Cardiometabolic disease risk screening - are we doing it right?

AUTHORS: Liam Farrell[1], Gauri Godbole[2], Jennifer Moroney[2], Hayden Houlten[2] **(All correspondence to : Gauri.Godbole@health.nsw.gov.au)**

[1]School of Biomedical Sciences and Pharmacy, University of Newcastle, Callaghan, NSW, Australia [2]Central Coast Local Health District, Gosford Hospital, NSW, Australia

Background

Patients with mental health conditions are at an increased risk of developing cardiometabolic diseases (CM) due to medications and lifestyle factors.

It is therefore prudent to ensure all patients admitted in the mental health unit get a CM disease risk screening. CM disease risk screening is essential to assess any emerging conditions such as dyslipidaemia, type II diabetes Mellitus, and weight gain.

Previous studies have noted that there is a prominent decrease in CM screening for mental health care inpatients, with serum tests being overlooked in the screening process.

Further, there are limited studies regarding follow-up of a patient with CM disease in hospital, and whether CM screening results and a consequent plan are detailed in a discharge summary.

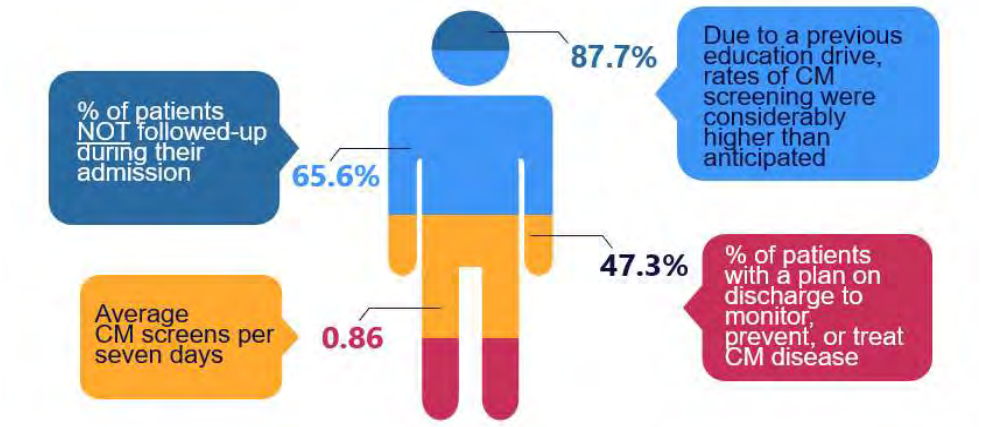
Methods

The study was undertaken as a retrospective audit over six months in an acute mental health unit. Patients discharged during this period were included in the audit.

Electronic medical records for all patients were utilised to assess the frequency of CM screening, whether any CM disease was present, and if the patient was followed-up during their admission.

Discharge summaries were also evaluated to assess if the patients had CM results included, and whether a plan was included to monitor, prevent, or treat any CM disease.

Key Findings



Results

Figure 1: Number of Patients Requiring a CM Screen and Whether They Were Screened During Their Stay

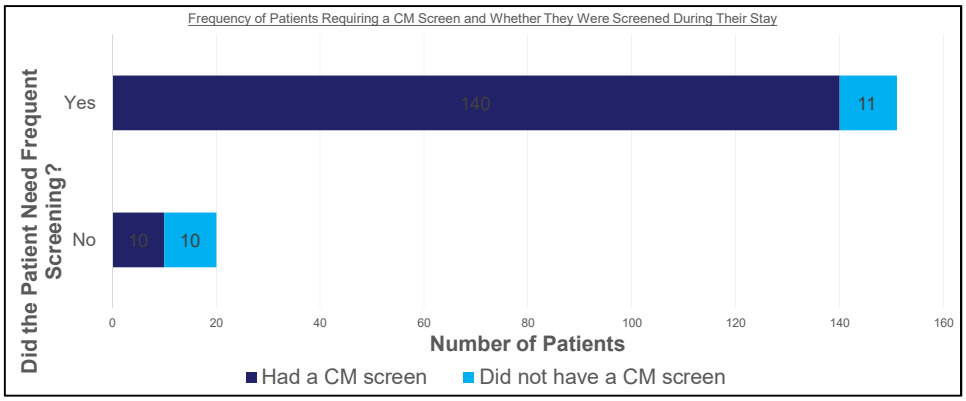


Table 1: Frequencies of Different Cardiometabolic Diseases/Risks

Frequencies of Different Cardiometabolic Diseases/Risks		
Cardiometabolic Disease	**Frequency**	**Percentage of Population (1d.p.)**
Waist/BMI risk	97/122	79.5%
Weight Gain	23/122	18.9%
Dyslipidaemia	35/122	28.7%
Hypertension	25/122	20.5%
Hyperglycaemia	9/122	7.4%
Hyperprolactinaemia	11/122	9.0%

Conclusion

The cardiometabolic screening process is an integral part of treating and caring for mental health patients in a hospital setting. We found that the rates of cardiometabolic screening were exceptional following previous education sessions for clinicians, but there were still some patients that required screening but did not get screened during their inpatient stay. This is quite important as every patient is still at risk of developing disease no matter how small or large their anti-psychotic medication load. We observed that some patients with low CM risk got screened frequently over patients with high CM risk-an area we can improve in.

On the other hand, action taken after patients who were screened was very limited. There must be more emphasis on following-up with patients if they are identified to have developed CM disease, and to ensure this information is relayed to their community general practitioner alongside a plan. One solution being explored is to include a separate section for CM screening in daily medical rounding template and in the discharge summary template.

Overall, further education interventions for clinical staff about the importance of acting upon CM disease risk screening (both developed and developing disease) could be influential in ensuring adequate management of these disorders in mental health patients.