PSC AT OXFORD AHSN

Simple improvements lead to a 50 per cent increase in mental health service users returning to wards on time

The issue

Service users absconding from acute psychiatric wards is a significant safety issue that can have a range of negative consequences for them, their relatives, and staff.

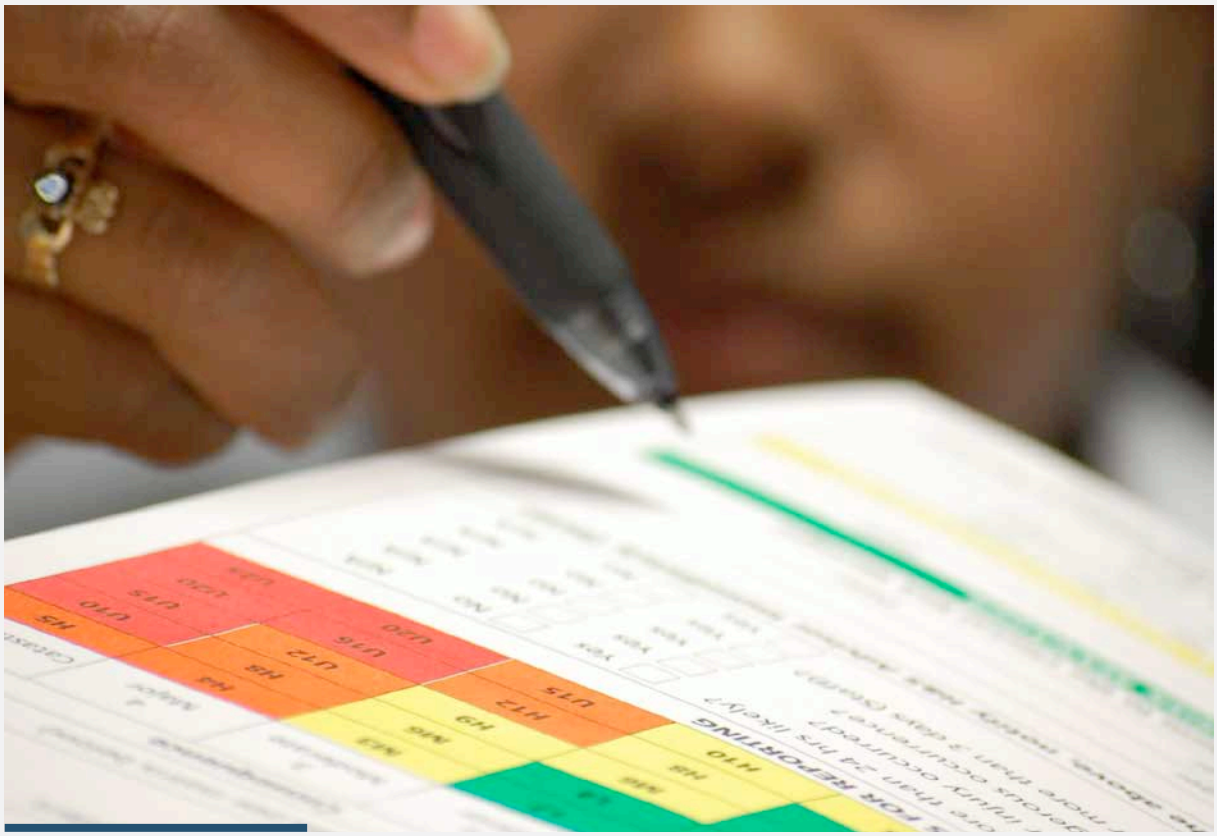
Between 2003 and 2013, 22 per cent of suicides in England occurred when a service user absconded from a mental health ward.

Service users are at greater risk of self-harm, self-neglect, missed medication and interruptions to treatment plans. Absconding incidents can also cause relatives and staff distress and anxiety, and can lead to deterioration in the relationship between staff and service users' relatives.

What we did

We set out to improve the rates of safe return of both detained and informal service users who were taking planned leave, or time away, from acute psychiatric wards. We engaged three NHS trusts within Oxford AHSN, which are all providers of both mental health and community services across large, dispersed populations.

On the lead ward, baseline data was collected over 17 weeks, and the mean rate for service users returning on time was just over half of the total number of service users returning to the ward.



We worked with ward staff to develop four tests of change, using Plan, Do, Study, Act cycles including:

- PDSA cycle 1: establishment of a signing in and out book
- PDSA cycle 2: ward phone card
- PDSA cycle 3: service user information leaflets
- PDSA cycle 4: introduction of a pre-leave form

After implementing the improvement cycles, the number of service users who returned to the ward on time increased to 87 per cent. This is an improvement of 56 per cent.

A further five wards in the Oxford Health NHS Foundation Trust achieved mean return-on-time rates of above 85 per cent.

Berkshire Healthcare NHS Foundation Trust achieved a mean of 91 per cent return-on-time rate, on its lead ward, after implementing the improvement cycles.

Central and North West London NHS Foundation Trusts are now commencing their diagnostic phase prior to implementing the improvement cycle.

This work is being shared through the mental health cluster.

"Through its understanding and passion for patient care and safety, and its drive and support for our teams, Oxford AHSN Patient Safety Collaborative has enabled the wards to achieve excellent success in implementing, maintaining and sustaining the safe return of mental health patients from leave using quality improvement methodology."

Nokuthula Ndimande, Matron, Oxford Health NHS Foundation Trust