Reducing Incidences of self harm

Leicestershire Partnership NHS Trust and

Health Innovation East Midlands

Psychological Safety

Please be mindful that we will be using the word suicide, discussing mental health risk assessment and safety throughout this presentation.

Please consider your wellbeing and if this is the appropriate time for you to listen to this presentation.

It is important that we use the word suicide to break down stigma and ensure we are having meaningful conversations. Suicide prevention is everybody's business.

If you feel affected by this presentation, please reach out for support.

Slide content courtesy of ***Northamptonshire Healthcare NHS Foundation Trust***

Mental Health Patient Safety

Improving Safety Through Experiences

Feeling Empowered

Feeling Validated

Compassionate Language

Suicide Prevention

Preventing Suicide & Self-Harm

Patient & Public Involvement

Enabling Better Outcomes

Sharing the Load

Collective Voice

S·H·A·R·E·D

HOPE

Confidence

Spark Ideas

Role Modelling

Sexual Safety

The Golden Thread of Co-Production

New Ways of Using Data

Working as a Regionwide Team

Pinching with Pride

Caring Can't be done in Isolation

Sharing Resources

Reducing Restrictive Practice

Reduce Blanket Restrictions

Valuing Lived Experience

Sharing Expertise

Greater Impact

Regionwide

Working Together

Hear Us

Quality Improvement

Our Culture has allowed us to work well

Relationships Beyond Organisational Boundaries

Promoting Awareness

Ripple Effect of Innovation

Health Innovation East Midlands
Local change, national impact

Proud to be supported by East Midlands Alliance
for Mental Health, Learning Disabilities and Autism

By Julia Bakay

Introducing the team

- **Dan Given**, RMN. Charge Nurse, (Leicestershire Partnership NHS Trust)
- **Mat Williams**, RMN. Suicide Prevention and Self-Harm Lead (Leicestershire Partnership NHS Trust)
- **Elena Relph,** Quality Improvement Practitioner (Leicestershire Partnership NHS Trust)
- **Hannah Jackson-Cox**, RN. Senior Improvement Lead (Health Innovation East Midlands)

This presentation

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- Frame patient safety improvement.
- What we did and how we did it.
- How to replicate this project in your own area.
- Our Learning for sustainability.
- Ask your questions to the team.

Reducing incidences of self-harm

Aim: To reduce number (count) of Self Harm incidents by December 2024

Patient Safety Improvement

- It’s complex
- Many of our priorities are discussed as discrete ‘projects’.
- But, more often they co-exist together at the point of care.

Delivery of safer, higher-quality care: *Patient safety improvement projects must reflect the complexity of how care co-exists in practice.*

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There is a relationship between self-harm and restrictive practice, yet these are often reported and acted on as discrete priorities.

So, we sought to change this, our goal was always holistic and sustainable patient safety improvement.

Successful therapeutic care is achieved through holistic patient centred care, and this must also be reflected in the way we deliver projects.

