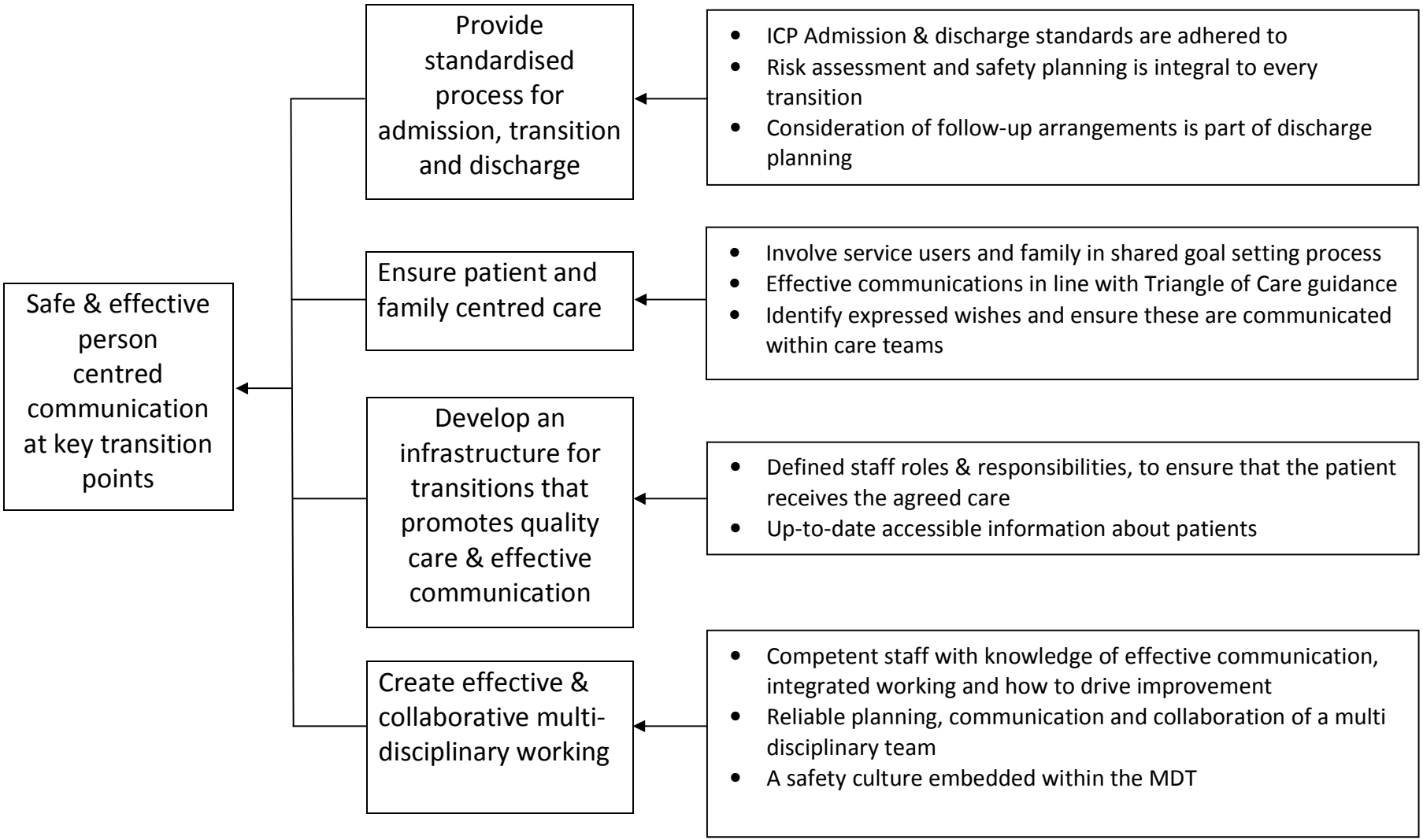
SCOTTISH PATIENT SAFETY PROGRAMME

MENTAL HEALTH

Communication at Transition Driver Diagram

Phase Two

The Scottish Patient Safety Programme is co-ordinated by Healthcare Improvement Scotland


Safe & effective person centred communication at key transition points
Provide standardised process for admission, transition and discharge
ICP Admission & discharge standards are adhered to
Risk assessment and safety planning is integral to every transition
Consideration of follow-up arrangements is part of discharge planning
Ensure patient and family centred care
Involve service users and family in shared goal setting process
Effective communications in line with Triangle of Care guidance
Identify expressed wishes and ensure these are communicated within care teams
Develop an infrastructure for transitions that promotes quality care & effective communication
Defined staff roles & responsibilities, to ensure that the patient receives the agreed care
Up-to-date accessible information about patients
Create effective & collaborative multi-disciplinary working
Competent staff with knowledge of effective communication, integrated working and how to drive improvement
Reliable planning, communication and collaboration of a multi disciplinary team
A safety culture embedded within the MDT

