NHS
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7 steps to patient safety in mental health

GOOD PRACTICE EXAMPLES

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Good practice example: Safety is paramount
Rochford Hospital South Essex Partnership: NHS Foundation Trust

Safety was paramount in every aspect of the new development of the 100-bed Rochford Hospital in South Essex, serving a population of 150,000.

Staff, patients and other stakeholders carefully considered how the new facility could be designed to promote safety and security, while facilitating communication and therapeutic care.

The aim was to develop a building that fitted the integrated service model, maximising safety, recovery and inclusion. No decision on fixtures and fittings was made lightly; everything was thought out, down to the anti-ligature door handles and sensor taps, doors with no visible hinges, curtains hung on collapsible hooks, non-breakable mirrors and no false ceilings in patient areas.

The end result is accommodation that is safe, modern and where risks of patients harming themselves or others has as far as possible been eliminated.

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Good practice example: Feedback and support
Sussex Partnership NHS Trust

Sussex Partnership Foundation NHS Trust has developed a 'Report and Learn Bulletin'. This allows regular dissemination of incidents and risks to be shared throughout the organisation.

The quarterly bulletin contains information and lessons that have been learnt as a result of patient safety incidents and subsequent actions. It also lists resources and advertises training linked to incidents that have been reported. For example, improving inter-agency working and communication following an incident where essential safety information about a patient was not passed on from team to another. Feedback from staff is very positive as they can see that reporting incidents is worthwhile and results in changes being made to improve patient safety.

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Good practice example: Unified framework for managing care
North Wales NHS Trust (Central Area)

North Wales NHS Trust has developed a framework to provide a unified system approach to support the delivery of assessment, treatment and care.

This approach was aimed at helping practitioners balance the rights of the individuals to freedom and self determination, and the reduction of risk to individuals, their families and the public.

To support the risk management process, a Care Coordinators Handbook was developed. This provides helpful information which clarifies the roles and responsibilities of the practitioner, to enhance their clinical practice.

The emphasis of the trust's approach was on 'positive risk management', requiring meaningful collaboration between agencies, service users and carers.

This work was in response to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, which advised services to align more closely their Care Programme Approach (CPA) with their risk management process.

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The NPSA gratefully acknowledges the NHS trusts who contributed these good practice examples.
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Good practice example: Effective inter-agency working

West London Mental Health NHS Trust

A collaborative venture between the London Borough of Hounslow, the Hounslow Primary Care Trust and West London Mental Health NHS Trust has adapted the NPSA's original *Seven steps to patient safety* for local use. The guide is aimed at senior managers in organisations delivering mental health services in Hounslow. The guide has been developed in recognition that safe and high quality mental healthcare can only be delivered through effective inter-agency work. It contains a number of agreed inter-agency commitments including developing a centralised cross-agency system for collecting data on incidents and inter-agency risk assessments to proactively improve patient care.

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Good practice example: improving reporting

Cornwall Partnership NHS Trust

Historically, the practice on a ward in the trust was not in line with the PCT policy on reporting of accidents/incidents.

There was confusion amongst the team as to when an incident report should be completed.

To address the issue, the ward manager organised a health and safety away day with the aim of:

- addressing the culture on the ward regarding reporting;
- indentifying incident reporting training needs;
- educating staff in preventing slips, trips and falls.

The ward team came away extremely motivated and reporting increased dramatically.

Through staff reports, incidents on the ward relating to the flooring were highlighted. An assessment was undertaken by the H&SE laboratories department. The results identified that the risk was high and hence the rational for new specialised flooring was undertaken throughout the ward.

Other preventative methods were put in place to prevent future incidents, such as the purchasing of non-slip slippers and a change to the cleaning schedules.

The implementation of this project is still in its infancy. However, staff have reported positive outcomes to patient care and continue to look at ways of improving safety on the ward.

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Good practice example: Electronic incident reporting
North Staffordshire Combined Healthcare NHS Trust

North Staffordshire Combined Healthcare is a large mental health/learning disabilities trust. It operates from a varied range of premises, hospitals, learning disabilities community bungalows, health centres etc. over a wide geographical area of approximately 270 sq miles.

The trust aimed to provide access to the electronic incident reporting form to over 6,000 staff spread over 80 properties in North Staffordshire. An innovative approach was used to build this tailored incident report system – the system was developed from scratch, in-house, by collaboration between the health and safety team and colleagues in IT, utilising specialist local talents.

Over 1,000 paper forms were received a month – this number has not changed since the introduction of the new electronic version, demonstrating that staff have faith in the system and are utilising it fully.

Overall, throughout the development of an innovative reporting system, the trust has ensured incidents affecting patient safety are reported quickly, and solutions found to improve the healthcare environment and the patient experience.

