

Learning Lessons Quarterly Bulletin

Newsletter Date July 2015

Focus on Reducing Incidents of Absconding

Inside This Issues

Welcome Cover

Statistics Cover

Features:

Further actions to be taken 2

Strategies to Reduce Missing Patients: A Practical Workbook 3

Learning Lessons Features 4

National Updates 5

Risk Management Team 6

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 updated the bulletin issued in June 2013 which focused on reducing incidents of absconding. It includes a number of actions which the Mental Health Division have committed to implementing in order to reduce

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



Further actions agreed to be undertaken:

AWOL Proforma

A proforma has been developed for staff to complete as soon as it is identified that a service user has absconded from Trust property. This proforma has been developed in conjunction with the police authorities and support multi-agency decision making about risk level and ensuing response. The proforma has been piloted in Staffordshire and is now ready for roll out across the Trust.

- ◆ All staff to complete the AWOL proforma at the point it has been identified that a service user has absconded from an inpatient ward.
- ◆ Proforma to be scanned and stored on Rio in the “Inpatient Management” folder.
- ◆ An entry to be made on Rio “AWOL today—see notes in Inpatient Management Folder”
- ◆ Rio team have been asked to develop a form on Rio as a longer term strategy.

Physical Environment

- ◆ A new higher fence is being built on the Redwoods site. And a review of fencing to be undertaken on both sites
- ◆ PICU / HDU bed to be explored as part of the acute care workstream

Ward Reviews

Absconding also regularly take place post ward round and case review and following family time (this relates to improving relational security.)

- ◆ Doctors should consider if bad news is likely to be delivered to the service user then a nurse should join the review.
- ◆ If there is no nurse in the review and during the review, it becomes apparent there is going to be an issue, then the doctor must come out of the meeting and ask a nurse to join the meeting.
- ◆ The review time should be entered on the PSAG board on the wards
- ◆ Engagement policy to be instigated rather than observations policy after bad news.
- ◆ Following an incident of absconding, there should always be a debrief and explore any triggers and this be used to inform the risk management plan.

Relational Security

- ◆ SafeWards being considered for introduction on all wards against a phased plan
- ◆ MOCA training – to be rolled out to all wards

Corporate Actions:

- ◆ AWOL policy to be reviewed
- ◆ SOPS for searching to be developed



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.

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.

2013/14 Absconding Thematic 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 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.
- ◇ 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.
- ◇ 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.

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>

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>

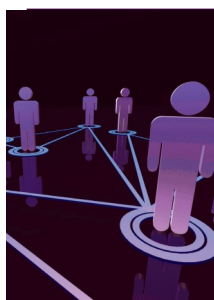
Preventing suicide in England

A cross government outcomes strategy to save lives

HM Government

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>



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.nmhd.u.org.uk/silo/files/a-strategy-to-reduce-missing-patients--a-practical-workbook.pdf>



Safewards

Safe wards—<http://www.safewards.net/>



MOCA - Model of Creative Ability—<http://www.vdtmocaf-uk.com/>



Your Risk Management Team:

Liz Lockett
Associate Director Quality & Risk
liz.lockett@sssft.nhs.uk

Sarah Hankey
Risk & Claims Manager
sarah.hankey@sssft.nhs.uk

Giles Perry
Local Security Management Specialist
Giles.perry@sssft.nhs.uk

Jenny Ball
Serious Incident Review Co-coordinator
jenny.ball@sssft.nhs.uk

Alison Turner
Risk Management Officer
alison.turner@sssft.nhs.uk

Nicholas Hulme
Quality & Risk Information Analyst
nicholas.hulme@sssft.nhs.uk

Sheila Kavanagh
Team Secretary
sheila.kavanagh@sssft.nhs.uk



This Bulletin is available on the Trust website at :

[http://
www.southstaffsandshropshealthcareft.
nhs.uk/Default.aspx](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

- 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

For all enquiries and comments please Contact:

Sarah Hankey (Risk & Claims Manager)
Sarah.hankey@sssft.nhs.uk
Or for confidential inquiries please contact:
Risk.management2@nhs.net