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Leicestershire Partnership NHS Trust

Trust Board – 28th November 2023

Patient Safety Incident and Serious Incident Learning Assurance Report November 2023

Purpose of the report

This report for September and October 2023 provides assurance on LPTs incident management and Duty of Candour compliance processes. The process reviews systems of control which continue to be robust, effective, and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction. The report also provides assurance on 'Being Open', numbers of serious incident (SI) investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

Teams are working together to continuously improve our ability to review and triangulate incidents with other sources of quality data with the data we have available. The quality of our data and the ability to triangulate this data is essential to the culture of continuous improvement. We are exploring opportunities both internally and externally to consider options to improve this data and provide more sensitive and easier to use data for this. Through adopting a safety culture lens of 'problem sensing and not comfort seeking', our mind set is slowly changing characterised by actively seeking out weaknesses in the system from multiple data sources and seeking any evidence that there is an incipient risk of complacency. This culture is supported through, inviting staff to share concerns and ideas to improve rather than waiting to feel they need to 'speak up' and will support staff to feel psychologically safer.

World Patient Safety Day 17th September

This year for the first time we came together with partner organisations and the ICB to meet with patients to hear from them about what makes them feel safe when receiving healthcare. This event evaluated well, and we have committed to make this an annual event, supporting and complementing our work in relation to shared decision making.

Patient Safety Strategy (NHSE 2019)

Patient Safety Partners (*involving everyone*)– we have recruited two patient safety partners, who have started to familiarise themselves with the current patient safety priorities and are completing their induction. The patient safety strategy suggests that our patient safety partners attend two of our safety committees, and we plan to invite our partners to attend the Patient Safety Improvement Group (PSIG) and Quality Forum (QF). The patient safety partners will then have an overview of the QI improvement work and have the opportunity to volunteer where they feel they can add value.

Change Leaders – (***importance of culture***) Our Future Our Way change leaders have now analysed their data from the information shared with them by our staff and have identified key areas to work

on. The patient safety team are leading on the work in relation to psychological safety, which will be designed considering the academic work in this area as well as National learning.

Learning From Patient Safety Events (LFPSE)

This is the replacement software that has been nationally introduced to improve learning from incidents which we have implemented.. We have shared feedback with the national team around suggested improvements to the process particularly around reporting incidents for other organisations.

Patient Safety Incident Response Framework (PSIRF) -

- Following agreement of the Patient Safety Incident Response Plan (PSIRP) by the LLR ICB, LPT transitioned to Patient Safety Incident Response Framework (PSIRF) on 1st November 2023.
- Directorates are progressing plans for management of incidents locally and to carry out reviews of incidents not falling under the trust plan, using SEIPS and AAR human factors methodologies.
- Confidence and capability building with the new framework and processes for staff is a key piece of work that is progressing, with training and support from the Patient Safety Team.).
- Engagement of smaller commissioners continue, with meetings where necessary to further support their understanding of PSIRF and provide assurance of the new processes.
- The IRM continues to meet to ensure that incidents that may require an enhanced level of review are still considered and there is a robust governance process to agree the type of review and provide oversight that this approach is identifying learning.

Investigation compliance with timescales set out in the current serious incident framework – Challenges continue with compliance with timescales. This is however an improving picture (see graphs in slides) and we are reporting weekly
As we have now transitioned to PSIRF we are looking at more efficient ways to investigate and therefore beginning to reduce the number of lengthy reports required.
The Patient Safety Team together with the We Improve Q Team have developed a training session for staff around action planning based on the Hierarchy of Effectiveness and describing the links between actions/system thinking and quality improvement.

Analysis of Patient Safety Incidents reported - Appendix 1 contains Statistical Process Control (SPC) charts utilising the NHSI Toolkit to support the narrative and analysis and local speciality incident information. The overall position is also included for all investigations and action plans.

All incidents reported across LPT - Incident reporting should not be seen as a good single indicator of safety in the clinical environments; however, these can provide an early indication of incident change in specialities or even across the Trust or a wider healthcare system.

Review of Patient Safety Related Incidents - The overall numbers of all reported incidents continue to sit just above or on the mean and can be seen in our accompanying appendices.

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care –
We continue to see normal variation in the number of Category 2, 3 or 4 pressure ulcers developed or deteriorated in our care. CHS Community Nursing identified four Quality Improvement (QI) projects, based on thematic review and learning from previous incidents; Registered Nurse oversight of Category 2 pressure ulcer reviews; holistic assessment; wound photography and mental capacity act training. A CHS Pressure Ulcer Delivery group was established in September 2023 to lead and drive the improvement plans, reporting through to the Trust Pressure Ulcer prevention group. Whilst we are yet to see improvement in terms of prevalence, a review of the data and audit of standards over the last quarter at the Trust Strategic Pressure Ulcer group highlighted several quality improvements:

- Improved performance for care plan frequency and reassessment – Green @ 96.9%
- Improved performance for documented patient/carer advice and how to escalate concerns – Green @92.4% and 92.1%
- Improving performance for capacity assessment and recording – @78.5%
- Improving performance for individualised care plans – @70.8%

Community Hospitals Hinckley Hospital Pressure Ulcer Prevention (PUP) QI project has concluded. The project included introduction of a PUP 'first aid' cupboard, utilising pressure ulcer safety crosses and huddles, enhanced training, and an equipment review. We have seen positive impact with no patients on North Ward developing a pressure ulcer in our care since April 2023. The project is currently being upscaled and learning shared through the service and directorate and at the Trust Pressure Ulcer Prevention Group. We have also seen the following quality improvements:

- 28% Reduction in Category 2 pressure ulcers developed or deteriorated in Community Hospitals
- Achieving 99.6% compliance in the pressure relieving cushion audit.
- Improved performance – weekly Waterlow risk assessment – @ 90%
- Improving performance PUP care plan – @ 87.5%
- Improving performance aSSKINg daily reviews –@ 75%

The aim of the Group Pressure Ulcer QI collaborative has been to improve the knowledge and understanding of the importance of nutrition, hydration and keep moving in the prevention and healing of pressure ulcers for patients, carers, and staff by June 2024. In LPT the test sites are within the in-patient Community Hospitals, Clarendon & Beechwood wards. Project outcome measures to include numbers developed and deteriorated in our care, staff and patient questionnaires, dietetic referrals and completion of the nutrition, hydration and keep moving in aSSKINg. Updates on the projects are being reported quarterly to the quality forum and will be included in the highlight report to the quality and safety committee.

Falls Incidents

Hot spots remain on Aston Ward and Mill Lodge where most falls can be attributed to 2 patients; however, one of these patients has now been transferred to another unit. Aston is a male dementia ward where often patients exhibit behavioural issues due to their condition and one fall last month related to an incident between two patients. However, it has been noted that the number of repeat falls as a percentage of the total number of falls has decreased in the MHSOP wards, which suggests the response to first falls and management of ongoing falls prevention is improving.

Incidents are reviewed at ward and directorate level and there is ongoing reinforcement of good practice and identification.

Deteriorating Patients – The DPRG policy has been written in draft and is awaiting directorates sign off before final for sign off and agreement. A sepsis working group has also been developed to prioritise work with relation to sepsis for the Trust and a Trust lead is being considered. VTE is also a key focus for the group, and we have been focusing on how to ensure that DPRG has assurance around VTE assessments across the Trust,. This work is on-going with a review of the VTE policy and a deep dive into prophylaxis on the wards. The collaborative work with NHFT continues to develop and is focusing on work on improving the recording and escalation of NEWS2 scores across the Trust.

Groups related to self-harm and suicide prevention:

The trust self-harm and suicide prevention group - This group met during October to consider the

key priorities and developed matrix to assess areas of further work by self-assessment against the recently published NHSE Suicide Prevention Strategy and NCISH self-harm toolkit. A new suicide and self-harm prevention lead has been recently appointed which will afford a dedicated lead to drive, report and evaluate this plan.

MH Safe and Therapeutic Observations Task and finish group - The group consists of 5 work streams:

1. Learning from Incidents / SI's / CQC enquires / Complaints.
2. Engagement and co-production – patients, staff and carers.
3. Training and competency Assessments
4. Recording incidents.
5. Creating Best Practice Guidance

During October 2023, the Recording Incidents and Creating Best Practice group agreed a revised handover guidance including the role of the nurse in charge in assessing the skill mix of staff on duty to carry out observations competently. The Engagement workstream presented the finding from the staff, patient and carer surveys/ focus groups which will feed into other workstreams. The group is closely linked to the NHFT/LPT MH Observation Improvement Collaborative, and 3 areas have been identified for quality improvement projects:

- Inpatient pathway review – acute care
- Nighttime observation – safety vs therapeutic relationship and sleep hygiene
- Training and competences/use of technology

The projects will be developed in a session in November 23 with change ideas being commenced in January 24.

Medication incidents – Medication Safety – The patient safety team are working with the medicine safety groups to align the model with the patient safety strategy and to ensure there is appropriate oversight of data and reporting in from Directorates. Key areas for review are management and administration of controlled drugs and 'critical drug' omissions.
a Medicines Safety Officer (MSO) post is being developed which is an important role is essential to build on the improvement work in relation to medicines safety.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC – The CQC receives 72hr reports for newly notified SI's, completed SI reports/action plans/evidence and any additional information required. We continue to work with our other 'commissioners' to provide assurances. The patient safety team are working with all commissioners to update and work with them as to how they will receive assurance, moving from relying on Serious Incident as we implement PSIRF.

Learning from Deaths (LfD) - This process is supported by a Trust co-ordinator and bereavement nurse, providing valuable service to our patients' families. Feedback from families is carefully gathered to understand where there are examples of good care or areas for improvement. This supports teams to understand what is working well and where changes to process is required. Themes identified: the quality of communication with families and the information shared and the ability of staff to attend patients in the community that are end of life. The End-of-Life Steering Group are overseeing improvements in this area. The learning from deaths group is currently considering the transferrable learning from a national report into their mortality recording and processes. There will be learning to improve our process for monitoring and learning from deaths.

Patient Stories/Sharing Learning - Patient stories are used to share learning. It is important that we learn from both when things go well and not so well Trust-wide to ensure focused learning is part of our culture and new way of thinking. Evidence suggests that staff learn better from patient stories, and we are working to ensure our stories are based on system thinking and human factors. The appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning. Learning is based on human factors and therefore transferrable.

Decision required

- Review and confirm that the content and presentation of the report provides assurance around all levels and categories of incidents and proportionality of response.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- To enable sighting of the Senior Trust team of emerging themes, concerns through incident reporting and management and patient safety improvements.

