

Co-design Partners in Care case study

From ward to community – an all-inclusive perspective: MH&AS discharge experience (Bay of Plenty District Health Board)



Context

The Office of the Auditor-General released a report which highlighted the pressure on the mental health system and support services, and challenges with planning for discharging people from inpatient units.¹ The report recommended that mental health and addiction services (MH&AS) urgently work on ways to collaborate more effectively with all stakeholders on discharge plans for people about to be discharged from an inpatient unit.

Within Bay of Plenty District Health Board (BOP DHB), the protocol for discharging someone from MH&AS states that coordination with multidisciplinary services throughout the discharge process is encouraged, and there needs to be effective communication between staff, the patient and their family/whānau.²

¹ Schollum, G. 2017. *Mental Health: Effectiveness of the planning to discharge people from hospital*. Wellington: Office of the Auditor-General.

² Bay of Plenty District Health Board. 2015. *Protocol MHAS.A1.31: Discharge from Mental Health and Addiction Services*. Tauranga: Bay of Plenty District Health Board.

Two staff members at BOP DHB had identified through their clinical experience that there are gaps in the transfer of care from inpatient to community, for people needing MH&AS. The staff members initiated this project to improve the discharge process. A third staff member's role of advocating and supporting consumer participation across all aspects of MH&AS made her excited to be part of a co-design project to improve this process.

Two consumer/tangata whai ora members joined the group to use their knowledge and experience to inform and improve the discharge experience for other people who had need of MH&AS.

Our project focused on the inpatient to community care discharge process/experience at Te Toki Maurere (adult inpatient unit) in Whakatāne.

Aim

Our goal was to improve the process to enable a better experience for people admitted into Te Toki Maurere and then discharged into community care. We specifically focused on the inpatient to community care experience, from the day someone is admitted into Te Toki Maurere until seven days post-discharge from the inpatient unit.

Engage

We would meet as a co-design team monthly, at a minimum. We made sure that at least one of the consumer team members (Margaret Gundersen and Michael Tokona) was able to be present at each meeting. Margaret and Michael were actively involved in the training and planning throughout the project. The clinical leader (Robert Davies) at Whakatāne Community Mental Health and consumer participation coordinator for MH&AS (Sherida Davy) met with both team leaders for inpatient and community services to explain the purpose and plan for the project; the team leaders were very open to working with us.

The project fits clearly with national and DHB directives to improve the discharge process, which made it easier to get management support for the project. The team leader at Te Toki Maurere agreed to act as our project sponsor, to communicate with her staff about the project, encourage them to engage and allow them time to do so.

To engage staff members from Whakatāne Community Mental Health and Te Toki Maurere, the co-design team designed an elevator pitch flyer, which was handed out before the project was presented at the relevant staff meetings.

To engage consumers for the capture phase, we developed an information sheet about the project, which explained why we were inviting them to be involved and what would happen with their information. When designing our elevator pitch, information sheet and questions for participants, we asked Margaret and Michael to make sure the language was clear and understandable from a consumer's perspective, and whether there was any information that needed changing or adding. Robert visited inpatients on the ward and delivered the elevator pitch to seek their agreement to engage with us post-discharge. This resulted in only one person expressing an interest in being involved. Next, Sherida cold-called people who had recently been discharged from Te Toki Maurere to explain the project and invite them to participate, which resulted in one more person agreeing to be involved.

We also approached non-government organisation (NGO) partners. Michael approached the NGO service he had regular contact with and asked whether a hui could be set up with a consumer/tangata whai ora from their service, who had recently been discharged from Te Toki Maurere. We were able to arrange one hui within our timeframe. One issue was the logistical challenge of meeting up with clients who may be from anywhere across the Eastern Bay of Plenty.

Finally, to engage with community NGO stakeholders, Sherida emailed our elevator pitch and a short outline of what we were doing to all Eastern Bay of Plenty NGO partners. We invited them to share their perspective and be part of the project. We heard back from four NGO services interested in being involved.

Capture

We were able to capture the experiences of the majority of key stakeholders, using a range of tools. We captured 27 experiences in total.

BOP DHB staff

- Five Community Mental Health staff.
- Six inpatient staff.

At Whakatāne Community Mental Health, Jane (needs assessor and service coordinator) approached a colleague who agreed to answer our questions. When finished, we (jokingly) suggested she may only leave if she was willing to go and recruit the next interviewee from her colleagues. This strategy worked well, and we were able to speak with five individuals within the two hours we had there.

