Bowers, L., Simpson, A., Eyres, S., Nijman, H., Hall, C., Grange, A. & Phillips, L. (2006). Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins Acute Ward Study. International Journal Of Mental Health Nursing, 15(4), pp. 226-234. doi: 10.1111/j.1447-0349.2006.00428.x

Bowers, L., **Simpson, A.,** Eyres, E., Nijman, H., Hall, C., Grange, A. & Phillips, L. (2006) Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins Acute Ward Study. International Journal of Mental Health Nursing, 15(4), 226-234.

SERIOUS UNTOWARD INCIDENTS AND THEIR AFTERMATH IN ACUTE INPATIENT PSYCHIATRY: THE TOMPKINS ACUTE WARD STUDY

Len Bowers
Professor of Psychiatric Nursing, City University

Alan Simpson
Research Fellow, City University

Sophie Eyres
Research Assistant, City University

Henk Nijman
Professor and Senior Researcher, City University and de Kijvelanden

Cerdic Hall
Professional Development Nurse, East London and the City Mental Health NHS Trust

Angela Grange
Lead Nurse Research & Development, Bradford Teaching Hospitals NHS Trust

Louise Phillips
Lecturer, City University

LB designed the study, LB and AS conducted the data analysis, SE, HN, CH, AG and LP contributed to the interpretation and presentation of findings and on their implications.

Address for correspondence:

Dr Len Bowers
Professor of Psychiatric Nursing
St Bartholomew School of Nursing and Midwifery
City University
Philpot Street
London E1 2EA

Tel: 020 7040 5824
Fax: 020 7040 5811
E Mail: L.Bowers@city.ac.uk

SERIOUS UNTOWARD INCIDENTS AND THEIR AFTERMATH IN ACUTE INPATIENT PSYCHIATRY: THE TOMPKINS ACUTE WARD STUDY

ABSTRACT

Background: Serious untoward incidents, or sentinel events (suicide, homicide, suicide attempt, serious assault and elopement of high risk patients) occur from time to time in association with acute psychiatric inpatient wards.

Aim: To discover the impact of serious untoward incidents on inpatient wards.

Method: Doctors, nurses and occupational therapists at three hospitals were interviewed about these events and their impact on their wards.

Findings: Staff reported feelings of shock, depression, demoralisation, upset, loss, and grief, followed by ruminations, guilt and anxiety. Levels of containment increased, as did the focus on risk assessment. Processing of the emotional impact was hindered by the pace of ward life, a lack of external support, and management investigations. Patient responses were largely ignored. A few staff responded negatively, hindering service improvements.

Conclusions: Much more attention needs to be given to the needs of the patient group following incidents. Substantial planning, organisation and investment are required to properly prepare for such events and manage their outcome. Without this planning and action, acute inpatient work has the capacity to be damaging to staff.

Keywords: Self-Injurious Behaviour, Homicide, Suicide, Violence, Absconding.

INTRODUCTION

The risk of serious untoward incidents in acute inpatient psychiatry is small, but appreciable and ever present. The inpatient suicide rate in England is 0.14%, or one for every 714 admissions (Powell et al 2000). The number of suicide attempts exceeds the number of completed suicides by a factor of ten (i.e., 2700 attempts versus 240 suicides in The Netherlands; Brunnenberg & Bijl, 1998). The figure for homicides by inpatients is 9 per year in England and Wales (Department of Health 2001). Violent incidents are, however, fairly common on acute inpatient wards. Nijman et al (2004) report a mean rate across Europe of 9.3 per patient year, although a large majority of these involve verbal abuse and property damage, rather than actual physical assault. Absconding (elopement) by patients is also common, although negative outcomes are not. Bowers et al (1999, 2003) report an absconding rate of 6.1 per patient year, although many of these are not officially reported as such, and only 3.6% result in any kind of adverse outcome.

In the UK, a serious untoward incident (SUI) in psychiatric services is generally considered to be any incident where medical treatment was required or death occurred, or where moderate to high financial loss, or loss of reputation might occur. The National Patient Safety Agency (NPSA, 2006) defines a 'patient safety incident' even more broadly as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving National Health Service funded care. An SUI is similar to a 'sentinel' event in the USA, as defined by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 2005), which is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk

thereof." Both JCAHO and the NPSA mandate Root Cause Analysis for the investigation of such incidents. Root Cause Analysis is a systematic approach to the identification of underlying reasons behind errors and mistakes which has been widely used in industrial and other settings (Rooney and Vanden Heuvel, 2004). In a Root Cause Analysis, detailed data is collected about the sequence of events, which is then analysed using a variety of diagrammatic tools such as “cause-and-effect”, “interrelationship” and “current reality tree” (Doggett 2004). This causal analysis is directed towards identifying the reasons why the identified causes existed, proceeding step by step until the “root causes” (those that if changed will prevent future incidents throughout the organisation) are recognized.

