7 MINUTE BRIEFING - LEARNING FROM PATIENT SAFETY INCIDENTS

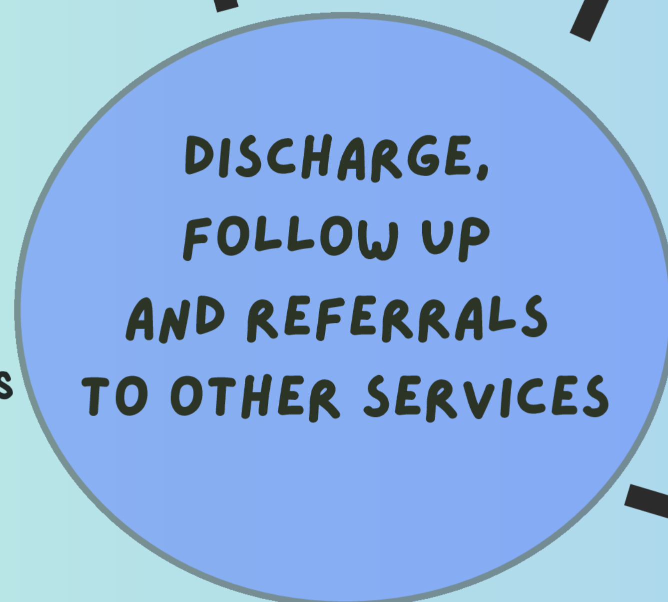
NHS East London NHS Foundation Trust

1) 42-year old male who came to Crisis Line's attention in April 2022 after incidents involving distressed behaviour in the community.

- Admitted under S2 following suicide attempt. Declined offers of support or follow up from services, Risk plan put in place
- Once discharged, there was no record of a 72 hour follow up or of a planned referral being made to CMHT
- Had further contact with crisis services, but tragically found deceased by suicide by family in September 2022.

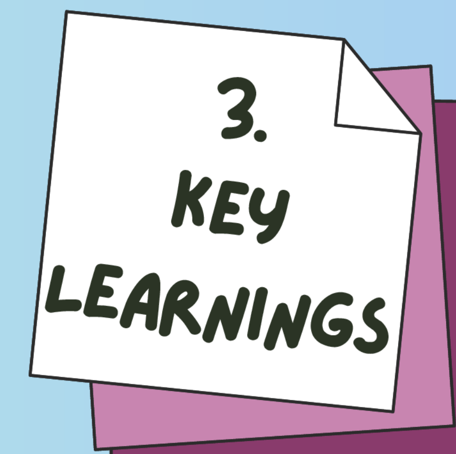
2) Male inpatient, first admitted following suicide attempt.

- When discharged, the plan was for a 72 hour follow up and for CMHT to follow up via booking an outpatient appt
- 72 hour follow up completed late (at 7 days - discovered due to being flagged as breached) as the discharge papers were accidentally sent to wrong community team. No outpatient appt was arranged, as this request had been missed off the discharge documents.
- Patient readmitted to hospital approx 1 month later with compound fracture after further suicide attempt.

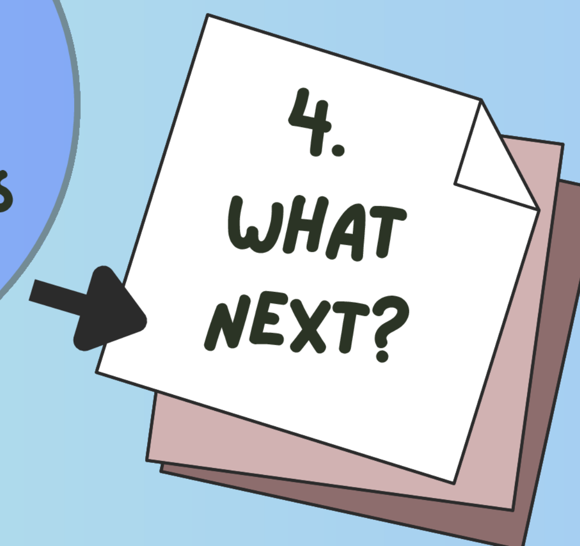


<u>Good practice:</u>

- There was evidence of good care and support during inpatient stay
- Physical health observations (bloods) carried out and infection markers appropriately escalated, resulting in a referral for IV fluid management



- Suicide risk is at its highest immediately after discharge. As such, ensuring 48-72 hour follow ups happen in time is important.
- Relying on individual staff and/or assuming communication has reached the intended recipient is risky. It's important to have robust systems and work processes in place to guard against this.



Please discuss and consider with your team:

(1) Do you have systems in place to prioiritse 72 hour follow ups and identify problems / gaps? What working conditions lead to successful 72 hour follow up, and how can we apply that elsewhere?

(2) Have you got opportunities to address issues that prevent you from completing 72 hour follow ups?

(3) Are there protocols or work processes in place to ensure that communication and onward referrals are received successfully?

(4) We continue to learn and improve our practice based on feedback from patients and carers, or based on reviews of incidents, near misses and good practice examples. We already know that where we take specific actions to improve, we tend to see them - but how do we embed these and make them business as usual, so that they remain in place over time? How can we 'future proof' improvements into our working processes and practice?