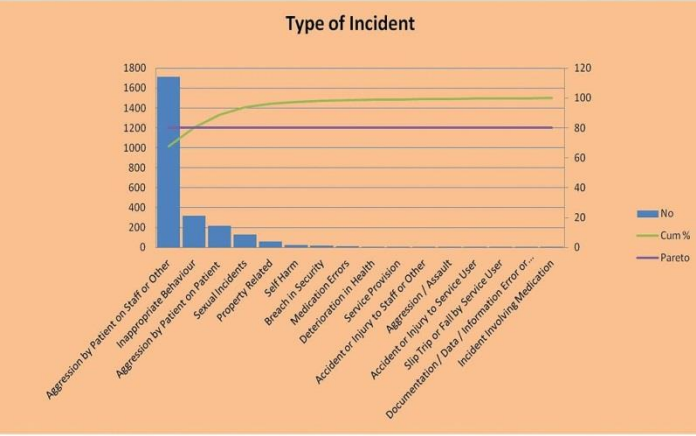
Measurement and Monitoring of Safety Framework: from reactive to proactive safety at Ashworth Hospital

Background

Ashworth Hospital at Mersey Care NHS Foundation Trust provides mental health care for patients requiring a high-security environment.

Some patients are located at Ashworth on a short term basis, whilst others remain for much longer periods. The patient case types, high secure environment, and prolonged length of stay provides challenges for patients often resulting in incidents of violence and aggression (V&A) against staff and other patients, accounting for a large amount of incidents.



A team at the Trust applied the Measuring and Monitoring of Safety Framework at ward level, where V&A was highlighted as a particular hotspot. The aim was to see how the framework could help staff better understand the contributory factors that lead to episodes of V&A, from a broader perspective, in order to predict episodes of V&A before they occur and deescalate situations to make patients and staff safer.

Learning outcomes using the framework

The team began by mapping existing measures onto the framework's domains, which allowed them to first look at which measures already worked and what needed improving. The team were then able to use the framework to approach the single recurrent safety issue of V&A, whilst through the mapped measures to understand the system wide contributory factors that lead to these incidents occurring, as well as the incidents impact on patients and staff.

This led to a better understanding and use of the data to begin tackling V&A; "we started off with a fair idea of what we wanted to do, to start on V&A. The framework helped us to know how we needed to focus on anticipation and preparedness, we began looking at the what days and times our highest level`s of incidents occurred". Understanding why these incidents occurred at particular times and looking at how many staff were required to deal with aggressive "incidents, provided a picture of how reliable the current system was.

Example of mapping current measurement and monitoring activity around the MMSF

Has patient care been safe in the past?

- Complaints (number and themes)
- Incidents of violence
- Incidents of aggression
- Claims
- Staff feedback
- Patient feedback
- Patient Tracker
- Sickness & Absence rates

Are we responding and improving?

- Oxford Model events
- 72 Hour reviews
- Thematic review of incidents
- Staff meetings
- Reflective Practice
- Supervision
- Capacity & capability of staff accessing and understanding improvement data
- Staff surveys (safety culture)
- Staff feedback
- Patient feedback
- Dashboard of information

Are our clinical systems and processes reliable?

- Compliance with security checks
- Consistency of staff approaches
- Post-incident debrief
- Compliance with safe staffing levels
- Compliance with increased observation policy
- Utilization of ward atmosphere assessment
- Compliance with environmental audits
- Compliance with security audits
- Use of risk assessments
- Handovers
- Supervision
- Reflective practice
- Compliance with infection control audits
- Number of incidents

Will care be safe in the future?

- Soft intelligence reports
- Patient feedback
- Staff feedback
- Safety training rates
- Sickness absence rates
- Percentage of completed appraisals
- Number of incidents
- Ward atmosphere ratings
- Staffing levels (per shift)
- LOG Meetings
- Planned admissions
- Risk Assessments
- MDT Meetings

Is care safe today?

