Open disclosure in The Mental Health Setting

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Objectives

- To familiarise services with a community mental Health services approach to Open Disclosure
- To explore use of open disclosure with service users with different levels of capacity
- ·To establish the variety of different contexts that open disclosure may be used in mental health
- To examine use of open disclosure in incidents in a mental health setting at all levels from negligible to extreme impact
- ·o emphasis an integrated approach to Open disclosure in Mental Health a services journey

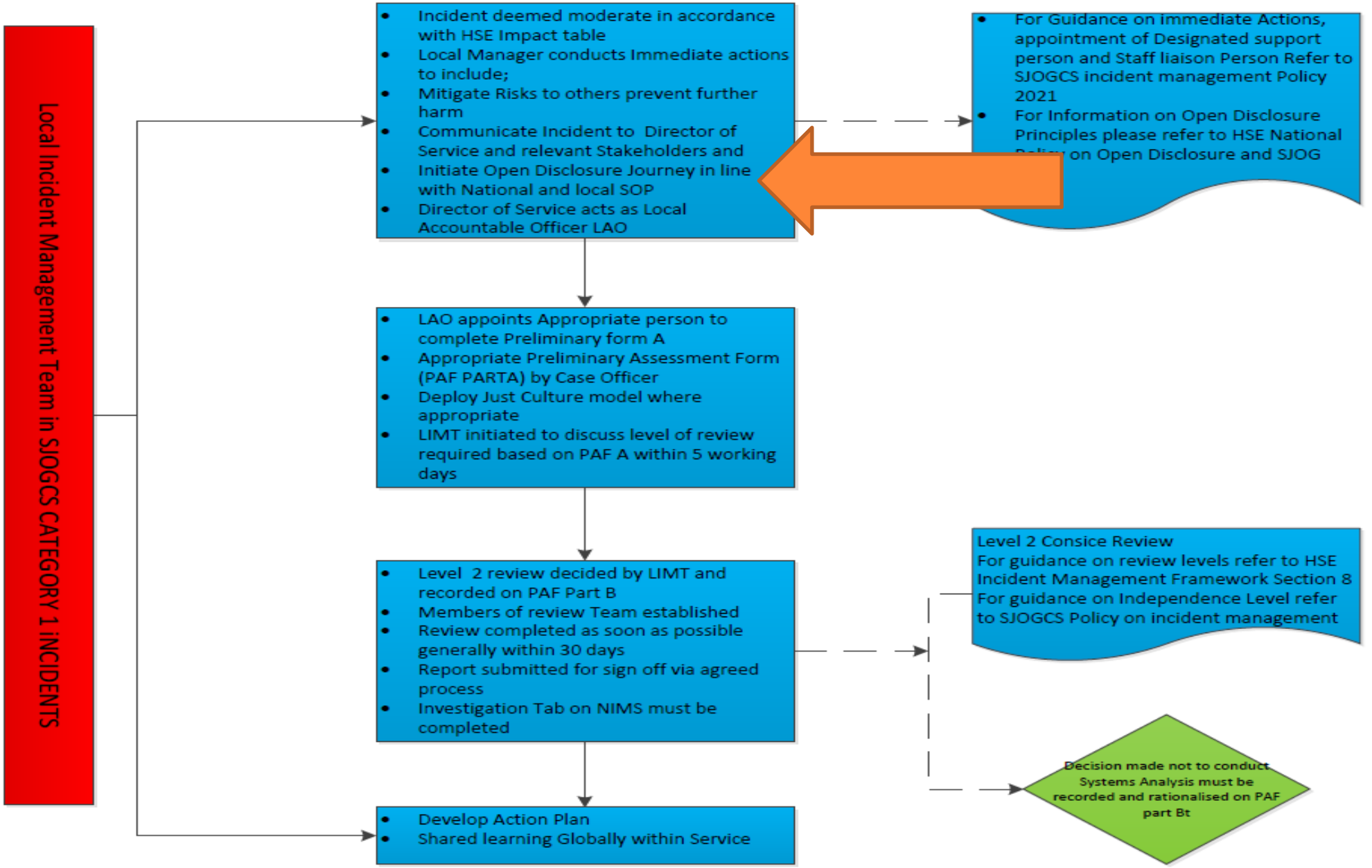
Setting the scene

Whatever it is or However bad we think it is.. We must and will communicate it ..far, far worse and wrong that we don't or withhold information

