Serious Incident / Mortality Audit
Adult Liaison Psychiatry Service
Royal Cornwall Hospital

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Adult Liaison Psychiatry Service Royal Cornwall Hospital

- Cornwall Partnership NHS Foundation Trust
- Consultant Psychiatrist, Team manager Band 7 Psychiatric Liaison Nurses Band 6, Trainee Drs – Core Trainee in Psychiatry and F1
- 2013 - 9 to 5 service 7 days weekly
- 2014 October extended hours till 20:00 7 days weekly.
- Service sees 2000 patients a year.
- Out of above hours patients are admitted to Clinical Decisions Unit or referred to on call Dr for Psychiatry who is supported by On call Consultant Psychiatrist.

Background

- In Cornwall, around 60 people per year lose their life to suicide, more than the number lost to Road Traffic Accidents. The rate in Devon, Cornwall and the Isles of Scilly (11.3/100,000 in 2013) is higher than the England average but fewer people who die seem to be known to mental health services. In Cornwall all deaths by suicide are audited by Public Health.

Cornwall & Isles of Scilly Health Community Suicide Audit Group Annual Report

Background

- When a death is reported within CFT as a Serious Incident, for any current patient or one within 12 months of previous contact, the cause of death is sought and if there is any possibility of suicide, it is listed as a probable suicide in the Serious Incident shared drive and an investigation commenced
- In 2014, 19 deaths by suicide or presumed suicide were reported to CFT.

Suicides in Cornwall 2014: known to CFT in year prior to death16th February 2016Dr Ellen Wilkinson, Medical Director

Royal Cornwall Hospital

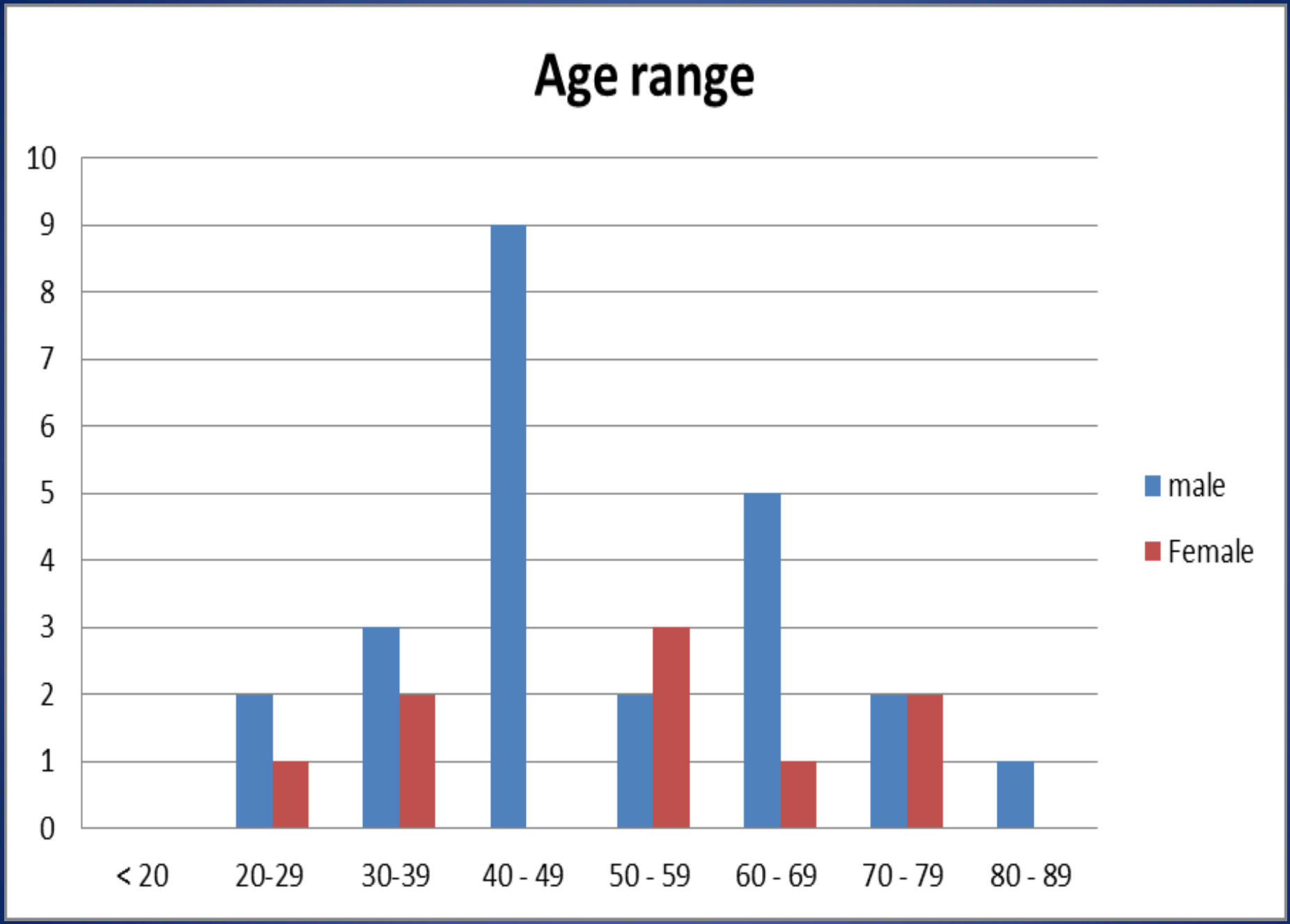
- Aprox 1300 self harm presentations to Royal Cornwall Hospital Emergency Dept a year – ED Clinical Coding & Multiple self harm presentation audits
- Aprox 80 to 90% patients receive specialist psychosocial assessment - Liaison Psychiatry Audits

The Study

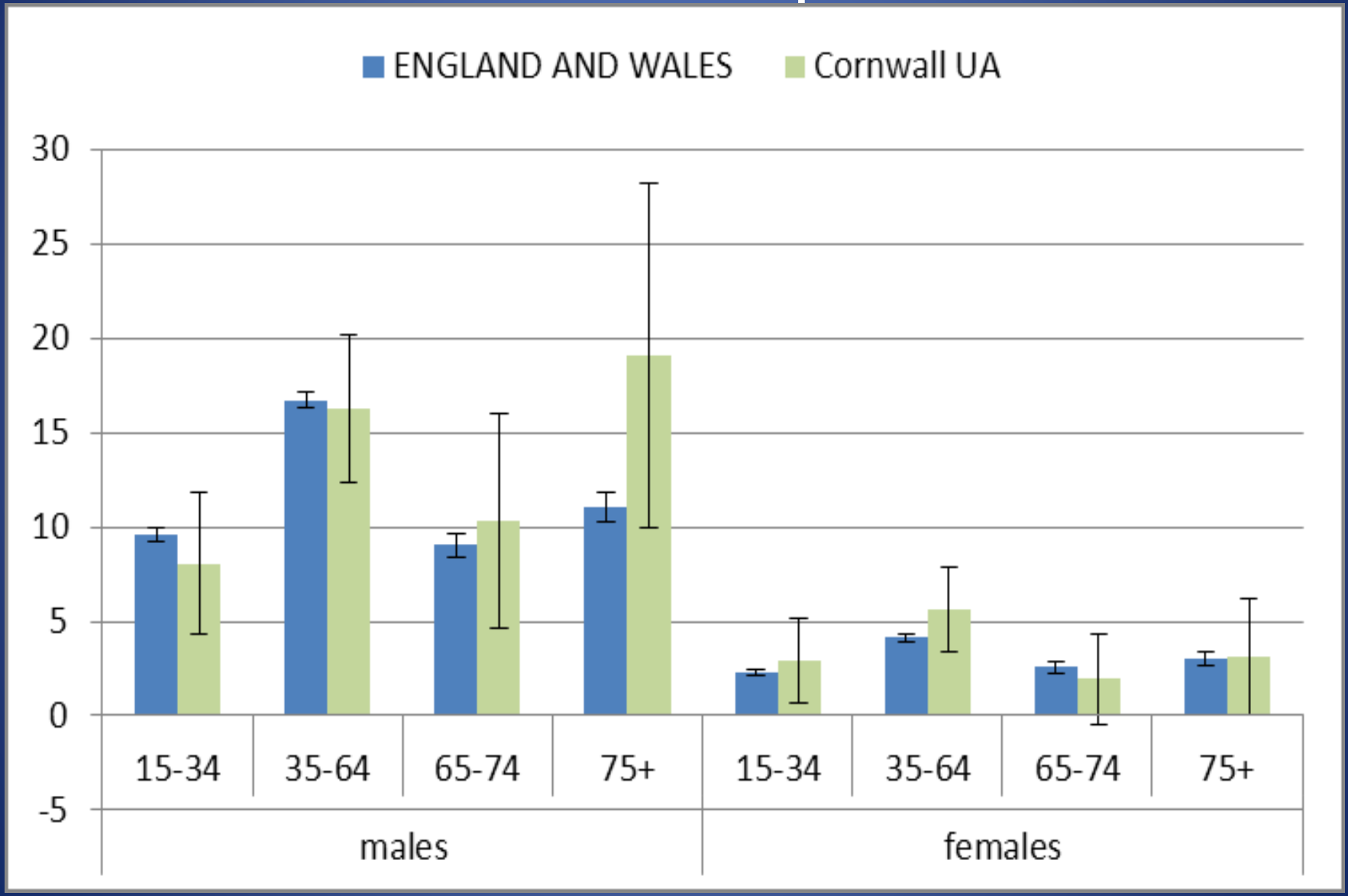
- Continuous Data Collection since beginning 2013
- Reviews of Coroners reports and Serious Incident Reports.
- Includes all patients who were seen for self harm or reported suicidal / self harm thoughts or acute mental illness
- Some of these patients died of substance misuse related problems or cause of death unknown.
- Patients seen with solely substance misuse problems who died of substance misuse related problems or other patients who died of unrelated causes were excluded
- Data may be incomplete

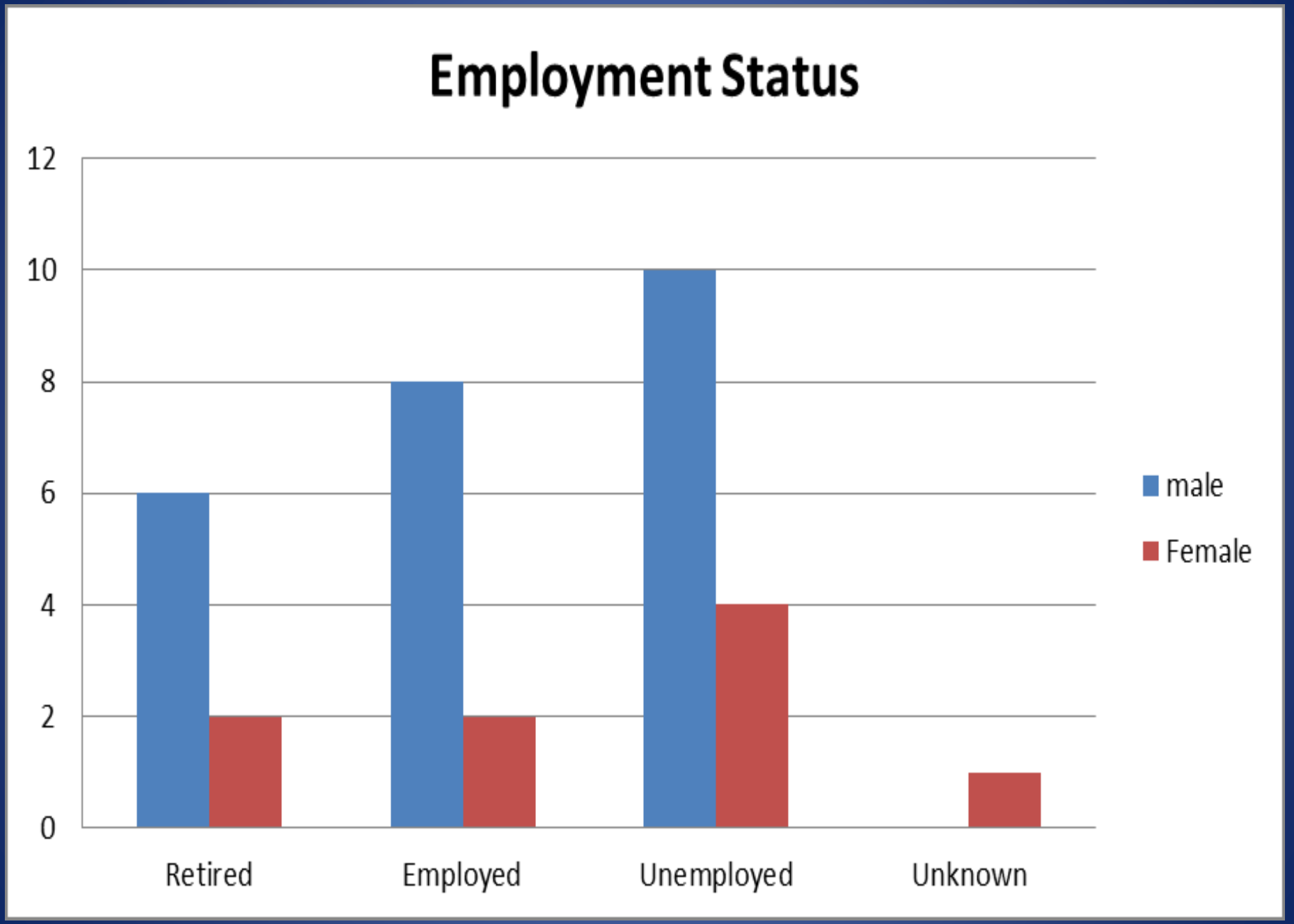
Mortality Data

- 2013 - 16 deaths
- 2014 - 15 deaths
- 2015 - 2
- Male – 24
- Female – 9
- All White British
- Patients sexuality was usually recorded.

