SELF ASSESSMENT

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Why Self Assessment?

Self assessment contributes to continuous improvement by providing a structured opportunity to assess performance and identify improvements. Self assessment helps to answer the question *"How well are we doing?"* as well as other questions that follow on from it: *"How do we know?"* and *"How can we do better?"*. Self assessment allows each mental health service to examine its everyday activities and assess them against the Best Practice Guidance. It facilitates an examination of where the service has been, where it is now, and where it will need to go next. The process also allows teams and services to realise what they do well and the areas they need to improve upon. It also helps in terms of ownership of the process and its outcomes, thereby strengthening accountability and responsibility for acting on the findings.

Preparation for Self Assessment

In order to comprehensively self assess a service, a self assessment team must be established by the management team. The membership of the self assessment team should reflect the multidisciplinary members providing integrated care within the service. Membership should be reflective of staff knowledge and experience, not necessarily the position they hold within the team/organisation.

Multi-disciplinary self assessment teams may include front line direct and indirect care/service providers and professionals, organisation leaders, management, service users, family and carers, community partners, volunteers etc. Direct and indirect care/services may include such areas as healthcare assistant staff, nursing, psychiatry, psychology, pharmacy, dietician, pastoral care, speech/ language therapy, social work, occupational therapy, household, catering, security and administration.

Self Assessment Teams

Assessing against the Best Practice Guidance provides an opportunity for mental health services to get a shared understanding of the quality of care being provided within their services and in particular, those areas that need greater focus and action. This can be achieved by assessing the indicators as a multidisciplinary team. This team based approach supports the generation of discussion around the quality of service being delivered as well as the capacity and capability within the service to support the delivery.

Identifying a designated lead within the self assessment team is an essential step, as this person will be the overall named lead person for both the coordination of the assessment process and arranging the collation of the services assessment information. The designated lead should be a senior staff member who has strong leadership and coordinating skills and have an understanding of the quality assessment and improvement process. The lead will engage with all relevant staff, ensuring broad participation throughout the process. The lead person will also be the key link between their service, the management team (through the agreed internal channels identified) and the National Mental Health QSUS team.

Membership of the team is dependant on the size of the service, but it is advisable to have between 6-8 members per self assessment team. The team should consist of:

- One Consultant Psychiatrist
- One Service User or Carer or Family Member
- One Senior Nurse Manager
- Two to four Health & Social Care Professionals – depending on the service
- One Site Manager (CNM 2 / CNM 3 / Team Coordinator)
- One Management / Administration staff member.

How to Self-Assess?

The self assessment process is carried out by the self assessment teams over an average period of 9 – 10 months. During this period the team meet on a regular basis. Frequency of team meetings may vary from once a week (for one to two hours), to teams meeting for half a day once a month.

Whatever structure is employed it is necessary for a self assessment team to follow some key steps in the process. These areas are outlined here and discussed further below.

1. Knowledge of the self assessment process and their own role
2. Discussion
3. Planning the schedule of self assessment
4. Gathering evidence / triangulation of multiple sources of evidence
5. Completing the Guidance Assessment Improvement Tool – GAIT
6. Onsite documentation to support self assessment
7. Level of Achievement and Risk Rating.
8. Developing and monitoring Quality Improvement Plans (QIP) / Corrective and Preventative Action Plans (CAPA's).

1. Knowledge

Before beginning self assessment, each team member should have a good understanding and knowledge of their own role, and the aims and objectives of the self assessment process. The Quality Service User Safety (QSUS) team will provide specific education sessions for nominated Quality Champions / Trained Trainers, in each of the CHO areas. The Quality Champions / Trained Trainers will provide training and mentoring to the self assessment teams within their area. Individual self assessment team members should read all the Guidance and the checklists and be familiar with their contents. This will enable team members to get a clear understanding of what each area covers. The indicators and features will assist in explaining each aim.