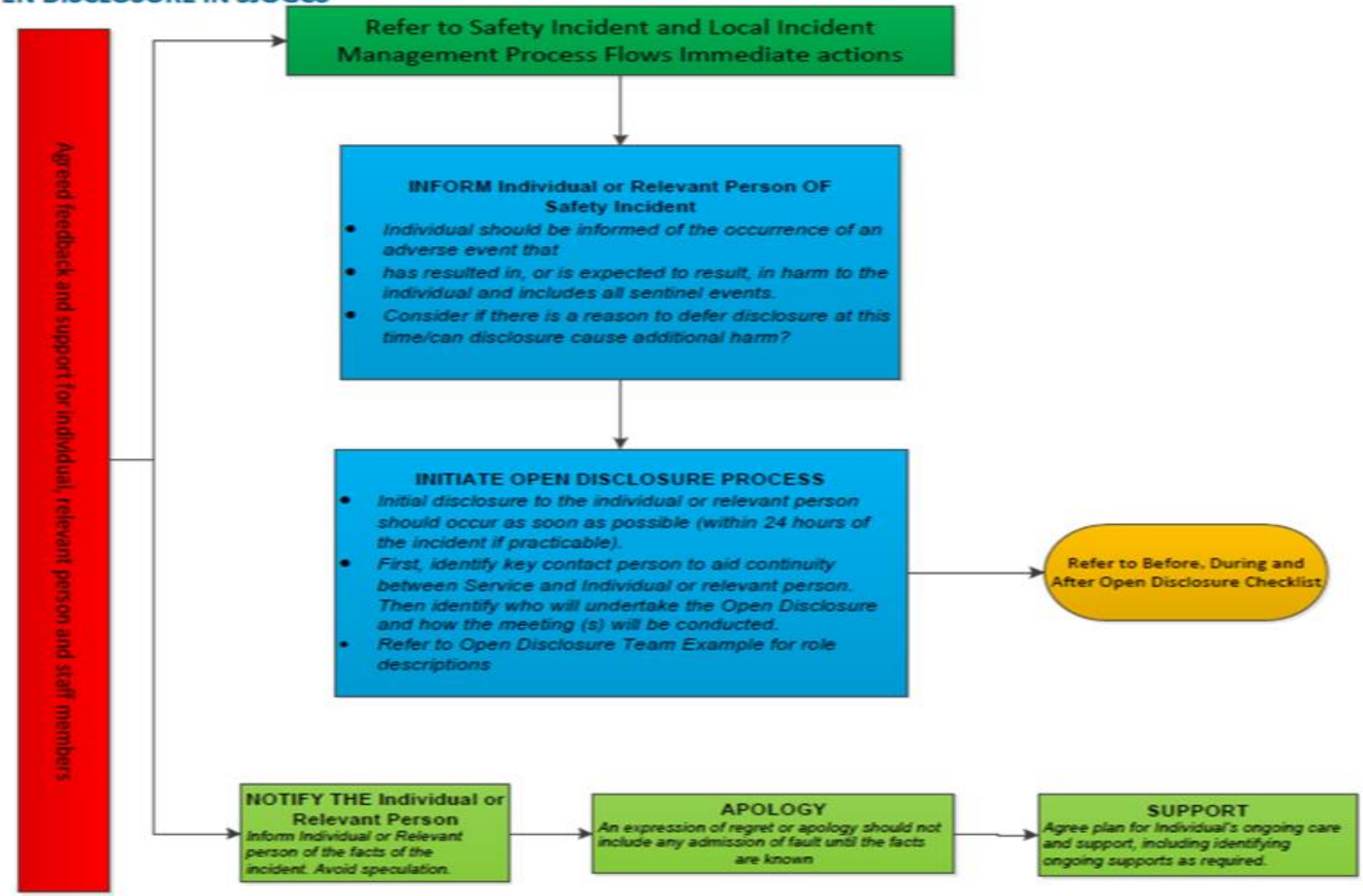
Our Journey

- It continues…. Recognition that sometimes Open disclosure is not a one time event!!! It's a journey
- Study of National Policy 2019
- National Lead brief to leadership forum in 2019
- How best to implement it – Director/SMT Liaison with Angela and team
- Implementation Plan and Timeline
- Train the Trainer identified and trained by National Office
- Draft of local SOP **this is crucial…**How does it affect my service with integral use of **Incident Management** and **Risk Management** policies
- Approval by Board
- Local Governance… Accountability.. Responsibility
- Culture! Culture! Culture!

