Borderline Personality Disorder Pathway Re-Audit 2022

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1. Introduction

- Long unstructured inpatient admissions can be detrimental to patients with Borderline Personality Disorder (BPD) (NICE 2009, Paris 2004), however admissions can not always be avoided.
- In 2017 the “Pathway for Patients with Borderline Personality Disorder (BPD) within Mental Health and Learning Disabilities” (BPD Pathway) was developed in Grampian to support clinicians with the management of inpatients with BPD.
- The standards set in this pathway were audited before and after the introduction in 2017.

2. Aims

This re-audit aimed to assess if there was any change in meeting the standards set in the BPD Pathway for inpatients treated in Royal Cornhill Hospital (RCH).

3. Methodology

Between 1st May 2022 – 31st October 2022 a total of 73 admissions to RCH with a diagnosis of BPD were identified.
A retrospective review of medical and nursing notes was carried out. The standards were set with regard to the recommendations of the BPD Pathway Version 3.2 (2019). Patients presenting with symptoms of co-morbid major mental illness e.g. psychosis were excluded.

4. Results

- There were a total of 57 admissions during the 6 months period
- 84% were female with a average age of 32 years
- 50% of patients had no psychiatric co-morbidity, with substance misuse and a mood disorder constituting 22% and 15% respectively
- 25% were referred by the police and 28% by the CMHT (fig 1)
- 84% were admitted in the context of crisis
- 35% had a crisis plan available on admission (fig 2)

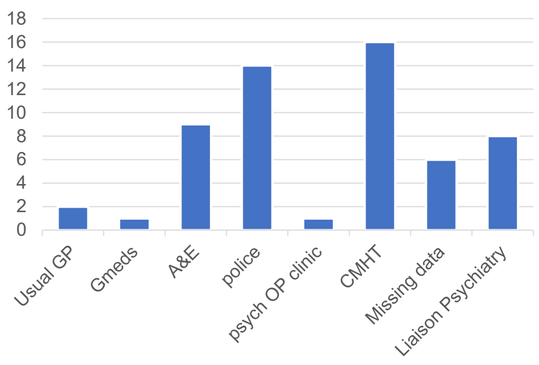

Figure 1: Referral source in total numbers

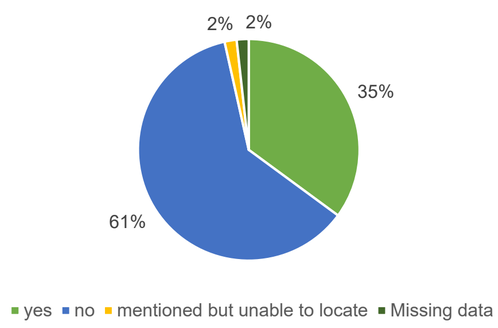

Figure 2: Crisis plan available on admission

- 18% of patients had a time limitation noted at admission, 25% at senior review with 52% not having a time limitation noted in their records.
- 56% of patients had their purpose of admission recorded at admission with 18% recorded at senior review (fig 3).

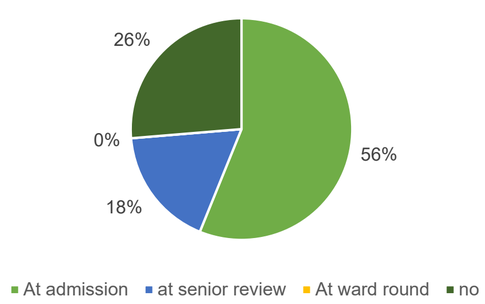

Figure 3: Purpose of admission recorded

4. Results

- 91% of patients were admitted on an informal basis
- 33% of the patients were given freedom of movement when admitted (fig 4)

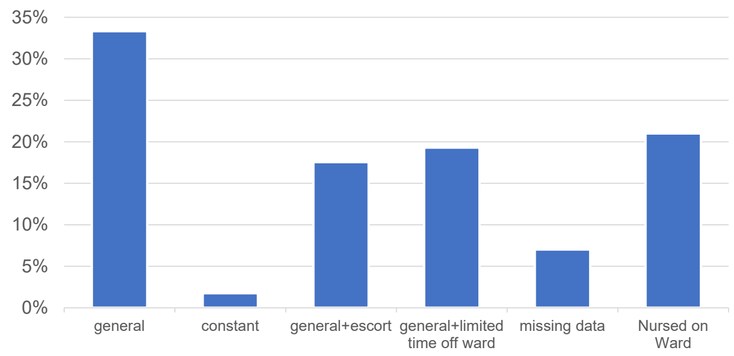

Figure 4: Observation level on admission

- 91% of patients did not have their crisis plan reviewed during their admission.
- 52% of patients were not offered daily therapeutic activity whilst admitted (fig 5)
- 34% of the patients had new medication started
- The average length of stay for patients was 18 days with 41% staying 7 days or less (fig 6)

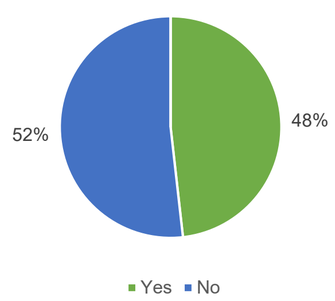

Figure 5: Daily meaningful activities

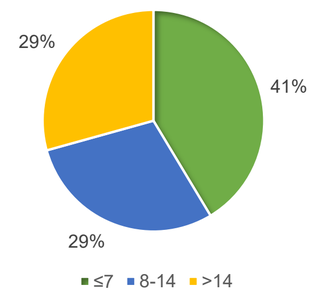

Figure 6: Length of admission in days

5. Discussion

Overall the number of admissions has remained stable between the 3 audit periods. The percentage from patient being brought in by the police has increased from 12% to 25%. Similar to the previous audit 67% of patients had their movement restricted when they were admitted to hospital, but informal admission remained high at around 90%.
Unfortunately, we are seeing a stagnation at 35% of patients having a crisis plan on admission. However, there was a significant increase from 20% to 56% of patients who had the purpose of the admission was recorded.
During the admission only 9% had their crisis plan reviewed compared to 23% during the previous audit and only in 48% an offer of daily meaningful activity was documented. 34% of the cases had been started on new medication on discharge which is a slight reduction from 44% from the previous audit. Unfortunately, there has been a reduction in patients being admitted for 7 or less days from 63% to 41%.

6. Conclusion

Compared to the previous audits there is an improvement in some areas such as documenting the goal of an admission and in avoiding new medication to be started. However there is a deterioration in other areas such as a tendency towards longer admissions and a decrease in patients who have their crisis plan reviewed. In most other areas there does not seem to be a change in practice. Overall there seems to be a need for a more consistent implementation of the recommendations of the pathway. Furthermore a change in culture might be needed to improve a collaborative working with patients.

References:
NICE (2009). Borderline Personality Disorder: Treatment and Management. CG78
Paris, J. (2004). Is hospitalisation useful for suicidal patients with borderline personality disorder? Journal of Personality Disorders, 18, 240-7
NHSG Pathway for Patients with Borderline Personality Disorder (BPD) within Mental Health and Learning Disabilities