

**Regional Learning  
Session 2-North**



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**Welcome and  
Opening Remarks**

Julie Fletcher, NHS Grampian



**Programme  
Update**

David Hall, Clinical Lead



## With a focus on adult psychiatric inpatient units, including admission and discharge processes

Year Zero  
(Pre work)  
Jan 12 – Aug 12

Year One  
(Testing)  
Aug 12- Sep 13

Year Two  
Sep 13 – Sep 14

Years Three  
and Four  
Sep 14 – Sep 16

# Final Outcomes

- Less harm experienced by people using in-patient mental health services
- Patients feel and are safe
- Staff feel and are safe
- Avoidable harm from restraint and seclusion reduced
- Avoidable harm from medicines reduced
- Systems that improve and support communications at all key transition points
- Risk assessments are accurate, concise, person centred and collaborative
- Climate tool for patients and staff developed to inform continual improvements and reduce harm in patient care

# What resources are available?

- National safety team working with national partner organisations to co-ordinate the collaborative approach to patient safety in in-patient mental healthcare
- Information pack on patient safety
- Guidelines
- Good practice guides
- Colleges
- NMC

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- NMC
- **YOU**



# What are the activities?

- Workstream Development Groups
- National and local learning sessions
- Tools development
- Training and development opportunities
- Site visits
- Patient and staff climate tools
- Webex

# Who is engaged and involved?

- The collaborative engages;
  - Service users
  - Carers and families
  - Staff
  - Boards
  - Students
  - Peers

# Change Action Package Spread

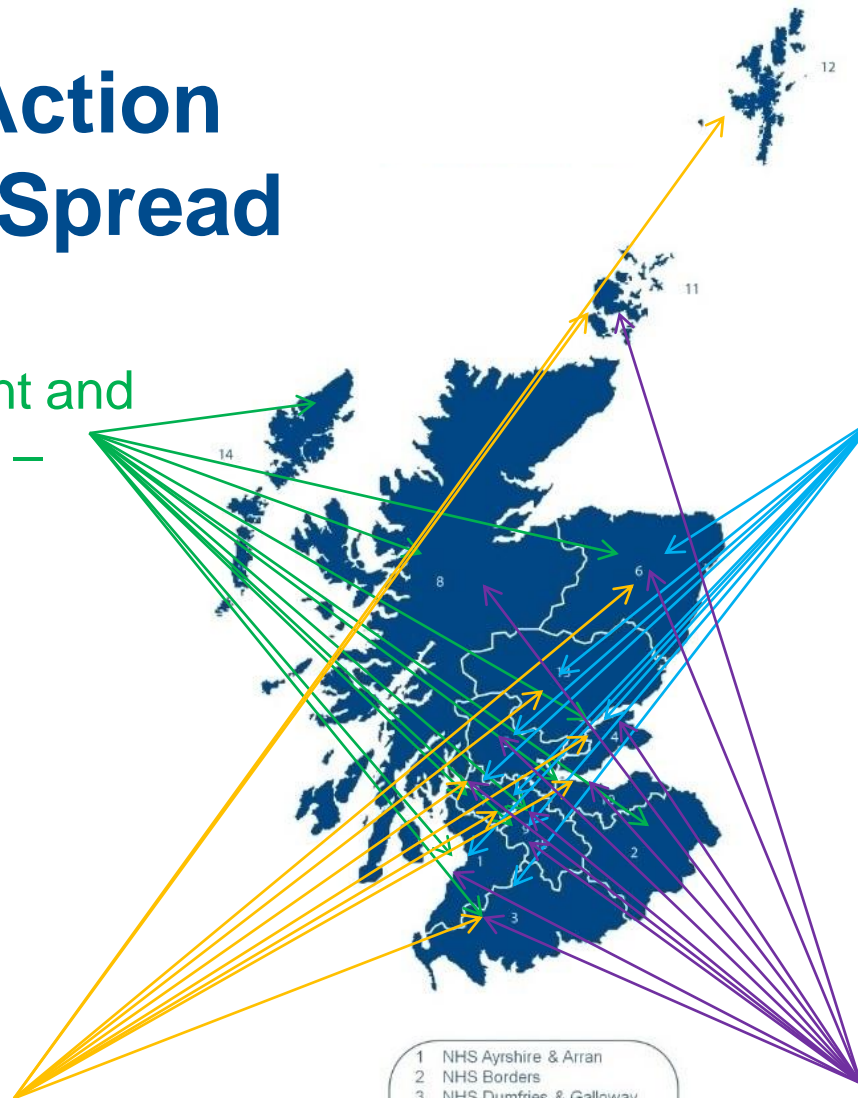
(Oct 2013)

