MENTAL HEALTH FACT SHEET 3

Communicating about physiological deterioration

The management of physiological deterioration in a mental health setting is complex, as multiple healthcare providers from more than one team, and across different locations, may be involved. Effective communication is central to ensuring that any patient who is deteriorating receives appropriate and timely treatment.

This is the third in a series of four mental health fact sheets. The others in the series are:

- Mental health fact sheet 1: An overview of recognition and response systems
- Mental health fact sheet 2: Operational considerations
- Mental health fact sheet 4: Strategies for engaging mental health clinicians in the implementation of recognition and response systems.

Lapses in communication, particularly during clinical handover, can contribute to adverse events in health care.[1] Insufficient or poor communication and inadequate clinical documentation can result in discontinuity of care, delays in treatment and increased morbidity and mortality.[2] Poor communication also poses risks to patient safety when patients are transferred between clinical areas, and during critical events such as rapid response system calls.[3]

Structured communication tools and techniques have been shown to improve communication across all healthcare settings, including mental health. They allow vital information to be conveyed quickly and effectively. The principles of clinical handover can be applied when developing communication pathways for recognition and response systems for the mental health setting, even when the situation is not a structured handover. Three main communication pathways need to be considered:

1. Communication between clinicians, patients and carers.
2. Communication between clinicians within the mental health team.
3. Communication between clinicians on the mental health team and the rapid response team.

More information about implementing effective clinical handover systems is available at:

www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/

Communication between clinicians, patients and carers

Patients and carers are an important source of information about physiological deterioration.[4] They are often the first to recognise that a behaviour or presentation is unusual for the person. The service should ensure that a clear process for communicating this information to relevant clinicians is in place. Coroners have made a number of comments about the vital role that patients and families play in identifying clinical deterioration, and the need to implement formalised communication systems to enable them to escalate care.[5-6]

> *"It would have been helpful if more regard had been paid by junior medical staff to the family's opinion that the condition of the deceased was deteriorating. The deceased's wife had been with him constantly (except at night) and was well placed to notice changes in his condition....the concerns of the family could have alerted medical staff to the need for review of the deceased's condition."*[6]

A patient and family escalation system should include information about:

- Who the patient or carer should contact first if they have concerns, e.g. the allocated RN for that shift.
- What timeframe they can expect a response within.
- What kind of response they can expect, e.g. senior nurse review, medical review, rapid response team review.
- A process for escalating the need for attention to another level of response if they are not satisfied the initial contact has been effective.

Systems for patients or carers to directly escalate care to rapid response teams have been implemented in a number of hospitals both in Australia and internationally. Early data indicates these systems operate effectively, are used appropriately, and achieve outcomes that are similar to when clinicians follow escalation of care protocols.[7]

The Clinical Excellence Commission in NSW has established a Patient and Family Esclation Network to enable health services to collaborate and share reources. More information can be found at:

www.cec.health.nsw.gov.au/programs/partnering-with-patients#PFAE_Network

Developing a protocol for patient/carer communication about physiological deterioration presents an opportunity for mental health services to partner with consumers and carers in the design and planning of services, which is part of NSQHS *Standard 2: Partnering with Consumers*.[8]

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

recognising + responding TO CLINICAL DETERIORATION

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Communication between clinicians within the mental health team

It is the multidisciplinary mental health team that has the initial clinical responsibility for recognising and responding to physiological deterioration in mental health units. All members of the team have a role in safeguarding patient safety. Effectively communicating information is essential to providing an effective response.

Factors that will positively influence outcomes include structured communication systems, education and ward culture. Strategies to address these factors include:

- Developing and adapting current handover frameworks to establish a minimum data set of information, including physical health status, to be communicated in every handover. This should be established with input from clinical staff to ensure that it is 'fit for purpose' for the local setting.
- Documenting clear plans for the monitoring of the physiological status of patients, including parameters to indicate clinical factors that necessitate review of these plans.
- Training for clinical staff in effectively communicating concerns. It has been identified that doctors and nurses expect different things in clinical communications, consistent with their disciplinary training, and this can contribute to miscommunication. Clear structures for delivering information can reduce this problem.
- Training for non-clinical staff in recognising signs of physiological deterioration, and communicating this to clinical staff promptly.
- Training for clinical staff in listening to non-clinical staff and patients and carers, so as not to miss crucial information.
- A formalised process for reviewing incidents or 'near misses' at the local level, involving all relevant staff. This should not replace, nor be replaced by other reportable event processes (e.g. RIBs or RCAs), but will provide opportunity for local learning from local events.

Communication between the mental health team and clinicians from other clinical care teams

When planning recognition and response systems, it is important to outline who is responsible for what when a team outside of the mental health service is called for assistance. When rapid response systems are implemented, ensure that both the rapid response team and the mental health team have clearly outlined roles and responsibilities. Consider who is responsible for:

- verbally handing over and documenting the reasons for the rapid response call
- documenting assessment findings and interventions made during the rapid response call
- completing transfer documentation and handing over if the patient requires transfer to another care area (e.g. high dependency or intensive care)
- following up test results and/or the patient's response to treatment
- communicating the circumstances and outcome of the call to the clinical team with overall responsibility for the patient
- communicating the circumstances and outcome of the call to the patient and/or carers.

Standardised rapid response case report forms and checklists can help to ensure that details of rapid response calls are consistently communicated to the right people at the right time.

A strategy some services have successfully implemented to foster mutual understanding and respect between the teams is to roster clinicians on a supernumerary shift with other teams. For example, rostering a mental health clinician to spend a day with the medical emergency team will assist them to understand how the MET interacts with ward staff in other clinical areas, and what issues might arise in the mental health unit. Resources for these shifts can be drawn from clinicians' professional development quota.

References

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