Restrictive Practice

Self-harm prevention

Theory of change

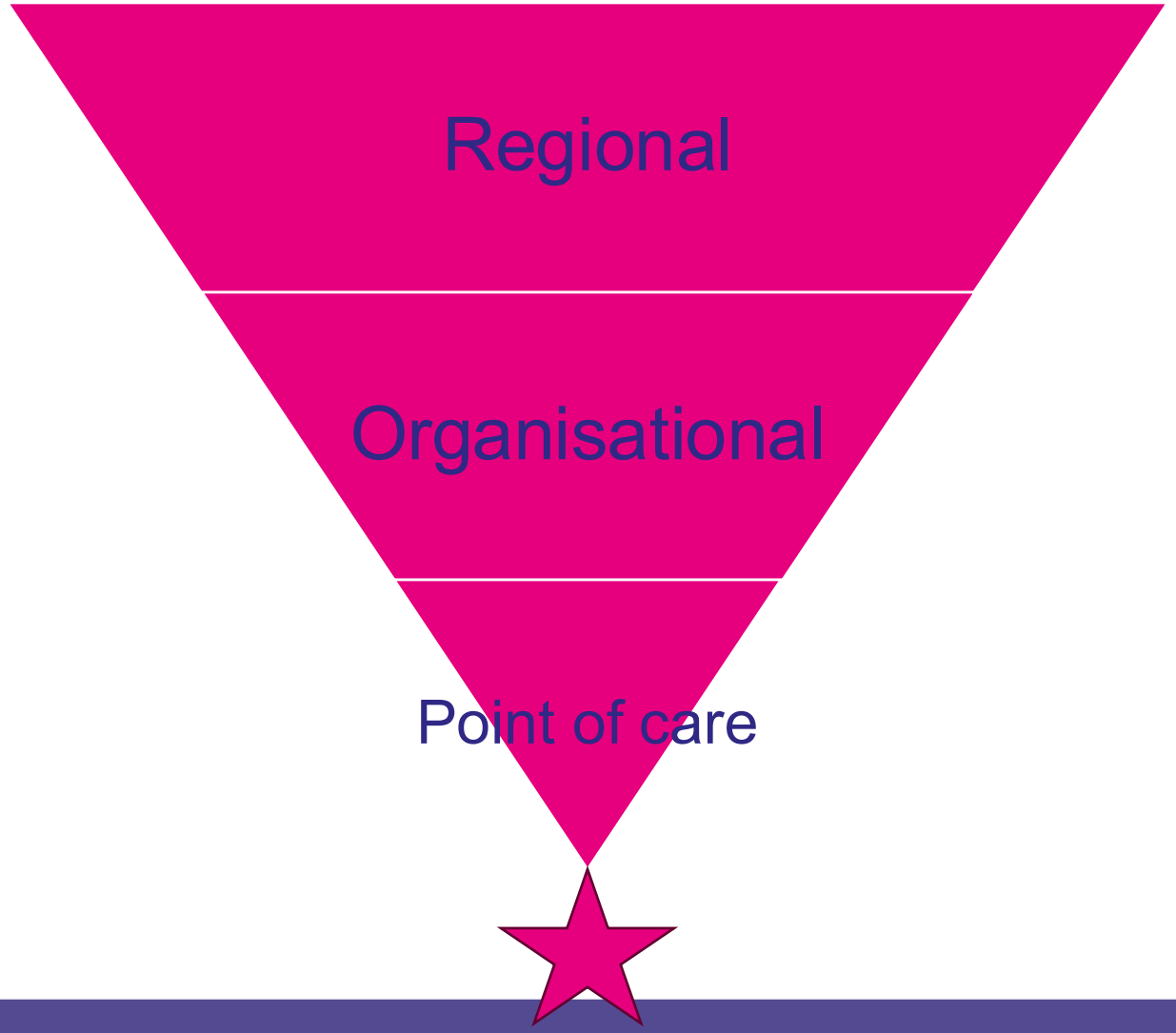
All our change ideas will ‘add’ to current care rather than to ‘remove’.

In other words, we will reduce self-harm without increasing restrictions.

Not setting an improvement target

- Not replace personalised care/clinical care.
- Would targeting 100% reduction be the right thing to do?.
- Might that adversely affect morale.
- Driving better care, we knew that a reduction would fall out that.
- Any improvement was an improvement.

From Regionwide to ward level



To reduce the incidences of self harm both in frequency and severity on the ward

Introducing the ward

Female acute inpatient ward

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Organisational

- Consistently the highest incidences of self-harm in all adult areas in LPT.

Local

- Working age females.
- 18 bedded ward.
- 28 days average LoS

Getting started

Data driven from the beginning

Data driven

When and where were incidents happening most often?

Environment: Bedroom, corridors

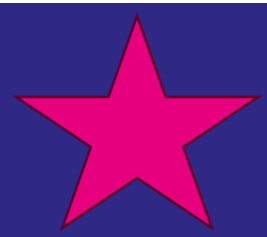
Time of day: In the afternoon and early hours of the morning.

Data driven

When and where were incidents happening least often?

Day of the week: Thursdays

Why might that be?



Doing more of what works well

What happened on Thursdays

- Community meeting
- Led by Ward Management team
- Open to all patients
- Encouraging patients' active participation for feedback on ward for development

All changes ideas needed to…

- Active patient participation
- Free
- Could not be restrictive

Adding value to care

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Conventional thinking:

"Stop access to bedrooms at 'peak' times"

In this project:

"How can we have more 'Thursdays'?"

