# Northumberland, Tyne and Wear NHS

**NHS Foundation Trust**

**ACTION PLAN POST INDEPENDENT INVESTIGATION – PUBLISHED ON WEBSITE**

| Serious Incident Review Proforma | | | |
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| **Patient ID/Other** | **Date of Incident** | **Service** | **STEIS Number (if applicable)** |
| Patient G | 5 January 2009 | Clifton Mount Community Mental Health Team | 2009/131 |
| Summary of Incident:  Discharged male patient killed a man with a claw hammer.  He pleaded guilty to murder and was sentence to life imprisonment. | | | |

| Recommendations Following Independent Investigation | Actions Undertaken / Planned | Lead / Timescale / Date Completed |
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| 1.  All new referrals should receive a risk assessment, preferably standardised.  There should also be an episodic re-assessment of risk which should be held in a way that is accessible to all involved clinicians.  This is particularly pertinent when a case is being managed by trainee clinicians. | **Policy and Procedure**<br>Trust Care Co-ordination and CPA Policy NTW(C)20 ratified in November 2010 is a joint policy with six Local Authority partners and incorporates the requirements of Refocusing CPA.<br><br>Within Practice Guidance the trust has set an internal standard for service users on CPA that their care and treatment will be reviewed as required by need but at least every 6 months.<br><br>The assessment process includes a risk assessment for all referred cases.<br><br>Core components of NTW Care Co-ordination are:<br><br>• Assessment<br>   • Referral source and reason, including any advocacy needs and capacity | Completed |

concerns in relation to the assessment

- Service user needs and expectations/presenting problem
- Carers/relatives views and information from third party sources
- Current medication
- History of mental health problems
- Social circumstances (to include housing, employment and financial circumstances, caring information including children as per Laming requirements)
- Mental state at interview
- Formulation/summary of assessment
- Diagnosis/differential diagnosis
- Plan

- Risk assessment
- Care planning incorporating crisis and risk management
- Review
- Inpatient admission and discharge

All staff are contractually obliged to have a working knowledge of the Trust policies that affect their day-to-day delivery of care. Team Managers are required to have a local system to ensure that staff are aware of new Policy and Procedure. This is consolidated and reinforced within regular supervision.

**Training and Awareness**
A programme of training is available that is mandatory for all qualified staff that have contact with service users and is detailed within the Trust Training Prospectus.

The Trust has reviewed the appropriateness of the Risk Assessment Tool used for patients who are non CPA and from 1st April 2013 an enhanced Narrative Risk Assessment has been introduced which aims to help clinicians to be more reflective when assessing and formulating risk.

Link to Narrative Risk Template:

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| | http://nww1.ntw.nhs.uk/Captivate/Narrative%20Risk%20Assessment/Narrative%20Risk%20Assessment%20v3.htm<br><br>**Audit and Outcomes**<br>Clinical audit to ensure appropriate implementation of Care Co-ordination is undertaken e.g. the annual Trust-wide Quality Monitoring Tools.<br><br>The Trust's electronic patient records system (RiO) produces reports for managers for the supervisory process that identifies if the key components of Care Co-ordination have been completed this includes reviews.<br><br>The new build of the electronic patient records system (RiO) has incorporated a navigation page that identifies if the key components of Care Co-ordination have been completed; including reviews, again this will be available for managers to use in clinical supervision.<br><br>Within the CQ Essential Standards of quality & safety there is a requirement under Outcome 14 for Trusts to ensure that staff receive among other things regular supervision to ensure that appropriate levels of care and treatment are provided and Policy and Procedure are being observed. Every month this requirement is reviewed by all Trust Service Managers via the utilisation of the CQC Essential Standards pre-visit questionnaire.<br><br>In planned care in a recent audit from the Trust dashboard system it identified that over 95% of service users on CPA have an up to date FACE risk assessment.<br><br>To undertake a qualitative and quantitative audit of risk assessment for those patients on non CPA, this will include an initial informatics report detailing the number of patients whose lead professional is a doctor and who has had a narrative risk assessment or FACE risk assessment completed within the last 12 months and the date of the last assessment. Report produced and saved on database. | Completed |

