



Birmingham and Solihull Mental Health NHS Foundation Trust
Unit B1, Trust Headquarters
50 Summerhill Road,
Birmingham
B1 3RB

XXXXRedactedXXXX

Inspection Manager
Hospitals; Mental Health
(Central West) Central Region
XXXXRedactedXXXX

31st January 2022

Your reference: RGP1-10053519614
Account number: RXT

Dear XXXXRedactedXXXX

**Re: Care Quality Commission
Health and Social Care Act 2008
Notice of decision to impose conditions on your registration as a service provider in
respect of regulated activities
Reporting schedule**

Condition 3 - Commencing from 5 February 2021 the registered provider must report to the Commission on a monthly basis setting out progress being made in respect of and including mitigating measures being put in place until all ligature risks are addressed.

Condition 5 - Commencing from 1 March 2021, the Registered Provider must report to the Commission on a monthly basis the results of any monitoring data and audits undertaken that provide assurance that the system implemented is effective.

I am pleased to enclose for your attention our latest position relating to the implementation of the section 31 improvement plan for XXXXRedactedXXXX and for improving the safety of the physical environment.

Since our last submission to you, we have been continuing with work to strengthen our relational, procedural and environmental measures to improve patient safety. These actions focus on installation of the en-suite door alarm systems in our Acute Care inpatient settings, XXXXRedactedXXXX

Chair: Danielle Oum | Chief Executive: Roisín Fallon-Williams

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approach to ensure safe staffing given some of the ongoing challenges in this area

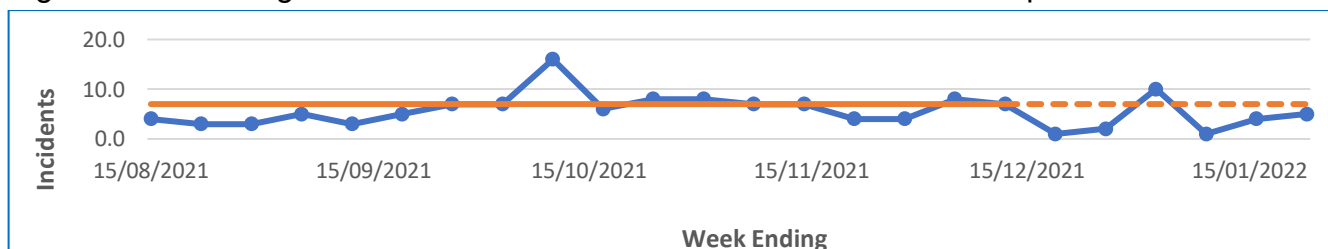
XXXXRedactedXXXX. Next steps agreed to enable effective use of the MHOST tool mentioned in our previous submission are:

- Our Medical Director and Deputy Director of Nursing are working with Heads of Nursing and AHPs and Clinical Directors to look at observation practice within teams, with a specific focus on the use of level 2, 15 minutes observations which appear to be utilised as a baseline observation as opposed to an enhanced observation level.
- Chief Nursing Officer Safer Staffing fellows will then re engage with the above staff and use 10 new case studies to assess staff in using the acuity rating and once approved we will plan our first teams to use MHOST.

Following the evaluation of the trial of the bedroom door alarm system on Larimar, work is now underway to install this system on the rest of the ward by the end of this financial year. Despite some delays in commencing enabling works in the South PFI, the rest of the programme remains on track for completion by the dates set out in the action plan. We also had some delays to the installation on Ward 1 Mary Seacole House due to a COVID outbreak. Consequently, only 4 out of the 16 en-suites have been installed to date. Works will recommence as soon as these types of activities are possible on the ward.

XXXXRedactedXXXX

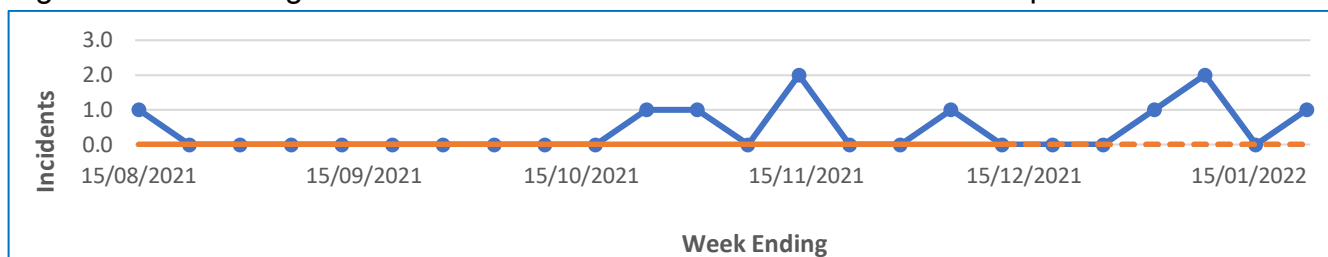
Figure 2 –Actual Ligature Incidents with No Anchor Point in our Acute Inpatient Wards



We also note a decrease in the number no anchor point incidents for the reporting period. These incidents continue to largely occur on our female wards such as Melissa, Larimar and Eden Female PICU, and MSH Ward 2. All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) with positive feedback.
- Daily safety huddles
- Psychology input
- Supporting service users with techniques to benefit longer term recovery and safety
- Medical Review and update to Care Plans and Risk Assessments
- 1:1 de-brief time between staff and patient
- Reducing Restrictive Practice QI Collaborative
- Safewards programme
- Therapeutic activities programme

Figure 3 – Actual Ligature Incidents with an Anchor Point in our Acute Inpatient Wards



We note four anchor point incidents for the reporting period, which all occurred on Melissa Ward. Although installation of the door alarm system for the en-suite doors was programmed to be completed in the first quarter of 2022/23, the installation of the same system for bedroom doors was added for the same date as the Safety Risk Review Group recognised this as a high clinical risk area based on incident data.

