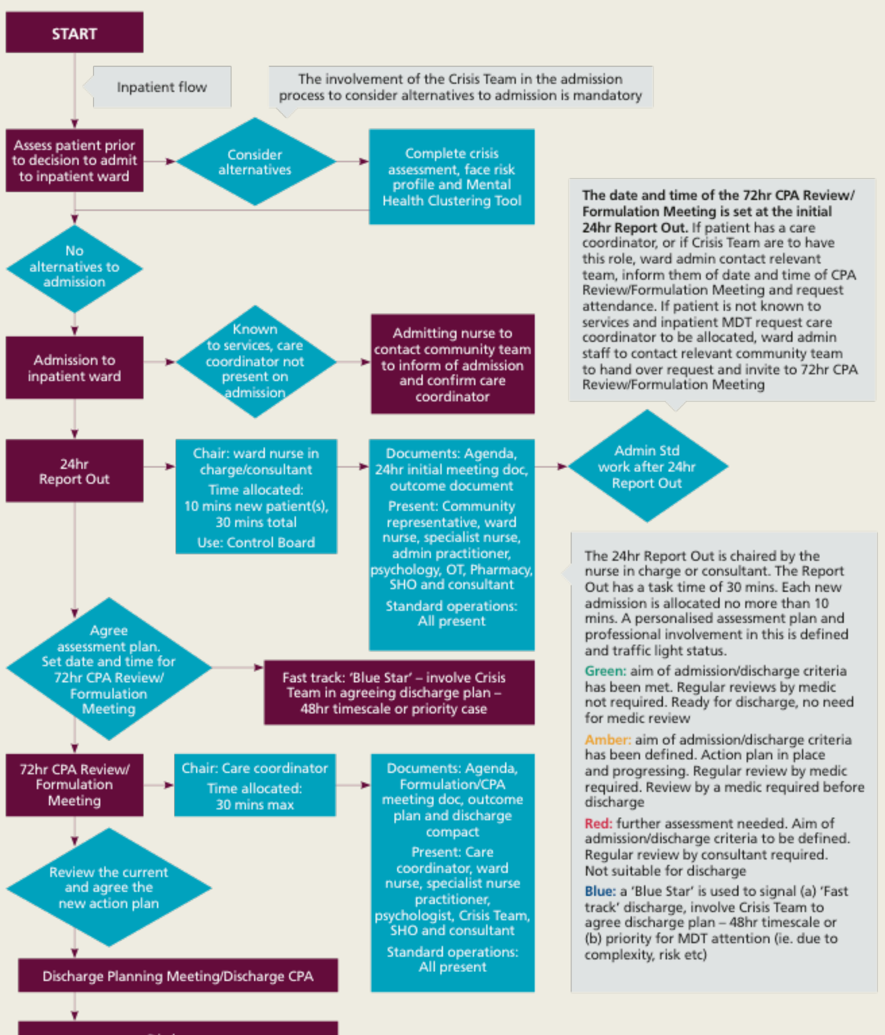
Based on NICE Guidance

Dr J S Phull

CONTEXT

- The following is intended to offer information derived from NICE guidance and good practice principles
- This guidance ought to be used as principle based information only and any health care provided must be individualised to specific risks and presentation of the patient.

PROCESS



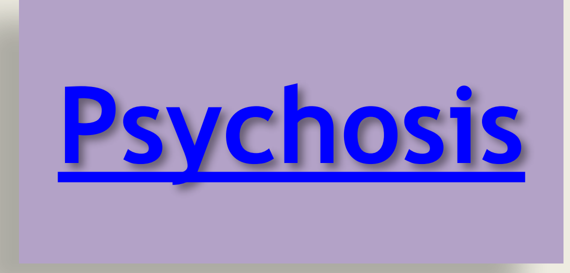
Crisp, 2016

NICE CLINICAL PATHWAYS

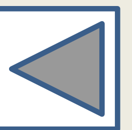
- Rehabilitation services are considered at the assessment stage when criteria for early rehab is met - *see early rehab referral assessment tool*
- Individualised, patient focused throughout; focused on secondary care
- The pathway recommended by NICE are divided into stages.
- Click here to get a general introduction to these stages.

