Appendix D13: Root Cause Analysis Investigation Report.
Redacted Version October 2019

EXECUTIVE SUMMARY

Brief Incident Description:

- **Incident reference number:** 2016/2198
- **Incident date:** 22.1.16
- **Incident type:** Substantial injuries to patient who has fallen from an AWP building whilst an inpatient and under distress.
- **Incident description and consequences:** The service user was seen to be climbing a low roof area accessed from the garden at 18.40hrs and moving slates off the roof and declined to come down. She rapidly climbed up the roof. At 06.05 am on 23.1.16 the service user appeared to slip or fall off the ward roof at the highest point and sustained a number of serious injuries. She was taken by emergency ambulance and admitted to a General Hospital with multiple injuries, including jaw, hip, pelvis and facial injuries. Required surgery and intubation and had to be physically restrained due to her high level of distress. Discharged from the Acute Inpatient Ward 1. Mental Health Liaison team at the General Hospital are currently providing management of the service user's mental health whilst in a general hospital and undergoing medical intervention.
- **Healthcare specialty:** Acute inpatient
- **Actual effect on patient and/or service:** Serious injury as stated above.
- **Actual severity of the incident:** Catastrophic.

Level of investigation conducted:

Root Cause Analysis Level 2 (Comprehensive)

Involvement and support of the patient and/or relatives:

- 22nd January 2016, 18.40: Person 1 was present when incident took place with the service user.
- Modern Matron talked to Person 1. This not recorded on RIO however outlined in an email to the investigators. Person 1 was contacted and apology was offered on Saturday 26th January 2016. Further phone conversation took place to person 1 on Sunday 27th January 2016 and further support available to him was discussed and person1 was advised that we would be completing an initial investigation and a further more comprehensive RCA would take place and he would have the opportunity to contribute if indicated and to receive feedback. Further contact was however Person 1 declined at that point in time. (Email 1st March 2016)
- 25th January 2016: phone call from person 10 to Person 1 to express sympathies and further explanation
- 23rd March 2016: contacted service user and person 1 by investigator regarding RCA.

Message left

- 24 Mar 2016: up-date on RCA progress. Informed that meeting had gone ahead and arrange to meet 31st March 2016. Both service user and person 1 are keen to participate and feel that this would be helpful to them. Care co-ordinator up-dated and invite extended.

The chairs are assured that the Trust has adhered to its Duty of Candour (as outlined on the Being Open Policy). There was no written confirmation made of the incident and this was discussed as not appropriate as the service user had sustain significant injuries and spent a significant amount of time on the Intensive Care Unit.

Detection of Incident:

The incident was witness by person 1- on call senior manager and Nursing staff were alerted that an incident was taking place.

Notable Practice

- Particularly one member of nursing staff engaged well with the service user and felt that they had a good rapport. She also stayed on after her shift had finished supporting staff and patients.

- Staff supported each other well during and after the incident staying on longer then required.

- During the RCA meeting staff showed a very caring and compassionate attitude towards the service user, person 1 and their wellbeing.

Care and Service Delivery Problems

Care Delivery Problems:

- Risk Assessments and up-dating of risk assessment: the risk assessment was not completed but ‘cut and paste’ the same three lines in each box of the risk assessment: the service user 'had been admitted to the Acute Inpatient Ward 1 as there were no beds in local area' – following added post meeting. A risk assessment is expected to be completed within 72 hours and this took place however cutting and pasting does not imply a good and detailed assessment. The modern matron explained that they have been aware that everyone ‘cuts and pastes’ information in to the risk assessment from the core assessment and from the progress notes and that this normally relates to updating parts of the risk assessment where it is most appropriate. However this cannot be accepted as completing a risk assessment.
- Assessment of Risk of absconding on an inpatient ward - there is no evidence in the records that risk of absconding was specifically assessed as there are no details in general. This has been addressed by up-dating the Garden Policy and introduction of an allocated garden nurse.
- Involvement of relatives in assessment: It is expected that relatives and cares are involved in a service user’s care as much as possible with appropriate consent given. There is a discrepancy of perception about the level of involvement of person 1 however overall it appears that he could have been more involved particularly as he was aware that the service user felt unsafe on the ward.

Service Delivery Problems:

- Risk coding and escalation process: there needs to be some check/balance that has a significant score - How to follow up unresolved risk. The RCA Meeting highlighted that there is a systematic fault. As outlined above the risk was on the health and safety register, it was highlighted annually and escalated Trust Wide. It was agreed that the process of highlighting risk, escalating it, managing it and flagging up unresolved risks has been disjointed as the risk was on the Health and Safety Register but the risk management did not move on from the clinical management to addressing the low roof line as such. The coding has been addressed and an incident of a service user being on the roof would have been coded as a roof related incident rather than absconding.

Contributory factors

Contributory have been looked at in line with the NPSA Contributory Factors Classification Framework.

1. Patient Factors – Mental/Psychological Factors & Interpersonal relationships

The service user presented with paranoid delusions which appeared to be initially mainly around her home however also included the ward environment. This emerged mainly by talked to the service user and person 1 after the incident. The service user had agreed to admission to hospital but found the ward unsettling particularly after an incident which involved the police. This increased her fear of being unsafe and therefore enforced her paranoid delusions in general. It would have made the service user vigilant about her environment and created a cycle of increased fear triggering further psychotic symptoms. In addition the service user said that she heard a member of staff stating that ‘she has never seen anything like it in 18 years’ and was also told by other service users that she would never leave the ward again. The service user referred several times during the meeting on the 31st March 2016 to above statements which were clearly of significance to her and increased the degree of feeling paranoid about the ward. Therefore the service user was less likely to engage with ward staff freely, expressing her fears. Ward staff was therefore not aware of the level of paranoid beliefs about the ward and the fear never to be able to get out. This would have influenced the quality of the risk assessment particularly of absconding and the subsequent action taken and therefore contributed to the Care Delivery Problem ‘Risk Assessment’. This frame of mind would also increase the risk of a service user considering absconding from the ward using a low roof line as possible escape route.

