Late to the Party, but Ready to Dance!

Dr Helen Smith
Clinical Lead for the South of England Improving Safety in Mental Health Collaborative
Consultant Forensic Psychiatrist and Co-Medical Director

James Rooney
Managing Partner for Patient Safety

Learning Lab
1.00 pm to 4.30 pm
Sunday 7 December 2014

Session Objectives

- Gain an understanding of the organisational infrastructure required to support quality improvement
- See how utilising demand and capacity skills can improve the safety and cost effectiveness of community mental health services
- Identify and implement the changes required to reduce preventable harm in mental health
Session Content

- Developing an organisational infrastructure
- Supporting teams to deliver great care
- Creating a rich learning opportunity
- Building the foundations for improvement
Why would anyone want to leave here?

Inpatient Deaths

19 26 41 49

29 36 57

17 26 52

54
Add…

---

**AWOL Bundle**

- Completion of a semi-structured interview with the patient within 72 hours of admission
- New patient information clarifying ‘leave’ and expectations to be discussed with the patient during orientation to the unit
- Whiteboard which people complete before going on any leave
- Leave checklist - to be completed immediately before patient goes on leave
- Business card with contact details and in/out of hours for use by patient/carer
AWOL Bundle

Quality Improvement Work streams

- AWOLs
- Falls
- Medication Management

More recently…
- Named nurse
- Care planning
- 1:1 time
Managing Demand and Capacity

- Value identified as: quick access/diagnosis/treatment/or signposting to another service
- Pre-work waiting times were 31 days
- Post work 90% of routine referrals seen 10 days and urgent referrals seen in 5 days (against a National target of 28 days)

Question 1

What would need to change in your department to develop an organisation/system that consistently delivers high quality safe care?
Supporting Teams to Deliver Great Care

“When a team outgrows individual performance and learns team confidence, excellence becomes a reality”
Joe Paterno

Context

- To say accidents are due to human failing is like saying falls are due to gravity. It is true but it does not help us learn from them nor prevent them.

- The session focusses on evidence of the human factors that impact on the work that we all do and how we can minimise that impact.

- Not a black art, a pragmatic and robust process.
Human Factors

- Encompass all those factors that can influence people and their behaviour in a work context.
- Environmental, organisational, job and individual characteristics which influence behaviour at work.

Non technical skills

- Situation awareness
- Communication
- Team working
- Decision making
- Leadership
- Managing stress
- Coping with fatigue
## Non Technical Skills Framework

<table>
<thead>
<tr>
<th>Situation awareness</th>
<th>Examples of markers of good behaviour</th>
<th>Examples of markers of poor behaviour</th>
<th>Observations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering all information</td>
<td>Ensures participants have access to all the information available</td>
<td>Does not check that they have access to all the information available</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Interpretation of that information</td>
<td>Identifies gaps in info required to inform good decision making</td>
<td>Does not consider whether other information is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of plans to minimize risk/improve recovery</td>
<td>Ensures understanding of potential cases and risk-anticipates decision consequences/future scenarios</td>
<td>Does not anticipate decision consequences/future scenarios</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develops contingency plans</td>
<td>Does not develop contingency plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Considers time/other constraints</td>
<td>Does not consider time/other constraints with this contingency plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitors and reports changes in behaviour/other system state</td>
<td>Does not proactively report change in behaviour/system</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team working</th>
<th>Examples of markers of good behaviour</th>
<th>Examples of markers of poor behaviour</th>
<th>Observations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordinates activities with team members</td>
<td>Establishes atmosphere for open communication and participation</td>
<td>Does not actively engage others in discussion</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Exchanging information</td>
<td>Concentrates on what’s right rather than who’s right</td>
<td>Does not focus discussion of the team on the core issue needing resolution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using authority and assertiveness</td>
<td>Confirms roles and responsibilities of team members</td>
<td>Does not clarify roles/responsibility/purpose of meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessing team capabilities</td>
<td>Behaviour supports the effective functioning of the team</td>
<td>Rises too much on familiarity of team for getting things done makes assumptions, takes things for granted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting others</td>
<td>Accepts and uses suggestions and information offered by others constructively to improve the practice decisions made by team</td>
<td>Intervenes without informing/involving others</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respects views, experience, expertise and cultural background of colleagues</td>
<td>Does not involve team in tasks/decision making</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Non Technical Skills Framework

<table>
<thead>
<tr>
<th>Communication</th>
<th>Examples of markers of good behaviour</th>
<th>Examples of markers of poor behaviour</th>
<th>Observations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relays oral, written and/or electronic messages in a clear, accurate and concise manner</td>
<td>Information relayed in a rambling/not focussed manner</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discusses their analysis of the information including potential risks and scenarios</td>
<td>Does not provide analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shares situation updates/reports key events</td>
<td>Does not provide appropriate updates</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actively listens to information being relayed</td>
<td>Does not actively listen/interrupts unnecessarily</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asks constructive questions</td>
<td>Displays negative/destructive behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provides analysis and recommendations to support decision making</td>
<td>Does not contribute to analysis or recommendations for robust care delivery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Non Technical Skills Framework

