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Tweet us at **#quality2019**

F2 #qff2

Institute *for* Healthcare Improvement

BMJ

Healthcare Improvement Scotland

NHS East London NHS Foundation Trust

Safety improvement in mental health

@DavidTheMains

@DrAmarShah

Objectives for this session

1. Describe safety improvement efforts in Scotland and East London NHS Foundation Trust

2. Consider how to apply systematic continuous improvement to mental health safety issues

3. Look to the future of safety improvement in mental health settings

The Scottish Patient Safety Programme- Mental Health

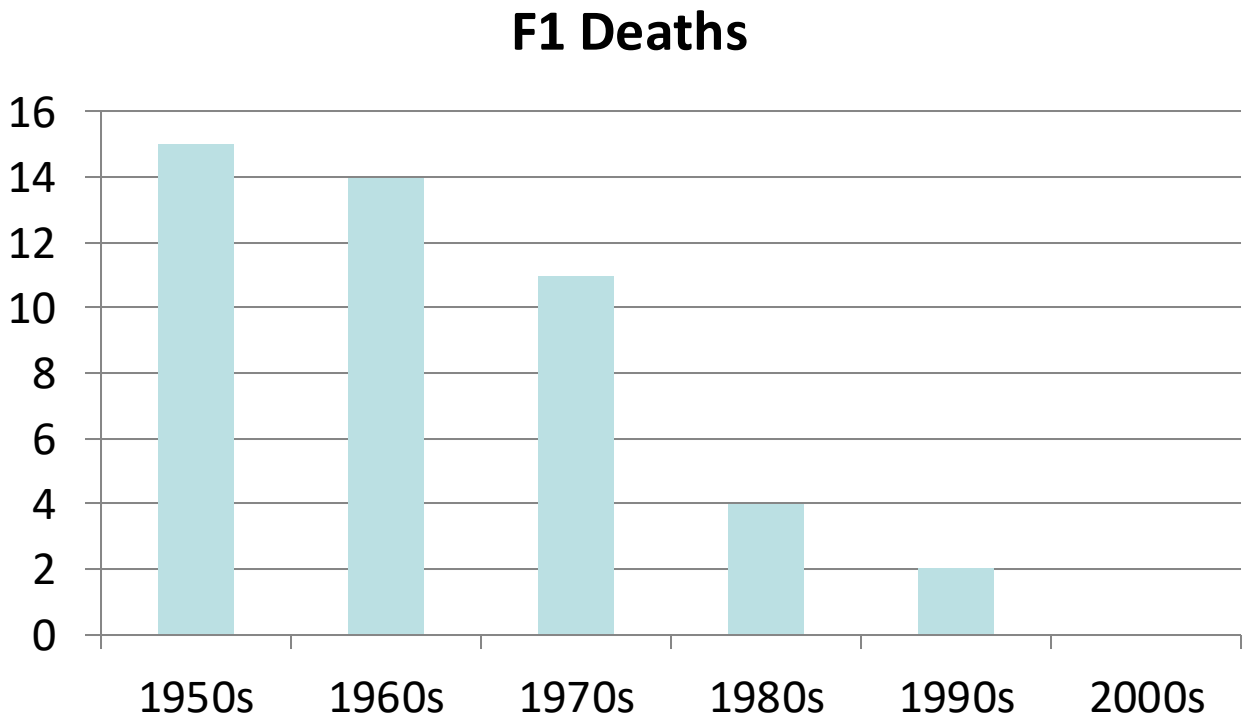
Dr David J Hall, National Clinical Lead

Mark Twain 1835-1910

“If you do what you’ve always done, you’ll get what you’ve always got”

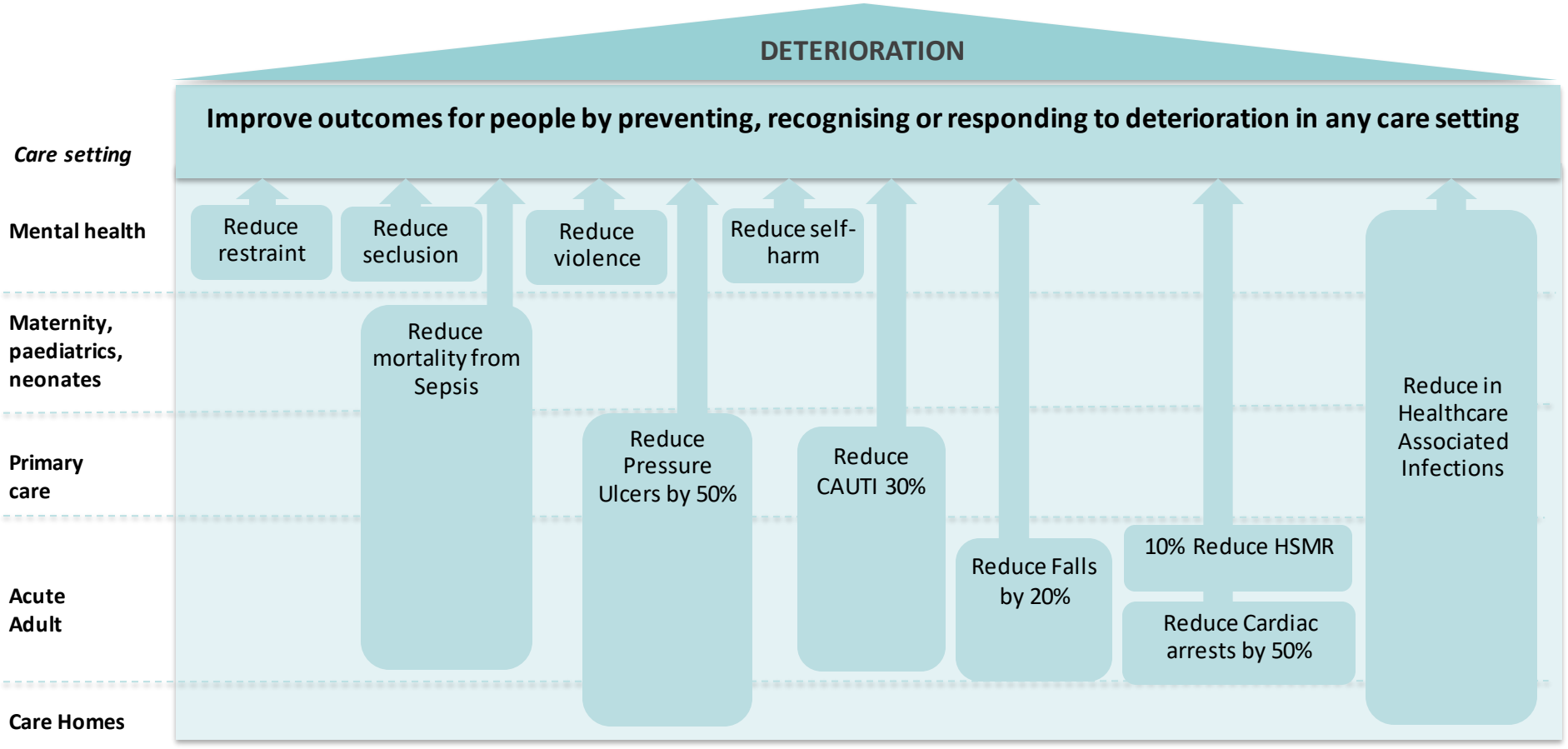
#mhimprove


BOSS
MEN'S FASHION


F1 Deaths
16
14
12
10
8
6
4
2
0
1950s
1960s
1970s
1980s
1990s
2000s

HSMR across Scotland

Outcome - People using health and social care services are safe from **harm**.



Healthcare Improvement Scotland

EVERY PERSON EVERY TIME SCOTTISH PATIENT SAFETY PROGRAMME

Physical Social Sexual Psychological

Patients are and feel safe, Staff feel and are safe

#mhimprove

Healthcare Improvement Scotland

EVERY PERSON EVERY TIME SCOTTISH PATIENT SAFETY PROGRAMME

Safer Medicines Management

Risk Assessment and Safety Planning

Leadership and Culture

Violence, Restraint and Seclusion Reduction

Communication at Transitions

Data and Measurement

- Of the 40 wards reliably reporting the rate of violence 28 (70%) wards are reporting improvement
- Of the 37 wards reliably reporting the rate of restraint 28 (75%) wards are reporting improvement
- Of the 36 wards reliably reporting the rate of self-harm 22 (61%) wards are reporting improvement

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

Some examples…

SPSP-MH Safety Principles

There are four revised Safety Principles:

- Communication

- Leadership & Culture

- Least Restrictive Practice

- Physical Health

Leading Learning Improving

Making Healthy Change Happen.

Mental Health Quality Improvement Programme

Planning for the future

Paul Smith
Quality Improvement Advisor
Jane Cheeseman
Clinical QI Lead & Consultant Psychiatrist

@LothianQuality
#qilothianmentalhealth

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BETTER HEALTH, BETTER CARE, BETTER VALUE
Mental Health Quality Improvement Programme

110 staff trained locally "Qi Bites"
165 staff formally trained via Qi Academy
15 trained coaches

Local
- **Qi & Clinical Innovation Forun**

National
- **Scottish Patient Safety Programme**

International
- **International Forum on Quality and Safety**
- **#MHImprove**

112 projects

Dec '18

Nov '16

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International Forum on Quality & Safety in Healthcare

Improving Prison Clinic Efficiency Through Improvement Science

Dr Chris O'Shea – Forensic Psychiatry Registrar
NHS Lothian

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Background

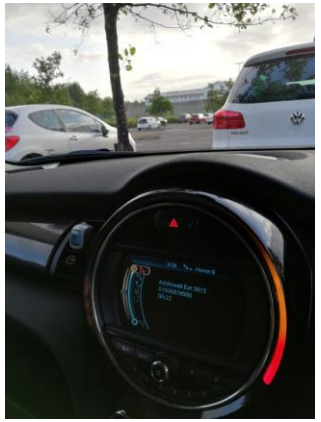
- HMP Addiewell
- 700 Capacity
- Health → NHS Lothian Responsibility
- Clinics in prison are challenging to deliver

Data

	Pre-Interventions (n=17 clinics)
Mean number of patients seen per clinic	2.75
Mean time waiting on 1st patient to arrive (minutes)	22
Mean time waiting between patients (minutes)	29
Proportion of clinic in direct patient contact (percentage)	59.1

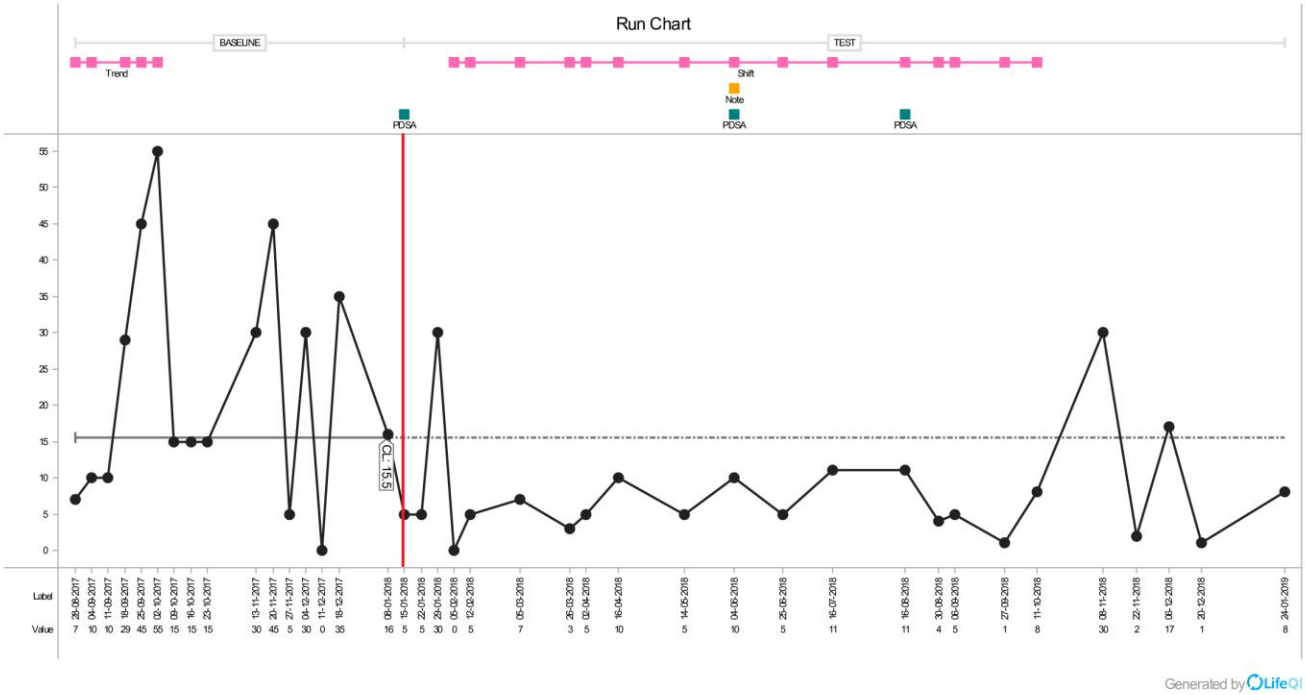
"When will I see you again?"

Change Ideas



- **Jan 2018** – ‘Call from the car park’
- **June 2018** – Briefing with health centre officer
- **August 2018** – rearranging medical cover

Wait Time for First Patient



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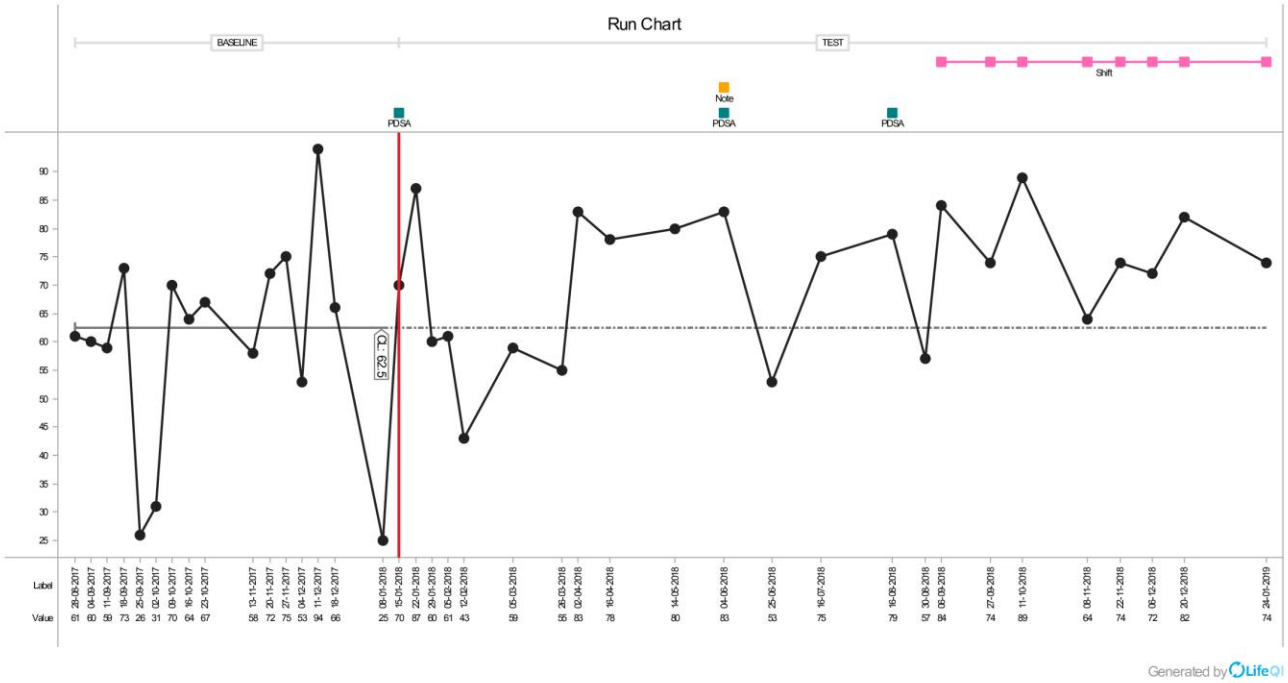
% of Clinic in Patient Contact



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Successes

	Pre-Interventions (n=17 clinics)
Mean number of patients seen per clinic	2.75
Mean time waiting on 1st patient to arrive (minutes)	22
Mean time waiting between patients (minutes)	29
Proportion of clinic in direct patient contact (percentage)	59.1

Successes

	Pre-Interventions (n=17 clinics)	Post-Interventions (n=23 clinics)	% Change
Mean number of patients seen per clinic	2.75	3.70	↑35%
Mean time waiting on 1st patient to arrive (minutes)	22	8	↓63%
Mean time waiting between patients (minutes)	29	12	↓58%
Proportion of clinic in direct patient contact (percentage)	59.1	71.1	↑20%

Leading Learning Improving

Making Healthy Change Happen.