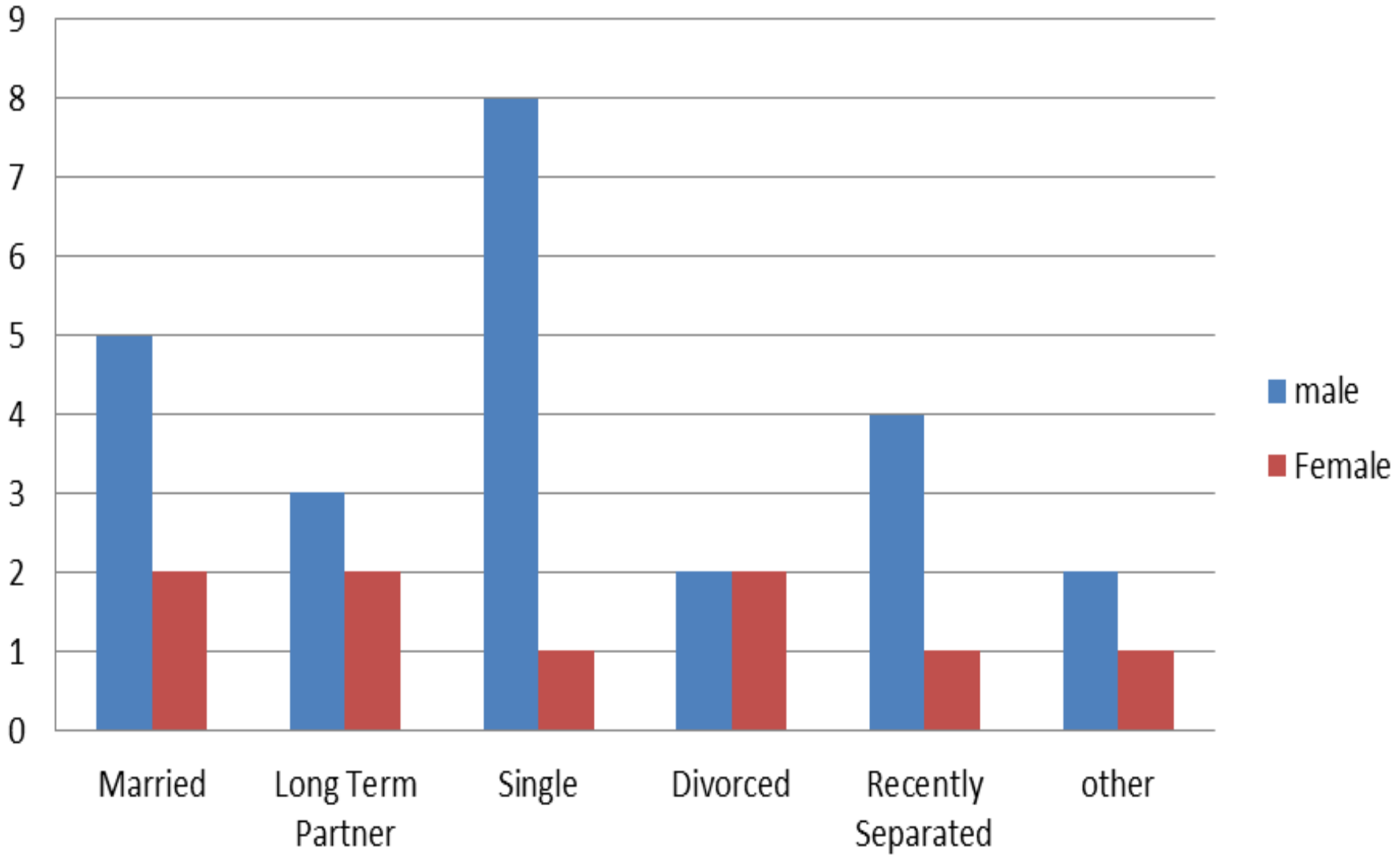

Age range
10
9
8
7
6
5
4
3
2
1
0
< 20
20-29
30-39
40 - 49
50 - 59
60 - 69
70 - 79
80 - 89
male
Female

% Suicide rates by Age and Sex 2011 – 2013 pooled

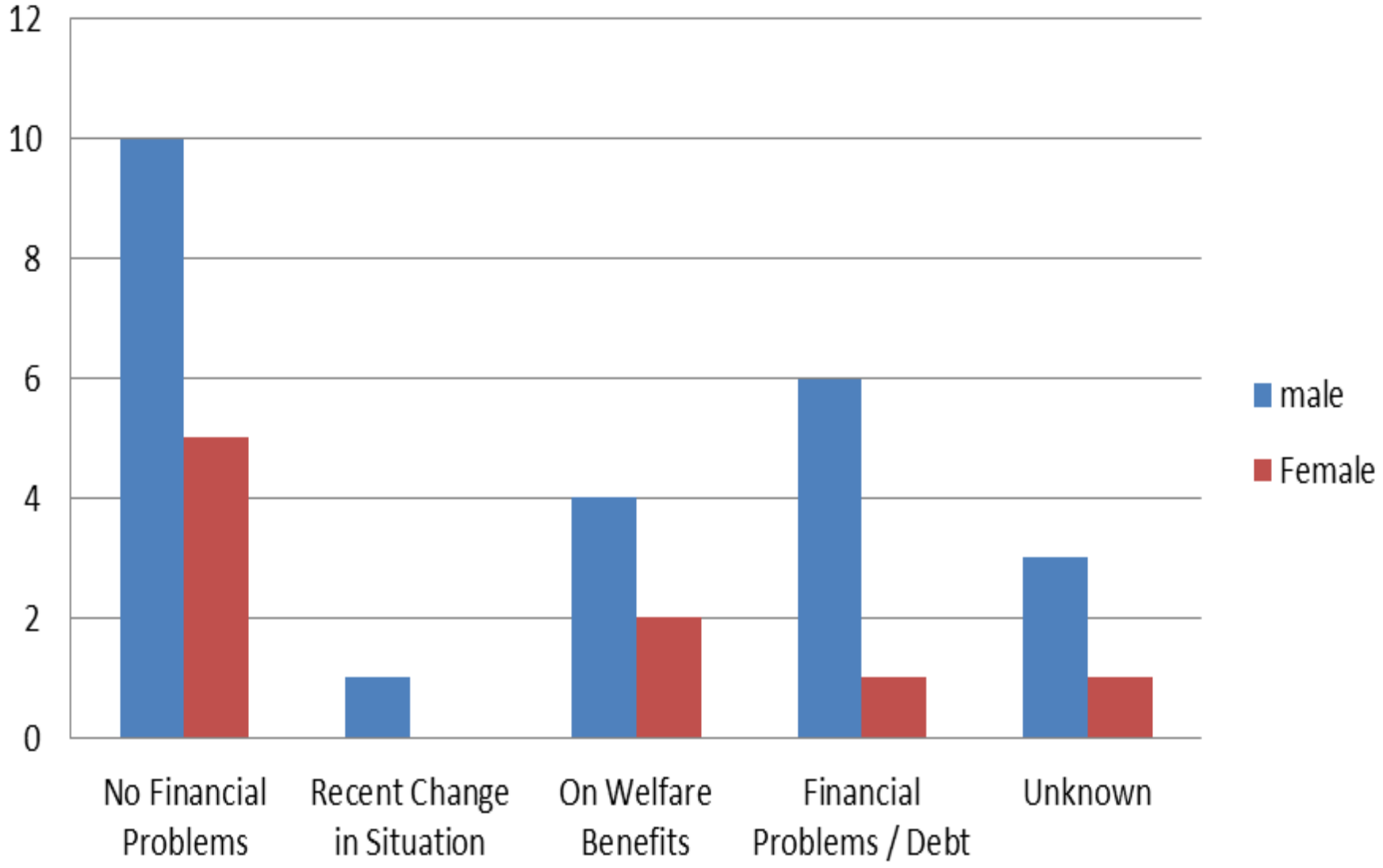



Employment Status
12
10
8
6
4
2
0
Retired
Employed
Unemployed
Unknown
male
Female