Little (1992) describes three stages in staff responses to suicide; disbelief and fear of further suicides, turmoil and exhaustion, followed by growth or prolonged disability. These contrast with the stages described by Bartels (1987) of shock, recoil (guilt, shame, anger, depression, self-doubt), and a search for meaning; a pattern confirmed by Cotton et al (1983). There is a significant literature on staff responses to attempted suicide (e.g. Main 1957, Maltsberger et al 1974) most of which stems from the psychoanalytic tradition and suggests that such patients are rejected and avoided by staff, possibly increasing suicide risk (Morgan and Priest 1991). Only two papers on the effects of homicide on staff could be located. One (Turns and Gruenberg 1973) found no impact on the use of containment (increases in transfers to closed wards or tranquilliser use, decrease in home leaves and discharges). A similar result was reported more recently by Bowers (in press), although an increase in staff leaving the service was found. There is a plentiful literature on the impact of less severe patient violence on

staff, although most of this relates specifically to staff who have been victims of attacks, and not to vicarious violence witnessed occurring to other staff or to patients. Ryan and Poster (1989) report that staff suffer from post traumatic stress disorder, and Baxter et al (1992) reporting that half of nurses consider it can take several months to recover emotionally. In interviews of nurses about absconding by patients, Clark et al (1999) found emotional reactions primarily of anxiety and fear of blame.

The data we report here were collected as part of the Tompkins Acute Ward Study, a multi-method longitudinal investigation of links between adverse incidents and staff factors. Previous papers from this study have described the nature and purpose of acute wards (Bowers et al 2005), the role of the Occupational Therapist (Simpson et al 2005), and the relationship of adverse incidents to patient flow (Bowers et al, in press a), and aggression related training (Bowers et al 2006). In this paper we examine the impact of serious untoward incidents on inpatient wards, and how those events affect the subsequent practice of acute psychiatry.

MATERIALS AND METHODS

DESIGN

Cross-sectional interview survey of multidisciplinary staff working on acute psychiatric wards

SAMPLE

Multidisciplinary staff (n = 56) in one NHS Trust, composed of Ward Managers (n = 16 [0]), F Grade mental health nurses (n = 17 [0]), Occupational Therapists (n = 14, [3]) and Consultant Psychiatrists (n = 9, [15]). Numbers in the square brackets are of those who declined to participate, or did not respond to an invitation to do so. Staff from 14 acute psychiatric wards and three psychiatric intensive care units were included in the study, and all Ward Managers, Occupational Therapists and Consultant Psychiatrists were approached and asked to participate. Where there was more than one F Grade nurse on a ward, the person first contacted was asked to participate. The interviews were conducted from October to December 2003. The 17 wards were on three hospital sites, and provided a comprehensive psychiatric service to a population of nearly half a million. The mean rate of admissions (2002-2004) was 3.15 per ward per week; 57% were male, 48% under 35 years of age and 54% had a psychotic disorder. Most included wards had 18 beds, and were staffed by a combination of qualified psychiatric nurses (approximately 75%) and unqualified health care assistants.

INSTRUMENT

The Operational Philosophy and Policy Interview (OPPI) was developed for this study. This semi-structured interview, used in its baseline form, covers the general care philosophy of the subject, their concept of the purpose of acute inpatient psychiatry, interdisciplinary relationships, team strengths and weaknesses, ward structure, the recent history of events and changes on the ward and plans for changes in practice in the

coming six months. The interview framework was initially created by the principal investigator (LB) and derived from current knowledge of the field plus his previous research work in the area. It was then reviewed twice by the research team and suggested changes incorporated.