<table>
<thead>
<tr>
<th>Decision making</th>
<th>Examples of markers of good behaviour</th>
<th>Examples of markers of poor behaviour</th>
<th>Observations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify options</td>
<td>Reviews causal factors with team members</td>
<td>Jumps straight to solutions</td>
<td>0 1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>Balance risks &amp; select options</td>
<td>Discusses alternative courses of action with team members for options</td>
<td>Does not discuss options/involve staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilizes intuitive, risk-based, options and creative decision making as appropriate</td>
<td>Considers and shares risks of alternative scenarios/courses of action</td>
<td>Does not consider risk to deal with alternative scenarios associated with risk needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-evaluating the provisional decision reached</td>
<td>Checks outcome against plan</td>
<td>Does not check outcome nor adjust plan accordingly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize at least 3 decision making types</td>
<td>Relates intuitive decision making style only</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Non Technical Skills Framework**

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Examples of markers of good behaviour</th>
<th>Examples of markers of poor behaviour</th>
<th>Observations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and preparing</td>
<td>Takes initiative to ensure involvement of team and task completion.</td>
<td>Does not take initiative some of the team are not engaged.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Prioritising</td>
<td>Intervenes if task completion deviates from standards.</td>
<td>Lets team drift not focused.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing and maintaining standards</td>
<td>Clearly states intentions and goals.</td>
<td>Intention and goals not clear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying and utilizing resources</td>
<td>Prioritises objectives and plan work to make best use of time and resources.</td>
<td>Task overruns.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enabling appropriate facilitation</td>
<td>Recognises changes in circumstances promptly and adjusts plans and activities accordingly.</td>
<td>Does not recognise changes nor adjust plans.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Managing Stress/Anxiety                        | Takes condition of other team members into account. | Does not consider the needs of team. | | | |
|                                                | Helps other team members in demanding situations. | Does not act to support staff in demanding situations. | | | |
|                                                | Offers supportive and constructive assistance to team members. | Does not offer support. | | | |
|                                                | Deals with differences of opinion and conflicts constructively in ways which respect other team members points of view. | Does not respect other peoples opinions. | | | |
|                                                | Agree sensible and achievable objectives. | Sets unrealistic objectives. | | | |
|                                                | Give a consistent and reliable performance. | | | | |

**Question 2a**

What are the strengths and weaknesses of this approach and how might it be improved?
Question 2b

What do you do in your organisations to strengthen team performance?

Creating a Rich Learning Opportunity

“To err is human, to repent divine to persist devilish”

Benjamin Franklin
Accident reports

- What happened?
- Who to?
- When?
- How it happened
- But not why

Technical myopia
Failure to consider human factors

But not as simple as we think ..

- ‘This accident was the result of human error’
- Error or rule-breaking put down to:
  - ‘Lack of competence’
  - ‘Poor supervision’
  - ‘Not paying attention’
- It’s not usually as simple as that!
Human failure taxonomy

Human failures

- Intended actions
  - Violation - Intended consequences: When the person decided to act without complying with a known rule or procedure
  - Errors - Unintended consequences: Mistakes, Lapses, Slips
    - Mistakes: When the person does what they meant to, but should have done something else
    - Lapses: When the person forgets to do something
    - Slips: When the person does something, but not what they meant to do

- Unintended actions

Mistakes

Mistakes are defined as or failures in the judgmental processes involved in the selection of an action or in the specification of the means to achieve it, irrespective of whether or not the actions taken by this decision scheme runs according to plan.
Mistakes

Mistakes could be further sub-divided into:

- Failure of expertise (rule based). Some pre-established plan, or problem solution is applied inappropriately (e.g. safeguarding) and

- The lack of expertise (knowledge based) with the individual not having an appropriate off the shelf routine. The person is forced to work out a plan of action from first principles relying upon whatever relevant knowledge s/he currently possesses (infrequently met or a new problem)

Improvements

Each failure type has a different set of solutions designed to prevent their reoccurrence. For example (not exhaustive):

- Slip/Lapse
  - NOT training
  - Hardware solutions
  - Cross checks/Checklists
  - MDT discussion

- Error
  - Training e.g. scenarios
  - Group support
  - Challenge
  - MDT discussion

- Violations
  - Behaviour modification
  - Culture improvement-within the Team
**Question 3a**

What are the strengths and weaknesses of this approach and how might it be improved?

---

**Question 3b**

What do you do in your organisations to learn from your accidents/incidents/near misses?
Building the Foundations for Improvement

To make any improvement a reality requires three elements:

a) Knowledge
b) Skills
c) Motivation/desire

Question 4

How would you create the desire within to improve in your organisation?
Quote

“For every thousand hacking at the leaves of evil, there is one striking at the root”

Henry David Thoreau

How to improve

- Tell Me, and I will forget
- Teach Me, and I will remember
- Involve Me, and I will learn

Benjamin Franklin, 1706–1790