


# Use of a quality improvement strategy to introduce co-design of the mental health discharge plan in rural and remote New South Wales

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## Abstract

**Problem:** Patients have not traditionally partnered in the design of their discharge plans, with discharge summaries at times not completed. In rural settings, discharge planning communicates care to a complex geographic area with fragmented resources. Patients may also be socially disadvantaged, with relatives and friends sometimes excluded.

**Design:** Situational analysis and liaison with key partners occurred in the months prior to the core project. Opportunities for improvement were noted. An audit of all discharges in May 2020 was planned to assess rates of discharge completion, co-design and inclusion of next of kin. Qualitative feedback was also noted from staff.

**Setting:** Dubbo inpatient mental health units (Gundaymarra and Barraminya).

**Key measures for improvement:** Rates of discharge summary completion, co-design of discharge plan, engagement of next of kin. Qualitative measures included reflections of clinical staff involved.

**Strategy for change:** Junior doctors were key in facilitating each patient to co-design their discharge plan and collaborate with all biological and psychosocial treatments and providers in a forum for open discussion. The inclusion of nominated next of kin was core.

**Effects of change:** Discharge summary completion rates were high; co-design of discharge plans occurred frequently; and next of kin were involved with few exceptions. The adoption of the person as expert in modifying their plan became a norm. Medical staff wanted this care frame for each person.

**Lessons learnt:** Engaging patients and their next of kin directly in their discharge planning improves care opportunities in a rural setting, as well as understanding for all parties. This approach also prioritises the process of discharge completion.

## KEY WORDS

co-design, co-production, discharge summary, junior medical officer, mental health

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## 1 | INTRODUCTION

Two key themes of interest were at the foundation of this quality improvement project. The first was the successful completion of discharge summaries for all patients. The second was to include a co-design<sup>1</sup> aspect in the process so that patients and their next of kin could participate in the discharge plan.

The setting of the Dubbo and regions mental health inpatient units, Gundaymarra and Barraminya (20 beds total), serves a geographic region that is rural, remote and very remote with a population of approximately 130 000 and 13% of people identifying as Aboriginal.<sup>2</sup> The 2018 Barraminya executive report identified 29.3% of inpatients as Aboriginal<sup>3</sup> highlighting the greater use of acute resources in this cohort.

Effective planning and communication between patients and various care providers are associated with a better clinical outcome.<sup>4</sup> The hospital discharge summary is the key enduring communication strategy between hospital and community, yet there are few universal standards or cultural norms governing its creation or completion. Electronic discharge summary performance rates across the Western New South Wales Local Health District (WNSWLHD) are arguably deficient.<sup>5</sup> The WNSWLHD Health Intelligence Unit reported electronic discharge summary rate completion of 84.0% (all inpatient mental health), 45.5% (emergency department) and 76.9% (general inpatient) in April 2020.<sup>5</sup> This indicates a gap in communication to stakeholders.

Where completed, discharge summaries tend to be framed by the 'Situation-Background-Assessment-Recommendations' (SBAR) method, which focuses on clinician dialogue and generally omits patient input.<sup>6</sup> The discharge summary and plan are something that is done to the patient, rather than something that is done with the patient. Excluding the patient as an expert, who may have better knowledge of resources available in their own community, is a loss. This is particularly so in a rural and remote setting where a doctor preparing the discharge summary may have scant knowledge of a discharge destination often hundreds of kilometres away.

The complex and fragmented health framework is best understood in partnership with members of the community who are more likely to have knowledge regarding connections with Aboriginal medical services or other supports available to patients on discharge.<sup>7</sup> Reasonable attempts to find bridges to people who can provide ideas and future support, be it family, friends or others, are often not made in the planning process. Complaints from, and the sadness experienced by, next of kin about their lack of inclusion in the process of mental health admission and discharge planning also find merit in this context.<sup>8-10</sup> There is some evidence of better adherence to treatment and health outcomes when next of kin are engaged which may (or may not) be generalised to the rural, mental health setting in Australia.<sup>11</sup> The limited literature in this important area reflects the need for more studies such as this one.

### What is already known on this subject:

- Discharge summary completion rates can be improved in rural settings and this improves clinical outcomes
- Rural and remotes areas have complex resources arrangements that are best understood in partnership
- Patients do not usually explicitly co-design their discharge plans and are not always sought as experts in their community environments

### What this study adds:

- Co-design of a discharge plan with a patient was viable and simple to implement via the junior medical staff
- This process ensured a high discharge summary completion rate and an increased sense of ownership and engagement by medical staff
- Involving next of kin, as well as patients, as experts in care increases partnership and understanding, especially in complex rural health environments where resources may be limited

## 2 | METHOD

From January to March 2020, situational analysis was performed by the local mental health drug and alcohol executive team reviewing recent critical events (such as feedback from root cause analyses) and surveying senior and junior medical staff, nurses, allied health staff, Aboriginal health clinicians, consumer representatives who serve on local committees, peer workers, patients, families and external stakeholders. Key questions were as follows: What is going well with the discharge process? What is not going well? And what can be improved?

