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Six years' experience in Oxford

Review of serious incidents

Deaths of patients under psychiatric care, especially if they are in-patients, have been the subject of a number of retrospective studies (Copas & Robin, 1982; Morgan & Priest, 1991; Modestin *et al*, 1992; Roy & Draper, 1995; Proulx *et al*, 1997). They have also been a particular focus of the National Confidential Inquiry (Appleby *et al*, 1999) as well as many individual inquiries. In contrast, little has been published on how individual psychiatric departments and trusts might best review and learn from local deaths or 'near misses' of patients under their care. In particular, there is no well publicised or widely accepted model for routinely examining such occurrences.

This paper describes a serious-incident rolling review process that has been in continuous operation for six years within a large mental health trust serving a total population of approximately 660 000. The aim of this review process has always been three-fold. First, to have a systematic way of learning lessons from serious incidents, particularly those involving the death of people receiving in-patient care, and to ensure that these lessons are put into practice. Second, to do this in a way that can detect patterns of incidents over time, and finally, to stimulate ongoing debate among adult mental health care workers on how to provide the best care in the safest way. The serious incidents covered by the review process include all deaths or 'near misses' of in-patients; deaths of most but not all people currently or recently in contact with community psychiatric services; and other serious events, such as assaults and fires. The structure of the review system will be described, followed by a summary of the incidents reviewed over the six-year period, and the main lessons learnt from them. The strengths and difficulties encountered in this way of working will be considered.

How the review process works

Structure of the review meetings

Three times a year a morning is set aside to review serious incidents that have recently occurred. Two mental health professionals, usually a senior psychiatrist and a senior nurse, both from outside the department or trust, are invited to facilitate the meeting.

Each meeting begins with a progress report on action points arising from previous reviews. This is followed by presentations of each of the incidents that are being covered. Presentations are usually made jointly by the relevant members of the team involved and may include findings of a single incident review that would usually have been carried out beforehand. Presentations are followed by discussion focusing on aspects of care that may have influenced the final outcome. Three or four incidents are usually presented during the morning, which ends with an overview discussion to see whether there are any common themes or patterns connecting the incidents. Finally, the two facilitators draw the main strands of the discussion together and summarise possible lessons arising from the incidents. In addition to local incidents, from time to time findings from national inquiries are also presented in order to see whether there are local lessons to be learnt.

Role of the facilitators

The role of the facilitators is to help identify any lessons that they feel may have arisen from the cases discussed and to recommend changes that may reduce the risk of further incidents. This is a demanding task that needs a combination of supportiveness, critical enquiry, fairness and an ability to maintain a relevant focus.

It is important that facilitators have an outsider's perspective and professional knowledge of clinical care. For this reason, facilitators are invited from other departments or trusts and are usually senior medical or nursing clinicians. Facilitators work in pairs, each individual coming from a different discipline, and are replaced at each review. These arrangements ensure that many different points of view are incorporated in the review process over time. After the meeting, the two facilitators jointly produce an independent report with recommendations for action where appropriate.

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Role of the audience

The 'engine room' of the review process is the peer group discussion of the presented cases. These discussions are enriched by the inclusion of a wide range of people who may look at the cases from many different perspectives. From within the department, representatives from all of the psychiatric disciplines, as well as from the in-patient and community teams, general hospital teams and psychotherapy services, would normally attend. From outside the department, professionals representing the police, the fire service, health and safety, and medical ethics are all usually present. There are plans to include a lay and a legal representative. In addition, two executive members of the trust's Board have recently started attending: the Medical Director and the Director of Nursing.

Discussions are invariably lively and most commonly focus on aspects of care quality. This energy, which is characteristic of the review meetings, seems to spring partly from the range of perspectives brought together and partly from the recognition that if you are talking about care quality, there can be no more important starting point than a bad clinical outcome.

The role and status of the facilitator's report

Following each serious-incident review, a facilitator's report is produced. Recommendations for change are translated into action points, with responsibility for each part assigned to a key individual. The review and implementation process is coordinated by a senior nurse manager who monitors actions taken and reports progress at each subsequent review meeting. The process also has the help of an administrator. An annual summary of reports, recommendations and progress goes to the trust's Board and audits of progress on recommendations are regularly held. The serious-incident review process is currently being incorporated into the trust's system for clinical governance.