2. Communication - Written communication

The record keeping of the admission on Acute Inpatient Ward 2 and the time prior to the incident is poor. It has been difficult for the investigators to get an impression of the care of the service user prior to the incident. For example a conversation with the service user and husband took place however the content is not recorded. The risk assessment is a ‘cut and paste’ sentence which doesn’t provide sufficient information. This would have made it difficult for any member of staff to up-date the risk assessment or continue an assessment of the service user as hardly any information was available in the first place. This would have an impact on the Care Delivery problem – Risk Assessment.

3. Work Environment – environment and time

Ward environment: the ward was described as busy on the 22nd January. When person 1 arrived and realised that the service user was about to run to the roof he was not able to find a member of staff. Identifying a member of staff on a busy ward can be difficult and therefore staff might have been close by but person 1 not realising this. This caused a delay in ward staff being aware of the service user's beliefs and her trying to escape using the roof and hence affected the risk assessment. However even if staff had been fully aware of the service user's paranoid beliefs and been present with the service user in the garden the incident could have happened nevertheless.

It is difficult to tell how much the busy environment impacted on ward staff involving person 1. Person 1 felt that he wasn't included as much as he would have liked to be but staff at the RCA Meeting reported talking to him and the service user for 1.5 hours. As the content of the meeting is not recorded on RIO it is not possible to comment on this. Overall an acute, busy ward environment would reduce the time staff had available to spend with individual service users and relatives/carers and this would therefore influence Care Deliver Problem 'Involvement of relatives/carers'.

Short duration of admission: engaging a service user with psychotic beliefs takes time and that service user had only been one day on the ward. The service user was seen in a timely manner by the doctor and her presentation discussed with the ward consultant. Antipsychotic medication was prescribed however this has a time lag between commencing and taking effect. Therefore ward staff did not have time to be expected to have established a trusting therapeutic relationship with the service user and to fully explore collateral information. This would contribute to assessment of risk and involvement of person1 and therefore can be perceived as a contributing factor to both CDP 'Risk Assessment' and 'Involvement of relatives/carers'.

4. Organisational – safety culture

It was highlighted in the RCA Meeting that the risk of the low roof line had been highlighted and that annual risk assessments have been conducted. The risk was also escalated Trust wide when the triumvirate in the locality came in. The outcome was that the risk should be managed clinically. Whilst this might be sufficient as an interim measure it is not sufficient as the long-term solution. No risk assessment is fool-proof and there is no evidence base for risk assessment tools to assess risk of absconding. Risk assessments are founded on clinical assessment, mental state examination, past risk history and collateral information. This is difficult in a service user who has only just been admitted to a ward, without mental health history and not much collateral history. Therefore particularly new service users will be difficult to fully assess. Therefore the environment of an acute psychiatric inpatient ward needs to be as safe as possible which would have included addressing the low roof line as this is the easiest point to escape from the ward. The acceptance to manage the risk of the low roof line purely clinically could have contributed to the Service Deliver Problem as there might have been the perception that the risk has been sufficiently managed. This would have slowed down the process of addressing the issue further despite its remaining on the risk register.

Root causes

The root cause of the incident can be perceived as the mental state of the service user. It meant that the service user had paranoid beliefs about the ward which were increased by the environment and comments from staff/other service users. The frame of mind made it difficult for the service user to trust and engage with staff and disclose her worries rather than considering escaping. Staff made efforts to engage with the service user however unfortunately at the time the service user was not able to trust staff.

All other contributory factors identified influence the Service Delivery and Care Delivery Problems which would have made it less likely for the incident to take place however it would not be possible to state that the incident would not have happened if these factors had been addressed.

Lessons learned

- RIO record keeping – RIO records are sparse in relation to the incident (in management report) and made the investigation difficult.

- Impact of adverse incidents on service users on an acute inpatient ward – the service user felt increasingly paranoid about the ward environment as a result of the adverse incident involving the police

- Impact of ward environment on a service user particularly without previous admission – both service user and person 1 found the ward environment difficult and not what they expected. Ward staff needs to be aware of this and this needs to be addressed when talking to a service user. This might have taken place but is not recorded on RIO.

Recommendations

Recommendations already addressed

- **Garden policy:** The Assistant Director of Nursing reviewed the garden policy and arranged for interim control measures to be implemented (specific level of observation relating to risk assessment of all service users). This measure will continue until further reviewed. Every handover includes a risk assessment of absconding. If considered ‘medium’ the engagement policy will be followed and if ‘high’ the service user would be on ‘one to one’ observation or not allowed in the garden.

- **Allocated Garden Nurse:** there is now an allocated garden nurse in central lines who has good visual of the garden. If low risk = keep eye on, medium = nurse will go into the garden with the service user; high=follow individual care plan.

Team Recommendations:

- **RIO record keeping** –Trust standards were not adhered to regarding concise up to date record keeping. Inpatient Ward Manager and Senior Practitioner to ensure case notes are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.
- **Risk Assessments and up-dating of risk assessment** – Trust standards were not adhered to regarding robust risk assessment risk of absconding was not always considered. Inpatient Ward Manager and Senior Practitioner to ensure risk assessments are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.
- **Involvement of relatives/carers** – the relative had not been invited to the ward review meeting, and although staff had spent time with him, the relative did not feel involved in the service user care and treatment plan. Inpatient MDT to ensure that relatives are invited to attend ward reviews CPA's etc... and are allowed 1-1 time with the nursing staff during visits, to discuss their concerns**.**

Delivery Unit Recommendations

- **Record keeping and risk assessments were not completed to Trust standards** - This issue may be replicated across the LDU. A Care Plan and Risk Assessment audit has been formulated and distributed by the Service Improvement Lead. Action plans to be developed form findings of audit.
- **Risk of absconding** – Acute Inpatient Ward 1's low roof line has been added to the LDU risk register. Although changes to operational and clinical practice have been made a permanent structural solution is required regarding the estate to reduce the accessibility to the roof. Threes solutions have been proposed by the Health and Safety and estates department. Feasibility of these options is underway.

