Improving the transfer of physically deteriorating patients between the Mental Health Unit and the Acute Hospital

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Introduction:

Forth Valley Royal Hospital is a large district general hospital containing all acute medical, surgical and psychiatric wards for NHS Forth Valley. Patients in the Mental Health Unit (MHU) are routinely transferred to the Acute Hospital (AH) if they become physically unwell; and return to the MHU when their physical health improves. This quality improvement project set out to improve safety of this transfer process.

Method:

Patient transfers both to and from the AH were identified using the electronic patient flow system and through daily consultation with the psychiatry duty doctor. Data was collected prospectively from patient notes in three cycles over the period 7 December 2017- 28 July 2019.

Sample:

Over cycles 1-3 there were 51 transfers from the MHU to the AH. During cycles 2-3 there were 34 return transfers.

Aim 1: Reduce the median transfer time from the MHU to the AH from 3hours 10mins to 1hour.

Tests of Change:

- Introduction of a new policy stipulating the transfer of physically deteriorating patients from the MHU to the AH within one hour. The policy included an escalation flow chart which would be instigated if the one hour target was breached.
- The policy was integrated into the psychiatry junior doctor induction and made available on the staff intranet.

Aim 2: Standardise and improve the consistency of patient handover between the MHU and the AH through the completion of Transfer Forms (TF) for 100% of patient transfers (see Figures 1 & 2).

Tests of Change:

- A new policy covering patient handover during transfers between the MHU and the AH was introduced. This included the use of TF and also mandated that all patients returning from the AH must be discussed with the psychiatry duty doctor prior to transfer.
- TF were made available electronically and in hard copy on all MHU wards and in the doctors' room.
- Medical and nursing staff in the MHU were made aware of the policy and TF. This information was also integrated into the psychiatry junior doctor induction.

