

## Being Open report

<b>Meeting Date:</b>	5 <sup>th</sup> September 2016
<b>Title of paper:</b>	Being Open Report
<b>Who is presenting paper:</b>	Janet Bell, Head of Governance
<b>Lead ED</b>	Beverley Murphy, Director of Nursing & Patient Experience
<b>Why is the paper being presented:</b>	This paper is to brief the meeting of the serious incidents, coroner's inquests, information governance incidents, complaints, patient opinion and claims received during the month of August 2016.
<b>What does the paper tell us about the quality of care being provided:</b>	<p>In August there were:-</p> <ul style="list-style-type: none"> <li>• 3 serious incident level 2s and 11 level 1 reviews commissioned.</li> <li>• 10 local team reviews were commissioned.</li> <li>• 16 deaths were reported.</li> <li>• 1 inquest was held, with another 3 planned.</li> <li>• 19 information governance incidents reported.</li> <li>• There were 30 new complaints raised, of which all were acknowledged within 3 working days.</li> <li>• 28 complaints were closed, 12 of which were closed in time.</li> <li>• 4 complaints were upheld, 10 not upheld and 14 partially upheld.</li> <li>• There were no complaints referred to the ombudsman.</li> <li>• 14 Patient Opinion stories were posted, 1 not responded to.</li> <li>• There were 5 new claim received, and 1 claim closed.</li> </ul>
<b>What is the committee/meeting being asked to do:</b>	To note and take action where required
<b>Does this link to an existing BAF risk?</b>	Yes - 4217
<b>Does the BAF need amending in light of this paper?</b>	No

**1. Level 1 & Level 2 Serious Incident Reviews Commissioned in August**

Level of review	Level of harm	Date of incident	Details/ comments
1	None	August 2016	No Tier 4 bed available, young patient admitted to adult ward.
1	None	August 2016	No Tier 4 bed available, young patient admitted to adult ward.
1	Moderate	August 2016	Staff member physically assaulted had to attend A & E.
1	None	August 2016	No Tier 4 bed available.
2	Death	August 2016	Patient found deceased in home, cause and circumstances of death unknown
1	Moderate	August 2016	Staff required to wear full Personal Protective Equipment suits whilst escorting a patient resulting in a breach of the privacy and dignity of the patient in a public place
2	Death	August 2016	18 year old male patient arrested for murder (by stabbing) of an 18 year old fellow resident of the hostel where the patient lived. Remanded in custody.
1	Death	July 2016	Patient death suspected natural causes
1	Death	August 2016	Patient death cause of death not known at this time.
1	Death	August 2016	Patient death cause of death not known at this time.
1	Moderate	20/08/2016	The kitchen shutter fell injuring staff member.
1	Damage to property	August 2016	Trust property damaged by patient
1	Death	August 2016	Patient death cause of death not known at this time.
2	None	August 2016	Patient damage property PMVA technique used to secure precautionary holds and patient relocated to the seclusion room.

## **2. Local Team Reviews Commissioned in August**

Level of harm	Date of incident	Details/ comments
None	August 2016	Patient suffered a seizure patient transferred to Hospital.
None	August 2016	Patient injured apparent self-harm escorted to A&E.
None	August 2016	Patient raised concerns that another patient was giving him his medication.
Moderate	August 2016	Patient appeared to have escorted to A&E
Minor	August 2016	Patient to patient altercation
Low	August 2016	Patient injured apparent self-harm escorted to A&E.
None	August 2016	Patient absconded
Minor	August 2016	Patient on extended leave treatment missed
None	August 2016	Inappropriate pathway assigned to patient after discharge from A & E
None	August 2016	Incorrect anti-depressant prescribed, was corrected.

## **3. Mortality data for August**

Cause of death	Place of Death	Detail
Natural Causes	Hospital	Patient death suspected natural causes
Unknown	Unknown	Staff informed by GP surgery that patient had passed away. No further information available.
Natural Causes	EGH	Patient death suspected natural causes
Unknown	Home address	Patient death causes unknown

Unknown	Unknown	Patient death causes unknown
Unknown	Home address	Patient death causes unknown possible suicide.
Apparent Natural Causes (Unexpected)	Home address	Patient death suspected natural causes
Apparent Natural Causes (Unexpected)	Home address	Patient death suspected natural causes
Apparent Natural Causes (Unexpected)	Home address	Patient is found dead at home address.
Apparent Natural Causes (Unexpected)	Hospital	Patient death suspected natural causes
Apparent Natural Causes (Unexpected)	Hospital	Patient death suspected natural causes
Natural Causes (Expected - Palliative Care)	Home address	Patient death suspected natural causes
Apparent Natural Causes (Unexpected)	Care home	Patient death suspected natural causes
Unknown	Hospital	Patient death suspected natural causes
Unknown	Hospital	Patient death suspected natural causes
Unknown	Home address	Patient death suspected natural causes