Governance table

For Board and Board Committees:	Public Trust Board 28th November, 2023	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHP's and Quality	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	15th November 2023	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	PSIG-Learning from Deaths-Incident oversight Assurance of the individual work streams are monitored through the governance structure.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly reports to Board	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	1. Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 2. Trust may not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	Yes	

Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during September and October 2023

Any detail that requires further clarity please contact the Corporate Patient Safety Team

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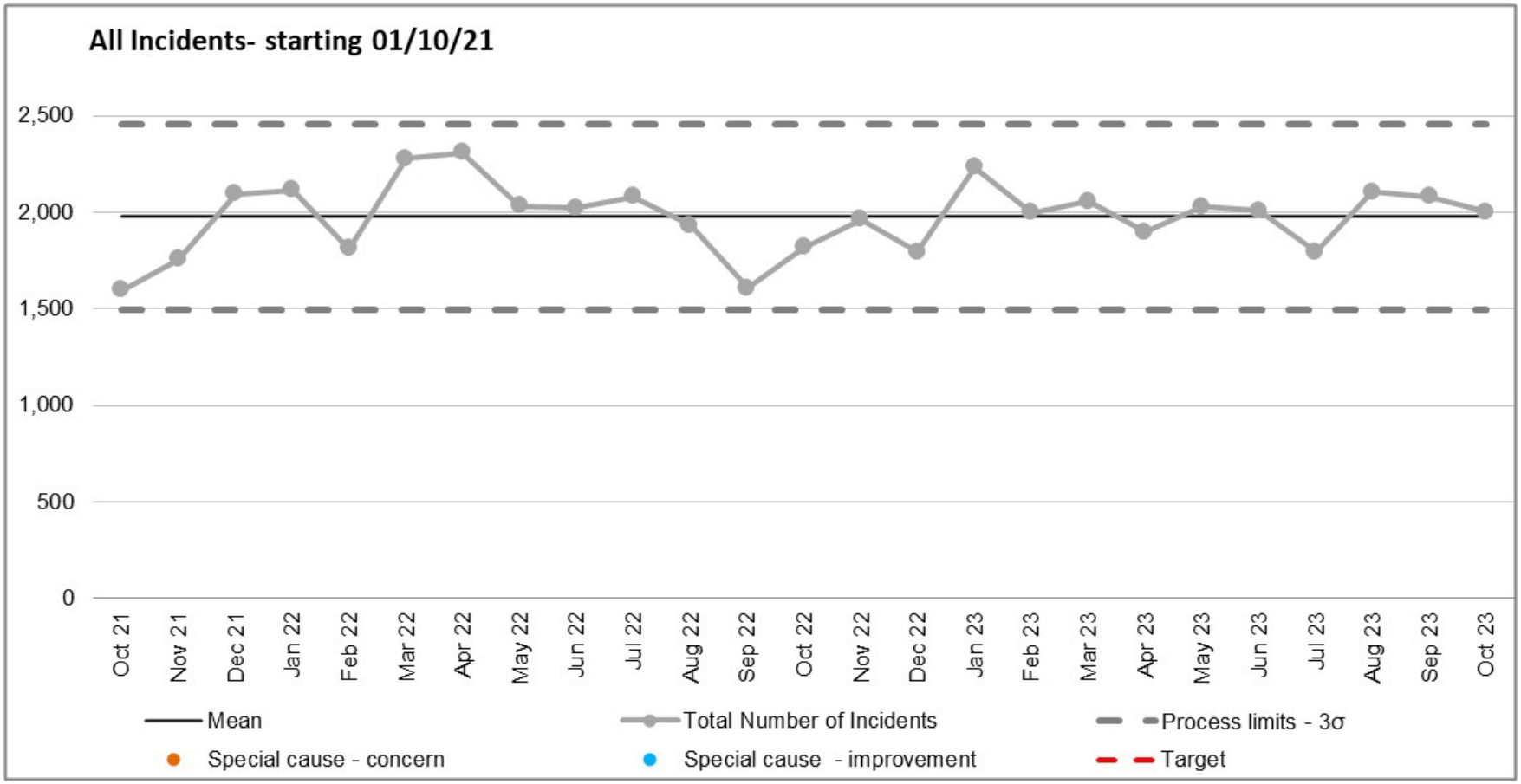
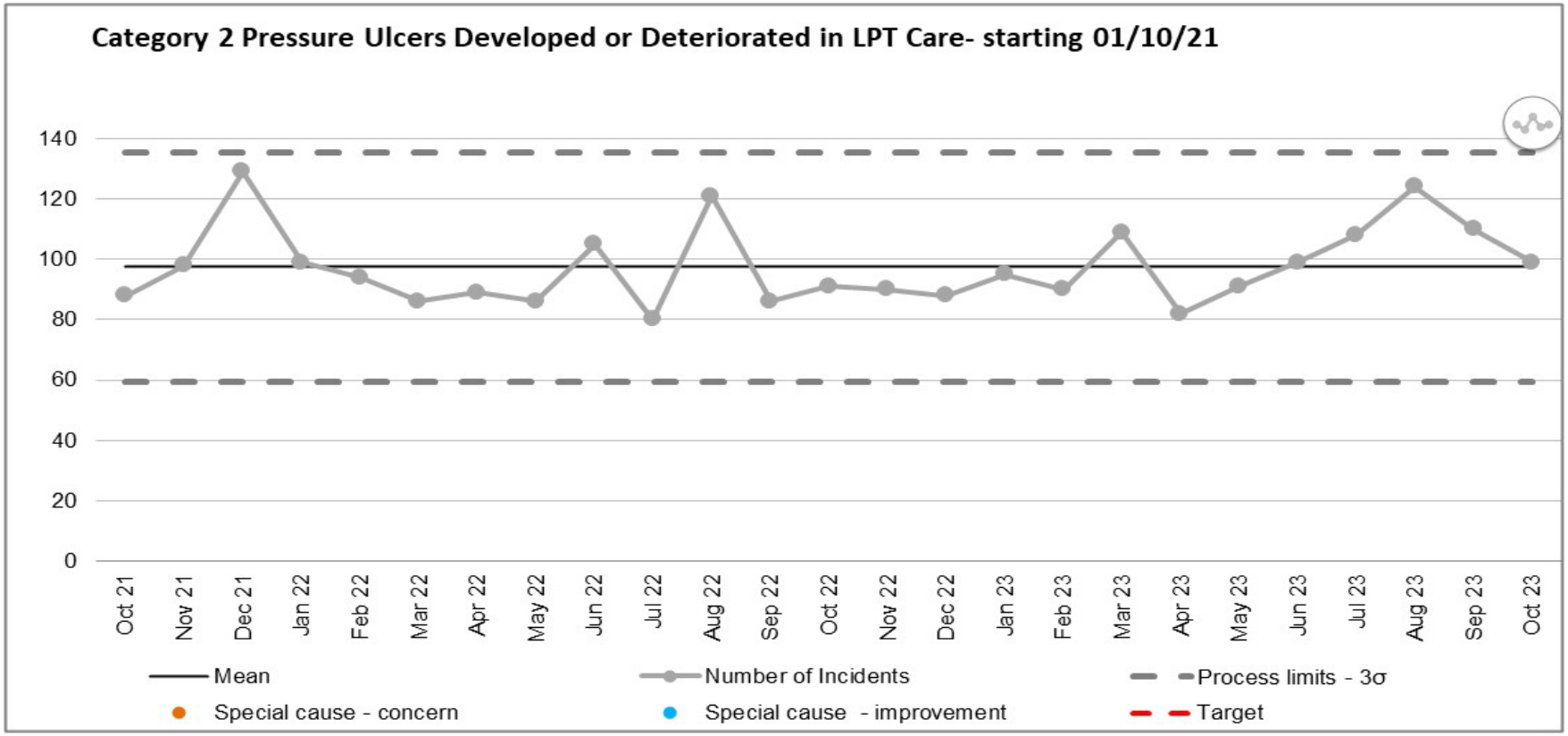
1. All incidents



