Open disclosure in The Mental Health Setting

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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 when we have it Clare Dempsey CEO

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
- Our Process
- Our Staff

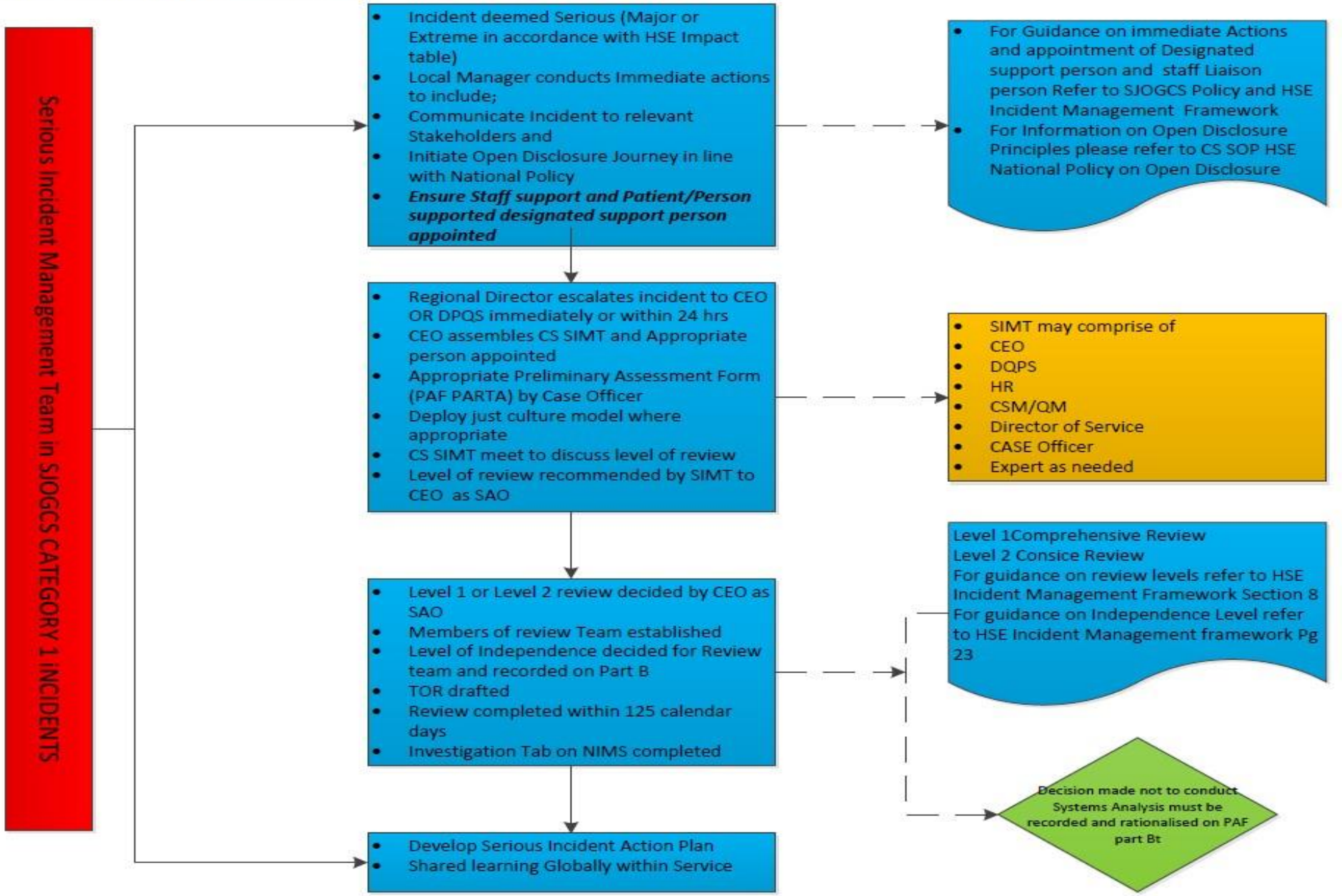
Our Journey

- 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!

