NHS
National Patient Safety Agency
National Reporting and Learning Service

7 steps to patient safety in mental health

SUMMARY

The NPSA gratefully acknowledges the following for their contribution and advice:

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Malcolm Rae, Joint Lead Acute Care Programme, National Institute for Mental Health in England (NIMHE)

The artwork used in *Seven steps to patient safety in mental health* is all original work, created by service users at Mersey Care NHS Trust, facilitated by occupational therapy services. The work was created as part of the celebration of Liverpool's European Capital of Culture year and reflects the rich diversity of innovative and creative projects happening in mental health.

Contents

Introduction

Mental and behavioural disorders are common; more than 25 per cent of all people are affected at some point during their lives and every year one million service users in England and Wales receive specialist mental healthcare[1].

The National Patient Safety Agency (NPSA) was established in 2001 to lead and support all NHS organisations in improving patient safety, in particular through managing a national patient safety incident reporting system.

Over 100,000 patient safety incidents* are reported to the NPSA's Reporting and Learning System (RLS) from mental health services every year.

Improving patient safety in mental health is a great challenge for all staff working in frontline services. The key to addressing this is for services to work in partnership with the NPSA and other national organisations, service user groups, professional organisations and carers to continually improve the safety of mental health services in all delivery settings.

Good practice in this area is readily identifiable in many organisations and we need to ensure that this continues to develop so that all service users benefit throughout England and Wales.

The *Seven steps to patient safety in mental health* describes a framework for mental health organisations, staff and teams on which to build work towards improving the safety of service users.

The steps are part of a continuing process: step one is the foundation step; steps two to seven help you build your safety culture.

This summary document is part of a series of seven steps publications from the NPSA. There is a seven steps summary and a full reference guide for all healthcare settings, and a seven steps for primary care.

Future publications will include **a more detailed version for mental health** and a focused version for General Practitioners. All resources linked to the seven steps can be found at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/**

Patient safety concerns everyone in the NHS, and by tackling the specific issues that effect mental healthcare in a collective and systematic way, as set out in the *Seven steps to patient safety in mental health,* you can make a positive impact on the quality and safety of the care you provide.

[1]Department of Health. Hospital Episodes Statistics (admissions to NHS hospitals under mental illness specialities by gender and age on admission, 1997–1998 to 2003–2004, Table 5.01). Available at: **www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en**

*As 'patient safety' is an accepted term used throughout healthcare, we have used this term when referring to incidents. Elsewhere in the document we have used 'service user' rather than patient.

The seven steps to patient safety in mental health

Step 1: Build a safety culture

Create a culture that is open and fair

Step 2: Lead and support your staff

Establish a clear and strong focus on patient safety throughout your organisation

Step 3: Integrate your risk management activity

Develop systems and processes to manage your risks, and identify and assess things that could go wrong

Step 4: Strengthen reporting in mental healthcare

Ensure your staff can easily report incidents locally and nationally

Step 5: Involve and communicate with service users and the public

Develop ways to communicate openly and listen to service users and the public

Step 6: Learn and share safety lessons

Encourage staff to use root cause analysis to learn how and why incidents happen

Step 7: Implement solutions to prevent harm

Embed lessons through changes in practice, processes or systems

STEP 1

Build a safety culture

A safety culture is where staff within an organisation have a constant and active awareness of the potential for things to go wrong, and both staff and the organisation are able to acknowledge mistakes, learn from them, and take action to put things right.

A safety culture is also manifested in sharing information openly and freely with service users when things go wrong ('being open').

The systems approach to safety acknowledges that the causes of a patient safety incident cannot simply be linked to the actions of the individual healthcare staff involved. All incidents are also linked to the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring.

Mental health organisations manage multiple systemic risks which have variable visibility to frontline staff. A mature, high-functioning safety culture will ensure that clinical and managerial staff are aware not only of the individual service user risks, but also of the risks associated within the systems that they are working. This culture is an essential framework for staff to be able to identify, own and manage risk within the organisation.

