Dorset HealthCare
Transfer of Care
Dorset HealthCare NHS University Foundation Trust

- 300 sites
- 6500 staff
- Covers prison healthcare in Devon
Why!

Patients:
Inconsistent patient satisfaction.
Complex needs.
Patients not being involved in their care planning.
Multi-agency involvement.

Staff:
Reluctance to change.
Competing priorities.
Staff unaware of the outcome and therefore not aware there is a problem.

Task:
Lack of protocols & policies.
Inconsistency in paperwork and procedure across the organisation.

Communication:
Inconsistent use of verbal and written communication.
Not all relevant information provided.
No agreed standards across agencies.

Education + Training:
Staff awareness with improvement methodology.
Change process
Staff and patient engagement and Involvement

Equipment + resources:
IT systems incompatible with internal & external agencies
Varying methods of referral across the organisation, lack of consistency.

Working condition factors:
Multiple sites and external organisations. External agencies that impact on care
5 acute hospitals
3 local authorities
20 Community Hospitals
Mental Health inpatient Sites

Teams:
Lack of clarity about roles and responsibilities resulting in inconsistent use of documentation.
Reluctance to change.
Lack of supervision

Organisational + strategic:
Safety culture being driven by top down.
Diverse type of services.
Geographical spread.
Clinical Services Review

To provide safe and effective care at point of transfer
Aim of the work stream:
To provide safe and effective care at the point of transfer

Why:
With such a diverse catalogue of services across a wide geographical location handover of patient care happens frequently. However, Audit, adverse incidents and complaints suggest this may not always be safe.

Work streams included:
• Transfer documentation – fit for purpose
• Handover from one healthcare member to another is succinct and involves the patient.
• To reduce the number of patients readmitted to healthcare following discharge from community hospital by contacting them post discharge.
• To support the transition of patients from children to adult services.
Initial Problem

**Admission and discharge** information was incomplete or delayed for patients in:
- Community Hospitals
- Prison Healthcare

Information that was critical to prevent **readmission was missed** for patients using:
- Crisis Service
- Older People Mental Health Service
- Community Hospitals

The information shared at a ward level handover, **took too long** and did not always include all relevant details.

Patients discharged home with a package of care, were **readmitted** to hospital.
Dorset Healthcare University NHS Foundation Trust - Transfer of Care Team

The team consists of all grades of staff from across this large and diverse organisation including; community and inpatient mental health hospitals, community services for physical and mental health and prison healthcare.

A number of the team came with existing knowledge and experience of quality improvement but for many it was their first exposure to the improvement methodology. The quality improvement novice in the team claimed to feel empowered to be able to make changes.
Where to Start
Measurement
Evidence base (local incident data)

Community Hospitals
Discharge and Transfer Incidents
17.07.2014 - 17.07.2015

Mental Health Hospitals
Discharge and Transfer Incidents
17.07.2014 - 17.07.2015
Dorset Healthcare University NHS Foundation Trust-Transfer of Care Team

JOURNEY SUMMARY

During the period of the Collaborative the Dorset Healthcare Transfers of Care team has:

• **Improved the patients’ experience** of the 72 hours following discharge from a Community Hospital.

• **Improved the safe discharge of patients** in adult mental health units by introducing a check list to ensure key factors had been considered

• **Improved the triage process** used by the Tissue Viability Service, to ensure prompt review by the specialist service.
Dorset Healthcare University NHS Foundation Trust-Transfer of Care Team

JOURNEY SUMMARY

- **Introduced bed side handover** to enable the patient to be involved in the handover between nurses.
- **Developed documentation** to be used during transfer from one provider to another.
- **Developed relationships** with neighbouring organisations to support safe transfer of care from one organisation to another.

At the final Learning Event in February 2016, which focused on “Sharing, Spread and Celebration”, the team was presented with the Wessex Patient Safety Collaborative Award for “Most Integrated Team”.

Your Learning Journey
Our successes and results:

- **Overall successes**
  - Bedside handover embedded within the ward, patients feel more involved in their care
  - Feedback from patients being followed up for 72 hours in one hospital is extremely positive

- **Overall results – still in the early stages from 3 of our projects**
  - Staff now leave work mostly on time
  - The 30-day risk ratio shows patients who did not receive a follow-up phone call post-discharge would be 25 times as likely to be readmitted
  - Early measurement has identified excessive time ascertaining relevant information prior to admission to the community hospital

- **Learning from the above**
  - Rome wasn’t built in a day, small steps
Our barriers and challenges:

**Barriers and Challenges:**
- Lack of staff understanding of improvement methodology and how to test on small scale.
- Identifying the baseline before introducing a solution.
- Staff motivation, change process
- Identifying, collecting and presenting data
- Sustaining the impetus

**Lessons learnt:**
- How to introduce the improvement methodology.
- Process map and get a baseline to understand the issues instead of relying on hearsay
- Understanding the baseline and measure for improvement, gaining advice from organisational experts at the onset.
Congratulations to
Dorset Healthcare University NHS Foundation Trust – ToC Team

For winning the 2015/16 award for
“the most integrated team”

Wessex Patient Safety Collaborative
Sepsis and Transfers of Care Collaborative 2015/16