The three diagnoses below remain the most common for acute admission

Click on the icon to access pathway



ADMISSION STAGES

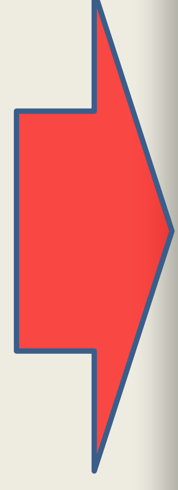


Assessment

- Risk formulation
- Care pathway goals
- EDD set
- PbR/coding
- Accommodation and social needs assessment
- Utilised when all other options have been exhausted.

Treatment

- Interventions based on assessment
- Treatment of mental disorder
- Managing associated risks
- Physical health
- Social rehabilitation
- Occupational Rehabilitation

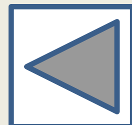


Transition

- Aftercare
- Transitional work
- Leave and medication testing
- Communication with GP, multi agency, carer & community team
- *Structured discharge arrangements*

PERSONALITY DISORDERS
F60

Personality Disorder Assessment



Assessment* is through a structured assessment of the personality disorder and of the co-morbidities

- A clear purpose, care pathway goals and estimated discharge date (EDD), are set consistent with crisis plans and overall formulation.
- Inpatient admission is used when all community options inappropriate
- Ideally patients are voluntarily admitted in collaboration with shared goals via review with the patient, clinical team, notes and carers.
- An informal contract should be used to support CPGs
- Clarity on aftercare and discharge accommodation
- CPA to be used actively, esp. if admitted 2x/6months
- Suitability for specialised care ought to be considered

Dissocial PD

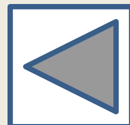
likely targets include:

- impulsivity
- anger
- interpersonal issues

*[Dissocial PD](#)
*[Borderline PD](#)

Transition

Personality Disorder Assessment



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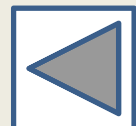
Borderline PD

targets include:

- emotional dysregulation
- intermittent psychotic symptoms
- problem solving difficulties
- self harming

*Dissocial PD
*Borderline PD

Transition



Personality Disorder Treatment

Treatment is individualised, focused on a risk management plan and care pathway goals with multi agency care when required

- Medications
- Psychological interventions -based on past history
- Links should be made with local community based pathways, external agencies and networks
- Address: co-morbidities, substance misuse issues, occupational, social, rehabilitative and physical health needs
- NICE based for insomnia and self harm with specialised services (and networks) consulted and utilised where appropriate.
- Personal responsibility supported through exploration of alternative coping methods especially during crises and encouraging them to consider alternative treatment methods and their consequences.

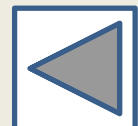
Medications

- Primarily for co-morbidities
- Discouraged for general use
- Short term crisis management (e.g. for 1 week)

Assessment

Transition

Personality Disorder Treatment



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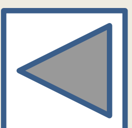
Psychological Interventions

- Initial psychoeducation
- Brief interventions and understanding of need for further treatments
- Further psychotherapy supported, where appropriate: ideally within the community

Assessment
Transition

Personality Disorder Transition



- **Managed endings** through setting of early discharge date, key worker interventions and agreement with carers and community teams
- Key transitional outcomes based on: personal functioning, substance abuse, self harm and risks, co-morbidities and specific target symptoms
- Medication self management testing
- Safe leave protocol* used and home safety considered
- Aftercare arrangements - early warning signs and crisis plans reviewed
- Care plans stating how to manage distress, cope with future crises, access services and re engage with community mental health services