Safety culture assessment

The first stage in developing a safety culture is to establish the culture of your organisation at present. A number of tools are available to help determine underlying beliefs, attitudes and behaviour. Most are in the form of checklists or questionnaires for staff to complete. They address a variety of issues, including:

- senior management visibility and commitment to safety;
- communication between staff and managers;
- attitudes to incident reporting, blame and punishment;
- factors in the work environment that influence performance (for example, fatigue, distractions, equipment design or usability).

Action points

At organisation level:

- Undertake an organisation-wide baseline assessment of safety culture using appropriate tools (see 'How the NPSA can help'). The assessment will necessarily involve staff and service users.
- Disseminate the results of the assessment so that all staff are aware of the current situation. Engage staff and service users in designing an improvement plan based on this assessment.
- Build in a regular re-assessment process so that progress can be measured.
- Ensure your policies describe individual roles and accountability when things go wrong.
- Show the Board's commitment to patient safety. Ensure the Board participates in regular safety rounds and that patient safety is high on the agenda.

For your mental health team:

- Discuss with your colleagues, including temporary staff and students, what they hope and expect will happen when they report something that has gone wrong. Do you all have the same trust in the system?
- Build into regular team meetings a prompt to discuss any emerging risks that might need to be reported – and agree who will report them on behalf of the team.
- Model the behaviour you'd expect for serious incidents in your everyday practice; minor incidents unrelated to patient safety (for example, a failure to book a staff meeting room) give you a chance to demonstrate you're fair and open minded.

How the NPSA can help

The Manchester Patient Safety Framework (MaPSaF)

This tool has been developed to help NHS organisations assess their progress in developing a safety culture. It can help identify areas of particular strength or weakness, and enable resources to be channelled appropriately to improve the safety culture. MaPSaF uses 'dimensions' of patient safety, and for each of these describes what an organisation would look like at five levels of patient safety. MaPSaF is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/mapsaf/**

Being open

The NPSA has developed guidance, a model policy and training to help NHS staff facing the difficult task of talking to patients and their relatives following a serious patient safety incident. *Being open* resources are available at: **www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/**

Incident Decision Tree

The Incident Decision Tree (IDT) is an interactive web-based tool for NHS managers and organisations dealing with staff who have been involved in an incident. It helps to identify whether the action(s) of individuals were due to systems failures or whether the individual knowingly committed a reckless, intentional unsafe or criminal act. The tool changes the focus from asking 'Who was to blame?' to 'Why did the individual act in this way?' The IDT is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/incidentdecisiontree/**

STEP 2

Lead and support your staff

Building a safer culture depends on strong leadership with clear policies in relation to safety, and a willingness to implement best practice at service level.

To show that safety is a priority and that the management of the organisation is committed to improvement, leaders must be visible and active in leading patient safety initiatives.

In mental health and social care organisations, many of the patient safety issues identified are not new, for example, the risk of inpatient suicide, missing persons and the vulnerability of woman on mixed wards to sexual assault. Other issues have been more recently identified, for example the difficulties with resuscitation in inpatient settings.

The dramatic decrease in inpatient suicides by hanging from non-collapsible rails shows that the implementation of a solution can be extremely effective when the process is clear, the Board has responsibility and accountability, and staff delivering care are fully involved in the process.

A more mature safety culture will improve the implementation of solutions to both old and new patient safety problems.

Action points

At organisation level:

- Ensure there is an Executive Board member with responsibility for patient safety and that staff in the organisation know who this is.
- Put patient safety high on the Board agenda and management team meetings.
- Identify patient safety champions in each directorate, division or department. The champion needs a clearly defined remit and role which is communicated to staff.
- Use regular patient safety leadership walkabouts to gather information and ideas from staff and service users about safety concerns in the service. Use this information in combination with information from reporting to target a small number of key areas at one time and actively feedback to the teams the ideas generated at these meetings.
- Set realistic targets to measure success, for example aim for a reduction in vulnerable missing persons. The targets should be set at aspects of the process which can be changed rather than a blanket decrease.
- Participate in the leadership interventions in the 1,000 Lives Campaign (Wales) or the Patient Safety First Campaign (England). Go to: **www.npsa.nhs.uk/nrls/improving patientsafety/campaigns/** for further information.

