South of England Improving Safety in Mental Health Collaborative

The case for working collaboratively to improve patient safety

Ros Alstead & Helen Mackenzie
The South of England Mental Health Collaborative – March 2013

Four collaborative learning sets delivered underpinned by:

- IHI Breakthrough Series Collaborative model
  - all teach, all learn
- Model for Improvement
  - Defects are opportunities to learn
- Driver diagrams
- Measurement & sampling strategy
  - Measurement is not a threat it is a resource
The Faculty

– Improvement experts and leaders from a range of backgrounds
  • Executive Director, Performance and Improvement, IHI
  • NHS Trust Senior Clinical Advisor for Patient Safety
  • NHS CEO and Director of Nursing and Clinical Standards
  • Clinicians with experience as Improvement Fellows (IHI and NHS Institute for Improvement and Innovation)
  • NHS Clinicians leading improvement programmes (Senior nurses, pharmacists, psychiatrists, haematologist, radiologist)
  • Governance Lead and Director of Risk & Safety
Role of Faculty -

• To engage executive teams
• To lead the design and implementation and evaluation of collaborative learning approach to enable:
  – All clinicians and managers to actively participate in the improvement of systems of care
  – Acquire the skills to do so
  – Develop the confidence to speak up when things go wrong
  – Involve patients as active partners and co-produces in their own care
Participant Organisations

• Oxford Health NHS Foundation Trust
• Berkshire Healthcare NHS Foundation Trust
• 2Gether NHS Foundation Trust
• Cornwall partnership NHS Foundation Trust
• Devon Partnership NHS Foundation Trust
• Dorset healthcare University NHS Foundation Trust
• Isle of Wight NHS Trust
• Kent & Medway NHS & Social Care Partnership Trust
• Plymouth Community Healthcare
• Somerset Partnership NHS Foundation Trust
• Surrey and Borders Partnership NHS Foundation Trust
• Sussex Partnership NHS Foundation Trust
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Work streams

- Leadership for safety
  – Safe & reliable delivery of mental health care
  – Improving the physical health of patients
  – Getting medicines right

Team work & communication – integrated
Delivering patient and family centred care - integrated
Leadership for Safety

- Patient safety culture within organisations is improved
- Establish programme of dedicated safety walkarounds by the Executive Team
- To support and enable Programme Managers to deliver, report changes and bring about cultural change
Safe and reliable delivery of mental health care:

• deaths as a result of self harm in patients on inpatient wards
• deaths as a result of self harm in patients in receipt of care from community teams
• severe harm in patients on inpatient wards
• severe harm in patients in receipt of care from community teams
• unplanned absence from wards
• Improve the satisfaction of patients and carers
Improving the physical care of patients:

- Harm from falls
- Pressure ulcers – grade 2 – 4
- Venous thromboembolism – risk assessment and appropriate prophylaxis
- Recognition and rescue of physical deterioration
- Catheter associated urinary tract infections (for organisations providing community services only)
- Unexpected deaths due to physical illness in patients on inpatient wards
- Improve the satisfaction of patients and carers
Getting medicines right

Medication adverse events:

• number of blank boxes (no signature, no code) on medication charts
• number of missed doses due to prescribed medicines being unavailable
• agreed critical medicines administered at, or within 2 hours of, the prescribed
• patients having full medicines reconciliation completed within 24 hours of admission to an inpatient
• patients having full medicines reconciliation completed within 12 hours of admission to an inpatient unit
• Improve the satisfaction of patients and carers
Examples of outcomes of harm reduction work with clinical teams at Oxford Health NHS Foundation Trust
Aim: to reduce death by probable suicide to 300 days between in CRHT teams

Baseline Measure: Days between occurred every 62 days over previous 2 years
Aim: to reduce death by probable suicide to 300 days between in CRHT teams- Always Events (process measures)
Aim: to reduce death by probable suicide to 300 days between in CRHT teams- Always Events (process measures)
Aim: To reduce AWOL by 50% by Sept 2014 (patients who fail to return from leave (detained and informal))
BHFT Safe and reliable mental health.

- Wards trialling different methods to prevent patients absconding for wards
- Asked patients and staff how we might prevent this happening
- One ward is testing the ward doors being unlocked for periods in the day
- One ward is providing business cards to patients with ward phone number on so that patients can easily contact whilst absent
- One ward provides a diary to patients for their reflections on how they feel about leave and discuss in the daily ward meeting
Number of patients who Abscond from BHFT

- Median
- AWOL workshop
- MDT template tested on 1 ward

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South of England
Getting medicines right – missed medications

- Posters to remind staff about filling in blank boxes
- Shift coordinator checking that there are no blank boxes on medication chart
- Recording as incidents all blank boxes.
- All charts for non-stock in pharmacy transcribed and returned immediately so charts always available
Improving Physical Health:

• Devise a falls risk assessment and care plan for acute MH wards, this has been spread.

• Falls champions on all wards identified

• Patient safety at a glance poster

• Working with community health services on the pressure ulcer strategy and testing different initiatives – 3 wards achieved over 200 days without developing a pressure ulcer
Sorrel Ward (PICU) in 2012/13 there were 15 falls
### Patient's Needs at a Glance – Mental Health

#### Patient's Name: 

<table>
<thead>
<tr>
<th>Nutrition</th>
<th>Assistance (please tick a circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special diet:</td>
<td><img src="Image" alt="All assistance needed" /></td>
</tr>
<tr>
<td>Aids required:</td>
<td><img src="Image" alt="Assistance to get up" /></td>
</tr>
<tr>
<td>Snacks/Supplements:</td>
<td><img src="Image" alt="Prompt encourage" /></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td><img src="Image" alt="Independent" /></td>
</tr>
</tbody>
</table>

#### Transfers (check if aids required)

<table>
<thead>
<tr>
<th>Dec rest</th>
<th>Bed rest</th>
<th>Independent</th>
<th>Supervision</th>
<th>Interpretor</th>
<th>Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="Image" alt="Yes" /></td>
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#### Mobility (check if aids required)

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#### Positioning Advice

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#### Pressure-Relieving Equipment

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</thead>
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#### Visual Alerts (Please tick all that apply)

- ![Tick](Image)
- ![Tick](Image)
- ![Tick](Image)
- ![Tick](Image)
- ![Tick](Image)
- ![Tick](Image)

#### Key Nurse:
- ![Name](Image)

#### Consultant:
- ![Status of Patient](Image)

#### Wash and Dressing:
- ![OT needs](Image)

#### Assessment and Monitoring Needs

- ![Critical Medications](Image)
- ![Specify which medication](Image)
Why the Collaborative works

- Mental health and community trusts across the South of England involved – scale and volume
- Relationships built which previously have not existed
- Networks established
- Share good practice
- Grass roots approach with strong methodology starting to deliver results which are owned
- Working to common metrics (based on evidence)