April 2006 S6/2006

Letter addressed to the Chief Executives of All Boards and Trusts

Dear

MONITORING OF UNTOWARD EVENTS BY THE MENTAL HEALTH COMMISSION (REVISED GUIDANCE)

Under the Provisions of Articles 86(2) of the Mental Health (Northern Ireland) Order 1986 (the Order) the Commission has a duty to make inquiry into any case where it appears to the Commission that there may be, amongst other things, ill treatment or deficiency in care or treatment.

The Commission last issued guidance on this issue in April 2000 and in the light of experience gained since then it has reviewed and updated the reporting requirements. The Commission wishes to promote a culture of learning and continuous improvement.

The types of incidents which are required to be reported are as follows:-

i. the death of any patient or client not resulting from natural causes whether this occurred in the hospital or the community;

ii. suspected suicides whether in the hospital or community;

iii. sexual assaults or serious sexual allegations whether in the hospital or community;

iv. actual or alleged physical assaults by members of staff whether in the hospital or community;

v. Serious assaults by patients, in hospital or the community, on others (other patients, visitors or staff);

vi. Alleged gross professional misconduct and/or serious deficiencies in standards of care; and

vii. Any other incident that the provider feels should be brought to the attention of the Commission, for example, unexplained serious injury.

Where any of the above incidents have occurred within the community the Commission would not normally require a report on patients or clients who have not received care or treatment for a mental disorder for more than two years. ***The Commission acknowledges that sometimes incidents occur without Trust staff becoming aware of them.***

Boards and Trusts should also notify the Commission of incidents involving independent contractors (e.g. General Practitioners) which meet the above definitions.

A brief account of the circumstances of the incident should be sent to the Commission **within three working days** of becoming aware of the incident.

A Review meeting which will usually be multi-disciplinary should be held as soon as possible but **no later than eight weeks** after the event and the report sent to the Commission **within twelve weeks** of the incident being reported to the Commission

The Commission expects that Multi-disciplinary or Serious Incident Reviews will comprise, as a minimum;

Consultant Psychiatrist (RMO)
Named Nurse or Keyworker
Senior Manager

Multi-disciplinary or Serious Incident Reviews should include an approved social worker.

Other professionals and staff with significant involvement in the case, including independent contractors and/or Suicide Awareness Workers where available, should be invited to attend as required. Service users and carers and/or their representatives should also be encouraged to participate where appropriate.

In a suspected case of suicide the Review should be chaired by an independent person ***with relevant professional experience*** from outside the relevant programme or directorate.

Review Reports should include the following;

(a) date of the incident, when reported to the Commission and how and when the organisation became aware of the incident;

(b) names and designations of those attending the Review meeting;

(c) information ***on the background and past history including*** the mental state of the patient, ***if known***, particularly at the time of the incident;

(d) information regarding any other person involved in the incident indicating whether staff, patient or member of the public; and

(e) summary of the involvement of each key professional including dates seen and planned future appointments at time of incident/death;

(f) recommendations for future practice arising from the review, including preventative measures required and the associated implementation plan;

(g) the minutes of the meeting should be dated and signed ***by the Chair*** including a record of the date of the review meeting.

(h) any issues for independent contractors (particularly GPs) including preventative measures required and the associated implementation plan.

(i) the steps taken to offer support to staff, relatives and others.

Where there is no multi-disciplinary involvement with the patient the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action to be taken as a result of the investigation within six weeks of the incident being reported to the Commission.

These guidelines relate to all patients suffering from mental disorder as defined in Article 3 of the Order who have received treatment or care in the previous two years, whether in hospital on a voluntary or compulsory basis or in the community.

The Commission expects that Trusts will record, monitor and review all accidents, incidents and untoward events. If any incident occurs which does not fall within these guidelines but the Trust wishes it to be drawn to the attention of the Commission it should feel free to do so. The Commission may, during the course of its visits to hospitals and facilities in the community, inspect records and review management's policies and procedures regarding all untoward events.

The Commission also expects that all Boards and Trusts through their formal contracts or Service Level Agreements (SLA's) with independent sector

providers will insist that the Commission is notified of any incidents consistent with the advice contained within this letter.

Yours sincerely

Chief Executive

Action by Mental Health Commission on Receipt of Reports

Following consideration of all relevant case material, the Mental Health Commission will normally take one of the following courses of action

(a) No Further Action (including letter of closure);

(b) Letter requiring further information or clarification;

(c) Referral to another body, if appropriate; and

(d) In the event of non-compliance with timescales and other requirements, the Mental Health Commission reserves the right to carry out an unannounced visit to inspect all relevant records and to interview relevant individuals. This action will be considered when there is consistent failure to comply with the timescales laid down by the Commission (Ref; Article 86,)

Highlighting Good Practice

As already indicated, the Mental Health Commission wishes to promote a culture of learning from suicides and other untoward events rather than a culture of blame. Therefore, the Commission will seek to;

(a) Analyse and audit all reports received

(b) Carry out trend analysis

(c) Promote good practice using a variety of methods including publication of the Annual Report.