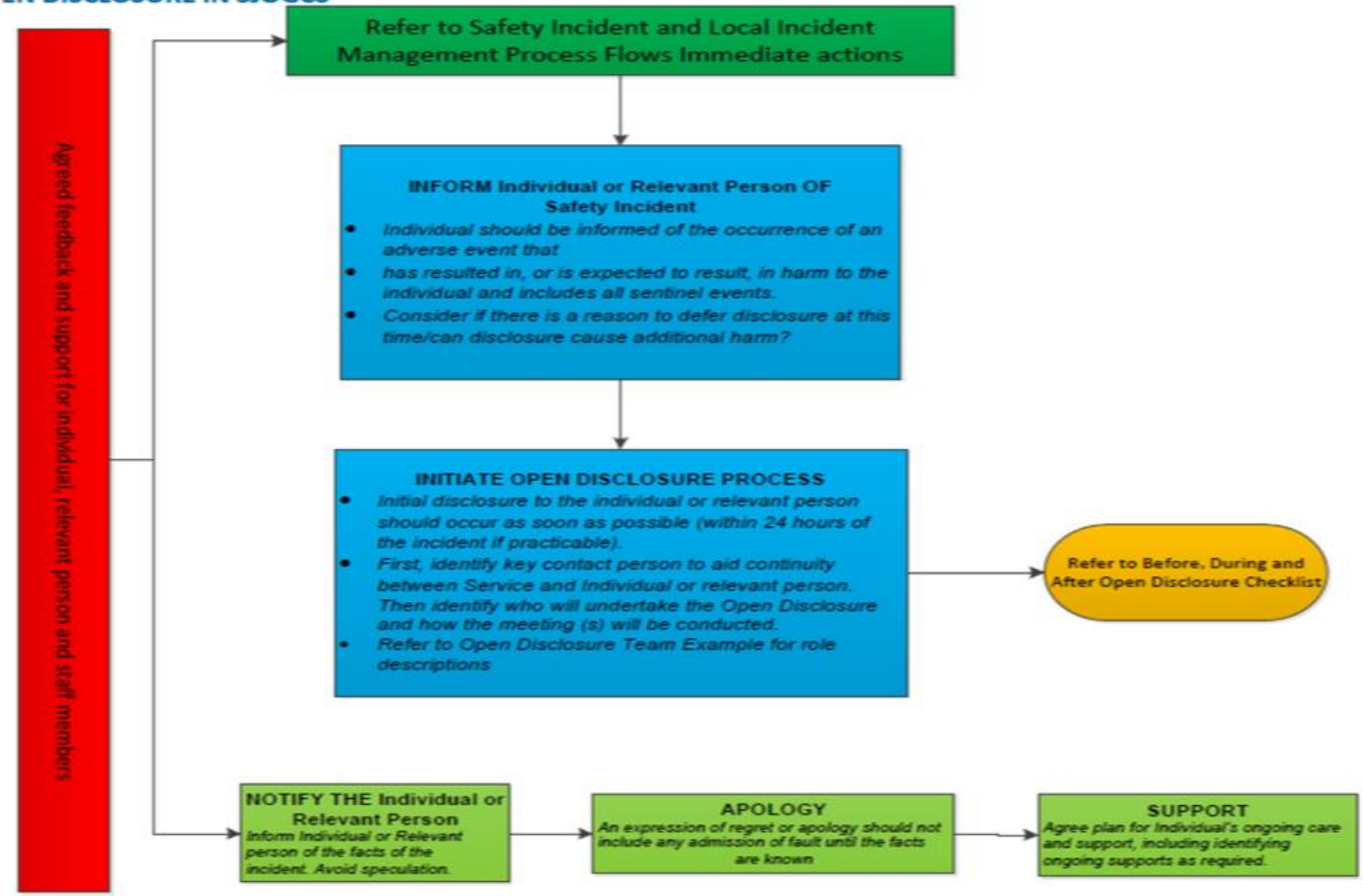
Our Process

- Incident Management Policy is crucial we always follow the 6 steps where required.. **Follow it**
- Appointment of liaison persons is crucial both for staff and families
- Prelim A an aid for decision making
- All suicides are unexpected deaths and need to be preliminary screened.
- **Not suggestive that anything was "done wrong"**
- ***Rarely go to systems after prelim A for suicides***
- Each circumstance is always different
- "Normalisation" of this approach – culture of safety and openess
- How we best can support staff

