Mental Health Nurse in General Practice

General Practice Orientation Guide

Queensland Government
Queensland Health

Disclaimer

This Mental Health Nurse General Practice Orientation Guide has been developed primarily to support General Practitioners & Practice staff to prepare for employment of a Mental Health Nurse. The Guide should be read in conjunction with the Mental Health Nurse Incentive Program Guidelines (2111.18.03.08) & the IWMDGP Summary for General Practice. The Guide has been developed collaboratively by Ipswich & West Moreton Division of General Practice and West Moreton South Burnett Integrated Mental Health Service, and was jointly funded by Queensland Health and General Practice Queensland through the Partners in Mind Framework, and the Department of Health & Ageing through the Mental Health Nurse Incentive Program. The information in this document was correct as of July 2008.

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ACRONYMS

GP	General Practitioner
HoNOS	Health of the Nation Outcome Scales
MHN	Mental Health Nurse
MHNIP	Mental Health Nurse Incentive Program

IPSWICH & WEST MORETON
DIVISION OF GENERAL PRACTICE

How will the referral to the Mental Health Nurse work?

A General Practitioner (GP) will determine which patients are eligible for referral to the Mental Health Nurse (MHN) based on the criteria listed in *The General Practice Orientation Guide* developed by IWMDGP (p 5,6). The steps of referral may differ slightly from Practice to Practice; however, standard referral templates have been developed and, prior to the MHN commencing at a Practice, these forms will be loaded into the medical software by the MHN in consultation with the Practice staff.

Steps of Referral

1. GP will identify eligible patients, discuss the service with the patient and obtain agreement for referral to a MHN.
2. GP completes the referral to MHN.
3. Referral form is given to Practice staff who book the patient to the next available appointment, advising patient of the date and time.
4. The day before the MHN session, the Practice staff contact the patient and confirm the appointment.
5. The MHN is provided with the relevant patient information - access to patient record and the current GP Mental Health Care Plan if in place.
6. The referring GP or Practice Principal will be available for relevant clinical discussion as required by the MHN.
7. The MHN will complete all relevant documentation for each patient and inform the GP of any actions either in consultation or via internal email.
8. The MHN, in consultation with the Practice staff, will be responsible for booking of patient reviews as clinically indicated and/or 3 monthly as outlined in the Care Plan.

Mental Health Nurse contribution to GP Mental Health Care Plans

It is a requirement of the Mental Health Nurse Incentive Program (MHNIP) Guidelines that each eligible patient will have a GP Mental Health Care Plan in place. As you are aware, a completed Plan (Item 2710) claimed under Medicare allows referral to psychologists, social workers, Occupational Therapists and Psychiatrists and is available for the patient. However, a GP Mental Health Care Plan is also suitable for a patient who does not require referral to the above services and can be managed appropriately by a GP and a MHN.

It is required that a GP Mental Health Care Plan be put in place with the nurse to define the roles of the GP and MHN in the care of the patient.

No General Practitioner Mental Health Plan

1. The GP is responsible for establishing the initial Care Plan and for the final completion – treatment actions and referrals.
2. The MHN can provide assistance through an initial comprehensive assessment and at the interim care plan process, including administering the relevant Health of the Nation Outcome Scales (HoNOS) outcome tool. The HoNOS scale will be completed at the initial assessment, every 90 days and on exit from the program.

No General Practitioner Mental Health Plan (Cont.)

3. The MHN is able to complete the Assessment component, provide recommendations and set any tasks through an interim plan which will inform the GP Mental Health Care Plan (item 2710).
4. The patient is then required to see the GP to complete the plan process.
5. The completed Care Plan is discussed with the patient and, if in agreement, the patient signs and is given a copy. The Care Plan is included as part of the patient record.
6. The Plan must include specific reference to the roles and responsibilities of the patient, MHN and the treating GP. Treatment must be provided according to the Plan and the relevant clinical guidelines for the treatment of that disorder. The GP must regularly review the Care Plan in collaboration with the MHN. The review should include, where appropriate, input from a clinical psychologist, registered psychologist or other allied health professional.