Mental Health Quality Improvement Programme

International Forum on Quality & Safety in Healthcare

March 29th 2019

James Boyle PBS Coach

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Restrictive Interventions & Positive Behavioural Support Project.

The research and development of a framework for the reduction of restrictive

Interventions within the Royal Edinburgh and Associated Services (REAS) which

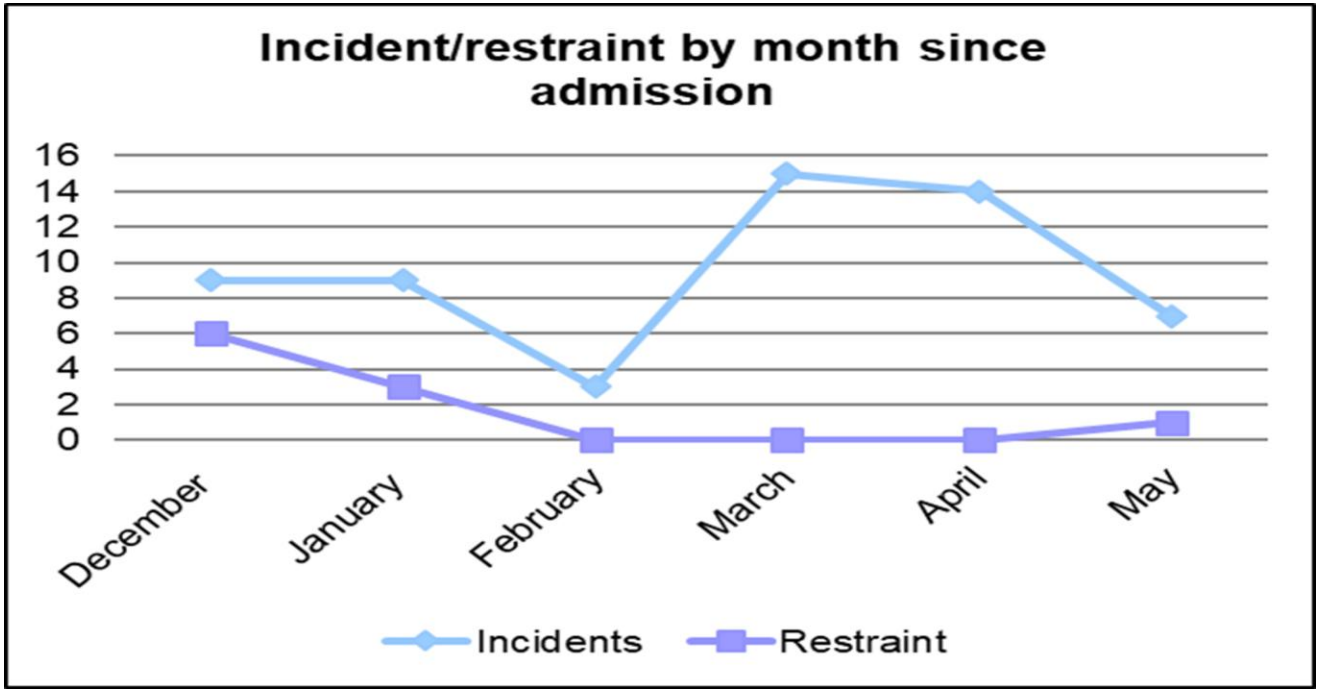
includes aspects such as:

- Evidence of service user involvement.
- Development of PBS training programme and delivery of this.
- Enhanced understanding and application of trauma informed care concepts.
- Up skilling of staff in the implementation of PBS plans.
- The development of effective post incident prevention and support interventions for staff, patients and carers.

Person-Focused Training

Design and implement a training programme and operational implementation process is based on: Person-Focused Training (PFT)						
October -November 2017 Block 1 training (1 – 2 days)		December 2017 Assignment (4 weeks) Information collection	January 2018 Block Two(1 day) Information Collation	January 2018 Assignment (4 weeks)	March 2018 Block 2	June 2018 6 months
• Reactive strategies • Crisis management • Crisis support	• Positive behavioural support. • Behavioural principles. • Challenging behaviour. • Mediator analysis. • Environmental and ecological analysis • Motivational analysis • Behavioural assessment and formulation • PBS planning and structure	• Patient identification • Functional assessment • Incident analysis • Baseline recording	• Formulation • Functional analysis • PBS plan framework	• PBS plans • Intervention and implementation	• PBS plans review	• Periodic service review • Programme report

Data Driven


Incident/restraint by month since admission
16
14
12
10
8
6
4
2
0
December
January
February
March
April
May
Incidents
Restraint

Future Developments

- Using the pathway and tools to develop and implement further PBS plans in Braids and other areas in MH in NHS Lothian
- Training of 2 further PBS Coaches
- The application of PBS as part of an eclectic approach in a new complex care unit
- Establish partnership links with NHS Lothian QI Department to develop robust implementation and monitoring of PBS methodology
- Incorporate Trauma informed education and practise within the PBS framework

Leading Learning Improving

Making Healthy Change Happen.

Mental Health Quality Improvement Programme

To improve access to psychological therapies for older people, by reducing waiting times

Dr Lucy Birch (Clinical Psychologist)

@LothianQuality
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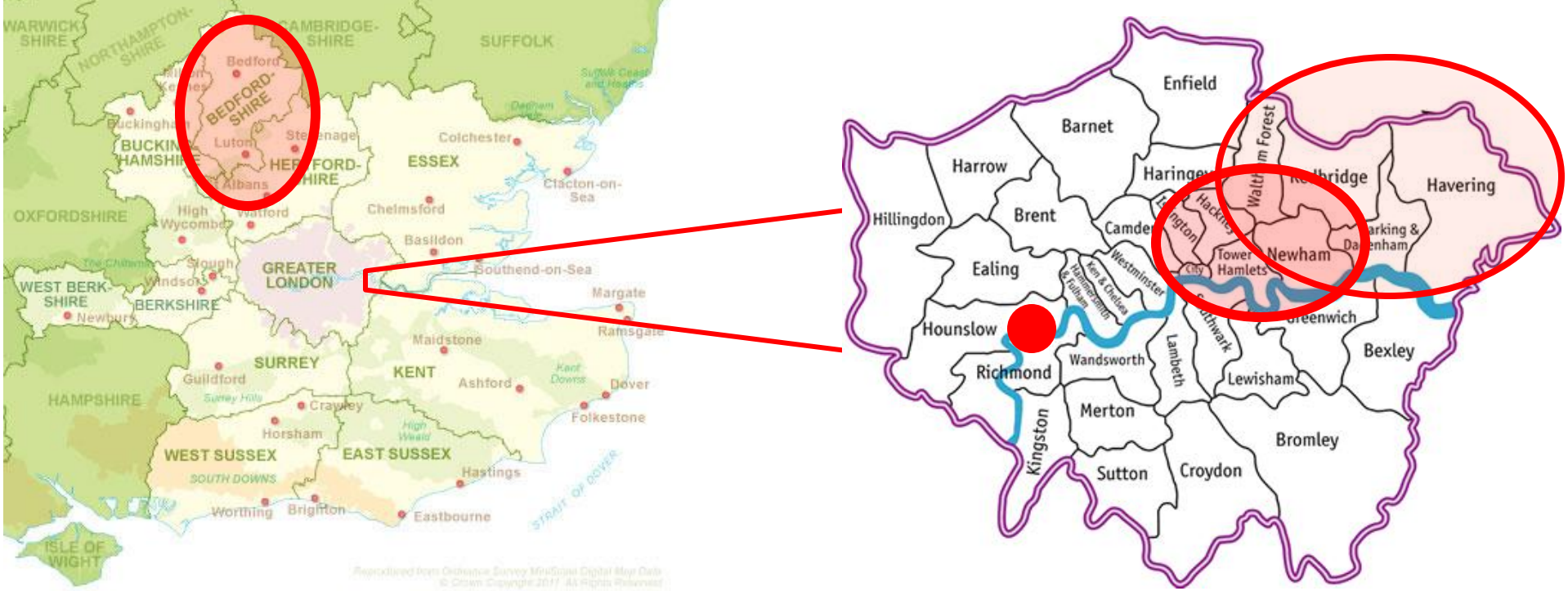
- **Context**
  - NHS Lothian Older People's Psychology Service
  - Two sectors
  - Team: a range of psychological therapists
- **Problem**
  - Long waiting times for psychological therapy, variability across geographical sectors
  - One sector not meeting the national waiting time target of ≤18 weeks from referral to psychological therapy
  - ≥90% of patients to wait ≤18 weeks for psychological therapy by August 2019
- **Intervention**
  - Several efficiency measures introduced to date, e.g. weekly appointments, opt-in letters, therapy agreement
  - More planned, e.g. routine scheduling of new and return appointments

- **Strategy for change**
  - Based on prioritisation matrix and staff group discussions
  - Need to include the views of service users, clinicians and referrers
- **Measurement of improvement**
  - Waiting times figures
  - Life QI, run charts, baseline, PDSA, shifts & trends explored
- **Effects of changes**
  - Improvement in one sector
  - Decline in the other sector (staff vacancy)
  - Greater clinician engagement in waiting times
  - Local issues are relevant, small team, efficiency measures are part of the solution
  - Ongoing project

Safety improvement at East London NHS Foundation Trust

@DrAmarShah

qi.elft.nhs.uk



Mental health services

Newham, Tower Hamlets, City & Hackney, Luton & Bedfordshire

Forensic services

All above & Waltham Forest, Redbridge, Barking, Dagenham, Havering

Child & Adolescent services, including tier 4 inpatient service

Regional Mother & Baby unit

Community health services

Newham, Tower Hamlets & Bedfordshire

IAPT

Newham, Tower Hamlets, Richmond and Bedfordshire


10
YEARS AGO

Performing well?

Trust Board Scorecard Q4 2009/10

KEY MONITOR, NATIONAL, PARTNER AND LOCAL TARGETS	2009/10 Target	2008/09 Actual	2009/10 Q3	2009/10 Q4	Trend Q3-Q4	Comment
Monitor Targets						
Annual number of MRSA bloodstream infections reported	0	0	0	0	→	
Reduction in C. Diff	0	0	0	0	→	
CPA inpatient discharges followed up within 7 days (face to face and telephone)	95.0%	99.5%	99.0%	99.1%	→	
Patients occupying beds with delayed transfer of care	7.5%	3.5%	1.8%	1.8%	→	CQC Indicator definition covers only April-Aug 2009
Admissions made via Crisis Resolution Teams (end of period)	90.0%	98.3%	99.0%	96.7%	↓	
Number of Crisis Resolution Teams	7.1	7.3	7.3	7.3	→	
Other National/CQC Targets						
Completeness of Ethnicity Coding – PART ONE. Inpatient in MHMDS (Year to date)	85%	98.1%	97.3%	97.3%	→	Local target 95%.
Completeness of Mental Health Minimum data set – PART ONE (As per 2008/9)	99%	97.6% Underachieved	99.4%	99.4%	→	Target assumed 99% as per CQC threshold 2008/9. MONITOR have confirmed 99% threshold for 2010/11 for this indicator.
Completeness of Mental Health Minimum data set – PART TWO (New – confirmed 22/12/2009)	TBA	Not Used	45.0%	45.0%	→	No threshold set by CQC or MONITOR for 2009/10 therefore cannot assess compliance.
Patterns of Care – assignment of Care Co-ordinator within Mental Health Minimum data set	80%	99.6%	93.2%	93.2%	→	
CAMHS - National Priorities - Six targets graded 1 (lowest) to 4 (best)	24	22	22	24	↑	Maximum Score 24
Annual Staff Survey (Job Satisfaction)	Benchmarked	Satisfactory	N/A	TBC		Survey based - Annual, threshold not available yet
Patient Survey	Benchmarked	Below Average	N/A	TBC		As above
Drug Misusers in effective Treatment	90.0%	95.5%	92.9%	92.9%	→	
Access to healthcare for people with a learning disability – report compliance to CQC	Yes	Not Used	N/A	Yes		
Best practice in mental health services for people with a learning disability – Green Light Toolkit Score	48	40/48 Underachieved	42	46	↑	Max Score 48
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98.0%	97.5%	98.3%	98.3%	→	Partner target for acute trusts. This will be excluded from future reports.
PCT Contract and Mandatory Targets						
Number of Early Intervention Services Teams	3	3	3	3	→	
Early Intervention Services Caseload	511	569	534	544	↑	
Newly diagnosed cases of first episode psychosis receiving Early intervention Services	176	243	199	248	↑	
Number of patients receiving Adult Crisis Resolution Services (Episodes for Year to date)	2280	2,346	1874	2552	↑	
Specialist Addictions – % of discharges retained 12 weeks or more	85.0%	96.1%	92.9%	92.9%	→	
Specialist Addictions - Number of drug misusers in treatment (snapshot at period end)	678	710	780	776	↓	
CAMHS Service protocols	12	12	12	12	→	Maximum Score 12
Mixed Sex accommodation breaches	0	0	0	1	↑	Reported as required to PCTs, no penalties or compliance issues.
Patient Experience - Community						
Assessment within 28 days of referral	95%	Not Used	88.2%	92.8%	↑	Local target of 95%
CPA patients - care plans in date	95%	93.1%	93.3%	94.2%	→	
Patient Experience - Inpatients						
Adult Acute Inpatient Bed Occupancy Year to Date (excluding home leave)	95%	95.3%	98.3%	97.3%	↓	See graphs overleaf for more detail.
Information Governance/Assurance						
Information Governance Toolkit score	90.0%	87.0%	87.0%	90.9%	↑	Next assessment expected October 2010

Mental health

Three patients die on psychiatric ward

Three patients have died within 12 months on the same ward following warnings from unions about budget cuts