Aside from a lack of communication where no discharge summary was completed, 3 core areas for improvement were identified: including the patient and next of kin in discharge planning; accurately canvassing the scope of follow-up care, including a review of discharge medications and correct identification of medical and psychosocial supports; and recognising and incorporating Aboriginality and other cultural needs.

The local health district asks all admitted patients to record their Aboriginal or Torres Strait Islander status but this information is then often ignored, representing a missed opportunity to offer to connect patients to Aboriginal clinicians in hospital or Aboriginal specific health services on discharge, if

patients wished for these arrangements. The phrase ‘Nothing about us without us’<sup>12</sup> captures the essence of this project for all patients but in particular reflects the ideals clearly voiced in documents such as the *Redfern Statement*.<sup>13</sup> We have a duty to strive harder and work in partnership with Aboriginal people in meeting their everyday health care needs. Framing the problem in this way, the ideal discharge summary is reconceptualised as a documentation of the process that led to the plan on discharge. It does not merely stipulate the recommendations of one individual clinician but instead reflects a whole of community approach to problem-solving the unique health, psychosocial and cultural needs of an individual. It rightfully recognises the patient and their next of kin as ‘experts’ in their own community and positions the person as a co-producer at the clinical micro-system level, an active role that has been evidenced to improve patients’ experiences with treatment and care.<sup>14</sup> This is of immense importance, especially in rural and Aboriginal communities. In order for a discharge summary to achieve these purposes, 7 elements of focus targeting core areas for improvement in co-design were specified (Table 1).

In April 2020, the local Clinical Director of Mental Health Drug and Alcohol conducted an information session with key participants: junior psychiatry trainees (main agents) and other staff supporting the inception and ongoing progress of the project including the nursing unit manager and local hub operational manager. This included education regarding the evidence base associated with completed discharge summaries, reconceptualising the discharge summary as a dynamic process and education on the 7 domains that characterise a co-designed discharge plan. This was key in empowering staff members to implement the project. Cases with poor outcomes due to neglect of key elements of focus (eg next of kin not involved, Aboriginal people not linked to relevant cultural services) were discussed. The theoretical concepts of co-design and co-production, of moving away from ‘doing to’ and ‘doing for’ to ‘doing with’ were also discussed.<sup>15,16</sup> The likely impact of shifting from paternalism to a closer sharing of ideas and responsibilities with patients and their loved ones was appreciated,<sup>16</sup> igniting optimism in staff that their efforts would not only enhance patient autonomy, but also boost their satisfaction at work.<sup>17</sup>

Throughout the project, regular discussions regarding cultural aspects of care continued as it emerged as the most fertile area for learning. The potential for this approach to address clear disparities in health outcomes in the inpatient population became evident and served to further motivate staff. The project was reinforced by a directive in the form of a memo and emails checking that the tasks had been completed.

In June 2020, an audit of all May 2020 discharges from Gundaymarra and Barraminya was conducted to determine

**TABLE 1** Seven elements of focus in the discharge plan co-design

**The person's view and their co-design**

What is the person's view of the plan? Are there additional items they may like to add? How do they see their ideal frame of care in the context of their community?

**Next of kin**

Who is the next of kin? What are their ideas for care? How will they be involved in patient's care post-discharge?

**Medications**

What medications is the person on? A discussion is helpful. Is there understanding? Does the person have questions?

**Practitioner**

Who is the actual medical practitioner? Is the current health record correct?

Are there other medical practitioners involved? Have follow-up appointments been made?

**Psychosocial treatments**

What other treatments are arranged? Are other providers involved? Have follow-up appointments been made?

**Aboriginality**

Is the person Aboriginal? What is their Aboriginal Nation (if known)? Can we involve an Aboriginal Health Practitioner in their care or offer another connection to be made?

**Other cultural needs**

Are there other cultural needs (eg language other than English, religion, sex, sexuality)?