Trust Recommendations

- **Risk coding and escalation process:** there needs to be some check/balance that has a significant score. Risk coding must be reviewed to ensure that incident data and nature is captured accurately.

- **Risk Registers – A robust process is required to ensure that** unresolved risks are followed up. Changes have been recently made to the risk register system and every LDU must present to the Audit and Risk committee, escalating unresolved risks through to the Clinical and Operational executive Teams.

Action Plan

Rec. for Team or LDU or Trust	Describe the issue we are trying to address	What SMART actions do we need to take	Date for actions to be completed	Responsible Named Individual
Team	The RIO record keeping reviewed on the electronic medical record was not to the expected Trust standards	Inpatient Ward Manager and Senior Practitioner to ensure case notes are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.	June 2016	Service Manager UHB, AWP Safeguarding Team, Community Forensic Practitioner
Team	The Risk Assessments within the electronic medical record reviewed was not to the expected Trust standard	Inpatient Ward Manager and Senior Practitioner to ensure risk assessments are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.	June 2016	Service Manager UHB, AWP Safeguarding Team, Community Forensic Practitioner
Team	The relative/care did not feel involved with the care and treatment plan for the Service User.	Inpatient MDT to ensure that relatives are invited to attend ward reviews CPA's etc.. and are allowed 1-1 time with the nursing staff during visits, to discuss their concerns.	June 2016	Service Manager UHB, AWP Safeguarding Team, Community Forensic Practitioner
LDU	Record keeping and risk assessments were not completed to Trust	A Care Plan and Risk Assessment audit has been	June 2016	Operations Manager, Clinical Lead

	standards	formulated and distributed by the Service Improvement Lead. Action plans to be developed form findings of audit.		Wiltshire Service Development Directorate
LDU	The Risk of absconding on Acute Inpatient Ward 1 is increased due to the low roof line.	Although changes to operational and clinical practice have been made a permanent structural solution is required regarding the estate to reduce the accessibility to the roof. Three solutions have been proposed by the Health and Safety and estates department. Feasibility of these options is underway	July 2016	Service Manager, Head of Health and Safety, Head of Nursing
Trust	The Risk coding and escalation process for incidents is not sufficiently clear.	Risk coding must be reviewed to ensure that incident data and nature is captured accurately.	June 2016	Head of Health and Safety, Head of Patient Safety and Risk
Trust	A robust process is required regrading Risk Registers to ensure that unresolved risks are followed up	Changes have been recently made to the risk register system and every LDU must present to the Audit and Risk committee, escalating unresolved risks through to the Clinical and Operational executive Teams.	Completed	XXX

Arrangements for Sharing Learning

This report will be distributed to participants and recommendations taken forward through the Trust's governance arrangements both CIOG (Critical Incident Overview Group) and IGG (Integrated Governance Group). In particular, the report will be tabled at the Locality quality and Healthcare Governance group and discussed within the Acute Inpatient Ward 1 Team meeting.

MAIN REPORT

Cover sheet

Case Identification
STEIS Ref. 2016/2198
Details of the report author(s)
Consultant Psychiatrist North Wiltshire Intensive Service Team Manager, Acute Mental Health Liaison Team
Deadline for approved and ratified report
Week 25th April 2016 – delayed due to delay of receiving statements, annual leave of both investigators and sickness of ward manager.
Details of the Clinical Director who has approved the report
Details of the Executive Director who has ratified the report
Interim Medical Director

Identification of individuals involved in the incident		
Name of person	**How they are identified in the report (e.g. service user, care co-ordinator, etc)**	**Contact details**
	Service user	
	Person 1; husband	
	Person 2; Health care support worker	
	Person 3; Nurse nights, Acute Inpatient Ward 1	

	Person 4, Community Nurse	
	Person 5	
	Person 6; Social Worker	
	Person 7; Community nurse	
	Person 8, Trainee doctor	
	Person 9, Trainee Doctor	
	Person 10, Consultant Psychiatrist	
	Street Triage	
	On call senior manager	
	On call manager	
	RGN RMN 'agency nurse'	
	On call SHO	
	HCA	
	Assistant Director of Nursing	

Document Version Tracking

Version	Comment	Status*	Date	Person Responsible
		Approved	29/04/16	
		Ratified	03/05/16	

CONTENTS

25. Appendices

1. Incident description and consequences

The service user was an informal inpatient of Acute Inpatient Ward 1.

The service user was admitted on 21.1.16 to Acute Inpatient Ward 1 as no bed available in local area.

The service user had been assessed by the Mental Health liaison team-LDU and LDU intensive team for bed gatekeeping. A decision had been made to admit the service user as an informal patient.

On the 22nd January 2016 the service user was on day two of admission. She was out in the ward garden with Person 1.

The service user was seen to be climbing a low roof area accessed from the garden at 18.40hrs and moving slates off the roof and declined to come down. She rapidly climbed up the roof.

Emergency services were called immediately by Ward Staff at 18.40pm and attended immediately at 18.50hrs.

The service user remained on the roof from 18.40 pm on 22.1.16 to 06.05 hrs on 23/1/16.

The service user was in a distressed state and refused intervention from attending services which included a skilled negotiator/Ambulance/fire and Police at 18.50.

The service user remained on the roof all night and refused clothes, food and fluids or any support. Person 1 remained with her and witnessed the event.

At 06.05 am on 23.1.16 the service user appeared to slip or fell off Acute Inpatient Ward 1 roof at the highest point and sustained a number of serious injuries and was transferred to the General hospital at 07.00hrs on 23.01.16. The service user sustained multiple injuries, including jaw, hip, pelvis and facial injuries. She required surgery and intubation and had to be physically restrained due to her high level of distress.

