SCOTTISH PATIENT SAFETY PROGRAMME

MENTAL HEALTH

Phase two
Measurement plan

The Scottish Patient Safety Programme is co-ordinated by Healthcare Improvement Scotland

1.0 Introduction

SPSP-MH Programme Objective:

To systematically reduce harm experienced by people using mental health services in Scotland by empowering staff to work with service users and carers to identify opportunities for improvement, to test and reliably implement interventions, and to then spread successful changes across their NHS Board area.

The Scottish Patient Safety Programme – Mental Health has seen a successful Phase one with broad engagement and some excellent pieces of work which show considerable promise in making mental health services in Scotland safer.

Phase two of the Programme will look to:

- consolidate and support existing good practice around improvement and harm reduction
- promote and support the use of data for improvement
- test areas that have not yet been tested across the workstreams

As we progress through the crucial second phase we are conscious that we do not over burden boards. However, all areas need to start focusing more clearly on the outcome and process measures to clearly identify where change is occurring and improvements are taking place.
The SPSP-MH Programme is not just testing **how to implement changes** that reduce harm but also **what part of the system** needs changing to reduce harm**, what specific changes** will lead to a reduction in harm and **what measures** can be used to reliably measure levels of harm.

Measurement is an important tool of any effort to improve care. The use of data specifically to make care safer will help you in two areas:

- identifying changes that will result in an improvement
- assessing the results of the changes you make.

Identifying problems in your system that pose particular safety risk can be challenging because the data most hospitals have on hand, spontaneous reports of errors on incident reports, account for, at most, approximately 10% of all errors. For this reason, you cannot rely on this data alone to either plan improvement strategies or measure the effect of patient safety efforts. Often, system flaws become clearer when we use a different lens to view the system such as actively looking for and assessing levels of harm, and examining how processes function within our current systems.

In Phase two of the SPSP-MH Programme we will continue to be using a data collection strategy that will allow you to identify solutions and track the impact of changes over time. The SPSP-MH excel toolkit provided for Phase two is designed to do just this. The resulting data should give you confidence that you are identifying and impacting a large percentage of the harm events occurring in your hospital, without requiring that you spend all of your time or resources collecting data. With this in mind we are encouraging all areas to share the data with the teams involved in generating it for learning and development.

2.0 Overview of SPSP-MH Data Collection Strategy

The SPSP-MH Data Collection Strategy currently focuses attention on the following areas:

- Mental Health Outcome Measures
- Safety Culture Measures –staff safety climate survey and the patient safety climate tool
- Balancing Measures
- Process Measures

2.1 Mental Health Outcome Measures

There is no one measure that can tell us the level of harm on psychiatric inpatient units. This is in part because of the different types of harm that occur to individuals experiencing a mental health crisis including physical, psychological, sexual and social.

- 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 persons vulnerabilities
- Sexual – e.g. adults at risk due to sexual disinhibition or the manipulation of an individuals vulnerabilities

The SPSP-MH Programme has developed outcome measures that reflect work from the prototyping year in Phase one and will now be collected during the first year of Phase two. These are identified in Section Three.

2.2 Safety Culture Measures

Patient Safety Climate Tool

During Phase two of the programme, all boards are asked to use the Patient Safety Climate Tool to ask patients what they feel about the safety of the wards they are in. This is an exciting partnership initiative involving service users and carers, boards and the voluntary sector. This survey will help individual wards, units and boards to find out what needs to be changed and what is working well, with anticipated shared learning across the country.

The SPSP-MH National Team will offer the following support with the Patient Safety Climate Tool:

- Support to identify capacity to facilitate the survey. We recognise that this will vary from board to board, but **it is essential that the facilitation is carried out by individuals who are not directly employed or involved as core members of a ward or unit team.**
- Each board will be supported by the SPSP-MH National Team to develop facilitator and patient briefing documents before using the tool that are particular to and focused on the local area.
- Support for the analysis and development of action planning from feedback received.

Staff Safety Climate Tool

IHI Safety Climate Survey (UK Version) was tested in Phase One and refined for Phase two. This tool should be completed a minimum of once per year but more frequently as required, six monthly where possible. Data collection forms, excel spreadsheets for analysis and guidance on use/scoring are available on the Knowledge Network - www.knowledge.scot.nhs.uk/spspmh.aspx.

It is acknowledged that momentum becomes an issue when using the same tool in the same format over a period of time. With this in mind both tools will have scheduled reviews and any changes will be discussed with Programme Managers, the SPSP-MH Delivery Group and the Authors Group in relation to the Patient Safety Climate Tool.