#### **4. Coroner's Inquests held in August 2016**

3 August 2016	Patient found hanged at home	<p>The Coroner concluded that <i>Post mortem result: <b>1a Hanging</b></i></p> <p><i>Coroner's Conclusions: <b>Suicide</b></i> The Coroner did not issue a PFD (Prevent Future Death) and there were no care or service delivery issues identified at the inquest or in the Level 2 SI review.</p>
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## 5. Future Coroners Inquests

September 2016	Patient admitted on 24/12/16. Difficult to engage and was only taking restricted food/fluids. Suffered a cardiac arrest on 01/01/16 and subsequently died in Charing Cross ICU on 09/01/16. The family and Trust are being legally represented.
October 2016	Patient was found lying on the kitchen door in his flat following a welfare check by Police. This had been requested by the family as they had not seen patient for 9 days. Last seen by Trust on the 10 April 2015. Patient regular attender at the Ealing Clozapine Clinic last seen there on the 11th March was due next to be seen on the 8th April.
November 2016	Patient admitted on 05/01/15. Agreed overnight stay at home address on night of 06/01/15. Patient died by jumping in front of a train on 07/01/16. The family and Trust are being legally represented.

## 6. Information Governance Incidents reported in August

### Category of IG Incident

	Total
Breach of patient confidentiality	0
Lost RiO cards	9
Misdirected patient data	3
Lost or Stolen confidential paperwork	1
Other	2
Non-secure management of confidential data	2
Lost or stolen ICT equipment	0
Unauthorised access/disclosure of confidential data	2
Total =	19

Category	Detail	Actions Taken
<b>Mis-directed Patient Data (Letter, Fax or Email)</b>	Letter sent to patients old address – information had not been updated on RiO	Records updated, apology letter sent to patient, letter returned to the Trust
<b>Loss of RiO Smart Card</b>	Smart card lost	New card issued

<b>Other</b>	PC left unlocked with Smartcard logged in	Staff member reminded of the importance of locking PC and removing smartcard when away from the desk, asked to undertake IG training
<b>Loss or stolen confidential paperwork</b>	Prescription chart misplaced	Chart re-written search conducted to locate missing chart.
<b>Other</b>	Staff member noticed envelope labels did not match the correct patient addresses on letters, no letters had yet been sent out	Unclear how labels were printed incorrectly, issue resolved.
<b>Non-Secure management of personal confidential data (paper or IT Equip)</b>	Patient information sent to another NHS provider not using nhs.net	Staff member informed of Trust procedures and supplied with NHS.net account
<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued
<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued
<b>Non-Secure management of personal confidential data (paper or IT Equip)</b>	Patient information sent not using nhs.net email	Staff member asked to undertake IG training
<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued
<b>Unauthorised access/disclosure to personal confidential data</b>	Staff member with no legitimate relationship accessed RiO record of deceased patient	Staff member asked to undertake further IG training, matter referred to Director of Nursing
<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued
<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued

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<b>Loss of RIO Smart Card</b>	Smart card lost	New card issued
<b>Unauthorised access/disclosure to personal confidential data</b>	Email containing staff information printed off – PC not locked	Staff member reminded to lock PC
<b>Mis-directed Patient Data (Letter, Fax or Email)</b>	Patient address recorded incorrectly on system, letter sent to incorrect address	Letter returned to the Trust patient record updated to correct address
<b>Mis-directed Patient Data (Letter, Fax or Email)</b>	Patient letter sent to wrong GP and home address	Unclear how the incident occurred patient not contactable

## **7. Complaints raised between 1<sup>st</sup> August – 30<sup>th</sup> August 2016**

30 complaints were raised in total, eight in Local Services, 18 in High Secure Services, three in West London Forensic Services and one in Estates and Corporate Services.

### **Subject of complaints**

	<b>Total</b>
<b>Admissions, discharge and transfer arrangements</b>	<b>1</b>
<b>All aspects of clinical treatment</b>	<b>11</b>
<b>Appointments, delay/cancellation (outpatient)</b>	<b>1</b>
<b>Attitude of staff</b>	<b>10</b>
<b>Communication/information to patients (written and oral)</b>	<b>2</b>
<b>Failure to follow agreed procedures</b>	<b>1</b>
<b>Patients privacy and dignity</b>	<b>1</b>
<b>Patients property and expenses</b>	<b>3</b>
<b>Total =</b>	<b>30</b>