Mark Gould

Tuesday 12 April 2011
13.10 BST

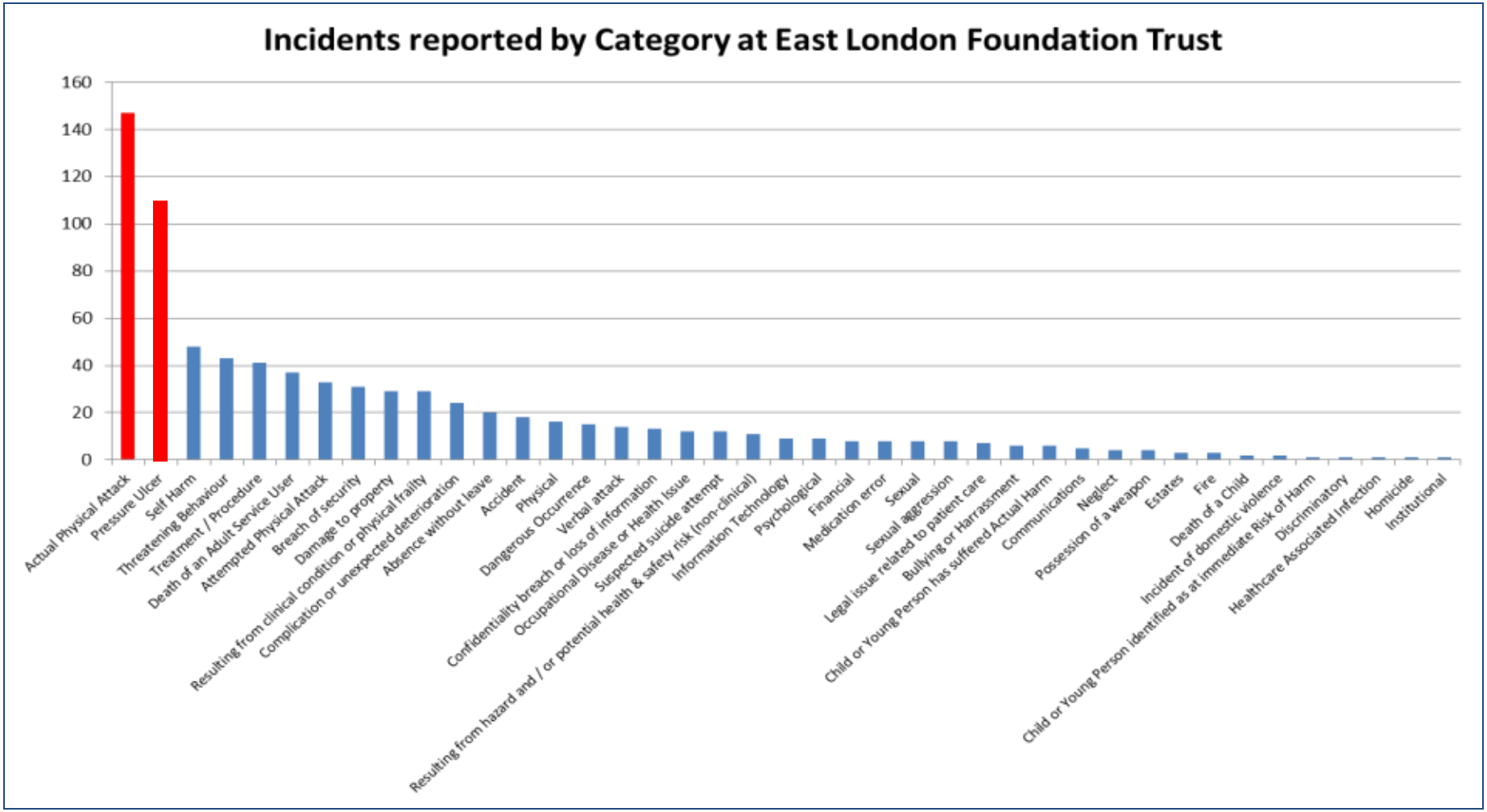
Unison warned that budget cuts would compromise staff and patient safety. Photograph: Case/Phanie/Rex

Most popular

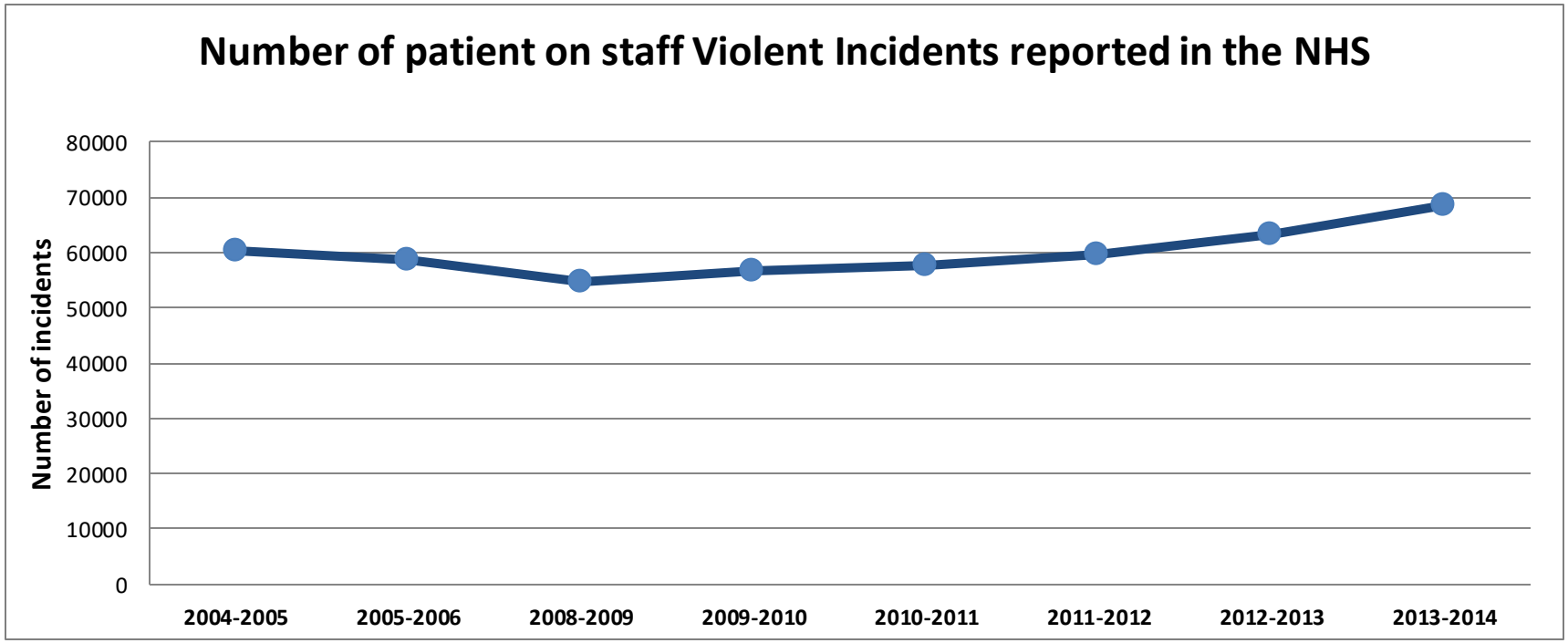
Star architect Zaha Hadid dies aged 65 from heart attack


CHANGE OF
STRATEGY
AHEAD

Local Context



Violence levels over the last few years…



Three times as many violent incidents occur in mental health services than other NHS services

1. NHS Protect website http://www.nhsbsa.nhs.uk/3645.aspx

Impact…

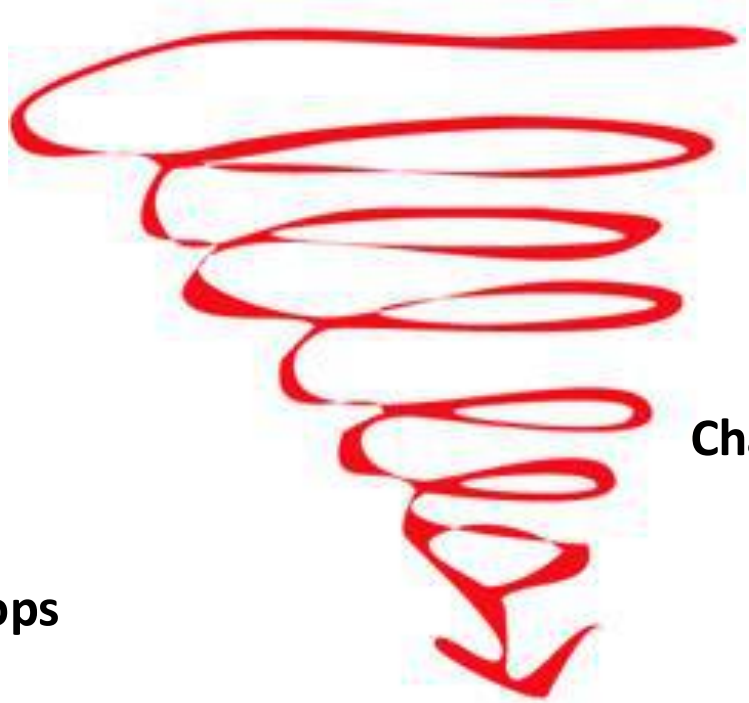
Physical injury

Dread of work

Psychological:
Stress, Fear, Trauma

Service users feeling threatened and fearful

Staff sickness



Ward team depleted

Experience often resonates with histories of abuse

Negative feelings amongst team

Changes service users behaviour (e.g. staying in rooms

Morale drops

Staff leave

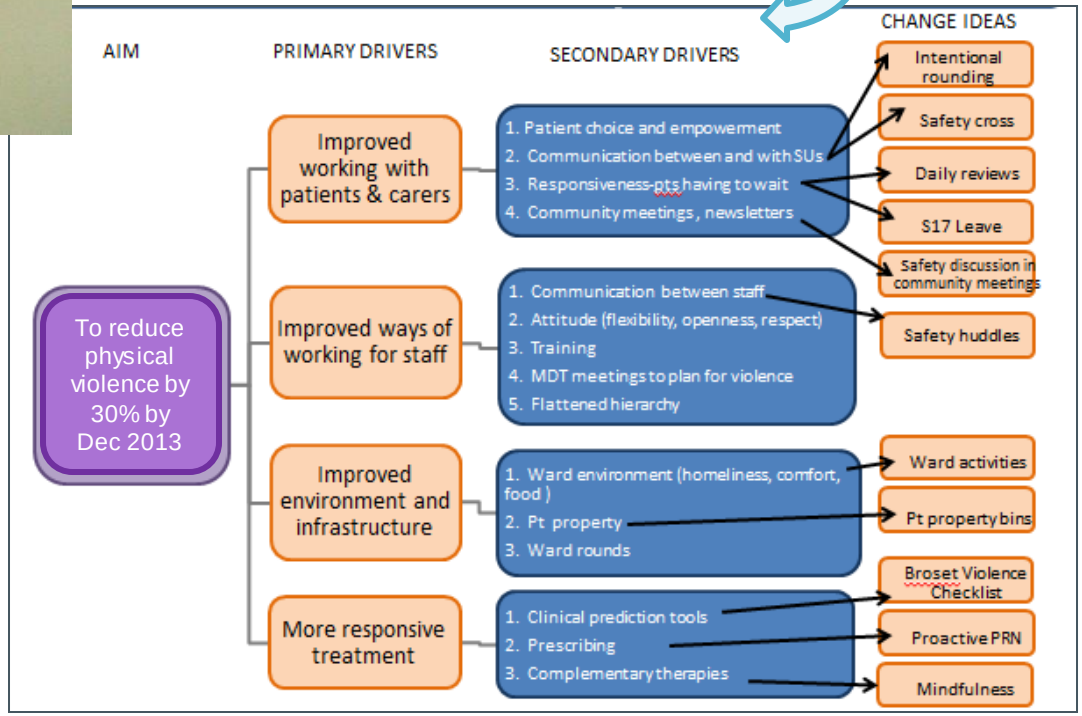
Staff desensitized

Impedes recovery

Bank staff won't take shifts on ward…

Service users spend longer on ward

Literature search presented to team as part of developing theory of change

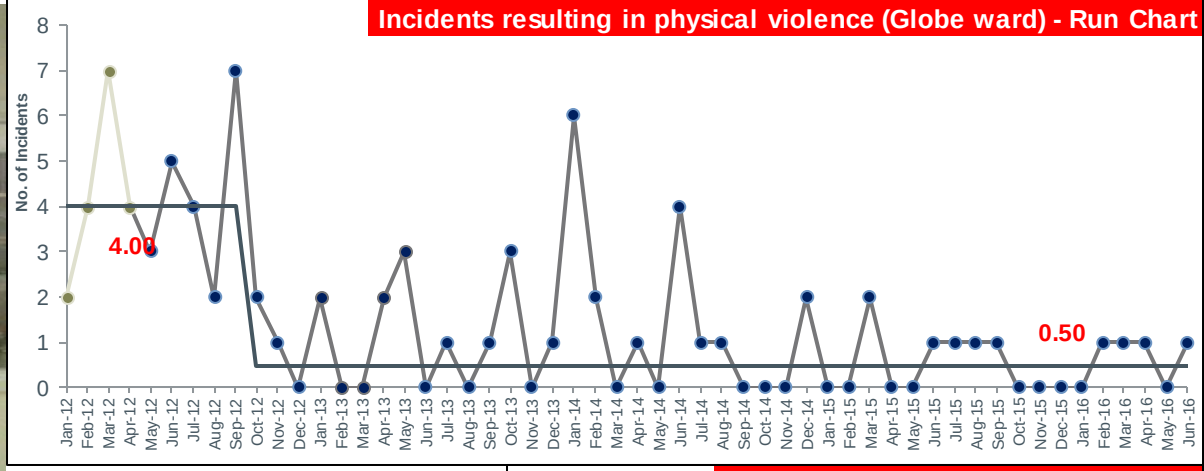


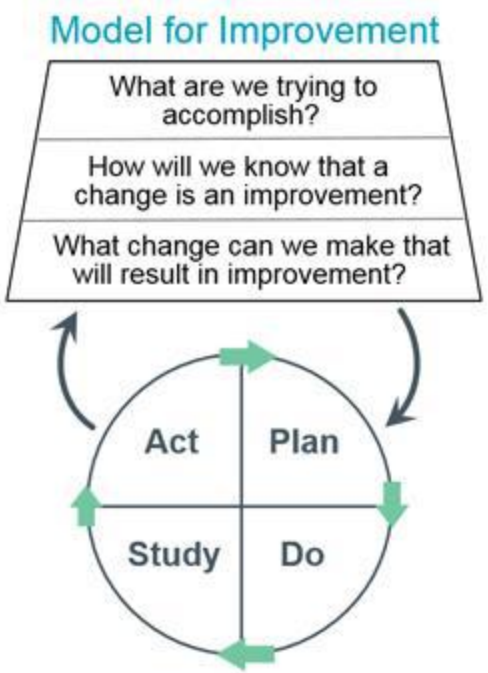
One of our first ever QI projects at East London NHS FT, starting in 2012…

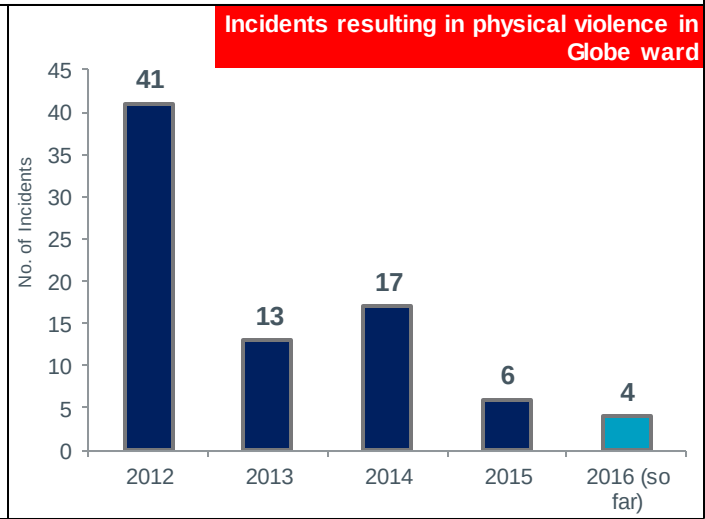
With no real support structure, and before we knew what we were doing!