2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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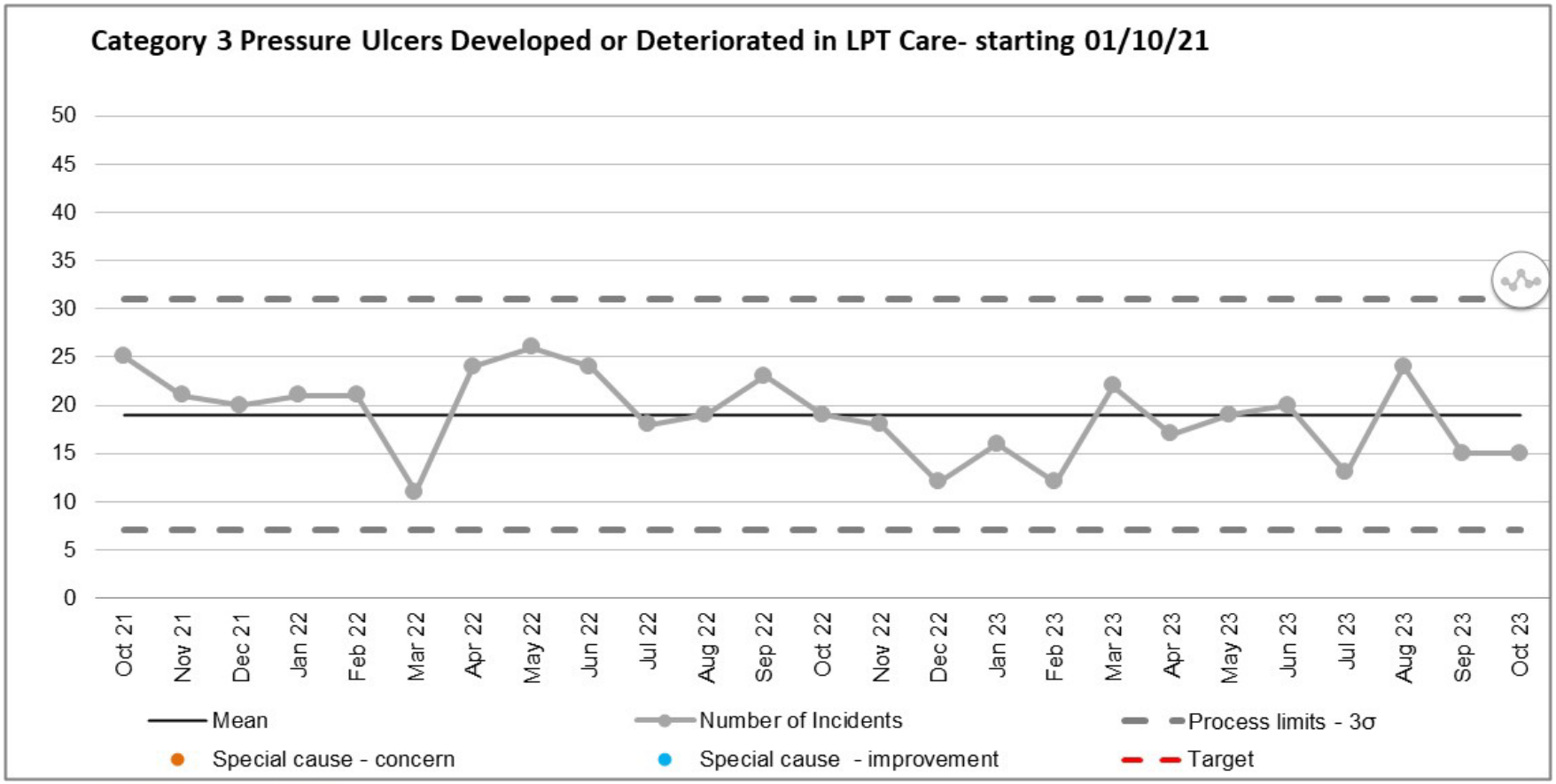
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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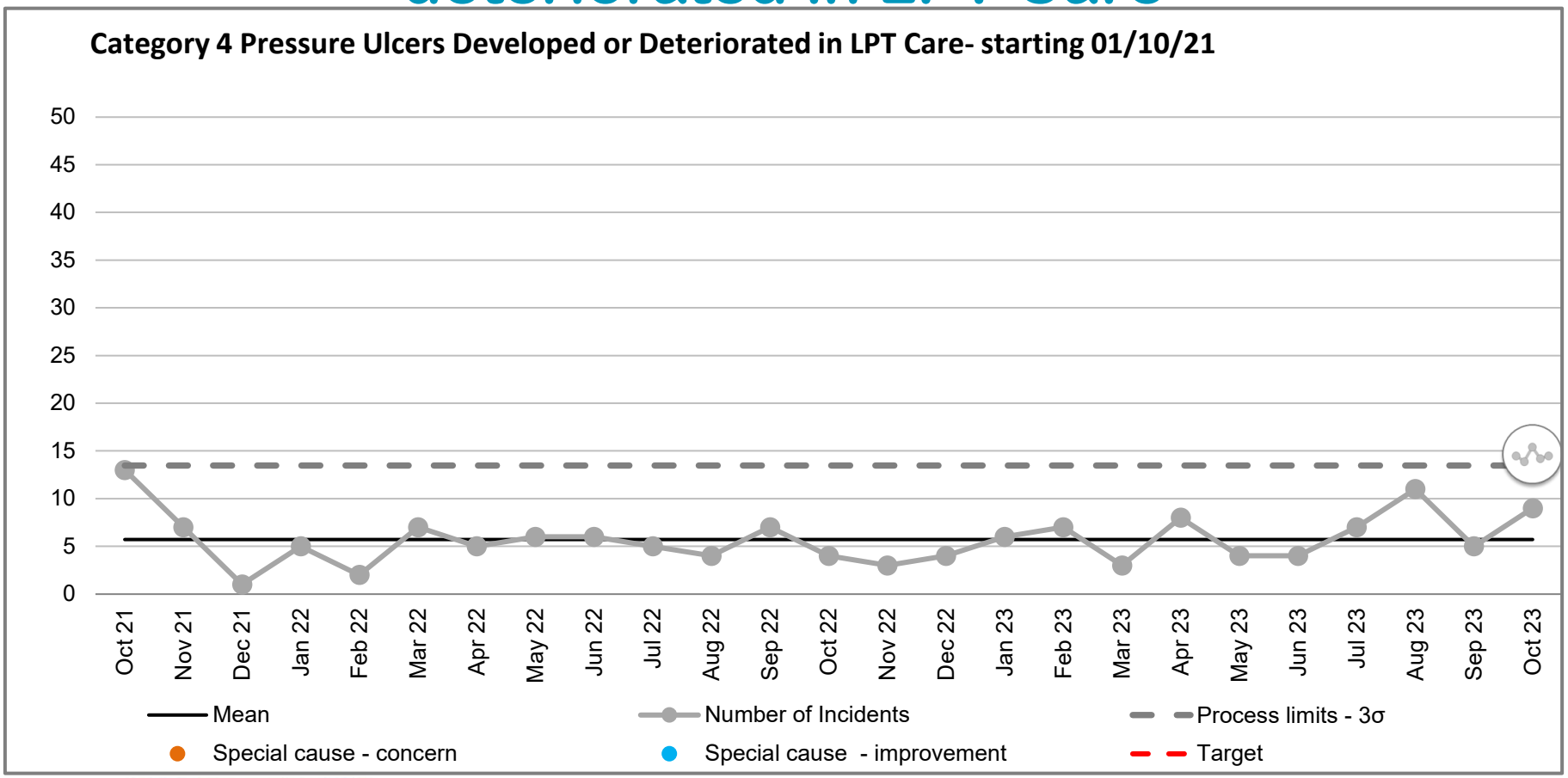
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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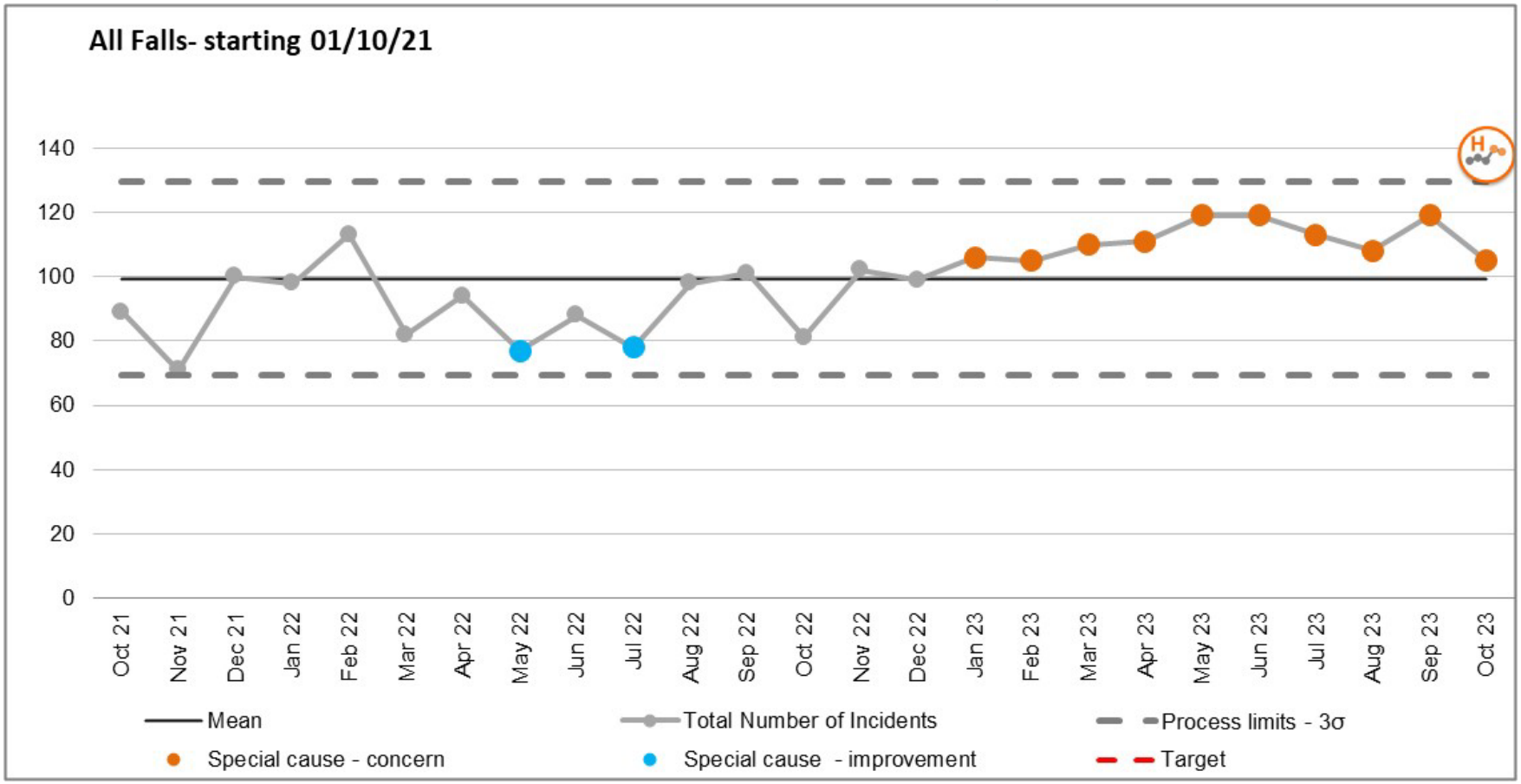
5. All falls incidents reported



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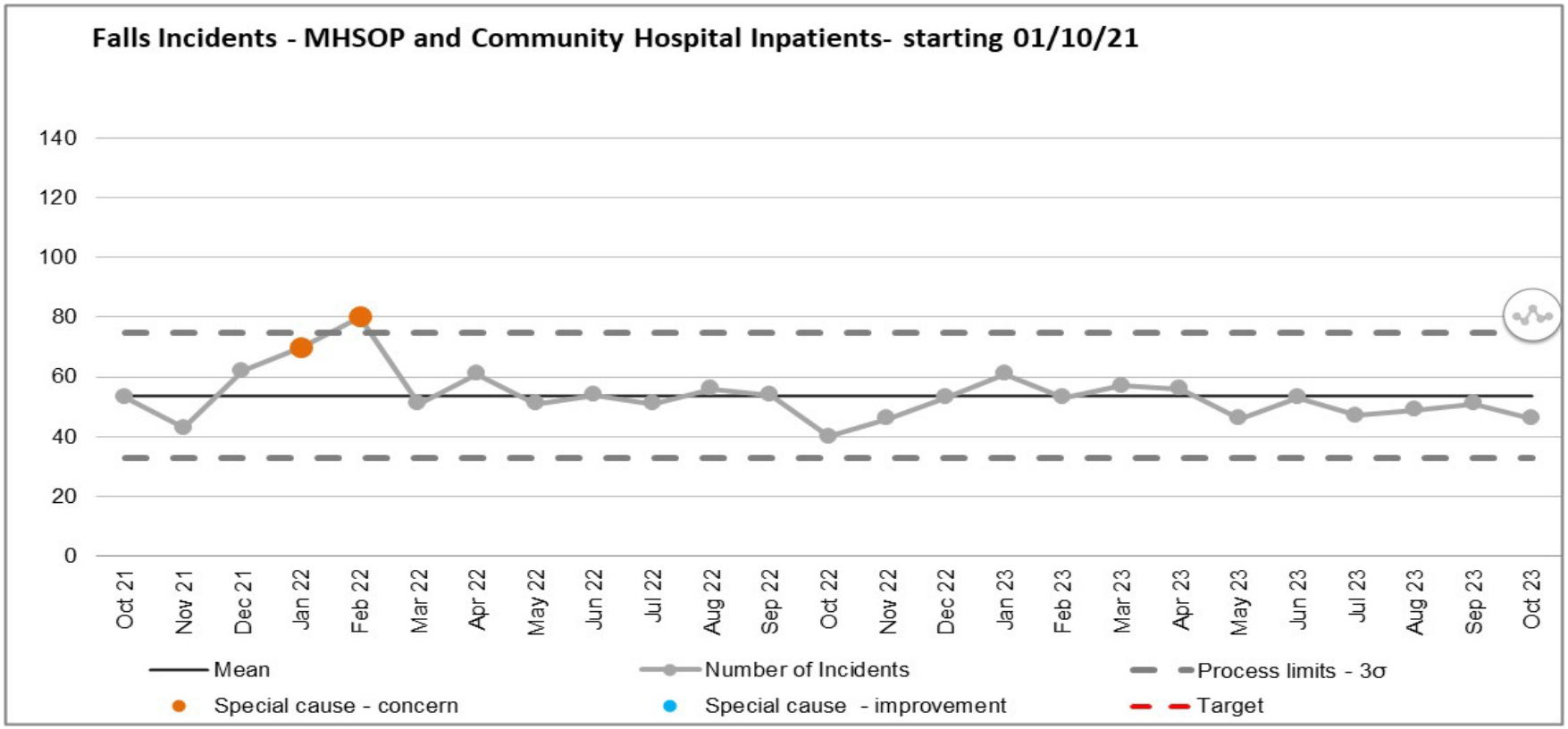
6. Falls incidents reported – MHSOP and Community Inpatients