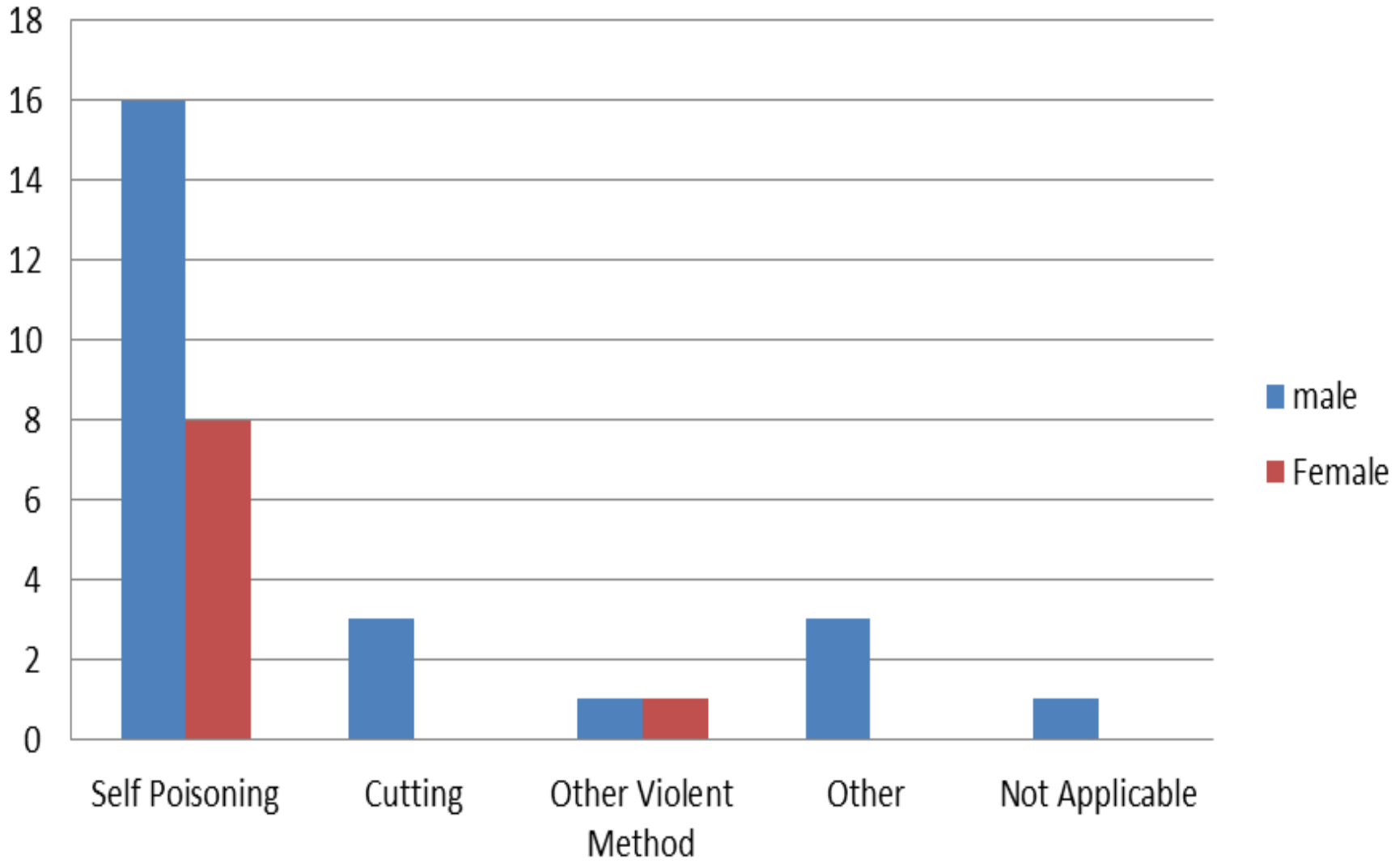
Marital Status



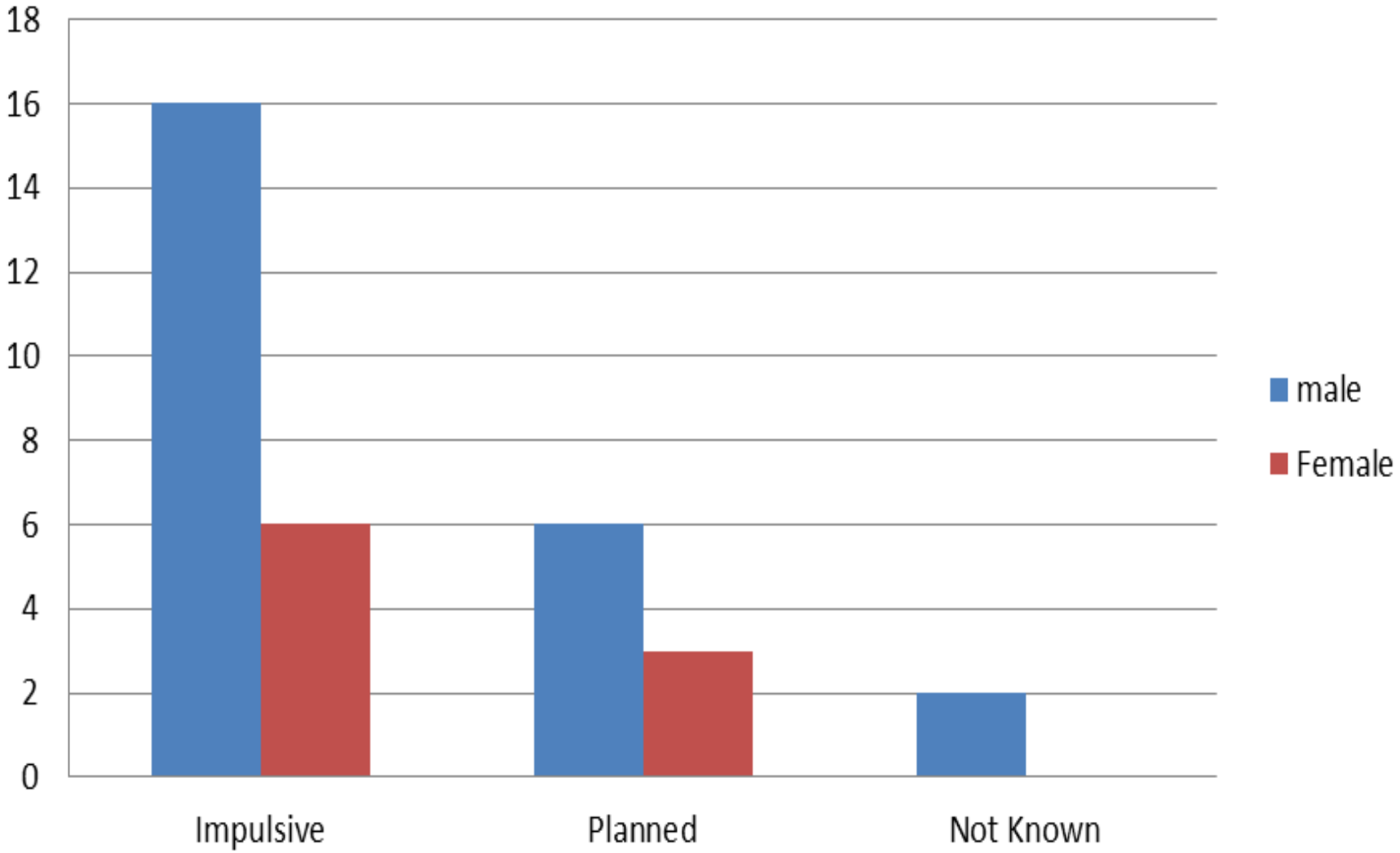
Financial Situation



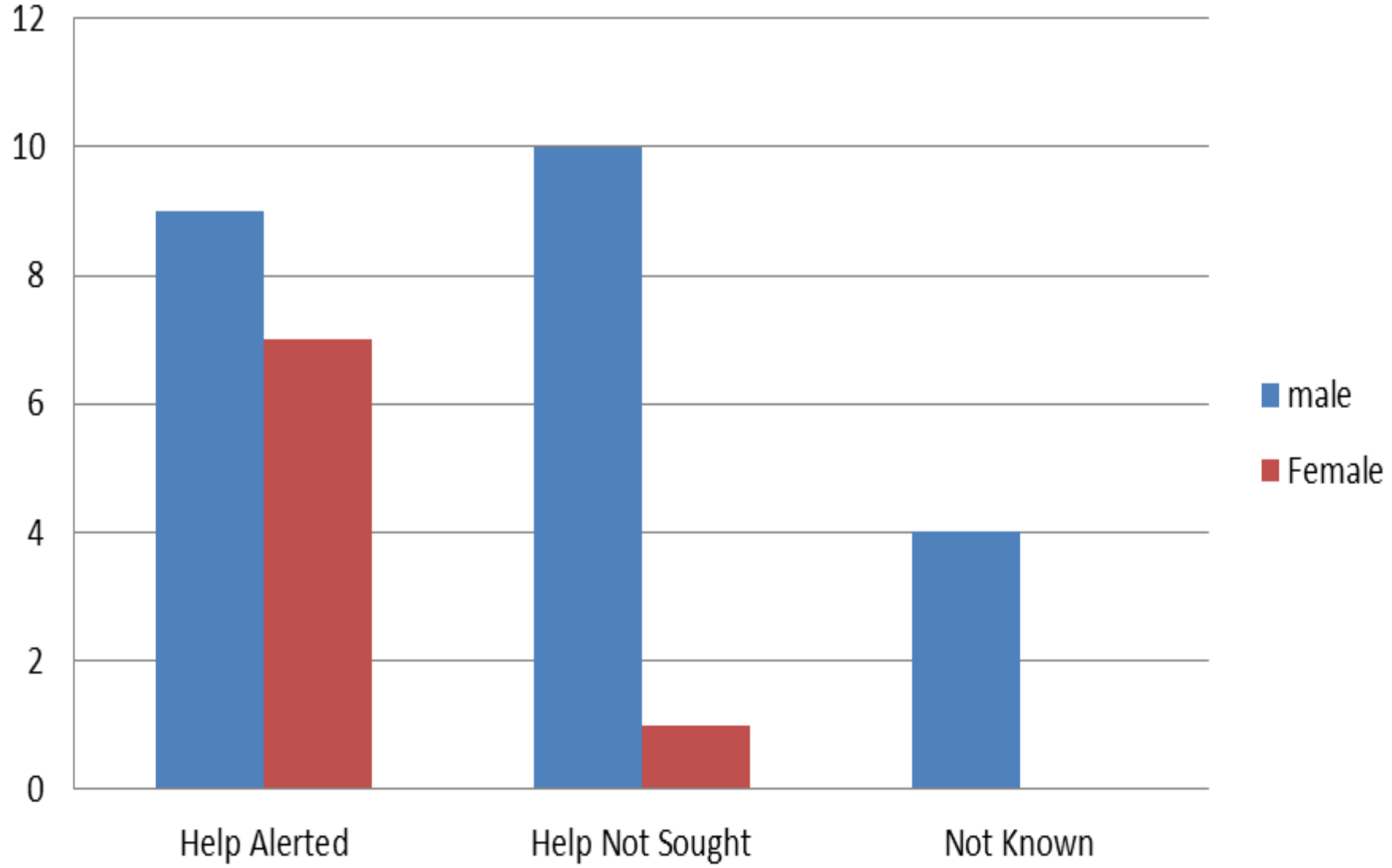
Self Harm Presentation



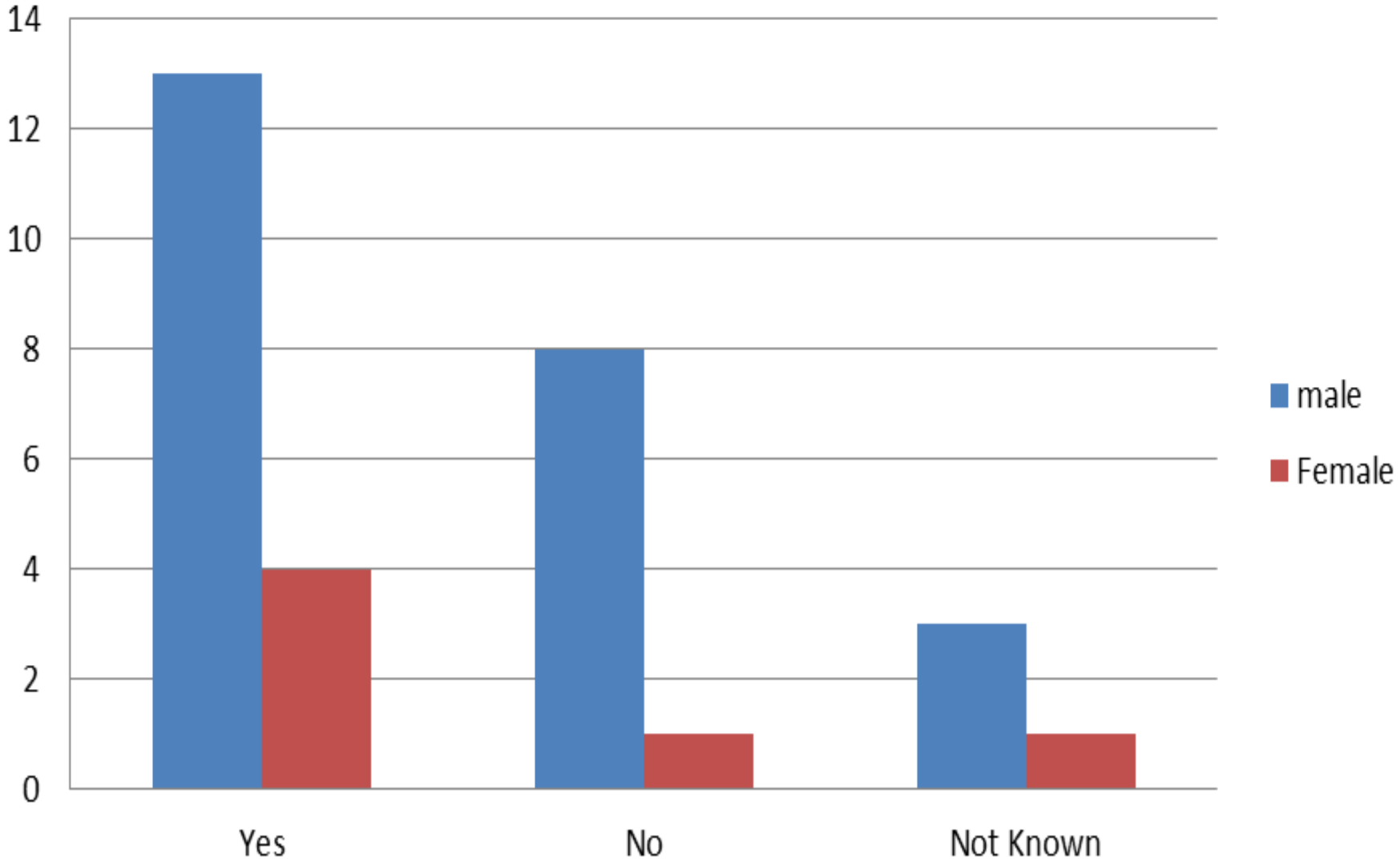