In day-to-day clinical life, the process of the review seems to have been incorporated into people's way of thinking. Attending reviews over the years results in many staff sharing a common pool of knowledge about a wide range of difficult and challenging situations. Incidents discussed in past reviews are often used as reference points in general discussions about clinical care or when clinical difficulties occur. In day-to-day management, recommendations from the reviews achieve added importance by virtue of having arisen from a serious incident. Dealing with the recommendations then becomes part of the trust's risk-management strategy. On some occasions, recommendations that involve new resources, particularly in relation to building works and training, can become an influential lever for bringing about change.

Summary of incidents reviewed

During a period of six years, 63 serious incidents were reviewed in 15 meetings. Of these, 18 involved

Table 1. Serious incidents reviewed 1994–1999 (*n*=83)

Incident	Death of patient: In hospital or within 1 month of discharge	Death of patient: In contact with community psychiatric services	Serious incident not resulting in death of patient
Hanging/suffocation	7	2	4
Falls			
From buildings	4	2	7
Into path of vehicle/train	3	0	0
Drowning	1	0	0
Electrocution	1	0	0
Alcohol poisoning	1	0	0
Natural causes	1	0	0
Carbon monoxide poisoning	0	2	0
Overdose	0	3	0
Homicide followed by suicide	0	1	0
Patient assault			
On staff	0	0	8
On another patient	0	0	6
Arson	0	0	7
Hypothermia while AWOL	0	0	1
Cardiac arrest during ECT	0	0	1
Patient found unconscious in disused part of hospital	0	0	1
Total	18	10	35

AWOL, absent without leave; ECT, electroconvulsive therapy.

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unexpected deaths of in-patients or people just discharged from hospital; 10 involved the death of people in contact with the community services; and 35 involved incidents not resulting in death. Of the incidents not resulting in death, 14 were assaults and seven involved arson. Details of the incidents are given in Table 1. The number of in-patient deaths caused by probable suicide (*n*=16) averages just under three deaths per year, accounting for approximately 4% of all deaths by suicide in Oxfordshire. This is a similar proportion to that found in most epidemiological surveys (King, 1994; Proulx *et al*, 1997; Appleby *et al*, 1999).

Summary of the main lessons learnt

Lessons learnt from reviewing the 63 incidents are summarised in the Appendix and fall into five categories.

Reducing means of self-injury

Actions have included the raising of parapets on two local bridges; increasing security measures at a local under-used multi-storey car park; finding alternatives to plastic bin liners on the acute wards; and designing three brand new acute units with particular attention to safety. Two of these units are 'up and running' and the third should be built next year.

Improvement of care quality

Probably the most tenacious theme to have emerged over the six years has been the bad effect of providing a service in the face of bed occupancy usually approaching 100%. High bed occupancy has become the norm within NHS acute psychiatric services, and the potentially damaging knock-on effects identified by the serious-incident reviews have included a higher frequency of transferring patients between units than would otherwise be needed; delays in admitting some patients; and the inappropriate hastening of some discharges from hospital.

Another recurrent theme has been the multiplicity of demands on over-stretched in-patient staff, which is felt to have progressively reduced the amount of one-to-one time spent with patients in recent years. Increased administration duties and greater use of high nursing observations with no compensatory increase in nurse numbers are thought to have been especially influential. Improvements in ward nursing levels, in the availability of therapeutic activities during the day, and an emphasis on each patient having one-to-one regular contact with their named nurse have been valuable recent changes, but high bed occupancy levels continue unabated and the increasing expectation of patients, carers and advocates ensures continued pressure to improve the quality of clinical care on wards.

Training

Over the years, multi-disciplinary training, particularly in relation to risk assessment, resuscitation and dealing with aggression, has been repeatedly identified as an essential part of staff induction and ongoing educational programmes. Regular training workshops are now provided in these areas.

Clinical practice and procedures

Over the lifetime of the serious-incident review a large number of protocols and procedures have been developed (see Appendix), some with the help of outside agencies such as the police. We have learnt that it is extremely important that these documents are produced through wide consultation and that they are regularly updated and incorporated, where appropriate, into training.

Staff needs

Serious incidents can be traumatising for staff. One important outcome of the reviews has been to set up a post-incident counselling resource for use both by teams and by individuals. Incidents that have highlighted staff safety problems have resulted in improvements in lighting in the hospital grounds; the introduction of video surveillance cameras; improved security at entrances to buildings; and improved chaperone and alarm arrangements.

Strengths and difficulties

Three main strengths emerge from the review process. First, it provides a systematic means of tracking patterns of care difficulties that may emerge over time. Solving these difficulties can then be given the highest priority. Second, it provides an opportunity regularly to micro-analyse key aspects of care in a way that incorporates viewpoints from a very wide range of disciplines. This multiple-perspective way of evaluating clinical care may then become incorporated into the way of thinking of those who attend the review, influencing their clinical and management decisions at other times. Finally, it helps ensure that where care quality is debated, those aspects of care that may reduce the risk of a serious incident are clearly highlighted and prioritised.