Insomnia

- **Primary** insomnia can be differentiated from (**secondary**) insomnia associated with factors such as personal circumstances, **physical or psychiatric co-morbidities, concomitant drug treatments or substance abuse.**
- A clear history and assessment are *essential*
- 1. Appropriate management of **existing co-morbidities** may relieve the symptoms.
- 2. The provision of advice on appropriate routines to encourage **good sleep hygiene** is key to the overall management strategy, for example, avoiding stimulants and maintaining regular sleeping hours with a suitable environment for sleep.
- 3. Other **non-pharmacological interventions** (for example, CBT-i) have also been shown to be effective in the management of persistent insomnia.
- 4. **Polysomnography** *may* be considered (noting time taken to get to sleep, duration of sleep and number of awakenings)
- 5. Pharmacological - **zaleplon, zolpidem, zopiclone and the shorter-acting benzodiazepines are preferred,** noting that patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others from the same class
- **Problems with benzodiazepines** include- tolerance, dependence, withdrawal syndrome may be prolonged and may develop at any time up to **3 weeks after cessation of a long-acting benzodiazepine, or a few hours after cessation of a short-acting one. The syndrome includes anxiety, depression, nausea and perceptual changes.**
- '**Rebound insomnia'** can also occur following withdrawal and is characterised by a worsening of the original insomnia symptoms.
- There are also problems of **abuse** with benzodiazepines as they enhance and often prolong the 'high' obtained from other drugs and alleviate their withdrawal effects.
- Hypnotics should be prescribed for **short periods of time only at the lowest possible dose.** Benzodiazepines can be used for severe insomnia and should be **avoided** being prescribed beyond **4 weeks** (CSM guidance).
- **Switching** of hypnotics should only usually occur if a patient experiences adverse effects.

Self harm: long term management

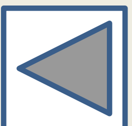
- Self-harm is defined as **any act of self-poisoning or self-injury**
- Offer a comprehensive **psychosocial assessment** of needs and risks to understand and engage and to initiate a therapeutic relationship.
- Explore the *meaning* of self-harm for the individual.
- Patients over 65 years *or* younger individuals with multiple risk factors require **specific** risk assessment consideration. All acts of self injury should be considered as evidence of *serious intent* in older adults.
- **Personal assessment**: skills, strengths and assets/coping strategies/ mental and physical health problems or disorders/social circumstances and problems/psychosocial and occupational functioning, and vulnerabilities/ recent and current life difficulties/ the need for intervention and treatment for any associated conditions/ including the needs of any dependent children or adults
- **Consider: s**pecific risk and protective factors that may increase or decrease the risks associated with self-harm/coping strategies/ significant relationships that may either be supportive or represent a threat/immediate and longer-term risks.

Self harm: long term management

- **Care plans** aim to: prevent escalation of self-harm/ reduce harm arising from self-harm or reduce or stop self-harm/ reduce or stop other risk-related behaviour/ improve social or occupational functioning/ improve quality of life/ improve any associated mental health conditions/ identify realistic and optimistic long-term goals, including education, employment and occupation/ identify short-term treatment goals (linked to the long-term goals) and steps to achieve them/ identify the roles and responsibilities of any team members and the person who self-harms/include a jointly prepared risk management plan be shared with the person's GP. Such plans should be subject to regular & timely reviews.
- **Risk Management Plans** aim to address: risk factors addressing immediate & longer term risks, include a crisis plan outlining self-management strategies & how to access services
- **Avoid** offering medication treatment as a specific singular intervention to reduce self-harm and consider offering 3-12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm and discuss harm minimisation strategies (alternatives) and treat any co-morbid mental disorder.

PSYCHOSIS F20/F23/F25

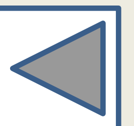
Psychosis Assessment



- Establish a clear purpose, care pathway goals and estimated discharge dates for admission that are consistent with crisis plans and overall formulations
- Patients are admitted with shared goals via review with patient, clinical team, history and carers
- Precipitants to relapse and perpetuating stresses are considered
- Involve advocacy and offer second opinion if requested
- Consider rehabilitation if needed via early identification

Treatment
Transition

Psychosis Treatment



[Acute](#)

[Post-acute](#)

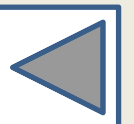
Acute

- Establish antipsychotic (consider depot) plus augmentation (if required) in conjunction with CBT-P/Family therapies & possible arts therapy (negative symptoms)
- Consider *EI pathway* if first episode psychosis
- Measure metabolic profile before and after treatment. Consider: response, risks (QRISK2/ QDSCORE) and other side effects.
- Manage physical health needs through LESTER tool and NICE based pathways & Medic-alerts.
- Consider NICE violence and relevant guidance
- Educate about discontinuation of treatment / psychoeducation; peer support; physical health interventions including smoking cessation; offer advocacy; substance misuse and co morbidity treatments.

