



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 October 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 care planning 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

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

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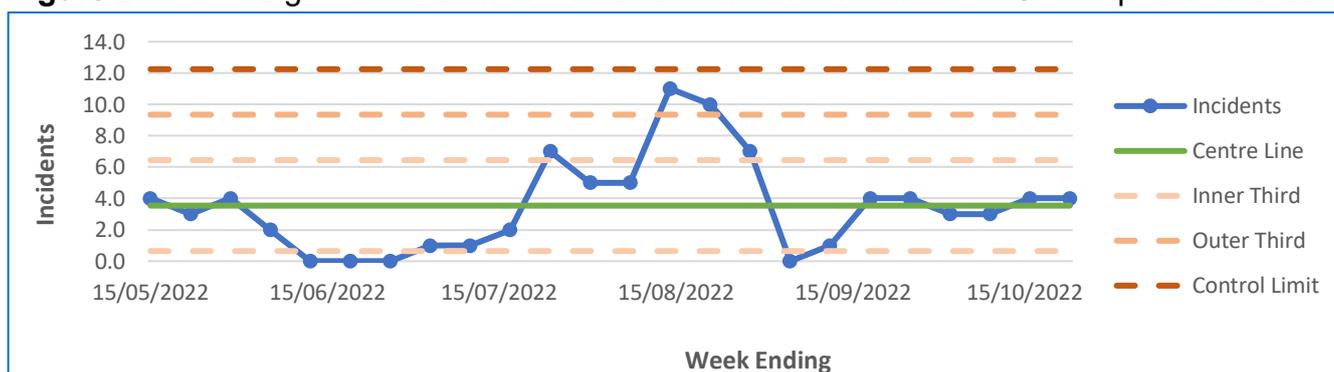
focus on installation of the en-suite door alarm systems in our Acute Care inpatient settings and some bedroom doors in the service, XXXXRedactedXXXX improve staffing shortfalls. Further to previous updates on our actions to address the staffing challenges, we continue to recruit to our vacancies and are attending recruitment events when possible. International recruitment continues to be successful with 16 new staff recruited to date, and we will be putting a bid in for the next financial so we can continue our project.

The revised door programme for the installation of the en-suite doors in Acute Care is now complete. These doors at the Zinnia now have all required connectivity however some snagging issues were found regarding the volume of the alarms, and this is expected to be resolved by mid-November and those at the Oleaster will have connectivity in two weeks' time however the doors on Melissa will be prioritised as part of this process.

Compared to the previous reporting period, there has also been a decrease in the numbers of no anchor point incidents. Measures being used to manage this risk continue to include, where there are service users with a presentation of high risk of self-harm, it is addressed by use of individual risk assessments, discussed in weekly MDTs, daily safety huddles and where beneficial in complex case reviews with a wider clinical membership to provide a more comprehensive approach to clinical safety. Risk formulation huddles continue to be used across the service area.

XXXXRedactedXXXX

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

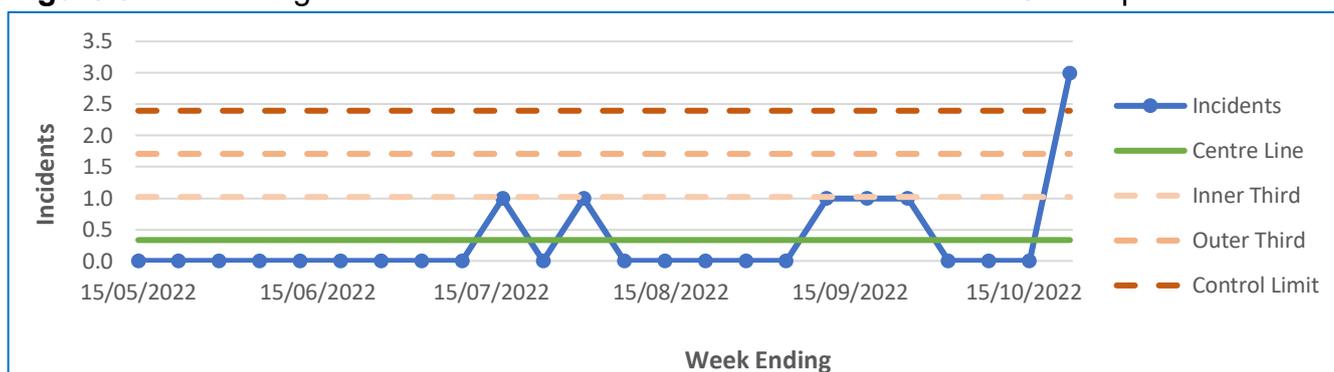


All incidents were managed through relational and procedural controls. Such controls included:

- Risk formulation huddles have commenced on four wards (George, Tazetta, Eden PICU and MSH Ward 2) and now in QEHB Liaison Psychiatry team.
- 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 Quality Improvement Collaborative
- Therapeutic activities programme
- Sensory Wards project
- Support for patients with autism and learning disability prior to admission in Home Treatment
- Two Band 7 Clinicians for out of hours to support clinical decision making

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



There were four anchor point incidents involving two service users in Acute Care since our last submission. Three were on Larimar on XXXXRedactedXXXX (patient 1), XXXXRedactedXXXX (patient 2), and XXXXRedactedXXXX patient 2) and one on Melissa on XXXXRedactedXXXX (patient 1).

Incident 1 on Larimar involved the same service user that was later involved in incident 4 on Melissa. In this incident alarms were sounded and when staff attended the bedroom the service users was XXXXRedactedXXXX. The ligature was removed without a ligature cutter and the service user's physical observations was taken which was within normal range and she was breathing unaided. She was offered PRN, which she accepted as well as 1:1 debrief and reassurance.

Incident 2 on Larimar involved the same service user as in incident 3. In this incident, staff members responded to the door monitoring alarm sounding and took the ligature cutters with them. When staff entered the bedroom, XXXXRedactedXXXX. One staff member took her body weight, while the other attempted to cut through the ligature. Prior to this incident, staff checked the service user's room at the start of the shift, and it was checked again an hour later for any items that could be used for self-harm, the room was thoroughly searched, and nothing was found. It is believed that the XXXXRedactedXXXX used to create the ligature was acquired from another patient. She was given PRN, her vital signs were checked with no abnormalities, the on-call duty doctor was informed of incident and reassurance given to her. In this incident the patient was found with a ligature tied XXXXRedactedXXXX. There were also XXXXRedactedXXXX. The ligature was removed, and physical health checks, wound

assessment and dressing were offered as well as one to one support, but these were declined, however, respiratory rate was normal.

The final incident was on Melissa where upon staff completing therapeutic checks, staff noted that the service user's XXXXRedactedXXXX. Staff held her weight and when assistance arrived the ligature was removed without the need for cutters.

Crash call was put out and she was in and out of consciousness until Paramedics arrived and they continued to assess medically, and she was conscious at time of transfer to A&E for assessment. She was assessed at A&E and no concerns were noted, other than pain and some redness to neck area which they advised paracetamol.

She was placed on Level 3 (1:1) observations on the ward and psychology support was being reviewed. Both the service user and the staff involved were debriefed.

All of the above incidents were/ are subject to a 72-hour review by the Patient Safety team and the learning has been/ will be shared with the relevant wards.

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

Yours sincerely,

Steve Forsyth
Interim Executive Director of Quality and Safety (Chief Nurse)