For your mental health team:

- Know who your own champion or lead is for patient safety. Invite them to visit your area, meet the team, and explain their role.
- Discuss what patient safety means to all the members of your team, and where each team member can make a difference.
- Promote an ethos where all individuals within your team are respected and feel able to challenge when they think something may be going wrong.
- Support individuals within your team when something does go wrong.

How the NPSA can help

Leadership checklist for patient safety leads and champions

The NPSA has developed a safety checklist for patient safety leads and champions in the form of a self assessment tool. It gives individuals or groups of leaders a range of choices to consider, periodically revisit and use to trigger action. The safety checklist is available in step 2 of the NPSA's detailed guide, *Seven steps to patient safety – the full reference guide*, available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/**

Leadership checklist for NHS Chief Executives

Also available is a leadership checklist for NHS Chief Executives which provides executives with a range of patient safety questions to consider at Board level, to periodically revisit and to use to trigger action. The leadership checklist is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/**

STEP 3

Integrate your risk management activity

A mental health organisation's risk management system is designed to help the organisation manage incidents effectively and reduce the chances of them happening again.

Patient safety is a key component of risk management, and should be integrated with staff safety, complaints management, litigation and claims handling, and financial and environmental risk.

An organisation's risk management system should also be supported by an organisational risk management strategy (involving a consistent approach to training, management, analysis and investigation of all risks), a programme of proactive risk assessments and the compilation of an organisation-wide risk register.

Integration of all risk will assist organisations in complying with standards, clinical governance, assessments, and the *Corporate Manslaughter and Corporate Homicide Act 2007*.

The goal of integrating and actively managing risk across an organisation is to become a 'high reliability organisation'. Characteristics of high reliability organisations are:

- Preoccupation with failure.
- Commitment to resilience, proactively seeing out potential hazards and containing them before they cause harm.
- A culture of safety in which individuals are able to speak up and are listened to.
- High reporting culture and an expert-led process of investigation which focuses on the underlying structural or process mechanisms.
- Interventions which target the system, leading to longer-lasting impact on the delivery of safe, high quality care.

Action points

At organisation level:

- Review your structures and processes for managing clinical and non-clinical risk, and ensure these are integrated with service user and staff safety, complaints and clinical negligence, and financial and environmental risk.
- Develop performance indicators for your risk management system which can be monitored by your Board.
- Use the information generated by your incident reporting system and organisation-wide risk assessments to proactively improve service user care.

For your mental health team:

- Discuss the reports your organisation provides on incidents, complaints, etc as a team, to identify new areas your team can make improvements in.
- Feedback any suggestions on improving the information provided to your team.
- Nominate team members to link with other teams to work on particular risk issues in your area of practice, for example vulnerable missing persons, falls prevention or self harm.
- Keep risk assessment of issues affecting your team or area active – does everyone know what the top 10 risks on your local risk register are? Are there new risks you need to feed into the organisation-wide risk assessment process and risk register?

How the NPSA can help

Risk assessment made easy

This easy-to-use risk assessment tool helps promote vigilance in identifying risk and the ways in which risk can be minimised. It also includes guidance that will encourage greater consistency in the way risk assessment is communicated across the NHS. The tool is intended to be used by frontline staff or as a teaching tool for those involved in promoting risk assessment. The guide is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/**

Foresight training resource pack

This pack supports nurses working in all care settings to improve awareness of the factors that combine to increase the likelihood of patient safety incidents; to increase local learning through sharing experiences and to improve understanding of risk prone situations and situations that could be considered as 'near misses'. The pack contains a range of training scenarios, paper and video based, and supporting materials for use by a facilitator. Each scenario has a set of detailed 'foresight factors' to encourage discussion and learning, with the intention that participants will be more attuned to seeing these factors in the future, before a patient safety incident occurs. The pack is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/foresight/**