SERIOUS INCIDENT MANAGEMENT PROCESS FLOW



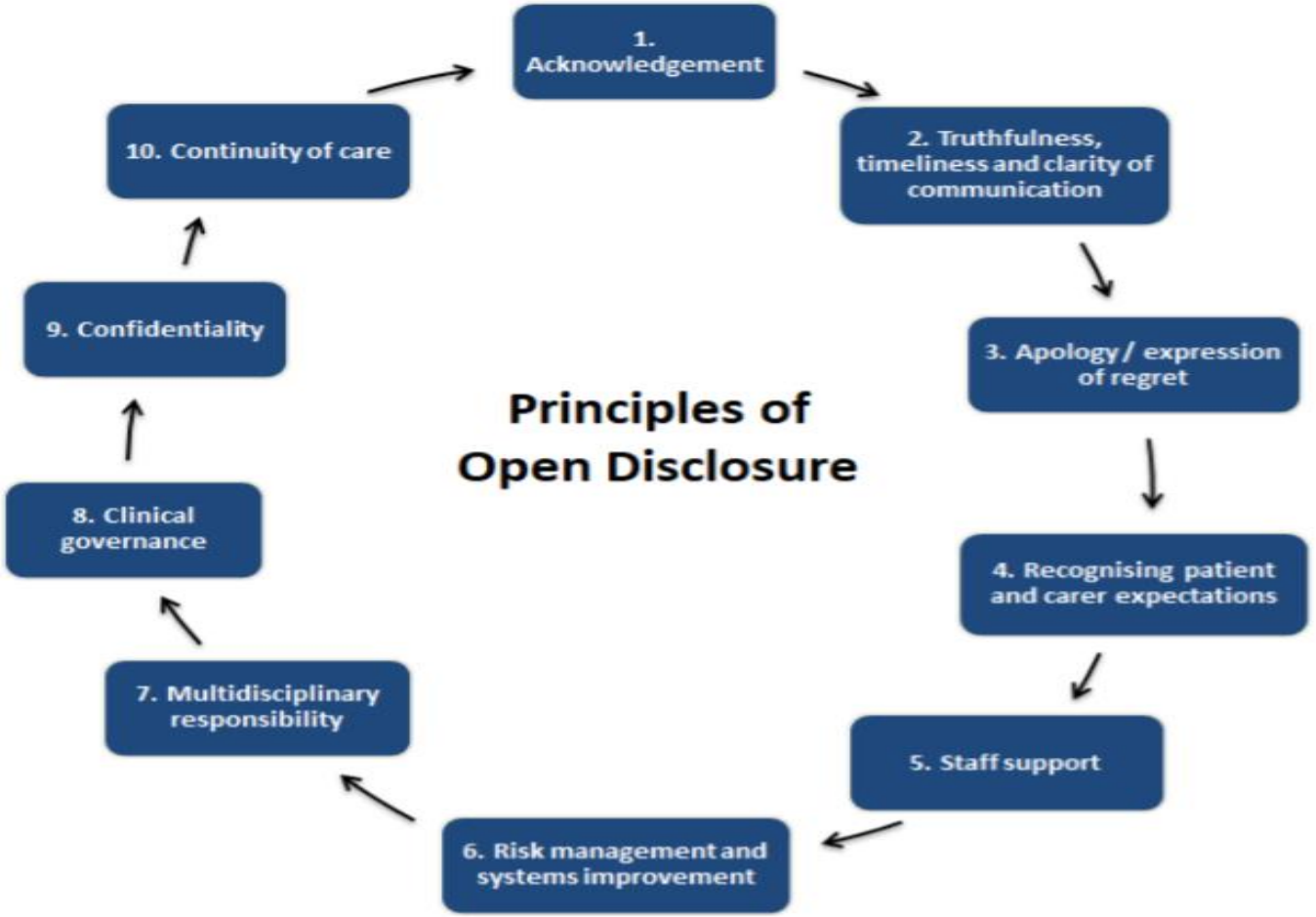
Appendix 2: OPEN DISCLOSURE IN SJOGCS



CASE 1: THIS MIGHT BE TYPICAL

- **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**

Some worked scenarios-Apply all the principles

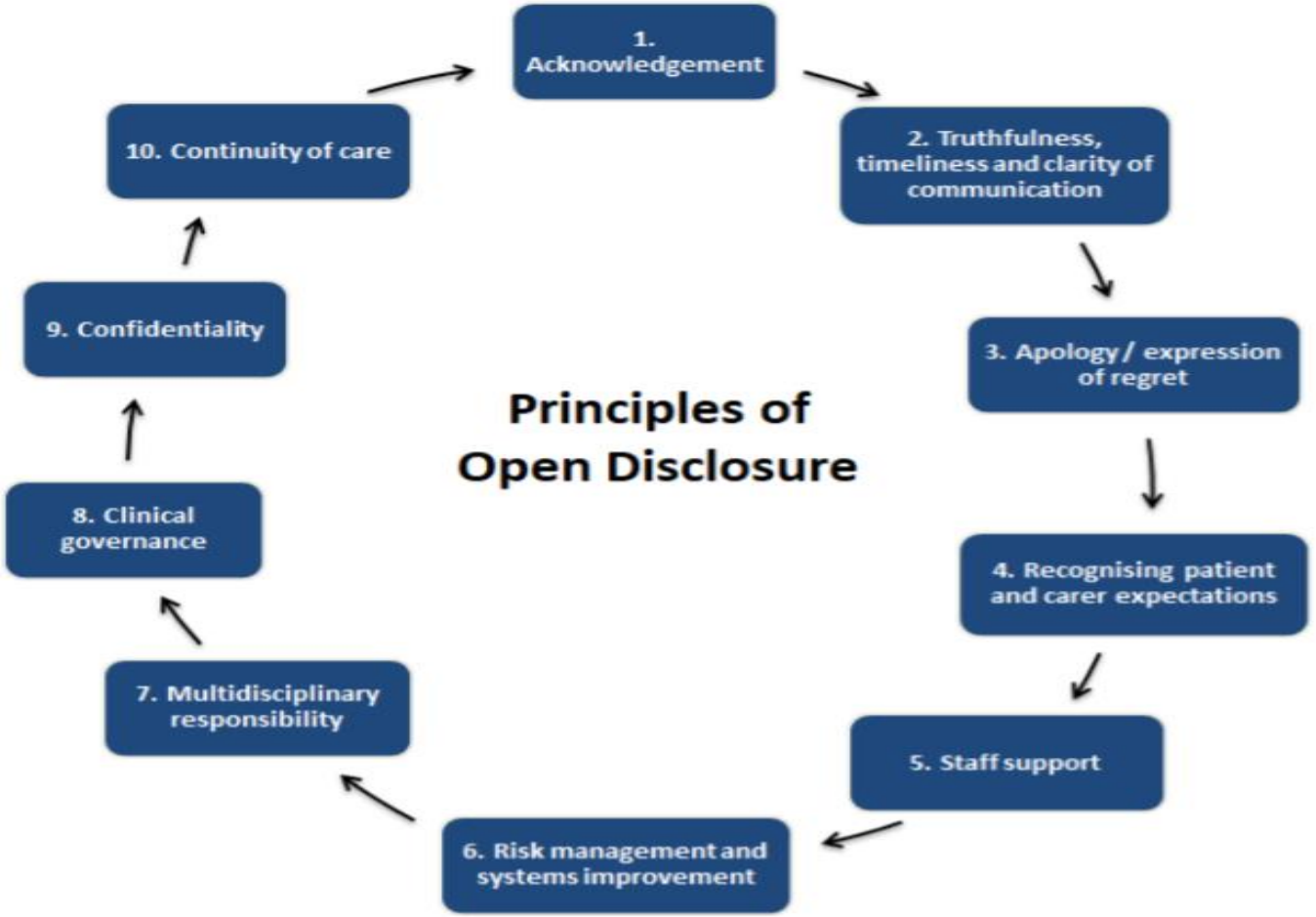


What if you found a causal factor

- The process is no different
