LM Learning Matters

Issue 10: January 2020

Special mental health edition

Introduction

Welcome to a special 'mental health' edition of the Learning Matters Newsletter.

Investigation reports into mental health serious adverse incidents (SAIs) frequently identify regional learning. This is usually disseminated through:

Safety & Quality learning letters and reminder of best practice letters (available to HSC staff at http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html)

and

Occasional articles in the Learning Matters Newsletter (also available at the above website)

This special edition of the Learning Matters Newsletter presents six articles on topics which have been recognised to be recurring themes in a number of mental health SAIs.

Involving family in safety plans

A A patient was in receipt of support from the Crisis Response Home Treatment team at the time of their death and was known to mental health services for nine years. This patient suffered from anxiety, had a depressive disorder, a history of trauma, substance misuse and had lost a friend to suicide prior to taking their own life. The patient had a supportive family who visited them daily. During the review process the family of the patient expressed concerns that they had not been aware that they had been identified as a protective factor within the patients' safety plan. They also felt they should have been involved in their relatives discharge planning as they played a key role in providing ongoing support to them.

Key Learning

- Family involvement in safety planning should always be recognised as a significant supportive resource for the individual at risk of suicide, if the patient identifies them as such.
- Recognition should be made to engaging in Think FamilyNI using The Family Model (TFM) - www.cypsp.org/regional-subgroups/think-family - to engage in family focused practice. Staff should undertake the E Learning foundation programme cited at HSC Leadership Centre www.hsclearning.com
- When safety planning with patients, clinical staff must consider, the involvement of family in the development and implementation of the safety plan.
- Clinicians must also ensure that those family members named in the safety plan are in agreement to accept the responsibility.
- Clinicians must also ensure that those named in the safety plan are provided with the appropriate information and resources to provide support in a crisis situation.

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Listening to families

It has been noted in a number of recent SAIs that families have not felt engaged or involved sufficiently in the care of their relative. Often families are aware of the signs of deteriorating mental health but they feel unable to discuss this with mental health staff.

Key Learning

- On first presentation of serious mental illness the CMHT should meet with the family, even if the service user is reluctant. While professional confidentiality should be properly respected the engagement of the family is absolutely crucial to their mental health and quality of care.
- Recognition should be made to engaging in Think FamilyNI using The Family Model (TFM) to engage in family focused practice. Staff should undertake the E Learning foundation programme cited at HSC Leadership Centre. www.hsclearning.com
- All carers should be offered a carers support assessment. This gives the carer the opportunity to describe and discuss the service users condition and stresses, which will provide corroboration of the service users ill health.
- Families should be made aware that if they have any concerns about the patient they should not hesitate to make contact with the key worker (or CMHT)
- Families should be provided with information on Recovery Colleges and how to access them.

Risk of plastic bags on mental health inpatient units

Staff found a patient lying on the floor who had intentionally tied a plastic bag over their head in an act of self-harm. There have been a number of subsequent near miss incidents relating to the same issue.

Key Learning

- Staff should ask patients and relatives not to bring plastic bags onto the ward.
- It is good practice to have paper bags (at the entrance to the ward) as an alternative for patients and relatives to transfer items into.
- It is recommended to include plastic bags as a restricted item in ward information booklets.
- It is recommended in the main part of ward/communal areas/bedrooms/bathrooms etc. to have an alternative to placing plastic bags in bins due to safety risk.
- Small paper bags should be provided for all sanitary products and then placed into the bin.
- Plastic bags should only be used in restricted areas e.g. kitchen and clinical room where there is supervision.

Management of Risk for Patients with Mental Health Conditions in the General Hospital Setting

A patient died following a non-accidental fall within an acute hospital facility. The patient left the ward and whilst still within the hospital the tragic incident occurred. The patient was known to Mental Health Services within the Trust.

The process for managing this case focused mainly on the patient's physical needs. The patient's mental health information was not given significant consideration by the general hospital staff in the context of the patient's overall presentation.

Key Learning

- A parallel process of physical care and mental health needs of a patient should be considered together where indicated. This means seeking input from Trust 'liaison psychiatry' services as soon as possible: (these services may not be available in all Trust locations on a 24/7 basis).
- There should be clearly documented medical and nursing assessments to evaluate both physical and mental health risks. Mental health staff should provide input where possible for general hospital medical and nursing assessments and plans, for meeting the patients mental health needs.
- A clearly documented joint management plan agreed between medical and nursing staff to minimise physical and mental health risk, and an escalation plan to include the transfer to a mental health unit if necessary.
- An agreed process by both general and mental health staff to be produced outlining how a patient can be transferred in a timely manner from the general setting into the care of mental health services when this is assessed as a priority.

Reducing service Interfaces

In a SAI a patient's death was made known to Mental Health Services.

The patient was referred by the GP eight months prior to the event with a history of mental ill health and a long standing history of low mood and anxiety. They subsequently presented to the GP on a number of occasions, initially with suicidal thoughts and self-harm in the form of cutting, and subsequently there were further presentations with emotional distress.

From the first referral to the Community Mental Health Team (CMHT) and the second referral by the GP eight months later, the patient had been assessed by the CMHT and referred to the Psychological Therapies Service (PTS). The patient was then assessed by the PTS and referred for Community Addictions Team (CAT) input but the patient was not keen to engage with this service. The patient was also then referred to the Gateway Service who completed the relevant checks but an Initial Assessment was not completed.

In summary there were numerous attempts to engage this patient by three different service teams resulting in no engagement/intervention over eight to nine months.

Key Learning

- Assessment and onward referral, without intervention or engagement, is not supportive for service users.
- Where there are numerous interfaces across service teams this can cause delay in assessment and treatment for patients and a poor service user experience.
- Recognition should be made to engaging in Think FamilyNI using The Family Model (TFM) to engage in family focused practice. Staff should undertake the E Learning foundation programme cited at HSC Leadership Centre www.hsclearning.com
- Trusts should ensure supports are identified and signposting provided to patients and their families while they wait for assessment and treatment.

Avoiding medication errors

A medication error occurred while a patient was in a psychiatric in patient unit.

During transcribing of information from an old Kardex to a new Kardex, the Doctor mistakenly recorded Amitriptyline 200mg as opposed to the correct medication which was Amisulpride 200mg. The ward was busy and staffing was reduced due to study leave and sick leave, a doctor from another service offered to help the duty doctor as he had capacity to do so. He was tasked with re-writing a patients medication Kardex and undertook this task at the nurse's station, where there were numerous interruptions.

The error was not noted for a number of days and during this time the patient had been noted to be physically deteriorating.

Following the discovery of the error and admission and treatment in general hospital, the patient returned to their former level of physical health.

Key Learning

- On admission to a new ward a Kardex should be written based on the information in the patient's notes and not transcribed from one Kardex to another.
- Kardex's should be written in quiet rooms to reduce the risk of interruption. These should be checked and reviewed by senior medical staff and changes in medications should be clearly communicated to the patient's primary nurse and senior nurse in charge.
- Transfer of information and summary of transfer between wards should be documented in the patient's notes upon transfer.
- Whilst administering medications nursing staff should be aware of the effects and side effects of all medication that each patient is receiving.
- When a patient physical condition deteriorates medications should be reviewed.
- Inpatient managers should consider the introduction of daily safety briefings on each ward. This is an opportunity to review any patient or ward issue and ensure information is shared with all staff.

Contact us

HSC Health and Social Care

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net or by telephone on **0300 555 0114 ext: 361130**

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