Reducing harm in Mental Health Settings - The Scottish Patient Safety Programme's approach

@spsp_mh #mhimprove

Conflicts of interest

David Hall is an NHS employee. He has also been employed as an IHI Faculty member. He has previously received honoraria from a pharmaceutical company (Janssen-cilag) for chairing and speaking at educational events and for sitting on advisory panels.
“If you do what you’ve always done, you’ll get what you’ve always got”

Mark Twain 1835-1910
Outcome - People using health and social care services are safe from harm.

DETERIORATION

Improve outcomes for people by preventing, recognising or responding to deterioration in any care setting

- Reduce restraint
- Reduce seclusion
- Reduce violence
- Reduce self-harm
- Reduce mortality from Sepsis
- Reduce Pressure Ulcers by 50%
- Reduce CAUTI 30%
- Reduce Falls by 20%
- Reduce in Healthcare Associated Infections
- 10% Reduce HSMR
- Reduce Cardiac arrests by 50%
What is distinctive about harm in mental health care?
Example 1

- A female in-patient with severe depression and is under 15 minutes observation manages to leave the ward and is later found to have gone into a local river and drowned.
- Is this harm?

Example 2

- A young male with a history of psychosis becomes increasingly agitated demanding to be allowed out of the ward. He is restrained and given IM medication.
- The restraint takes place in the day-room with a number of other patients present.
- Is this harm?
Example 3

• A female psychiatric in-patient with a history of abuse finds herself too anxious to leave her bedroom to sit in the mixed-sex TV room
• Is this harm?

Example 4

• A female patient returns home after 2 weeks in hospital under detention. A neighbour comments that it must have been very upsetting for the police to have ‘taken her away’.
• Is this harm?
What is distinctive about harm in mental health care?

- **Physical**
  - e.g. harm resulting from medication errors, harm resulting from restraint

- **Psychological**
  - e.g. due to conduct or experiences which cause fear, alarm or distress

- **Social**
  - e.g. harm caused to social relationships or financial harm resulting from the person’s vulnerabilities

- **Sexual**
  - e.g. adults at risk due to sexual disinhibition or the manipulation of an individual’s vulnerabilities

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**Programme Objective**

1. To systematically
2. Reduce harm experienced by people using mental health services in Scotland
3. By empowering staff to work with service users and carers
4. To identify opportunities for improvement
5. To test and
6. Reliably implement interventions
7. And to then spread successful changes across NHS Board areas
Patients are and feel safe, Staff feel and are safe

‘The way I would want to be treated....me and my family’
The Sequence for Improvement

- Theory & prediction
- Developing a change
- Testing a change
- Implementing a change
- Make part of routine operations
- Sustaining and Spreading a change to other locations

PDSA Cycle

Act
Plan
Study
Do
The value of “failed tests”

“I did not fail one thousand times; I have found one thousand ways how not to make a light bulb.”

Thomas Edison
All 13 boards with inpatient facilities
31 separate sites
74 reporting wards (out of 124)
All boards have one or more wards with an improvement or sustained improvement
**Measurement**

- Design measures around aims - *‘How Good, By When’*
- Establish a reliable baseline
- Track progress over time
- Use sampling where appropriate
- Integrate measurement into daily routine
- **Use qualitative and quantitative data**
- The key purpose of measurement for improvement is for learning.
- Teams need measures to give them feedback that the changes they are making are having the desired effect and are resulting in improvement.

**Measurement**

- **SPSP-MH Outcome measures**
- **Safety Culture Measures** (safety climate tool- service users and staff)
- **Process Measures**
**Safer Medicines Management**

- As required psychotropic monitoring, review and assessment
- High risk medicine monitoring and management – lithium/Clozapine (no avoidable treatment breaks) and polypharmacy
- Patient, staff and carer education
- Medicines reconciliation
- Safer Prescribing and Administration processes – missed dose, correct administration, error free

**Risk Assessment and Safety Planning**

- Training and refresher training
- Risk assessment timing and review – 2 hours on admission/72 hour review
- Live risk assessment – linked to goal setting
- Discharge
- Inclusion of sexual, physical, child protection, social and psychological risk
- Observation

**Violence, Restraint and Seclusion Reduction**

- Training – right balance of theory and practical with a trauma informed point of view
- Debrief following restraint/near miss
- Trauma Informed Care
- Restraint monitoring – techniques used, de-escalation methods, length of restraint….  
- Seclusion Policy and monitoring

**Leadership and Culture**

- Patient safety climate tool
- Staff climate tool
- Leadership Walkrounds/safety conversations
- Learning from adverse events

**Communication at Transitions**

- Admission/Discharge- including discharge pause 24 hours in advance of discharge
- Daily Goal Setting/What matters to you – developed in Person Centred Safety Briefings and Huddles
- Physical health at key transition points (and at all other times)
- Absconding/Missing Persons/Pass Plan
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http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

Safety Principles

Workstream development groups (WDG) and SPSP Delivery Group are developing Safety Principles in Mental Health, as agreed at SPSP MH Delivery Group meetings, where are a number of interventions and processes that are either being reviewed and tested with the view that all or a combination of these will contribute to reduction of harm measurable through the SPSP MH Outcome Measures. These are being defined, refined and evidenced.
7 wards/units showing reduction in the percentage of patients who self harm of up to 75%
9 wards/units showing a reduction or sustained reduction in the rates of restraint of up to 64%
15 wards/units showing a reduction/sustained reduction in the rates of violence of up to 80%
Over 500 facilitated patient safety climate tools completed
Over 3000 staff safety climate questionnaires completed
SPSP-MH beyond the current programme?

CAMHS

Older People’s Services

In-Patient

Perinatal

Community

#mhimprove
What advice would we share?

- Build the will
- Start small, quick wins
- Generate your own evidence
- What can we take straight away from elsewhere?
- Be nice......
- Be brave!

Cultural change takes time
‘We don’t really call it SPSP, that’s just what we do……’

@spsp_mh
@davidthemains
#mhimprove

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