PROCEDURE

This study received ethical approval from the Local Research Ethics Committee, and conforms to the provisions of the Declaration of Helsinki in 1995 (as revised in Edinburgh 2000). Prospective interviewees were contacted by phone and initially asked if they would participate. Subject to their agreement, a mutually convenient appointment was made. At that time a researcher explained the study in more detail, gave the subject an information sheet, and asked for their signed consent. Interviews were then conducted, mostly on the wards or in adjacent offices. All interviews were tape recorded and transcribed except one (where notes were taken). Following transcription, the accuracy of the transcripts was checked against the initial recordings, and corrections made.

DATA ANALYSIS

Interview transcripts were imported into qualitative data analysis software (QSR N6) and basic factual coding completed (e.g. ward, profession, etc.). All interviews were then read by three researchers, who met to collate ideas on analytic categories and priorities. A strategy for coding was then agreed. As a preliminary step, interviews were

coded to the broad topic areas of the structured interview questions. For the findings reported in this paper, interviewees' responses about serious untoward incidents were read and re-read. As an interim step, a table of incidents by ward was created, so that differing accounts of the same incident could be readily identified. Key themes were identified and coded for each professional group interviewed. A serious untoward incident was considered to be whatever interviewees mentioned in response to questions about whether there had ever been a serious incident on the ward. This did not necessarily match the local definition of SUI for all respondents, although all SUIs as defined by Trust policy were mentioned in response to this question. Once an incident had been identified by the subject, they were asked follow up questions on the impact and consequences.

RESULTS

All interviewees spoke about serious untoward incidents when asked. Between them they identified 39 incidents: 11 completed suicides, 5 attempted suicides, 2 homicides, 3 natural deaths, 7 serious absconds (elopements), 4 assaults, 1 alleged rape, 1 attempted rape, 3 serious threats, 1 accidental injury and 1 self harm incident. In addition to these incidents affecting patients, they spoke about 2 incidents of alleged staff misconduct, and one staff completed suicide. By no means had all of the incidents taken place on the ward – many had not. Neither was the perpetrator always an inpatient at the time – if they were known by the ward staff there would still be a certain amount of impact. And those effects endured for long periods of time. Although many of the

incidents we were told about had occurred during the year preceding the interviews, a substantial number were far more distant in time, with some being 2 or 3 years ago, and one having taken place ten years previously. Nevertheless, it was clear that these incidents, although distant in time, were still having an influence on practice in the present.

IMPACT ON MORALE

The emotional effect of the less severe of these incidents was largely restricted to the wards where they occurred. However the more severe incidents, particularly those involving deaths, had effects across the hospital where they occurred. On several occasions interviewees told us about events on other wards that had had an effect on theirs.

Interviewees spoke of the depression and demoralisation of the ward team that could occur following an SUI, with one Consultant Psychiatrist saying "the atmosphere on the ward was very sombre for a while", and another saying "people were rather numbed and troubled by it and so the staff lost their zest". Several of the nurses spoke about these events having a large negative impact on morale. However often linked with these statements were comments about the driving force of the ward routine and the needs of other patients, new patients, and how that necessity to focus on current problems forced the staff to get on with things, preventing them from dealing with their feelings about the SUI. The ward "has to carry on producing the goods irrespective" in the words of one ward manager.

People are always talking about it for a little while afterwards if something like that's happened. Because the ward is so hectic it's hard to, people might sometimes feel a bit guilty about not moving on, because, I remember when this guy died on the ward, somebody needed a bed and the bed area hadn't been cleared and I think it was a bit of a respectful thing to maybe leave it just for a day or so. But they're under so much pressure that they had to get it cleared. (Occupational Therapist)

After SUIs in which patients died, people also spoke about their sense of upset, loss and grief. These feelings were particularly acute when the patient had been known for some time, or the team had a real commitment to them, with one ward manager saying "she was so well known to us, she was almost like a member of the family, it definitely hit me so hard that", and another:

Well we had an SUI, when a patient killed themselves and that had a hell of an impact on the nurses. The patient had been with us for quite a while, and it's like all of us including the doctors, obviously everybody domestic, everybody, and it was first admission, you just had a soft spot for him, and everybody was really concerned about him, and everybody was basically involved in his care, and every week he got seen, every ward round he got reviewed and so on. Then he started looking a bit brighter, a bit more hope for the future, he went home for [leave]. The day he killed himself, he was talking to me, it was the first time I'd seen him looking so bright, and then about less than ten hours later we heard he'd just died, and that was just like, the impact it had on everybody on the ward, we couldn't understand why it happened. (Ward Manager)

Others also commented that SUIs came as a shock, were unexpected, and more devastating because of that. This sense of shock went across the board for all types of events – staff were definitely shocked by deaths, however they were also shocked by attempted suicides, violent assaults, and by allegations of misconduct by a member of the team.