Activity coordinator quote:

"It has been great to be able to work with patients coming up with activities that truly means something to them, something that they properly benefit from."

Working with patients to generate change ideas

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GARDENING CLUB

A WARD BAND

INVITING PEER SUPPORT WORKERS

INTRODUCING MORE ‘COFFEE AFTERNOONS’

AND MORE…

Change ideas

- Invited peer support workers.
- Introduced community meetings on the days where there was the greatest number of incidents (Mondays).
- Focussed on safety planning as part of ward processes.
- Working towards a low-stimulus room for supporting patients late at night.
- Activity grab bags for low-stimulus activities in the evenings.

Aim: To reduce number (count) of Self Harm incidents by December 2024

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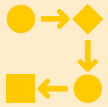
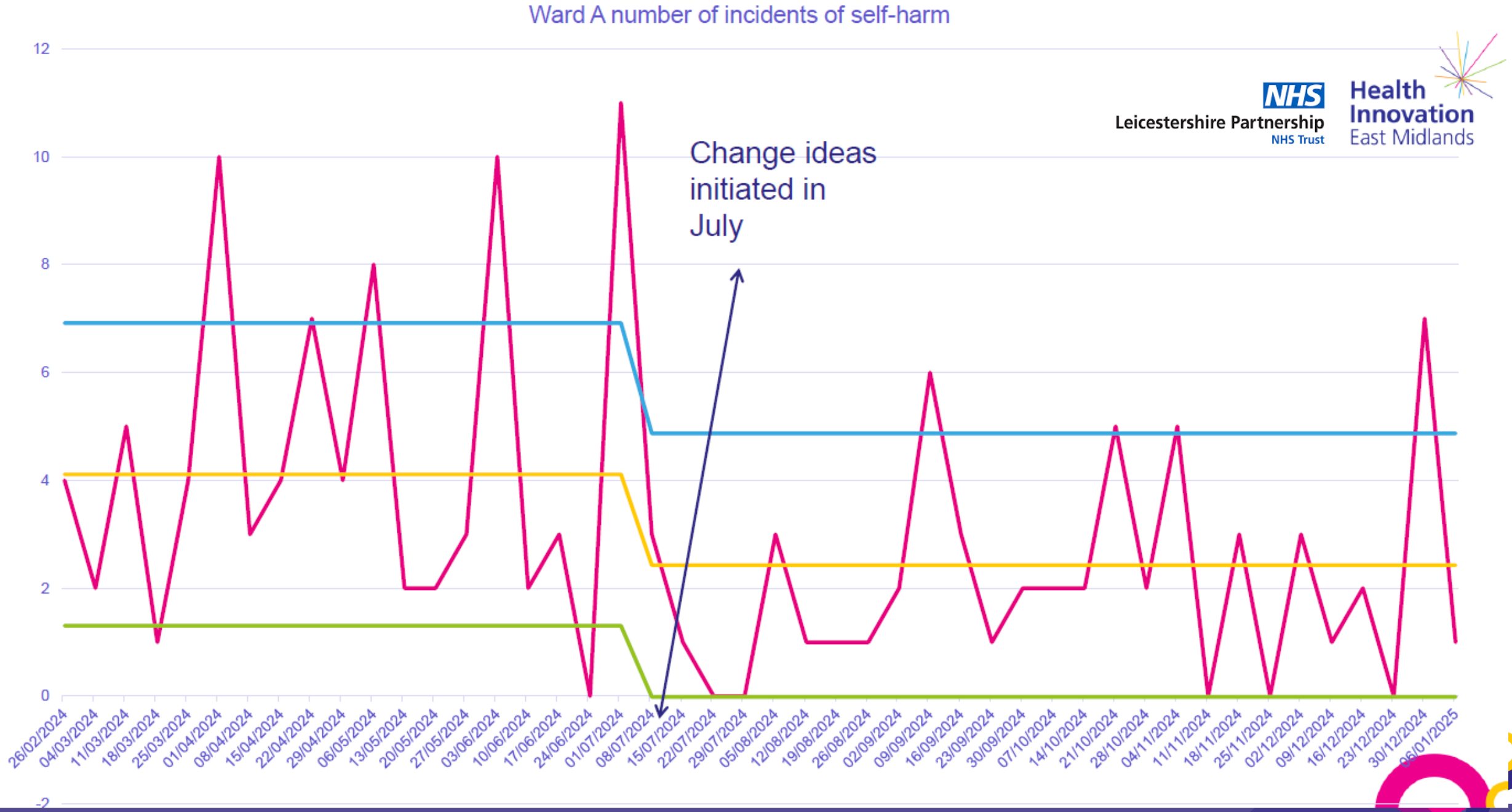
Project planning began June 2024