2.3 Process Measures

In addition to monitoring overall levels of harm to assess whether the changes are made are resulting in a reduction, it is also vital to put in place measures to assess whether the proposed changes to processes are being adhered to. Otherwise there is no way of knowing if a failure to reduce harm is because the intervention didn't lead to that outcome or simply because the intervention wasn't reliably implemented.

The continuing work includes identifying both the changes that will lead to a reduction in harm and ways of measuring whether the changes are being reliably implemented. Furthermore the process measures need to relate to the specific change/s that are being tested. There is no point collecting data on processes that the ward is not focused on improving.

This means:

- The process measures will be different for each workstream as they must relate to the changes being tested
- Each workstream will need a set of process measures that covers the spectrum of issues identified on the driver diagram. However, wards will then need to pick a subset of these depending on which actual changes they are focused on testing at any one moment in time.

- Once a process has been improved, wards will need to continue to collect data to assess sustained adherence to the new process but the frequency of reporting can be reduced once there is evidence that the change has been implemented.

There continues to be flexibility at this stage for individual wards to develop and test their own process measures; the national programme is not putting compulsory process measures in place at this stage in Phase two. It is anticipated that there will be workstream specific process measures in place for all Boards to use by the end of 2014. The workstream development groups for Restraint and Seclusion, Risk Assessment and Safety Planning, Safer Medicines Management, Communication at Transitions and Leadership and Culture will look to generate useful and practical measures that will be made available to areas for testing**.**

2.4 Balancing Measures

Balancing measures are used where there are concerns that working on one area of the system might have negative consequences elsewhere. The balancing measure is a way of monitoring this and identifying early on if these negative unintended consequences are occurring so that remedial action can then be taken. For example, one concern has been that focusing on safety issues in mental health units could result in an overly cautious approach to risk, that impacts negatively on an individual's recovery journey.

2.5 Frequency of Reporting

For improvement work, the aim is to report data as frequently as possible as this enables changes to be quickly identified. However, this has to be balanced out with the number of incidents occurring. For instance, a ward with very high turnover may be able to usefully report average length of stay weekly whilst one with a lower turnover will need to use monthly data.

For incidents which happen rarely, data should be reported as time between incidents occurring. As a general rule of thumb, if more half have no incidents, then time between should be used. For some of the data points the picture is still building regarding the rate of incidents. Further, the frequency of occurrence may be impacted by the type of ward. This will need to be assessed at an individual ward level to decide what the most appropriate approach to use is. This will be reviewed in the first year of Phase two up until October 2014.

2.6 Summary and Review

The approach and usefulness of the data being collected should and will be constantly reviewed. There will be the flexibility to add additional approaches if it becomes clear that there is a gap and also to remove measures if these are clearly not helping to identify harm or assess whether the changes being made are reducing harm. Furthermore the aim of this work is not to add a significant data collection burden to already busy and stretched wards. Therefore the amount of time that taken to collect the relevant data will also be kept under review.

Section 3– Overall Measure of Harm Reduction

As with Phase one this will also enable continued assessment as to whether some workstreams are having more significant impacts on harm reduction than others, which will then inform the direction of travel and focus of Phase two as it progresses.

These measures should be collected by all wards identified by Boards participating in Phase two.

The revised Scottish Patient Safety Programme for Mental Health Outcome Measures are as follows:

- Rate of violence and aggression
- Percentage of patients engaged in violent and aggressive behaviour
- Rate of patients being restrained
- Percentage of patients being restrained
- Percentage of patients who experience one or more episodes of seclusion
- Percentage of patients who experience self harm
- Days between inpatient suicide
- Percentage of patients who have emergency detention or use of nurse holding power

Balancing measures will be:

- Average length of stay
- Total number of hours of patients receiving high level observations
- Percentage of patients receiving high level observations
- Average hours per patient on high level observations

SPSP-MH Harm Reduction Outcomes Measures for Phase two

	Measure	Operational Definition	Data Source	Frequency of Reporting	Historical data available for base-lining (for wards/units joining in Phase 2)
MHO1a	Rate of incidents of physical violence per 1000 occupied bed days	Physical violence is defined as the use of physical force that is intended to hurt or injure another. (Numerator: Total number of incidents/ Denominator: Total occupied bed days in index month) X1000	Data should already be collected through incident reporting.	Monthly	This should be available from local incident reporting forms. Wards will need to assess how reliably this has been reported to make a decision as to whether to use historical data for base lining.
MHO1b	% of patients who engage in physically violent behaviour	Physical violence is defined as the use of physical force that is intended to hurt or injure another. (Numerator: Total number of patients who engage in physically violent behaviour to both patients and staff/ Denominator: Number of unique patients on unit throughout index month) x100	Data should already be collected through incident reporting.	Monthly	This should be available from local incident reporting forms. Wards will need to assess how reliably this has been reported to make a decision as to whether to use historical data for base lining.