SEARCH FOR UNDERSTANDING

Hard on the heels of feelings of shock, grief and depression came ruminations about whether anything could have been done to prevent the incident from occurring. Such ruminations were frequently mixed with tentative feelings of guilt and dismay, with the events rehearsed and alternatives explored and rejected. At the time of the interviews some of these circular thoughts had become a well-worn track.

We had a serious self-harm on the ward, somebody who had a history of self-*harm, ...* were in a one to one position but it didn't work out because some people resent being under one to one observation. And we tried to use options,can we give her more space, or do we do it whether she likes it or not? But those were the difficult situation and I think, on reflection, sometimes we have to take complete control of people's care, sometimes to prevent an incident, but on the other hand, you always have to balance it, what is definitely the best interest for the patient as well. And the thing is it is difficult to get that balance right. I, we only don't get it right sometimes. (Ward Manager)

Others spoke of wishing they could have done more, wondering whether they could have acted differently, or of reassuring themselves that there was nothing else they could have done. Some spoke of feeling guilty just because someone had died, whilst also fully knowing there was nothing they could have done. Sometimes mixed in with these feelings were a sense of general stress, heightened anxiety, and specific fears. In relation to violent incidents and threats, the anxiety was about the future behaviour of the assaultive or threatening patient, with an Occupational Therapist commenting "It made me feel quite unsafe on the ward for a little while after, a little bit nervous". For absconds, there was anxiety about what the patient might do while away from the ward, "for an hour and a half when I was phoned on the Saturday, you know your career flashes in front of your eyes, and you think if he was to go and kill himself, that would be it, and you feel quite exposed and vulnerable." In relation to other incidents, primarily those involving deaths, the anxiety was about the reaction of managers and the public, "people were scared, people were shocked I think people were afraid that they were then going to be criticised or blamed". Other spoke about the feeling that their practice would be inspected, and that their professional registration might be under threat.

It devastated the team because we had a dreadful management structure that it was, the blame culture was overwhelming. I just had to go the mortuary to identify him, the very same day senior managers came, trying to blame somebody, all different staff. When something happens, it doesn't matter who's fault it is, you're under scrutiny, as an individual, as a practitioner, as a human being. (Ward Manager)

Several spoke about a continuing anxiety and worry that such an incident might happen again at any time, coupled with a feeling that even their best efforts were probably not enough to prevent all eventualities. One interviewee noted that these feelings of anxiety were not confined to the ward staff themselves, but seized hold of the entire management hierarchy.

I think there was, I think there was a lot of fear really, a lot of fear and I don't think that was just fear on the ward, I think there was fear going up the management levels as well so I don't think it just affected you know unqualified staff, D grades [and] E grades [qualified nurses], myself. I think it, it had an effect on the operational manager, it had an effect on the matron, it had an effect on the lead nurse and so I think it was felt all the way, all the way through really. (Occupational Therapist)

MANAGERIAL RESPONSES

Interviewees mentioned a variety of managerial responses, and these fell into three groups: support, investigation and change.

(a) Support

Support was, of course, received very positively by staff, who were emotionally traumatised by some SUIs. The presence of managers on the ward, visiting even if only for short periods to ask how staff were was highly valued. However this seemed more

likely to be mentioned if the incident was of a lesser severity, or if it was immediately apparent to everyone concerned that nothing could have been done to prevent its occurrence. A couple of interviewees mentioned that professionals from 'outside' had been drafted in to facilitate discussions, or that counselling for staff had been made available; both of these were experienced as supportive and helpful.

(b) Investigation

Investigation of the SUI was experienced in different ways. For very serious incidents, managers came to the ward and took away all notes and records, and while one interviewee saw this as normal procedure, another saw it as part of a process of looking for someone to blame. Discussion and debriefing about the incident occurred at different levels. The ward manager might bring the staff together to talk, or managers might come to the ward to discuss the event with the staff. These meetings could be helpful, as they got things into the open with the team, and enabled those who were not on duty at the time of the incident to talk more easily with those who were. However at these meetings difficult questions might be asked about why certain actions were or were not carried out, hence they could be uncomfortable.

