South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Learning Lessons Quarterly Bulletin

Issue 2
December 2011

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Welcome

Welcome to this festive addition of 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.

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

Liz Lockett

Associate Director Quality & Risk

NHSLA Risk Management Standards Level 1 Achievement

On 21st November 2011 the Trust was assessed against the NHSLA Risk Management Standards for NHS Trusts Providing Mental Health and Learning Disability Services 2011/12. The organisation was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The Trust has now received confirmation of success at level 1 achieving the maximum compliance score of 50 with the report soon to be available on the NHSLA website at: http://www.nhsla.com/Publications/

The Trust have already set a provisional date for assessment against the level 2 standards for September 2012 and full details of the evidence required to support this assessment have been uploaded onto the Trust Performance Plus system. For any questions regarding NHSLA please contact:

Sarah Hankey (Quality & Risk Officer) on 01785 257888 ext 5548

Safeguarding Large Scale Investigation (LSI) Stonefield House, St George's Hospital

The LSI process commenced in 2009 following allegations from staff related to the way the staff team worked, poor communication and cooperation, and the impact on the care of service users. The LSI process continued following receipt of an anonymous letter by the Health Service Ombudsman. These issues were investigated as a Serious Incident (SI) and the process was concluded in April 2011.

The contributory factors identified within the investigation included

- Lack of a team ethos,
- Powerful personalities,
- Staff feeling disempowered, and
- Poor practice
- Dynamics between service users with a range of complex challenging needs and an increase in incident reporting

The root cause was felt to be staff attitude and behaviour, and poor practice on behalf of some staff resulting in disciplinary action, with subsequent reports sent to the NMC and GMC, and Independent Safeguarding Authority. The Trust and interagency reporting systems were robust and ensured that internal and external scrutiny was achieved. The Care Quality Commission were also engaged in the process.

The lessons learnt from engaging in the LSI process included:

- The need to develop a team ethos, engage expertise within the trust to improve performance, and review services. This has been achieved through regular team away days facilitated by the Human Resources Dept. Team aims have been developed and the introduction of the productive ward initiative has helped to improve communication and cooperation amongst the team.
- Staff are encouraged to raise issues with senior members of staff and develop an open culture of reporting safeguarding concerns. Regular monitoring of mandatory training for MAPA and safeguarding is required
- Unannounced visits have assisted in gaining snapshots of working practices by senior managers, departmental staff within the Trust, Non Executive and Executive Directors, and Membership Council representatives
- Individual clinical reviews for service users to inform care planning, linked to number of incidents reported and trends analysis have helped to identify triggers and respond in a proactive rather than reactive way eg self injurious behaviour, incidents of aggression. There is a need to assess service users prior to admission regarding potential dynamics with other service users. There is an effective system of incident reporting within the Trust
- The standard of record keeping and risk assessment needed to improve with a recommendation to develop standards for care plans across the Trust. To include the benefits of section 17 leave related to the care plan. A group has been set up with Trust wide representation to address this and ensure consistency of standards. Action plans following audit need to be acted upon
- Having a critical mass of staff and monitoring of use of bank and agency staff. Action has included developing long term placements at Stonefield House to provide continuity. Regular reporting through Trust NHSP group was already in place within the Trust
- Interagency safeguarding policy body maps are to be utilised within the individual health record with a new body map completed for each incident if required.
- Post incident debriefing to be encouraged and recorded for staff and service users
- Trust policies to be updated in a timely way eg MAPA

Importance of maintaining partnerships with other agencies in working through investigations eg local social services depts., Joint Commissioners, PCT's, and safeguarding leads

If you would like further discussion regarding the lessons learnt please contact:

Caron Thomas, Clinical Director, or
Penny Pritchard, Acting Service Director on 01785 257888 ext 5013 or 5479

Independent Investigation—Norfolk & Waveney Mental Health Trust

In August 2011 the NHS East of England Strategic Health Authority published an independent investigation report of a mental health service user homicide case in Norfolk.

The investigation reports on the care and treatment provided in the case that occurred in 2006 whilst the service user was under the care of Norfolk and Waveney Mental Health Trust. The full Independent investigation report and its recommendations can be found at the following link. Extracts from the executive summary are provided below.
https://www.eoe.nhs.uk/page.php?page_id=2188

Adverse Event Overview
On 24 May2006, the service user was visited by his friend. The friend had gone to his home to undertake some work on his vehicle. The service user had a ramp and car pit that he was able to use. When his friend arrived at the house he went to the workshop at its rear. On entering this, the service user hit him over the head with a heavy object and then decapitated him. The incident shocked the local community not only because of its violent nature but because the service user and the victim were firm friends. Both were active members of the community. At the time of the incident the service user was suffering from a relapse of his mental health disorder.

Main conclusions of the independent review
The death of the victim, and the manner of his death, has deeply affected his family, the local community in which he lived, his friends, the family of the service user, and the service user himself. At the time of the incident the service user had been without medication since 24 April 2006, having previously attended for this on 31 March 2006. Unmedicated his relapse was predictable. That he might harm someone if he remained unmedicated was also predictable. Sixteen years prior to the attack on this victim, the service user had attacked his father who sustained a near fatal injury. He had also, in the same time period, attended at a public house near to his home at the time with the intent to cause harm to a person he knew. These incidents occurred in 1990 the last time the service user had been without medication.