	Measure	Operational Definition	Data Source	Frequency of Reporting	Historical data available for base-lining (for wards/units joining in Phase 2)
MHO2a	Rate of restraint incidents per 1000 occupied bed days	(Numerator: Total number of restraint incidents/ Denominator: Total occupied bed days in index month) X1000	Data should already be collected through incident reporting.	Monthly	This should be available from local incident reporting forms. Wards will need to assess how reliably this has been reported to make a decision as to whether to use historical data for base lining.
MHO2b	% of patients who experience one or more episodes of restraint	(Numerator: Total number of patients who experience one or more episodes of restraint/ Denominator: Number of unique patients on unit throughout index month) x100	Data should already be collected through incident reporting.	Monthly	This should be available from local incident reporting forms. Wards will need to assess how reliably this has been reported to make a decision as to whether to use historical data for base lining.
MHO3	% of patients who experience seclusion	Seclusion is defined as the supervised confinement of a patient, alone in a designated room / area which is locked to protect others from significant harm (Numerator: Total number of	Data should already be collected through incident reporting and seclusion monitoring policies.	Monthly	This data should be available from local incident reporting forms – as all episodes of restraint should already be reliably reported. Wards will need to assess how reliably this has been reported to make

	Measure	Operational Definition	Data Source	Frequency of Reporting	Historical data available for base-lining (for wards/units joining in Phase 2)
		patients who experience one or more episodes of seclusion in the given index month/ Denominator: Number of unique patients on unit throughout index month) x100			a decision as to whether to use historical data for base lining.
MH04	% of patients who experience self harm	Self harm is defined as an intentional act of self-poisoning or self-injury, and includes suicide attempts (Numerator Total number of patients who experience one or more episodes of self harm in the given index month. Denominator: Number of unique patients on unit throughout index month) x100	Data should already be collected through incident reporting.	Monthly	This data should be available from local incident reporting forms – as all episodes of self harm should already be reliably reported. Wards will need to assess how reliably this has been reported to make a decision as to whether to use historical data for base lining
MHO5	Number of days since last inpatient suicide	This includes a suicide that: Occurs on the ward Anywhere off the ward (LOA,Pass,missing person) but whilst still an inpatient	Data should already be collected through incident reporting.	Days between	This data should be available from local incident reporting forms – as all episodes of death on psychiatric units should already be reliably reported

	Measure	Operational Definition	Data Source	Frequency of Reporting	Historical data available for base-lining (for wards/units joining in Phase 2)
					through this mechanism.
MH06a	% of patients who are subject to use of nurses holding power	(Numerator: Number of patients who experience use of nurse holding power on unit after having been voluntarily/informally admitted/ Denominator: Number of unique patients on unit throughout index month) x100	Systems will already be in place to collect this data locally as routinely reported to MWC	Monthly	This data is routinely collected and reported to the MWC so will be available for base lining.
MH06b	% of patients who have emergency detention	(Numerator: Number of patients who experience an episode of emergency detention on unit after having been voluntarily/informally admitted/ Denominator: Number of unique patients on unit throughout index month) x100	Systems will already be in place to collect this data locally as routinely reported to MWC	Monthly	This data is routinely collected and reported to the MWC so will be available for base lining.

Section 4– Balancing Measures

Balancing measures are used where there are concerns that working on one bit of the system might have negative consequences elsewhere. The balancing measure is a way of monitoring this and identifying early on if these negative unintended consequences are occurring so that remedial action can then be taken.

	Measure	Operational Definition	Data Source	Frequency of Reporting	Historical data available for base-lining
MHB1	Average length of stay	(Numerator: Total occupied bed days for all patients discharged from ward during index month/ Denominator: number of patients discharged during the index month.	This data is routinely available from local systems. Local Boards need to set up a system for wards to receive regular updated reports.	Monthly	This data is routinely available from local systems so historical data should be available for base lining.
MHB2	% of patients on high observations	High observation is defined as 1:1 or greater constant/high observation **% of patients on high observations:** (Numerator: Number of individuals receiving high observation levels/ Denominator: Number of unique patients on unit throughout index month) x100	Will need to put local systems in place to collect this data.	Monthly	

MHB2		**Average hours on high observations:** (Numerator: total number of hours for all patients on high observations in index month**.** Denominator: Number of unique patients on high level observation in index month)			