Assessment

Transition

Psychosis Treatment



Acute

Post-acute

Post -Acute

- Document patient's view on their experience
- Establish a shared understanding of precipitants, educate and monitor EWS
- Consider diagnosis and further treatment

If non response to acute treatment occurs-

- Consider compliance, substance misuse, diagnosis, perpetuating stressors +/- physical illness, is psychological treatment tolerated
- Clozapine if 2 non success with augmentation , only if above considered for 6-8wks (and as a 10 week trial)
- Re: medications choice: consider- *metabolic; EPS; CVS; hormonal and other side effects*
- Offer supported activities/education/ employment and document activity in care plans and aim for occupational outcomes

Assessment

Transition

Psychosis Transition

- **Managed endings** through setting of early discharge date, key worker 1:1s and links with carers and community teams
- Key transitional outcomes include: treatment response; personal functioning; co-morbidities; occupational and social functioning; adherence to medications and risks.
- Medication self management and safe leave tested (safe leave protocol)
- Safe discharge protocol utilised
- Aftercare arrangements (including potential CTO/guardianship/s.41 etc), WRAP, EWS and crisis plans reviewed

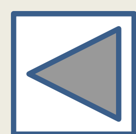
Violence

- **Pre intervention**- Provide information to patient -1. Name of keyworker 2. why they were admitted 3. rights for treatment/MHA 4. what happens if disturbed
- Discuss with patient their preferences when violent/disturbed, **EWS, trigger factors (attitudinal, situational, organisational, environmental), medication history plus adve events are recorded
- Record physical needs/ disabilities, and provide a daily timetable, including activities.
- Provide access to the dayroom for those who do not sleep
- Ensure the policy for harassment and abuse including safeguarding use are utilised when appropriate
- Ensure availability of medication and resuscitation equipment
- Ensure awareness of those with Hepatitis/HIV/contagious disease when acting in a disturbed manner
- Create a risk formulation based on a suitable violence risk assessment and ***risk factors (clinical, situational, personal) including EWS
- Utility of a search policy for patient/visitors
- Adopt a preventative approach to violent behaviour through a focus on– i. De-escalation + ii. Observation

- **Facial expressions tense and angry.Increased or prolonged restlessness/ body tension/ pacing/ General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils)/ Increased volume of speech/ erratic movements/.Prolonged eye contact/ Discontentment/ refusal to communicate/ withdrawal/ fear,/irritation/Thought processes unclear/ poor concentration/.Delusions or hallucinations with violent content./ Verbal threats or gestures.*

- **Intervention**- RT (rapid tranquillisation), seclusion and restraint reserved for when other methods have not worked and consistent with MHA - not used as punitive and avoid when significant self harming/etc.
- *During RT* – consider – benzodiazepines (LoC, respiratory depression, CV collapse especially clozapine), antipsychotic (EPS, CV collapse, seizures, fits), antihistamine (sedation, anticholinergic, pain) – document: risk- benefits and rationale
- **Post Intervention** – consider – response/monitoring/physical needs/opportunity to discuss post intervention
- Generic – consider – physical and clinical environment (patient / activities/ safety/ alarms) / police working/ observation policy/staff training
- Post intervention, utilise every opportunity to establish whether the patient understands why this has happened; ideally should be carried out by a staff member not directly involved in the intervention