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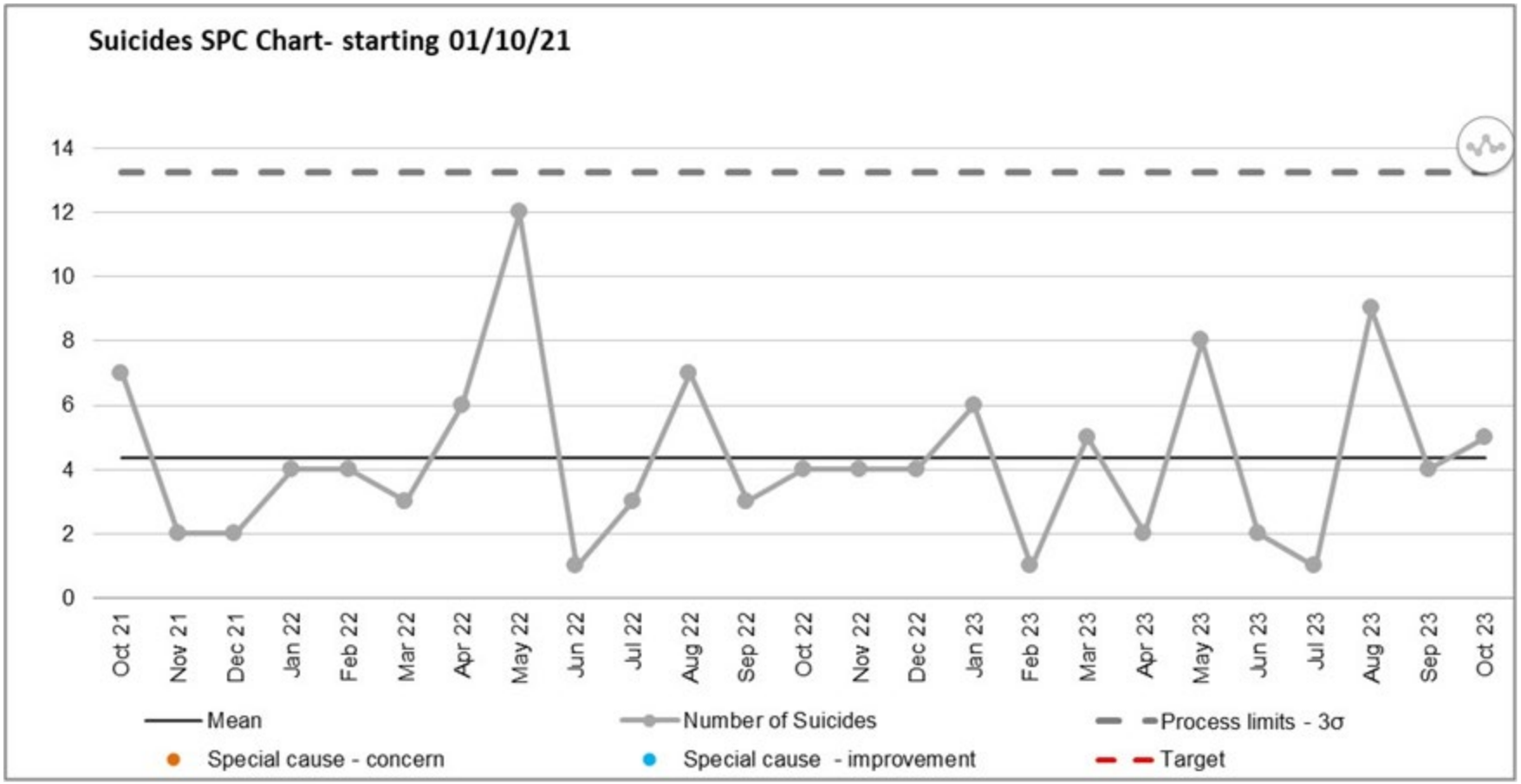
7. All reported Suicides



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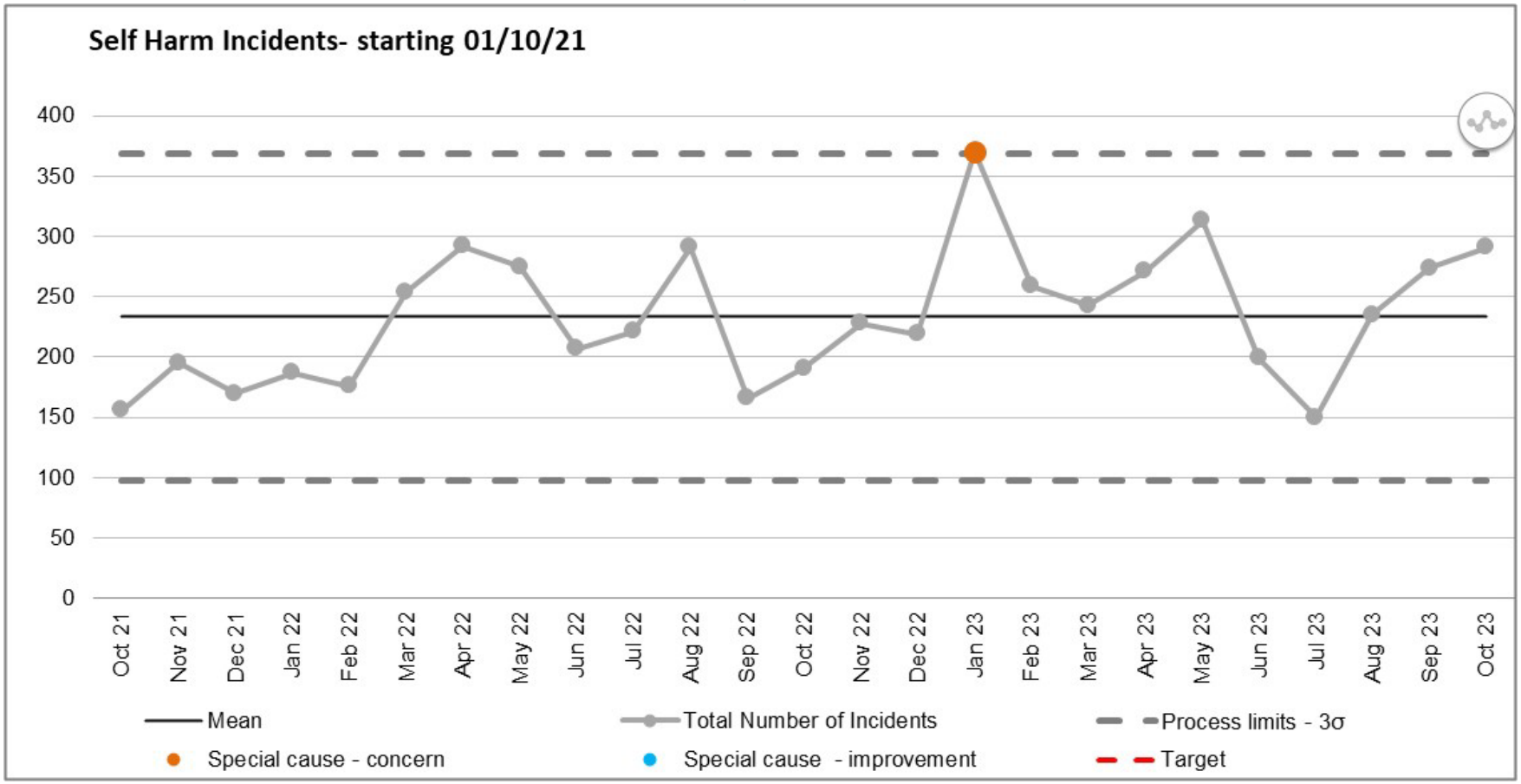
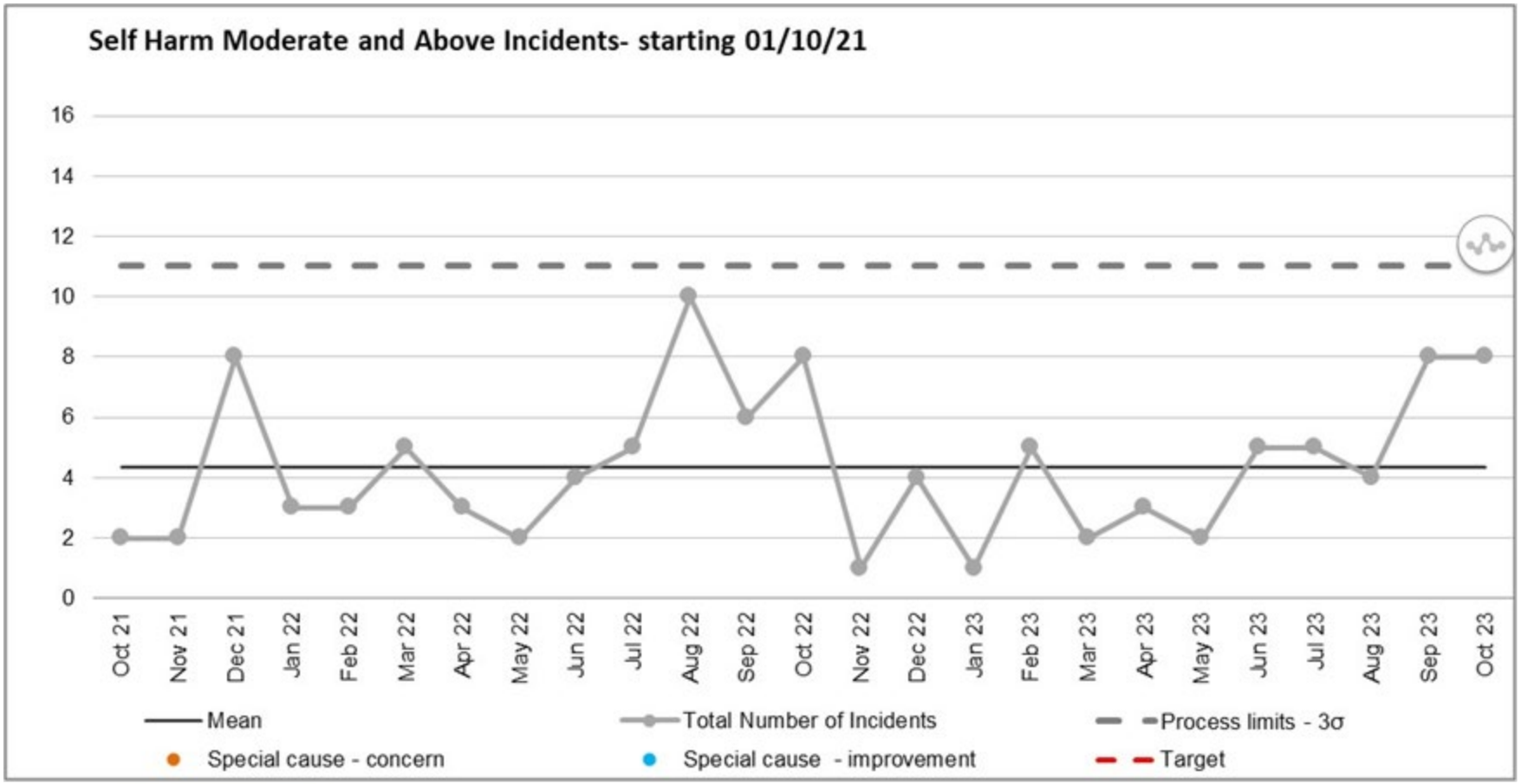
8. Self Harm reported Incidents