Impulsive vs Planned



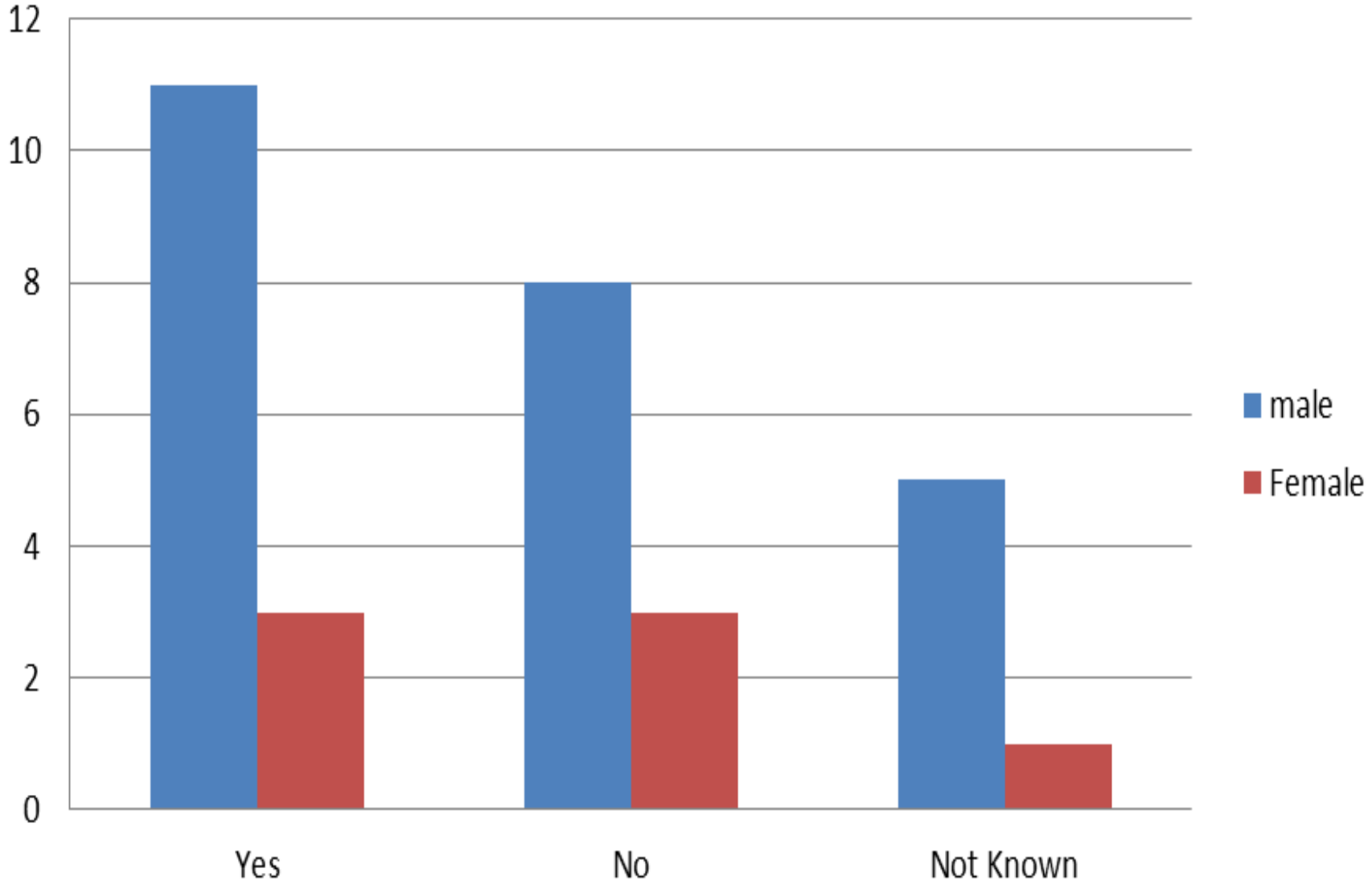
Was Help Sought?



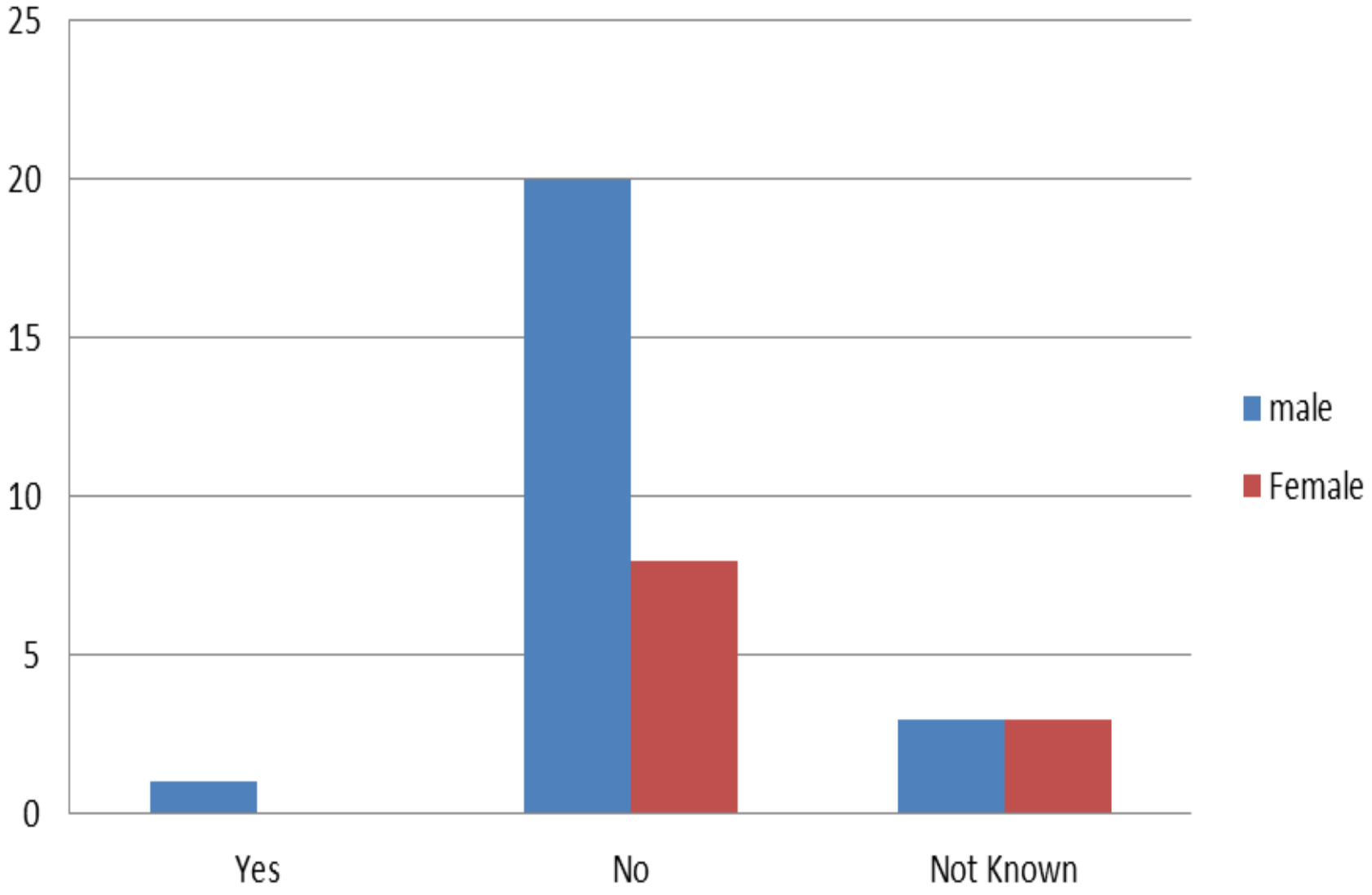
Was Medical Intervention Required?



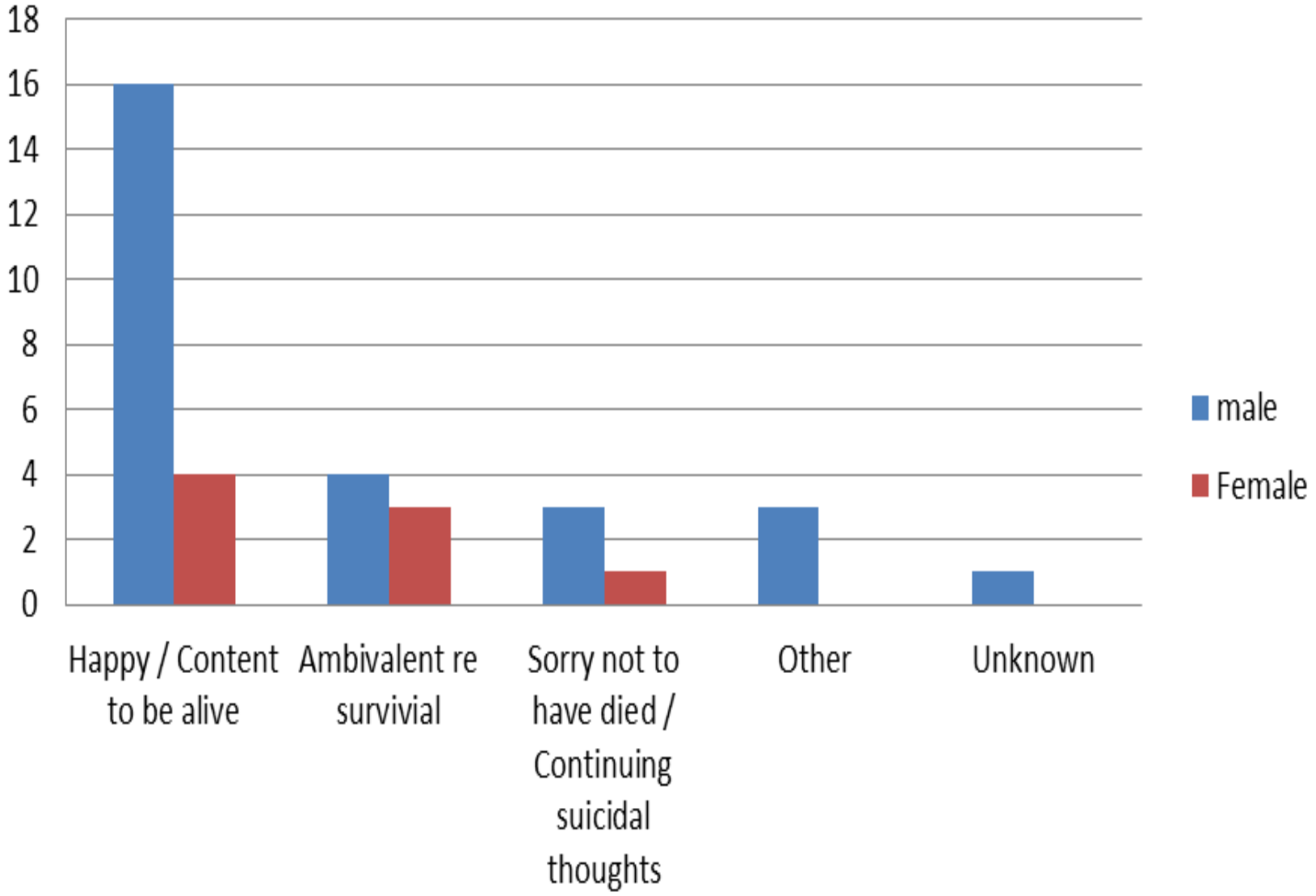
Could Self Harm Have Resulted in Death?