Three important difficulties have emerged during the review process. First, it is important to allow a delay of at least two months, and sometimes longer, before including a case in the review and, preferably, an individual case review should already have occurred. Staff need to have begun to come to terms with their experience before exposing themselves to the scrutiny of a large forum. Second, it can be difficult to maintain the energy needed to complete the cycle of actioning review recommendations in a way that keeps making a difference to clinical care. Having a senior nurse responsible for coordinating those accountable for specific actions has proved helpful, as has the inclusion of administrative support. Trust and departmental ownership of the process is also crucial. Finally, there is a difficulty about how the review is perceived from outside the trust by

interested parties such as carers and relatives. The review does not have the formality or powers of an official inquiry. It does have an external facilitator and some representation from non-health and social agencies, but in other ways it is an internal, peer review process and may therefore be open to criticism of bias. Against this drawback of a lack of complete objectivity, however, must be set the considerable benefit of the review process occurring in a clinical peer group rather than a legal inquiry setting. The clinical setting arguably allows a less inhibited and more adventurous and productive debate about the key aspects of care that are under scrutiny.

Conclusion

A regular serious-incident peer group review process is described, which over a period of six years has become an integral part of the life of an adult psychiatric department. Anticipated resistance to the review has never materialised and the review has become a key forum to debate care quality, and to initiate and monitor changes designed to improve clinical outcome for patients. It is recommended that psychiatric departments and trusts should consider developing some form of comparable routine review process as an integral part of their clinical governance and risk-management strategy.

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Appendix: summary of the main lessons learnt from the serious incident reviews

Reduce means of self-injury

(a) Remove and replace plastic bags on wards (e.g. bin bags).
(b) Precautions during building works.
(c) Anti-jumping measures (local bridges, car parks).
(d) Use of electric circuit breakers.
(e) Inform visitors not to bring in potential objects of self-harm.
(f) Replace outdated admission wards where it is difficult to manage 'at-risk' patients.

Improve care quality

(a) Increase provision of one-to-one therapeutic work on wards.
(b) Increase privacy for women in hospital.
(c) Reduce bed occupancy to 85%.
(d) Improve response to needs of those from ethnic minorities.
(e) Increase work with relatives.
(f) Regular medical examinations for long-term patients.
(g) Well recorded risk assessments before transfer/leave/discharge.

Multi-disciplinary training in specific areas

(a) Risk assessment and recording.
(b) Absent without leave and special observation procedures.
(c) Fire and resuscitation.
(d) Dealing with actual or threatened violence.
(e) Helping relatives (breaking bad news, helping the bereaved).

Clinical practice and procedures

(a) Regular review of absence without leave and special observation procedures.
(b) New or revised procedures in relation to patient transfers; illicit drugs and offending behaviour on hospital property; organ donation; dealing with intruders; general hospital and community mental health team/in-patient unit liaison; assessments in custody; visitors; dealing with the media, etc.
(c) Regular liaison meetings with local police.
(d) Need for better access to clinical information out of hours.
(e) Need for improved communication at times of transfer/discharge.
(f) Audit patient experience of special nursing observations.

Staff

(a) Improve access to help and advice following major incidents.
(b) Improve security in hospital and grounds.

References

APPLEBY, L., SHAW, J., AMOS, T., *et al* (1999) *Safer Services: Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

COPAS, J. B. & ROBIN, A. (1982) Suicide in psychiatric in-patients. *British Journal of Psychiatry*, **141**, 503–511.

KING, E. (1994) Suicide in the mentally ill. An epidemiological sample and implications for clinicians. *British Journal of Psychiatry*, **165**, 658–663.

MODESTIN, J., ZARRO, I. & WALDVOGEL, D. (1992) A study of suicide in schizophrenic in-patients. *British Journal of Psychiatry*, **160**, 398–401.

MORGAN, H. G. & PRIEST, P. (1991) Suicide and other unexpected deaths among psychiatric in-patients. The Bristol confidential inquiry. *British Journal of Psychiatry*, **158**, 368–374.

PROULX, F., LESAGE, A. D. & GRUNBERG, F. (1997) One hundred in-patient suicides. *British Journal of Psychiatry*, **171**, 247–250.

ROY, A. & DRAPER, R. (1995) Suicide among hospital in-patients. *Psychological Medicine*, **25**, 199–202.

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