**TABLE 2** Dubbo inpatient mental health units completed discharges

| Month (2019/2020) | Complete (N) | Incomplete (N) | Total (N) | Complete (%) |
|-------------------|--------------|----------------|-----------|--------------|
| July              | 33           | 7              | 40        | 82.5         |
| August            | 18           | 25             | 43        | 41.9         |
| September         | 21           | 21             | 42        | 50.0         |
| October           | 12           | 24             | 36        | 33.3         |
| November          | 14           | 12             | 26        | 53.8         |
| December          | 26           | 12             | 38        | 68.4         |
| January           | 22           | 16             | 38        | 57.9         |
| February          | 36           | 5              | 41        | 87.8         |
| March             | 47           | 4              | 51        | 92.2         |
| April             | 36           | 2              | 38        | 94.7         |
| May               | 37           | 0              | 37        | 100          |

discharge summary completion rates, co-design and next of kin involvement.

Working in a culturally attuned manner with patients, including Aboriginal patients and families to deliver care, is core business for WNSWLHD, guided by local demographics, good practice and policy. Understanding aspects of the nuances of a person's narrative, if a person wishes to share,

**TABLE 3** Dubbo inpatient mental health unit discharge summaries May 2020

|   | N  | %    |
|---|----|------|
| Total discharged to the community                                 | 37 | 100  |
| Discharge summaries completed                                     | 37 | 100  |
| Discharge summaries co-designed                                   | 32 | 86.5 |
| Next of kin contacted and engaged in the process of care planning | 36 | 97.3 |
| Discharge summaries not co-designed                               | 5  | 13.5 |

be it cultural or related to another dimension that may be associated with health inequity, is also the usual process of a mental health admission.

## 2.1 | Ethics approval

The project was deemed to be a Quality Improvement Project by the local Ethics processes of Western NSW local health district (evidence letter available on request). The project title and number allocated was: '2020-056 Collaboration, co-design and co-production of the MH Discharge'.

## 3 | RESULTS

Discharge summary completion rates were high during this May 2020 project and collaborative. Monthly discharge summary completion rates for the Dubbo inpatient mental health units from July 2019 to May 2020 are reported (Table 2).<sup>5</sup> Co-design data and next of kin involvement were new data measures as these are not traditionally included in discharge summaries.

Two patients were transferred internally and early in admission to another hospital ward and excluded from analysis. Where practically possible, all patients co-designed their plans. Of those patients who did not, four had discharged against medical advice and one had not returned from leave. Only one patient did not want a next of kin involved. The completion of a discharge plan with the patient and next of kin as co-designers became the standard (Table 3).

There were multiple qualitative effects. The local mental health drug and alcohol executive team and all inpatient psychiatrists noted an improvement in the standard of the discharge summaries during and following the May 2020 project, which now included key support people of patients and were quite specific to the person and their context. As a result of increased collaboration between Aboriginal staff and non-Aboriginal staff in providing care for Aboriginal persons, staff learned to provide more effective cultural-based care.

Staff involved reported a deeper sense of engagement with their patients. The discharge process necessitated an

understanding of the patient on an individual level, with a consideration of their health care and cultural needs, of the support services available in their community and of their personal preferences, as well as that of their loved ones. It involved discussions not only with the patient and next of kin but at the very least, initialising communications with key community care providers. Junior doctors reported a deeper sense of responsibility and reflection with the question 'if this was my family member, what would I want for them?' at the forefront of their minds.

A limitation is that no data from consumers or their next of kin were obtained.

## 4 | DISCUSSION

The main challenge of this project is to perpetuate what has been created when there is a regular turnover of junior medical staff. Discharge summary completion rates can be poor and this impedes effective care and collaboration. This project was accomplished with a full staff compliment amid motivated professionals who enjoyed their engagement with patients and their loved ones. Nonetheless, it has now set the tone for what is relatively easy to achieve and can be adopted as a standard of best practice: to complete a discharge summary in collaboration with key stakeholders. It is an anchor of care.

A core element that must be improved, with vigilance, is the input of Aboriginal people as care informers both within the local health service and as continuing partners in care.

Input from patients and next of kin should be sought to evaluate this project and determine the impact on care. Currently, there are limited studies into the discharge process, especially in the specific context of the rural setting. Further outcome measures that may be explored in follow-up research includes patient and next of kin satisfaction, engagement with follow-up care (particularly in different patient groups), improvement in communication between various stakeholders and re-presentations to hospital.

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## DISCLOSURE

No funding was received for this project.

## AUTHOR CONTRIBUTIONS

WKB: conceptualization, data curation, formal analysis, methodology, project administration, resources, software, supervision, validation, visualization, writing-original draft, writing-review & editing. CO: formal analysis, methodology, project administration, validation, writing-original draft, writing-review & editing. LV: methodology, project administration, writing-original draft. RW and PB: investigation, methodology, project administration, writing-original draft.

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