I highlighted to people that, you know, 10 p.m. why would you give somebody a razor who is not going out to work in the morning, who is, who lives here, you know, 24 hours, why would you give him a razor? Oh I thought, you know, theory said, I said forget about theory, forget about, use your head. (Ward Manager)

(c) Change

Changes introduced in the wake of an SUI could take place straight away, or be introduced later as a response to issues thrown up by more thorough investigation (e.g. the removal of potential ligature points). Senior managers sometimes had to take more drastic action, such as suspending staff, occasionally ultimately terminating their employment. In due course a number of other changes were introduced to prevent the recurrence of the same incidents, these could include new policies, documentation, or physical changes to the ward environment. Interviewees mentioned new policies for special observation (with associated documentation), and changes to window and fence design, and to door security practices. New policies were also variously received by staff, with some seeing them as a device to further blame frontline staff when things went wrong, whilst others saw them, if followed, as protective of staff because they described best practice.

As these changes indicate, SUIs led to increases in the use of various means of containing acutely mentally disturbed patients, and a general tightening of all procedures in this area. This tended to happen quite separately from, and additionally to, the managerial responses to the incident. Interviewees mentioned a greater emphasis on risk assessment, a greater reluctance to give patients leave from the ward, more rigorous documentation and form-filling, more regular checks on patients throughout the day and night, and the nailing up of windows providing ventilation (as well as egress). Doctors noticed that nurses required them to take more decisions, with those decisions being recorded and signed for. Nurses noticed that doctors were more prone to put patients on

continuous special observation. All in all there was a heightened sense of vigilance and alertness.

PATIENT RESPONSES

There were few comments about the reactions of other patients to these incidents. Some interviewees spoke of breaking the news of a death to other patients, with an Occupational Therapist reporting that there had been discussion about how to do so, another mentioning that patients had received counselling, and a Consultant Psychiatrist who was struck by the lack of reaction.

We had lots of different meetings over the course of the day, which was really quite surreal, but one of them involved all the other patients because obviously we had to tell them and I was struck by how disinterested they superficially appeared. Very few of them seemed to take any of that information on board at all and I did talk about it with a few people subsequently, but people seemed to move on very quickly. (Consultant Psychiatrist)

Other comments about patient reactions were concern about copycat incidents, and an acknowledgement that patients experienced heightened fear and anxiety following an assault. Although the scope of the interview questions asked were broad, for example "did that have an impact on the ward", this was largely interpreted by interviewees to mean exclusively the staff.

DISCUSSION

Acute feelings were aroused in staff as a consequence of SUIs. Factors involved in the impact of SUIs appeared to be the severity and outcome of the incident, the strength of the relationship with the patient involved, the availability (or lack of) support and aftercare directly after the incident, the perception of whether the SUI could have been prevented in some way, and managerial responses.

Although some of the resulting feelings were akin to those following loss and bereavement, there was no obvious sequence or process to those feelings. However the nature of the feelings reported is similar to previous studies (Cotton 1983; Bartels 1987; Little 1992). Staff struggled to keep things in proportion regarding investigations when they were in a state of emotional shock and turmoil. Managers conducting the investigation were also not immune to anxiety and dysphoria, perhaps in part arising out of their complicity in organisational policy and practice, and in part out of the fact that they themselves will be judged by those above them, and increasingly by the media (Paterson and Stark 2001). Clearly managers, who are responsible for investigating the incident, and who may need support themselves, cannot at the same time give those staff support in a genuine or meaningful way. The inexorable pace of ward life compelled staff to put their feelings to one side and get on with caring for others. In combination with a lack of external support in many cases, this hindered staff in talking with each other about the event and its consequences.

Frontline staff in these interviews spoke of the value of outside support where it was made available. This could be commissioned by employers, but not provided by them, or provided by different managers or specialist personnel within the organisation (separate from those responsible for post-incident investigation). This would not then prejudice the outcome of any investigation. It could be that such help aids staff in recovering, but it could also be that it makes post-incident adjustment more difficult or worse. In the latter case, the pace of ward life and the lack of external support may actually be protective, and oblige staff to make a quick recovery. However, virtually no research has been done on the impact of SUIs on staff over the longer term. The staff in this study clearly expressed their need for (and valuing of) external support, and these evaluations should be taken seriously and support provided.