Change ideas started to be implemented in July 2024.

Project resulted in a 40% decrease in incidents.


Ward A number of incidents of self-harm
Change ideas initiated in July
12
10
8
6
4
2
0
-2
26/02/2024
04/03/2024
11/03/2024
18/03/2024
25/03/2024
01/04/2024
08/04/2024
15/04/2024
22/04/2024
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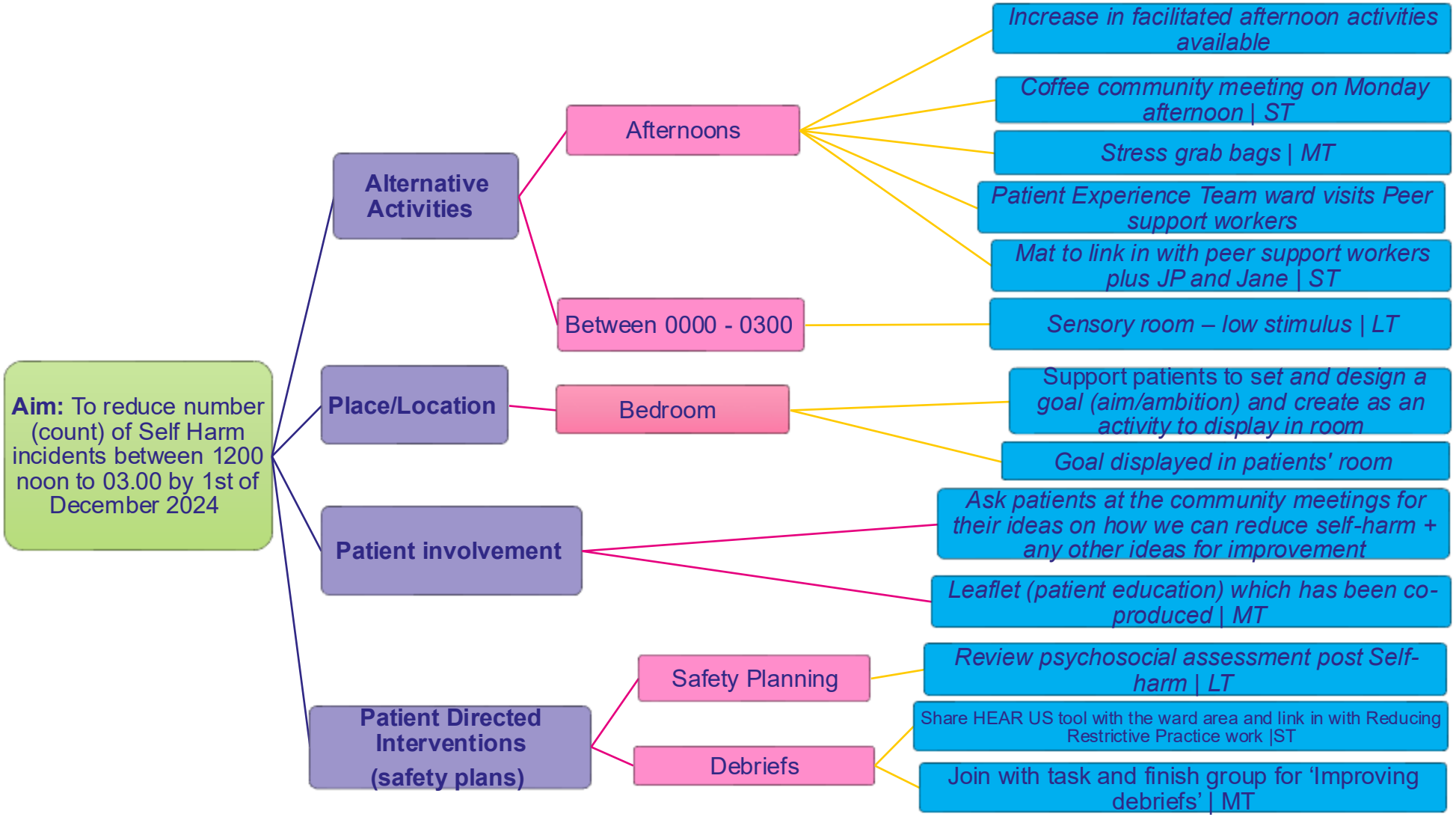
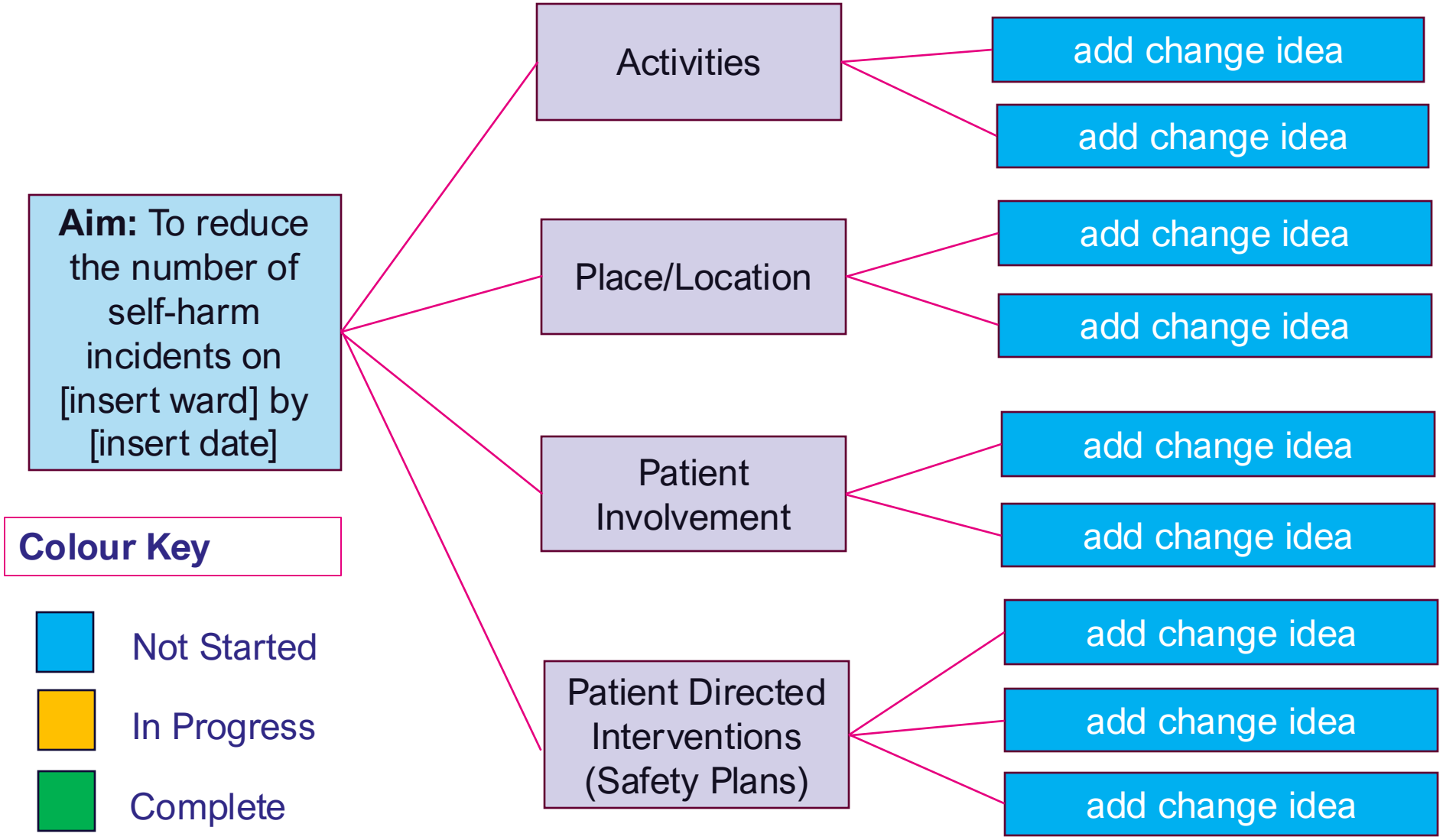
06/01/2025