Severity level: High/RED Catastrophic. 5

2. Pre-investigation risk assessment *(i.e. as stated on the initial incident report's risk ranking matrix)*

A **Potential Severity (1-5)**	**B** **Likelihood of recurrence at that severity (1-5)**	**C** **Risk Rating (C = A x B)**
		Red

3. Detection of incident

The incident of the service user climbing on the roof was witness by person 1 who had accompanied her in the garden from the inpatient ward 1. The service user was on 10 mins observations.

Nursing staff were alerted that an incident was taking place and immediately contacted emergency services, LDU Street Triage team and Manager on call on 22.1.16. The service user remained on the roof from 18.40 pm on 22.1.16 to 06.05 hrs on 23/1/16. At 06.05 am on 23.1.16 the service user appeared to slip or fell off Acute Inpatient Ward 1 roof at the highest point and sustained a number of serious injuries and was transferred to the General hospital at 07.00hrs on 23.01.16.

Incident form not completed until 25.1.16

4. Terms of reference

- AWP Risk Assessment department following a Red Management serious incident report.
- Commissioned with reference to the AWP Policy for the Reporting, Management and Investigation of Adverse Incidents (including Serious Untoward Incidents)(Also known as The Incident Policy) (2011).
- Joint protocol not required. AWP the only service investigating.

- The aim of the investigation. To explore whether the serious injuries that were life threatening were caused by any Care or Service Delivery Problems which need to be addressed by the Trust.

- **The objectives of the investigation.**

  - To establish the facts: what happened, to whom, when, how and why (the root causes)
  - To establish if there were failings in the delivery of care
  - To review whether all appropriate resources, e.g. staffing numbers, staffing mix, risk assessments, Health and safety and appropriate services were called.
  - To look for improvements in how care can be provided.
  - To establish how the risk of recurrence of similar incidents can be decreased
  - To formulate recommendations and an action plan
  - To provide a report as a record of the investigation
  - To provide a means of sharing learning

- That the report will be approved and administered in accordance with Trust Policy.

5. The investigation team

- Consultant Crisis Team.
- Team Manager, Acute Mental Health Liaison

6. Scope and level of investigation

- The investigation type: Root Cause Analysis Level 2 (Comprehensive)
- January 15.01.2016 (Referral to PCLS) to 23.01.2016 (service user fallen off the roof)
- Research carried out in the NHS has shown that systems failures are often the root cause of safety incidents. RCA investigations are not intended to investigate individual performance or disciplinary issues. Should any issues emerge during an RCA investigation they will be subject to separate HR process and will not be considered in the RCA report.

7. Investigation type, process and methods used

- Root Cause Analysis Level 2 (Comprehensive)
- Both chairs reviewed the documents listed under 'Information and evidence gathered' below.
- A tabular timeline has been constructed in is attached
- A RCA Meeting with staff was held on the 23rd March 2016
- NPSA Contributory Factors Classification Framework

- **Involvement and support of service user/carers/family/others affected by the incident**
- 22nd January 2016, 18.40: Person 1 was present when incident took place with the service user.
- Modern Matron talked to Person 1. This not recorded on RIO however outlined in an email to the investigators. Person 1 was contacted and apology was offered on Saturday 26th January 2016. Further phone conversation took place to person 1 on Sunday 27th January 2016 and further support available to him was discussed and person1 was advised that we would be completing an initial investigation and a further more comprehensive RCA would take place and he would have the opportunity to contribute if indicated and to receive feedback. Further contact was however Person 1 declined at that point in time. (Email 1st March 2016)
- 25th January 2016: phone call from person 10 to Person 1 to express sympathies and further explanation
- 23rd March 2016: contacted service user and person 1 by investigator regarding RCA. Message left
- 24 Mar 2016: up-date on RCA progress. Informed that meeting had gone ahead and arrange to meet 31st March 2016. Both service user and person 1 are keen to participate and feel that this would be helpful to them. Care co-ordinator up-dated and invite extended.
- Meeting with the service user and person 1 on the 31th March 2016

The chairs are assured that the Trust has adhered to its Duty of Candour (as outlined on the Being Open Policy. There was no written confirmation made of the incident and this was discussed as not appropriate as the service user had sustain significant injuries and spent a significant amount of time on the Intensive Care Unit.

8. Involvement and support provided for staff involved

Staff involvement in the investigation:

- Relevant staff was asked to provide statements.
- Relevant staff attended the RCA Meeting. The minutes of the RCA meeting were circulated amongst the attendees for comments and the draft report will be circulated.

Support given following the incident:

- Staff on Acute Inpatient Ward 1 was supported by the modern matron and ward manager. It is recorded in the management report and on RIO that the Modern Matron and Assistant Director of Nursing attended the ward and offered a debrief to staff on duty. The Modern Matron also called staff and set up the debriefing.
- Debrief Meeting on the 16th and 17th February. Some members of nursing staff stated in the RCA Meeting that this felt a little late. Also one member missed the debriefing altogether but felt that there was no need for further action.
- Apologies were offered for the fact that she missed the debriefing and a separate meeting was offered.
- The RCA meeting was used to reflect on the incident.

List any staff who attended an RCA meeting as part of the investigation:

XXX

List any staff who sent apologies or who did not attend any RCA meeting:

Apologies:

XXX

Expected but did not attend:

XXX

9. Information and evidence gathered

- Incident form
- 72 hour management report
- RIO Record
- Trust Policies and Procedures – Garden Policy
- Statements as listed below

List any statements provided to the chair/investigation team

- XXX
- XXX
- XXX

List information obtained from the service user or their family/carer – e.g. minutes of meetings, complaint letters, etc.

- Meeting with the service user and person 1 on the 31th March 2016

~~10. Chronology of events~~

11. Analysis

There incident can be divided into different aspects to look at. One would be the care the service user received by AWP prior to the incident, the negotiation period and the issues around the low roof line and its risk coding and escalation process.