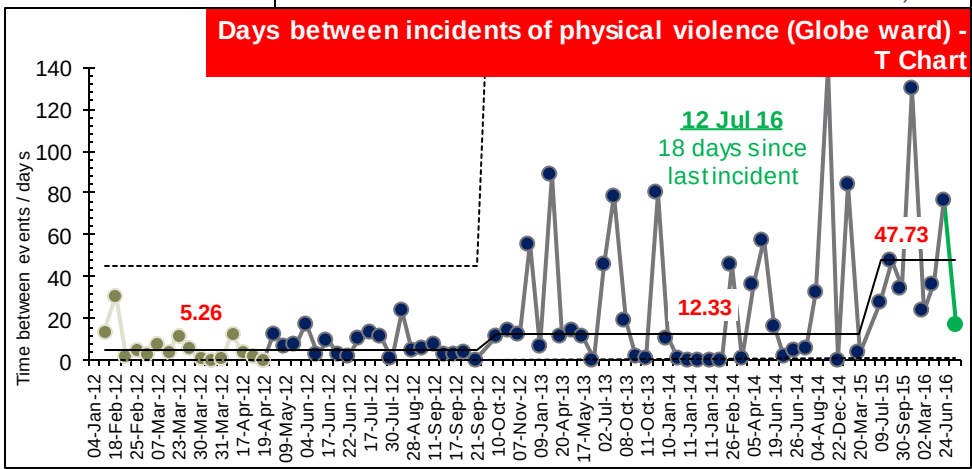
NHS East London NHS Foundation Trust


WELCOME TO GLOBE WARD
NOMINATED FOR TEAM OF THE YEAR AWARD 2013

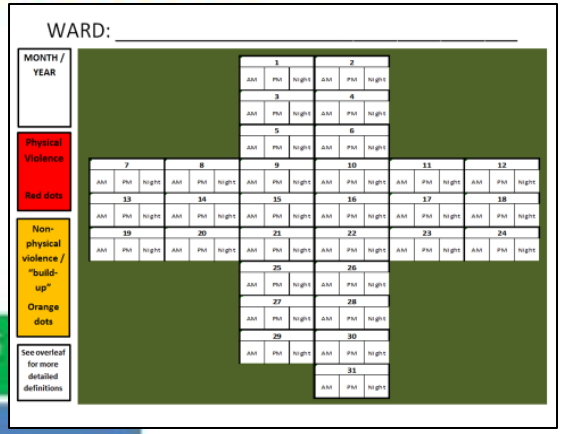

Incidents resulting in physical violence (Globe ward) - Run Chart
No. of Incidents
4.00
0.50


Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do


Incidents resulting in physical violence in Globe ward
No. of Incidents
41
13
17
6
4
2012
2013
2014
2015
2016 (so far)


Days between incidents of physical violence (Globe ward) - T Chart
Time between events / days
12 Jul 16
18 days since last incident
5.26
12.33
47.73

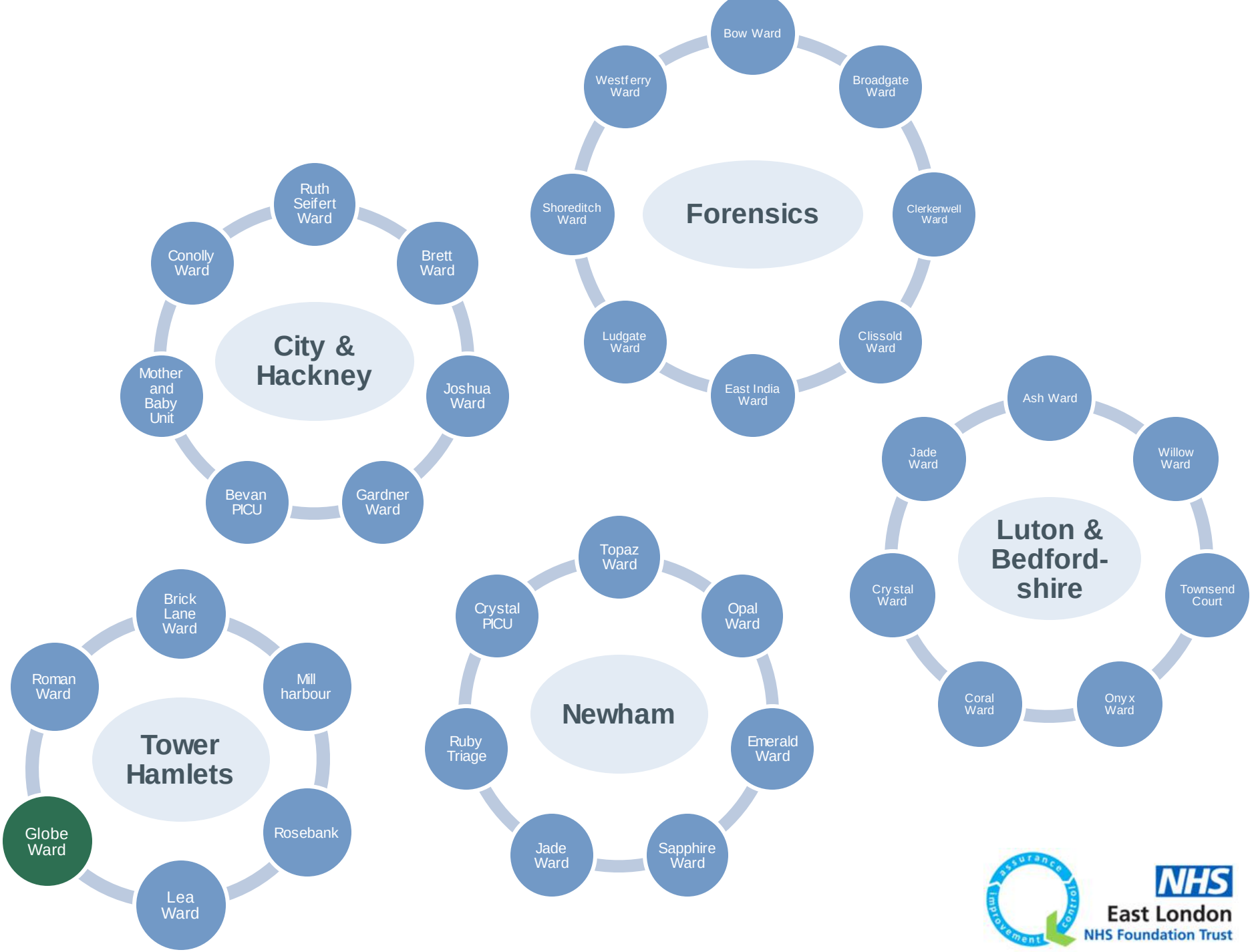
Safety Culture Change Bundle



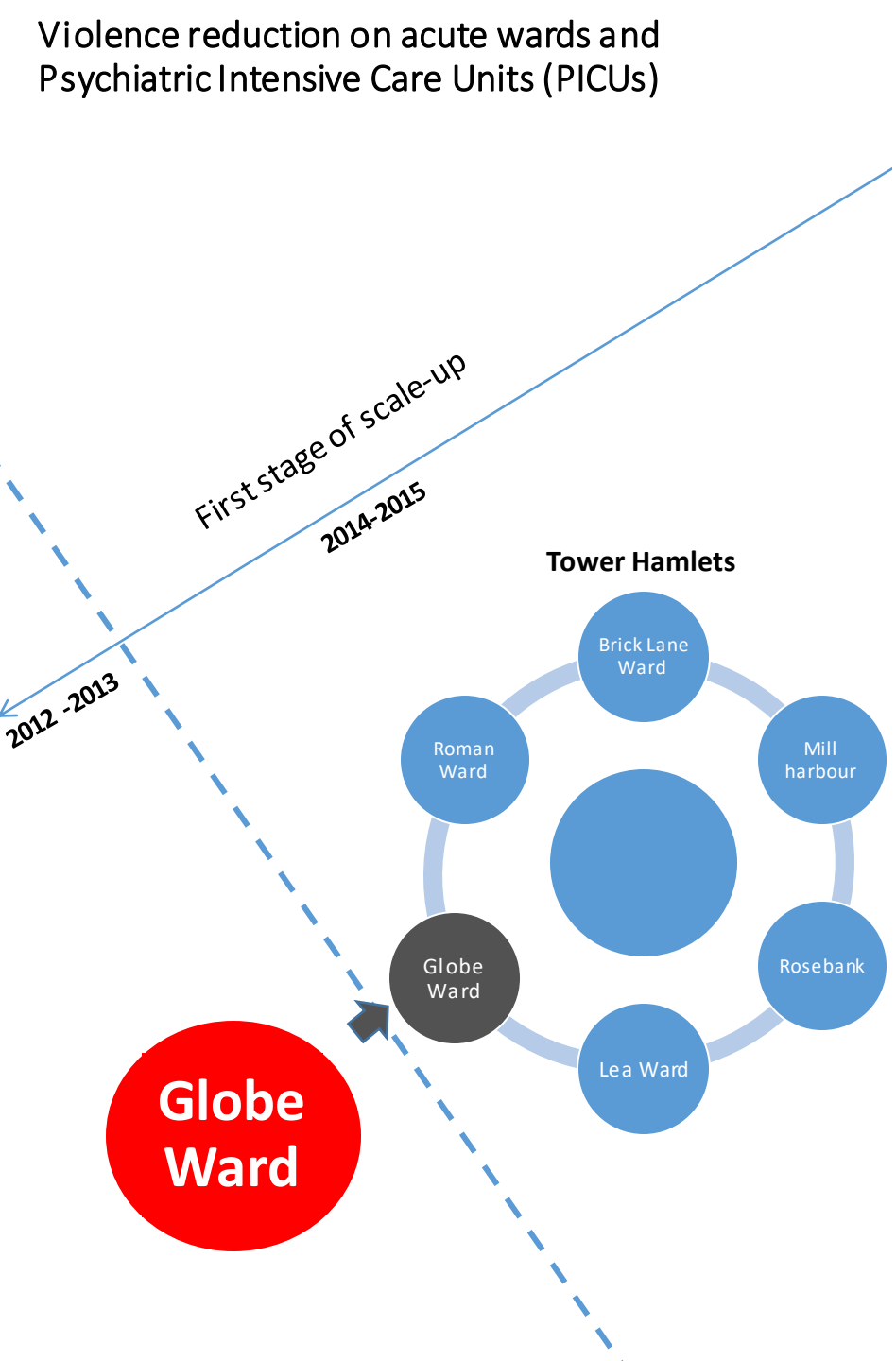
Driver	Change ideas
Increasing prediction and responsiveness	• Safety Huddle • Broset Violence Checklist
Openness, transparency and sharing safety as a priority for our ward community	• Safety Cross • Community Meetings

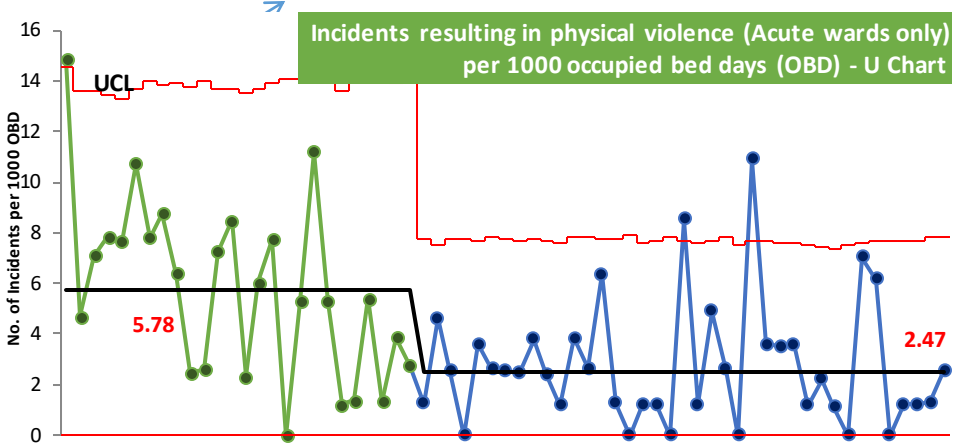
	Monday / /			Tuesday / /		
	Night	Day	Eve	Night	Day	Eve
Confused						
Irritable						
Boisterous						
Verbal threats						
Physical threats						
Attacking objects						
SUM						
INTERVENTIONS						

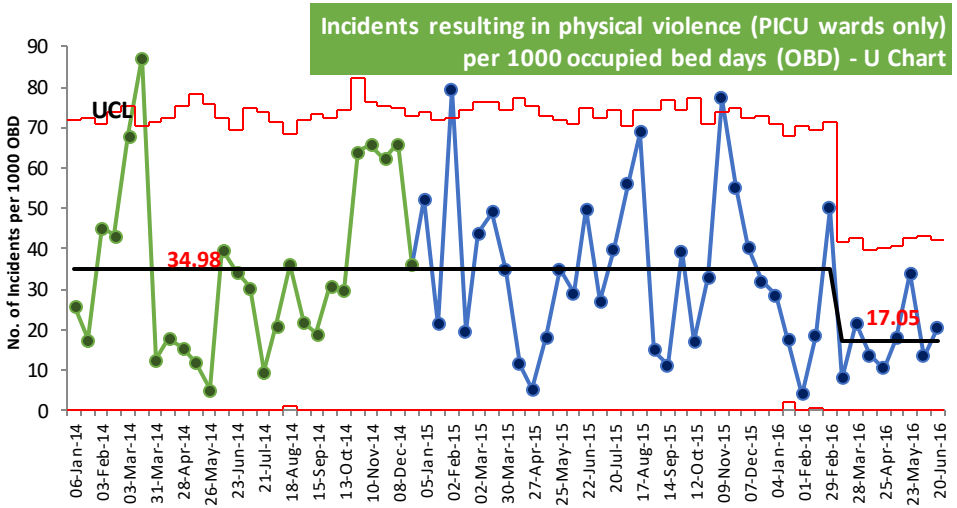
	INIT	DATE/TIME	SIGNAT
0 = no interventions			
1 = verbal de-escalation			
2 = diversional activity			
3 = i stimulation			


Bow Ward
Broadgate Ward
Clerkenwell Ward
Clissold Ward
East India Ward
Ludgate Ward
Shoreditch Ward
Westferry Ward
Forensics
Ruth Seifert Ward
Brett Ward
Joshua Ward
Gardner Ward
Bevan PICU
Mother and Baby Unit
Conolly Ward
City & Hackney
Ash Ward
Willow Ward
Townsend Court
Onyx Ward
Coral Ward
Crystal Ward
Jade Ward
Luton & Bedford-shire
Topaz Ward
Opal Ward
Emerald Ward
Sapphire Ward
Jade Ward
Ruby Triage
Crystal PICU
Newham
Brick Lane Ward
Mill harbour
Rosebank
Lea Ward
Globe Ward
Roman Ward
Tower Hamlets
assurance
improvement
control
NHS
East London
NHS Foundation Trust

Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs)

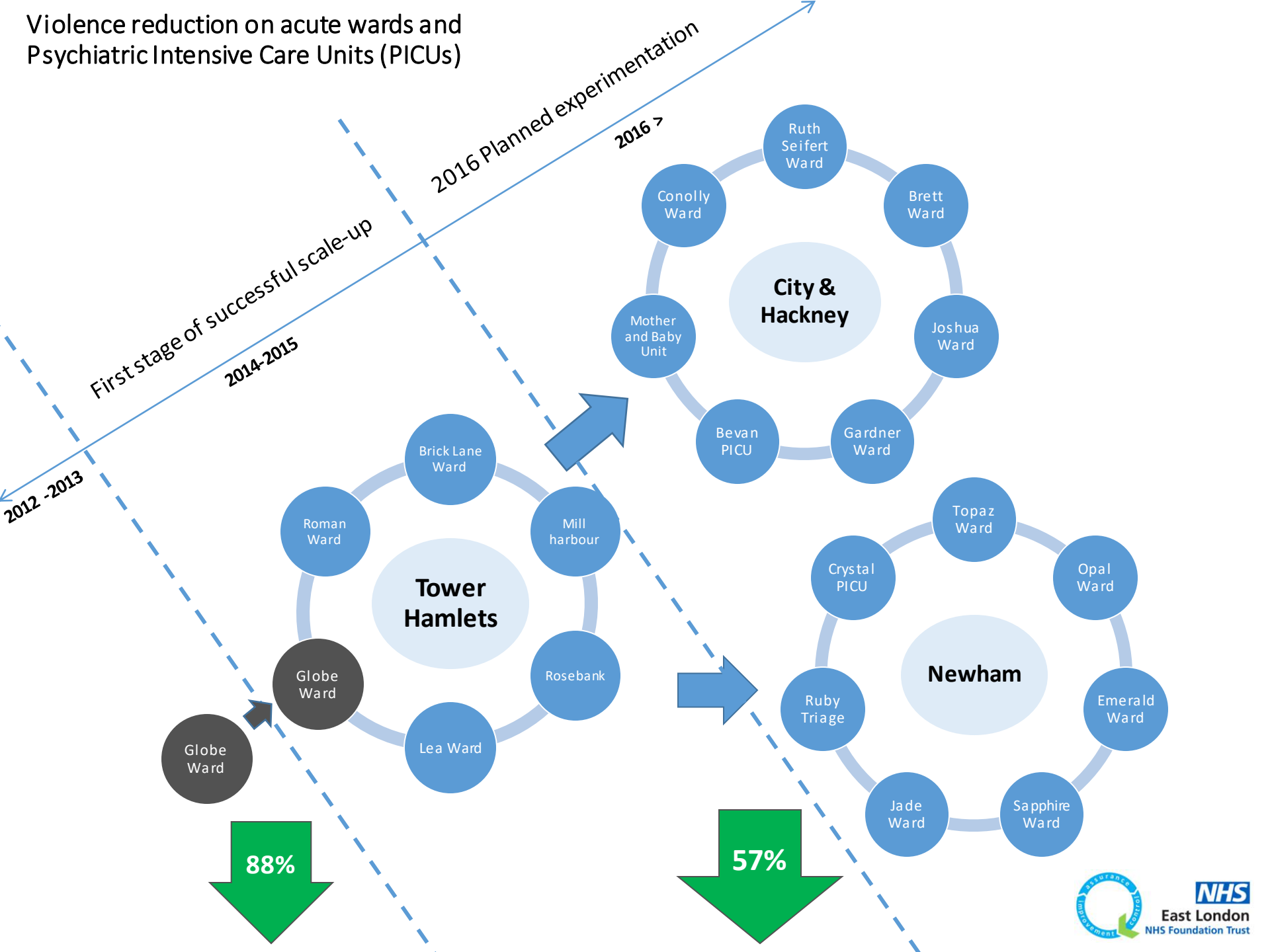






NHS East London NHS Foundation Trust

Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs)



NHS East London NHS Foundation Trust

Test	RunOrder	Safety Huddle	Safety discussion within Community Meeting	BVC	Safety Cross
1	Opal	-	-	-	-
2	Ruth Seifert	+	-	-	+
3	Gardner	-	+	-	+
4	Emerald	+	+	-	-
5	Joshua	-	-	+	+
6	Sapphire	+	-	+	-
7	Topaz	-	+	+	-
8	Conolly	+	+	+	+

Fractional Factorial design 2 (4)

- Four Factors
- Each has two levels

Orchestrated testing

- Wards were able to choose which combination they wanted to test

Testing Matrix - Fractional Factorial Design - 2 (7-4) = 8 runs

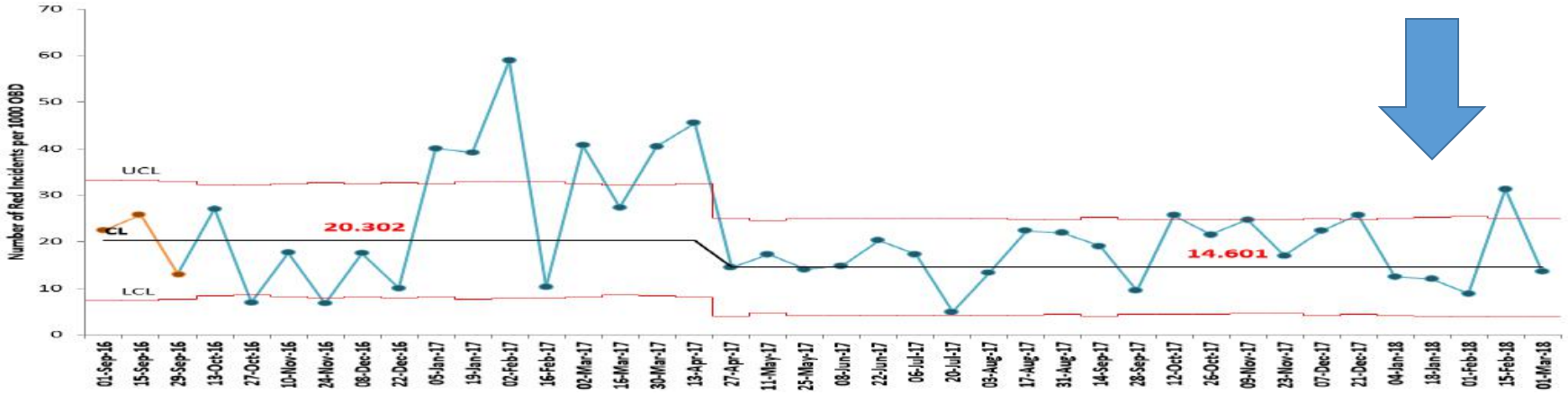
have the same effect you will need to do a follow up study

Remove negatives in all four combination to change from full factorial to fraction factorial

	-	No	No	No	No											
	+	Yes	Yes	Yes	Yes											
Test	Run Order	Safety Huddle	Safety discussio n	Broset Violence Checklist	Safety Cross	BVC & SC	BVC & SH	BVC & SD	SC & SH	SC & SD	SH & SD	BVC, SC, SH	BVC, SH, SD	BVC, SC, SD	SC, SD, SH	BVC, SC, SH, SD
1	Opal	-1	-1	-1	-1	1	1	1	1	1	1	-1	-1	-1	-1	1
2	Ruth Seifert	1	-1	-1	1	-1	-1	1	-1	-1	-1	-1	1	1	-1	1
3	Gardner	-1	1	-1	1	-1	1	-1	-1	1	-1	1	1	-1	-1	1
4	Emerald	1	1	-1	-1	1	-1	-1	1	-1	1	1	-1	1	-1	1
5	Joshua	-1	-1	1	1	1	-1	-1	1	-1	1	-1	1	-1	1	1
6	Sapphire	1	-1	1	-1	-1	1	-1	-1	1	-1	-1	-1	1	1	1
7	Topaz	-1	1	1	-1	-1	-1	1	-1	-1	-1	1	-1	-1	1	1
8	Conolly	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
9	no ward	-1	-1	1	-1	-1	-1	-1	1	1	1	1	1	1	-1	-1
10	no ward	1	1	1	-1	-1	1	1	1	-1	1	-1	1	-1	-1	-1
11	no ward	-1	1	1	1	1	-1	1	-1	1	-1	-1	-1	1	-1	-1
12	no ward	-1	-1	-1	1	-1	1	1	1	-1	1	1	-1	1	1	-1

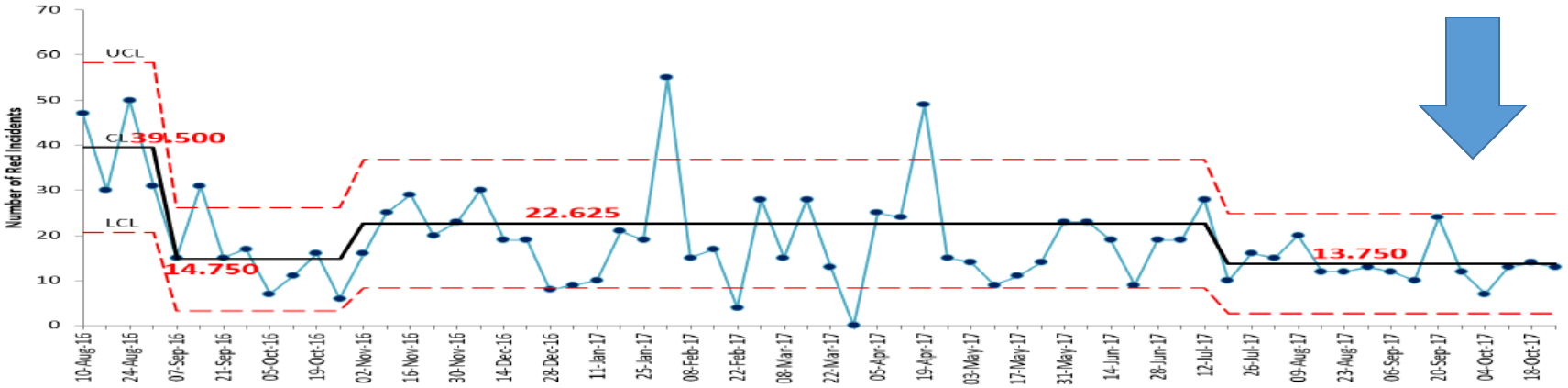
Newham Violence Reduction Collaborative

28% reduction

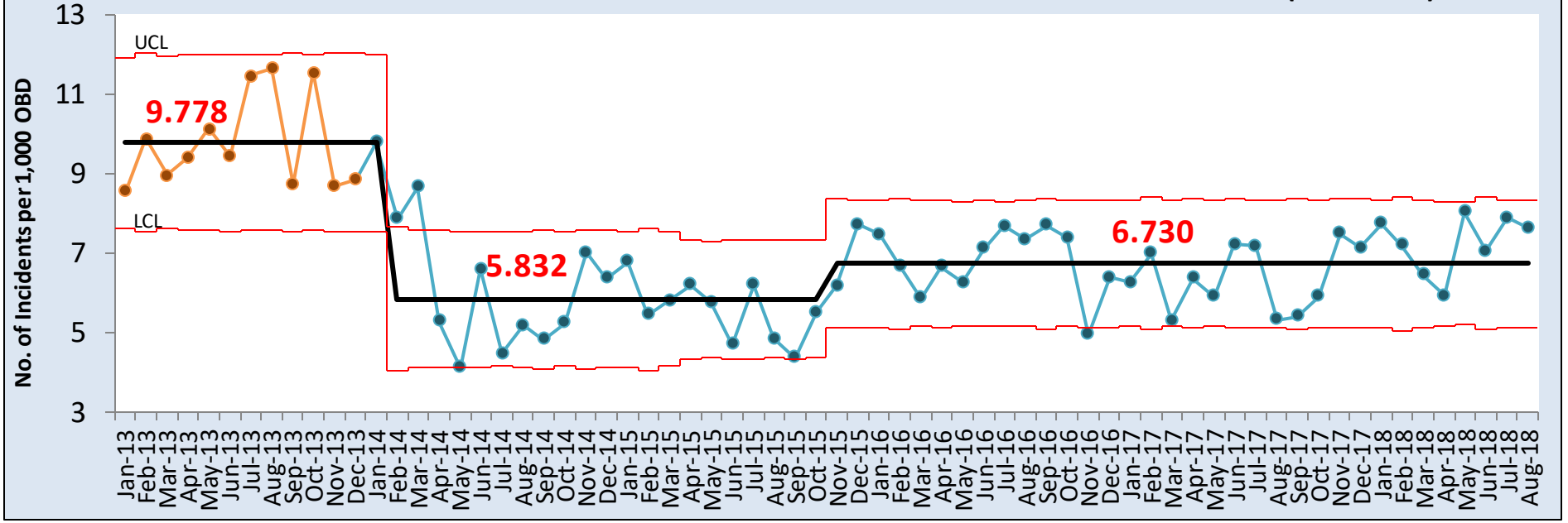


City and Hackney Violence Reduction Collaborative

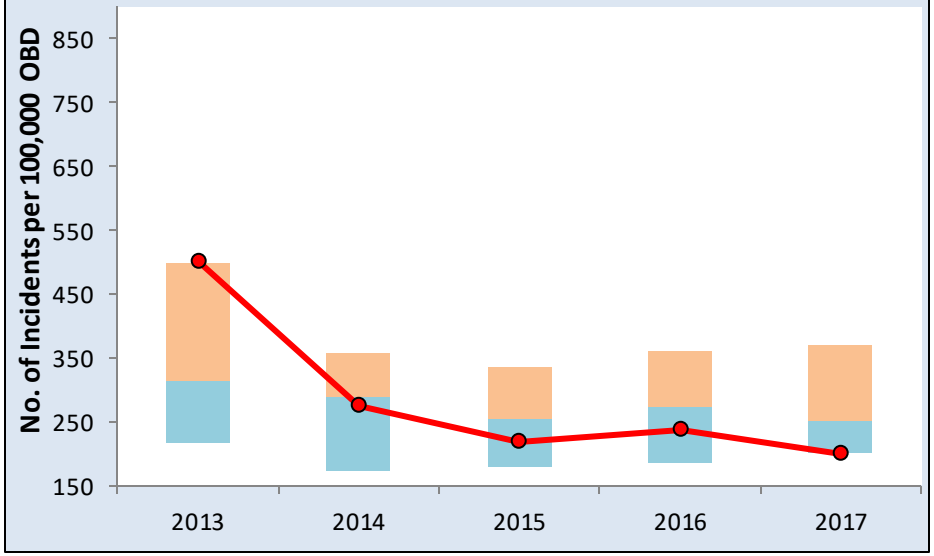
40% reduction



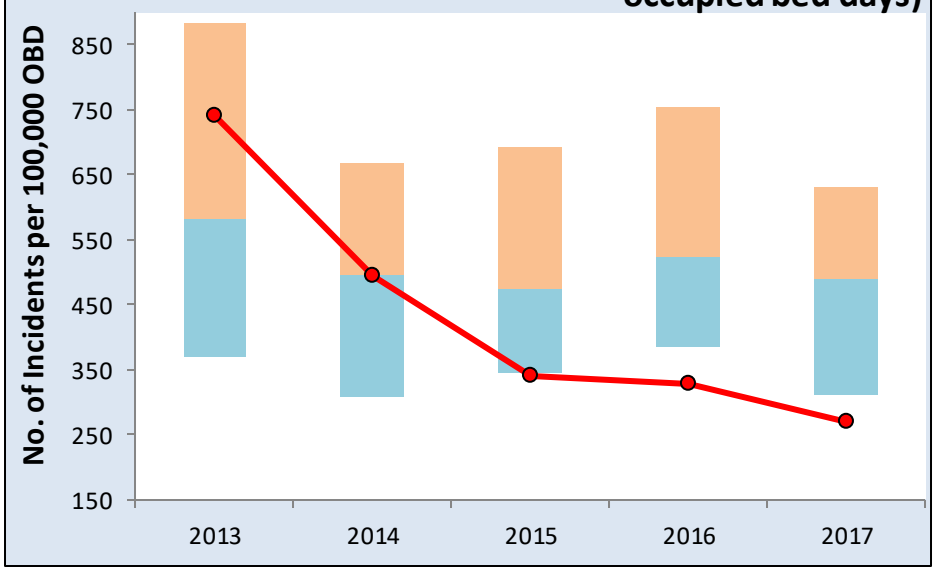
Incidents resulting in physical violence (Trustwide) - U Chart