RCA investigation report tools

A consistent approach to the investigation and analysis of incidents, claims, complaints, hazards and risks can be promoted through implementation of NPSA RCA investigation report tools. Resources in this collection have been developed to assist NHS organisations in integrating and standardising incident investigation processes, and include: 'Triggers for investigation', 'Investigation Report Template', and guidance on 'Three levels of Investigation' and 'RCA Report Writing'. These tools are available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/rootcauseanalysis/rca-investigation-report-tools/**

STEP 4

Strengthen reporting in mental healthcare

A high level of reporting within an organisation indicates a better safety culture: the more aware staff are of safety problems, the more likely they are to report.

The level of reporting from mental health organisations in England and Wales has significantly improved. However, the NPSA is aware that not all incidents are reported both within organisations and to the NPSA.

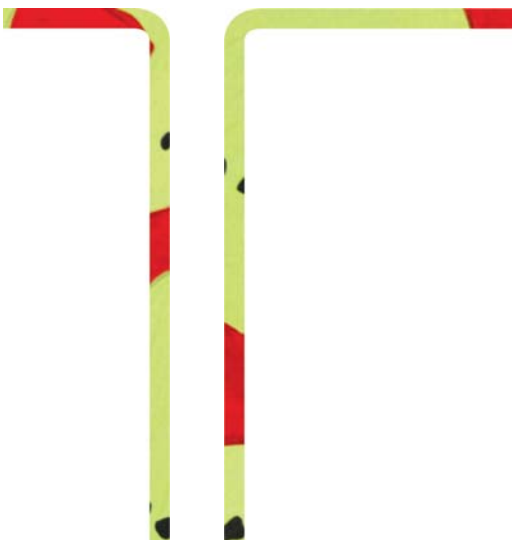
All mental health organisations have implemented a system for collecting data on patient safety incidents. This enables organisations to:

- analyse the type, frequency and severity of incidents;
- respond to incidents in a timely manner;
- escalate incidents depending on their severity and nature;
- use this information to develop corrective strategies and to improve systems and clinical care;

In addition to local reporting, organisations participate in national reporting by uploading their incidents to the Reporting and Learning System (RLS). A benefit of this national data collection is the aggregation of hazards and risks. This means that sufficient numbers of incidents that are low frequency from a clinician's or organisation's perspective (i.e. they may only be seen at most once or twice a year) are collected and aggregated with all reports from mental health organisations. The NPSA then produces guidance to help reduce risk and improve patient safety.

Another key benefit of the RLS is to spot new and emerging issues quickly so that remedial actions can be disseminated to organisations rapidly to prevent further harm. The timeliness of organisations submitting incidents to the RLS impacts on the NPSA in undertaking this vital national surveillance function.

A significant barrier to reporting can be the perception from staff that they report but receive no feedback from their organisation. A key to improving reporting is ensuring that learning from the reports received are widely disseminated and then acted upon.



Action points

At organisation level:

- Establish the current level of reporting within your organisation and check how it compares with similar organisations using the organisational feedback reports sent by the NPSA.
- Look at reporting rates and type of incidents reported across similar teams, for example all CAHMS teams or adult mental health teams. Discrepancy in reporting rates or types of incidents reported can be an indicator of particular problems in reporting culture.
- Determine any barriers for frontline staff to report incidents, for example, overly bureaucratic processes or lack of feedback. Many organisations now use a simplified electronic system to help staff report more easily.
- Provide regular feedback to staff including newsletters, trend analysis, patient stories and include action that has been taken.
- Ensure that your incidents are uploaded to the RLS on at least a monthly basis.
- Incidents with a degree of harm rated as death or severe should be **uploaded within 36 hours of the incident occurring.**

For your mental health team:

- Encourage your colleagues to actively report all patient safety incidents, including those where staff intervened and no harm came to the service user.
- Remember to thank team members who report incidents, and keep them in the loop on any subsequent actions.
- When changes are introduced as a result of a reported incident, for example a new training programme, or an environmental improvement, use these to remind your team that reporting can make a difference.
- Give as many staff as possible an opportunity to get involved in producing and implementing action plans following incidents.