- ****Personal - History of disturbed/violent behaviour. History of misuse of substances or alcohol. Carers reporting service user's previous anger or violent feelings. Previous expression of intent to harm others. Evidence of rootlessness or 'social restlessness'. Previous use of weapons. Previous dangerous impulsive acts. Denial of previous established dangerous acts. Severity of previous acts. Known personal trigger factors. Verbal threats of violence. Evidence of recent severe stress, particularly loss event or the threat of loss.*
- *Clinical - Misuse of substances and/or alcohol. Drug/medication effects (disinhibition, akathisia). Active symptoms of schizophrenia or mania, especially delusions or hallucinations focused on a particular person, command hallucinations, preoccupation with violent fantasy, delusions of control (especially with violent theme), agitation, excitement, overt hostility or suspiciousness. Poor collaboration with suggested treatments. Antisocial, explosive or impulsive personality traits or disorder. Organic dysfunction.*
- *Situational - Extent of social support. Immediate availability of a potential weapon. Relationship to potential victim (for example, difficulties in relationship are known). Access to potential victim. Limit setting (for example, staff members setting parameters for activities, choices etc.). Staff attitudes.*



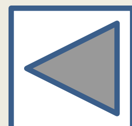
MOOD DISORDERS
F30

Depressive Disorder

Bipolar Disorder

DEPRESSIVE DISORDER
F30

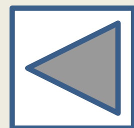
Depressive Disorder Assessment



- Clear purpose, care pathway goals, estimated discharge date are set consistent with crisis plans and overall formulations
- Assess **severity** of the depressive disorder and provide information on diagnosis: e.g. moderate depressive episode. Risk management is key.
- Patients are admitted with shared goals via review with patient, clinical team, notes and carers
- Precipitants; predispositions to relapse and perpetuating stresses are considered
- Involve advocacy and offer second opinion if requested
- Admission reserved for more complex and severe depressive conditions associated with significant risks

Treatment
Transition

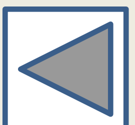
Depressive Disorder Treatment



Treatment is according to stepped care process dictated by severity, using:

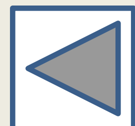
- A combination of antidepressant medications and a high-intensity psychological intervention (CBT or IPT) for **moderate-severe depression**
- For medications: consider interactions, physical health, toxicity, tolerability and discontinuation plus side effects profile. Continue for at least 6/12 post remission. Review and alter treatment at 6-8 weeks.
- Benzodiazepines helpful in initial phases but note increased agitation and risk
- For **psychotic depression** augmenting the treatment with antipsychotic medication is considered usual practice.
- Address co morbidities especially substance misuse and personality disorder.
- Consider ECT -acute treatment of **severe depression** that is life–threatening: when a rapid response is reqd./other treatments have failed.

Depressive Disorder Transition



- Managed endings through setting of early discharge date, key worker and links with carers and community teams
- Medication self management and safe leave tested
- Key transitional outcomes: personal functioning; occupational functioning; symptoms; risks and engagement.
- Use of safe discharge format
- Aftercare arrangements (including potential the use of MHA, where appropriate), WRAP, EWS and crisis contingency plans reviewed

BIPOLAR DISORDER
F30

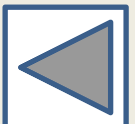


Bipolar Disorder Assessment

- Clear purpose, care pathway goals, estimated discharge date are set consistent with crisis plans and overall formulations
- Patients are admitted with shared goals via review with patient, clinical team, notes and carers
- Precipitants to relapse and perpetuating stresses are considered
- Involve advocacy and offer second opinion if requested
- Admission reserved for more complex and severe depressive conditions associated with significant risks
- Consider rehabilitation and create a physical health plan
- Document a thorough history
- Mood rating scale (e.g. Young's mania rating scale etc.) and provide psychoeducation

Transition

Bipolar Disorder Assessment



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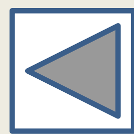
Review:

- Family history
- Review of previous episodes
- Symptoms now & between episodes
- Triggers
- Substance misuse
- Anxiety
- Physical health
- Differential diagnosis
- Psychosocial stressors

Transition



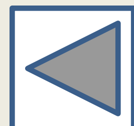
Bipolar Disorder Treatment

- Provide information on ward, diagnosis and treatment
- Regular 1:1 contact with key worker, medics and access to pharmacy
- Meaningful activity and dietary care interventions
- Continuity of care with care coordinator
- Patient views considered- access to advocacy and support