Risk Assessment and Safety Planning –  
11 Boards  
22 Wards

Restraint, Seclusion and Emergency Sedation – 9 Boards  
24 Wards

Communications at Transitions –  
9 Boards  
23 Wards

Safer Medicines Management –  
12 Boards  
30 Wards



- 1 NHS Ayrshire & Arran
- 2 NHS Borders
- 3 NHS Dumfries & Galloway
- 4 NHS Fife
- 5 NHS Forth Valley
- 6 NHS Grampian
- 7 NHS Greater Glasgow & Clyde
- 8 NHS Highland
- 9 NHS Lanarkshire
- 10 NHS Lothian
- 11 NHS Orkney
- 12 NHS Shetland
- 13 NHS Tayside
- 14 NHS Western Isles
- 15 The State Hospital

# How will people react? What changes in awareness are needed?

- Raised awareness amongst all stakeholders of what unsafe behaviours and practices look like
- Staff feel empowered and supported to address issues
- Patients/public more aware of potential for harm expectations
- Boards have a positive attitude towards the programme
- Staff work with service users and carers to identify areas for improvement

# Changes in knowledge, attitudes, skills, aspirations

- Staff receptive to patient feedback and can recognise unsafe behaviours and practices
- Openness to learning across boards and staff, who understand links with other improvement initiatives
- Staff know that safety is important to the organisation
- Staff have knowledge and skills to use QI tools and data
- Learning for improvement is shared across NHS board areas

# Patient Safety Climate Tool

Has been used in 11  
boards with 270 service  
users

Date		Time		Name of ward	
------	--	------	--	--------------	--

How long have you been an inpatient in this ward?			
Less than 1 week	Between 1 week and 1 month	More than 1 month	Would rather not say

How old are you?					
Under 18	18-24	25-44	45-64	65+	Would rather not say

Are you detained under the Mental Health Act?		
Yes	No	Would rather not say

Gender?		
Male	Female	Would rather not say

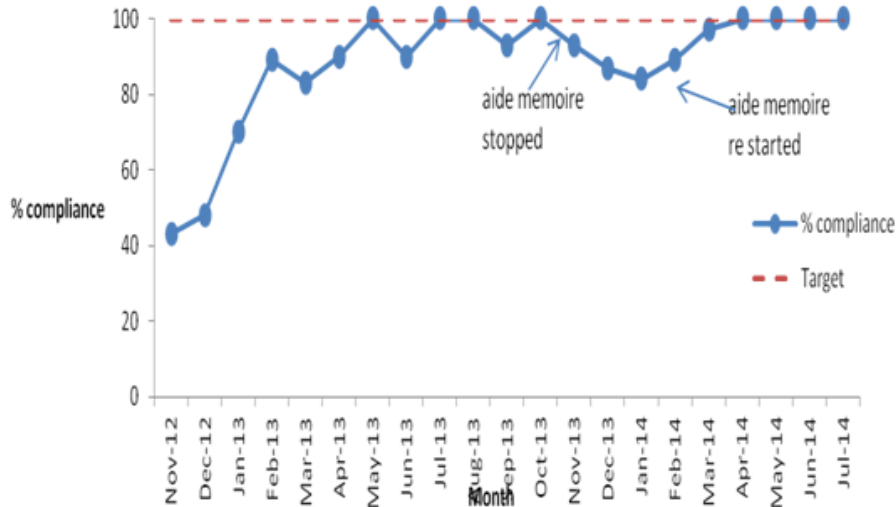
Is this your first admission?		
Yes	No	Would rather not say

Please rate the following by placing a tick under the response that best fits with your experiences from strongly disagree to strongly agree		1 Strongly disagree	2 Slightly disagree	3 Neither agree or disagree	4 Slightly agree	5 Strongly agree	X Not applicable
01	I usually feel safe in the day time.						
	Comments						
02	I feel safe in the shared areas of the ward.						
	Comments						
03	I feel safe during the period when staff change over shifts.						
	Comments						

