Positively Different

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

Learning Lessons Quarterly Bulletin

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Focus on Reducing Incidents of Absconding

Welcome to South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Learning Lessons bulletin.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses, and know that if this is done effectively it can help to minimise future risk and strengthen the quality of the services we provide.

The Trust is committed to quality improvement, and will continue its strong focus on delivering high quality, safe and effective services. This new quarterly bulletin is an important component of a number of key approaches embraced by the Trust to drive forward the quality agenda.

The ultimate aim of evaluating our services and learning lessons is to improve outcomes for service users. This bulletin is intended to support this aim by communicating and strengthening local and national lessons to be learnt from both positive practice and areas for improvement.

In this issue we have focused on reducing incidents of absconding which remain a high risk for services.

We hope that you find this bulletin informative and useful and welcome your ideas and input into future issues.

ABSCONDING STATISTICS

- 250,000 people are reported missing in the UK each year (The Home Office, 2010: 5).
- *Lost from View* found that in a sample of reported missing adults, 16% went missing unintentionally, the vast majority of unintentional absences concerned elderly people who were suffering from dementia with these cases accounting for 10% of the total sample (Biehal et al, 2003: 25).
- A 1998 longitudinal study of more than 100 older people with dementia found that more than 40% went missing at some point during the study (McShane et al, 1998).
- The average 20 bed psychiatric ward, working at full capacity, has about 120 absconds every year (Bowers, 1999).
- Patients who abscond from hospitals or psychiatric wards are at risk of harming both themselves and others. One study showed that 4% of absconders harmed themselves or others whilst away (Bowers et al, 1999); another found that 27% of inpatient suicides take place off the ward (Manchester University, 2006).
- It has been suggested that one of the possible motivations for absconding may be not running away from a hospital so much as running toward a significant family member (Bowers, 1998).

Learning Lessons Features

Thematic Review of Absconding Incidents 2012/13

In 2013 Quality Governance Committee received a review of incidents of absconding across the organisation. This page summarises the findings of that review

Key Findings:

◊ 149 incidents 6% resulted in self harm and in death. The 9 individual service users involved in those incidents were all identified as being at risk of self harm. Of 119 incidents were there was no specified outcome ie no reported harm, 80% were identified as being "at risk of self harm".

◊ 13% of incidents service users were returned to the ward under the influence of drugs or alcohol (90% alcohol). The 20 incidents involved 13 service users with 4 of the service users absconding on more than one occasion. All service users had been identified as being at risk of substance misuse.

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◊ 32% of reported incidents of absconding were identified as being via the ward garden fence. This is an area of high risk given that it is not known how many of the incidents where the method was not stated were also via the fence. In only 1 incident was the service user on 1:1 observations when scaling the fence in all of the other reported incidents the service users were not on observations whilst in the garden

◊ 43% of female service users compared to 27% of male service users absconded on more than one occasion.

◊ 76% of absconding incidents occurred from the Acute Wards on the main sites of the Trust.

◊ 80% of incident reports did not cite a reason for leaving. Of the 29 incident reports which did cite a reason, 48% were following contact with family.

◊ 20% of the incidents occurred following a case review

"The incident details are uploaded to outside agencies such as the NPSA and CQC. That's why there should be no person identifiable information".

Risk Management Team

Learning Lessons Features

Strategies to Reduce Missing Patients: A Practical Workbook

In 2009 the Mental Health Development Unit released a workbook for staff on mental health units to support them in managing incidents of absconding. This workbook was the result of research carried out by Len Bowers and is therefore supported by a strong evidence base. This section highlights the key features of the workbook.

Strategy One—Understanding the Problem

When a patient goes missing, this should be recorded as a clinical incident. By seeking out this information and analysing it, we can learn lessons about who might leave, how they leave, where they go to, the reasons they leave and when this occurs. From the analysis, we can then look to develop preventative measures to help reduce missing patients incidents.

Strategy Two - Developing entry and exit policies

Patients are admitted to adult acute inpatient units for a variety of different reasons. The function of an inpatient unit is to provide care in the least restrictive environment. The needs of the individual may range from 1:1 on a PICU to minimal observations on acute wards. It is for this reason that entrance/exit policies need to be flexible to the needs of all patients whilst acknowledging varying degrees of individual risk.

An entrance and exit policy allows staff to monitor the flow of patients in and out of the ward or mental health unit. Just as importantly, it also allows staff the opportunity to engage, assess and, if necessary, intervene with patients. (Rae, 2007)

Strategy Three—Providing meaningful engagement

'Meaningful engagement' covers the broad spectrum of assessment, planning, implementation and evaluation of care, through the use of 1:1 contact with the patient. This should be achieved collaboratively and needs to be meaningful to both the member of staff and the service user. The 1:1's should continue throughout the patient's admission.

Strategy Four—Structuring the day

Bowers et al (1999) reported that patients often leave mental health units because they feel trapped and claustrophobic, or disinterested and bored whilst on our wards.

A structured day provides patients with the opportunity to engage in meaningful and therapeutic activity. Examples of these include recovery groups, self esteem groups, and community meetings. We can also reduce ward disturbances, and the tendency for violence by adequately structuring and resourcing our wards to enable diversional, recreational, and social activities to take place.