LOCAL INCIDENT MANAGEMENT PROCESS FLOW for MODERATE INCIDENTS 2021



Appendix 2: OPEN DISCLOSURE IN SJOGCS



Second Trauma and Second Victim –Staff Support

Peer Support. EAP. CISM. Risk Assessment. Just Culture around incident management

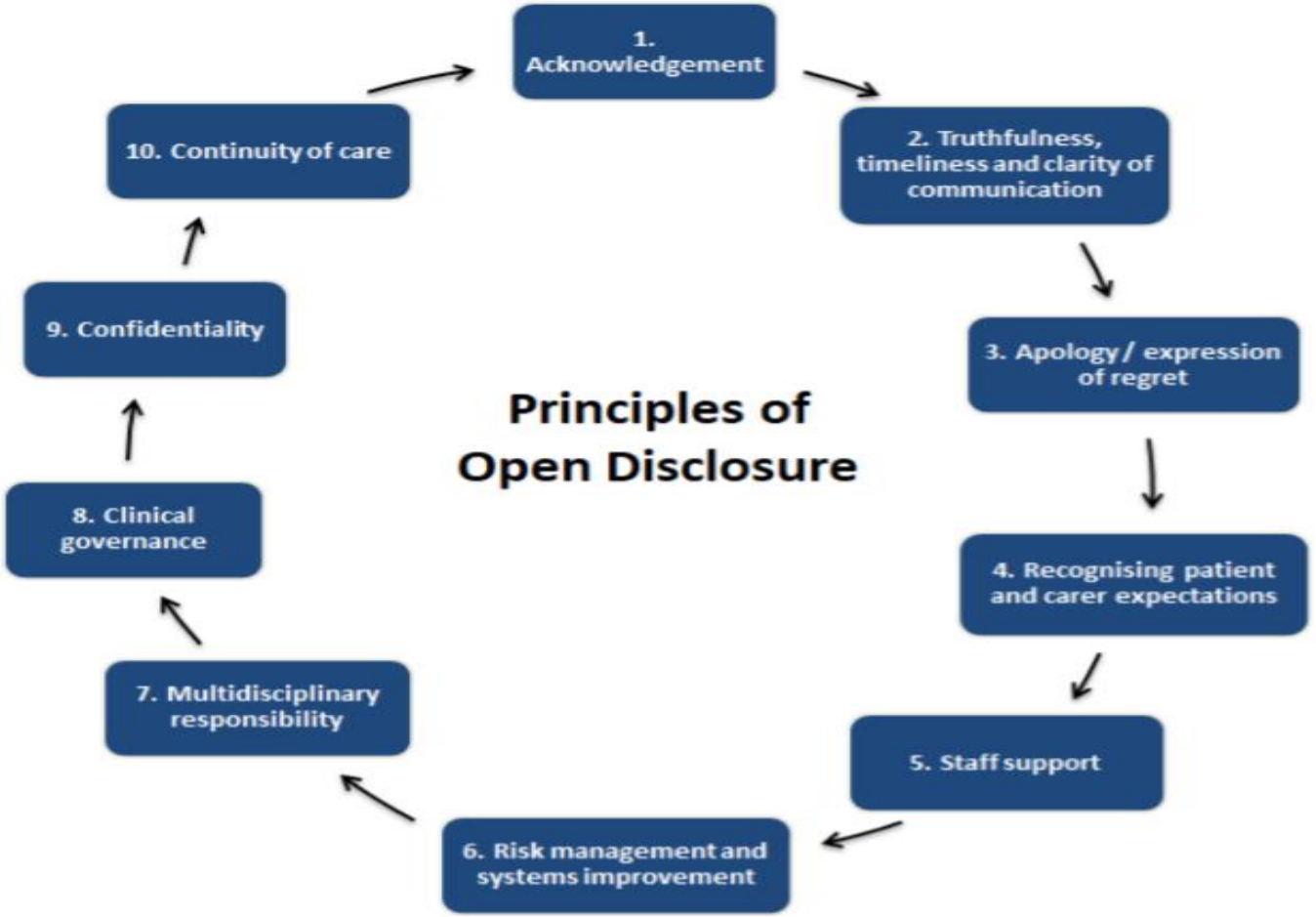
The Moral Injury

There can be little doubt that for the majority of 2020, and probably before then too, many healthcare workers (HCWs) have worked long hours in high-pressured environments characterised by exposure to traumatic events and moral dilemmas. Healthcare staff who have not been on the 'COVID frontline' have also had to adapt to new ways of working, and all have had to contend with a wide range of non-work stressors that have affected the rest of society as well

Prof Neil Greenberg (2020)

https://mdujournal.themdu.com/issue-archive/winter-2020/moral-injury-in-healthcare-workers

Some worked scenarios-Apply all the principles



Do we get it right always

- No Of course Not
- Understanding a Low level response. This is just as important and discussed in our scenarios
- Importance of Documenting all responses
- Learning Notice issued