- Observation levels
- Handovers
- Daily briefings
- Staffing levels
- Ward atmosphere assessment
- Staff skill mix
- Compliance with risk assessments
- Percentage of short notice sickness absence
- Timeliness of meal/rest breaks (staff)
- Soft intelligence reports

Improvements & outcomes

After applying the framework, the team quickly began to see what improvements were needed by integrating their learning to bring about the change necessary to reduce V&A. "We needed an assessment process for predicting V&A quickly.....having data available for staff to see what's going on was also important".

The team began researching solutions – "the framework created opportunities to research further; we had to look at what was out there and if it had any solid guidance attached to it". Three solutions for improvement were established; the Dynamic Assessment for Situational Aggression tool (DASA), a comfort room for patients, and data dashboard for staff. "As soon as we established our goals, we had to look at how we would implement it. First we began to relate it to the framework, does it have any solid guidance attached to it, such as from the National Institute for Clinical Excellence? Then it was about finding how our staff and patients from ward level felt about it and then we put it all together".

Using the DASA tool led to an overall reduction in V&A, with only minor exceptions. Staff have been able to predict the likeliness of aggression occurring and have quickly de-escalated the situation. The comfort room has added additional support in preventing aggression escalating, by providing a less 'high security' feeling experienced with current rooms, which will give a relaxed environment for patients to talk to staff about issues.

Culture changes

The project team saw a cultural shift in the way safety conversations changed at both frontline and board level. A team member explained; "we previously talked about and acted on safety very reactively, but the framework allowed us to think more proactively, particularly with anticipation and preparedness". This notable shift in cultural change provided structure to safety conversations, such as during clinical decision making, which normally was made on opinion.

Other cultural changes among frontline staff included giving a more clear picture of safety; "It gave us the opportunity of knowing what safety is and how it could be addressed in their environment, it gave us an understanding of what safety means". Another frontline staff said that the framework "helped us to understand the detail of safety and then to have those conversations".

Example measurement sources mapped around the Measurement and Monitoring of Safety Framework

Has patient care been safe in the past? (past harm)
Reduce aggression to make wards safer
1711 incidents of aggression on staff and others (24 months)
Wednesday our highest for incidents
3–4 pm worst time of day/lowest handover time 2-3pm

Are we responding & Improving (Integration & Learning)
Staff training – use of the DASA
Staff/Patient feedback DASA Dr Feelwell?
LINK safety framework to the 3 trust priorities
Review DASA of 3 pilot wards pre/post DASA
Appreciative enquiry– patient journalls/activity

Are our clinical systems & processes reliable? (reliability)
Datix & Incident data collected
Consistency of staff approaches/attitudes
Staff & Patient questionnaires (ward experience) DASA impact on reducing aggression (pre/post DASA questionnaires/training feedback)

Will care be safe in the future? (Anticipation & Preparedness)
Roll out DASA
Staff & Patient feedback
DASA pre/post questionnaires
Safety dash board
Positive behavioural support

Is care safe today? (Sensitivity to operations)
Environment (comfort room)
Hot spots–bedrooms/seclusion room
Staff/patient questionnaires
DASA–Structured assessment alongside clinical decision making High score – 3 interventions

Capability building

From a capability point of view, the framework has helped staff to identify knowledge and skills gaps, such as QI, data analysis, teaching and project management skills. This allowed the team to build capability, with themselves and frontline staff; “we have had to learn new skills, such as how to look at data and teach about the framework at ward level”.

Key learning for other organisations

We conclude this case study by providing the three key messages the project team would pass onto other organisations that are considering introduction the framework;

- Create champions on each ward who know the framework well and can guide staff on how to apply it to practice.
- Build a good project team with staff having the right motivation and right experiences; “because that will help with the process of using the framework and bringing about any improvements”.
- “Get the foundations right before moving ahead.... you need a good understanding of the framework first, the rest will follow”.

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