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| | This framework should form the basis for improvements in performance and further qualitative analysis to be agreed and undertaken. | Planned Care Group Triumvirate January 2014 |
| 2. Within their governance arrangements, the Trust should have procedures to manage and share risk. Where such procedures exist, which is the case within this Trust, training should be provided, regularly updated, actively promoted and supported through in service education. | **Policy and Procedure** With regard to this particular incident Bridge View is now part of NTW Addictions Services and is using the RiO Electronic Health Record System | Completed |
| | The Addictions Service has established a formal process of sharing risk and developing individual case reviews in complex case panels. Copy of referral form saved on database for reference. | Completed |
| | To provide further guidance to staff in communicating and sharing information, particularly in relation to joint working with Specialist services, the operational groups have ratified new joint working guidance which they will disseminate and will be incorporated into the next update of relevant policy / PGN.  Final draft Briefing note to support staff | |
| | Planned care is updating previous guidance around the sharing of information with the voluntary sector. The latest draft protocol (attached) will be shared for comment with other agencies in draft so it can be amended if necessary.  Process to follow when working in partn | Directorate Manager Planned Care January 2014 |
| | **Audit and Outcomes** The Trust has a dashboard system which is used as a performance tool and training figures are discussed regularly at group Quality and Performance | Ongoing training |

| | meetings and are reviewed on a weekly basis by the Senior Management Team.  Live dashboard figures at any point in time are available on request. | |
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| 3.  Where the sole source of information is from the patient, the appropriate weight should be accorded to the information, and efforts made to corroborate the information from other sources. | **Policy and Procedure**<br>As mentioned in recommendation 1, the Trust Care Co-ordination policy which highlights the importance of gathering carers/relatives views and information from third party sources.  Clinicians are also aware that they should always search for and acquire previous records relating to service users | Completed |
| | The Trust has a formal process for requesting information from the Police with regard to a persons risk history.   Guidance notes on requesting information from the Police and Proforma for staff to complete are saved on the database.<br><br>Deputy Director of Quality and Safety has written a safety message for the Chief Executive bulletin to highlight the process for requesting information from the police in relation to a patient's risk history.<br><br>20131119093726372<br>.pdf | Completed |
| | Safety messages for staff in the Chief Executive's Bulletin are published regularly in relation to risk.  Messages were published on 22.05.12, 04.09.12, 15.01.13, 11.06.13 and 22.10.13. | Completed |
| 4.  Where there is a history of violent or sexual offending, or where there is a concern about risk of harm to others in the future, consideration should be given to referral to the forensic service, or alternatively advice, support and guidance should be sought from that service. The Trust should actively | **Policy and Procedure**<br>The focus on scaffolding and improved access to community forensic teams has improved this area.<br><br>The joint working protocol outlined in recommendation 2 includes working with the Forensic Community Personality Disorder Team.<br><br>Regular community team consultation clinics now take place where individual clinicians can bring cases for discussion and a joint formulation can be undertaken if required | |

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| promote the role of the forensic services in improving and sharing the management of a patient with such a forensic history and ensure their expertise in forensic matters is disseminated by means of shared training and through professional development. | Deputy Director of Quality and Safety to circulate a safety message to highlight the above process to all staff. | Specialist Group Medical Director to provide information for CAS Alert by Deputy Director Quality and Safety as above. |
| | **Training and Awareness**<br>HCR20 training is provided by Trust forensic staff to other teams when requested. | Ongoing training |
| | As part of the review of the approach to risk assessment and associated training a working group has been established chaired by the Group Medical Director Specialist Care.  The group is currently considering how HCR 20 training, delivered by Forensic staff can be required training and delivered to all clinicians. | Specialist Group Medical Director |
| | In line with new Principal Community Pathway developments, the Trust is in discussions with NHS England and local commissioners to review communication pathways to improve accessibility in obtaining forensic expertise. | Specialist Group Medical Director, |
| 5.  Evidence of discussions at CMHTs should be incorporated into the patient's mental health records. | **Policy and Procedure**<br>The Trust's electronic health record (RiO) is the unified health record which is used by all NTW staff involved in the patient's care and this would include making entries in relation to CMHT discussions this requirement is set out in the Trust's records keeping standards PGN (attached NTW(O)09PGN-02Section 3.8.3).<br><br>📄 PDF<br>MR-PGN-02-Record Kpg Stds-with apps-V | Completed |