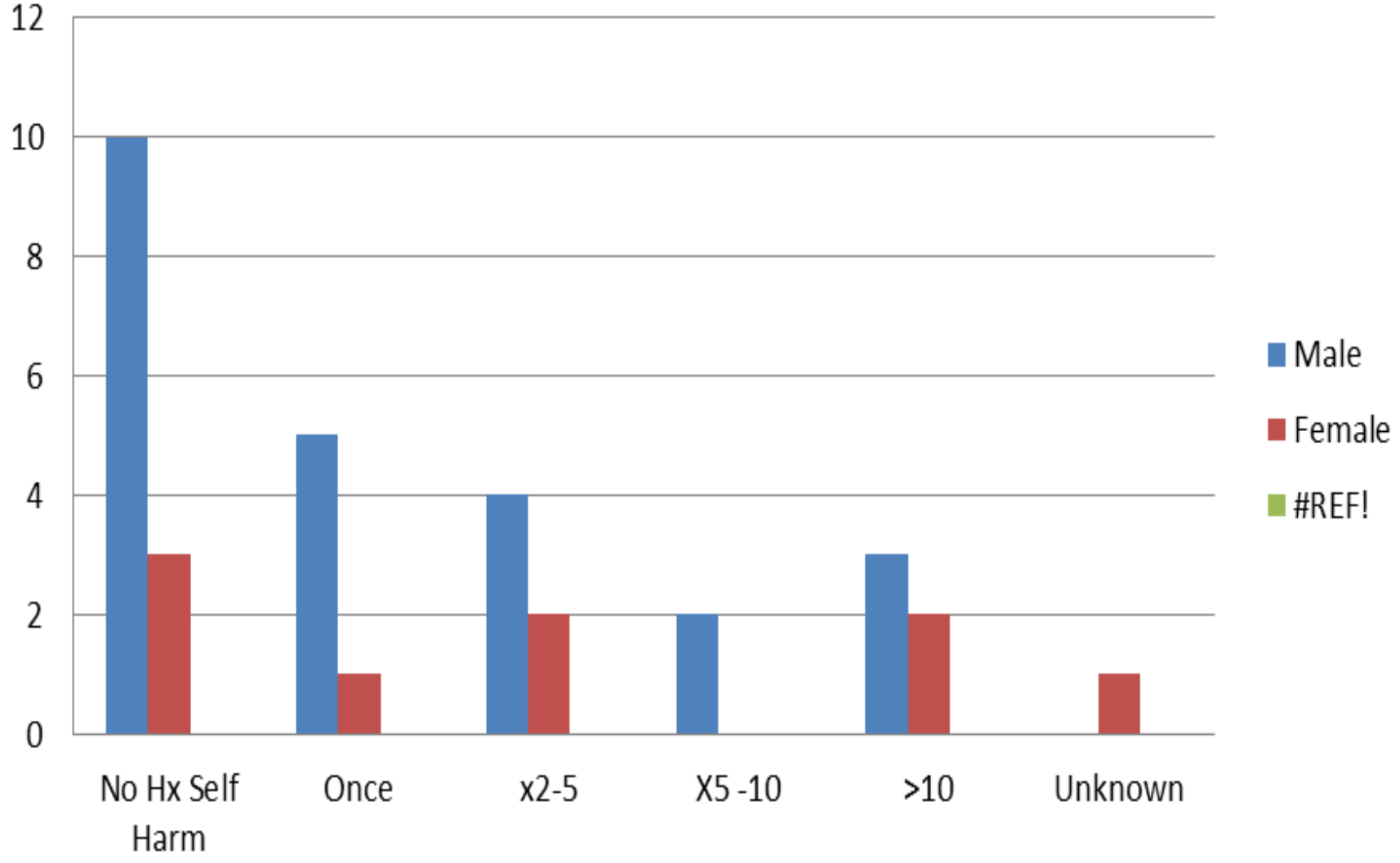
Were There Any Final Acts / Note Written?



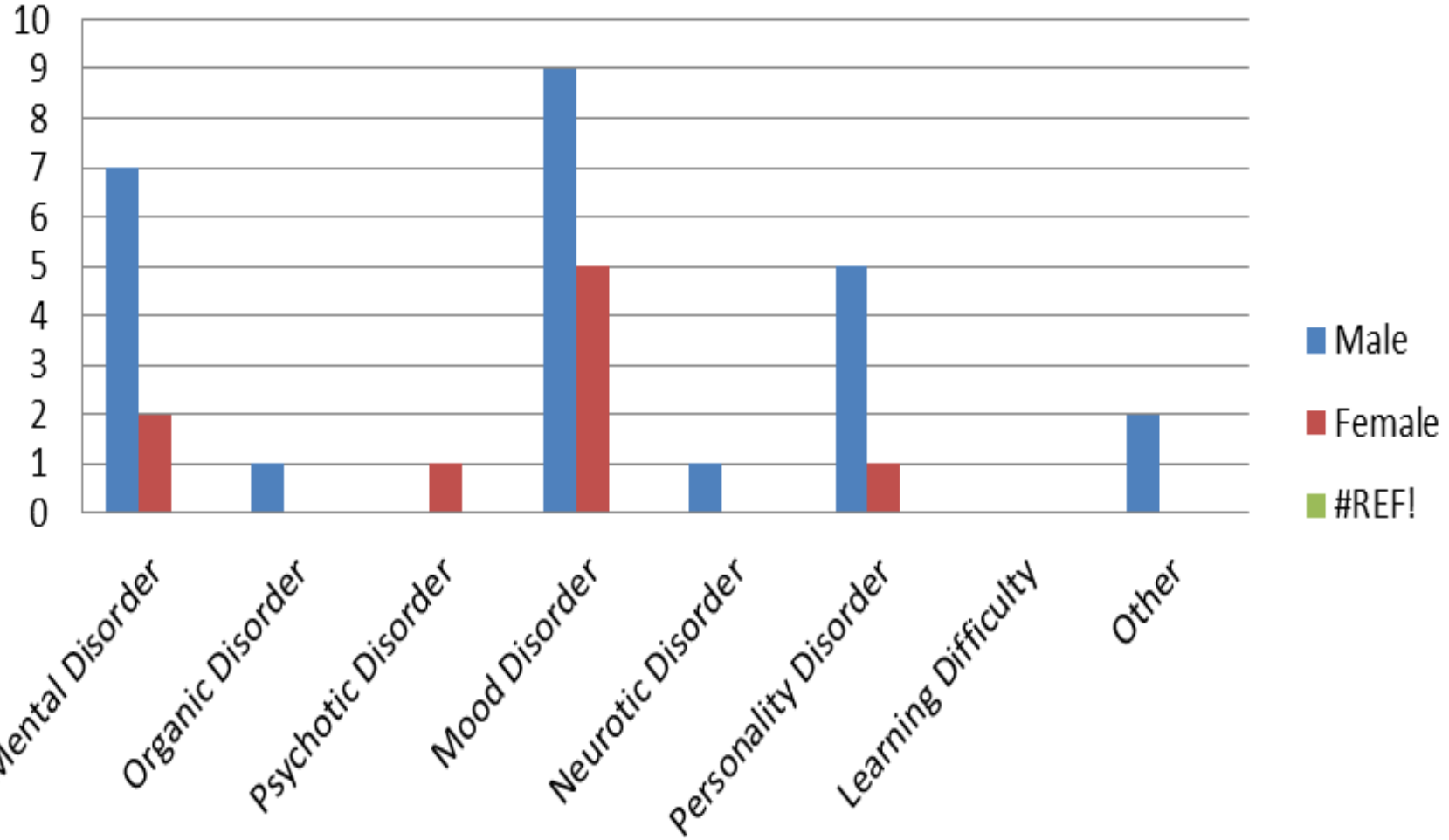
Reported Thoughts / Feeling Re Self Harm