Care prior to the incident:

The service user felt particularly unsafe after the police attended the ward and said that this increased her feelings of not being safe on the ward. It might be essential in future to consider talking to other service users after incidents to ensure that service users feel safe particularly if they are presenting as paranoid already. In addition it is important to involve relatives and carers in assessments and reviews and talking in more detail to person 1 might have provided more information about the level of paranoid thinking related to the ward. This might have influenced the questions asked when the service user and risk of absconding were assessed. However this is speculation particularly as there is a difference in perception in the level of involvement of person 1 between person 1, service user and ward staff. Also as outlined above it would have not prevented the service user from being permitted to enter the garden.

The service user climbed onto the roof and initially person 1 and a member of staff had hold of her. The service user crabbed a loose tile. She said that she did not intent to throw it at anyone. Staff let the service user go and person 1 was told to let go of her as well. It would have been inappropriate for staff or person 1 to continue to hold on to person 1 and/or consider climbing the roof for own safety reasons. The appropriate action was taken by letting her go and calling the police.

Negotiation:

There is difference in perception of the quality of negotiation. Ward staff during the RCA meeting stated that they felt excluded and that the negotiators didn't seem familiar with mental health problems. The felt disempowered and also overheard the negotiator talking in a harsh manner to the service user. In the RCA meeting we discussed that the service user spend an entire night on the roof, the perception that no safety measures were put in place to prevent injury in case of her falling off the roof and that it appeared that person 1 had been excluded from the process.

In talking to the service user and person 1 they praised the negotiating team and said that they were very good. The service user described feeling scared and that she would under no circumstances come down from the roof and return to the ward. She said that she is a stubborn person. She said that she decided that it would be better to fall off the roof and sustain physical injuries and be taken to a general hospital rather than returning to the ward which she perceived as unsafe and a place she would never be allowed to leave again. Person 1 said that he was

involved in the negotiation process and that he discussed with the negotiators that the service user responds better to authoritative approach. This might have been overheard as a harsh approach by staff. Person 1 was present when the service user fell of the roof and felt fully included in the entire process. He said that it was discussed with him in detail what kind of safety measures would/would not be taken and why and his opinion taken seriously.

The ward manager and I discussed the difference in perception of the negotiating process and agreed that the incident was declared to the police as an emergency and that it is normal practise that the police take over and that therefore ward staff would have not been expected to be involved. It is down to the negotiating team how to conduct the incident. Both person 1 and service user were happy with the process and support received. The service user described herself as very paranoid at the time about the ward and as generally stubborn and this provides an explanation as to why the negotiation was difficult and lengthy.

Coding of risk, escalation of risk and process of the roof line:

The service user climbed onto the roof and initially person 1 and a member of staff had hold of her. The service user grabbed a loose tile. She said that she did not intent to throw it at anyone. Staff let the service user go and person 1 was told to let go of her as well.
It would have been inappropriate for staff or person 1 to continue to hold on to person 1 and/or consider climbing the roof for own safety reasons. The appropriate action was taken by letting her go and calling the police. The question arises around the access to a low roof leading on to a high roof with significant risk of injury if falling off. This was discussed at length in the RCA Meeting.

The site was built in 1999 and the entire building is low. There has been awareness of the low roof line and the risks related, and this has been on the Health and Safety Register. The central courtyard has access to the low roof line. It has glass on two sides and is therefore in general good to be observed by staff. The Observation/garden policy is linked with the Engagement policy and used all the time. The garden is the only designated smoking area. The risk has been recognised and the risk to patients has been raised every time for last eight years.

The Modern Matron explained that the risk has been highlighted and that annual risk assessments have been conducted. He explained that the risk was escalated Trust wide when the triumvirate in the locality came in. The outcome was that the risk should be managed clinically.
Whilst this might be sufficient as an interim measure it is not sufficient as the long-term solution. No risk assessment is fool-proof and there is no evidence base for risk assessment tools to assess risk of absconding. Risk assessments are founded on clinical assessment, mental state examination, past risk history and collateral information. This is difficult in a service user who has only just been admitted to a ward, without mental health history and not much collateral history. Therefore particularly new service users will be difficult to fully assess. Therefore the environment of an acute psychiatric inpatient ward needs to be as safe as possible which would have included addressing the low roof line as this is the easiest point to escape from the ward.

After the incident it was considered to shut the courtyard. The Acting Medical Director, in liaison with the quality director, went through exercises. If the courtyard would be closed the ward would have to use the other two gardens. It would cause more problems trying to manage two gardens. Also all service users use the courtyard. In addition it has caused problems such as staff being assaulted or windows are smashed when the courtyard was closed. Therefore part of the current procedure is that the courtyard can be locked under extreme situations.

The RCA Meeting highlighted that there is a systematic fault. As outlined above the risk was on the health and safety register, it was highlighted annually and escalated Trust Wide. It was agreed that the process of highlighting risk, escalating it, managing it and flagging up unresolved risks has been disjointed as the risk was on the Health and Safety Register but the risk management did not move on from the clinical management to addressing the low roof line as such.

When a risk is being coded the intent is taken into account. If a service user was on the roof the incident would have been coded as 'absconding'. The Modern Matron explained that this has been looked at and that for any further incidents two indent forms would be completed – one for absconding and one for a service user having been on the roof. He also suggested that height might be included. He explained that this decision was taken in Autumn 2015 and that the investigated incident has been the first incident since then.

It was discussed at the RCA Meeting that the risk was taken seriously but that there were financial aspects to it such as funding priorities. In autumn 2015 the garden areas where discussed as part of the ligature group. It was talked about the risk of getting on the roof and this was put on risk register. The Trust was looking at the risk of gardens which should be a therapeutic area rather than sterile space.

Just before Christmas 2015 a set of standards was agreed however this was towards the end of the financial years. He said this year's programme includes sourcing funding. It was discussed that it would be possible to implement changes although not aesthetically pleasing. It was discussed that changing the roof line would be a major project.

It was discussed that service users would be able to use items to climb up onto a roof even up to 3m. It was discussed that the service user was driven by her fear and that this can enable a person to act in extreme ways and might have enabled the service user to climb on to the roof regardless of the roof line. We agreed that the roof contributed to the incident and made it more likely to happen however that it could have still happened with a normal roof line.