Acute Mania
Prophylaxis of Mania
Bipolar Depression
Prophylaxis for Bipolar Depression
Long Term Management for Rapid Cycling
General Management
Medication Monitoring

Transition

Bipolar Disorder Treatment



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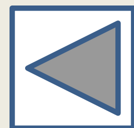
Acute Mania

- Stop/reduce antidepressant
- Add antipsychotic – haloperidol/ olanzapine/quetiapine/risperidone
- An alternative antipsychotic then a mood stabiliser (lithium then valproate) with optimisation of dosing. Consider benzodiazepines.
- Manage insomnia
- Note – interactions, co morbidities, effects of anticholinergic load, choice, if stopping- reduce meds over 4/52
- ECT –reserved for either severe mania or catatonia
- Gabapentin & topiramate not used

Assessment
Transition

Bipolar Disorder Treatment



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Prophylaxis of Mania

- Lithium
- Valproate
- Olanzapine
- Quetiapine
- Relapse prevention treatments

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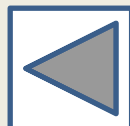

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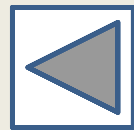
Bipolar Depression

- Increase anti manic medication
- Quetiapine as monotherapy
- SSRIs (+ gastro protection if reqd) co prescribed with olanzapine
- Psychological treatments
- Lithium optimisation
- ECT if severe
- Lithium augmentation with olanzapine or lamotrigine

Transition

Bipolar Disorder Treatment



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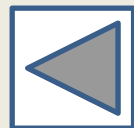
Prophylaxis for Bipolar Depression

- Long term minimal dose SSRI + mood stabiliser
- CBT in combination
- Quetiapine + Lamotrigine
- Relapse Prevention based interventions

Transition



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Long term Management for Rapid Cycling

- Lithium + Valproate
- Or Lithium on its own
- Antipsychotic medications

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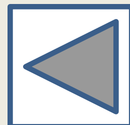

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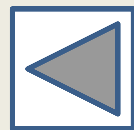
Medication Monitoring

General Management

- Regular activity
- Environment needs
- Coping strategies development
- Offer supported activities
- Education
- Employment
- Document activity in care plans and occupational outcomes
- Promote healthy lifestyle – QRISK2/QDSCORE
- Monitor physical health and treatments: even 2 yrs post medication discontinuation
- Risk management key

Assessment
Transition

Bipolar Disorder Treatment



- Provide information on ward, diagnosis and treatment
- Regular 1:1 contact with key worker, medics and access to pharmacy
- Meaningful activity and dietary care interventions
- Continuity of care with care coordinator
- Patient views considered- access to advocacy and support

Acute Mania
Prophylaxis of Mania
Bipolar Depression
Prophylaxis for Bipolar Depression
Long Term Management for Rapid Cycling
General Management
Medication Monitoring

Medication Monitoring

- **Lithium** – U&Es, TFTs, ECG, Ca and levels, risk of rebound with poor adherence, plasma levels after 1/52 + same after dose increase and 3-6/12, advice re toxicity (neurotoxicity, including paraesthesia, ataxia, tremor and cognitive impairment), NSAIDS/ ACEi/diuretics, reg. blood monitoring – discontinue if needed over 1-3/12.
- **Valproate** – Contraception advice, liver function, PTT, weight & FBC
- **Quetiapine** – Lipids, FBC, glucose, thyroid function, weight & ECG
- **Lamotrigine** – rash
- **Carbamazepine** – FBC, LFTs, U+Es, weight, interactions and levels

Assessment
Transition

Bipolar Disorder Transition

- **Managed endings** through setting of early discharge date, key worker and links with carers and community teams
- Medication self management and safe leave tested
- Safe discharge and leave protocol utilised
- Aftercare arrangements (including potential CTO/guardianship etc), WRAP, EWS and crisis plans are reviewed

HELP

- Click on icons to access topic
- Text in **blue** with underline carry links to further information
- Clicking will return to 'Pathways' page
- Clicking will take you to previous screen.

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