At Te Toki Maurere our project sponsor had already asked staff to join the discussion, which was in a group rather than the one-to-one style we had used with community staff. We were able to speak with six inpatient staff within the hour.

NGO services staff

- 12 staff experiences were captured from holding three hui/group sessions.

All NGO services that had a contract for MH&AS in Eastern Bay of Plenty were invited by email to participate, and some were invited in person.

Four of the NGO partners we contacted by email advised they would like to be involved. Sherida arranged a couple of days in Whakatāne to hold three hui sessions with two of the services. Robert and Michael followed up with another service and arranged a meeting. However, on arriving, they found the service thought the meeting was only to discuss being involved in the project, so did not have staff or a consumer/tangata whai ora group available to provide feedback. This was a good lesson for us in ensuring our communication was specific and clear. The last service we contacted felt that it could not contribute as none of its current clients had been inpatients within the past year.

Part of our learning in the co-design process was that, when we spoke with staff, we should have asked them about their feelings. Asking about feelings it is not something we do as part of our work culture. We got a clear sense of the frustration staff felt from the way they expressed themselves, but we did not specifically ask them to describe how they were feeling. We learned from this and ensured that from then on, we specifically asked consumers how they felt about each

'touchpoint' (point in the process that was important to the experience) they made. These words have become an important part of our data set.

Consumers

- Four consumer/tangata whai ora experiences were captured.

One person responded by email after an initial phone conversation, while the other three came together in a hui arranged through one of the NGO partners.

We had wanted to capture as many consumer/tangata whai ora experiences as we could, however we had a number of issues with finding participants able to engage. The geographical distance was a factor with three of the consumers/tangata whai ora based in Tauranga. Also, relying on other people and services to engage with consumers/tangata whai ora made it difficult to know if the right information about what we were doing had been shared with them. Finally, time was a factor in that some of the NGO services were willing to engage in the project but wanted to hold hui in June, which would be well outside the timeframe we had for the project. It was disappointing to the consumer/tangata whai ora members that the timing did not allow for them to be involved in capturing the consumer experience.

As a group we had discussions about the need to be mindful of cultural concerns and to utilise local staff and our Māori consumer/tangata whai ora member to assist with access to consumer/tangata whai ora. For the hui, Jane provided food and ensured the process started with a whakawhanaungatanga and getting to know one another.