First things First…Dealing with suicide

- Difficult for all involved Compassionate approach
- Staff and Family Support is vital. Managerial Peer EAP CISM AAR
- Suicide is not an automatic indication that a service provider has done something wrong or that the care was less than optimum
- Let your processes work Incident Management
- SJOGCS screen via the Prelim form A ***all*** Suicides as unexpected Deaths.
- We rarely proceed to systems analysis
- Appropriate Communication with family picking the time use ASSIST as a model

Disclosing to patients in mental health Services

- Assume Capacity until you know otherwise
- An individual whose decision making capacity is in question is entitled to Open Disclosure on an equal basis with others and to be supported in that process.
- ‘There is currently no legislative framework to govern how a decision about treatment and care should

Case 1: Waiting List

- **CAMHS Setting**
- **Report received from parents, that child on routine waiting list for 4 months (KPI:12 weeks) had been admitted to A&E following incident of self harm**
- **NIRF 1: Harm to Person Form Complete**
- **Prelim A (Moderate Incident)**
- **Consultant & Senior Managers met with parents (who were distressed)**
- **Open disclosure made in context of non compliance with CAMHS Operational Guidelines**
- **Initiatives to reduce waiting list implemented**

Case 2: medication

- **Residential Rehabilitation Setting (Adult Mental Health)**
- **Medication Audit found that over a 4 week period a daily dose of a benzodiazepine had been omitted for 1 individual due to a recording issue**
- **Reported the Director of Nursing and Consultant Psychiatrist**
- **NIRF Form 1: Harm to a person form complete**
- **Resident received clinical assessment and medication review from Consultant Psychiatrist**
- **Senior Nurse met with resident and a member of their Family**
- **Open Disclosure made in relation to non compliance with medication policy**
- **Prelim Review of Incident undertaken, recommendation that staff re inducted to medication policy**

Case 3: AWOL Incident

- **Adult Inpatient Setting**
- **Inpatient involuntary admission**
- **Absent without Leave for over 1hour before staff escalated incident**
- **Patient returned home, was paranoid about a member of their family and subsequently seriously assaulted them and victim admitted to A&E**
- **NIRF Form 1 completed: Harm to a person and Prelim form A (Escalated to SIMT)**
- **Consultant Psychiatrist and Social Worker convened family meeting (including victim)**
- **Open Disclosure made to the family in context of non compliance with observation policy**
- **On discharge from hospital Open Disclosure made by the clinical team to the patient in the presence of a chosen advocate (a friend)**
- **Observation policy and escalation guidelines reviewed**

CASE 4: VIOLENCE HARASSMENT & AGGRESSION

- **Adult Mental Health Service Outpatient Setting**
- **A service user who presented (unanounced) as psychotic was verbally aggressive and threatening to other patients in the waiting room**
- **A service user who was attending their initial assessment left the building without attending their appointment**
- **NIRF Form 1: Harm to a person form complete**
- **Community Mental Health Nurse did a home visit to the new service user**
- **Open Disclosure made in context of non compliance with local procedure on the management of incidents**

CASE 5: CARE PLAN

- **Adult Mental Health Service**
- **Serious Incident Review of a suicide that occurred in community found no causal factor, incidental finding was that at the time the person died they did not have an updated care plan**
- **Reviewers escalated finding to SIMT and Local Service Management**
- **Family of the deceased met with Consultant Psychiatrist & Senior Manager**
- **Open Disclosure made in context of non compliance with ICP policy**
- **Review of ICP policy undertaken**

Case 6: ADHD Treatment

- **CAMHS Setting**
- **Young person referred to CAMHS, Initial Assessment undertaken and diagnosis of ADHD made**
- **Parents did not wish child to be prescribed stimulant treatment**
- **Parents upset that there were limited non medication treatments available on the clinical team and lodged complaint**
- **Complaints manager and consultant psychiatrist met with parents:**
- **Open Disclosure made in relation to non compliance with CAMHS Operational Guidance and group intervention provided in other area of service**
- **ADHD Treatment Pathway developed**

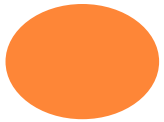
When you might not disclose in Mental Health

- Very rare and in the most exceptional circumstances
- Think Why would we not disclose
- National Policy gives excellent guidance
- When the patient is unable, for whatever reason (e.g. the patient is too ill), to provide consent the decision to disclose information to the relevant person must be made by the most responsible person (MRP) involved in the care of the patient i.e. the principal healthcare practitioner or an appropriate delegated person when the MRP is not available

In SJOGCS Governance for this provided by the Clinical Directors and the the SAO

A decision to defer or not disclose must be discussed with the CEO

Some examples of non disclosure



In summary

- Importance of adapting the National policy to your service Needs
- The use of the Incident and Risk Management policy
- All incidents to be disclosed
- Very limited circumstances where you might not
- Staff support is crucial