Learning paper

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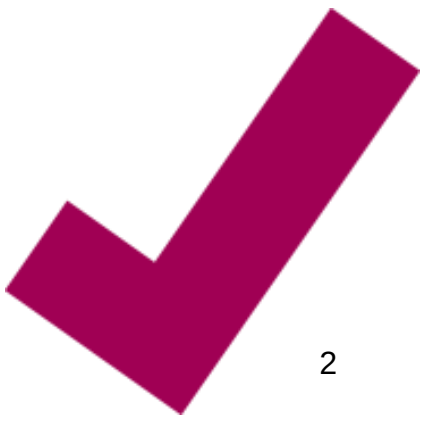

Contents

1 Introduction

This bulletin provides a brief overview of the learning ascertained from a quality assurance review undertaken by Sancus Solutions[1] into a death involving two patients who were, at the time of the incident, being supported by community mental health services.

2 Summary of cases

The two patients had a number of similar and significant risk factors, support needs and challenging mental and physical health issues. These included:

- long-standing histories of treatment-resistant paranoid schizophrenia, polysubstance and alcohol misuse, and non-compliance with their medication regimes
- ongoing resistance/difficulty in engaging with community mental health and substance services
- limited insight into their mental health difficulties and a significant history of disengagement with community mental health services
- numerous detentions under the Mental Health Act 1983
- previous long-stay inpatient admissions
- a history of inadequate housing and periods of homelessness
- a history of poor daily living skills and self-neglect
- vulnerability to exploitation from others, particularly during periods when they were experiencing a deterioration in their mental health
- limited contact with their primary care service.

[1] Sancus Solutions

3 Findings from the Serious Incident Reports

The following is a summary of the issues that were identified in both SIRs:

- deficits in the discharge planning and monitoring by inpatient and community mental health services
- a lack of action taken by the involved community mental health services when the patients failed to attend their scheduled appointments
- deficits in the ongoing care planning
- a lack of dynamic risk assessments and risk management planning
- a lack of involvement and support offered to both families.
- issues in the record-keeping
- deficits in the supervision of the CMHTs' care coordinators
- a lack of communication with other involved services, such as GPs and housing providers.

The Trust provided the investigation team with the most recent High Level Serious Incident Summary Report, which reported - actions are now completed on DATIX.[2] Progress of the action plan will be monitored via the trust's PIR panel and QIP[3] committee … RAG – Green – action plan closed.

The investigation team concluded that both SIRs:

- adequately addressed their respective Terms of Reference
- were comprehensive and well written
- identified where achievable actions were required with regard to practitioners and operational and senior managers as well as Trust's policies and best practice guidelines

[2] Datix is an electronic incident-reporting software/system that is used within Trusts
[3] Quality Improvement Priorities

With regard to cascading the learning from the SIRs, Sancus Solutions concluded:

Although there was an initial delay in convening the learning event [the Trust] was able to provide considerable evidence of a number of learning events that have now occurred.

Additionally, some of the CMHT staff who were interviewed reported that they had attended the learning events and had found it a valuable opportunity to reflect on the cases and their own practice. It was also reported that the learning events enabled the practitioners to consider where improvements were needed to the service models.

The investigation team were satisfied that there was considerable evidence of implementation of the SIR recommendations at both a local and an organisation level.

Additionally, evidence was provided of how the Trust utilises an ongoing notification system which encourages staff to learn from serious incidents and to reflect on their individual practices.

4 Learning

This section summarises a number of key lines of inquiry/questions that practitioners, operational, supervising and clinical managers need to be asking when assessing and managing high-risk patients. In addition, it also highlights key areas of scrutiny that needs to be considered at a Trust governance and at Integrated Care Board's (ICB) commissioning levels.

Clinical practitioners and operational managers

- How is risk information being ascertained and assessed?
- Are other involved agencies being routinely invited to contribute to risk assessments and planning? If not, are the reasons being clearly documented?
- How frequently is risk information/planning being updated and assessed – is there compliance with the Trust's policies, and is the risk planning proportionate to known historic, present and potential future risks?

- How are patients' risks being discussed and monitored in supervision and in multidisciplinary meetings?
- What information is informing risk assessments and support planning?
- Is there uniformity and compliance with the Trust's policies – for example, what triggers a review of a risk assessment, risk management plan and/or care plan?
- How and where are operational managers monitoring their team's risk assessments and compliance with the Trust's policies and best practice guidelines within their team?

Governance-systems-focused learning

The following questions need to be considered:

- How are individual services and operational structures demonstrating that the SIRs' learning is improving service delivery, risk management, compliance and the experience of patients and their families?
- How is the governance structure being assured that the lessons learned from all SIRs are informing and improving service delivery to vulnerable patients?

The Trust and Integrated Care Board (ICB)

The Trust should ensure that:

- They are able to provide evidence and assurance that they have adequate systems and protocols in place to improve the identification, assessment and management of risk in its community and inpatient services, with particular regards to patients being discharged under a Community Treatment Order.
- Have roust systems in place that is providing its ICB with demonstrable assurance that learning and recommendations from the SIRs have been implemented and are being monitored.
- Provide evidence that the involved services are adhering to its commitment with regard to the involvement of service users and their families in their care and support.

- Is there evidence of that the supervision of community mental health services' practitioners is being utilised to monitoring the quality of risk assessments/risk management and care plans?

- How does the trust monitor and evaluate the implementation of Serious Incident Reports' recommendations?

System learning - introduced Patient Safety Incident Response Framework (PSIRF)

- Can the Trust provide evidence of any changes that have been made to its approach/systems, including reporting structures and oversight, as part of the requirements of the recently introduced Patient Safety Incident Response Framework (PSIRF)?

- Are the relevant Trust's staff able to demonstrate their understanding of PSIRF?