The first incident was on XXXXRedactedXXXX, where it was handed over that the service user had tied multiple ligatures on the previous shifts. With this in mind, at the beginning of the shift, nursing staff had a 1:1 with the service user and encouraged them approach staff, should XXXXRedactedXXXX feel that XXXXRedactedXXXX cannot keep XXXXRedactedXXXX safe, or if XXXXRedactedXXXX felt XXXXRedactedXXXX would benefit from a 1:1, to try and prevent further incidents and provide XXXXRedactedXXXX with support.

XXXXRedactedXXXX

Nursing staff took service user's physical observations and these were within range, apart from an increased pulse. Duty doctor was contacted and assessed service user. Duty doctor and nursing staff discussed how best to keep the service user safe. To be least restrictive, it was agreed for the service user to remain on level 2 (15 minute) observations. Service user was asked to wear XXXXRedactedXXXX, and to sleep with bedroom door open and unlocked. XXXXRedactedXXXX.

Incidents 2, 3 and 4 involved the same service user and occurred on the XXXXRedactedXXXX

XXXXRedactedXXXX (Night shift)

The service user's observations were checked and handed over to the next member of staff. Due to the SU displaying Early Warning Signs (EWS), staff checked on them again, 8 minutes after the original check/ before checks were due and the SU XXXXRedactedXXXX. Nursing staff activated their alarms and took the SU's weight in order to reduce the pressure off the ligature. Ligature cutters were used to remove the ligature. Service user agreed to allow nursing staff to XXXXRedactedXXXX from XXXXRedactedXXXX bedroom in an attempt to prevent further ligatures, and to provide least restrictive practice opposed to immediately increasing level of observation. Service user was made aware that if XXXXRedactedXXXX

participated in any more risky behaviour, XXXXRedactedXXXX would be placed on a level 3 (1:1) observation to preserve XXXXRedactedXXXX safety. Service user had physical observations taken and they were within range except for a high pulse.

XXXXRedactedXXXX (Morning shift)

During therapeutic observations the SU was checked on and was noted to be lying in bed and appeared to be asleep. Prior to the next check being due, a housekeeper entered the SU's bedroom and alerted staff that there was an issue. Staff attended and noted that the SU had XXXXRedactedXXXX. The SU was resistant to staff trying to remove the ligature but they did so with the use of ligature cutters. Due to consistent risk and requirement for support it was deemed that a level 3 observation would be appropriate and XXXXRedactedXXXX was placed on level 3 1:1 observations. The service user's risk screening tool had been updated prior to the incident, clearly outlining the mitigations for supporting XXXXRedactedXXXX and keeping XXXXRedactedXXXX safe.

XXXXRedactedXXXX

Service user was presenting as low in mood throughout the duration of the afternoon and was offered multiple one to ones and different ways to distract XXXXRedactedXXXX thoughts. XXXXRedactedXXXX also had 1mg of PRN to help aid XXXXRedactedXXXX thoughts. XXXXRedactedXXXX had been spending time in XXXXRedactedXXXX bedroom, and then coming out into day areas pacing the ward but refusing to engage with staff. Frequent checks were being carried out and patient was found with a XXXXRedactedXXXX. Alarms were raised and the ligature was cut from the XXXXRedactedXXXX. Service user was already gasping for breath and no discolouration noted in complexion. XXXXRedactedXXXX was supported on 1:1, and encouraged to spend time out of XXXXRedactedXXXX bedroom to which XXXXRedactedXXXX complied. Talk down and de-escalation utilised from the start and throughout.

In total, there have been 6 anchor point ligature incidents from XXXXRedactedXXXX to date on the ward. Five of these incidents relate to the same service user. Both service users and XXXXRedactedXXXX and both have a diagnosis of an XXXXRedactedXXXX. The clinical team on Melissa Suite have been working hard with both of them to maintain least restrictive interventions while maintaining safety. This has included reviewing and flexing the levels of observations, one to one time with staff, distraction activities and the use of anti-rip clothing when and where appropriate. Both service users at one point were on level three one to one observation to prevent ligatures. The risks were discussed in safety huddles, and the consultant (RC) reviewed after each incident. One service user used the XXXXRedactedXXXX as a ligature point. Due to escalating risks and the balance of safety, this XXXXRedactedXXXX has now been transferred to Eden PICU unit.

The second service user used the XXXXRedactedXXXX as a ligature point on 4 occasions. Due to the bathroom door subsequently being locked for XXXXRedactedXXXX safety, XXXXRedactedXXXX 4th anchor point was a XXXXRedactedXXXX. Melissa Ward is scheduled to have replacement alarmed en-suite doors in April 2022. The staff are continuing

to manage this person on Melissa unit as part of using least restrictive interventions, with ongoing risk assessments and support. The team is continuing to work on support and positive engagement to maintain XXXXRedactedXXXX safety. In addition, as part of the 72 hour review completed by the Patient Safety team, there has been a recommendation to refer the service user to an MDT Complex Care panel/ case conference or to seek advice from the consultants at Ardenleigh, who have a lot of experience with managing service users with a diagnosis of XXXXRedactedXXXX

All of the above incidents have been subject to a 72 hour review by the Patient Safety team.

We welcome the opportunity to discuss any of these matters with you at our next meeting, however should you have any immediate queries or require any additional information then please do not hesitate to contact me.

Yours sincerely



Sarah Bloomfield
Executive Director of Quality and Safety (Chief Nurse)