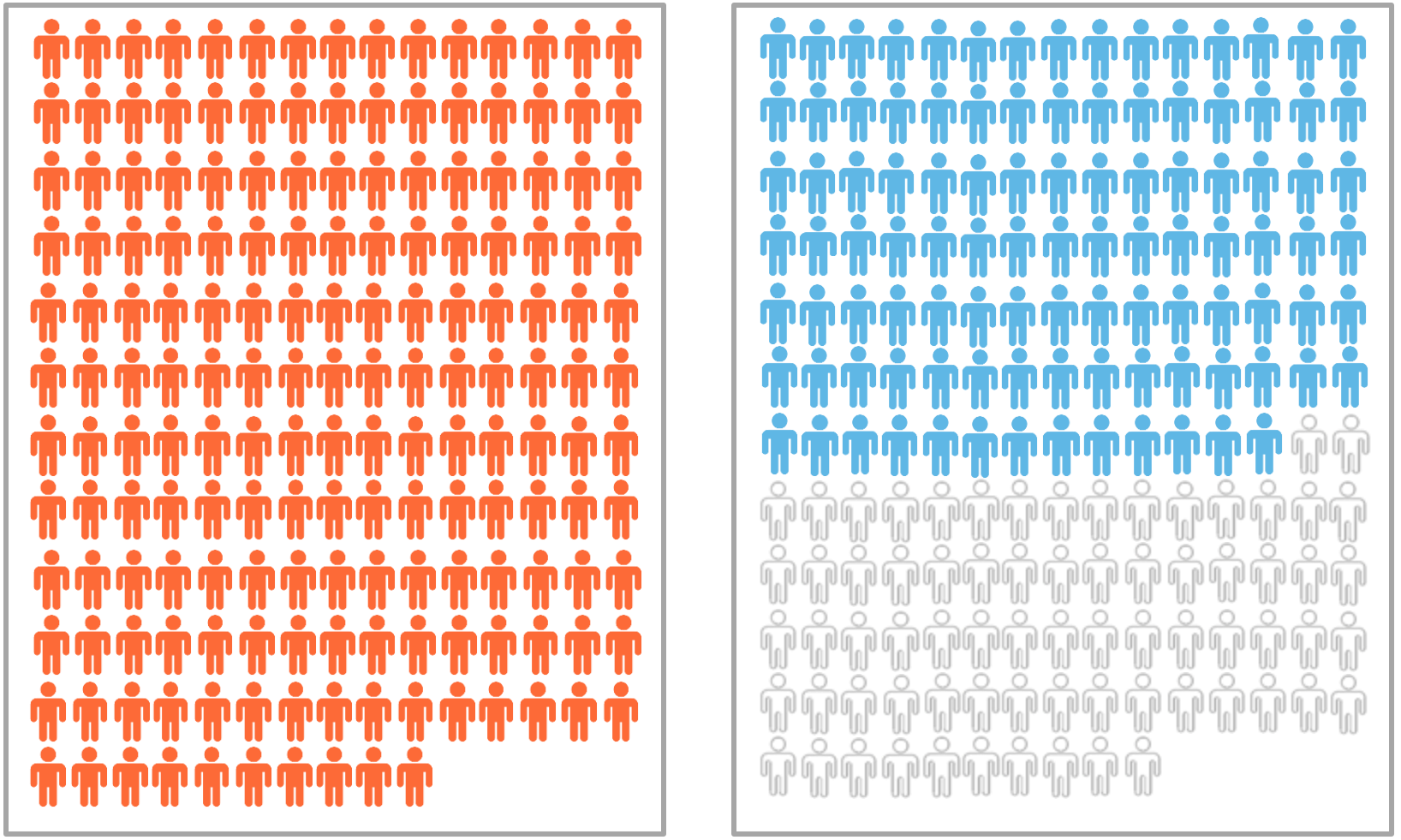


Physical violence to patients (per 100,000 occupied bed days)



Physical violence to staff (per 100,000 occupied bed days)





175 → 103

Average number of physical violent incidents per month

“I’ve been a nurse here for 20 years and I just thought this was how it was… Now I can see that it doesn’t have to be this way… ”

Improving Medicines Safety

@DrAmarShah

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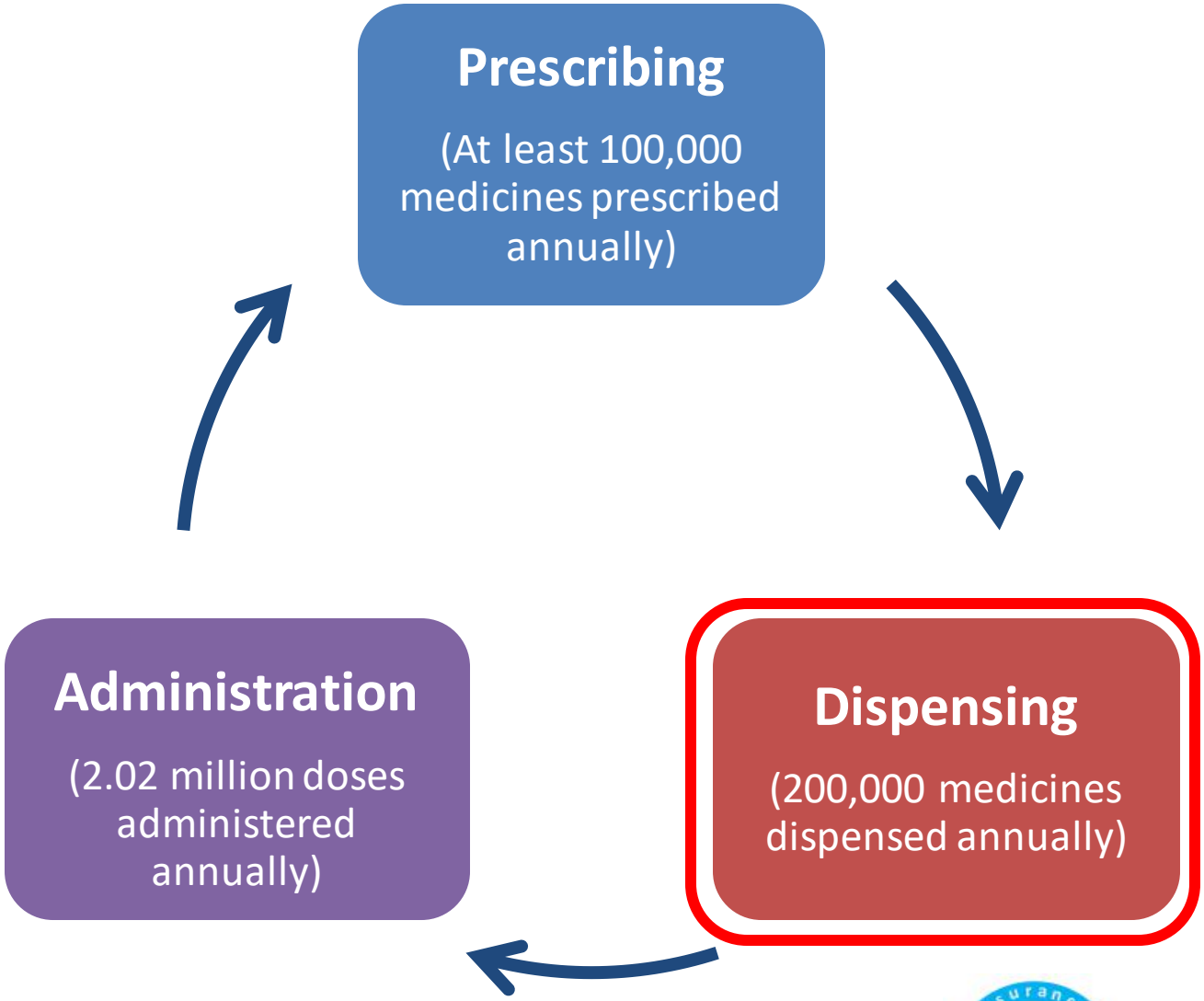

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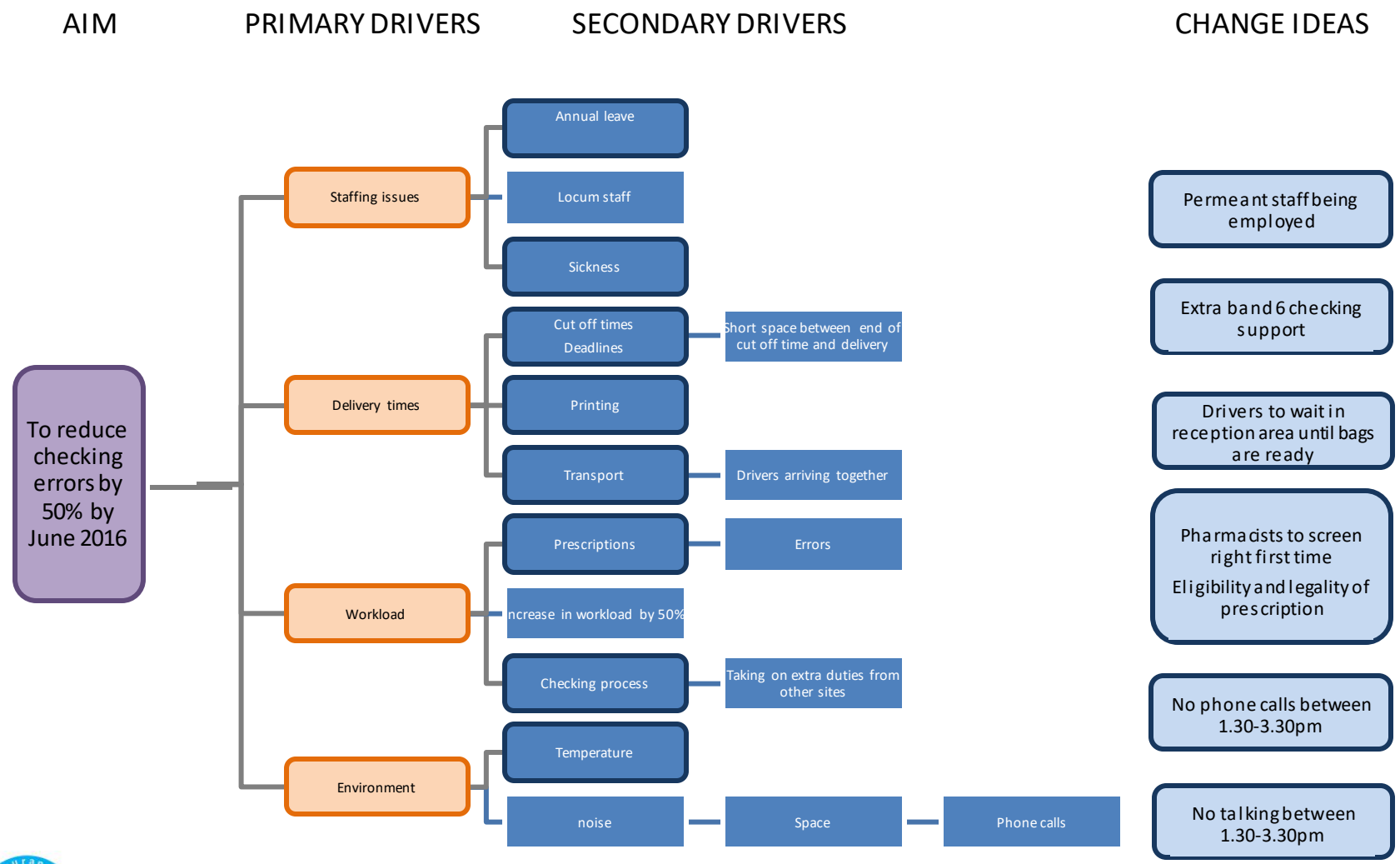
Driver diagram



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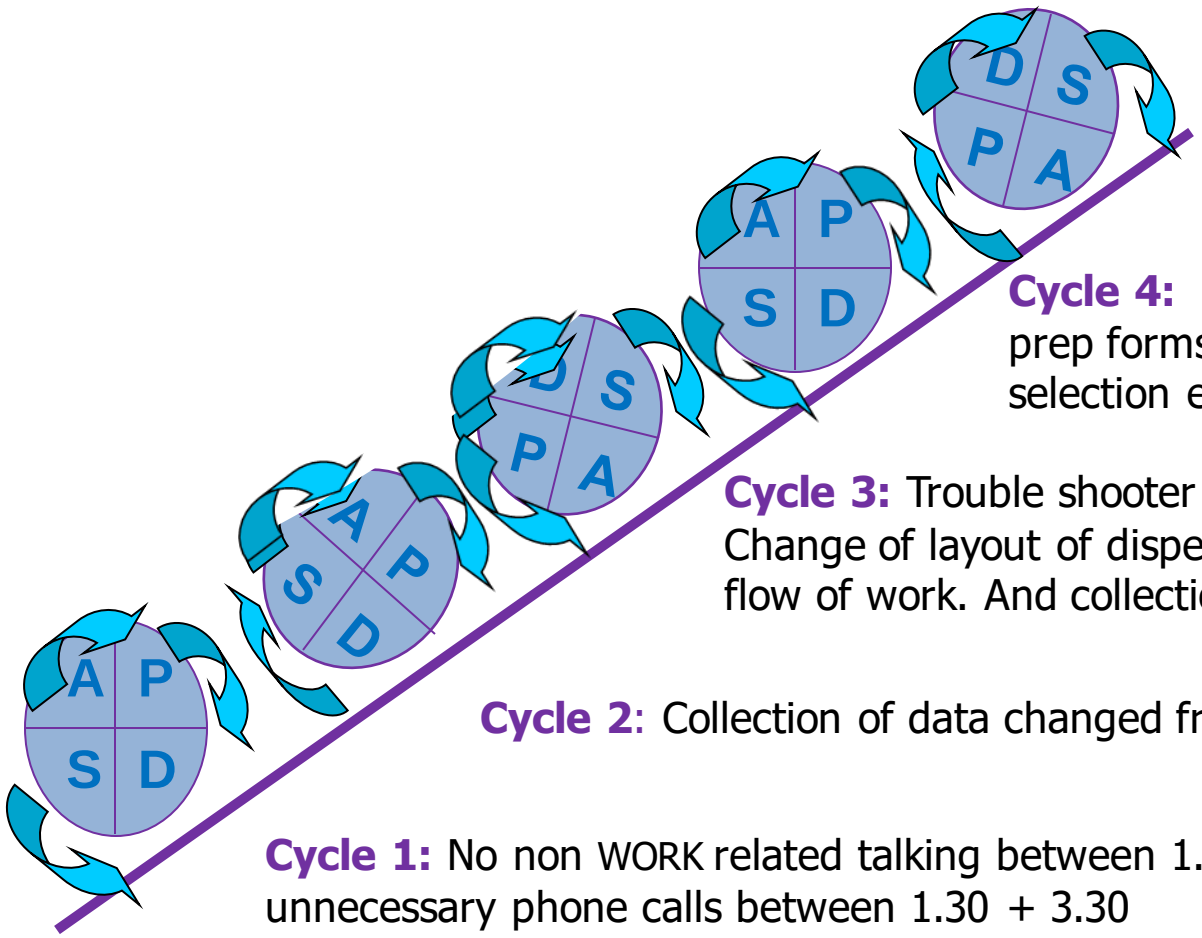
Sequence of PDSA's (1)