2. Discussion

The main points that will need to be discussed and agreed during the initial self assessment team meeting include:

- Assigning a designated lead for each self assessment team.
- Agreeing the membership of the self assessment team (a record of attendance should be kept by each Lead).
- Agreeing a schedule and the timelines for a completed assessment.
- Setting the dates, times and venues for the meetings.
- Agreeing who will facilitate each meeting and input information into the Guidance Assessment Improvement Tool (GAIT) during the meetings.
- Agreeing where the documentation identified by the self assessment teams during their assessment will be stored within the GAIT system, to enable easy uploading and retrieval on GAIT.

After the initial self assessment team meeting further meetings are facilitated by the lead and these are used to review the evidence and complete the GAIT.

3. Planning the schedule of Self Assessment

In view of the size of the task in assessing against 61 indicators it is proposed that each service sets out a realistic plan to undertake and complete the assessment against the Guidance. The following table provides a summary of the number of Themes, Aims and Indicators associated with the HSE Best Practice Guidance for mental health services.

	Theme	No of Aims	No of Indicators
Theme1	Recovery Oriented Care and Support	8	17
Theme 2	Effective Care and Support	7	18
Theme 3	Safe Care and Support	5	8
Theme 4	Leadership, Governance and Management	6	10
Theme 5	Workforce	4	8
Total		30	61 Indicators

Table 1: Number of Themes, Aims & Indicators.