How the NPSA can help

Reporting and Learning System Data Summaries

These summaries provide an overview of the number of patient safety incident reports received by the NPSA, and patterns and trends in these incidents. Data summary reports are available from: **www.npsa.nhs.uk/nrls/patient-safety-incident-data/quarterly-data-reports/**

Organisational Feedback Reports

Individual organisation feedback reports compare similar sized organisations from the same care setting to allow benchmarking on rates of reporting. **www.npsa.nhs.uk/nrls/patient-safety-incident-data/**

Act on reporting: NHS Confederation and NPSA briefing

This briefing describes how high levels of patient safety incident reporting suggest a stronger organisational culture. The document lists five actions to improve reporting. It is available at: **www.npsa.nhs.uk/nrls/reporting/five-actions-to-improve-reporting/**

Examples of local feedback mechanisms

Links to examples of local feedback newsletters developed by high reporting organsations can be found at: **www.npsa.nhs.uk/nrls/reporting/five-actions-to-improve-reporting/**

Engaging clinicians

This is a modular pack containing a variety of resources and examples of ways of which NHS organisations have already raised awareness of patient safety. It contains generic templates which can be customised with your own local examples to raise awareness of patient safety amongst all staff groups in your organisation. The pack is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/learning-materials/engaging-clinicians/**

With safety in mind: mental health services and patient safety

This second Patient Safety Observatory report from the NPSA includes detailed analysis of patient safety data relating to mental health service users, and factors affecting the safety of mental healthcare. This report is available at: **www.npsa.nhs.uk/nrls/alerts-and-directives/directives-guidance/mental-health/**

STEP 5

Involve and communicate with service users and the public

Involving and communicating openly with service users, their relatives/carers and the public is essential to improving safety.

Mental health services have been at the forefront of service user and carer involvement within healthcare settings, and can use this experience to support further service user and carer involvement in patient safety improvements.

There are three main areas in which organisations can involve service users and the public in making the service safer:

1. **Involving service users and the public in developing safer services at a strategic level:** Many service users are experts in their own condition and this expertise can be used to help identify risks and devise solutions to patient safety problems. When designing and reviewing services, it is important that service users are represented and their opinions considered.
2. **Involving service users in their own care and treatment:** Mental health organisations have put a significant amount of energy into changing practice so that service users are more involved in their own care and treatment. Feedback from service users and analysis of complaints show that there is still, however, much progress to be made. The needs of certain groups of service users are often overlooked, for example patients with learning disabilities, children, and people whose first language is not English. Information needs to be provided in a form which is appropriate to the service user as an individual so that involvement is meaningful.
3. **Encouraging an open, two-way dialogue between health professionals and service users when things go wrong:** Being open means saying sorry, explaining what has happened, and investigating the incident to help prevent it from happening again. Discussing the problem promptly, fully and compassionately can help service users cope better with the after-effects of when things have gone wrong.

Action points

At organisation level:

- Develop a local policy covering open communication about incidents with service users and their relatives/carers.
- Ensure service users and their relatives/carers are informed when things have gone wrong and they have been harmed as a result, and ensure that the information provided is in a form appropriate to that individual.
- Provide your staff with the support, training and encouragement they need to be open with service users and their relatives/carers.

For your mental health team:

- Ensure your team accesses the formal training your organisation offers to support them in being open with service users and their relatives/carers when something has gone wrong.
- Support informal learning within your team, for example asking more experienced staff to share difficult situations they have been through with more junior staff.
- Make appropriate apologies to service users, their relatives/carers and your colleagues part of the everyday response to minor things that go wrong.
- Listen in a respectful and sympathetic way and know what action to take whenever service users, their relatives/carers or colleagues tell them they think something is wrong.

