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Clinical Commissioning Groups

Risk Management Framework Case Study

Miss R

Background

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- Miss R is a 60 year old lady with a history of aggressive and violent behaviour.
- She was informed of a change in GP practice which triggered an increase in contact with multiple agencies.
- Repeated phone calls were received from Miss R complaining about the change in GP practice and often resulting in abusive language, threats to harm herself and others and Miss R terminating the call.
- On investigation Miss R had involvement with a wide range of professionals;
  - Housing
  - Local Authority
  - Fire Service
  - South Central Ambulance Service (SCAS)
  - Southern Health Foundation Trust (SHFT)
    - Community Nursing
    - Mental health
  - Primary Care
  - Police
- Several agencies were considering withdrawing from the care of Miss R.

Physical and Mental Health Needs

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- Type II diabetes
- Previous wounds on legs – healed but require washing and creaming
- Self harm – will scratch at legs to re-open wounds in order to maintain contact with the community nursing team
- No formal mental health diagnosis
- Assessed to have mental capacity around complex decision making

Challenging behaviour –

- Verbal abuse – to professionals and public (including children)
- Physically threatening
- Repeated calls to SCAS – threats to self harm/kill herself
- Hoarding within her property
- Wasting police time – previous fixed penalty notice served
- Racial abuse

Risk management framework

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- Due to the number of agencies involved and the escalation in challenging behaviour, the CCG Head of Vulnerable Adults and Safeguarding utilised the HSAB Risk management Framework.
- An initial meeting was held with all involved agencies in attendance except SCAS.
- The meeting covered the following:
  - Background
  - Summary of contact
  - Risks
  - Legal powers or remedies
  - Information sharing
  - Identification of lead co-ordinator
  - Contingency and escalation plan
  - Engagement with Miss R
- An action plan was drawn up with clear responsible agencies identified and timescales for completion
- Review meeting was planned for 3 months time

Risks Identified

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To self:

- Risk of fire
- Risk of falls due to clutter in house
- Risk of aggression from others
- Risk of damage to property following incidents of egg throwing
- Risk of eviction
- Risk of self harm
- Risks associated with self-neglect

To others:

- Risk of verbal aggression
- Risk of physical aggression

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Actions taken to mitigate risk

- The Community Mental Health Team (CMHT) provided Miss R with a dedicated day/time each week when she was able to contact the service for support
- The CMHT provided a management plan for dealing with her challenging behaviour
- The community nursing team discharged Miss R as she had no clinical needs that met their criteria
- A crib sheet of suggested responses to Miss R's concerns and threats was circulated to relevant professionals
- Clear boundaries set including consequences of racial/verbal/physical abuse
- Clinical assessment by GP
- All agencies identified a single point of contact for Miss R

Progress

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Frequent communication between all agencies via email kept all professionals up to date with events.

Miss R was aware that a meeting had been held about her and was aware that professionals were communicating between agencies.

Miss R was invited to the subsequent meeting but declined although she verbally complained about this. On at least one occasion whilst complaining to the CCG about the lack of care an ambulance was knocking at her door. She denied calling the ambulance.

Mental Health were providing a carer for Miss R at the time of the first meeting but this could not be continued so this also changed her care provision. Miss R was assessed and advised she must contribute to her care costs which would be provided by MENCAP. Miss R declined this and this was also a cause for her to be unhappy. Miss R would frequently ring and say she was denied care and she did not have a GP. She was frequently reassured care was available if she accepted it and she did indeed have a GP.

After a while Miss R realised professionals were working together and anything new she said to one professional was shared with the others. This continued until all professionals knew Miss R and what she was experiencing so were able to re-inforce the care plan.

Progress (continued)

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This was successful but Miss R started to withdraw from services because she was not hearing what she wanted to hear. This made way for a genuine concern for her physical health as despite Miss R ringing and demanding to see a GP when it was facilitated for her she would subsequently refuse.

Eventually the practice manager provided her with a date which was mutually agreeable, she was seen and assessed by the GP. With all the other changes to her care in the community she seemed to appreciate that the NHS was now working with her to ensure she gets the care she needed. She now attends the surgery and has regular managed conversations with the Practice manager and mental health team.

Learning

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- Utilisation of the multi-agency risk management framework allowed professionals to prioritise and work together to ensure the most appropriate care for the patient. It also made the most of efficiencies in care reducing services that were not required.
- Working with the patient in a framework allowed for sharing and support. This meant that when one agency had concerns they were shared with the group to ensure the safety of the individual.
- The use of the risk management framework meant that all professionals had a consistent approach to the care of Miss R.
- The identification of a lead co-ordinator was useful although challenging to establish.
- The CCG was active in supporting providers to create a working risk management plan.