8a. Self Harm reported Incidents



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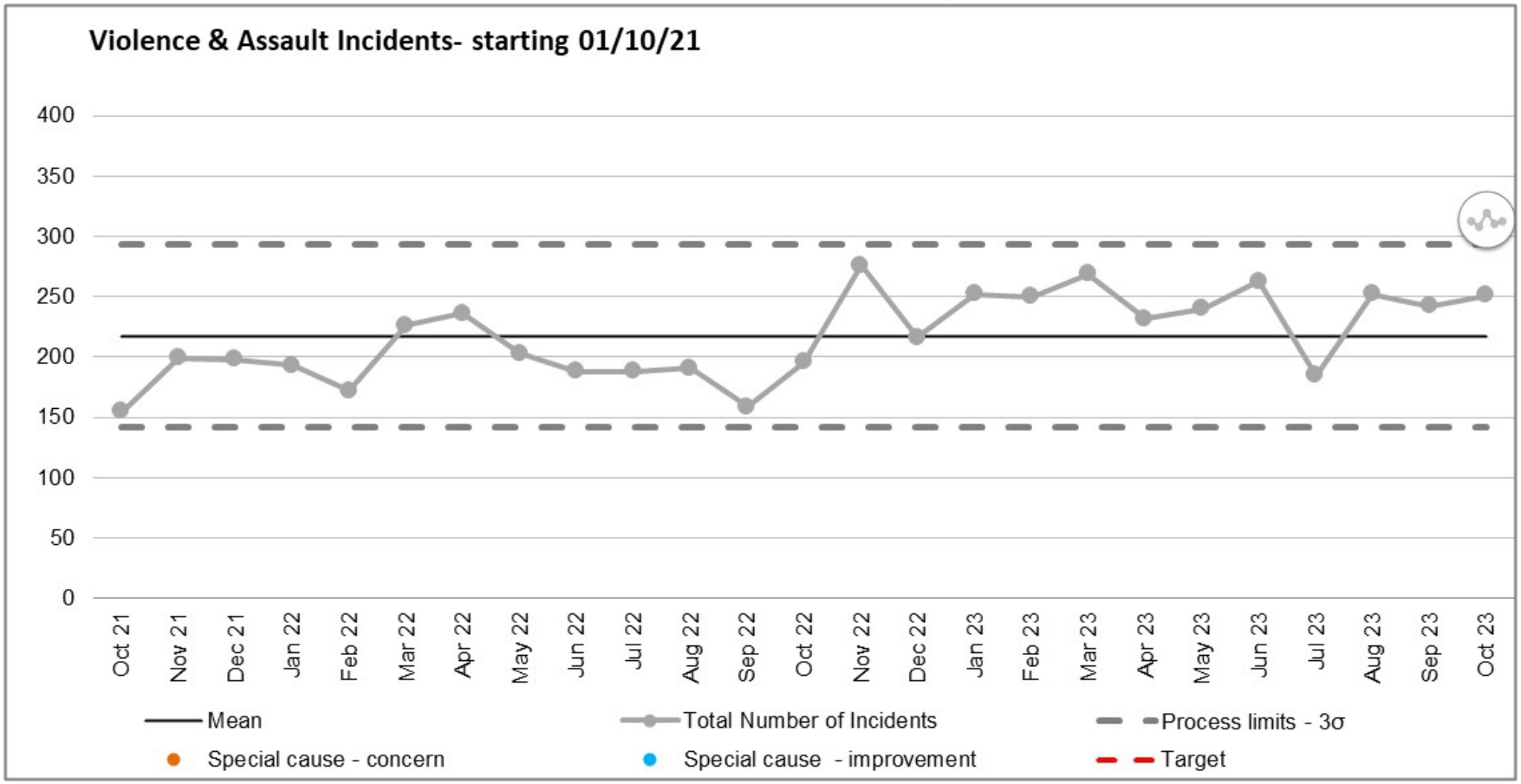
9. All Violence & Assaults reported Incidents



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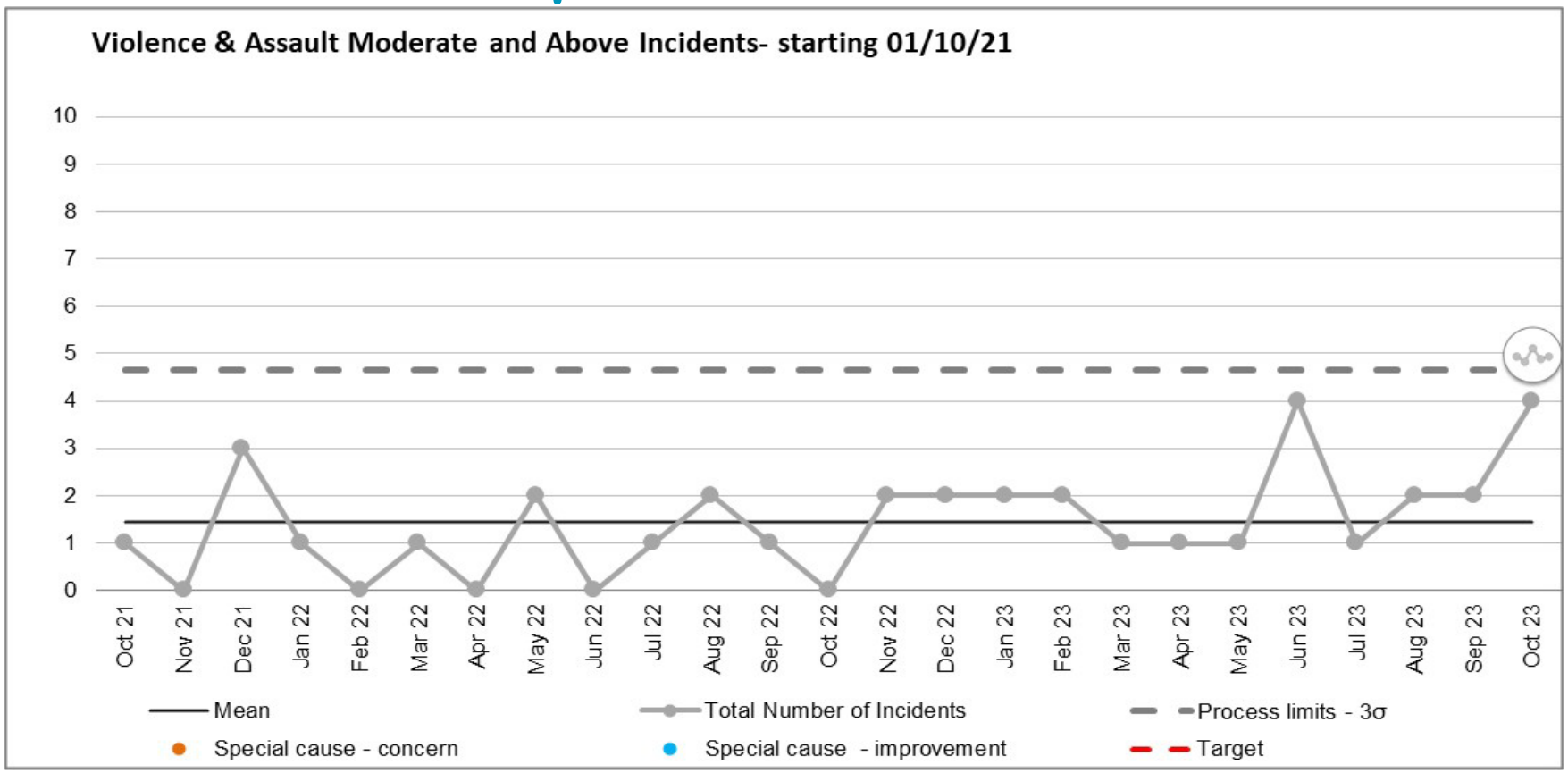
9a. Violence & Assaults moderate harm reported Incidents



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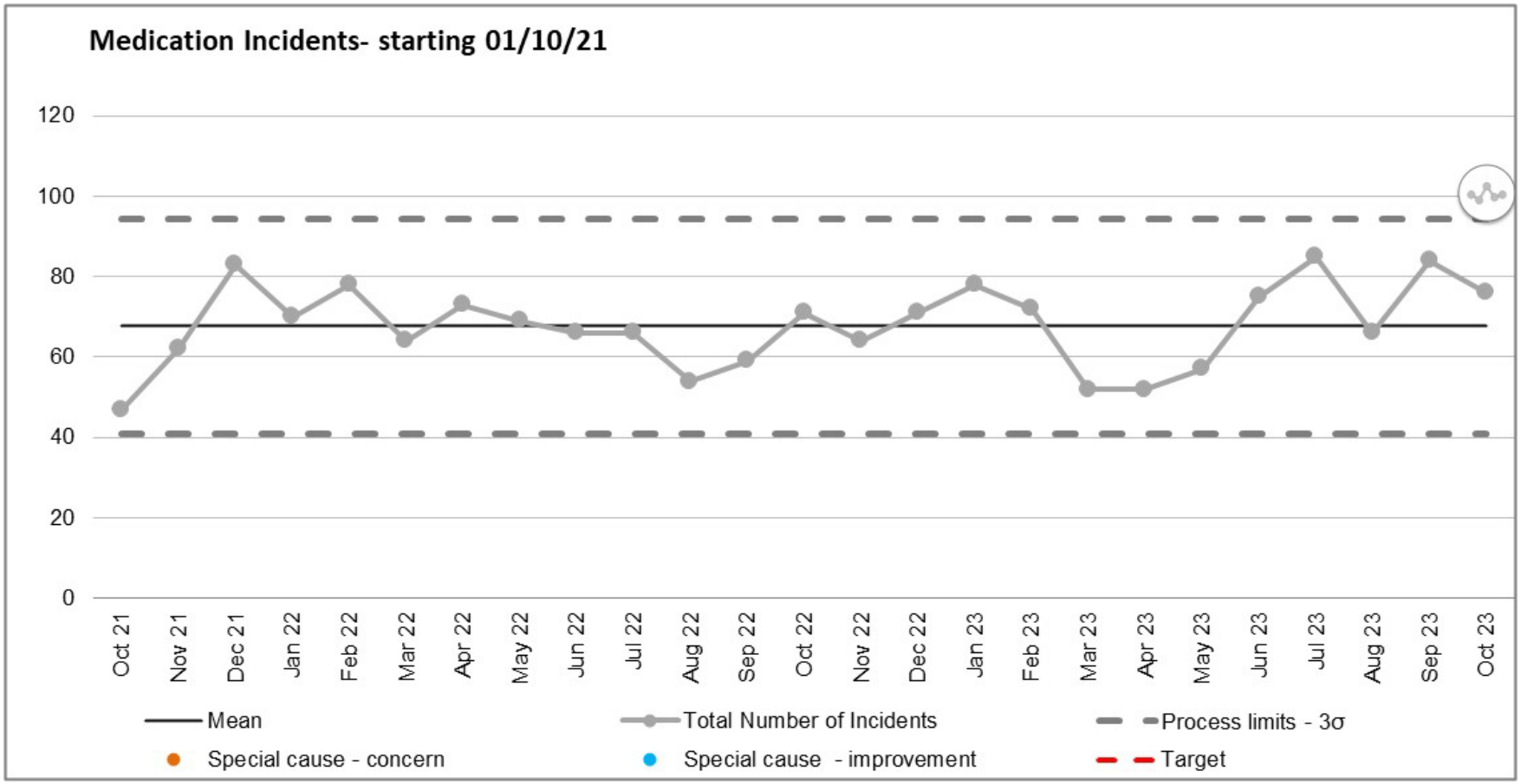
10. All Medication Incidents reported



