UNIVERSITY OF CAMBRIDGE
Engineering Design Centre

Safer Care Pathways in Mental Health

Closing the Gap in Patient Safety

Lead organisation: Hertfordshire Partnership NHS Foundation Trust

The Health Foundation
Inspiring Improvement

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.

SAFER CARE PATHWAYS
IN MENTAL HEALTH

850,000 in NHS per year incident

40 deaths due to errors in each NHS institution per year!

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

Error

A preventable adverse effect of healthcare…

…can be caused by:

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

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

Where?

all together, better — nep
CPFT
Working together for better mental health.
as One

Baseline data collection & Hospital Survey on Patient Safety Culture — Nov 2014

Pre-SSA Attitudes towards Patient Safety Questionnaire | System Safety Assessment (SSA) Workshops | Post-SSA Attitudes towards Patient Safety Questionnaire — Mar 2014

De-escalating aggression in mental health wards

Addressing violence and aggression – Bernard
Dealing with self-harm – Henneage

PRIMARY ISSUE (B)
There is an increasing amount of violence and aggression incidents at the trust
(H) Patients are at high risk of self-harm after discharge

RATIONALE (B)
In 2014/2015, 131 incidents were reported, posing risks to patients and staff
(H) The needs of patients should be recognised, understood and addressed

Action plan
(B)
- ☑ Improve day schedule and nap times
- ☑ Improve data collection on incidents
- ☑ Create a pathway for dealing with aggression

(H)
- ☑ Provide training to staff on the assessment and management of self-harm
- ☑ Monitor ward climate and organise community meetings
- ☑ Introduce safety plans and revise clinical handover sheets

MOVING FORWARD

Building skills

Goals
(B) Empowering staff members to deal with aggression and to minimise harm
Decreasing risks in the care environment and stimulating a calmer atmosphere
(H) Improving staff confidence in making the discharge decision

Values
Humanity
To strive for excellence
Creative collaboration
Keeping it simple

North Essex Partnership University NHS Foundation Trust

Dealing with falls and aggressive behaviour

PRIMARY ISSUE
High amounts of falls
Aggressive behavior of individuals with signs of dementia
aggression 1011 — falls 278

RATIONALE
Service users are fitter and more mobile than in the past. This has led to an increased frequency of falls and other risky behaviours

Action plan
1. Improving the prevention and management of aggression and falls
2. Increasing time spent with service users
3. Facilitating communications within and across services using SBAR
4. Using new occupational therapy service model

MOVING FORWARD

STAFF TRAINING

Goals
- **25%** Reduction in violence & agression in first 72h
- **10%** Reduction in recorded restraint within first 72h
- **10%** Reduction in falls overall

Working together for better mental health

Norfolk and Suffolk NHS Foundation Trust

Finding the balance for patient safety

Reducing falls and related harm

PRIMARY ISSUE
Increase in the number of falls between 2013 and 2014
2013: 134 — 2014: 182 falls

RATIONALE
Patients with complex mental and physical health needs experience a higher risk of falls, making falls prevention a top priority

Action plan
- ☑ Piloting the 'leaf' initiative: displaying patients' needs by colours
- ☑ Improving interior design by installing new equipment
- ☑ Training staff on the monitoring of falls
- ☑ Making falls a regular item on handover sheets

MOVING FORWARD

Goals
- Enhance communication processes
- Reduce the amount of falls
- Manage risks associated with falls

Professionalism
Respect
Innovation
Dignity
Empowerment

Cambridgeshire and Peterborough NHS Foundation Trust

Addressing patient safety issues during discharge

PRIMARY ISSUE
There is a risk of essential information loss between services. Service users and staff are insecure and anxious about the next steps

RATIONALE
Current care processes are too complex.There is a need for accessible and clear information for service users on care pathways and service links

Action plan
1. Using "moving on plans" to inform service users on their care pathway
2. Increasing the use of user friendly language
3. Improving and simplifying information provision
4. Introducing 'Care Call' within 48h of assessment to check up on patient

48h — Follow - up Care - Calls

MOVING FORWARD

Moving on Plans

Goals
- Empower service users and provide support
- Improve confidence during handovers
- Increase cooperation between services
- Promote safer discharge and transitions

Welcoming
Professional
Positive
Respectful
Kind

Hertfordshire Partnership University NHS Foundation Trust

Interviews — Feb 2015

Pre-HF Attitudes towards Patient Safety Questionnaires | Human Factors (HF) Training | Post-HF Attitudes towards Patient Safety Questionnaires and reflection logs — Oct 2015

Project Implementation — 2016

Endpoint data collection & Hospital Survey on Patient Safety Culture — Apr 2016

Interim findings

The *baseline evaluation* indicated that the patient safety culture in the trusts was mainly **reactive**. This means that risk was only addressed when it followed adverse events. **The safer system toolkit** addresses this issue, **and promotes a proactive patient safety culture**, where potential risk factors are monitored and care pathways are streamlined to minimise any chance of error.

The *Hospital Survey on Patient Safety Culture* revealed that the **areas that require improvement are; the staffing on wards, handoffs and transitions of patients, and response to errors caused by staff.** All three areas can be addressed by improving care pathways and teamwork, using the safer system toolkit.

The *Safer System Assessment workshops* have **enabled** each team **to identify** their main patient safety issues, and to come up with **effective care pathways improvements** (see project site actions above). These improvements aim to increase the safety and reliability of care. However, more training is required to enable participants to use the toolkit independently.

In the *Human Factors sessions*, participants have learnt to **reflect** on their work and to **enhance communication** with colleagues. The sessions also encouraged staff members to make patient safety a **discussable issue** and aimed to empower staff members to engage in patient safety improvements. As a result of the Human Factors sessions, **87.7% of the participants left feeling confident to apply human factors to their work** with minimal supervision. The SBAR technique was considered highly valuable during handoffs and transitions and the use of safe words and critical language have helped to align work among team members. **Nearly all participants were planning to use human factors in their work.**

Even though the exact effects of this project are **still to be evaluated**, *the Safer Care Pathways Project* has led to the implementation of several patient safety improvement projects, and has **facilitated shared learning** between organisations. As a result, it has been suggested the project has **strengthened patient safety culture** in the teams. This project **contributes to the lack of evidence** on the application of patient safety interventions in mental health care settings.

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

"Having listened to testimonies from a carer and service user has 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 identifying difficult areas"

Contributors

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