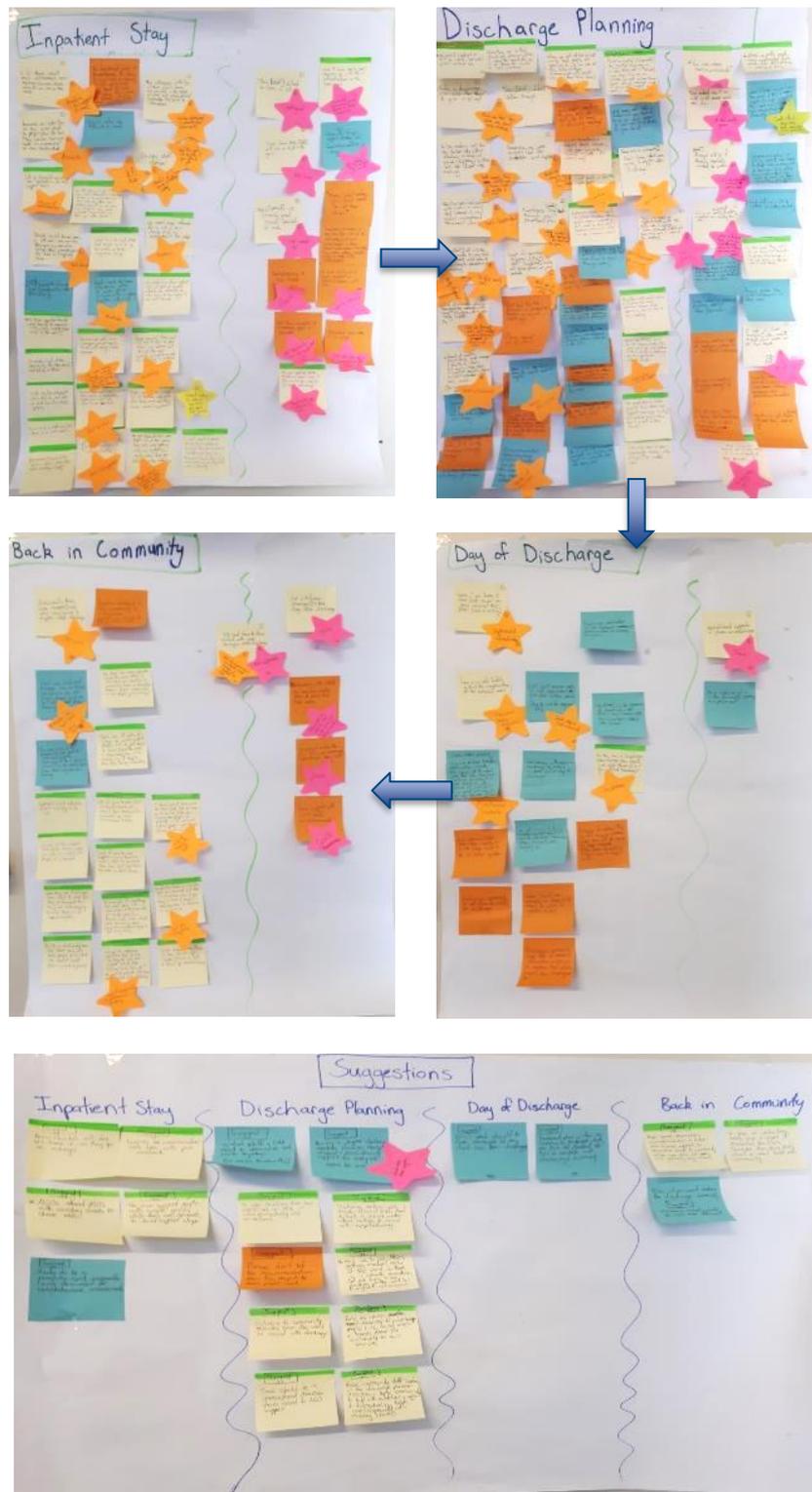
Understand

To organise the experiences we had captured, we sorted the touchpoints into a high-level map, which included four different points of the inpatient to community care process: inpatient stay, discharge planning, day of discharge and back in community (see Figure 1). Discharge planning was the section which ended up with the most touchpoints.

As a team we worked together to understand what the key themes were from all the touchpoints. We came up with three key themes: relationships, communication and historical default setting. The themes were identified based on the frequency of words relating to the theme and the number of people who were saying the same or similar things.

The theme 'historical default setting' arose out of the strength of emotion linked to what people said, and also what was unsaid. The current system and services were familiar to participants (staff and consumers/tangata whai ora). There was a sense of people being comfortable with the way services operated and not wanting to upset that, yet it also highlighted to the co-design team that consumers/tangata whai ora may not be aware of what services they should receive.

Figure 1: High-level maps of the discharge process



Relationships

All different groups/stakeholders had something positive to say about the kindness and caring of staff and the service. Consumer participants liked that staff were personable, familiar and known. It was great to see that staff were recognised as being friendly and showing compassion, which is one of the key CARE values for BOP DHB (Compassion, All-1-Team, Responsive, Excellence).

However, consumers/tangata whai ora also wanted or expected more from staff – their relationship with staff did not appear (to them) to be action/outcome oriented.

'Every client matters, you don't want to let them down.' (Inpatient staff member)

There appeared to be a good working relationship between inpatient staff and Community Mental Health staff, with both groups expressing respect for the work each other did. However, there was frustration with the failure of technology and processes to back up the good relationship both teams had established. With the inpatient unit still relying heavily on paper-based rather than computer-based files, there was a delay in waiting for files and medication charts to come through to Community Mental Health. This made it difficult for staff to provide excellence in their work with clients and meet key performance indicators.

The NGO participants had some positive touchpoints about their relationships with DHB staff, but overall indicated they felt a lack of respect from them. NGO staff suggested that having a 'support' role was viewed as inferior to having a clinical role.

Communication

'You can never over-communicate.' (NGO staff member)

Consumers/tangata whai ora all stated they had a meeting about discharge, but none of them received any written information about discharge.

'Would like something in writing.' (Consumer/tangata whai ora)

They spoke about not being able to retain the information from the discharge planning meeting and sometimes felt they were rushed through it. They expressed emotions of anger, frustration and feeling overwhelmed about the lack of information they received or retained. One of the consumers/tangata whai ora suggested that at meetings it would be useful if *'Maybe a support person [could be present] as all the information was a bit overwhelming for me and I cannot really remember what was said.'*

This inability to retain the information discussed at discharge planning meetings and not receiving anything in writing left consumers/tangata whai ora feeling unprepared for discharge, and anxious about leaving the safety of the inpatient unit.