This study shows that SUIs had a continuing emotional and practice influence up to 10 years after they had occurred. Heightened alertness, attentiveness to risk assessment, more rigorously pursued policies, greater use of containment methods like special observation and higher environmental security may or may not be good. They are certainly better than a laissez-faire, lax, overconfident, complacent staff culture which is imbued with the idea that incidents cannot really be prevented. However the use of containment methods (special observation, security measures, sedating medication, seclusion etc.) can become excessive to the degree that they have a negative and harmful impact on patients (Dodds and Bowles 2001), or risk assessment can be emphasised to the point that it dominates practice and draws attention away from treatment (Hardwick 2003). Only when the SUI is as a result of containment itself does this work the other way (e.g. Goldney et al 1986; Blofeld et al 2003). Finding the right

balance between risk and containment is complicated by the emotions left over from professionals' previous experiences of SUIs, and a lack of evidence on what constitutes good risk assessment or an effective level of containment. Thus judgments both vary widely and tend to be emotionally charged, perhaps the least helpful of all possible resulting scenarios.

It may help staff cope with the emotional repercussions if they prepare themselves for this reality, and consider in advance the possibility that SUIs may occur (Bartels 1987). The benefits of this would be more than a mindset that is more prepared to cope with the aftermath of an incident. There is a temptation to ignore the chance of such things happening (coupled with a hope that they will happen on someone else's shift or ward), which engenders a sense of powerlessness and passivity (Brennan et al in press). By avoiding this, a sense of openness and alertness can be maintained. In turn that means that the possibility of SUIs will be discussed, risks will be borne in mind, procedures will be followed correctly, reviewed frequently, and improvements to practice implemented swiftly and thoroughly. Further sound foundations for good practice related to SUIs are appropriate training and regular clinical supervision. Advance preparation means that when, as inevitably happens sometimes, an SUI does occur, staff will be to a lesser degree shocked, doubtful, guilty, or anxious about the investigation that follows, and more confident about their practice.

By adopting Root Cause Analysis, both JCAHO in the US and the NPSA in the UK are making a determined effort to shift the focus of post-incident investigation away from blaming individuals and towards the ways systems of work facilitate or hinder

errors. As this study collected data on events prior to the diffusion of this new method in the UK, it cannot provide direct evidence on whether this will be successful. However it does indicate that the primary sources of blame are from the staff who were involved: they blame themselves and each other. Secondly, the sheer fact of the post-incident investigation, the necessity to write reports, be interviewed, submit documentary evidence, all intensify the self-scrutiny that is already underway. It may take some time for Root Cause Analysis to impact upon these processes, if it can do so at all.

Critical incident analysis used in intensive care and anaesthesia as a means of structuring, collating and analysing information on critical incidents. This information is used in quality assurance programmes to improve patient care and is embedded within the workplace culture. The technique of voluntary, anonymous, non-punitive critical incident reporting has the potential to identify incidents and latent errors before they become self-evident through a major incident. This systems approach focuses on organisational and communication problems. Standards and guidelines may help in weighing up the benefits and risks of invasive procedures, and interventional studies have shown that implementation of standards and guidelines can improve outcome (Frey & Argent, 2004). There are also many other forms of post-incident analysis, derived from both industrial and healthcare settings, which may be usefully applied in psychiatry (Woloshynowych et al 2005).

Our interviews showed that many staff responded positively to the outcome of investigations, and implemented improvements to practice that increased their confidence. However there were indications that for a few, the feeling that they were

being blamed led them to reject improved policy and documentation as instruments of further blame in the future, or as devices to protect the organisation from future blame. Such feelings of passivity, vulnerability, victimisation and hostility clearly have the capacity to undermine good practice, and may make future SUIs more likely.

The relative lack of reference to the reactions of patients contrasted with the emphasis on staff concerns. Staff's preoccupation with their own reactions is perhaps understandable when they are so strong, and when so much has to be coped with suddenly, all at once. The care of other patients could perhaps be better organised by careful planning in advance how these things should be done, and how they should be followed up. Staff would then have guidelines and a format to follow at a time when their cognitive abilities are likely to be somewhat curtailed. Bringing in outside support for staff might also give space for staff to deal with their emotions, so that they can more properly care for other patients. This issue is important, because it is clear that adverse incidents can trigger similar actions in other patients (Bowers et al in press a).