- Clear honest communication inline with OD policy
- Remember …..

"An adverse event does not necessarily break down trust between people involved in an incident and the service, rather it is the way a service responds to an incident which does"

Some worked scenarios-Apply all the principles



Staff Support… what and How

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

Some supports

- ASSIST ME MODEL
- PEER TO PEER SUPPORT
- EAP
- AAR
- Conduct review sensitively as possible

- Emphatise about their situation.. I understand.. Effcetive listening

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

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

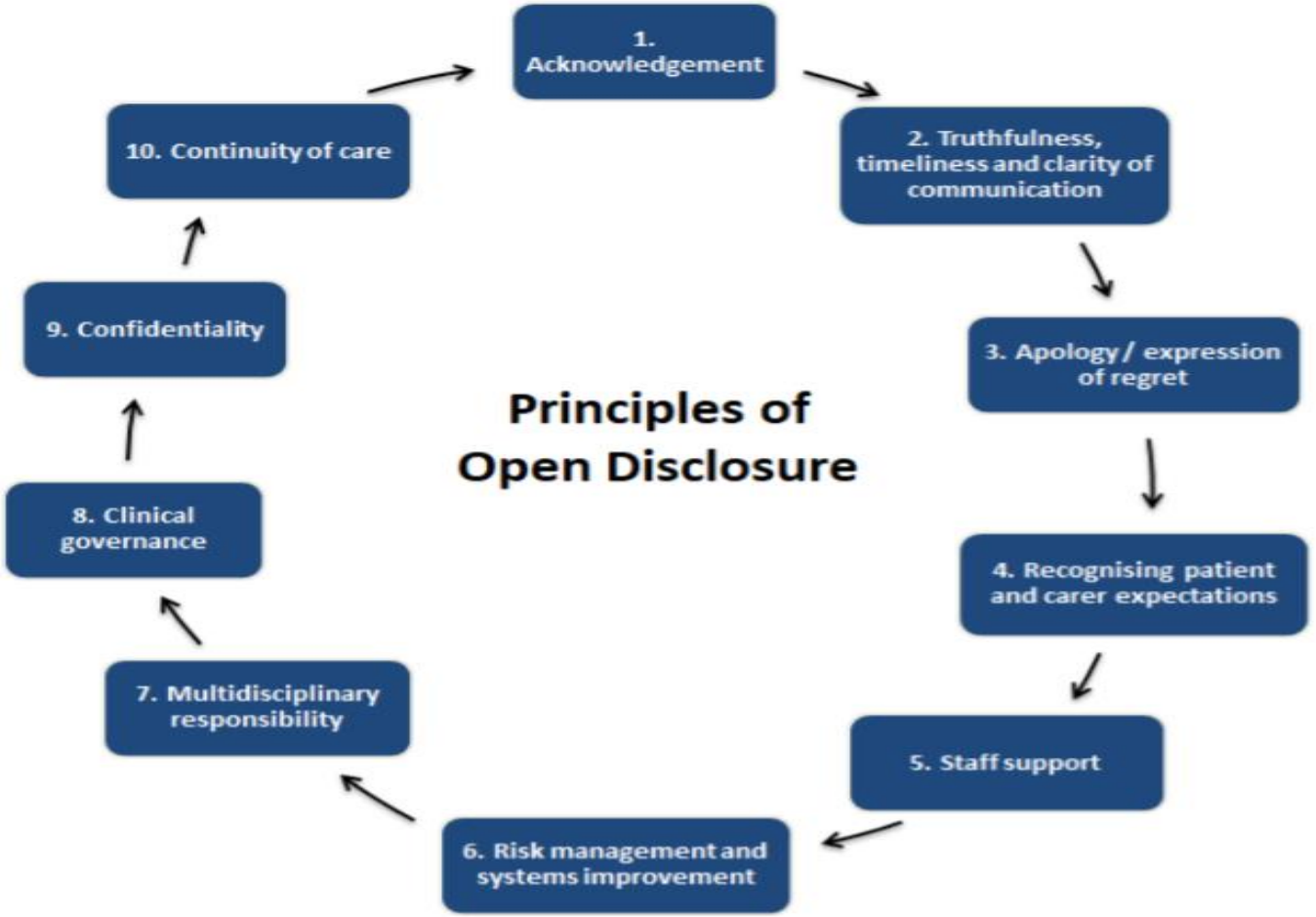
Case 1: Suicide following missed home visit