Garden policy:

The Assistant Director of Nursing reviewed the garden policy and arranged for interim control measures to be implemented (specific level of observation relating to risk assessment of all service users). This measure will continue until further reviewed.

Every handover includes a risk assessment of absconding. If considered 'medium' the engagement policy will be followed and if 'high' the service user would be on 'one to one' observation or not allowed in the garden. There is also an allocated garden nurse in central lines who has good oversight of the garden. If the risk of absconding has been assessed as 'medium' and patient goes into garden the garden nurse will go with them. If the risk is 'high' the individual care plan will be followed addressing the risk. It was discussed whether or not the reviewed Garden Policy would have made a difference to the management of the service user on the ward. We agreed that this would not have made a difference as the risk of absconding would have been perceived as 'low' given the assessment, information and behaviour of the service user on the ward.

12. Notable practice

- Particularly one member of nursing staff engaged well with the service user and felt that they had a good rapport. She also stayed on after her shift had finished supporting staff

and patients.

- Staff supported each other well during and after the incident staying on longer then required.

- During the RCA meeting staff showed a very caring and compassionate attitude towards the service user, person 1 and their wellbeing.

13. Care and service delivery problems (CDP's and SDP'S)

Care Delivery Problems

Risk Assessments and up-dating of risk assessment: the risk assessment was not completed but 'cut and paste' the same three lines in each box of the risk assessment: the service user 'had been admitted to Acute Inpatient Ward 1 as there were no beds in local area' – following added post meeting. A risk assessment is expected to be completed within 72 hours and this took place however cutting and pasting does not imply a good and detailed assessment. The modern matron explained that they have been aware that everyone 'cuts and pastes' information in to the risk assessment from the core assessment and from the progress notes and that this normally relates to updating parts of the risk assessment where it is most appropriate. However this cannot be accepted as completing a risk assessment.

Assessment of Risk of absconding on an inpatient ward - there is no evidence in the records that risk of absconding was specifically assessed as there are no details in general. This has been addressed by up-dating the Garden Policy and introduction of an allocated garden nurse.

Involvement of relatives in assessment: It is expected that relatives and cares are involved in a service user's care as much as possible with appropriate consent given. There is a discrepancy of perception about the level of involvement of person 1 however overall it appears that he could have been more involved particularly as he was aware that the service user felt unsafe on the ward.

Service Delivery Problems

Risk coding and escalation process: there needs to be some check/balance that has a significant score - How to follow up unresolved risk. The RCA Meeting highlighted that there is a systematic fault. As outlined above the risk was on the health and safety register, it was highlighted annually and escalated Trust Wide. It was agreed that the process of highlighting risk, escalating it, managing it and flagging up unresolved risks has been disjointed as the risk was on the Health and Safety Register but the risk management did not move on from the clinical management to addressing the low roof line as such. The coding has been addressed and an incident of a service user being on the roof would have been coded as a roof related incident rather than absconding.

Contributory factors

Contributory have been looked at in line with the NPSA Contributory Factors Classification

Framework.

1. **Patient Factors – Mental/Psychological Factors & Interpersonal relationships**

The service user presented with paranoid delusions which appeared to be initially mainly around her home however also included the ward environment. This emerged mainly by talked to the service user and person 1 after the incident. The service user had agreed to admission to hospital but found the ward unsettling particularly after an incident which involved the police. This increased her fear of being unsafe and therefore enforced her paranoid delusions in general. It would have made the service user vigilant about her environment and created a cycle of increased fear triggering further psychotic symptoms. In addition the service user said that she heard a member of staff stating that 'she has never seen anything like it in 18 years' and was also told by other service users that she would never leave the ward again. The service user referred several times during the meeting on the 31st March 2016 to above statements which were clearly of significance to her and increased the degree of feeling paranoid about the ward. Therefore the service user was less likely to engage with ward staff freely, expressing her fears. Ward staff was therefore not aware of the level of paranoid beliefs about the ward and the fear never to be able to get out. This would have influenced the quality of the risk assessment particularly of absconding and the subsequent action taken and therefore contributed to the Care Delivery Problem 'Risk Assessment'. This frame of mind would also increase the risk of a service user considering absconding from the ward using a low roof line as possible escape route.

2. **Communication - Written communication**

The record keeping of the admission on Acute Inpatient Ward 2 and the time prior to the incident is poor. It has been difficult for the investigators to get an impression of the care of the service user prior to the incident. For example a conversation with the service user and husband took place however the content is not recorded. The risk assessment is a 'cut and paste' sentence which doesn't provide sufficient information. This would have made it difficult for any member of staff to up-date the risk assessment or continue an assessment of the service user as hardly any information was available in the first place. This would have an impact on the Care Delivery problem – Risk Assessment.

3. **Work Environment – environment and time**

Ward environment: the Acute Inpatient Ward 1 was described as busy on the 22nd January. When person 1 arrived and realised that the service user was about to run to the roof he was not able to find a member of staff. Identifying a member of staff on a busy ward can be difficult and therefore staff might have been close by but person 1 not realising this. This caused a delay in ward staff being aware of the service user's beliefs and her trying to escape using the roof and hence affected the risk assessment. However even if staff had been fully aware of the service user's paranoid beliefs and been present with the service user in the garden the incident could have happened nevertheless.

It is difficult to tell how much the busy environment impacted on ward staff involving person 1. Person 1 felt that he wasn't included as much as he would have liked to be but staff at the RCA Meeting reported talking to him and the service user for 1.5 hours. As the content of the meeting is not recorded on RIO it is not possible to comment on this. Overall an acute, busy ward environment would reduce the time staff had available to spend with individual service users

and relatives/carers and this would therefore influence Care Deliver Problem 'Involvement of relatives/carers'.