Overview of Assessment Process

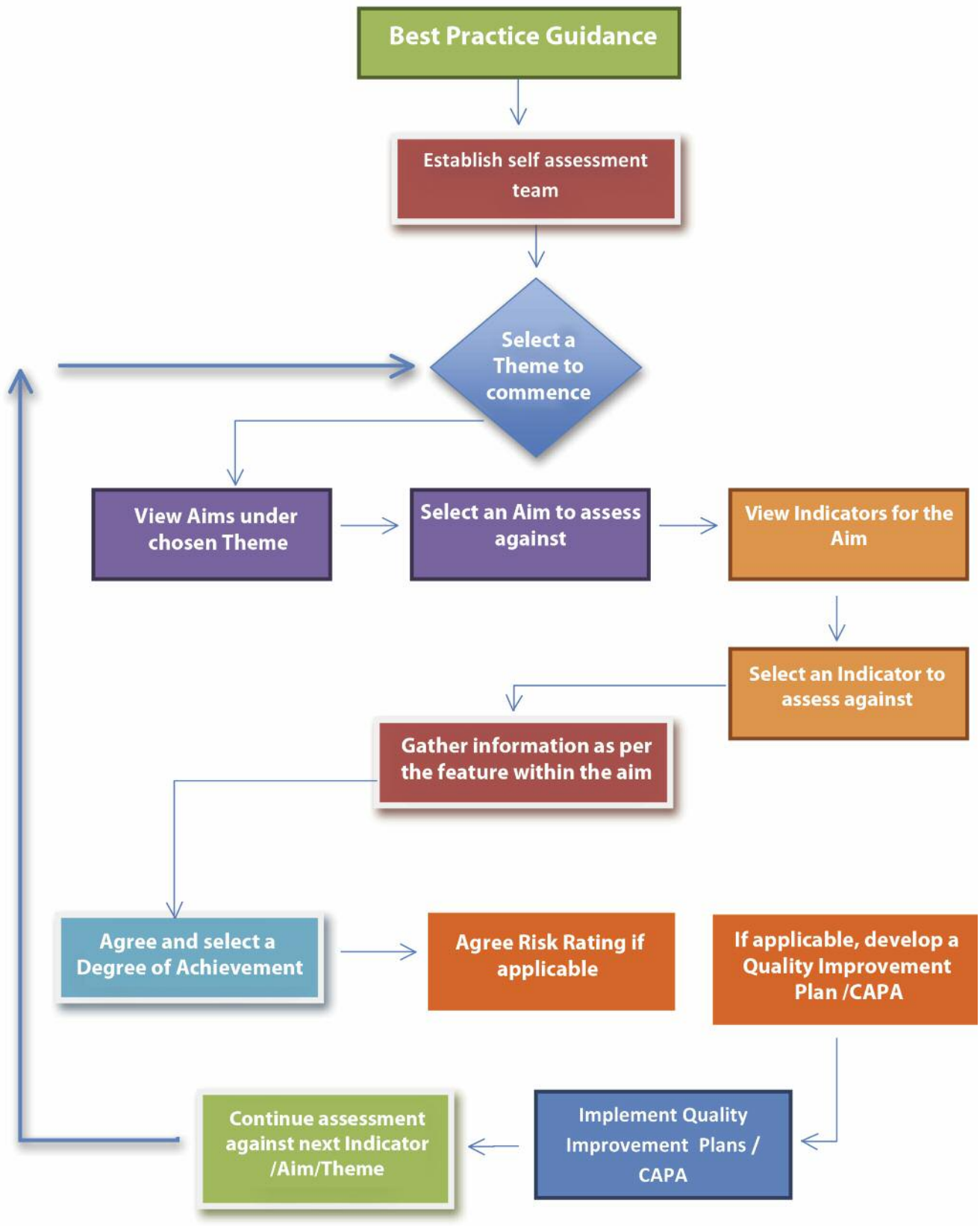
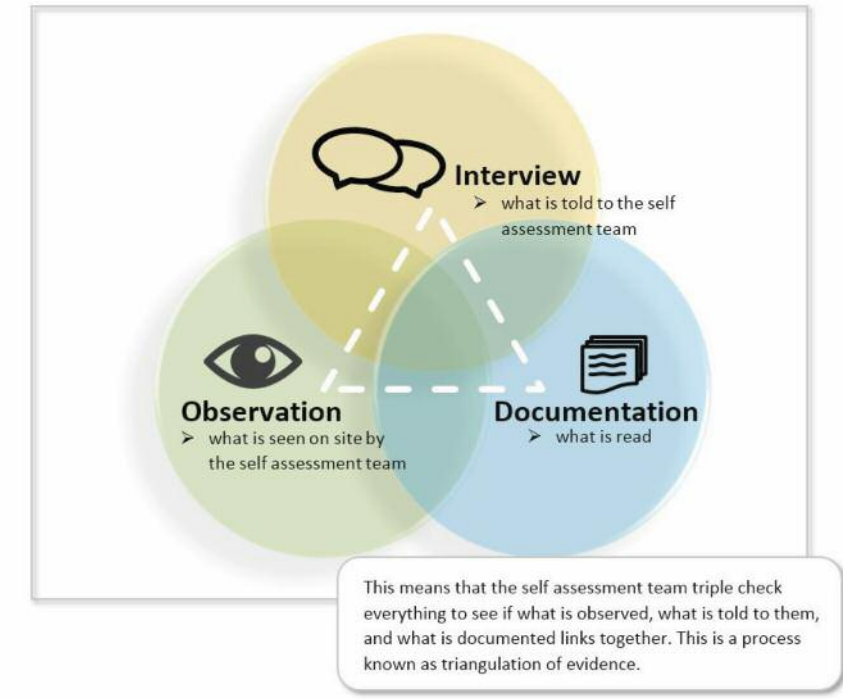


Figure 5: Overview of Assessment Process

4. Gathering evidence / triangulation of multiple sources of evidence

In conducting the self assessment, the team will make a determination of it's achievement with each of the indicators. In making a judgment on their level of achievement, the self assessment team will gather and analyse many sources of information to determine whether this judgement is supported by up to three separate sources of information, this process is known as triangulation. Sources of information can be a combination of available documentation, interviews and/or direct observation undertaken by the self assessment team. The key strengths in using triangulation are that multiple sources of information often give more information regarding the level of achievement.

On occasions where there is insufficient information available, a request for further information or clarification can be made to other members of the wider team or relevant service manager. Once it has been determined that there is enough information, the self assessment team agree the level of achievement.



