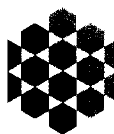
From the Chief Medical Officer,
Dr Michael McBride and the
Chief Nursing Officer, Martin Bradley



Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

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Your Ref:
Our Ref: S&Q Learning Communication 01/2009

Date: 20 January 2009

For action:
SABS Liaison Officers:
- to acknowledge receipt by 23 January 2009
- to indicate action underway by 30 June 2009
- to confirm completion by 29 January 2010

Chief Executives, HSC Trusts, for action and cascade to:

- Medical Directors
- Mental Health Directors
- Nursing Directors
- Social Care Directors
- HR Directors
- Chairs, Governance Committees
- Clinical & Social Care Governance leads
- Other relevant staff

Chief Executives, HSS Boards for cascade to

- Directors of Nursing
- Directors of Social Care
- Chairs, Governance Committees
- Clinical & Social Care Governance leads

For Information
Chief Executive, RQIA
Chief Executive, MHC
Chief Officers, HSS Councils
Director, HSC Safety Forum
Chief Executive, NIMDTA
Chief Executive, NIPEC
Professor Patrick Johnston, Head of School of Medicines, Dentistry and Biomedical Sciences, QUB
Professor Linda Johnston, Head of Nursing & Midwifery, QUB
Professor Hugh McKenna, Head of Life and Health Sciences, UU
Dr Owen Barr, Head of School of Nursing, UU

PATIENTS WITH MENTAL HEALTH NEEDS IN THE ACUTE SECTOR – LEARNING LESSONS

Dear Colleagues

We are writing to highlight to you a number of learning points arising from an investigation carried out by a HSC Trust into the events surrounding the tragic death of a patient with mental health needs. In the interests of learning, the Trust and the Department are communicating the relevant recommendations and learning identified which have regional implications.

As you will be aware, increasingly our acute general hospitals have to initially recognise and then manage and treat patients with complex mental health needs. The recommendations relate to:

- Detaining and restraining patients under the Mental Health Order;
- Staff training
- Communication among staff (clinical and non-clinical); and
- Security access.

It is important the recommendations and lessons from this incident are adopted and applied, where relevant, by all Trusts and that staff in each Trust consider their own practice and service so that the risk of recurrence is minimised.

Background

A person presenting to A&E may have mental health requirements for treatment as well as, or in addition to, physical symptoms. The patient may have had an episode of deliberate self-harm or have been found in a neglected and confused state and appropriate arrangements need to be in place to deal with such eventualities. While it is a not uncommon situation for acute general hospitals to have to manage and care for patients who have a mental disorder, on certain occasions this may even require urgent action to be taken for the patient's own safety, and others' safety. Also in some cases, it may necessitate the use of the Mental Health Order.

Learning arising

Consequently, the following recommendations should be brought to the attention of staff within your organisation so that the appropriate local learning and action can take place (ie. relevant governance groups, risk managers and key clinical and non-clinical staff).

(i) Awareness of responsibilities and powers under the Mental Health Order

- There is a responsibility on acute hospital staff to provide appropriate treatment and care for a patient on a temporary basis until suitable alternative arrangements can be made. In such a case, the hospital staff need to be in a position to recognise and identify the mental health needs and, when necessary, to secure the patient's safety until a psychiatric assessment can be conducted or an appropriate referral made for specialist treatment.

- Appropriate treatment and observation should be provided and this should include the need to be mindful of treating the physical wellbeing of someone with mental health issues and the implications of medicating for a variety of

conditions, including consideration of withdrawal from alcohol or drugs.

- When detaining a patient the process and documentation should be completed in accordance with the Mental Health Order and Code of Practice.

- The PSNI has a key role in assisting hospitals retrieve patients who have left the hospital site whilst detained under the Mental Health Order. The police have the authority to return the patients to the care of the hospital and should be informed at once if a patient is absent without leave.