| | In addition to this, clinicians have caseload management with their clinical supervisors on a regular basis, which includes a records check of three random open cases. | |
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| 6. Each CMHT should maintain a record of how patients are allocated and to whom. The decision not to allocate should be justified and recorded. There are clear guidelines on eligibility for enhanced care and transparent processes on how priorities are managed.<br><br>If the patient is 'outposted' to a team member at another location, here should be a file held at the CMHT office which recognises this, and at discharge from the team, these notes should be merged to form a CMHT record. In addition, consideration needs to be given, ideally at each review, as to whether the allocated care co-ordinator is fulfilling the role in a way that meets the patient's needs. In particular where social care elements are predominant, consideration should be given to exploring the skills of social work colleagues. | **Policy and Procedure**<br>Highlighted in Management of Records policy NTW(O)09, ratified in October 2012, which is NHSLA compliant. This includes a Practice Guidance note on record keeping standards for clinicians, which was ratified in December 2012. Northumberland Tyne and Wear NHS Foundation Trust is the only trust which has implemented a standard for time in relation to contemporaneous recording.<br><br>All information relating to the care and treatment of patients entered onto the Trust's electronic health record (RiO). This includes allocation or decision not to allocate in the progress notes.<br><br>In addition to this, clinicians have caseload management with their clinical supervisors on a regular basis, which includes a records check of three random open cases. This would include ensuring that regular reviews were taking place.<br><br>Safety message circulated in Chief Executive's bulletin regarding the importance of recording the outcome of casenote clinical supervision sessions and group discussions on RiO.<br><br>chief executives bulletin 13 a....<br><br>Since the incident MDT allocation processes have continued to be reviewed and improved. The current process is as follows: all referrals received by the CMHT go into a daily multidisciplinary meeting (MDT). The attendees consist of one team manager or a nurse deputy, social work representative | Completed<br><br><br><br><br><br><br><br><br><br>Completed<br><br><br><br><br><br>Completed |

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| At its regular business/allocation meetings, the CMHT should be mindful of each patient on its caseload wherever that patient is allocated and ensure that regular reviews take place. The allocation of patients within a team is part of a clinical process, the rationale for which needs to be recorded in the patient's notes.<br><br>The panel recognises that the 2008 CPA guidelines will impact upon the context of this recommendation and ask that the Trust embraces the spirit of the recommendation in the revised arrangements. | and medical staff, as a minimum.  The daily MDT considers all new referrals and presentations of completed assessments.  The MDT agree who should assess the patient dependent on presenting needs, this can be uni-disciplinary or a joint assessment with a member of the team or with input from local authority or specialist service.  The venue of the assessment is also considered dependent on service user need.  The CMHT runs a daily assessment clinic and the administrator books an appointment with the next available slot in the diary unless it is urgent where this can be arranged more quickly.<br><br>The assessors will present their assessments that day straight into the daily MDT for discussion and outcome.  The MDT decision making includes allocation having established the service users' needs, the role and skills of staff required to deliver treatment.  The team administrator is present and records who is present at the MDT, a record of the brief discussion and rationale for outcome straight into the electronic patient record RiO.<br><br>Within the design of new Principal Community Pathways, all non urgent referrals will go to an agreed single point of access and will be triaged by clinical staff within an MDT setting and automatically booked into a multidisciplinary assessment clinic in accordance with their relevant pathway within 7 days.  All information to aid a safe and robust assessment will be gathered by the access service from the referrer, previous notes and third parties to enable the assessor to undertake a high quality risk assessment.  Where possible the person undertaking the assessment will continue to provide treatment for the service user. | |
| 7.  Each patient engaged with mental health services should have a care/treatment plan which is clearly understood and accepted by the patient.  These plans should contain goals which are measurable, achievable and acknowledge the patient's strengths. They | **Policy and Procedure**<br>This would be covered under the Trust Care Co-ordination and CPA Policy NTW(C)20 ratified in November 2010 which incorporates the requirements of Refocusing CPA.<br><br>Care plans are reviewed and shared with patients.  There is a quality checking process or regular audit in place in Newcastle.  Over 95% of people are currently reviewed within 12 months. | Completed |