Short duration of admission: engaging a service user with psychotic beliefs takes time and that service user had only been one day on the ward. The service user was seen in a timely manner by the doctor and her presentation discussed with the ward consultant. Antipsychotic medication was prescribed however this has a time lag between commencing and taking effect. Therefore ward staff did not have time to be expected to have established a trusting therapeutic relationship with the service user and to fully explore collateral information. This would contribute to assessment of risk and involvement of person1 and therefore can be perceived as a contributing factor to both CDP 'Risk Assessment' and 'Involvement of relatives/carers'.

4. **Organisational – safety culture**

It was highlighted in the RCA Meeting that the risk of the low roof line had been highlighted and that annual risk assessments have been conducted. The risk was also escalated Trust wide when the triumvirate in the locality came in. The outcome was that the risk should be managed clinically. Whilst this might be sufficient as an interim measure it is not sufficient as the long-term solution. No risk assessment is fool-proof and there is no evidence base for risk assessment tools to assess risk of absconding. Risk assessments are founded on clinical assessment, mental state examination, past risk history and collateral information. This is difficult in a service user who has only just been admitted to a ward, without mental health history and not much collateral history. Therefore particularly new service users will be difficult to fully assess. Therefore the environment of an acute psychiatric inpatient ward needs to be as safe as possible which would have included addressing the low roof line as this is the easiest point to escape from the ward.
The acceptance to manage the risk of the low roof line purely clinically could have contributed to the Service Deliver Problem as there might have been the perception that the risk has been sufficiently managed. This would have slowed down the process of addressing the issue further despite its remaining on the risk register.

Root causes

The root cause of the incident can be perceived as the mental state of the service user. It meant that the service user had paranoid beliefs about the ward which were increased by the environment and comments from staff/other service users. The frame of mind made it difficult for the service user to trust and engage with staff and disclose her worries rather than considering escaping. Staff made efforts to engage with the service user however unfortunately at the time the service user was not able to trust staff.

All other contributory factors identified influence the Service Delivery and Care Delivery Problems which would have made it less likely for the incident to take place however it would not be possible to state that the incident would not have happened if these factors had been addressed.

Lessons learned

- RIO record keeping – RIO records are sparse in relation to the incident (in management report) and made the investigation difficult.

- Impact of adverse incidents on service users on an acute inpatient ward – the service user felt increasingly paranoid about the ward environment as a result of the adverse incident involving the police

- Impact of ward environment on a service user particularly without previous admission – both service user and person 1 found the ward environment difficult and not what they expected. Ward staff needs to be aware of this and this needs to be addressed when talking to a service user. This might have taken place but is not recorded on RIO.

Recommendations

Recommendations already addressed

- **Garden policy:** The Assistant Director of Nursing reviewed the garden policy and arranged for interim control measures to be implemented (specific level of observation relating to risk assessment of all service users). This measure will continue until further reviewed. Every handover includes a risk assessment of absconding. If considered 'medium' the engagement policy will be followed and if 'high' the service user would be on 'one to one' observation or not allowed in the garden.

- **Allocated Garden Nurse:** there is now an allocated garden nurse in central lines who has good visual of the garden. If low risk = keep eye on, medium = nurse will go into the garden with the service user; high=follow individual care plan.

Team Recommendations:

- **RIO record keeping** –Trust standards were not adhered to regarding concise up to date record keeping. Inpatient Ward Manager and Senior Practitioner to ensure case notes are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.

- **Risk Assessments and up-dating of risk assessment** – Trust standards were not adhered to regarding robust risk assessment risk of absconding was not always considered. Inpatient Ward Manager and Senior Practitioner to ensure risk assessments are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.

- **Involvement of relatives/carers** – the relative had not been invited to the ward review meeting, and although staff had spent time with him, the relative did not feel involved in the service user care and treatment plan. Inpatient MDT to ensure that relatives are invited to attend ward reviews CPA's etc… and are allowed 1-1 time with the nursing staff during visits, to discuss their concerns**.**

Delivery Unit Recommendations

- **Record keeping and risk assessments were not completed to Trust standards -** This issue may be replicated across the LDU. A Care Plan and Risk Assessment audit

has been formulated and distributed by the Service Improvement Lead. Action plans to be developed form findings of audit.

- **Risk of absconding** – Acute Inpatient Ward 1's low roof line has been added to the LDU risk register. Although changes to operational and clinical practice have been made a permanent structural solution is required regarding the estate to reduce the accessibility to the roof. Threes solutions have been proposed by the Health and Safety and estates department. Feasibility of these options is underway.

Trust Recommendations

- **Risk coding and escalation process:** there needs to be some check/balance that has a significant score. Risk coding must be reviewed to ensure that incident data and nature is captured accurately.

- **Risk Registers – A robust process is required to ensure that** unresolved risks are followed up. Changes have been recently made to the risk register system and every LDU must present to the Audit and Risk committee, escalating unresolved risks through to the Clinical and Operational executive Teams.

1 Arrangements for shared learning

This report will be distributed to participants and recommendations taken forward through the Trust's governance arrangements both CIOG (Critical Incident Overview Group) and IGG (Integrated Governance Group). In particular, the report will be tabled at the Locality quality and Healthcare Governance group and discussed within Acute Inpatient Ward 1's team meeting.

2 Action plan

Rec. for Team or LDU or Trust	Describe the issue we are trying to address	What SMART actions do we need to take	Date for actions to be completed	Responsible Named Individual
Team	The RIO record keeping reviewed on the electronic medical record was not to the expected Trust standards	Inpatient Ward Manager and Senior Practitioner to ensure case notes are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented	June 2016	XXX

		across the LDU.		
Team	The Risk Assessments within the electronic medical record reviewed was not to the expected Trust standard	Inpatient Ward Manager and Senior Practitioner to ensure risk assessments are reviewed within management supervision sessions. A Care Plan and Risk Assessment audit has been implemented across the LDU.	June 2016	XXX
Team	The relative/care did not feel involved with the care and treatment plan for the Service User.	Inpatient MDT to ensure that relatives are invited to attend ward reviews CPA's etc.. and are allowed 1-1 time with the nursing staff during visits, to discuss their concerns.	June 2016	XXX
LDU	Record keeping and risk assessments were not completed to Trust standards	A Care Plan and Risk Assessment audit has been formulated and distributed by the Service Improvement Lead. Action plans to be developed form findings of audit.	June 2016	XXX
LDU	The Risk of absconding on Acute Inpatient Ward 1 is increased due to the low roof line.	Although changes to operational and clinical practice have been made a permanent structural solution is required regarding the estate to reduce the accessibility to the roof. Three solutions have been proposed by the Health and	July 2016	XXX