(ii) Staff training

- Training of staff (clinical and non-clinical) should take place to raise awareness of the detention process, the potential consequences for patients, staff and the ward environment and the individual responsibilities and powers available to them under the Mental Health Order in order to maintain patient and staff safety (including familiarisation and completion of documentation/forms to detain a patient under the Mental Health Order).

- Training on use of therapeutic restraint which is proportionate to an acute setting should be provided to relevant clinical and non-clinical staff and updated regularly.

- Training on management of mental illness presenting in acute setting (and also recognising signs and symptoms of alcohol withdrawal).

(iii) Communication among staff (between clinical and non-clinical staff and with outside bodies)

- A communications protocol should be in place which ensures that all relevant clinical and non-clinical staff (ie. administrative, support services, security, portering, switchboard operators, etc) are made aware when action is to be taken when a patient has been detained under the Mental Health Order. In particular, it is important that all relevant personnel are promptly alerted to the presence of a detained patient as soon as the relevant paperwork and documentation is completed.

- On those occasions when there is a risk to the patient or others, there may be a need to intervene. Any intervention required to manage disturbed behaviour must be a reasonable and proportionate response to the risk it seeks to address. Organisations should take account of all available best practice guidance to inform their practice.

- Each Trust should have a 'Missing Persons' protocol in place which clearly defines the roles for clinical and non-clinical staff in the sharing and updating of information as an untoward event unfolds.

- Patients' details should be up-to-date and family/carer contact numbers updated/verified on a regular basis. All clinical contacts regarding the patient should be documented in the records (including those contacts by

telephone). In addition, to ensure important information is shared on a timely basis, clinical and non-clinical staff should have access to contact details for relevant external bodies, such as the local PSNI, and within the hospital environment, contacts for 9am-5pm weekdays; night manager; and co-ordinating sister for out of hours.

(iv) Security of premises

- When conducting a security audit in an acute hospital, ensure it takes account of the risks associated with access and egress of detained patients. As with all forms of risk assessment, an appropriate balance needs to be achieved with regards to the potential risk in relation to a detained patient and those posed to the general hospital population. All decisions pertaining to the security audit should be clearly documented.

- Risk assessment of the acute environment should be conducted in accordance with the guidance set out in MDEA(NI) 2007/083.

More generally, we would take the opportunity to highlight to you two informative papers:

1. NICE Clinical Guideline 25: short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments [Feb 2005][1]; and
   http://www.nice.org.uk/Guidance/CG25

2. Report of a Working Party: Alcohol – Can the NHS Afford It? Recommendations for a Coherent Alcohol Strategy for Hospitals. Royal College of Physicians [Feb 2001]. http://www.rcplondon.ac.uk/pubs/contents/ea90ff6a-fcd3-4112-b958-d98f0cc2246a.pdf

You should now bring this learning to the attention of all relevant staff and your governance committees in order that the appropriate action can be taken to minimise the risk of harm to patients in similar situations.

[1] The National Institute for Health and Clinical Excellence produced a clinical guideline on short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments in February 2005. As part of an ongoing programme, NICE is due to commence a review of this guideline in February 2009. Under the terms of the Department's agreement with NICE, the revised guidance will be reviewed for its applicability to Northern Ireland, and the HSC will be advised of the outcome. In the meantime it is referenced for information purposes.

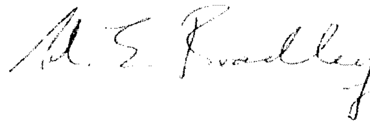
Action for HSC Trusts:
Trusts (and independent sector, where appropriate) should take immediate action to implement this learning. By:

- 30 June 2009, Trusts should have completed a review of current procedures and drawn up an action plan to address the issues identified in paragraphs (i) to (iv) above;

- 29 January 2010, ***all action should be completed.***

Trusts should provide assurance on this action to the new Regional Health and Social Care Board and copied to the Department via the Safety Alert Broadcast System.

Yours sincerely



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