The context of acute psychiatry in the UK makes the post-incident actions recommended in the literature difficult to follow. Occupancy and throughput of patients are both at extremely high levels, and nursing and psychiatrist vacancy rates are high (Garcia et al 2005, Royal College of Psychiatrists 2001). Closing the ward to allow reflection, cancelling patient leave, and holding staff meetings are nearly impossible to do in these circumstances. The most serious SUIs can also get adverse and hostile national media coverage. In such a system under pressure, only significant planning and

extra investment is likely to provide the context within which staff and patients can receive the proper post-incident support and care.

LIMITATIONS AND CONCLUSIONS

A strength of this study is that findings are derived from interviews of a substantial number of different professionals. However a limitation is that those interviews took place in a single organisation at one point in time, and some of the events referred to by subjects were quite distant. The memory of those events might therefore have faded, and there was no opportunity to follow the changing emotional and other reactions over time. In addition, interviewees may not have wished to disclose the entire range of feelings they had in response to incidents so, for example, reports of less socially acceptable feelings such as anger may have been withheld by some.

The findings confirm previous studies that staff suffer considerable stress and trauma as a result of patient suicides and other serious untoward incidents, show that impact is not restricted to the ward where the patient resided, and that it can endure for many years. There is a need for staff to prepare themselves for these events in advance, and for them to receive external support once they have occurred. Both may assist staff to respond in ways that positively improve their practice, rather than adopt a position in which they see themselves as victims of punitive system that blames them for events outside of their control. It is as yet unclear whether Root Cause Analysis will bring improvements to staff's capacity to respond positively. Resource constraints and an over

pressured work environment handicap proper post-incident support and management. There is an urgent need for a deeper consideration of the responses of other patients to these incidents, and to plan in advance how to help them respond positively. Finally, it would appear that these incidents drive an ever-increasing ratchet of greater security and more intensive containment, with ultimately unknown effects.

ACKNOWLEDGEMENTS

The research upon which this publication is based has been supported by funding from the Tompkins Foundation and the Department of Health. However the views expressed in this publication are those of the authors and not necessarily those of the funding bodies.

REFERENCES

Bartels, S (1987) The aftermath of suicide on the psychiatric inpatient unit. General Hospital Psychiatry 9 (3):189-197.

Baxter, E. Hafner, R. J. and Holme, G. (1992) Assaults by patients: the experience and attitudes of psychiatric hospital nurses. Australian & New Zealand Journal of Psychiatry. 26 (4):567-573.

Blofeld, J Sallah, D. Sashidharan, S. P Stone, R and Struthers, J. (2003) Independent inquiry into the death of David Bennett. Cambridge: Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

Bowers, L. (in press) Patient homicide causes nursing staff to leave. Journal of Psychiatric and Mental Health Nursing

Bowers, L., Alexander, J. and Gaskell, C. (2003) A Controlled Trial Of An Intervention To Reduce Absconding From Acute Psychiatric Wards. Journal of Psychiatric and Mental Health Nursing 10:410–416

Bowers, L., Allan, T., Simpson, A., Nijman, H., and Warren, J. (in press a) Adverse incidents, patient flow and nursing workforce variables on acute psychiatric wards: The Tompkins Acute Ward Study. International Journal of Social Psychiatry

Bowers, L., Jarrett, M. Clark, N., Kiyimba, F. & McFarlane, L. (1999) Absconding: outcome and risk. Journal of Psychiatric and Mental Health Nursing 6(3)213-218

Bowers, L., Nijman, H., Allan, T., Simpson, A., Warren, J., and Turner, L. (2006) Prevention and management of aggression training and officially reported violent incidents: The Tompkins Acute Ward Study. Psychiatric Services 57: 1022-1026

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A. and Warren, J. (2005) The Nature and Purpose of Acute Psychiatric Wards: The Tompkins Acute Ward Study. Journal of Mental Health 14(6)625-635

Brennan, G., Flood, C. and Bowers, L. (in press) Constraints and blocks to change and improvement on acute psychiatric wards – lessons from the City Nurses project. Journal of Psychiatric and Mental Health Nursing

Brunnenberg, W. & Bijl, R. (1998) Suicide en suicidepreventie: in het psychiatrisch ziekenhuis [Suicide and suicide prevention in the psychiatric hospital]. Maandblad Geestelijke Volksgezondheid [Monthly Journal of Mental Health]

Clark, N., Kiyimba, F. Bowers, L., Jarrett, M. & McFarlane, L. (1999) Absconding: nurses views and reactions. Journal of Psychiatric and Mental Health Nursing 6(3)219-224

Cotton, P Drake, R Whitaker, A and Potter, J (1983) Dealing with suicide on a psychiatric inpatient unit. Hospital and Community Psychiatry 34 (1):55-58.