Strategy Five—Engaging stakeholders

If initial assessment and interventions have failed, and the patient goes missing from the mental health unit or fails to return from leave, effective locally agreed processes need to be in place to ensure the safe return of the patient. This will be based on a shared understanding with key stakeholders such as the police of each other's roles and responsibilities. Therefore, it is good practice to have a policy for missing patients which includes a locally agreed integrated protocol of what can and cannot be done, in relation to locating and returning those patients back to the ward.

Recommendations From Absconding Serious Incident Investigations

Environmental:

1. Attention to be paid to the review and/or fixing of the fence panels attached to the open area of the ward in addition to the potential use of furniture that can be used as a ladder in addition to steel locks that have clearly been used to move over rather than under the fence.
2. Removal of garden furniture away from the fence
3. Consideration of the introduction of inhibitor factors e.g. planting of prickly bushes, anti-climb paint.
4. When "Locked door" policy is implemented this should include the locking of access to the garden.

Clinical:

5. Review and re-training in level observation policy and procedure on the part of all ward based staff
6. Routine checks on all patients whereabouts are to continue and a particular check is to be made prior to handovers.
7. Routine check on all in-patients inclusive of their location at regular intervals throughout the shift which can then be fed into the staff handover.
8. Much clearer and also regular application of therapeutic activity from 9.00am until 7.00pm from which the health well-being and location of all of the in-patients can be checked pre any hand over period.
9. Monitor the use of the locked door policy to ensure that doors are only locked for a necessary period in line with providing care within the least restrictive environment.
10. Ensure clinicians review changes in risk factors and subsequently update the risk management plan.
11. As per policy physical care on return should be assessed

12. Staff within crisis team and ward to engage in ensuring robust process of admission including plan in

Learning Lessons—High Risk Indicators for Absconding

It is positive that, despite the numbers of incidents of absconding there has been a very low occurrence of harm as a result. It is of note that a number of factors are identifiable as increasing risk of absconding namely:

1. **History of absconding**
   Service users who have a history of absconding are more likely to abscond again

2. **Family issues**
   Many service users abscond to address family issues which they do not feel they can manage while in hospital

3. **Care review**
   A number of service users have been known to abscond following a case review or 1:1 session.

4. **Substance misuse**
   A frequent occurrence when a service user absconds is that they access substances whilst out. Most usually this is alcohol

These issues are integral to effective risk management. They also indicate that, whilst environmental issues play a key part in the management of the risk of absconding, these issues need to be addressed in combination with clinical management of the service users particularly in relation to their emotional and social issues at the same time considering the freedom of all of the service users on the ward.

National Resources

Patient Safety First is a national campaign and is sponsored by the National Patient Safety Agency and the NHS Institute for Innovation & Improvement. The campaign aims to make safety of patients everyone's highest priority with no unavoidable deaths and no unavoidable harm . The Campaign website contains a range of simple, yet effective ideas for improving patient safety within organisations. The link to the Patient Safety First Campaign website is: http://www.patientsafetyfirst.nhs.uk

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Central Alerting System

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. Risk management distribute relevant alerts to directorate risk co-ordinators for cascading. Further information about alerts can be found at: https://www.cas.dh.gov.uk/Home.aspx

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On 10th December 2012 the Department of Health issued "Preventing Suicide– A Cross-Government Outcomes Strategy to Save Lives. The strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families. The strategy identifies measures to support families – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

Further information can be found at the following link: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

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Strategies to Reduce Missing Patients: A Practical Workbook

This workbook is for health professionals to work through in order to develop and implement strategies to reduce incidents of absconding from inpatient units. Further details about this guidance can be seen at the following link http://www.nmhdu.org.uk/silo/files/a-strategy-to-reduce-missing-patients--a-practical-workbook.pdf

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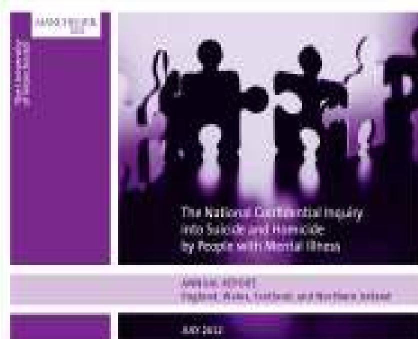

In July 2012 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness released its 2012 report. The report covers deaths by suicide for the period January 2000 to December 2010, people convicted of homicide (homicide convictions) between January 2000 and December 2010 and sudden unexplained deaths (SUD) in psychiatric in-patients for this period. . The link to the report on the University of Manchester website is: http://www.medicine.manchester.ac.uk/cmhr centreforsuicideprevention/nci/reports/annual_report_2012.pdf

This Bulletin is available on the Trust website at :

http://www.southstaffsandshropshealthcareft.nhs.uk/Default.aspx

Or alternatively

A hard copy can be obtained by contacting the Trust Risk Management Department on 07850 257888 ext 5953

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- We welcome your feedback on this Learning Lessons Bulletin to help us to ensure that future editions are helpful and informative

- We would also welcome your ideas for future features or areas of learning you feel are relevant to be cascaded across the Trust

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