Source	Detail	Acknowledged within 3 working days
Patient	Complaint about report and concerned about Treatment	Yes
Patient	Allegation of stolen property	Yes
Patient	Patient claims they were assaulted during a restraint and various other aspects of his care and treatment	Yes
SEAP	Complaint about transfer of Ward	Yes
SEAP	Complaint about a member of staff	Yes
Family	Staff attitude/behaviour	Yes
Patient	No reply to patients solicitor	Yes
SEAP	Staff attitude/behaviour	Yes
SEAP	Complaint made about the handling of a claim	Yes
SEAP	Staff attitude/behaviour	Yes
SEAP	Claim that has been both physically and sexually abused by staff	Yes
Other External Source	Complaint that a claim was not investigated adequately	Yes
SEAP	Complaint about not being served at the Café.	Yes
Patient	Patient not able to store food	Yes
Patient	Complaint about delayed discharge	Yes
Patient	Complaint about legal correspondence	Yes
CQC	Complaint about treatment plan	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Staff attitude/behaviour	Yes
Patient	Complaint about being discharged and delays in correspondence	Yes
Patient	Complaint about delay in providing medication	Yes
Patient	Delay in sending letter of referral for surgery and sending a reply about patient's blood test results	Yes
Patient	Patient cannot get in touch with psychology department	Yes
Other external source	Lack of action by care coordinator in working collaboratively with the social services and with housing to prevent eviction	Yes



<b>Family</b>	CPN allocated unintentionally	Yes
<b>Family</b>	Complaint about the care and treatment of patient	Yes
<b>Staff member (Social worker)</b>	Staff attitude/behaviour	Yes
<b>Patient</b>	Application for escorted leave not sent	Yes
<b>Patient</b>	Staff attitude/behaviour	Yes

## 7.1 Complaints closed

<b>Number of complaints closed</b>	<b>28</b>
<b>Number of complaints closed in time</b>	<b>12</b>
<b>Number of complaints closed outside of time</b>	<b>16</b>
<b>Number of overdue complaints</b>	<b>15</b>
<b>Number of complaints withdrawn</b>	<b>6</b>
<b>Number of complaints referred to Ombudsman</b>	<b>0</b>
<b>Number of complaints upheld</b>	<b>4</b>
<b>Number of complaints not upheld</b>	<b>10</b>
<b>Number of complaints partially upheld</b>	<b>14</b>

## 8. Patient Opinion

14 stories have been posted; 10 stories written by the patient, two unknown, one from a carer and one from a relative. Of the 14, 50% (n=7) received a response within three working days. One story is awaiting a response.

<b>Author</b>	<b>Detail</b>	<b>Date posted</b>	<b>Date acknowledged</b>
<b>Unknown</b>	In urgent need of a professional body from WLMHT	27/08/16	29/08/16
<b>Patient</b>	Blessed to have been allocated such a brilliant practitioner	05/08/16	05/08/16
<b>Unknown</b>	Left without contact for 8 weeks	05/08/16	08/08/16
<b>Patient</b>	Really turned my life around	06/08/16	10/08/16
<b>Patient</b>	I would definitely recommend this service	09/08/16	09/08/16
<b>Patient</b>	I am grateful for their time and wanting to help me	19/08/16	22/08/16

<b>Patient</b>	Amazing service	22/08/16	22/08/16
<b>Patient</b>	Waiting times and dreadful admin	03/08/16	09/08/16
<b>Parent</b>	My transgender son	03/08/16	09/08/16
<b>Patient</b>	Life isn't so overwhelming now	12/08/16	18/08/16
<b>Patient</b>	I wish every hospital had the expertise that I've received	12/08/16	18/08/16
<b>Patient</b>	Incredibly helpful and life changing	12/08/16	18/08/16
<b>Carer</b>	I no longer feel isolated	15/08/16	19/08/16
<b>Relative</b>	We've been supported at every step	12/08/16	No response

## 9. Claims

There were five (5) new claims made in August

Type	Category	Description
Clinical	Sexual related incident	Patient alleged sexual assault by another patient
Non-Clinical	Assault on staff by patient	Patient assault on staff
Non-Clinical	Injury to staff	Staff slipped on a flooded floor and fell.
Non-Clinical	Assault on staff by patient	Staff attacked by patient
Non-Clinical	Assault on staff by patient	Patient attack on staff

There was one (1) claim closed in August:

Type	Cost of Case	Description
Non-Clinical	£2500 (damages)	Fall

There was one (1) claim overdue for evidence gathering in August 2016:

Type	Description	Evidence Deadline	Portal case	Portal deadline
Non-clinical	Trapped finger in the door	24/8/2016	Yes	5/9/2016

**Janet Bell**  
**Head of Governance**  
**September 2016**