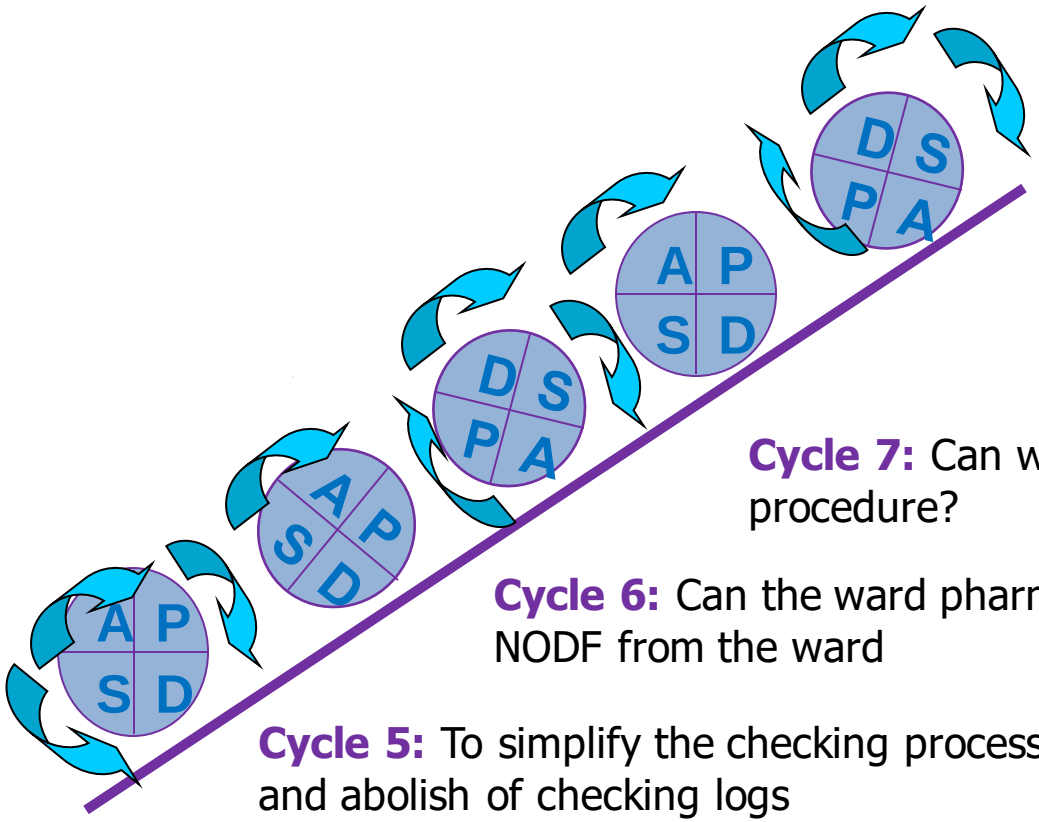
Cycle 4: Segregating the unusual prep forms with the aim of reducing selection errors

Cycle 3: Trouble shooter
Change of layout of dispensary to ensure smooth flow of work. And collection of phone call data

Cycle 2: Collection of data changed from monthly to weekly

Cycle 1: No non WORK related talking between 1.30 + 3.30 : No unnecessary phone calls between 1.30 + 3.30
No non-related talking extended until 5pm

Sequence of PDSA's (2)



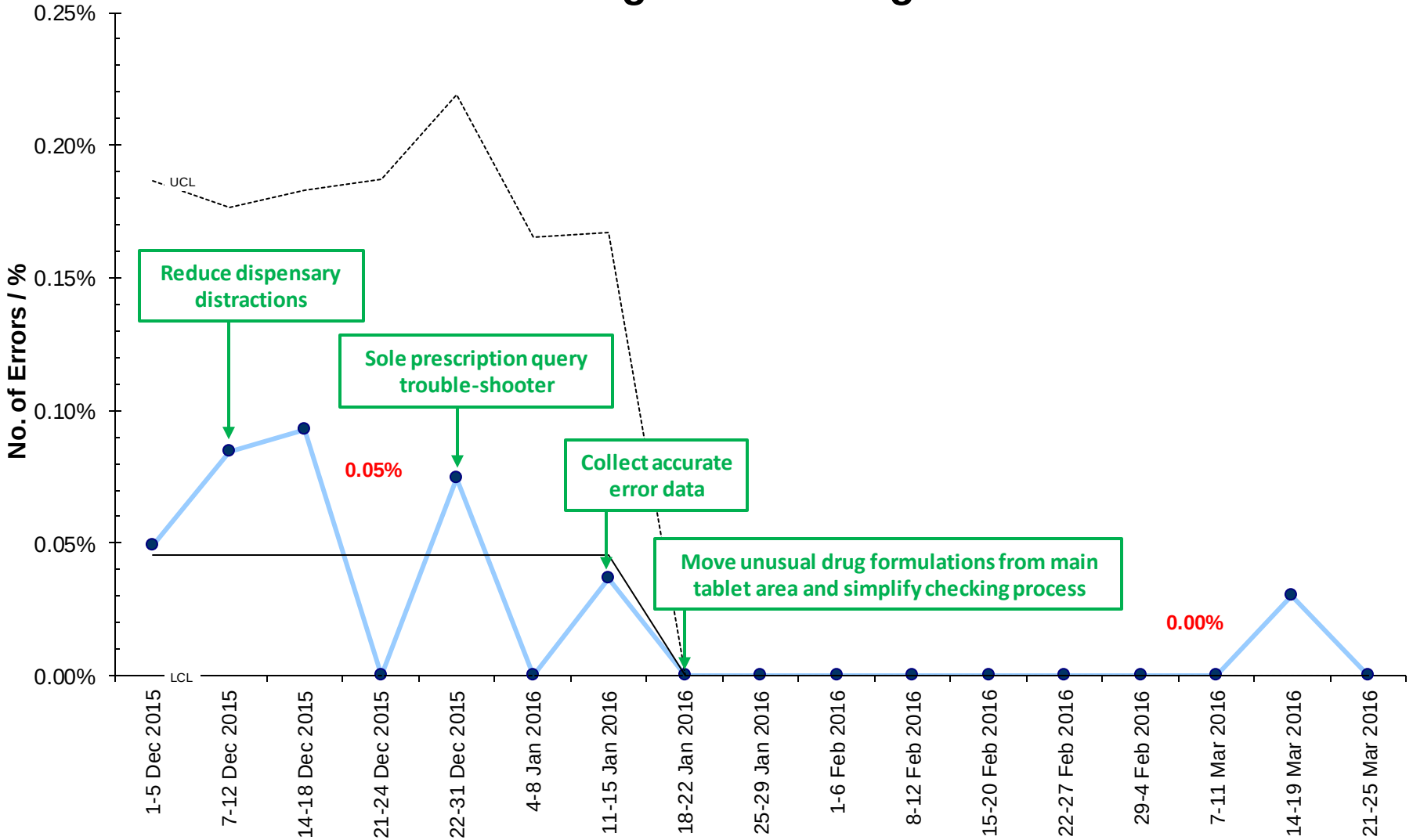
Cycle 8: Will not having to check Clozapine result help with the amount of calls being made? Will not photo copying a second copy of Discharge liaison form reduce a process for the checker?

Cycle 7: Can we reduce a process in the checking procedure?

Cycle 6: Can the ward pharmacist or Technician give a copy of the NODF from the ward

Cycle 5: To simplify the checking process by removal of a process and abolish of checking logs

Percentage of checking errors - P Chart



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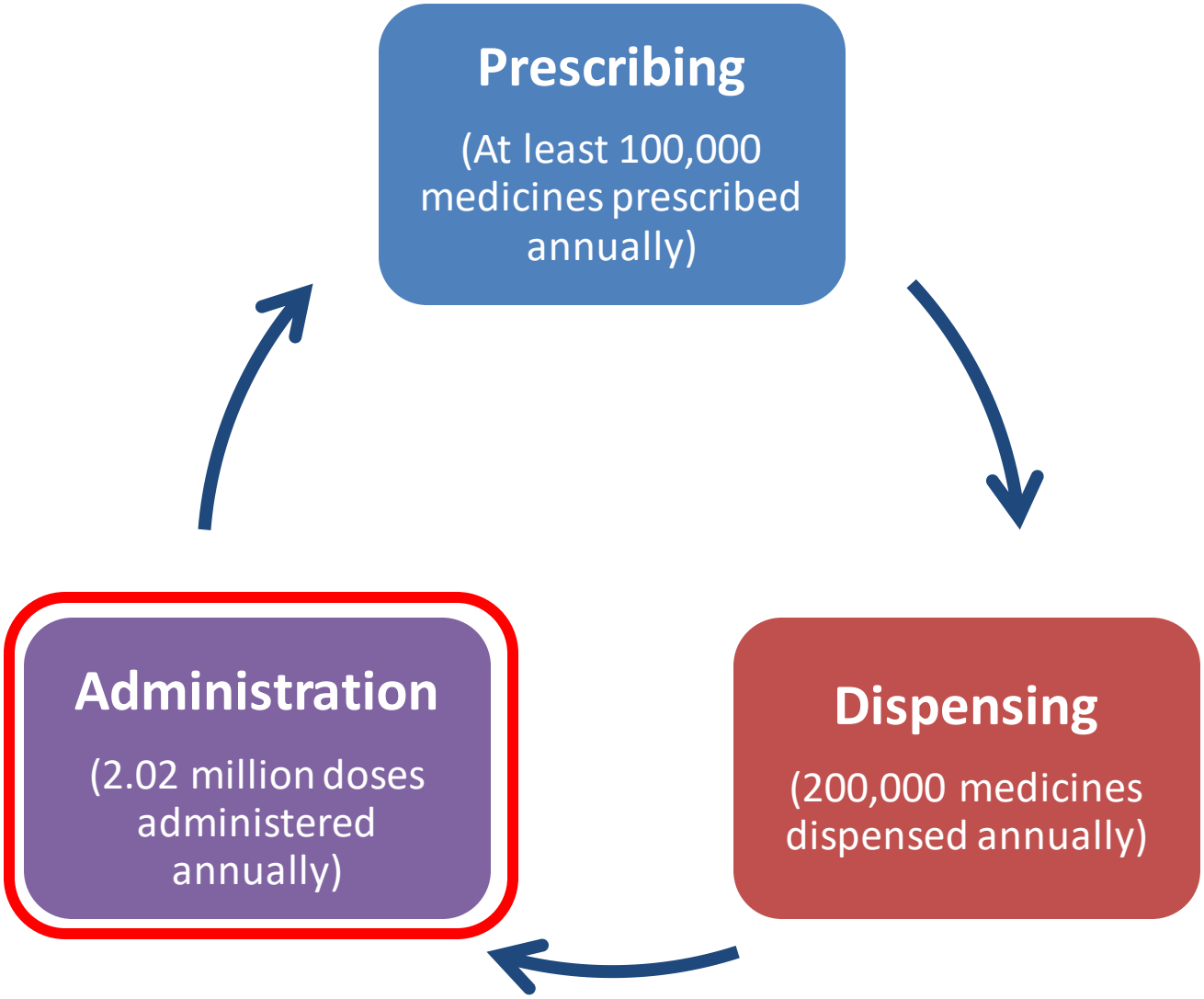

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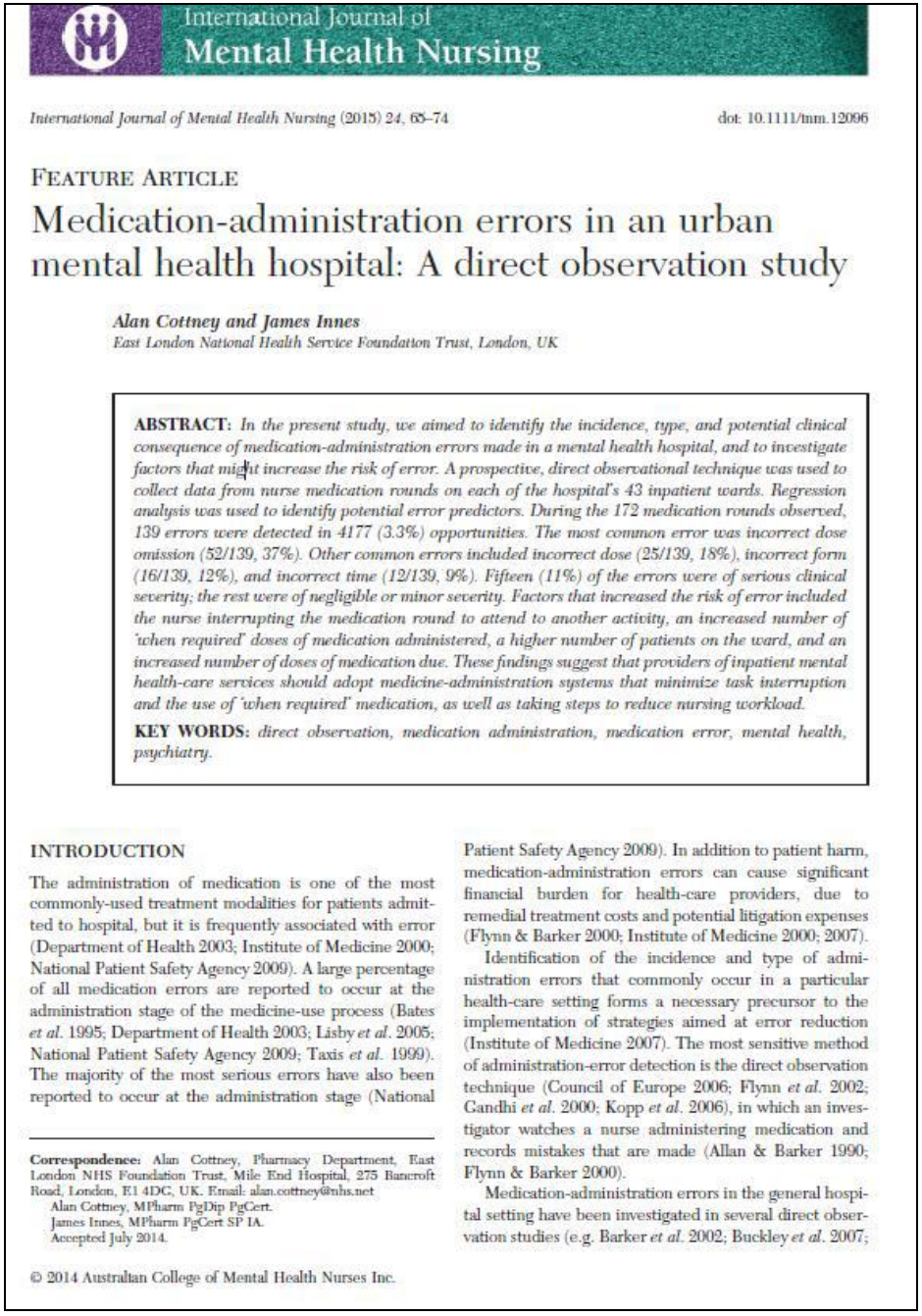
Gathering evidence

