# Implementing change to prevent patient deaths by suicide:

## *findings from a knowledge exchange secondment*

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*This work directly addresses policy recommendations for NI, as outlined in action point 6.4 of the Mental Health Action Plan for Northern Ireland*

**Research Method**
***- 3 Phases***

***Phase 1***
✓ International evidence reviewed
✓ **41** sources of international evidence
01/05 - 11/20

***Phase 2***
✓ Serious Adverse Incident (SAI) Reports: review of recommendations
✓ **188** reports from patient suicides
2015 - 2016

***Phase 3***
✓ Expert views: **5** MH Professional focus groups
✓ **27** Mental health professionals.
02/20 - 03/2020

Selected PhD Findings discussed at Q&As

***Category 1***
**Evidence-based progress:**
**Maintain investment**

***Category 2***
**Awareness exists:**
**Investment is needed**

***Category 3***
**New priorities:**
**Future investment required**

Finding 1

## Information Management

***Category 1:* Evidence-based progress: maintain investment.**

1. Regional Encompass system rollout to be prioritised with regular updates to staff.
2. Prioritise rollout of *warm handover process* between HSCTs and other services.

***Category 2:* Awareness exists: investment is needed**

1. Ensure staff have protected time to read and consider implementation of SAI recommendations.
2. SAI recommendations to be communicated to frontline staff, as soon as possible.
3. SAI recommendations should be clear on who is responsible for implementation, how they should be implemented, by when, and how will success be measured. Using the SMART objective structure is recommended.

***Category 3:* New priorities: future investment required**

1. GP records should be linked to Encompass.
2. One central system is needed for sharing outcomes and recommended actions from SAIs.
3. SAI recommendations should be communicated to all MH services for all ages.
4. Further training to understand consent as a process for sharing information that could save lives including partial consent and protecting the therapeutic relationship

> *"The number of times I have had to say that prisoners or people on bail "abscond" not unwell people, or people that are acutely distressed, not aggressive etc., etc., etc."*

5. Inter-professional learning groups to ensure all professions develop consistent policies on patient care information sharing and consent.
6. Use plain language in SAI reports.

Finding 2

## Working with Families and Carers

***Category 1:* Evidence-based progress: maintain investment.**

1. Regional training for staff on confidentiality vs risk, when sharing information with families, carers, and others.

***Category 2:* Awareness exists: investment is needed**

1. Improve the carers assessment promoting meaningful involvement and more collaborative language.
2. Effective gathering and recording of all support structures including family, carers, and safety plans, should become core competencies.
3. Improve families' understanding of the MH care system and pathways, including support they can access.

> *"We need consent to share and the need for information flow. A disclosure at the time of suicidal thoughts can help a person feel safe and de-escalate their acute ideation, however when they next appear at the GP, they may say that they feel better and so the GP is not aware of the previous ideation and so little action is taken to help support that person."*

***Category 3:* New priorities: future investment required**

1. Improve staff attention to the context in which people live e.g., existing support structures.
2. Develop policies and protocols to promote family involvement in supporting the patient through the care pathway, including ongoing two-way communication.
3. Allocate time for carer assessment processes and regular meetings.
4. Change the culture of SAI processes to make these more inclusive, less intimidating, and more valued for families.
5. Feedback to the family should be offered as a standard component of the SAI process, including changes proposed and implemented after the SAI review.

> *"There is often a lack of communication and feels like things are being explained away. It feels like a betrayal because services ought to be supporting and protecting family members."*

Finding 3

## Making Change Happen

***Category 1:* Evidence-based progress: maintain investment.**

1. Promote more rapid culture change by taking account of issues raised by staff.
2. Encourage staff to identify resource and other issues, when the system is failing patients, including whistle blowing.

***Category 2:* Awareness exists: investment is needed**

1. Continue focus on disrupting the concept that an SAI review is a process of placing blame.
2. All HSCTs should cooperate to develop a sustained learning culture.
3. Implement protected time for staff returning to work following an absence to enable them to access all critical communications.
4. Prioritise staff working with people with lived experience to prevent them from becoming de-sensitised around the issue of suicide.
5. Provide more opportunities for knowledge translation including research and quality improvement secondments.
6. A new regional process should be supported for SAI reviews, that offers real culture change and improved outcomes.

> *"Here we are 15 years later talking about changes that are required. So many issues are repeating and repeating but this project offers an opportunity to see real change."*

***Category 3:* New priorities: future investment required**

1. Ensure consistent specialist support for staff who experience a patient suicide.
2. Recommendations are not mandatory requirements. Using different language could support more effective implementation where critical change is required.
3. Greater accountability is needed for implementation of recommendations.
4. Any new regional SAI review process needs to reduce potential harm or trauma to families/carers.
5. Explore whether separating the SAI review process from the HSCT system may make things more transparent and effective.

> *"Families experience difficult language, endless recommendations that don't appear to result in changes, there is a culture of blame, of covering people's back. This is not good for people who have lost someone to suicide."*

Footnote: This knowledge translation secondment opportunity (the Q&As) examined only 3 out of 6 wider themes addressed in the research. For further information please get in touch: cramsey07@qub.ac.uk or k.galway@qub.ac.uk

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