Provide standardised process for admission, transition and discharge

Secondary Drivers	Change ideas for PDSA testing
ICP Admission & discharge standards are adhered to	• Standardised format in place for admission, transfer & discharge plans which includes timescales for follow-up • Admission, transfer & discharge plans developed in partnership with service users, carers and other relevant community services and includes service user preferences • Copy of discharge plan to service users and carers • Copy of discharge plan sent to all services named in it prior to discharge
Risk assessment and safety planning is integral to every transition.	• Safety briefings • SBAR • Relapse & crisis plans
Consideration of follow-up arrangements is part of discharge planning	• Ward staff have access to bookable community slots for follow-up • Relapse & crisis plans

Ensure patient and family centred care

Secondary Drivers	Change ideas for PDSA testing
Involve service users and family in shared goal setting process.	• Daily/weekly service user goals • Emotional Touchpoints • Information provided in a meaningful and understandable format customized to the patient's need
Effective communications in line with Triangle of Care guidance	• Care and Safety and Discharge planning processes include asking the service user who they want to share information with • Use of 'My View'
Identify expressed wishes and ensure these are communicated within teams	• Structured goal oriented multi-disciplinary rounds

Develop an infrastructure for transitions that promotes quality care & effective communication

Secondary Drivers	Change ideas for PDSA testing
Defined staff roles & responsibilities, to ensure that the service user receives the agreed care	• Use work shadowing across professions/services to develop understanding • Staff rotation between services • In-reach & out-reach
Up-to-date accessible information about service users	• Patient-status-at-a-glance techniques used to ensure key information is accessible

Create a highly effective & collaborative multidisciplinary team

Secondary Drivers	Change ideas for PDSA testing
Competent staff with knowledge of effective communication, integrated working and how to drive improvement.	• Training in effective communication, ward rounds, handovers, SBAR, safety briefing etc
Reliable planning communication and collaboration of a multi disciplinary team	• The multidisciplinary team complete the admission assessment together rather than sequentially • Joint assessment between community/ward team • Ward staff have access to bookable community slots for follow-up • Use in-reach/out-reach to improve transitions
A safety culture embedded within the MDT	• Care and Safety and Discharge planning processes include asking the service user who they want to share information with • Clear guidance on confidentiality • Clear concise protocols on sharing information

Potential Process Measures for Communication at Transitions Workstream – Version 2

As well as measuring the level of harm occurring on inpatient units, the SPSP-MH programme also requires wards to measure their compliance with processes put in place to reduce harm. The **national programme is not putting compulsory process measures in place at this date** as it wants to generate useful and focused measures. **Therefore wards have flexibility to set their own process measures.** Through WebEx, Leadership Reports, Knowledge Network Site, Workstream Development Group, Programme Manager events and National and Regional Learning Sessions there will be mechanisms in place to share ideas between wards and boards working on the same workstream and time at the learning sessions to share the usefulness of the measures used locally.

Wards are not expected to collect all of these measures – simply to use measures which focus on the particular parts of the process they are testing. So, a ward decides to work on the debrief issues and trauma informed care issues, initially it would just start collecting process measures attached to those two issues. Finally, it is important to remember to baseline the measures prior to starting any focused work related to them.

Secondary Driver	Phase 2 - Potential Measure	Comments
ICP Admission & discharge standards are adhered to	% of service users who receive safety briefing on admissions	Measurable using random audit of case notes
Risk assessment and safety planning is integral to every transition	% of service users where risk history, current risk assessment and reason for admissions available at admission	Measurable using random audit of case notes Wards need to consider whether audit weekly, every other week or monthly
Risk assessment and safety planning is integral to every transition	% of service users who have a relapse and crisis plan as part of discharge plans	Measurable using random audit of case notes
Involve service users and family in shared goal setting process	% of discharge planning at variance with service user's wishes	Measurable using random audit of case notes
Involve service users and family in shared goal setting process	% of discharge plans that reflect agreed goals and expressed wishes	Measurable using random audit of case notes
Consideration of follow-up arrangements is part of discharge planning	% of high risk individuals with follow-up arrangements completed within 7 days (or agreed specified timescales) following discharge	Measurable using random audit of case notes
Up-to-date accessible information about service users	% of service users who have an up-to-date risk assessment at discharge	Measurable using random audit of case notes
Consideration of follow-up arrangements is part of discharge planning	% of service users who do not attend follow-up appointment	From patient information/electronic record system