How the NPSA can help

Being open

The NPSA has developed guidance, a model policy and training to help NHS staff facing the difficult task of talking to patients and their relatives following a serious patient safety incident. *Being open* resources are available at: **www.npsa.nhs.uk/nrls/alerts-and-directives/notices/disclosure/**

Independent investigation of serious patient safety incidents in mental health services - good practice guidance

This document describes the three main stages of the independent investigation process. It also looks at how NHS organisations can support the victims of serious incidents. The guidance is available at: **www.npsa.nhs.uk/nrls/alerts-and-directives/directives-guidance/mental-health/**

STEP 6

Learn and share safety lessons

Reporting when things go wrong is essential in healthcare, but it is only part of the process of improving patient safety. It is equally important that mental health organisations look at the underlying causes of patient safety incidents and learn how to prevent them from happening again.

Often the underlying causes are many, and in the majority of cases extend beyond the individual staff member or team involved.

Organisations need to use a systematic approach such as Root Cause Analysis (RCA) in which staff know what type of incidents should be reported, what information is needed and when, and how to analyse and act on this information.

RCA techniques focus the key questions not on 'who is to blame for the incident?', but 'how and why did it occur?'. They pinpoint areas for change, and prompt recommendations for sustainable solutions that reduce the chances of the incident happening again.

Many mental health organisations are now using Aggregated RCA, which is the grouping of investigations (multi-incident) or reviewing the findings of many similar investigations (investigation aggregation). These techniques have the advantage of identifying actions to improve the safety of service users which are more likely to address common issues, for example following a number of inpatient or outpatient suicides and absconding episodes from wards.

The dissemination of the learning to clinicians and service managers is a critical component of the learning process. Most mental health organisations are large and based on more than one site, which causes significant communication challenges. It is highly unlikely that a single communication will lead to any implementable or sustainable learning.

Most patient safety problems such as absconding persons have complex systemic causes which require actions on an individual, team, directorate and organisational level. The actionable learning needs to be communicated in a sophisticated fashion, using multiple modalities which reflect the underlying complexities.

Action points

At organisation level:

- Ensure relevant staff are trained to undertake appropriate incident investigations, such as RCA, that will identify underlying causes.
- Develop a local policy which describes the criteria for when an organisation should undertake an RCA. These criteria should include all patient safety incidents that have lead to serious harm or death.
- Ensure that the Board has quality assurance processes that ensure RCA investigations meet a satisfactory standard and that staff use standard templates for analysis and report writing.

For your mental health team:

- Ensure your team accesses the formal training your organisation offers to you in incident investigation.
- Support informal learning, for example junior staff shadowing an experienced investigator.
- Share lessons from RCA investigations within team meetings, and review progress against action points.
- Seek out opportunities to discuss each other's learning from investigations, for example, visiting a team similar to yours in a neighbouring organisation, or setting up a discussion with a group of similar teams within your own organisation.

How the NPSA can help

RCA training

The NPSA has previously provided RCA training for a number of staff in all NHS organisations across England and Wales. RCA training for additional or new staff members may be available from some Strategic Health Authority Patient Safety Action Teams or sourced from independent training organisations.

RCA toolkit

The NPSA has developed a web-based e-learning toolkit to support staff attending training and conducting RCA investigations. The package provides a framework for the RCA process, guidance on how to analyse incidents, and an interactive tool to help staff develop confidence in performing RCA. This online resource centre also contains downloadable tools and templates for use when conducting an RCA. The toolkit is available at: **www.npsa.nhs.uk/rca**

RCA investigation report tools

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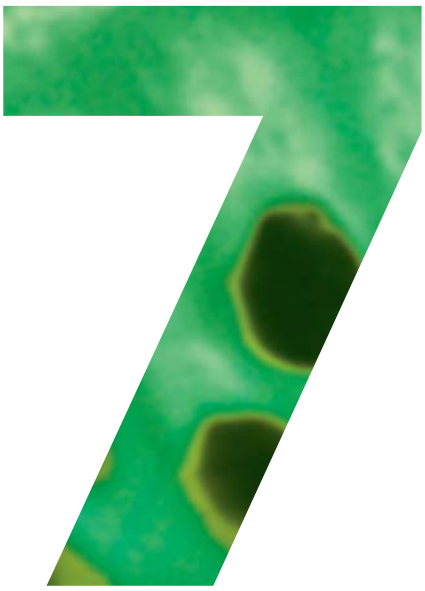

STEP 7

Implement solutions to prevent harm

Quicker and more reliable implementation of risk reduction strategies and safer practices are two major challenges in mental healthcare.