		Safety and estates department. Feasibility of these options is underway		
Trust	The Risk coding and escalation process for incidents is not sufficiently clear.	Risk coding must be reviewed to ensure that incident data and nature is captured accurately.	June 2016	XXX
Trust	A robust process is required regrading Risk Registers to ensure that unresolved risks are followed up	Changes have been recently made to the risk register system and every LDU must present to the Audit and Risk committee, escalating unresolved risks through to the Clinical and Operational executive Teams.	Completed	XXX

3 RCA report author details

RCA Author

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XXX, Team Manager, Acute Mental Health Liaison Team, XXX

Date 29th April 2016

4 Supervising reviewer details

5 Distribution list

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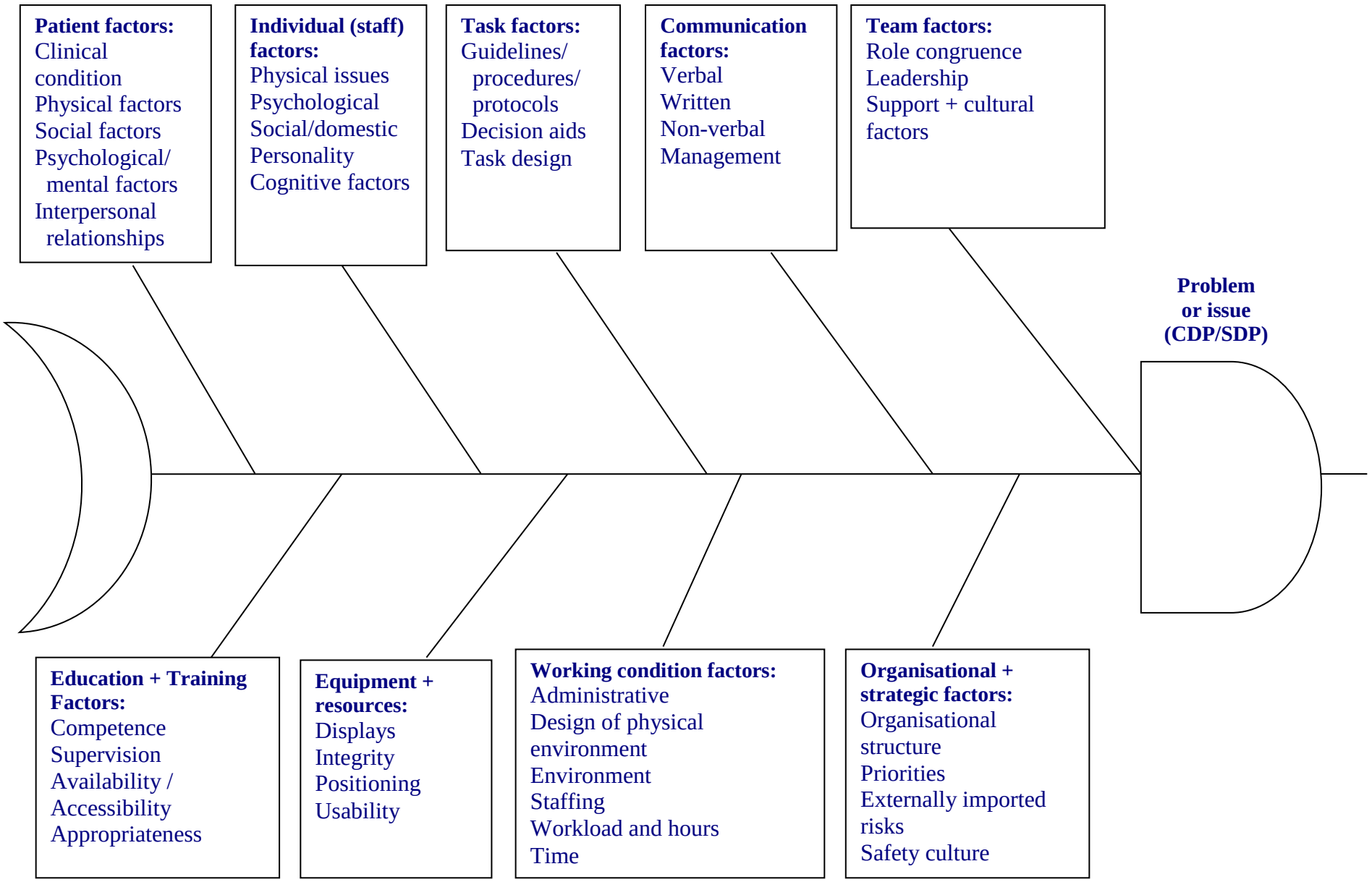
Appendices

~~Appendix 1: Timeline~~

Appendix 2

Fishbone Classification – Contributory Factors

See page 18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Physical factors
Social factors
Psychological/ mental factors
Interpersonal relationships
Individual (staff) factors:
Physical issues
Psychological
Social/domestic
Personality
Cognitive factors
Task factors:
Guidelines/ procedures/ protocols
Decision aids
Task design
Communication factors:
Verbal
Written
Non-verbal
Management
Team factors:
Role congruence
Leadership
Support + cultural factors
Problem or issue (CDP/SDP)
Education + Training Factors:
Competence
Supervision
Availability / Accessibility
Appropriateness
Equipment + resources:
Displays
Integrity
Positioning
Usability
Working condition factors:
Administrative
Design of physical environment
Environment
Staffing
Workload and hours
Time
Organisational + strategic factors:
Organisational structure
Priorities
Externally imported risks
Safety culture