Primary Issue

There is a large amount of patient safety incidents in mental healthcare settings across the UK.

Rationale

Though mentally ill patients face increased risks such as violence and aggression, falls, self-harm, and suicide, quality research on patient safety in mental health settings is limited.

Costs

The costs of patient safety issues amount to £1 billion per year in bed days alone.

Aims

Support clinical teams in improving care pathways and to promote safer clinical practice.

Intervention: Safer Care Pathways Toolkit

Unique approach addressing both System & Human Factors

System Safety Assessment

- Assist teams to identify risks along the care pathway, and to identify, analyze, and evaluate potential solutions

Safety Improvement projects

- Building on user and carer involvement, trust specific safety projects are identified, and implemented, using plan, do, study, act (PDSA) cycles

Human Factors Training

- Coach teams on communication skills & teamwork culture, embedding the impact of the SSA solutions

Error

A preventable adverse effect of healthcare...

...can be caused by:

1. System factors
   - Organizational/managerial errors
2. Medical Complexity
   - Medication or technological errors
3. Human Factors
   - Human errors occurring in medical staff

Baseline data collection & Hospital Survey on Patient Safety Culture

Pre-SSA Attitudes towards Patient Safety Questionnaire

System Safety Assessment (SSA) Workshops

Post-SSA Attitudes towards Patient Safety Questionnaire

Interim findings

Felt that good teamwork can compensate for the lack of staff and more things can be achieved in an effective manner.

Felt listened to testimonies from a carer and someone else that helped me to reflect on my own practice.

Today has been wonderful knowing that other trusts have reacted positively to our new handover tools... We are going to share our findings.

"The reflection log is my measurement tool, it helps me to reflect on my own practice"

"Having listened to testimonies from a carer and someone else that helped me to reflect on my own practice"

"I've learned that good teamwork can compensate for the lack of staff and more things can be achieved in an effective manner."

Addressing patient safety issues during discharge

.Where?

Hertfordshire Partnership University NHS Foundation Trust

Pre-HF Attitudes towards Patient Safety Questionnaires

Human Factors (HF) Training

Post-HF Attitudes towards Patient Safety Questionnaires and reflection logs

Project Implementation

Endpoint data collection & Hospital Survey on Patient Safety Culture

Contributors

Project team: Tim Byron, Clodagh Piatzek, Fiona Nicholas, Jane Cathie, Sarah Rob, John Clarkson, Jeremy Wallman, Oliver Stanley

Engineering Design Centre: Terry Dickinson, James Ward

Evaluation team (Policy Research Group): Kat Ruggles, Anne Maguire, Sanni Vers, Mark Cocks, Joanne Jakobs, Clare Bottle, Thomas Gardiner, Sarah Bussem, Robert Costin-Smith

Safer Care Pathways in Mental Health

Closing the Gap in Patient Safety

Lead organisation: Hertfordshire Partnership NHS Foundation Trust

Universe of Cambridge

Engineering Design Centre

The Health Foundation

Inspiring Improvement


due to errors in each NHS institution per year!