The amount of guidance produced each week in the NHS makes it hard for organisations to prioritise. Also, the amount of evidence for an individual clinician is overwhelming, and it is unrealistic for a clinician to be able to embed this into their daily clinical practice without support.

Changing practice - the problem:

- Spread and sustainability requires closing the gap between best practice and common practice, and is dependent upon NHS organisations mainstreaming and embedding new ideas.
- The last decade has seen an overwhelming level of information to improve patient safety – over two million articles on medical issues are published annually.
- There are numerous known factors which both hinder and facilitate implementation.

Changing practice - the solution:

There is a hierarchy in terms of solutions which range from designing out the potential for harm, designing systems which make it easy for people to do the right thing, to raising awareness and understanding.

Solutions need to be simple to implement and low cost. Developing them should take a step-by-step approach. They should require little training and effort and be measurable. They should be developed so that they:

- avoid reliance on memory;
- make things easy to do;
- simplify processes;
- standardise common processes and procedures.

The method of implementation should be based on the:

- type of practice;
- type of change expected;
- stakeholders involved;
- receptive context including local capacity;
- available resources.

Implementation methods which work are:

- the use of collaboratives and simple clinically-led interventions;
- use of respected individuals or peers who can influence others to change behaviour and practice – 'the opinion leader model';
- multi-modal methods using interactive educational meetings, audit, triggers, reminders, ritual practices and feedback;
- social marketing and behavioural change initiatives.

Measure patient safety indicators over time to demonstrate successful and sustained implementation, including:

- levels of implementation:
  - partial implementation;
  - full implementation in some areas;
  - full implementation throughout;
- safety culture;
- number and type of incidents;
- ratio of number of incidents and number of investigations;
- patient safety indicators, e.g. 'never events' – things that should never happen;
- retrospective case note review with the use of trigger tools;
- number and type of complaints and claims;
- mortality rates;
- before and after interventional measures.

Action points

At organisation level:

- Use a systematic approach to develop solutions, including risk assessing potential ones.
- Involve service users and staff in the process of gathering ideas, and ensure that there will be ownership of any proposed changes.
- Understand the problem or risks using evidence from RCAs and other sources of information, including examples of best practice from other services.
- Identify the changes that need to be made and explain to staff why they need to change their behaviour or practice.
- Review practice in relation to national recommendations and advice, and implement best practice guidance.
- Show that changes make a difference by using success measures, particularly if they result in safer services; this will help staff see the benefits.
- The NPSA issues Rapid Response Reports on urgent safety issues. Ensure these are received and acted upon.

For your mental health team:

- Always explain and justify proposed changes in practice; aim to win hearts as well as minds.
- Take part in collecting the measures for success, and use these to identify where you may need to give more support.
- Where you've successfully implemented a change, share the secrets of your success with peers.
- When you are sent Rapid Response Reports, quickly review what your team needs to do, and make sure all your colleagues know too.

How the NPSA can help

Rapid Response Reports

The NPSA issues Rapid Response Reports on urgent safety issues. These can be downloaded from: **www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/**

Root Cause Analysis tools and templates

When reviewing the safety aspects of a problem or risk during an RCA, it is useful to conduct a 'Barrier Analysis'. A template for this is available at: **www.msnpsa.nhs.uk/rcatoolkit/resources/word_docs/Templates/Template_Reactive_Barrier_Analysis.doc**

To promote a systematic approach to the development of solutions, it is valuable to involve the multidisciplinary team in conducting an 'Options Appraisal'. An 'Impact Analysis' can be conducted retrospectively to evaluate the effectiveness of solutions set in place. A template for this is available at: **www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/rootcauseanalysis/rca-investigation-report-tools/**

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