5. Completing the Guidance Assessment Improvement Tool – GAIT

To aid the introduction of the Best Practice Guidance, an information technology software framework has been developed by the QSUS office and the ICT projects office, to facilitate service self assessment. It is a web-enabled tool allowing each self–assessment team to record a rating against each indicator. The tool also supports the development and implementation of quality improvement plans and actions to address gaps identified during the assessment process. Each self assessment team records, maintains and monitors progress on the GAIT tool. This will help support regulatory compliance and the Mental Health Commission inspection process.

The tool will reflect the complete contents of the Best Practice Guidance along with all the accompanying checklists. It will enable discussion through management team meetings of each team's/service's level of completion and achievement, areas of good practice and opportunities for improvement. This will also support adhering to regulatory compliance and facilitate the Mental Health Inspection process.

6. Onsite documentation to support Self Assessment

Both during and upon completion of the self assessment process, each team will have access to the GAIT tool. This will enable teams to upload documentary evidence and to easily retrieve their evidence to support their level of achievement against the Guidance.

7. Level of Achievement and Risk Rating

The final stage of the self assessment process is the rating of the team's level of achievement and where applicable, the level of risk related to the indicator.

Rating Scale

The rating of an individual indicator is designed to assist self assessment teams and the service in general, to prioritise areas for improvement. To rate the degree of achievement against an indicator, the team must first ask itself what would constitute a 100% achievement of the indicator, i.e. what structures, processes and outcomes would have to exist for full achievement. The team must then determine what level of achievement they adhere to. The rating for the indicator can be determined based on the impact and the level of action that is required.

The self assessment team chooses a rating:

- Fully Achieved - **Green**
- Partially Achieved - **Yellow**
- Partially Achieved - **Amber**
- Not Achieved - **Red**

Assessment Rating Criteria:

Fully Achieved: Green • The assessment demonstrates that the indicator is fully met.
Partially Achieved: Yellow • The assessment demonstrates that some or most features of the indicator are met. • The impact on people who use services, visitors or staff is low. • The action required is minimal.
Partially Achieved: Amber • The assessment demonstrates some or little of the indicator is met. • The impact on people who use services, visitors or staff is medium. • The action required is moderate.
Not Achieved: Red • The assessment demonstrates that some or all of the indicator is not met. • The impact on people who use services, visitors or staff is high. • The action required is immediate.

Figure 6: Assessment Rating Criteria

Risk Assessment

Risk should be managed as an integrated part of the HSE's overall approach to quality improvement. The risk management process intertwines with the quality cycle in terms of risk assessment. Key to both quality improvement and risk management processes, are the identification of risks, agreeing improvement programmes to treat risks and on going monitoring and evaluation to manage the risks. Where a self assessment team has identified a level of achievement at **red**, it must consider the possibility of related risks with regard to the service user, staff or the service.

Where a self assessment team has identified a level of achievement at **amber**, the team may consider the possibility of related risks. To help identify these risks and prioritise those that are identified, the self assessment team carries out a risk rating.

Stage One involves making a determination of the impact of the event based on the failure to meet the indicator/s. To determine the impact of this harm should it occur, each risk area has been assigned descriptors over 5 levels ranging from negligible to extreme harm. In scoring impact, the anticipated outcome of the risk is grade from 1-5, with 5 indicating a more serious Impact.

The only area for self assessment teams to consider in relation to these risks within the risk impact table below is 'Compliance with Standards, statutory, clinical, professional and management).