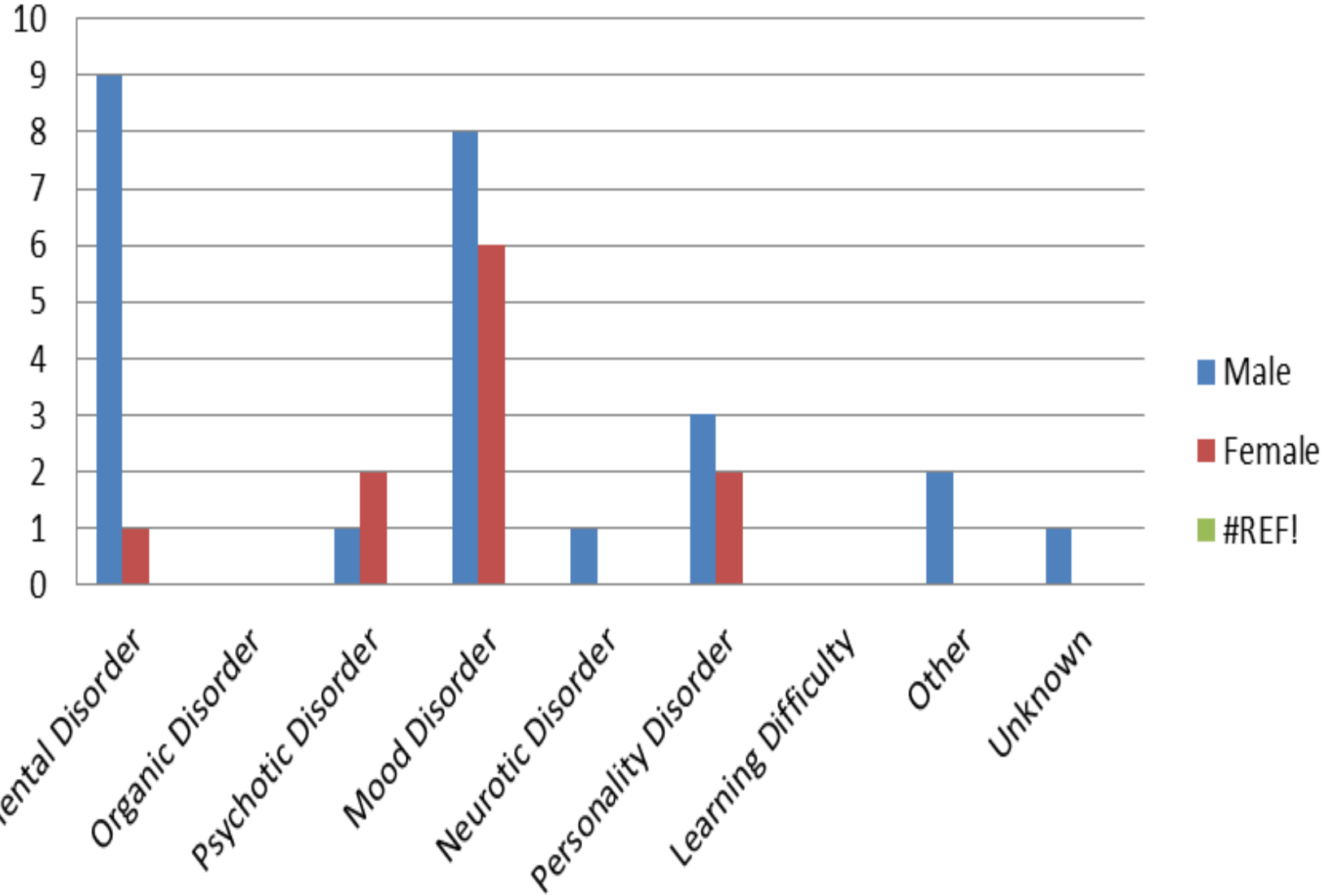
History of Self Harm



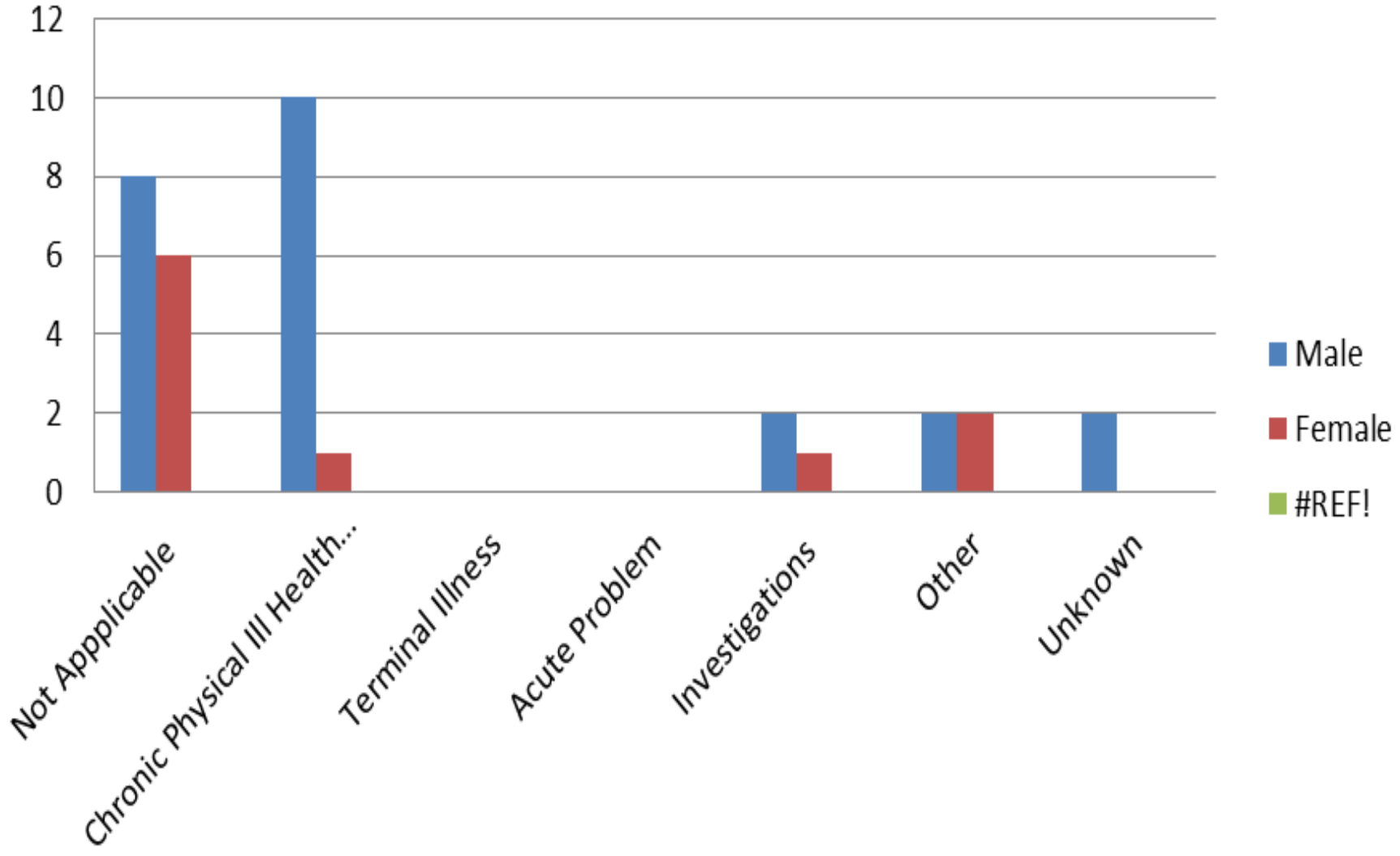
Impression of Mental Disorder When Assessed



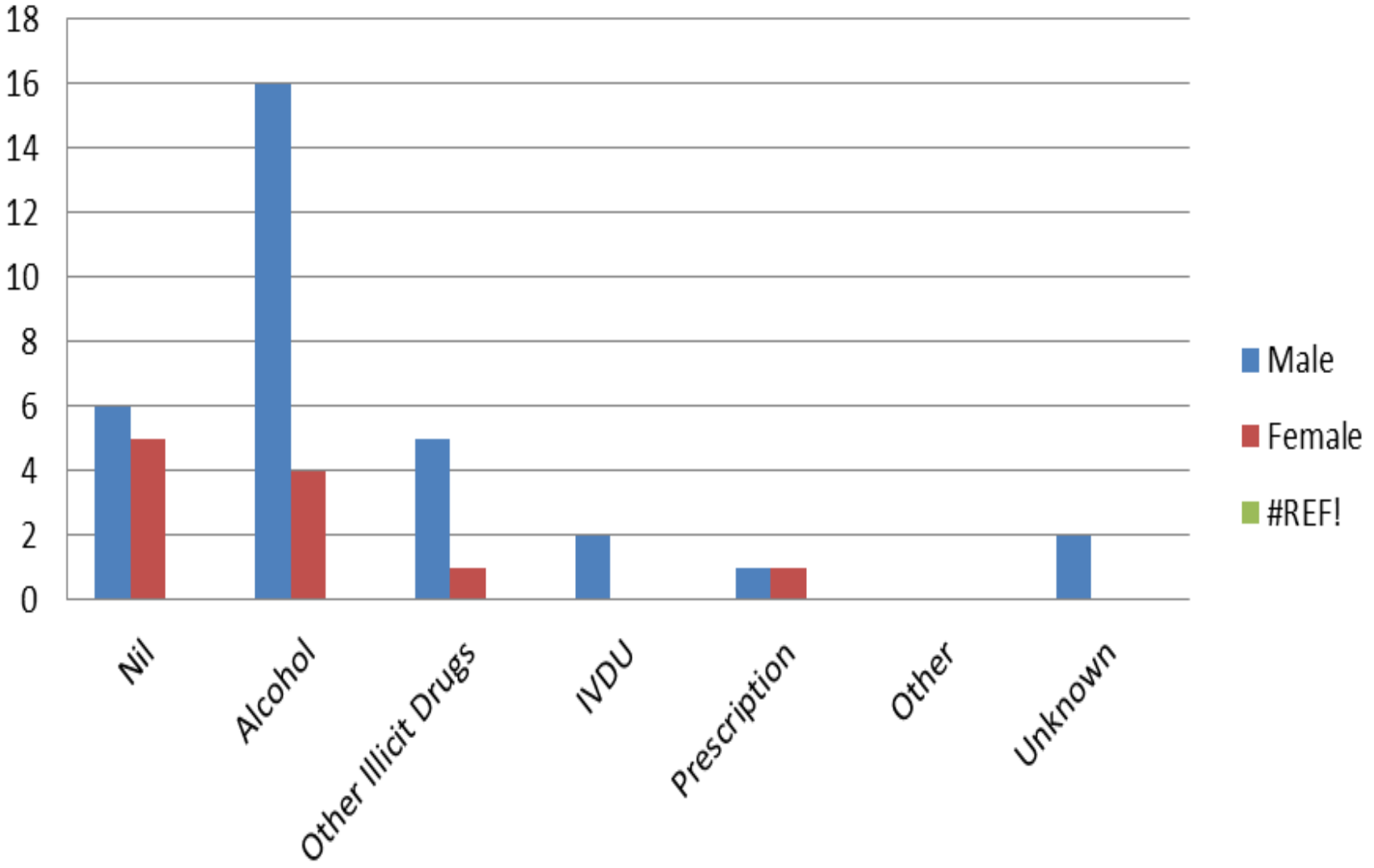
History of Mental Disorder When Assessed