| should be subject to regular assessment and evaluation and incorporated into the Trust's audit records. | In this case it is acknowledged that the service user did not have a care plan. Care plans currently produced acknowledge a service users strengths and the QMT Audit examines whether the care plan outlines the services users goals.<br><br>The most recent QMT Audit results show<br><br>**Planned Care**<br>74 % of care plans had been developed with the involvement of SU and their family/carer ( if appropriate)<br>67% incorporate SU determined goals<br><br>**Urgent Care**<br>83% of care plans had been developed with the involvement of SU and their family/carer ( if appropriate)<br>76% incorporate SU determined goals<br><br>**Specialist Care**<br>75% of care plans had been developed with the involvement of SU and their family/carer ( if appropriate)<br>70 % incorporate SU determined goals<br><br>The Trust dashboard shows that as at 28th October 2013, 80.1% of service users had discussed their care plan. This is currently a Trust Quality Priority and incorporates CPA and non CPA care plans.<br><br>Clinicians have caseload management with their clinical supervision on a regular basis which includes a records check of three open cases.  The clinical dashboards highlight any gaps in recordkeeping enabling the supervisor to focus on records which appear to be incomplete.<br><br>During Serious Incident reviews if it is identified that the service user did not have a care plan at the time of the incident this would be flagged up to the service manager to be managed via the disciplinary process if necessary. | |

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| 8. All clinical staff within mental health services who have responsibilities for formulating diagnosis should be aware of current evidence based guidance on the management of personality disorder. There are clear guidelines available many of which are supported with resources and which offer those with personality disorder a realistic opportunity of clinical improvement. Where clinicians suspect that a personality disorder is a possibility this must be fully investigated and if substantiated, proper treatment plan put in place. | The Trust has established a working group to look at service users with personality disorders and has appointed a Pathway Lead.<br><br>The Trust has established a Personality Disorder Pathway Development & Implementation group. The draft terms of reference are saved on the database. This group has a key role to play in the strategic direction the Trust takes in relation to Personality Disorder plus a supporting role to its clinical governance structures<br><br>Copy of the PD business case and a brief outline of its purpose and aims is saved on database. The Trust has developed a business case for the development of a Specialist Augmentation Personality Disorder Hub team. This proposed team will form part of the overall care pathways for service users within clusters 6 or 8 and who may have a diagnosis of emotionally unstable personality disorder or other personality disorder. The team will deliver the first 3 stages of a 5 stage model of care, focused on safety, containment and emotional control. The team will provide direct care co-ordination, treatment and management to up to 84 service users who present with personality disorder and high levels of risk, chaos or complexity. The team will be Trust-wide, and based centrally in Newcastle, but will provide assessments and advice, support and supervision to community staff, inpatient staff and crisis teams within each locality. They will also run therapeutic groups, contribute to a telephone support service for service users managed within the team and work closely with peer support workers to develop peer support groups in each locality alongside voluntary agencies and other community support structures. Once the hub team is operational, it is envisaged that the team will develop a partial day programme in order to prevent admission to hospital through more intensive therapeutic work, facilitate early discharge from hospital and promote positive social functioning and recovery through meaningful structured therapeutic and occupational activities. The business case is currently being discussed with commissioners across the Trust CCGs (see attached). | Completed |

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| | EUPD draft business case 23 08 13 - Trust

In addition, there are several members of Trust staff who have expertise in managing patients with personality disorder.  These staff help and support staff with the management of such patients which includes the attendance at strategy meetings for complex cases.

The joint working protocol outlined in recommendation 2 includes the Forensic Community Personality Disorder Team.

The Trust has also established an Advice Consultation and Engagement process (ACE) to help staff when dealing with service users who have a diagnosis of personality disorder.

**Primary Role of the ACE Team**:
To provide a rapid assessment of diagnosis, formulation, risk, psycho-pharmacology , psychotherapy and social management options for inpatients with Cluster 8 Personality Disorder.
    To prevent deterioration in Cluster 8 patients whilst in in-patient care by facilitating prompt discharge.

**Secondary Role of the ACE Team:**
- To prevent an escalation in self harm and/or suicide attempts whilst in in-patient care.
- To reduce copycat behaviours.
- To prevent delayed discharge and support the role of CRHT EDP.
- To provide support and second opinion without the need for complex case panel (with regards to; diagnostic formulation, positive risk taking, prescribing and signposting to alternative care pathways) | Completed |