	Negligible	Minor	Moderate	Major	Extreme
Injury	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning	Minor injury or illness, first aid treatment required <3 days absence < 3 days extended hospital stay Impaired psychosocial functioning greater than 3 days less than one month	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency reportable, e.g. HSA, Gardaí (violent and aggressive acts). >3 Days absence 3-8 Days extended hospital Stay Impaired psychosocial functioning greater than one month less than six months	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Impaired psychosocial functioning greater than six months	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or member of the public Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being to talked to & treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week)	Unsatisfactory service user experience related to poor treatment resulting in long term effects	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision
Compliance with Standards (Statutory, Clinical, Professional & Management)	Minor non compliance with internal standards. Small number of minor issues requiring improvement	Single failure to meet internal standards or follow protocol. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / Regulations (e.g. Mental Health, Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objectives/Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over – run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity	Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service.	Short term disruption to service with minor impact on service user care.	Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect
Adverse publicity/ Reputation	Rumours, no media coverage. No public concerns voiced. Little effect on employees morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on employees morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on employees morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken possible HSE review/investigation	National/International media/ adverse publicity, > than 3 days. Editorial follows days of news stories & features in National papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Minister forced to comment or intervene. Questions in the Dail. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.
Financial Loss (per local Contact)	<€1k	€1k – €10k	€10k – €100k	€100k – €1m	>€1m
Environment	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

Figure 7: HSE Risk Impact Table.

Stage Two of this process is to determine the likelihood of an event arising based on the failure to meet the indicator/s. The higher the likelihood score, the more urgent is the requirement for immediate action to be taken.

Rare/Remote (1)		Unlikely (2)		Possible (3)		Likely (4)		Almost Certain (5)	
Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At least monthly	99%

Figure 8: HSE Risk Likelihood Table.

Stage Three involves plotting both the likelihood and impact scores on the Risk Matrix grid and to determine the rating of the risk being assessed in terms of a colour and a numerical score for the risk (e.g. a moderate impact 3 and a possible likelihood 3 will result in a rating of an amber 9).

- The high risks are scored between 15 and 25 and are coloured **Red**.
- Medium risk are scored between 6 and 12 and are coloured **Amber**.
- Low risks are scored between 1 and 5 and are coloured **Green**.

	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Figure 9: HSE Risk Impact and Likelihood Table.

Stage Four requires the self assessment team to make decisions based on the outcome of the risk analysis regarding which risks require treatment and the priorities of that treatment. Depending on the risk rating and the adequacy of the current controls in place an evaluation is made whether to:

- accept the risk (A risk is called acceptable if it is not going to be treated) or
- treat the risk by: *i) Avoiding the risk,*

  ii) Transferring the risk or

  iii) Controlling the risk.

Criteria used to make decisions regarding accepting or treating the risk, should be consistent with the defined internal, external and risk management contexts and taking account of the service objectives and goals. The treatment of risks through a structured quality improvement process is a very powerful mechanism and one which is capable of targeting the quality programmes to areas of need in a prioritised way.

The self assessment team must enter the risk rating only into the GAIT.