- **Community Mental Health Nurse, at a patients house following a mental health crisis and missed 3 subsequent appointments**
- **Patient who had recently returned home from hospital and living alone died by suicide in their own home later in the same day.**
- **NIRF Form 1 completed form A (Escalated to SIMT and Review Commissioned)**
- **Consultant Psychiatrist and Social Worker convened family meeting (in the week following the funeral. Open Disclosure made to the family in context of missed appointment**
- **After Action Review commissioned and CMHN offered EAP**
- **Review of cancelled appointments to ensure other serious incidents had not occurred due to similar issues**

Case 2:Suicide

- **Day Centre**
- **Patient overdue for depot injection by 2 days, was later found to have died by suicide on the 1 month anniversary of his wife's death.**
- **NIRF Form 1 and Prelim A meeting**
- **Day Centre has a policy of 3 working days for home visit for a missed depot/Prelim meeting identified that should have been followed up earlier given the extenuating circumstances. Serious Incident Review Commissioned.**
- **Open disclosure journey began immediately following Prelim**
- **Senior Manager and consultant met with the adult children of the deceased regarding depot injection**

Some worked scenarios-Apply all the principles



Case 3: Serious Incident of assault

- **Adult Mental Health Outpatients**
- **23 year old male patient attended to see registrar, seeking benzodiazepines, disclosed baton concealed in sports bag.**
- **Registrar screamed and another patient ran into the room and was assaulted, incurring serious head injuries resulting in a 2 week hospitalisation and trauma counselling**
- **NIRF 1 Incident Form and later Prelim form A**
- **Prelim form A discovered, reduction in staff in building due to covid restrictions/Serious Incident Review Commissioned**
- **Senior Managers met with patient and advocate**
- **Open disclosure made in context of lack of safe staffing levels**

Case 4: 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 5 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 6: Disability Referral

- **CAMHS Setting**
- **Young person referred to CAMHS, Initial Assessment undertaken and later ADOS Assessment indicating Autism Spectrum Disorder Diagnosis**
- **Number of clinical interventions offered, and referral later made to disability services**
- **Parents upset that there was a delay in referral to disability services, given a long waiting time for those services thus adding to the delay**
- **Complaints manager and consultant psychiatrist met with parents**
- **Open Disclosure made in relation to non compliance with admission, transfer and discharge policy**
- **Guideline developed in relation to onward referral to disability services**

Disclosing to patients in mental health Services

- ***Always 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

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

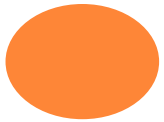
In SJOGCS Governance for this provided by the Clinical Directors and the the SAO

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

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

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