General Practitioner Mental Health Care Plan in Place

1. The MHN will review the Care Plan as part of the initial assessment and provide any additional recommendations in the patient record.
2. Record on the Care Plan any relevant information to reflect the MHN involvement in patient management.
3. The patient will then be provided with an updated copy of the Care Plan. A 2712 can be claimed providing it is 4 weeks to 6 months from the date of 2710, or 3 months from the last 2712 (review).

How will the information be recorded?

At the periodic review and repeat reviews, the MHN will provide documentation into the patient record and this can be done in one of three ways:

1. directly into the electronic patient's file *(ideal)*,
2. completed on template to be scanned into the system,
3. completed on template to be put into patient's file.

HoNOS Outcomes Measure

MHNs are required to use the Health of the Nation Outcomes Scale (HoNOS) for each patient at entry to the program and subsequently measure changes in patients' symptoms and functioning using these tools every 90 days and at exit from the initiative.

These measures include the Child and Adolescent (HoNOSCA), Adult (HoNOS), and Older Person (HoNOS65+) tools. All nurses are skilled in the use of the HONOS outcome measures and will use a combination of outcome tools as required.

What is needed within the clinic environment?

- Private consultation space
- Measures to ensure security alarm is heard
- Telephone
- Power outlet (for laptop)
- Locked filing space for patient records
- Access to Practice Medical Director to add notes to patients' files
- Person appointed as Practice contact (coming in or leaving, confirms appointments for the session, able to phone if late, etc.)
- If unable to access Medical Director, a nominated person or secure file storage for later filing/scanning into patient file

For your other Practice staff

- Introduction of the MHN to your staff and outline their role.
- Identify the role of other staff in relation to the MHN.
- Incorporate the MHN sessions into the Practice appointment schedule.
- An orientation to your facility, i.e., toilets, phone system, policies, procedures, parking.

Referral

Standard template will be downloaded into the Practice software system prior to commencement of the MHN service. The MHN is required to complete documentation for Medicare for each patient at each session. These details are to be provided to the MHN to access easily. The information required is:

- GP name and provider number
- Patient name and date of birth, Patient Medicare number

Additional information required by the MHN will relate to the following:

- Presenting problem, family/social history, mental health history
- Relevant medical conditions/complaints/allergies, medications
- Attach GP Mental Health Care Plan if one is completed.

Appointment System

For new appointments, the Practice staff should enter the patient appointment into the practice appointment booking system using the booking and recall guide times below. The Practice staff are required to place a reminder call to each patient 24 hours before the MHN sessions. If a patient is unable to attend, a replacement patient should be booked where possible.

Booking and Recall

New Patients (Individuals 1.5 hours, families 2 hours)

- To be booked for an appointment in the available session time
- Ensure availability of notes for clinical handover.
- Where no GP Mental Health Care Plan exists, book appointment sometime in the following 2 weeks to complete the GP Mental Health Care Plan following review by the MHN.
- Either allocate time for GP to attend part of consultation (so GP can bulk-bill consultation item) or obtain patient consent for referral to MHN.

Repeat Patients (Individual 30 minutes, families 45 minutes)

The MHN and the Practice staff in collaboration should ensure each patient is given a 3-monthly review appointment as outlined within the GP Mental Health Care Plan. For repeat visits, the MHN will issue a business card with the next appointment date and time. This is to be taken to front desk staff to diarise next appointment. Where the session has a number of patients booked, in negotiation with the MHN the patient will be offered an appointment at a future date and this will be written on an appointment card.

The MHN will require access to the appointment calendar and be informed by the agreed method if he/she is fully booked or no appointments have been made.

Discharge (Individual 1.5 hours, families 2 hours)

- Establishment of a discharge agreement for patient file
- Method of re-engaging the person with the MHN if required
- MHN will assist in developing plan for relapse prevention and crisis.

Safety

It is ESSENTIAL that a Safety Plan is in place for the Practice. This may include:

- Development of or adjusting Practice safety policy
- Presentation to Practice staff of personal alarm, i.e., what the alert sounds like, what to do in the event the alert is sounded
- Appointment of front desk staff to manage appointment process (check if appointment is suspiciously overtime or be contactable on internal messaging system)