It is the contention of the Independent Investigation Team that there were a number of lost opportunities in the care and management of the service user. Had different actions been taken at these points the death of the victim on 24 May 2006 may not have occurred. The most significant lost opportunities, in the opinion of the Independent Investigation Team were:

- The decision to grant the service user an absolute discharge from the Mental Health Act (1983) in 1997. This meant that the previous condition of medication compliance was removed.
- That the care plan devised for the service user by the forensic service was not continued as intended 'when his care was fully transferred to general adult mental health services from the forensic service in January 2000.
- The absence of a documented risk management and crisis intervention plan.
- The lack of an appropriately assertive plan of action when the community mental health team became aware that the service user was going to remain medication non-compliant (May 2006).
- That the clinical team in May 2006 gave too much weight to the service users wishes and insufficient weight to his past risk history when unmedicated.

Recommendations

- The Trust must ensure that all of its clinical staff engaged in the assessment of and care planning for service users have a comprehensive understanding of "insight"
- All mental health practitioners, including medical staff, must understand the thresholds for assessment under the Mental Health Act and the thresholds for the compulsory detention of an individual under the MHA.
- The Trust must implement a standardised report writing pro-forma for Mental Health Review Tribunals that leads the reporting clinician through a structured and balanced report
- The Trust needs to ensure that the care management and risk management plans contain a sufficient quality of information to minimise the loss of memory over time for long term service users with a significant risk history.
- The Trust must have a robust system for the registration and tracking of all service users on section 117 aftercare regardless of their MHA status
- When Primary Care Services contacts the Trust about a patient currently in receipt of mental health services the Trust must satisfy itself that the operational policies for all in-patient and community services set out what should happen.
- The Trust must satisfy itself its' Mental Health practitioners are complying with all current standards applicable to the involvement of, and support for, families and carers. In addition it is suggested the Trust adds a section to its' website under "Carers" entitled "What can I expect?" The Trust may also consider re labelling current "carer" tab to "Families and Carers" to maximise accessibility of the information.

Best Practice Tips From Serious Untoward Incident Investigations

The Trust promotes an open incident and near miss reporting culture and recognises that to learn from incidents and prevent reoccurrences, it is important that lessons are shared. Each edition of the Trust's Learning Lessons Bulletin includes a series of best practice tips that have been identified through the Trust's investigation into recent serious incidents.

The best practice tips not only focus on areas identified for improvement but also incorporate elements of positive practice that have been highlighted as part of the investigation process.

- **Service user notes should record a full history of risk and significant history of risk should be carried forward into the most recent volume of the records**
- **It is best practice that decisions to discharge service users are agreed with their referrer and that this is documented accordingly**
- **On admission inpatient staff should assess risk of fire setting for those service users who smoke and ensure that use of lighters is supervised where risks are identified**
- **Carers have an important role to play in the assessment and care delivery process. Professionals should endeavor to actively engage carers in the assessment and planning of care and provide them with information about the services being provided**
- **Care plans should be outcome focused and regularly updated to reflect changing needs**
- **It is important that all named nurses sessions are identified as such within the clinical documentation**
- **It is important that all clinical decisions and risk assessments are documented using the agreed documentation**
- **Shared multi-disciplinary decision making processes are important when managing service users who present as high risk**
- **It is important that all relevant information is shared with the inpatient multi-disciplinary team when they are making decisions regarding leave**
- **It is important to consider the increased suicide risk profile of young men and the need to be more flexible regarding communication, engagement and follow up of young men referred to service who appear to be disengaging**

National Updates

On 23rd January 2012 the National Patient Safety Agency and Patient Safety First will be launching a week focused on nutrition and hydration "**A taste of patient safety"**

During the week there will be a series of informative and interactive WebEx sessions hosted by experts in the field. Further details on this event can be found be visiting the Patient Safety First website at:
http://www.patientsafetyfirst.nhs.uk

In December 2011 the first full report of the National Audit of Dementia was released. The report identifies a need for significant improvements in hospital ward environments, staff training and the overall approach to care delivery for patients with dementia. The full report can be downloaded by visiting the Royal College of Psychiatrists website at:
http://www.rcpsych.ac.uk/press/pressreleases2011/nationalauditofdementia.aspx

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Fire services across the region are urging people to take extra precautions to ensure their Christmas does not go up in smoke as most accidental house fires happen during the festive season.
Older people and other vulnerable groups are particularly at risk as are smokers who fail to extinguish cigarettes properly.

Staff are also reminded to check that decorations put up around Trust buildings are away from heaters and that electrical decorations such as tree lights comply to the British Standard (BS EN 60598)

On 10th October 2011 the Department of Health launched its duty of candour consultation document. The document proposes making it a contractual requirement on NHS providers to be open with patients when things go wrong with their healthcare. This forms part of the Government's plans to modernise the NHS by making it more accountable and transparent. The Trust has responded to the consultation following feedback from members of the Quality Effectiveness & Risk Committee, the consultation has however been extended till the end of January 2012. The consultation document can be viewed by visiting the Department of Health website at: http://www.dh.gov.uk/en/index.htm

Your Risk Management Team:

Liz Lockett
Associate Director Quality & Risk
01785 257888 ext 5575

Sarah Hankey
Quality & Risk Officer
01785 257888 ext 5548

Giles Perry
Local Security Management Specialist
01785 257888 ext 5723

John Feast
Local Security Management Specialist
01743492142

John Freer
Health & Safety Advisor
01785 257888 ext 5313

Alison Turner
Risk Management Officer
01785 257888 ext 5454

Sheila Handley
Team Secretary
01785 257888 ext 5953

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 01785 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:

Liz Lockett (Associate Director Quality & Risk)
01785 257888 Ext 5575