

UTEC COMMITTEE GUIDANCE NOTE (August 2007)

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, including homicide, 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, including financial irregularities 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 2 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 and **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 Key worker
Approved Social Worker
Senior Manager

It would be considered best practice that a Multi-disciplinary or Serious Incident Review team should include the staff listed above, however, it is recognised that in a minority of cases, the service user may only have received unidisciplinary services. In this instance and, after careful consideration, staff from at least two of the care professions outlined should be involved.

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 Commission recommends that 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, particularly, **if known**, at the time of the incident;

- (d) whether consideration was given to the safety and welfare of any children in the family and was a risk assessment considered and carried out.
- (e) information regarding any other person involved in the incident indicating whether staff, patient or member of the public; and
- (f) summary of the involvement of each key professional including dates seen and planned future appointments at time of incident/death;
- (g) recommendations, if any are identified, for future practice arising from the review, including preventative measures required and the associated implementation plan;
- (h) the minutes of the multidisciplinary audit review meeting should be dated and signed by the Chairperson of the meeting;
- (i) any issues for independent contractors (particularly GPs) including preventative measures required and the associated implementation plan.
- (j) the steps taken to offer support to staff, relatives and others.

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.