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Good practice example: Involving patients in developing safer services
Norfolk and Waveney Mental Health NHS Foundation Trust

Following a suicide of a patient known to the trust, a root cause analysis showed that the family and carers of the deceased were not always provided with enough information regarding possible triggers and warning signs in relation to suicidal ideation and behaviour.

A booklet 'Information and guidance for those who are involved with suicidal people' was developed and incorporated into the ongoing suicide prevention work within the trust. This development was shared with the local PCT. The booklet also gained approval from the local coroner.

It was vital to include those who had been affected by suicide in some way in the development of the booklet. The deceased patient's family were keen to be involved in the process to try to prevent further tragedies. It was also agreed to seek a wider consultation of views and opinions as to what information may be helpful to those in similar circumstances. A number of meetings were attended by service users; other bereaved families; professionals involved with those experiencing suicidal thoughts/behaviour on a daily basis; the Samaritans and local voluntary sector services (Norfolk Suicidal Bereavement Group).

This consultation enabled the trust to gather a wide range of views and also provided an opportunity for these people to tell their stories and share their experiences, facilitating a significant part of the bereavement process.

After gathering all the information, the trust began developing the booklet, which aimed to be user-friendly and accessible. It contained a list of services for those with suicidal ideation, including alternatives to mental health services, as well as information for carers.

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Good practice example: Themes from serious incident reviews

Pembrokeshire & Derwen Hywel Dda NHS Trust

A small number of consistent themes were identified as running throughout all the trust's serious incidents. For example:

- Record keeping – mainly illegible signatures and writing, together with record keeping not reflecting the care given.
- Community Mental Health Teams – problems around communication within and between the teams, and allocation and role of the care co-ordinator (CC).
- Inter-agency communication – communication issues between mental health services and substance misuse services, and difficulties with communication with both social services and primary care.

The trust has revised its policies, which set out the guidelines from access to services to discharge.

A single Integrated Care Management Policy was implemented which sets out the standards required from all staff, including those with specialist roles and responsibilities such as Unified Assessment Process, integrated care management and Care Programme Approach.

This was complemented by a number of integrated care pathways and the decision to introduce FACE, an electronic risk assessment/case management system. This system standardised the risk assessment process and made available real-time information to staff that were on-call out of hours.

This work is currently being audited and work is ongoing to improve the quality of the documentation.

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Good practice example: Encouraging patients to remain on the ward

Greater Manchester West Mental Health Foundation NHS Trust

As one solution to the problem of an increase in the number of patients going missing, staff on Riley Ward, Meadowbrook Unit, have introduced 'protected time.' During protected time the nurses give all their time to the patients on the ward, engaging them in therapeutic activities or one-to-one conversations. During this time they do not carry out interdisciplinary work such as documentation and other administrative work, except in cases of emergency. Telephone calls are diverted to the ward administrator and visitors are encouraged not to come to the ward during these times. Each protected period of time varies according to the patient's needs, but takes place regularly between the hours of 2pm and 4pm on set days.

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Good practice example: Electronic swipe-card system

Leeds Partnership NHS Foundation Trust

Leeds Partnership NHS Foundation Trust has adopted an innovative approach to manage service user entry and exit from the Adult Acute Inpatient Service. Staff recognised that it was necessary to be able to provide the safest service that they could to those people who (at the time) required a higher level of observation and restriction, balanced against unduly inconveniencing or restricting other patients who have different needs.

The swipe-card system balances the right to liberty and the right to safety for all concerned. Patients are risk assessed individually to decide who should and should not have an electronic swipe-card. For those detained under the Mental Health Act, the default position is that they do not have a card programmed to allow them to leave the ward, unless a section 17 form has been completed indicating otherwise.

Informal patients have the right to have their card programmed to allow them to exit the ward at will. However, if an informal patient agrees willingly to admission on the grounds of their own safety/risk, it would be reasonable to ask them to consent to not having a card, if the shared assessment indicated that it would be an unacceptable level of risk. An alternate treatment plan would be considered if the patient was not in agreement.

The benefits of this system include that it is no longer necessary to impose observations on those deemed at high risk of leaving without staff knowledge and patients report that they feel safer on the ward.

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Good practice example: Responding to sexual assault allegations

Camden and Islington Mental and Social Care Trust

The trust has developed a detailed trigger list related to reporting of sexual harassment, assault and inappropriate conduct. The list provides guidance for clinicians to grade incidents in terms of severity from amorous remarks to incidents such as rape. Further developments have been the appointment of a women's lead, the women's forum and training that all staff attend regarding sexual safety. The trust's Risk and Assurance Committee regularly consider themed reports of incidents, including sexually related incidents.

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