GUIDELINES FOCUS ON IMPROVING PATIENT SAFETY IN MENTAL HEALTH

A resuscitation alert and a good-practice guide provide nurses with ways to safeguard patients in mental health and learning disability settings. Nerys Hairon finds out more

The National Patient Safety Agency launched two guidelines last week for mental health care staff. The first is an alert on resuscitating patients in mental health and learning disability settings (NPSA, 2008a), and the second is a best-practice guide outlining seven key areas that mental health organisations and care teams can work on to improve patient safety (NPSA, 2008b).

The first, the rapid-response report (NPSA, 2008a), applies to all NHS and independent organisations in England and Wales providing mental health or learning disability inpatient care. It was developed with the Resuscitation Council UK and NHS mental health services. Both documents were launched at the NPSA’s first conference on patient safety in mental health, held in Leeds last week.

RESUSCITATION

The NPSA launched the rapid-response report after performance and system concerns were raised by a review of the agency’s reporting and learning system. The alert aims to remind all nursing and medical staff of the standards that have already been set by NICE (2005) and the RCUK (2005). The review looked at incidents involving patients choking or experiencing cardiac/respiratory arrest in mental health and learning disability settings between January 2006 and the end of March 2008. This data search revealed 599 reports of at least moderate harm related to choking or cardiac/respiratory arrest in these settings that showed wide variations in resuscitation standards (NPSA, 2008a). Twenty-six of these incidents described a significant lack of staff knowledge or skills, such as in identifying cardiac arrest, or of equipment availability, including basic airways equipment and automated external defibrillators (AEDs). In addition, the review found three reports of patient deaths after choking on food, and another 22 moderate or severe-harm reports of patients choking, where staff did not always seem to have the skills to deliver effective first aid.

Patients with mental health conditions and learning disabilities can be vulnerable to cardiac/respiratory arrest through physical illness, self-harm and the effects of medication, including rapid tranquillisation (NPSA, 2008a). They are also vulnerable to choking, through dysphagia associated with illnesses such as dementia, or through intoxication, substance abuse or intentional self-harm. The rapid-response report reminds staff of the recommendations of both RCUK (2005) and NICE (2005) guidance. RCUK (2005) guidance requires all healthcare settings to offer basic life support. In addition, the NPSA report sets out some points for immediate action by medical and nurse directors providing mental health or learning disability inpatient care in the NHS and independent sector (see Box 1, p20). A specific date of 20 May 2009 is given for actions to be completed. A document with more information on the findings, links to resources and a compliance checklist is also available (NPSA, 2008c).

PATIENT SAFETY IN MENTAL HEALTH

The NPSA’s (2008b) guidance suggests clear strategies that mental health organisations, staff and teams should adopt locally to improve patient safety and meet clinical governance targets. The steps (outlined in Box 2, p20) are part of a continuing process – step 1 is the foundation step, while carrying out steps 2–7 will help to build a safety culture.
CLINICAL UPDATE

Each step includes action points at organisational level and for mental health teams. The guidance also outlines how the NPSA can help with each stage.

Step 1 focuses on building a safety culture. The guidance says that, in a safety culture, staff are constantly aware of the potential for adverse incidents, and both staff and the organisation are able to acknowledge mistakes, learn from them and take action to put things right.

The systems approach to safety acknowledges that the causes of patient safety incidents are not linked just to the actions of the staff involved – incidents are also linked to the systems in which people work. Looking at what was wrong in the system helps organisations to learn lessons that can prevent incidents from recurring in the future.

The first step in developing a safety culture is to establish the current culture in the organisation. An action point in step 1 recommends carrying out a baseline assessment of safety culture in the whole organisation. Actions for mental health teams include discussing with colleagues what they hope and expect will happen when they report adverse incidents, and building prompts into regular team meetings to discuss any emerging risks that might need to be reported.

Step 2 focuses on building a safer culture for patients through strong leadership. Actions for mental health teams involve knowing who the champion or lead is for patient safety, and promoting an ethos where all members of the team feel able to raise issues when they think something may be going wrong.

Step 4 is concerned with better incident reporting in mental health care. The guidance says a high level of reporting indicates a better safety culture. It points out that the level of reporting from mental health organisations in England and Wales has significantly improved. However, the NPSA acknowledges that not all incidents are reported both within services and to the agency.

Actions for mental health teams include discussing with colleagues actively reporting all patient safety incidents and thanking team members who do report them.

In step 5, on communication with service users and the public, the guidance says this is essential to improving patient safety. There are three main areas in which organisations can involve these groups in making services safer: involving service users and the public in developing safer services at a strategic level, involving clients in their own care and treatment, and in encouraging an open, two-way dialogue between health professionals and clients when things go wrong.

See the full guidance at www.npsa.nhs.uk for details on each of these seven steps.

Local organisations should ensure that:

- Their rolling programme of basic life support (BLS) training for all staff is based on RCUK (2005) standards including managing choking;
- All patient areas have immediate access to appropriate BLS equipment;
- All patient areas where a cardiac arrest might be expected at least once every five years should have access to automated external defibrillators (AEDs) within three minutes;
- All units where rapid tranquillisation, physical intervention or seclusion may be used have access to staff trained in immediate life support (ILS) and to all equipment specified in NICE (2005) guidance, including AEDs;
- Where feasible, training includes regular practices or drills in addition to classroom teaching;
- A leadership role for resuscitation issues is identified (including when resuscitation training is contracted out) and attendance levels at life-support training are routinely audited and reported to a senior level, and lapses acted on.

Source: NPSA (2008a)

REFERENCES


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