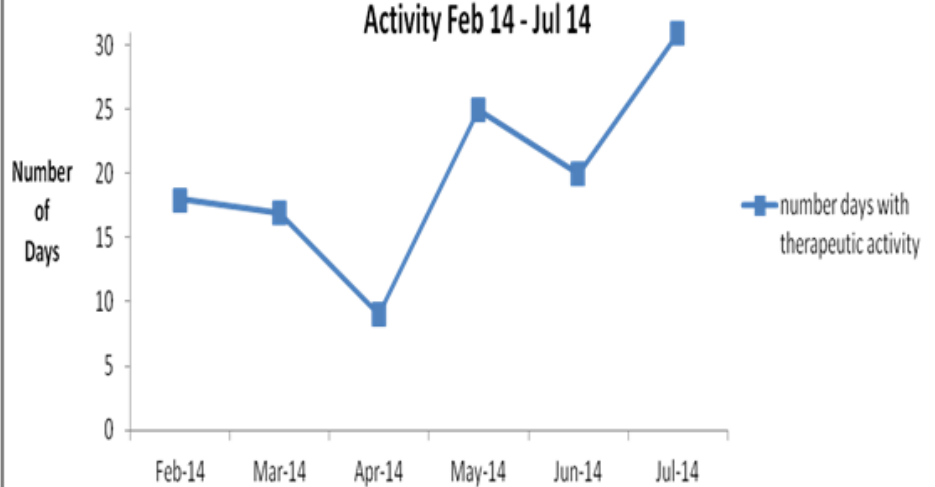
# Practice and behaviour change

- Staff challenge unsafe practices and processes
- Staff identify opportunities for improvement
- Staff make processes and activities safer
- Leadership supports the processes for delivering improvements
- Patient and staff safety climate tool used
- Risk assessment and safety plans for every service user
- Culture change

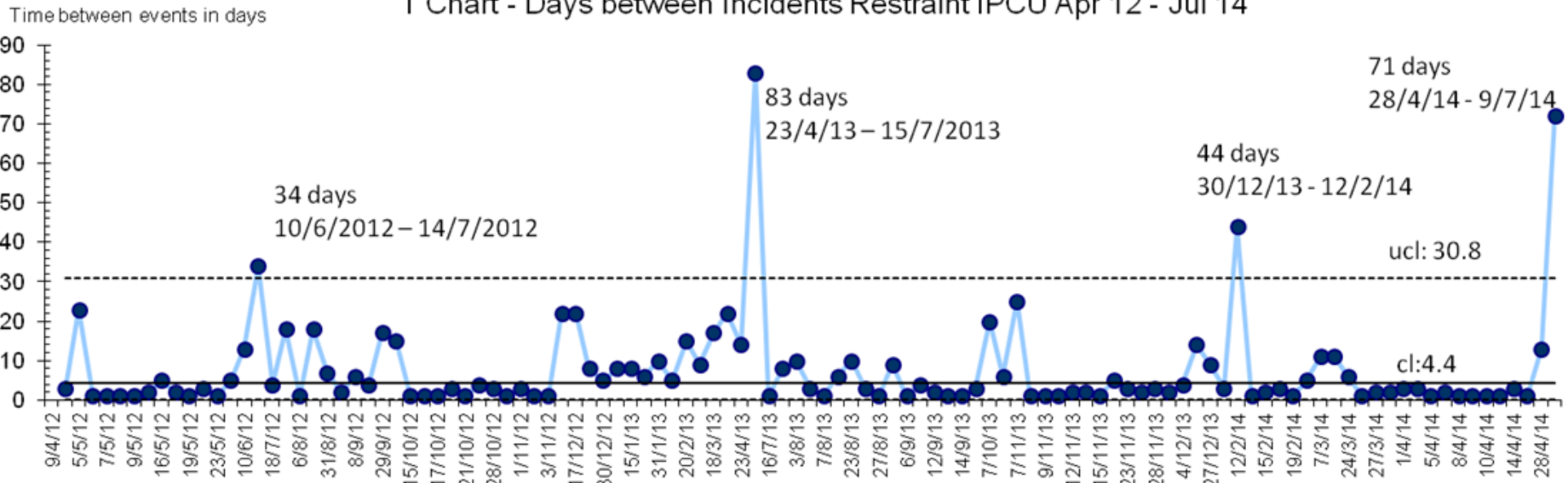
Monthly Safety Huddle compliance IPCU Nov 12 - Jun 14



Number of Days IPCU with Patients engaging in Nurse Led Therapeutic Activity Feb 14 - Jul 14



T Chart - Days between Incidents Restraint IPCU Apr 12 - Jul 14





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**Supporting Service User &  
Carer Involvement**

Gordon Johnston, VoX &  
Johnathan MacLennan, HIS

# Supporting Service User & Carer Involvement

- What does involvement look like in your area?
- How is this supported?
- What positive examples of engagement and involvement can you identify?
- How is learning from this shared?




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Tea and coffee break



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Workstream Development Groups



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Lunch



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World Cafes



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Round up and Next steps



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