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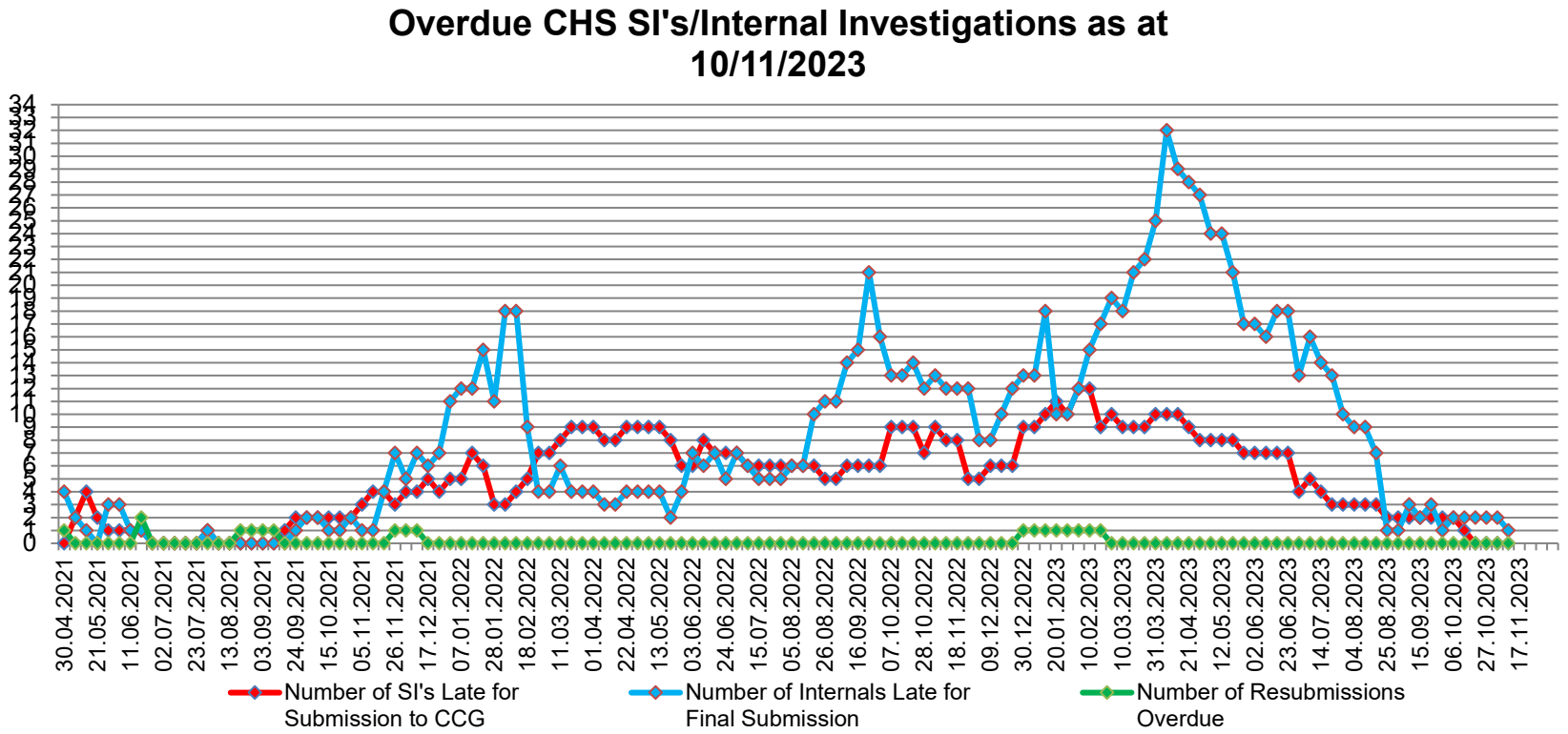
11. Ongoing - StEIS Notifications for Serious Incidents

2022-2023 StEIS Notifications and Internal Investigations								
	StEIS Notifications	SI INVESTIGATIONS				Internal Investigations		
	Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2022-								
April	0	2	0	2	10	3	3	3
May	0	3	0	0	12	5	0	4
June	0	4	1	2	7	2	1	3
July	0	4	1	4	8	4	1	6
August	0	7	1	1	7	5	2	2
September	0	3	1	3	10	8	2	9
October	0	4	0	3	4	4	4	11
November	0	6	0	1	4	6	0	8
December	0	7	1	2	4	6	2	10
January	0	2	0	1	9	3	0	10
February	0	4	1	1	9	7	2	6
March	0	1	0	0	11	9	1	5
2023-2024								
April	0	3	1	1	4	8	2	2
May	0	4	0	2	4	7	2	3
June	0	2	1	1	9	2	4	6
July	0	1	0	0	10	3	1	5
August	0	1	0	0	4	6	4	13
September	0	2	0	0	6	3	1	9
October	0	1	0	0	4	5	2	10
	0	61	8	24	136	96	34	125

12. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) – CHS as at 10.11.2023



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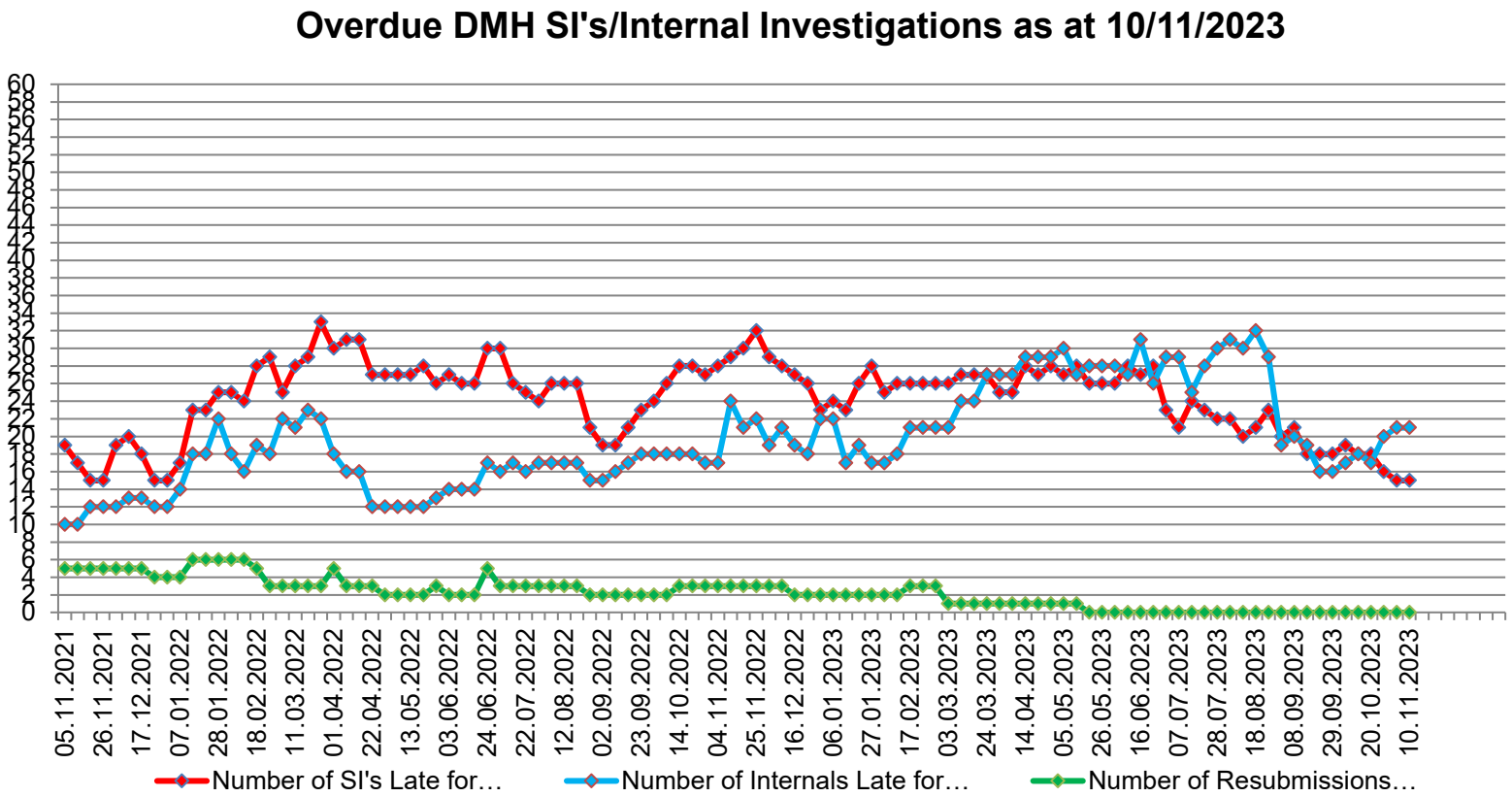
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH as at 10.11.2023



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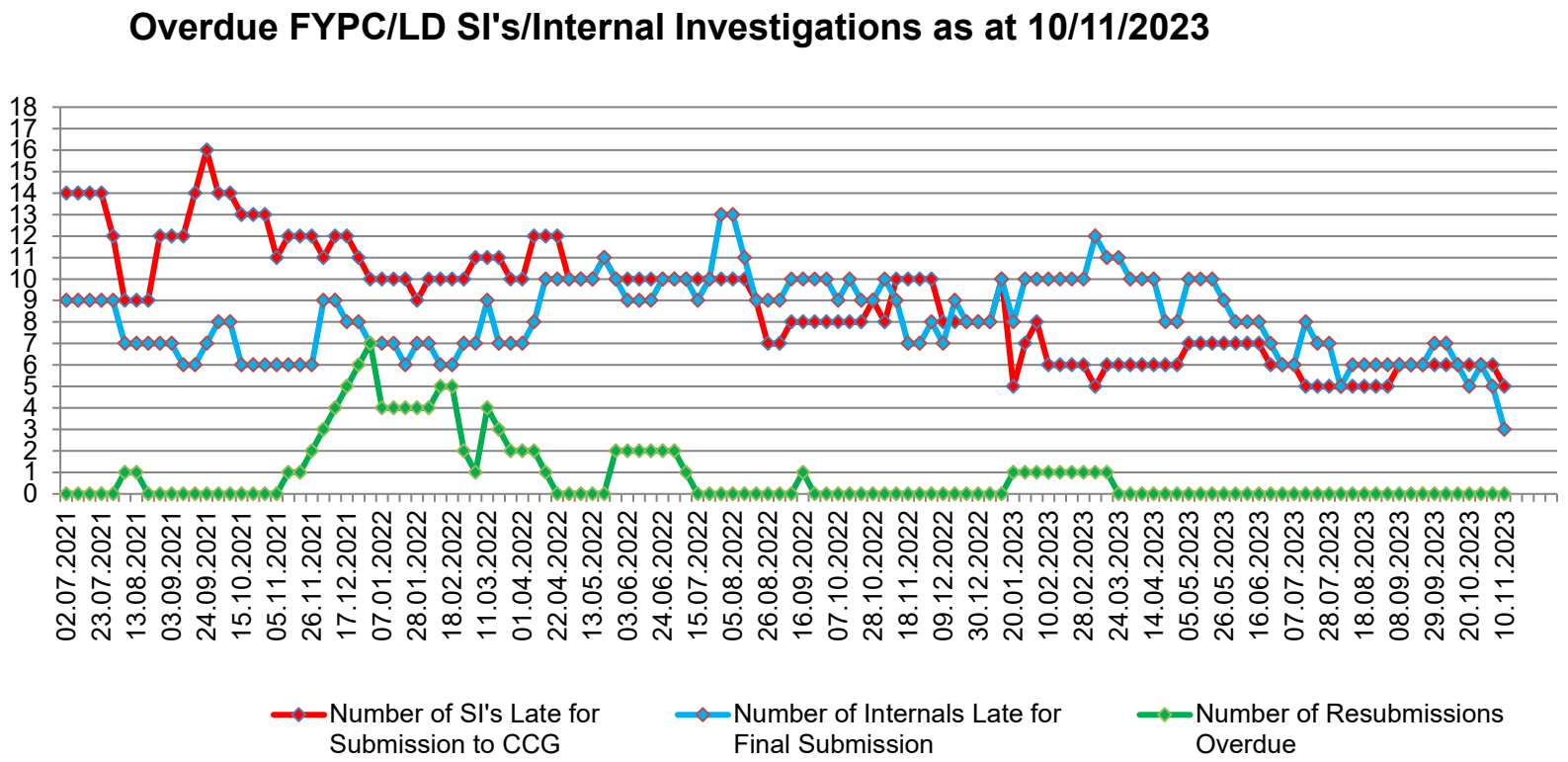
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) – FYPCLD as at 10.11.2023



