Leicestershire Partnership NHS Trust

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Patient safety – learning from incidents

Introducing Doris (not her real name).

Doris is a retired 79-year-old lady who moved to England in 1965. She is known to Mental Health Services for Older People who lives with schizoaffective disorder. She has complex physical health needs alongside her mental health needs. She was admitted under section 2 of the Mental Health Act 1983 to a functional inpatient ward for a period of assessment and treatment for her schizoaffective disorder. Doris has had a number of falls over the past few years and was given mobility aids whilst in the community, however she has been reluctant to use this of late.

What happened.

Doris was admitted under section 2 MHA 1983 in January 2022 due to a deterioration in her mental health. Doris also has complex physical health conditions, which includes deranged liver function, which was identified in the community prior to her admission to hospital.

On the 15th of February 2022 Doris sustained a fall, which resulted in a swelling on the right-side of head. Medical assessments were completed by the junior medical team on the ward. As part of the assessment the medical team contacted a Geriatrician Consultant to discuss Doris's presentation. The discussion concluded that a transfer to Emergency Decisions Unit (ED) would not add anything further to Doris's care at that time, which, given her mental health and presentation, was entirely reasonable and appropriate. It was concluded that ED would not have provided any further medical intervention that could not be achieved whilst allowing Doris to stay in the ward which was familiar to her.

Doris sustained a second fall the following day on the 16th of February 2022, which resulted in a suspected fracture to her left radius and ulnar (wrist) which was confirmed on the 17th of February 2022 following an Xray.

The junior mental health medical team assessing Doris recognised the risk factors in her history for fragility fracture and acted on this accordingly. Doris was supported to attend ED to be able to receive the specialist care and treatment she needed to treat her injury.

The investigation recognised that empowering junior medical staff to consider what is in the “best interest” of a patient in the wider circumstances, and consideration of other routes of investigation and observation, was good practice which should be encouraged, whilst seeking the advice of senior clinicians if unsure or unclear about the best course of action to take.

The investigation considered all the factors which may have contributed to Doris sustaining falls, including, physical health, environmental factors and prescribed medication. The falls Doris sustained were felt to be more likely as a result of her deteriorating mental health and agitation alongside a reluctance for her to use the mobility aids she had been prescribed. The investigation considered the psychiatric medication Doris had been prescribed, as this is known to increase the risk factors of falling, however, concluded that the falls were of a mechanical nature and not as a result of any medications she was prescribed to treat her mental health condition, which were being monitored and reviewed daily.

Furthermore on discussion with the Consultant Geriatrician, they did not raise any concerns or indicate that Doris’s medication regime was a significant contributory factor in either of the falls. The ward medical team showed evidence of balancing the risk of treating Doris’s psychosis whilst monitoring the risk of abnormal LFT’s.

Record keeping for medics were of a high standard however nursing records were found not to be adequate. Risk assessments and incident forms were completed in line with LPT falls pathway. At the time of the

Learning from the Incident.

- The conclusion of the investigation was that the falls Doris sustained could not have been prevented, and the risk of her falling was documented from admission.

As a result of the investigation further learning was identified:

- There were no adequate and comprehensive documentation recorded on SystmOne., from a nursing perspective, to determine the circumstances of the falls when they occurred on 15th and 16th of February 2022
- There was no evidence that neuro observations had been attempted following the falls
- Doris was declining to have her observations recorded, and Doris's decision not to accept physical observations were not routinely recorded
- Not all staff were competent and understood non-contact observations, an alternative method of assessing physical health observations without the need to close contact. This should be considered if a patient is non-concordant to care and treatment which was evident following both falls.
- To ensure that discussions surrounding risk assessments and therapeutic observation levels are documented in patient records including any changes to care, intervention or therapeutic observations levels. These should be reflected in care plans, risk assessments and shared handover documents.

How we improved.

- The non-contact observation policy has been adopted by the deteriorating patient group to ensure all staff are trained in recording non-contact observations as required
- Nursing documentation is reviewed on a monthly basis to ensure consistency and accuracy in record keeping
- Staff have participated in bite size training sessions and refresher sessions to support staff in improving the quality of their documentation
- Patients with a known risk of falls will follow the falls pathway and post fall huddles will be carried out to ensure immediate learning and actions are carried out following falls
- Therapeutic observation levels are reviewed with the daily board round which considers incidents and patients incidents from the previous 24 hours. Therapeutic observations are discussed and considered whilst balancing patient safety and risk management with maintaining least restrictive care.

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