Department of Health (2001) Five-year report of the National Confidential Inquiry into Suicide and Homicide by people with mental illness. London: Department of Health.

Dodds P. and Bowles N. (2001) Dismantling formal observation and refocusing nursing activity in acute inpatient psychiatry: a case study. Journal of Psychiatric and Mental Health Nursing 8:183-188.

Dogget, A. M. (2004) A Statistical Comparison of Three Root Cause Analysis Tools. Journal of Industrial Technology 20(2)2-9

Frey, B. & Argent, A. (2004) Safe paediatric intensive care. Part 2: workplace organisation, critical incident monitoring and guidelines. Intensive Care Medicine 30(7)1292-7.

Garcia, I Kennett, C Quraishi, M and Durcan G. (2005) Acute Care 2004. A national survey of adult psychiatric wards in England, London: Sainsbury Centre for Mental Health.

Goldney, R. D. Spence, N. D. and Bowes, J. A. (1986) The safe use of high dose neuroleptics in a psychiatric intensive care unit. Australian and New Zealand Journal of Psychiatry 20 (3):370-375.

Hardwick, P. (2003) Formarrhoea. Psychiatric Bulletin 27: 388-389

Healthcare Commission (2005) 2005 performance ratings for mental health trusts: suicide rate. http://ratings2005.healthcarecommission.org.uk/home.asp

Joint Commission on the Accreditation of Healthcare Organizations (2005) Sentinel Event Policy and Procedures. http://www.jcaho.org

Little, J. (1992) Staff response to inpatient and outpatient suicide: What happened and what do we do? Australian and New Zealand Journal of Psychiatry 26 (2):162-167.

Main. T. F. (1957) The Ailment. British Journal of Medical Psychiatry 30: 129-145.

Maltsberger J and Buie, D (1974) Countertransference hate in the treatment of suicidal patients. Archives of General Psychiatry 30:625-633.

Morgan H. G. and Priest, P. (1991) Suicide and Other Unexpected Deaths among Psychiatric In-patients: The Bristol Confidential Inquiry. British Journal of Psychiatry 158:368-374.

National Patient Safety Agency (2006) National Reporting and Learning System. http://www.npsa.nhs.uk

Nijman HLI, Palmstierna T, Almvik R, Stolker JJ. (2004) Fifteen years of research with the Staff Observation Aggression Scale: a review. Acta Psychiatrica Scandinavica 2004: 1–10.

Paterson, B. Stark C. (2001) Social policy and mental illness in England in the 1990s: violence, moral panic and critical discourse. Journal of Psychiatric and Mental Health Nursing 8(3) 257-267

Powell, J. Geddes, J. Deeks, J. and Goldacre, H. K. (2000) Suicide in Psychiatric Hospital In-patients: Risk factors and their predictive power. British Journal of Psychiatry 176:266-272.

Rooney, J. L. and Vanden Heuvel, L. N. (2004) Root Cause Analysis For Beginners. Quality Progress, July, pp45-53

Royal College of Psychiatrists (2001). Roles and Responsibilities of a Consultant in General Psychiatry: Council report. London: Royal College of Psychiatrists.

Ryan J and Poster E (1989) The assaulted nurse: Short-term and long-term responses. Archives of Psychiatric Nursing 3 (6):323-331.

Simpson, A., Bowers, L., Alexander, J., Ridley, C. and Warren, J. (2005) Occupational Therapy and Multidisciplinary Working on Acute Psychiatric Wards: The Tompkins Acute Ward Study. British Journal of Occupational Therapy 68(12)545-552

Turns D and Gruenberg, E (1973) An attendant is murdered: The state hospital responds. Psychiatric Quarterly 47 (4):487-494.

Vogel R and Wolfersdorf, M (1987) Staff response to the suicide of psychiatric inpatients. The Journal of Crisis Intervention and Suicide Prevention 8 (2):178-184.

Woloshynowych M, Rogers S, Taylor-Adams S, Vincent C. (2005) The investigation and analysis of critical incidents and adverse events in healthcare. Health Technology Assessment 9(19).