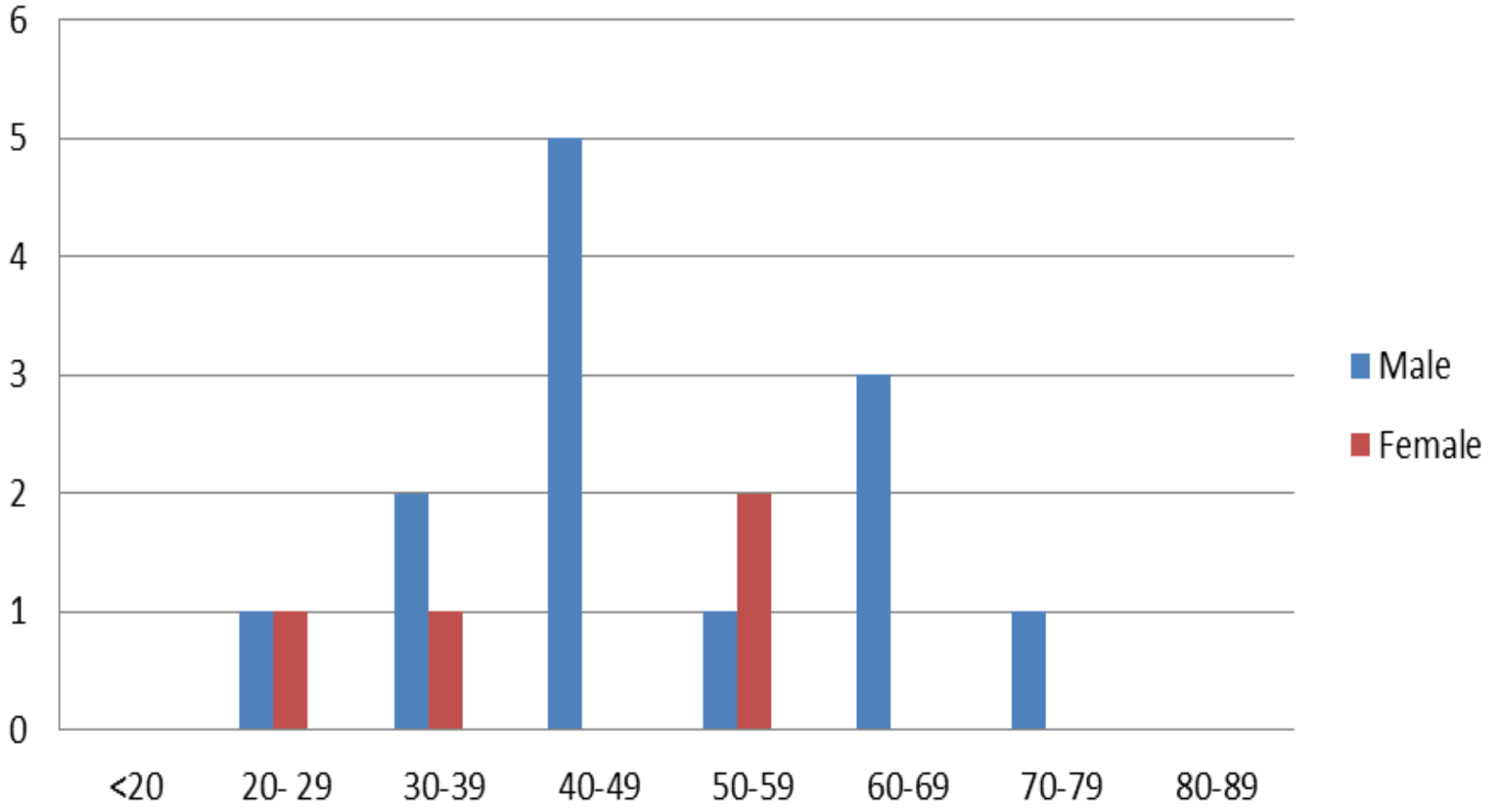
Physical Health History When Assessed



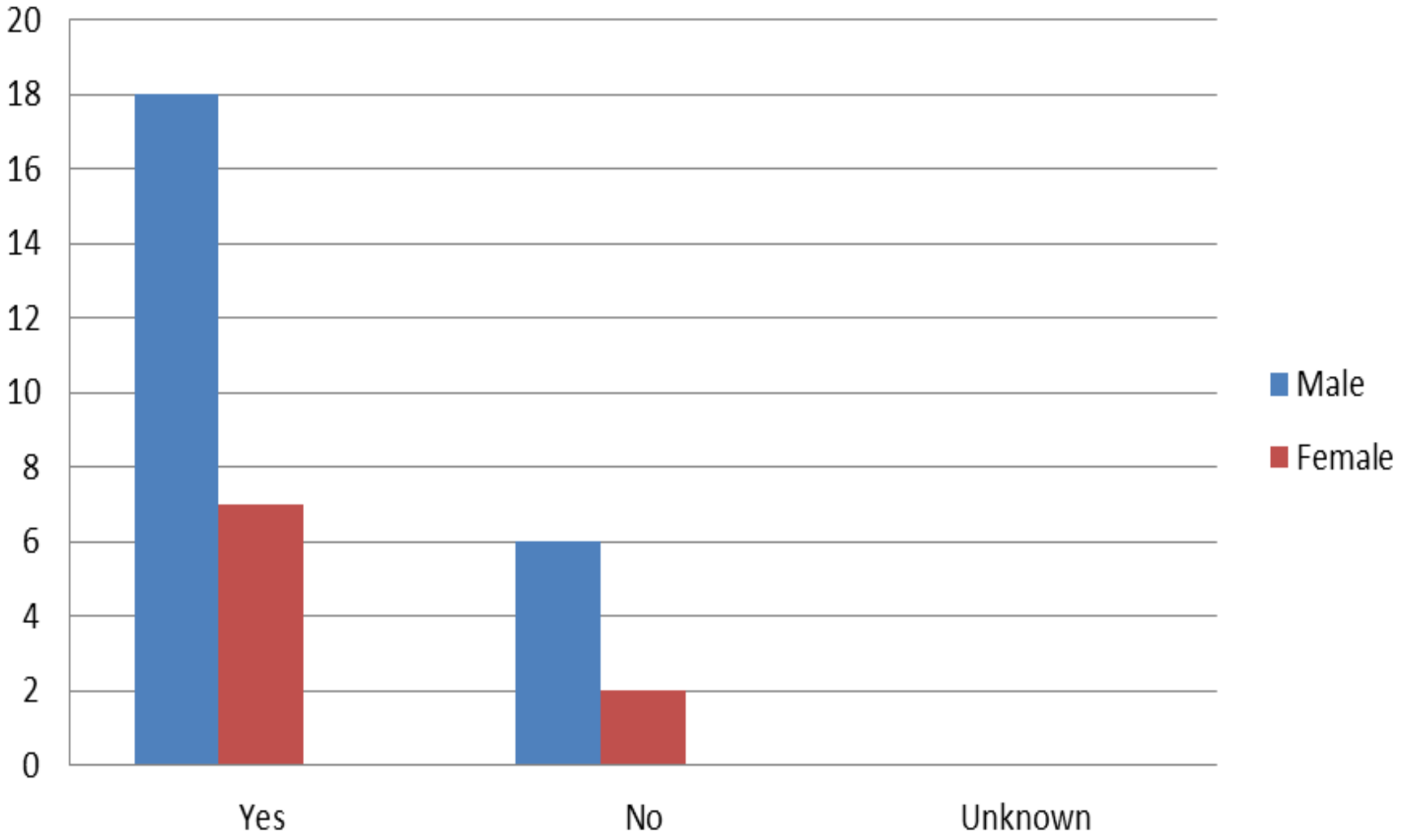
Substance Misuse When Assessed

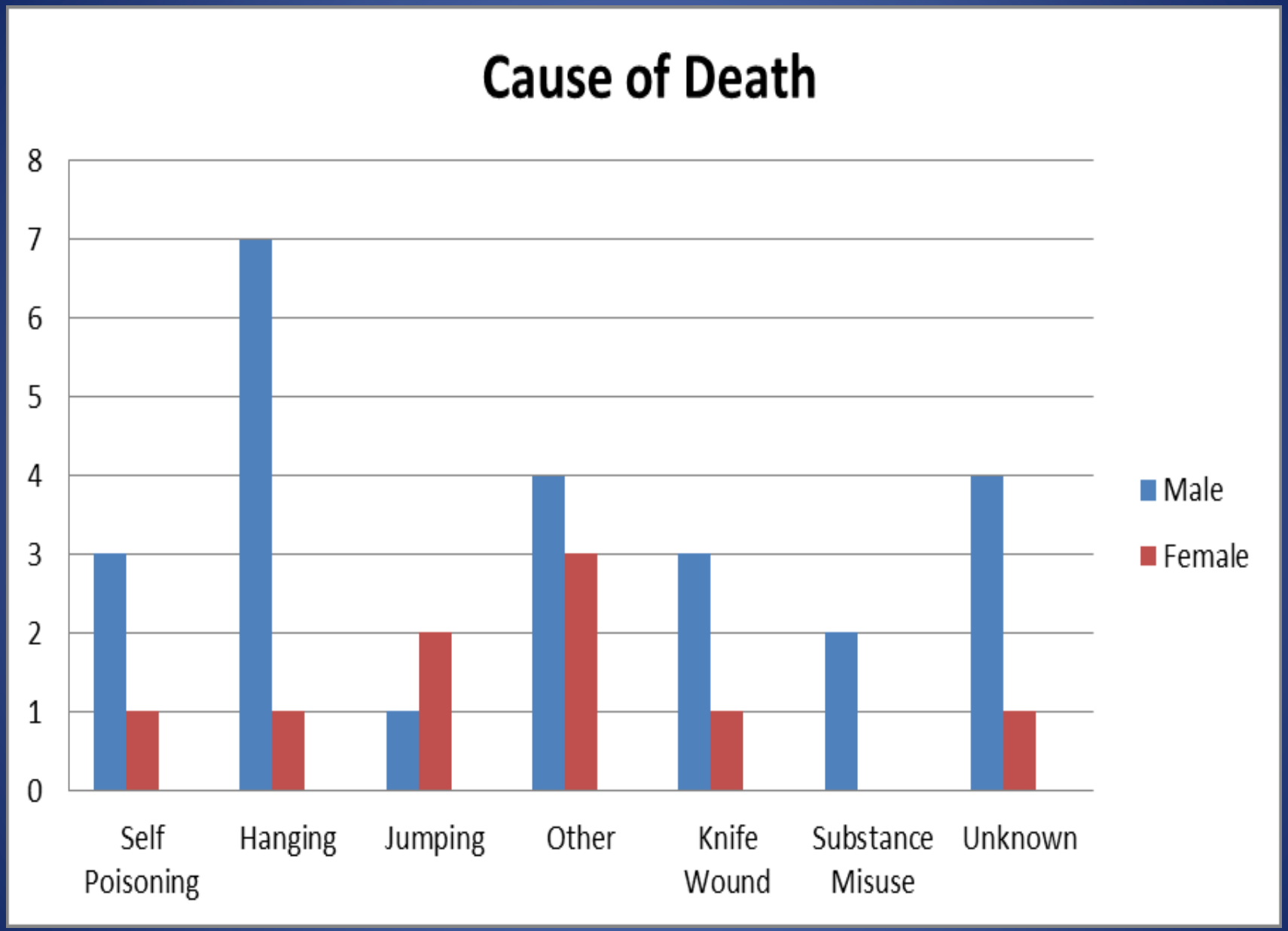


All Substance Misuse By Age
16 patients - Total 33

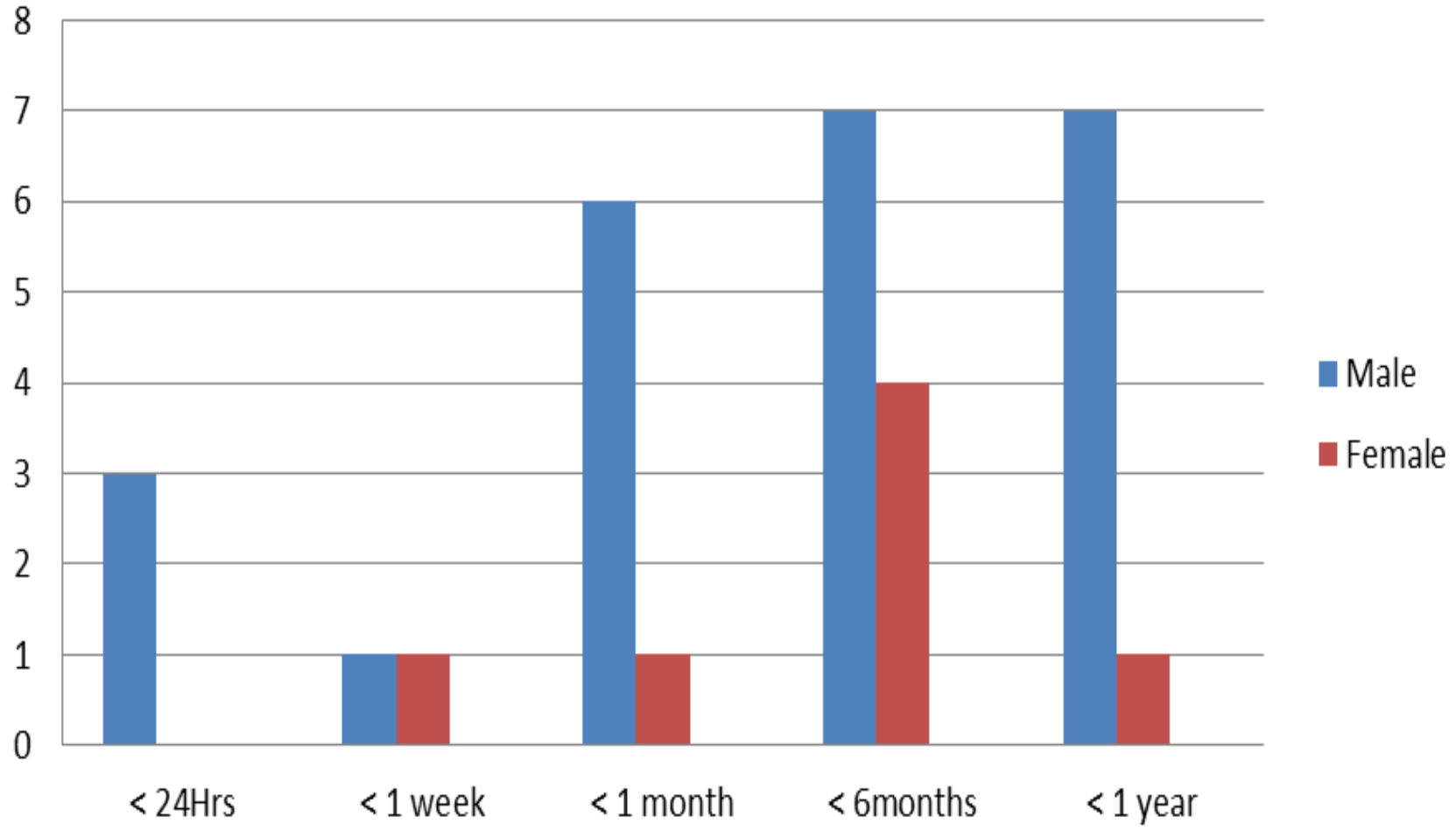


Recent Significant Life Events

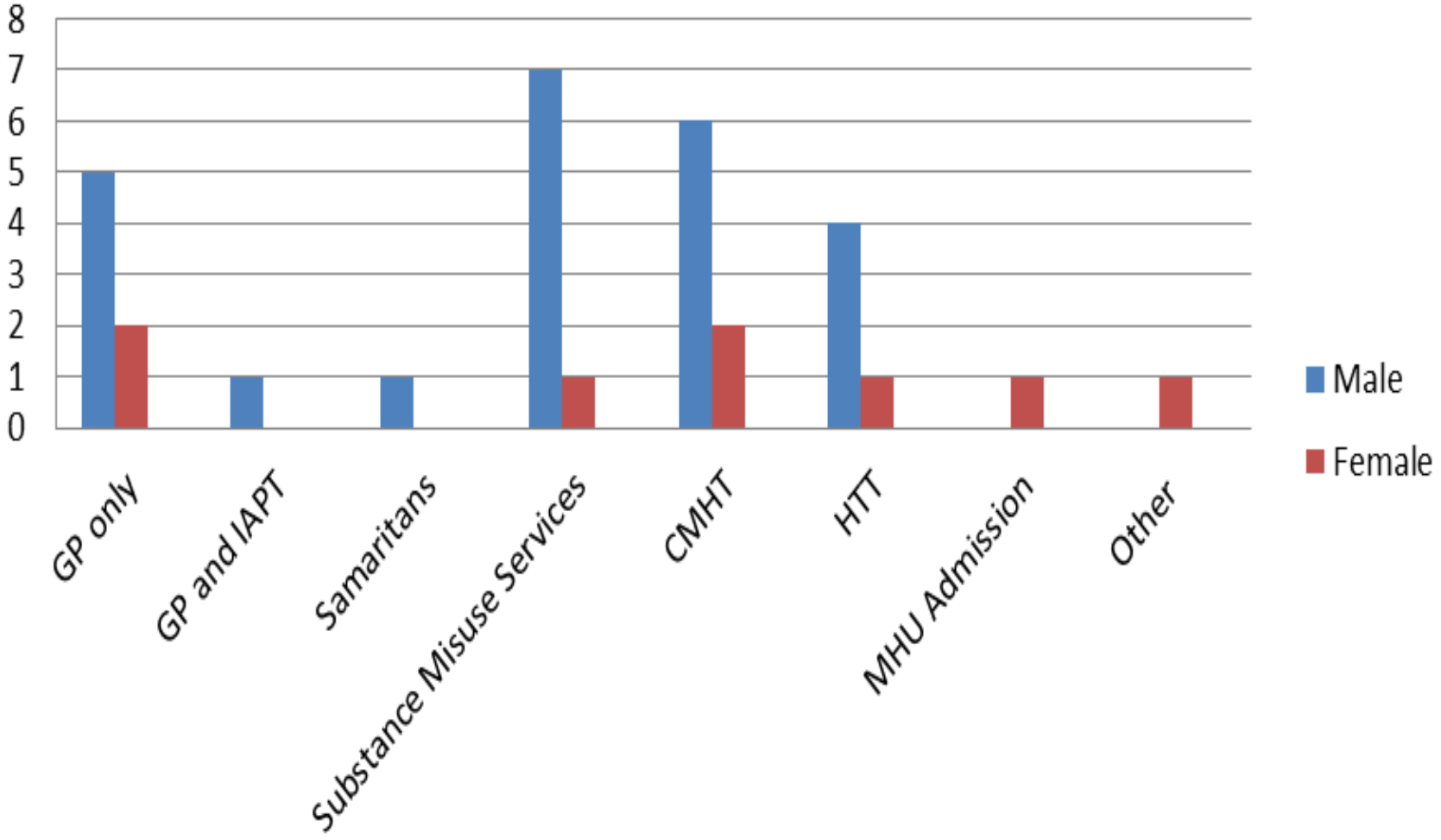



Cause of Death
8
7
6
5
4
3
2
1
0
Male
Female
Self Poisoning
Hanging
Jumping
Other
Knife Wound
Substance Misuse
Unknown

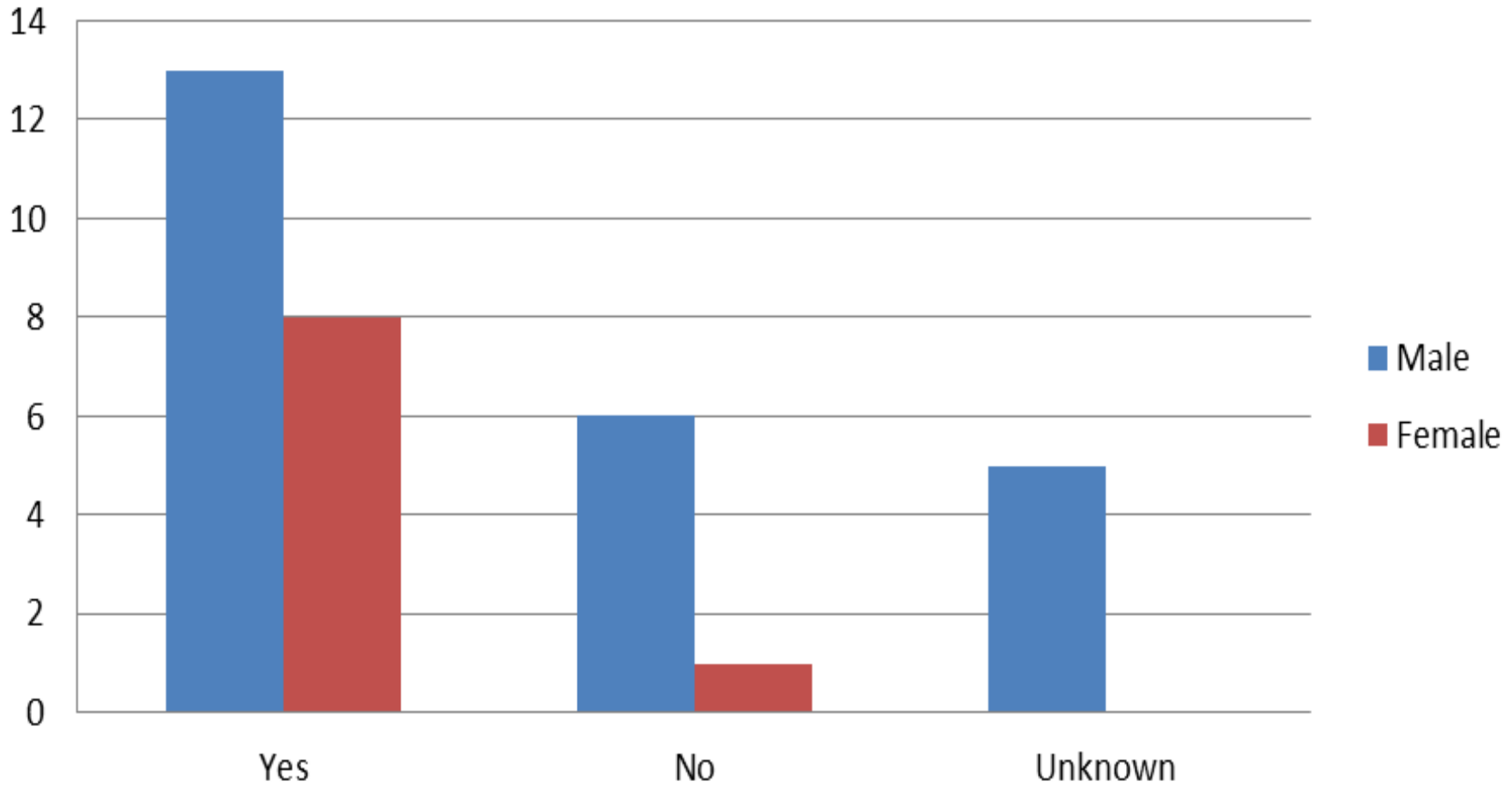
How long after last assessment did death occur



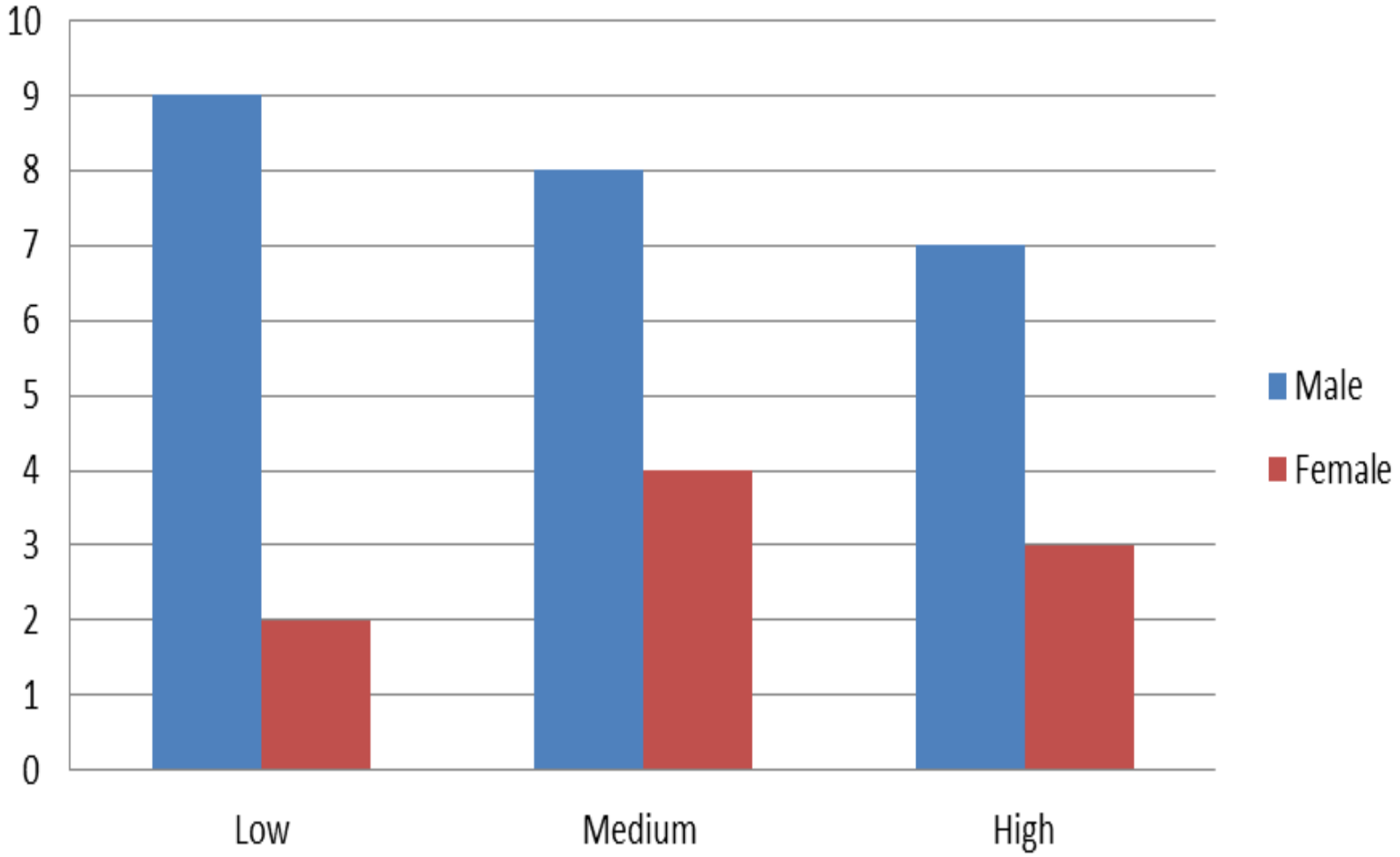
Who was the patient referred to following last assessment



Did The Patient see the Service they were referred to



What was the Risk Assessment of the Patient on the last Liaison Psychiatry assessment



Service Information

- All Assessment Documentation complied with the Adult Liaison Psychiatry and CFT (RIO) Operational Policies
- We will further Study all the Serious Incident Reports, whether changes in practice were recommended and have these changes been implemented
- All bar 4 of the incidents were discussed in Liaison Psychiatry team meetings or in clinical supervision

Staff Support

Template for supervision of staff following a suicide or serious incident:

- What would you like to be asked?
- What has stayed with you about this situation?
- Did you feel that you could have done anything differently?
- Do you feel frustrated or let down by the system following this situation e.g did not have enough time for the assessment, were particularly stretched, felt out of your depth?
- Comment:
- *In 8 Incidents Staff felt they required additional supervision / emotional support – This included a Joint Learning from Experience meeting with the Home Treatment Team.*