Driver diagram



Driver diagram resource



More than numbers

Patient/family testimonials – culture of care

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"I really like that the ward staff seem to be more present now, it gives me the sense that we are really valued."

"When I see staff around, I know that they are available to talk to, I don't like knocking on the door as I often feel like I'd be bothering staff."

Care team testimonials

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"When I got into nursing, it was focused on being there for patients and supporting them through their journeys. Sadly, some of this has been lost through the administrative side of it all. This feels like a step back in the right direction."

"It is surprising how simple some of the changes that we have made are."

This was always more than a project…

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Morale/staffing

- Nursing is a difficult profession
- Management of incidents can be draining
- This can compound over time
- Contribute to increased sickness

A Patient Safety Culture

Prioritise people:
- Patients at the centre of the care.
- Working with the teams and the patients.

Practise effectively:
- Assessing the patient need and delivering the appropriate care.
- Applying the right methodology to the right questions.

Preserve safety:
- To deliver safe and effective care and interventions that will sustain.
- Role modelled to both staff and patients that having an open reporting culture that tells us where practice needs to improve will be addressed in a safe and blame-free way.

Promote professionalism and trust:
- Demonstrated that by looking for the best in practice, you can transform care.
- We shouldn't shy away from complexity, but instead engage with it and ask those 'difficult questions.

Our Learning, one year on.

From 2025…

Our learning to enable better sustainability

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Persistence of Incidents

- Despite improvements, some issues still occur.
- This is a story of continuous improvement and current efforts include refining **debrief practices** and strengthening **safety plans.**

Organisational Impact and Spread

- Over the 12-month period, we had staff sickness that had an impact on delivering some of changes ideas.
- This disruption reinforced the value of the changes, as their absence was noticeable.
- We needed to highlight this as a concern and risk to patient safety.

Replicating this project

Replicating the methodology

Step by step guide- Identifying your aim

1. Identify your ward areas.
2. Identify some hypotheses as to why you might think incidences are highest. For example, do we have more incidences on a weekend? At handover?
3. Generate some data on incidences: Times, days, environment… You might need to dig into your incident data for this
4. Use your data and your hypotheses to ask questions of your data. Is it at handover where there are most incidences? Are there any surprising findings?
5. Identify where there is greatest opportunity to improve. *This will become your aim.*

Step by step guide- Identifying what works well

1. Use that **same** data and be curious: Are there any days of the week where you have fewer incidences? Any environments? Times of the day?
2. Use your findings to explore these as themes: For example, if there is a specific time of day where there are fewer incidences why might that be?
3. Write this down. *This is what you're going to do more of*.

Step by step guide-Generating change ideas

- **Involve patients** if you can – What is their opinion?

- For example, are incidences always lowest at times of the day where there are structured activities taking place?

- When you've identified what's working well, these will be your **constraints.**

Constraints

Constraints are all the things that all change ideas must adhere!

It can force us to be creative.

For example:

All change ideas must be:

1. Free (because there isn't a budget).
2. Non-restrictive.
3. Facilitated.

Working with the Health Innovation East Midlands Patient Safety team

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Thank you

Any questions or reflections

Evaluation

Community of Practices we support…

Six East Midlands Mental Health trusts, staff, clinicians and people with lived experience

Preventing Suicide and Self-harm

Reducing Restrictive Practice

Improving Sexual Safety

Join us!

Please provide details on the session evaluation form or email **richard.drakes@nottingham.ac.uk**

Please provide your details in the session evaluation

Thank you for attending this session

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