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| | ACE description.doc ACE Operational Plan.doc | |
| 9.  The Trust should refine and audit its supervision standards so that no patient under medical management by mental health services should be managed by a trainee or a locum for more than a 12 month period without his or her care reverting to a substantive postholder. | The Trust has made considerable progress in reducing the use of agency locum consultants within the Adult Mental Health Service. This has been achieved by employing a number of additional substantive consultants who are able to work flexibly to cover posts where there is a long term vacancy. Given this situation it is unlikely a locum would be in post for a period of more that 12 months: however a locum is a qualified member of staff who is subject to the same revalidation and supervision requirements as substantive members of staff.  This is with the addition that since 2012, locum career grade doctors have been subject to a performance monitoring process that includes gathering structured feedback from colleagues and sampling their clinical work at regular intervals.<br><br>Appendix 8 of the Trust Clinical Supervision Policy deals with the supervision of trainee doctors. The stipulations within this appendix are guided by GMC Standards as set out in the GMC document 'The Trainee Doctor'. The appendix makes it clear that:<br><br>• All new patients seen by Foundation doctors, general practice trainees and core psychiatry trainees (SHO level doctors in pre-Modernising Medical Careers terms) should be supervised live by the supervising clinician<br>• Every case on a trainee doctor's case load should be reviewed by the responsible consultant on at least two occasions during the trainee's placement.<br>• Trainee doctors should have "easy access to the consultant to discuss points of diagnosis, treatment, risk assessment or management"<br>• Information about the advice received during supervision should be recorded in the patient's clinical record<br><br>Since 2011, the Trust has made it a requirement for advanced trainees working in the trust to receive training in giving clinical supervision. Since 2012 it has | Completed |

been a requirement that all educational supervisors of trainee doctors to receive training in supervision methods.

Trust compliance with supervision requirements is monitored through regular interviews between trainee doctors and tutors and through the results of the GMC National Trainees' Survey.

This appendix is attached below:

App13-SupervTraine
e Drs-DrOwenV04-Iss

| 10. There should be a recorded process for handover, which could be in the form of a checklist between clinicians working in the same post, e.g. where a succession of trainee doctors or locums fill the same post consecutively, or where responsibility for management is passed between different professionals. | This recommendation concerns appropriate continuity of care and since this incident occurred, the Trust now has an electronic patient record RiO used by all clinical staff. In addition there is the record keeping standards practice guidance note which is applicable to all clinical staff (attached under recommendation 5.) <br><br> Although there is no current standardised format for handover between clinical staff there are a number of safeguards in place to assist safe transitions:- <br><br> o The electronic patient record system (RiO); <br> o The practice of allowing a period of 'crossover' whenever Locum and Substantive Consultants take over from each other whenever possible; <br> o All cases under the care of a 'trainee' are discussed at set intervals with the supervising consultant; <br> o The recording of these clinical supervision discussions in the RIO record; <br> o The practice of never having more than two trainees consecutively caring for an individual patient; <br> o The 'overview' of each case provided by a senior colleague provides continuity. <br><br> The Trust has produced a document which aims to support Locum medical staff working in Trust Services. | |

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| | Process To Support LocumsV2.do… | |
| | Transitions of care is a theme in the Safety Programme. The Trust has developed and agreed a transitions protocol and currently developing transitions protocol outlining standards for handover. In addition the use of case summaries/formulation approach is currently being reviewed. | Deputy Director Quality and Safety Update to be requested January 2014 |
| | Further work is ongoing as although to improve and give assurance on the current systems in place | Medical Directors Update December 2013 |
| | SBAR is a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. | |
| | SBAR can also be used effectively to enhance handovers between shifts or between staff in the same or different clinical areas. | |
| 11. Where patients present with a dual diagnosis, consideration should be given to whether a substitute prescribing services is the best resource to treat that patient. There is no doubt that in this respect the addiction team at Plummer Court have a wide range of expertise which could be deployed effectively and is contained within one location. This option must be considered when patients such as Patient | In this incident the service user had contact with Addictions Service and Cognitive Behavioural Therapy Service. Both of these services are co-located in the Plummer Court building but are separate services. Addictions services do not offer dual diagnosis work; they provide addictions work and co-work with CMHTs where there is a co-morbid mental illness. **North of Tyne Services** Community Mental Health Teams can access specialist clinical advice and support from Trust Addiction services. In addition there is 1 full-time Dual Diagnosis Clinician embedded into North Northumberland Community Mental Health Team and 1 further specialist part – | |