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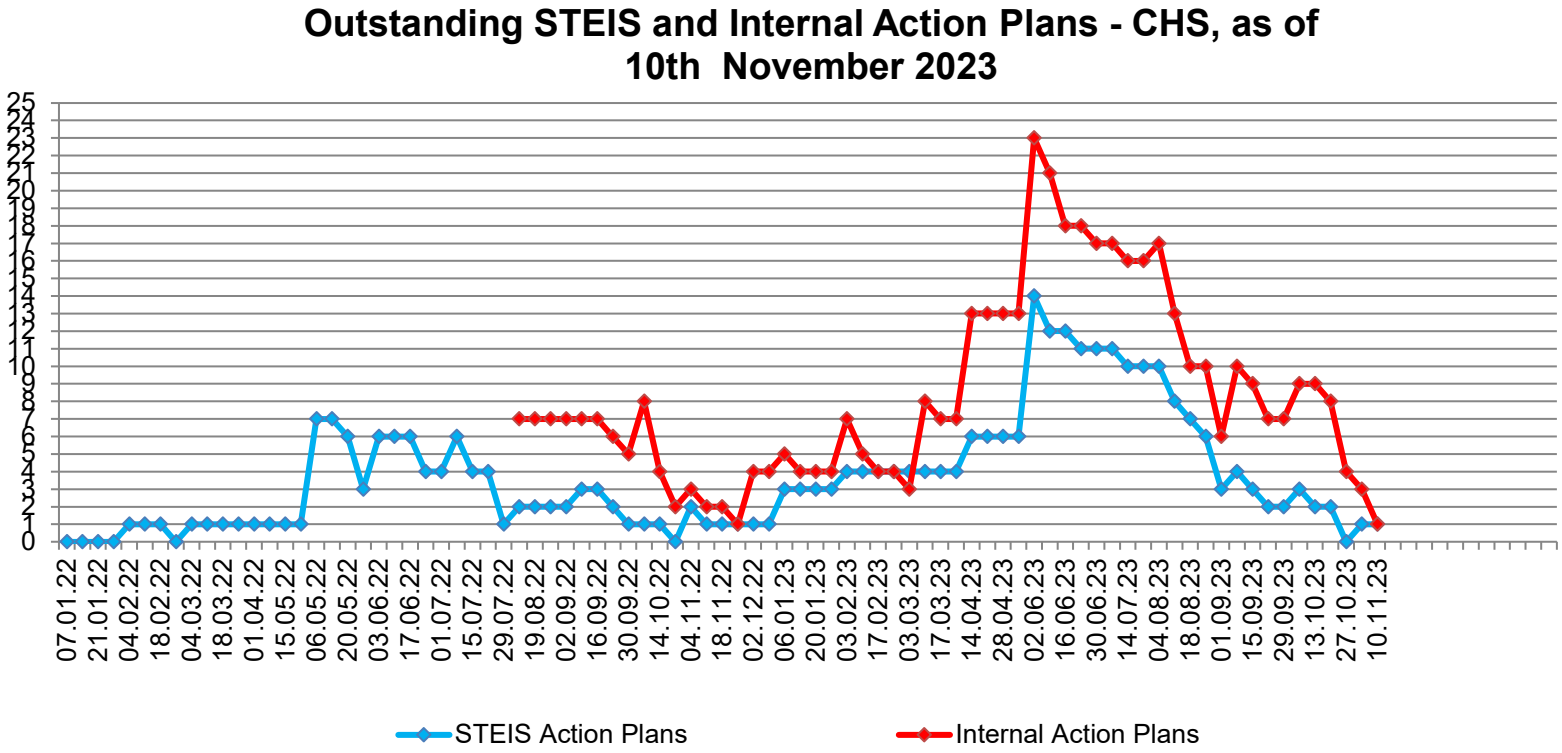
12b. Directorate SI Action Plan Compliance CHS Status 2021/22 as at 10.11.2023



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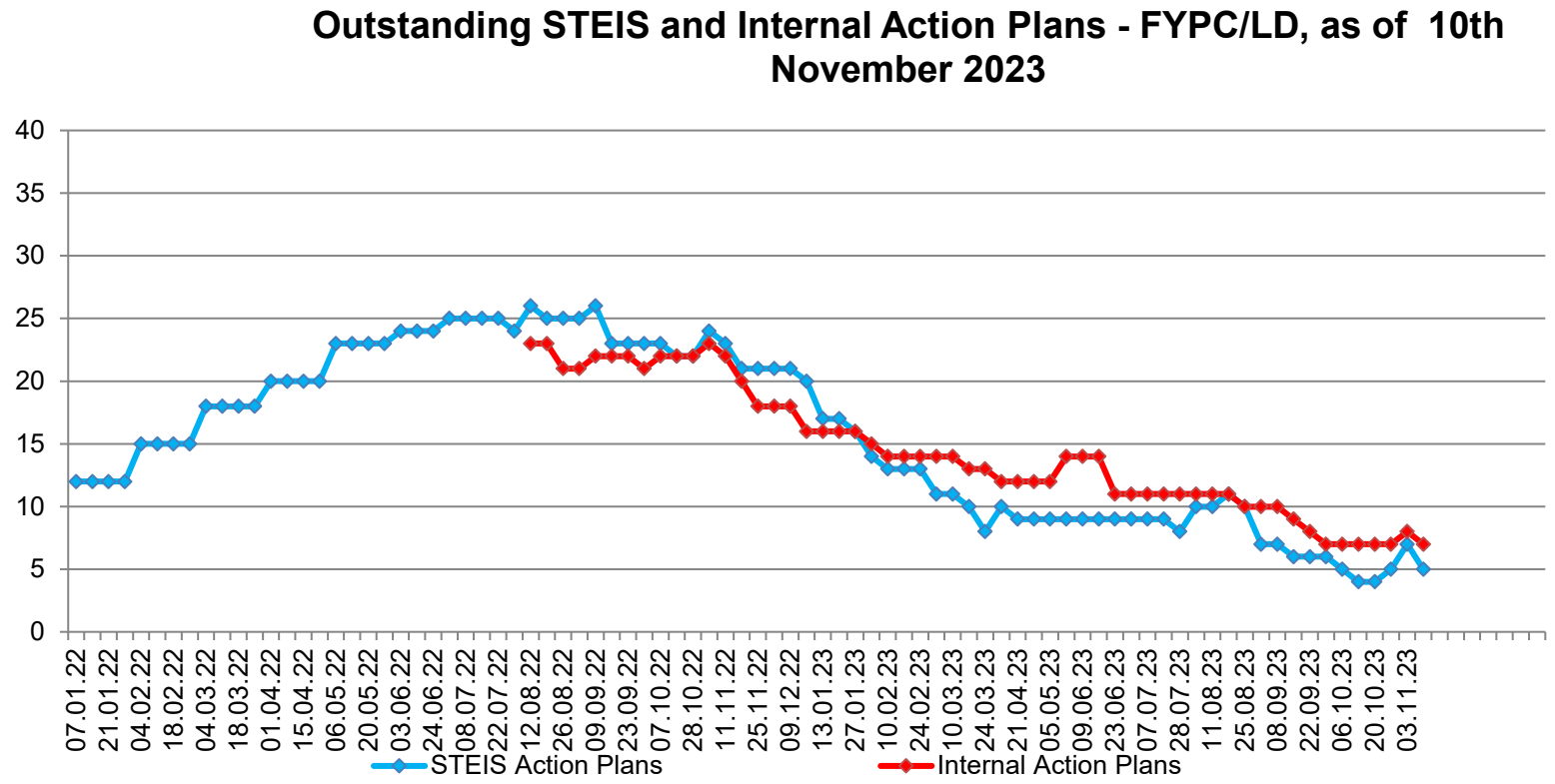
12b. Directorate SI Action Plan Compliance FYPC/LD Status 2021/22 as at 10.11.2023



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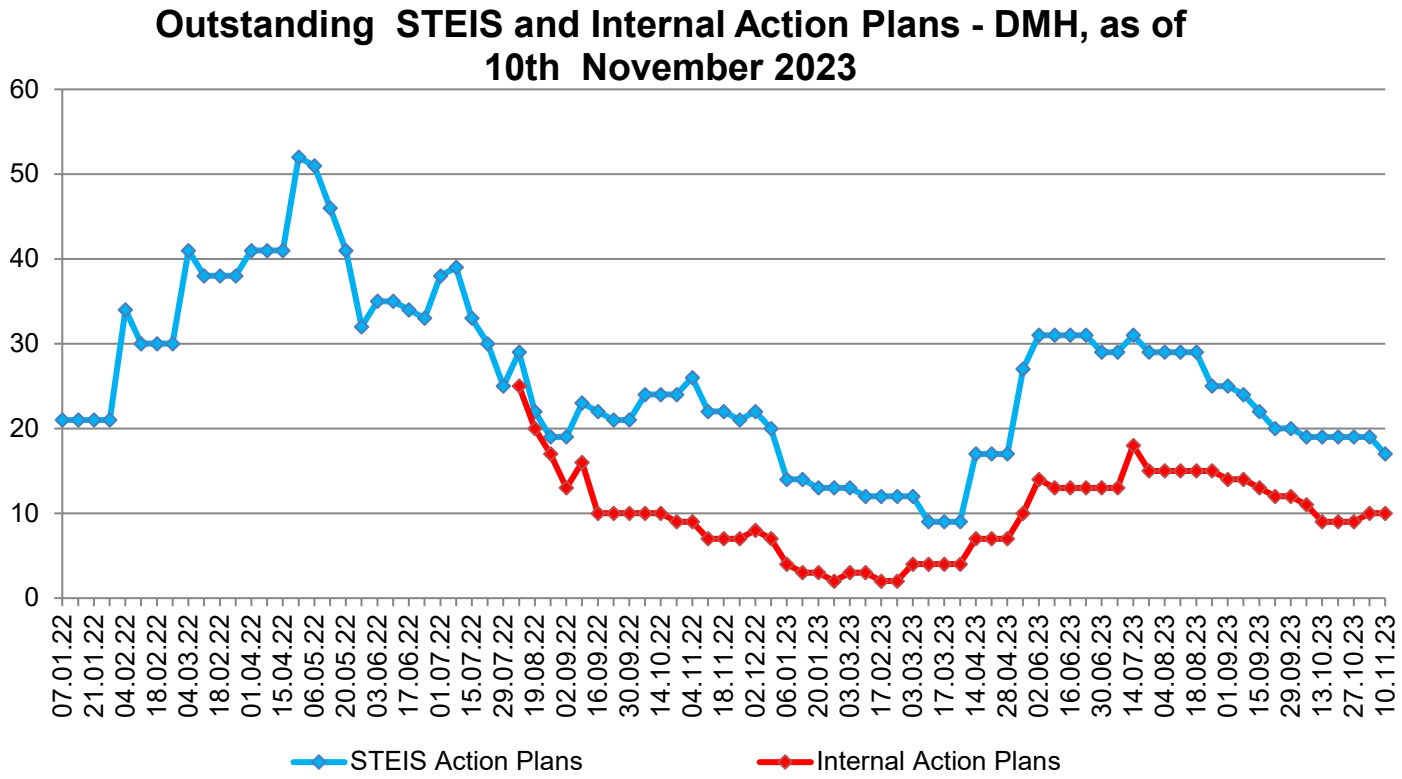
12b. Directorate SI Action Plan Compliance DMH Status 2021/22 as at 10.11.2023



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13. Learning from our learning response process

We have now transitioned to PSIRF we are working to skill wider groups of staff to use system thinking to consider incidents.