- Missed doses most common error (**40%**)
- Now we knew **missed doses** were the most common error in ELFT



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FEATURE ARTICLE

Medication-administration errors in an urban mental health hospital: A direct observation study

Alan Cottney and James Innes
East London National Health Service Foundation Trust, London, UK

ABSTRACT: *In the present study, we aimed to identify the incidence, type, and potential clinical consequence of medication-administration errors made in a mental health hospital, and to investigate factors that might increase the risk of error. A prospective, direct observational technique was used to collect data from nurse medication rounds on each of the hospital's 43 inpatient wards. Regression analysis was used to identify potential error predictors. During the 172 medication rounds observed, 139 errors were detected in 4177 (3.3%) opportunities. The most common error was incorrect dose omission (52/139, 37%). Other common errors included incorrect dose (25/139, 18%), incorrect form (16/139, 12%), and incorrect time (12/139, 9%). Fifteen (11%) of the errors were of serious clinical severity; the rest were of negligible or minor severity. Factors that increased the risk of error included the nurse interrupting the medication round to attend to another activity, an increased number of 'when required' doses of medication administered, a higher number of patients on the ward, and an increased number of doses of medication due. These findings suggest that providers of inpatient mental health-care services should adopt medicine-administration systems that minimize task interruption and the use of 'when required' medication, as well as taking steps to reduce nursing workload.*

KEY WORDS: *direct observation, medication administration, medication error, mental health, psychiatry.*

INTRODUCTION

The administration of medication is one of the most commonly-used treatment modalities for patients admitted to hospital, but it is frequently associated with error (Department of Health 2003; Institute of Medicine 2000; National Patient Safety Agency 2009). A large percentage of all medication errors are reported to occur at the administration stage of the medicine-use process (Bates *et al.* 1995; Department of Health 2003; Lisby *et al.* 2005; National Patient Safety Agency 2009; Taxis *et al.* 1999). The majority of the most serious errors have also been reported to occur at the administration stage (National Patient Safety Agency 2009). In addition to patient harm, medication-administration errors can cause significant financial burden for health-care providers, due to remedial treatment costs and potential litigation expenses (Flynn & Barker 2000; Institute of Medicine 2000; 2007).

Identification of the incidence and type of administration errors that commonly occur in a particular health-care setting forms a necessary precursor to the implementation of strategies aimed at error reduction (Institute of Medicine 2007). The most sensitive method of administration-error detection is the direct observation technique (Council of Europe 2006; Flynn *et al.* 2002; Gandhi *et al.* 2000; Kopp *et al.* 2006), in which an investigator watches a nurse administering medication and records mistakes that are made (Allan & Barker 1990; Flynn & Barker 2000).

Medication-administration errors in the general hospital setting have been investigated in several direct observation studies (e.g. Barker *et al.* 2002; Buckley *et al.* 2007;

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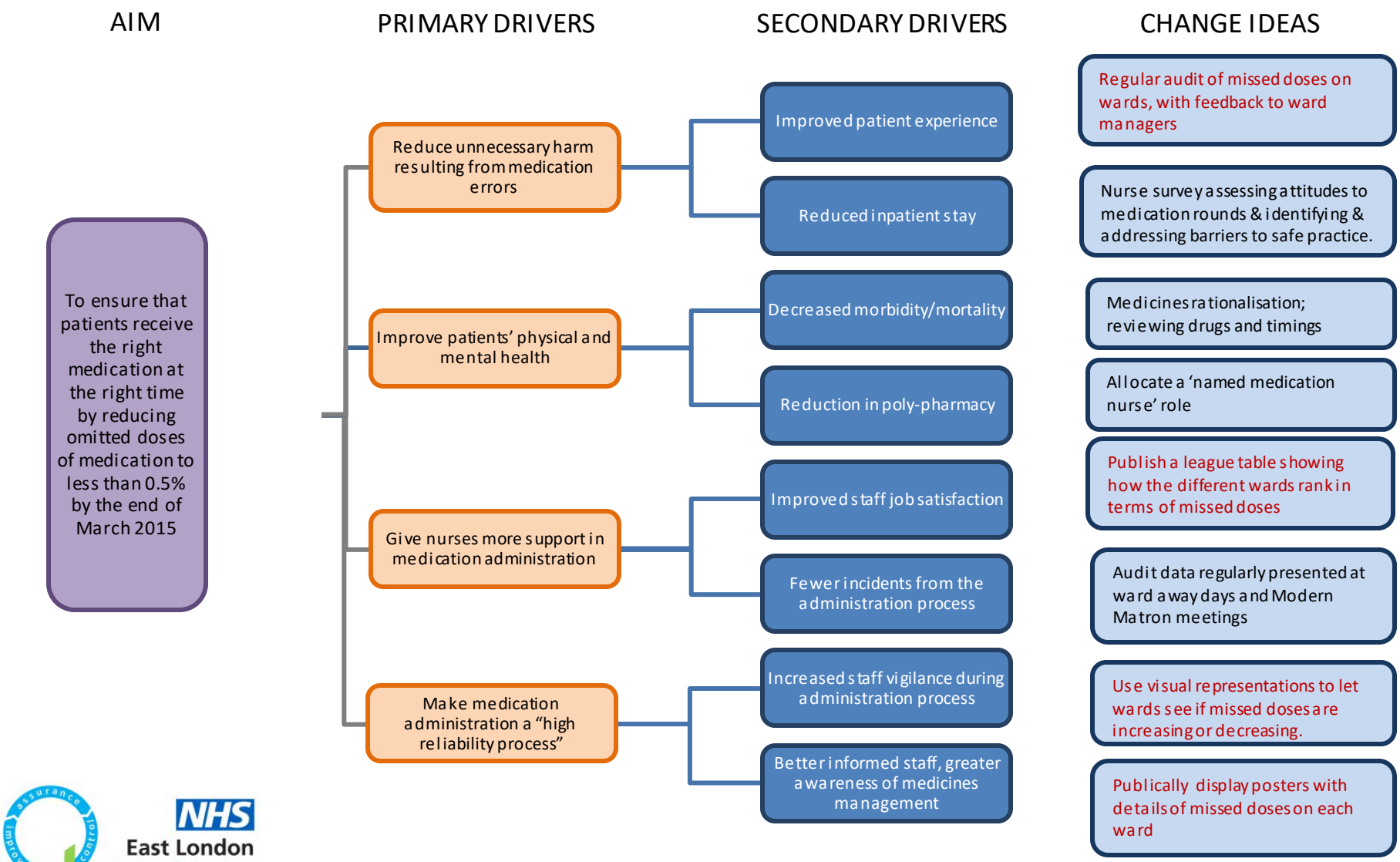
Alan Cottney, MPharm PgDip PgCert.
James Innes, MPharm PgCert SP IA.
Accepted July 2014.

Background

- Baseline investigation on 6 MHCOP wards:
  - Missed dose rate = 1.07%
  - Equates to approx. 2900 missed doses a year

- Project aim:
  - To reduce omitted doses of medication to less than 0.5% of total doses due by the end of March 2015

Reducing omitted doses of medication on the MHCOP wards



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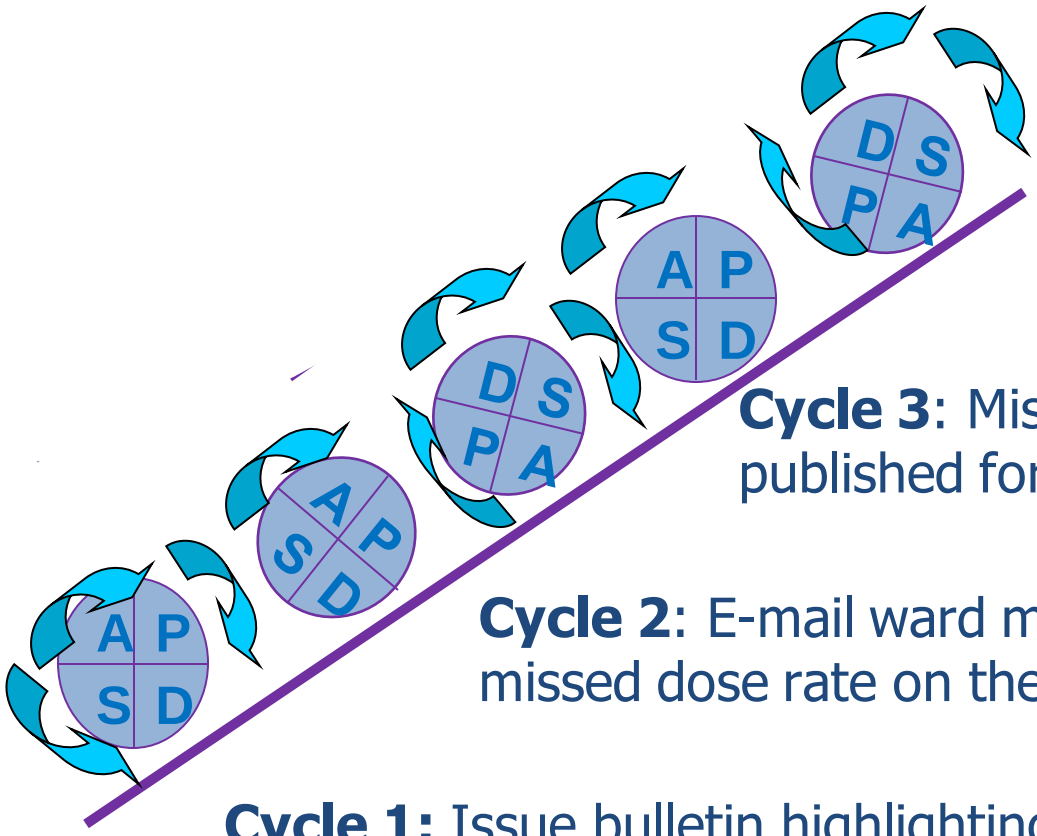
Sequence of PDSA's



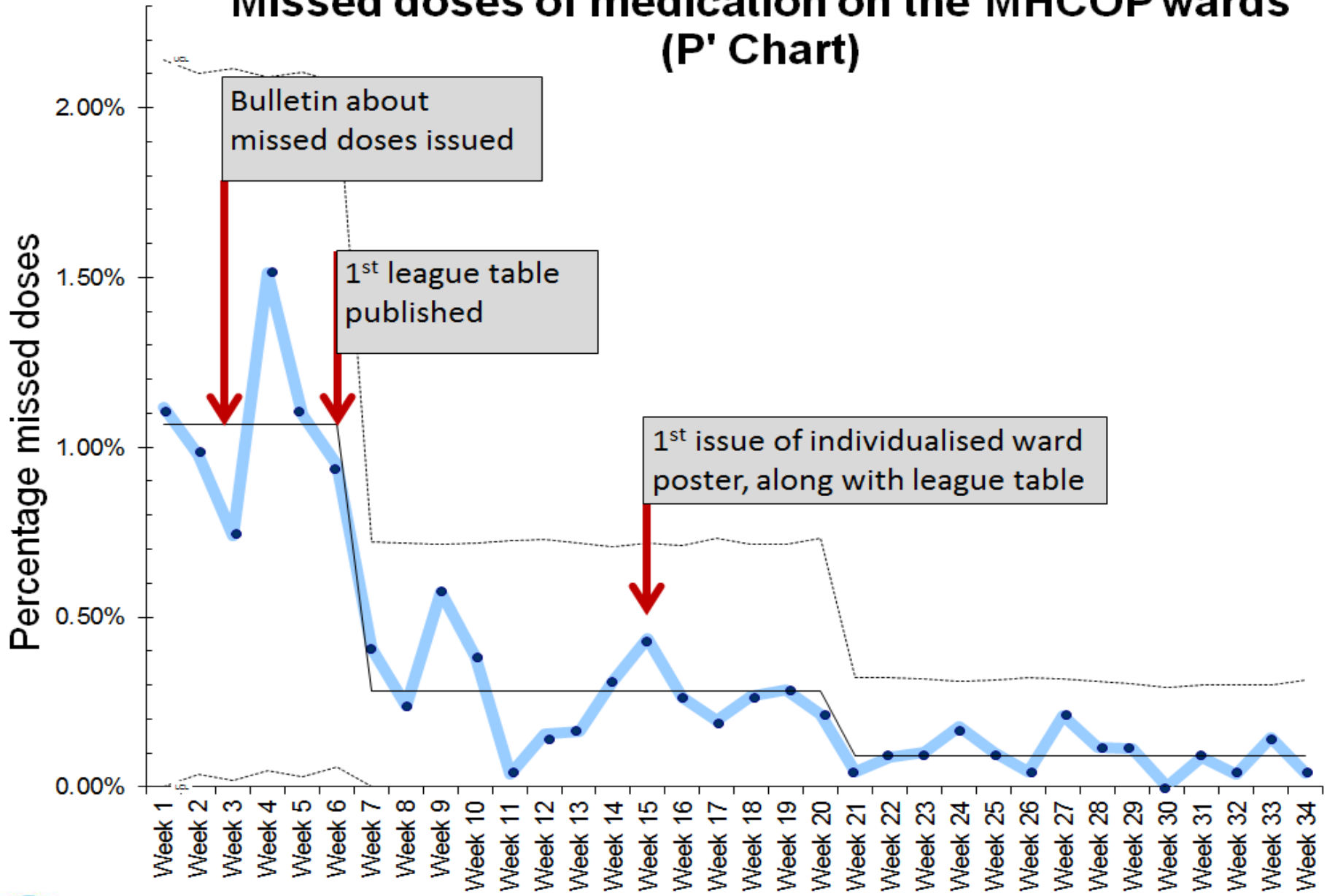
Cycle 4: Individualised ward poster published fortnightly.

Cycle 3: Missed dose league table published fortnightly.

Cycle 2: E-mail ward managers informing of the missed dose rate on their wards and asking for action

Cycle 1: Issue bulletin highlighting missed doses will be monitored

Missed doses of medication on the MHCOP wards (P' Chart)



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Healthcare Improvement Scotland

assurance control improvement

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The future of safety improvement?

Talking about “quality and safety” is like talking about “fruit and apples”. Safety cannot be divorced from quality.

Don Berwick

President Emeritus and senior fellow

IHI

Emerging Direction in Scotland

- CAMHS
- Infant Mental Health
- Perinatal
- Psychosis
- Custodial Settings
- Suicide Prevention

Emerging Direction in Scotland

- Safely reducing restrictive practice across all in-patient settings
- Improving services across the board ultimately linked to suicide reduction (20% by 2022)

Cultural change takes time

Continued improvement of complex safety issues

Service user led assurance

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Population health, quality and value as the triple aim

Redesign of our safety systems

Healthcare Improvement Scotland

assurance improvement control

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Questions?

@DavidTheMains

@DrAmarShah