| G present to either mental health or local addiction services. The Trust should also ensure that clinical decisions are supported by local training programmes targeted at staff who may be engaged with dual diagnosis cases. | time alcohol clinician based within West Northumberland Community Mental Health Team. | |
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| | **South of Tyne Dual Diagnosis Services** | |
| | Within Trust South of Tyne Planned Care services there are 7 full-time "Dual Diagnosis" Therapists. All Dual Diagnosis Therapists are highly experienced clinicians in their own right, having now had several years' clinical experience of working with complex substance misuse issues and co-occurring mental health concerns. | |
| | These clinicians provide expert clinical advice and support across Trust care teams in South of Tyne and are embedded into existing Community Treatment Teams to promote and augment Team clinical skills and expertise whilst working with substance misuse issues and to mitigate clinical risk. | |
| | All Dual Diagnosis therapists referred to above in both North and South of Tyne Services are in receipt of monthly 1 to 1 clinical supervision from the Planned Care Dual Diagnosis Nurse Lead. | |
| | **Training and Awareness** | |
| | Essential Awareness Training | |
| | Since June 2010 essential awareness NTW dual diagnosis instructor led training has been rolled out for all NTW clinical staff. | |
| | With Dual Diagnosis Therapists now in post and all contributing to the instructor led training: dual diagnosis essential awareness staff training completion target rates are: | |

| Service Line > Directorate | | Numerator | Denominator | Percent |
| --- | --- | --- | --- | --- |

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| **PLANNED CARE** | **Total** | **1,452** | **1,638** | **89%** | |
| **COMMUNITY** | **Total** | **1,103** | **1,229** | **90%** | |
| **STEPPED CARE** | **Total** | **349** | **409** | **85%** | |
| **URGENT CARE** | **Total** | **801** | **863** | **93%** | |
| **ADULT MENTAL HEALTH** | **Total** | **600** | **655** | **92%** | |
| **OLDER PEOPLES FUNCTIONAL & LEARNING DISABILITY** | **Total** | **201** | **208** | **97%** | |
| **SPECIALIST CARE** | **Total** | **1,207** | **1,459** | **83%** | |
| **CHILDREN & YOUNG PEOPLE** | **Total** | **411** | **480** | **86%** | |
| **SPECIALIST ADULT** | **Total** | **796** | **979** | **81%** | |
| **Total** | **Total** | **3,460** | **3,960** | **87%** | |

Specialist Dual Diagnosis Clinical Training

1. Motivational Interviewing training has been commissioned and hosted in South of Tyne during 2011, 2012 and 2013.

2. For all South of Tyne Trust clinicians there are also now a range of regular "open training events" facilitated by the Dual Diagnosis Therapists in each South of Tyne locality area:  e.g. Substance Misuse and Mental Health.

A Dual Diagnosis Training Plan for Planned Care services has been developed and submitted to Planned Care Clinical Director for further consideration and potential roll out under the Trust Quality Priority Training plans associated with Transforming Services and Skills Programme.

**Audit and Outcomes**
The Trust has a dashboard system which is used as a performance tool and training figures are discussed regularly at group Quality and Performance

Completed

| | meetings and are reviewed on a weekly basis by the Senior Management Team.  The live dashboard percentage for staff who have completed dual diagnosis training at any point in time is available on request.   Training figures are discussed at Quality and Performance meetings and are reviewed on a weekly basis by the Senior Management Team. | |
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| 12.  There are already clear national and other expert guidelines on the prescribing and administration of benzodiazepines with methadone.  Health care providers should ensure there is clear local guidance that wherever possible there should be a single prescriber.  Where more than one prescriber is unavoidable, there should be effective communication between them. | As mentioned earlier the Bridge View service is now part of NTW therefore there is only one addictions specialist service which has clear standards of communication regarding medicines management.<br><br>Local (NTW) guidance: Benzodiazepine prescribing guidance (PPT-PGN 21)<br><br>[PDF icon]<br><br>PGN - Benzodiazepine.pdf<br><br>National (NTA) guidance – 'Orange Book'<br>http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf | Completed |
| 13.  Where polypharmacy is a feature of clinical management, expert advice should be sought from either hospital or community pharmacists on optimal dosing and potential adverse effects. | The Trust provides mandatory training for all registered healthcare professional in medicines management, which includes good practice in prescribing. The Safe Prescribing module includes a specific section on antipsychotic polypharmacy (HDAT). Extensive local prescribing guidance is provided to Trust prescribers on HDAT, benzodiazepine and in other higher-risk areas of prescribing. Trust pharmacists provide expert advice in safe prescribing in person (in-patient and CHRT services) and by telephone (all staff and patients). Shared care prescribing guidelines for antipsychotics, lithium and other medicines commonly initiated by NTW prescribers and continued by GPs are developed in partnership with GPs and published via the Area Prescribing Committee website (http://www.northoftyneapc.nhs.uk/) | Completed |
| | A safety message was circulated in the Chief Executive's bulletin relating to this dated 27 November 2012.  the bulletin is attached below: | Completed |