- Teaching methodology for After Action Review (AAR) and System Engineering for Initiative for Patient Safety (SEIPS)
- Encouraging confidence to talk together about system learning and less focus on writing reports
- Strengthening processes for engaging with clinicians who may have been temporary staff or have left the organisation

14. Learning September/October 2023

Incidents/Complaints Emerging & Recurring Themes

- We are identifying through our incident reviews and talking to families that they do not feel they have been appropriately involved or informed about their relative's care.
- On review this is multifactorial and includes; Staffs fear of breaching confidentiality. Lack of staff continuity that means that deterioration is not always recognised and therefore communicated to families.

Action; local workstreams are in place to support staff to see the benefit of involving families and patient stories used to demonstrate this

15. Learning from incidents

- We are identifying through incident reviews areas of practice that we were not aware of previously eg poor record keeping, processes that are not robust and standardised – variation between teams. In addition, the findings do not always match audit findings

Action; governance teams and the we improve Q team together with patient safety are reviewing the process of audit and monitoring to ensure we have processes that are robust and useful to drive improvement

Leicestershire Partnership NHS Trust

Patient safety – learning from incidents – Lucy

Lucy is known to mental health services with a diagnosis of anxiety and depression. She had been admitted to hospital following an attempt on her own life. Lucy is currently an informal patient and was transferred to an acute surge step down ward. Prior to this incident there was no known history on records of harm to others.

What happened:

Lucy's distressed relative approached Practice Development Nurse (PDN) in the communal area of the unit during a visit and requested help.

Relative reported Lucy had disclosed to her that she had been non-concordant with her prescribed medication and had crushed the medication and had planned to poison another patient with them. Lucy had the medication on her person. The PDN asked the Ward sister who was in the vicinity to request, Nurse in charge on the ward attend the communal unit area.

The PDN approached Lucy with the relative and engaged in 1:1 contact regarding what her relative had stated. Lucy willingly handed over a hand towel from her pocket that contained crushed medication, however the quantity, dosage or drug type was unknown due to medication being crushed. Lucy reports that this was their morning medication. Lucy disclosed that she had planned to poison patient B with the medication in a drink, when asked what the intention behind the crushed tablets was. Patient appeared tearful and low in mood during interaction.

Lucy engaged in 1:1 with the PDN in the immediate incident. She appeared low in mood and tearful, she was expressing suicidal ideation and thoughts with plans to harm a fellow patient. Her relatives were given reassurance and their visit with Lucy ended to allow Lucy to spend 1:1 time with the nurse in charge to discuss the incident and review any risks and plans to support Lucy moving forward.

Learning:

- Lucy wasn't checked to ensure that she had swallowed her medication. Therefore, she was able to secrete it, with the intention to crush it and to give it to another patient.
- There was no record made of room searches being carried out when staff had been asked to do a search of this patient's bedroom.
- The risk-assessment had not been updated to record that Lucy had secreted the medication, and her intent to give it to another patient.

What we have Changed:

- We have reminded staff to ensure that any medication we give to patients is taken at the time and that the member of staff is sure this has been done. If there is doubt that the medication may not have been swallowed, staff can ask the patient to show that the medication has been swallowed.
- Staff are now recording any room searches that are done on the ward where it is clinically indicated, based on patients' presentation and risk. A short entry needs to be made in the patient's progress notes, clearly highlighting the reason for the search taking place, which member of staff has requested that the search take place and the findings of the search. Whenever possible, it is important that the search is carried-out WITH the patient and it should be completed by two staff.
- It is important that both risk-assessments and care-plans are updated as soon as possible after e-irfs are submitted. We have recently done very well to make sure this is happening and the progress we've all made on this needs to continue.
- We are using the handover sheet which updates the risk, also having the ALERT highlighted on SystemOne (on the patient Portal) and on the ligature at a glance board.
- We are auditing patient's progress notes to ensure that staff are consistently applying the searching of inpatient and policy and their property policy and making entries when checking and searching is undertaken. When a patient is checked and searched (bedroom) we are going into the progress notes to check it's being recorded.

Staff Reflections:

- Lucy could have been supported on Level 3 observation for 30 minutes post medication.
- For staff to be completely focused with no interruptions when giving medications so they have their full attention to the patients, ensuring the patients have taken their medication.
- Staff should wear the red tabard for medication that says do not disturb to support the protected time to administer medication.
- To encourage patients to come to the clinic room and reduce taking medication down to the patient's bedrooms to support medication concordance.
- Staff should only allow one patient in the clinic room area at any time to support the patient's privacy and dignity when taking medication and to reduce distractions for the dispensing nurse.
- When incidents are reported part of reviewing the incident should include updating risk assessments and care plans as appropriate.

NHS
Leicestershire Partnership
NHS Trust

Patient safety – Learning from Incidents

Jane's Story

Jane was an 86-year-old lady who lived alone in her own home she was still driving, enjoyed being outdoors and was mobile and independent. Jane had sustained a previous bleed on her brain in 2020 and her family report that she had an element of short-term memory loss following this.

In May 2022 Jane had a stroke and following this her cognition and capacity were affected resulting in her being unable to understand risks and communicate effectively, meaning that decisions were required to be made in her best interests to support her safety. Jane was reviewed by the Speech and Language team following her stroke who assessed that she had mild to moderate expressive aphasia (this occurs when there is damage to the brain and may cause effortful speech, reduced understanding and problems with speaking and writing.)

When Jane was transferred to CHS inpatients she was observed to make sudden movements and mobilise without the use of her walking frame or support from staff, causing her to be at high risk of falls, it was assessed that she needed to be observed by a staff member at all times to support her safety on the ward. During the period prior to the incident Jane was having direct supervision when she sustained 2 falls, these did not result in Jane sustaining any injuries.

What Happened?

At 05.45 hrs Jane was in bed asleep, the bed was at its lowest setting near to the floor, and a nurse was seated in a chair next to Jane's bed. Jane awoke suddenly and put her legs out of the bed, when asked by the nurse if she wanted to use the toilet she didn't reply, as the nurse assumed that she may want to use the toilet she began to assist Jane to put on her non slip socks, without any communication Jane stood up suddenly from a crouched position, as the bed was at its lowest height she overbalanced and fell to the floor. Jane was immediately assessed by a Registered Nurse (RN) who observed that her leg appeared shortened and rotated and therefore it was suspected Jane had broken her hip.

The RN rang 999 and requested an urgent assessment of Jane. Staff were unable to use the flat lifting equipment that was available on the ward as there was no staff on duty trained to use this and a decision was made not to use a hoist to move Jane off the floor due to the possible injury to her hip. Oral paracetamol was given to Jane, however she continued to say she was in pain. Jane remained on the floor for 2 hours until the day staff arrived on the ward who were trained to use the flat lifting equipment. Jane was moved to her bed and after a review by an Advanced Nurse Practitioner Jane was given both oral painkillers and a morphine injection. The paramedics arrived an hour later, and Jane was transferred to the Leicester Royal Infirmary where she received treatment for a broken hip.

Effect On Jane

Jane was nursed on the floor for 2 hours following her fall, during this time she experienced pain, it is possible that due to her cognitive impairment she may not have been able to accurately describe the severity of her pain. staff have shared that during this time Jane was disorientated and unable to understand why she was on the floor and was frequently trying to get up from the floor and needed constant reassurance from staff.

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Good Practice:

Jane's cognitive status was assessed promptly on admission to CHS, and one to one supervision instigated based on her level of risk.

Physical assessment was completed on Jane immediately followed her fall and possible fractured hip identified and escalated to 999.

Prescribed analgesia was given to Jane for pain management.

The decision not to use the hoist to lift jane was correct as this could have caused more damage and affect recovery (NICE guidance)

What's our learning?

The height of Janes bed was altered so that on occasions it was at its lowest setting, Jane's risk assessment highlighted that her bed should have been at a normal height. The bed being lowered may have impacted on Jane's cognition and caused her to be disorientated when she moved from the bed. In addition, patients who are able to stand independently should not be nursed on beds at a low height due to the risk of getting up from a low level. Ensuring the bed height that was required was visible to all staff by putting this information on the whiteboard above Jane's bed and including this information in her care plan would have supported staff to ensure the bed was at the correct height for Jane at all times.

Jane was prescribed medication for her high blood pressure, a lying and standing blood pressure was not completed during Jane's CHS admission, had this been completed it may have given information if Jane's medication was effective or if her blood pressure reduced when she stood up, it was recognised that as Jane stood up quickly and was often unable to communicate effectively due to her cognition that she may have experienced symptoms of altered blood pressure which she may have unable to describe due to her cognitive impairment.

After Jane's prescribed analgesia had been given she told staff that she still had pain, if the Out of Hours service had been informed of this they would have been able to remotely prescribe additional analgesia that could have been given to Jane to manage her pain more effectively whilst she was waiting for the emergency ambulance.

Jane was often not able to communicate her needs to staff quickly due to her cognitive impairment, staff have shared that using a picture board may have supported her to communicate her needs more promptly.

Completion of a fall's huddle and checklist following Jane's fall would have allowed all of the relevant information that staff knew following the event to be recorded to allow accurate and detailed record keeping and support future falls risk assessments.

The physical assessment that was performed on Jane by the RN following the fall was not recorded on the electronic records, this would have given accurate details of her clinical presentation to share with the ambulance crew to enable clinical assessments to be compared.

Leicestershire Partnership NHS Trust

Patient safety – learning from incidents – Hassan

About Hassan

Hassan is a 15-year-old young male who has been known to CAMHS Services since September 2020.

Hassan is a young person with complex needs, presenting with an underlying neurodevelopmental disorder (ASD), chronic and severe mental disorder, suicidal ideation and significantly deteriorating physical presentation, physical and dental health. There were on-going challenges with him struggling to engage and his ability to always work with his treatment plans.

He had historically expressed a reluctance to take medication as he felt it would "change him". Hassan was dismissive of his diagnosis of ASD. He was consistently reluctant to accept help, stating he would "figure it out himself". He presented with rigidity of thought and lacked insight into his difficulties.

Hassan also had two inpatient admissions at the CAMHS Beacon Unit from December 2020 to February 2021 and April 2021 to May 2021, during which improvements in his presentation were observed (Hassan would eat, wash and engage with staff on the ward) but this was not maintained when he returned home, with him reverting back to the same behaviours and his physical health and mental state rapidly deteriorating again.

In February 2022, Hassan's parents made the decision to start administering medication covertly - they discussed their decision with a clinician who provided the prescription and advice on safe titration. During this time Hassan made significant improvements. He engaged with professionals, his mental state improved, relationships at home were significantly better, he was attending education and was showering.

What happened:

Whilst being visited by an Occupational Therapist (OT), Hassan described that he had found a half empty bottle of medication. He had read the label, which stated fluoxetine, and subsequently looked it up on the internet. It was at this stage Hassan realised it was the same medication that a psychiatrist had previously being trying to prescribe for him.

The OT reviewed the electronic patient record in SystmOne to check for a covert administration of medication care plan / best interest and mental capacity discussions. This was not found.

Progress notes from three months earlier documented that Hassan had capacity to make decisions around medication and personal care.

Good practice:

This was a complex case and the professionals involved were working hard with Hassan's best interest in mind which was positive. The clinical decisions made were with the best of intentions with Hassan's welfare being paramount.

Learning:

A review of the Covert Medication Policy has taken place and includes guidance on the covert administration of medication by parents/carers for children and young people under the age of 16 which outlines the principles of Gillick competence.

The current Mental Capacity Act training is being reviewed to consider inclusion of legal issues for under 16s, competency to consent and principles of Gillick competence. Other training material and guidance on mental health capacity is also being sourced to support staff knowledge and understanding on this.

A process for escalation where there are concerns identified regarding children and young people's care and treatment has been developed to support resolution of differences in opinion between professionals.

Interim guidance has been developed for staff on how to document in SystmOne the assessments of Gillick competency for young people under 16.