Aim 1 Run Chart – Time to Transfer from MHU to AH

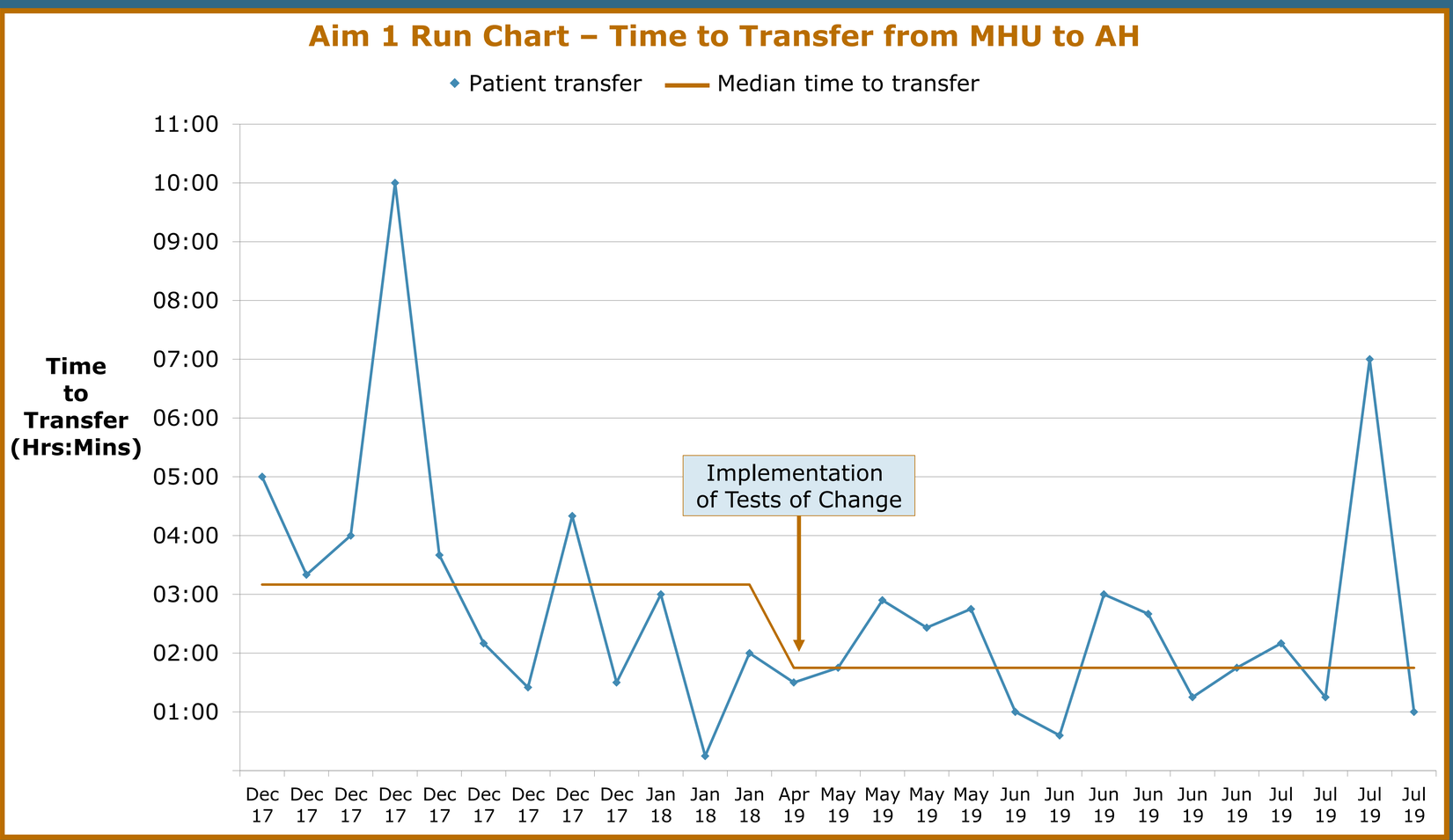

Figure 1: Transfer Form AH → MHU

Transfer of patient from Acute Hospital Ward to Mental Health Unit

Please note that the Mental Health Wards cannot administer IV fluids, Blood Products or antibiotics and have no piped oxygen. There are no RGNs in the Mental Health Unit.

This section of the form should be completed by the Duty Psychiatrist / ANP when the patient is deemed fit for transfer to Psychiatry, or considered for admission to Psychiatry from A&E / AAU– the decision should also be recorded in the Medical Notes.		
Patient Name:	Consultant:	CHI:
Reason for Transfer	☐ Patient Returning to their ward of origin in the Mental Health Unit ☐ Patient has been assessed by and accepted by Psychiatry	
Medical checklist- to be discussed and confirmed with the duty Psychiatrist	☐ **The patients NEWS score is stable and less than 5** ☐ **The patient does not require intravenous fluids / medications** ☐ **There are no significant abnormalities on the patients blood tests /ECG other physical investigations** ☐ **There is no evidence that the patient has delirium / delirium tremens** ☐ **If the patient were not to be admitted to Psychiatry, they would be physically well enough to be discharged to the community** ☐ **If ANY of the above conditions are not met the case has been discussed with the responsible Consultant Psychiatrist and the transfer authorised by them** **NAME OF CONSULTANT PSYCHIATRIST THE CASE HAS BEEN DISCUSSED WITH** …… **Time and date of discussion**……	
Date:	**Signature:**	**Print:**

Figure 2: Transfer Form MHU→ AH

Transfer of patient Mental Health Unit to Acute Hospital Ward

To be completed by duty Psychiatrist / ANP

This form should be completed when the patient is being transferred **to Acute Medical/Surgical Care** – the decision should also be recorded in the Medical Notes.		
Patient Name:	CHI:	Consultant Psychiatrist:
Reason for Transfer	*(Brief clinical details of why transfer is necessary)*	
Transfer / nursing observations	The patient does / does not need an escort to support safe management Discussed with mental health ward Charge Nurse. Name…… Where issues arise in managing the patient's mental health the ward of origin should be contacted and liaison/support discussed. Ward of origin……	
Escalation Plan	The ceiling of Treatment is: ☐ Ward level care only ☐ Discuss with critical care for consideration of level 2/3 care ☐ Undecided / not applicable	
Resuscitation	☐ Patient is for Resuscitation ☐ Do not attempt CPR Patient Aware (circle) **Yes No N/A** Family Aware (circle) **Yes No N/A**	
Communication	Treatment escalation discussed with: ☐ Patient ☐ Family ☐ Not applicable	
Capacity for Decision Making	Does the patient currently have capacity for: Fundamental Care Needs (circle) **Yes No** More complex decisions, e.g. care home placement (circle) **Yes No** Detained under the Mental Health Act **(**circle) **Yes No** Section:…… AWI in place? (circle) **Yes No** Welfare Power of Attorney/Guardian Name:……	
Safe to transfer	Patient at risk of suicide yes / no Patient a risk to others yes / no Patient a risk from others yes / no If yes to any of the above attach risk profile from care partners	
High Risk Medicines	Medicines have been reconciled and are correct on HePMA (circle) **Yes No** ☐ **This patient is prescribed Clozapine** (consider the complications associated with this therapy- agranulocytosis, bowel obstruction, DVT /PE, seizures). ☐ **This patient is prescribed Lithium** (consider renal impairment associated with lithium therapy and toxicity).	
Date:	**Signature:**	**Print:** **Grade:**

Aim 2: Table of Results

	Transfer Form Completed	
Direction of Transfer	**MHU → AH**	**AH → MHU**
Cycle 1	31%	-
Cycle 2	60%	32%
Cycle 3	79%	53%

Discussion:

Further PDSA cycles are required to achieve the specific aims set out at the start of this QI project. Future tests of change could be aimed at medical staff in the AH and psychiatric nursing staff; two groups that are vital in the safe transfer of patients. Psychiatry junior doctors also need to be empowered to follow the escalation policy when the 1hour transfer time is breached.

Expansion of this project could include the involvement of service users and carers, and additional aims targeting other aspects of patient transfer.

Conclusions:

Overall there was an improvement in the safety of transfers between the MHU and the AH. In particular there was a reduction in the time taken for patient transfer and an improvement in the consistency of patient handover.