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| | CE Bulletin 27.11 high dose antipsychot | |
| 14. All clinical records should be contemporaneous, legible, attributable and dated. Further, the Trust should continue its efforts to audit the quality of its note keeping. In addition, there should be an indication in each clinical record of the reasons why a patient is engaged with the service, what the treatment plans are and what the ideal outcome should be. This should be agreed and understood between the clinician and the patient and subject to regular review. | **Policy and Procedure**<br>Highlighted in Management of Records policy NTW(O)09, ratified in January 2009, which is NHSLA compliant. This includes a Practice Guidance note on record keeping standards for clinicians, which was ratified in December 2012.<br><br>**Audit and Outcomes**<br>The QMT audit specifically requests that information on the content of records and looks for use of abbreviations whether the records are contemporaneous and have been validated appropriately.<br><br>The electronic patents record (RiO) automatically attributes the entry to the person who has logged onto the system and dates when the entry was made and validated. Electronic records by their very nature ensures legibility<br>The most recent QMT Audit results show<br><br>**Specialist Care**<br>81% of records were abbreviation and jargon free<br>97 % had been entered timely<br>59% had been validated timely<br><br>**Urgent Care**<br>88% of records were abbreviation and jargon free<br>99% had been entered timely<br>34% had been validated timely<br><br>**Planned Care**<br>82% of records were abbreviation and jargon free<br>94% had been entered timely<br>70% had been validated timely<br><br>The structure for clinical records ( progress notes) developed and used by the | Completed<br><br><br><br>Completed |

| | Trust's Liaison Psychiatry service and Crisis and Home based treatment teams (see below) has been shared across the Trust as a model of good practice and is now incorporated into the Trust training on Clinical record keeping<br><br>• Present.<br>• Update.<br>• Mental state examination<br>• Risk factors.<br>• Current medication.<br>• Plan. | |
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| 15. Trusts should consider more diverse ways of contacting patients, e.g. by the use of mobile phones or text message to better promote attendance at appointments. | The Trust has in place standard practice for ascertaining a service users preferred method of contact and this is recorded on RiO.<br><br>Within the addictions service this includes mobiles (voice and text), contingency planning by getting details of other people they are allowed to contact and leaving messages with community pharmacies and GPs.<br><br>The use of automatic SMS via the RiO system is part of the NTW informatics strategy. The trust plans to implement automatic SMS within the wider transformation the trust is undergoing; the intention is to pilot automatic SMS within the trust's Principal Community Pathway programme.<br><br>The current position with Email is that this should be at the specific request of the service user, and is done at their own risk. The risks of using unsecure email to receive messages should be explained to them by the staff member. Copy of email save on file | Clinical Director Update required January 2014<br><br><br>Completed |
| 16. Non attendance at clinic should not be used in isolation as a reason to discharge a patient from care. It should be for the care co-ordinator/lead clinician to review all current and future issues affecting the | **Policy and Procedure**<br>The Trust has a comprehensive Non Attendance policy NTW(C)06 which was ratified in March 2010. It also has a policy called Promoting Engagement with Service Users, NTW(C) 07, which clearly articulates the expectation that staff will assertively try to engage with patients. If a service user does not engage or attend or if a carer raises a concern about a service user then the care coordinator or lead professional should actively seek to reengage and manage | Completed |

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| patient and to consider the views of other agencies with a regular input prior to a decision being taken which terminates care provision. Contingency planning arrangements should be established and clearly communicated to the patient. | any concerns raised.<br><br>At no point should an individual or team discharge a patient who has disengaged or where concerns are raised without a full discussion with the team and referrer about ongoing risks, needs and how to re refer if necessary. The CPA process embedded in Care Coordination Policy NTW (C) 20 would be the framework to ensure this happened.<br><br>The policy Clinical Supervision NTW (C) 31 would also support safe practice as the supervisor would be ensuring all actions had being taken to ensure safe decision making.<br><br>**Training and Implementation**<br>Training has occurred as part of the overall Care Co-ordination training. | |