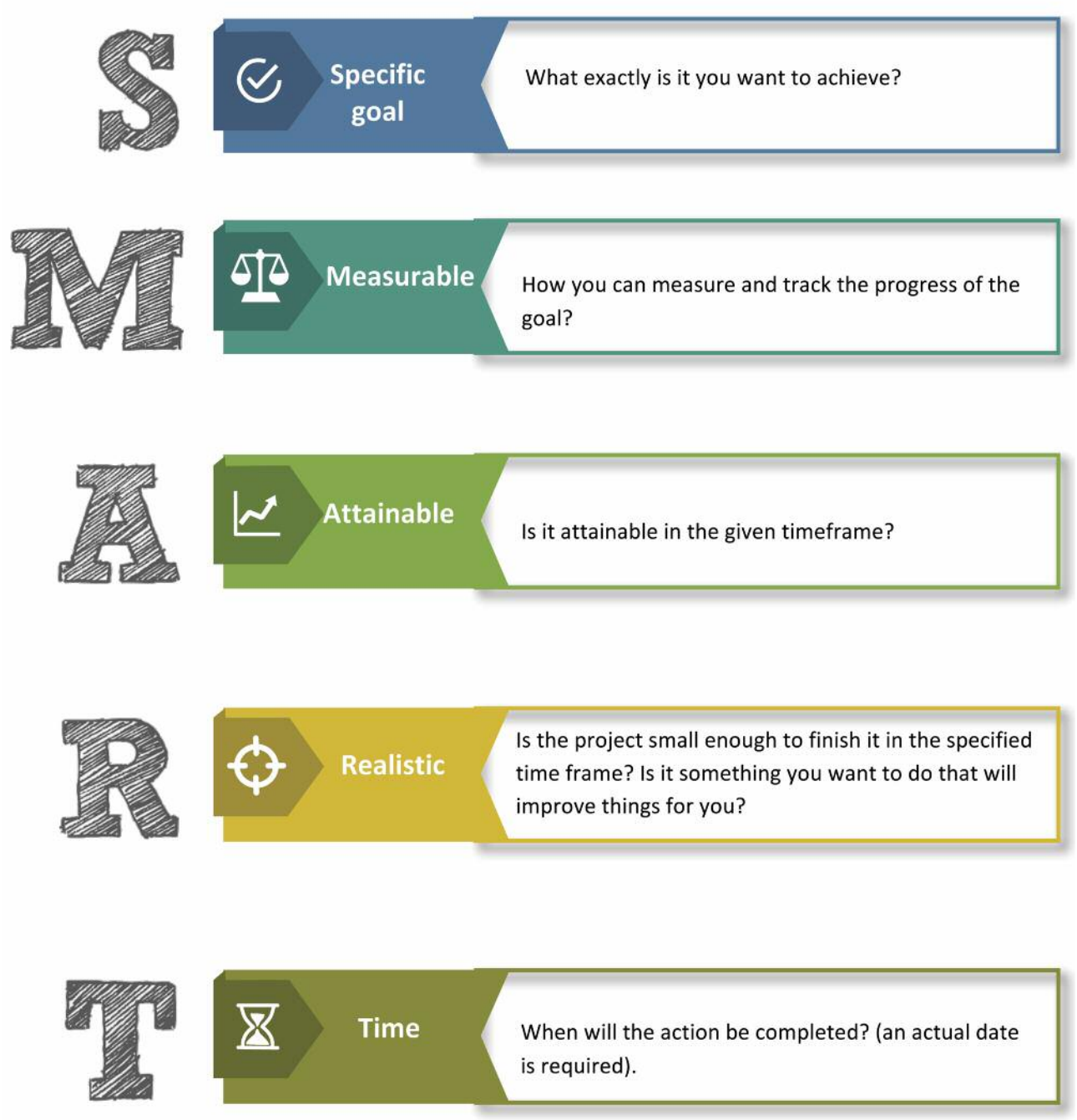
8. Developing and monitoring Quality Improvement Plans / CAPAs

For service areas that have been identified as requiring improvement, it will be necessary for the self assessment team to develop a Quality Improvement Plan (QIP) / CAPA for the key areas that require improvement (as determined by the team) The QIP / CAPA document informs everyone in the service as to the direction, timeline, activities required and outcomes expected in addressing the quality deficit.

The steps involved in developing a QIP / CAPA action plan include:

- Firstly identifying areas for improvement in response to the self assessment
- Devising responsive action plans (Using the SMART methodology described below).
- Appointing a person to manage and monitor progress and follow-up on issues
- Setting a review date for evaluation/completion of the plan
- Recording and maintaining plans and responses monitored on the GAIT tool.
- Escalating outstanding QIPs to the management teams – detailing their level of completion.

In developing a quality improvement plan, the following SMART methodology should be considered.



A named person is identified with responsibility for the completion of each action.

Figure 10: SMART Methodology.

The Quality Cycle – developed by W. Edwards Deming in the 1950's

Tools such as the 'Plan, Do, Check, Act (PDCA)' cycle can be a useful resource in determining and implementing required actions from Quality Improvement Plans.

The Plan Do Check Act (PDCA) cycle or quality cycle is an important improvement model based on four stages which ensure a structured approach to the improvement of quality. The PDCA cycle can be used for every quality activity/initiative/ project that is undertaken to help ensure that the best possible results are achieved. The underlying principle of the cycle is that an activity is not complete until evaluation shows that it has been effective. Following in the spirit of continuous quality improvement, the process utilises this evaluation for even greater improvement.

Figure 11: Quality Cycle - PDCA