Consumers/tangata whai ora also highlighted that they often felt things were being done *for* them and they were not involved in their care/treatment planning. One participant spoke about a discharge planning meeting taking place, but not knowing what it was until they were actually in the meeting. Another spoke of talking to staff about their medication and which one they felt good with, but then being given a different medication with no communication as to why their suggestion had not been followed.

'There's quite a lack of communication between patients and staff – you feel they make all these plans on your behalf without including you in the talk.' (Consumer/tangata whai ora)

NGO staff expressed frustration with the way DHB services communicated or did not communicate with them. NGO services were often not informed if their clients were admitted to the ward. One service had seen a great improvement in their relationship with Te Toki Maurere over the past

year. Staff in this service had also attended discharge planning meetings. However, all the NGO groups we spoke with indicated they often felt there was much room for improving communication between the services. NGOs felt their services were kept out of the loop, or consumers/tangata whai ora were not made aware the services existed.

Inpatient staff indicated that, as a team, they have good communication with each other. They also felt their communication with Community Mental Health was good – they would email/phone case managers about a current inpatient, and were comfortable sharing the information and plan with them. Inpatient staff stated that a discharge planning meeting took place for all inpatients except those who were very brief admissions, because it was difficult to have a planning meeting about someone who was only in for a few days. Staff spoke about there always being the intention to have everyone discharged with a plan but that '*plans never go to plan*'. Inpatient staff indicated that if it was known that an inpatient was involved with an NGO service, the NGO service would be invited to attend discharge planning meetings.

Community Mental Health staff backed up what inpatient staff said regarding the relatively good communication between Te Toki Maurere and Community Mental Health. Case managers felt they were kept up to date with what was happening for any clients they may have had on the ward. The issue Community Mental Health staff identified related to the delay in receiving someone's clinical files or medication chart.

Both groups of DHB staff spoke about the communication they had with each other and how processes hindered communication, but did not go into much detail about their communication with consumers/tangata whai ora or NGO groups.

All groups involved indicated communication was happening, but their responses showed that the right kind of communication – which resulted in everyone feeling informed, respected, heard and included in discharge planning – still needed work. Groups were not working in a way that ensured we are 'All-1-Team'.

Historical default setting

What came across from the experiences we captured was the way relationships and communication were experienced by the different participants. It highlighted to us that the historical/traditional 'medical model' of health care was still felt today.

By 'historical default setting' we mean staff/ consumers/tangata whai ora/NGO services continued to act under the traditional relationships of clinical staff/doctors being in charge as in the 'medical model'. Clinical staff working within the DHB were viewed by NGO and consumers/tangata whai ora participants as the people holding the power and sometimes showing lack of respect for other roles. DHB staff tended to focus on problems with the process of discharge rather than looking at how the different roles people hold may impact on that process. NGO participants sometimes felt like they were spoken down to for being a 'support' role. Consumers did not feel able to speak up within meetings about their care, to ask for written information or to have a support person present. This showed they did not feel comfortable or empowered as partners in care with staff, at the time of their admission.

It was wonderful that this project allowed all groups to express their feelings in a relatively neutral setting and there is a willingness from everyone to work more towards being true partners in care.

Improve

While we have not officially moved into the 'Improve' stage of our co-design project, Robert has been informally improving things by building more positive relationship with our NGO partners, for example, by meeting them face-to-face and discussing with them how we could improve the way we communicate across services. Community Mental Health is also starting to identify the consumers/tangata whai ora who also use NGO services, so case managers can inform the NGO if an individual is admitted to Te Toki Maurere, taking ownership of keeping the necessary people informed.

We will be sharing our results with all the participants and holding a planning workshop to decide what improvements we should make.

Measure

We have not reached this stage of our project yet.

Working as a co-design team

This project presented was a different way of working for staff members, in that when we started we had no specific aim/goal, rather a general focus on wanting to improve the quality of the discharge process. We were looking to consumers/tangata whai ora and other key stakeholders to direct where that improvement would take place.

It was rewarding to be able hear and read everyone's experiences and feel their happiness at being involved in something where they could be heard and make a difference.

As a group we worked well together. It was great that we set aside time before starting the project to meet and get to know one another. Consumers/tangata whai ora group members felt included throughout the process. We were able to talk through our frustrations at the various hold-ups. Having consumers/tangata whai ora on board helped staff members to be clear in their language and focus on the important aspects of the project.

The project team

Name	Role	Email	Organisation
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