Duty Of Candour Definitions

Apology – an expression of sorrow or regret in respect of a notifiable safety incident

Moderate harm – harm that requires a moderate increase in treatment AND significant but not permanent harm

Moderate increase in treatment = an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling or treatment, transfer to another treatment area

Notifiable safety incident = any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:……..

Severe harm = a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions inc removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition

On the death of the service user

BEING OPEN/DUTY OF CANDOUR - IF NOT UNDERTAKEN WHEN IMMEDIATELY NOTIFYING THEN COMPLETE AS PART OF 72 HOUR REPORT	
Please provide next of kin address and phone contacts:	
Did you:	Please delete as appropriate
inform the patient	Advised the patient Yes / No
relative of the incident	Informed the relative Yes / No
provide an apology	Provided and apology Yes/No
describe, actions taken to date	Described actions to date Yes/No
describe the next steps	Described next steps Yes/No
offer support	Offered support Yes/No
	If any of the above has not taken place, please detail why

Suicide Prevention

- Project Zero – southwest regional suicide reduction collaborative. http://www.mentalhealthalliancesouthwest.org.uk/resource/project-zero-south-west-regional-suicide-reduction-collaborative/
- Posters In Pubs campaign !

Next Steps ?

- Who Should Monitor Mortality ?
- PLAN Discussion / Advice Re Duty of Candour
- Regarding M&M, the Mazars' report into deaths at Southernhealth was accompanied by a request for data from NHS England and a requirement for a M&M meeting to be formed in every trust.

Thank you and please talk to someone if this presentation has raised concerns for you.