Bury Safeguarding Partnership

Desktop Review

Lisa and Emily

Contents

Introduction

1. The Bury Integrated Partnership Board agreed to undertake a Desktop Review of two cases to consider the local systems and practice when an adult presents with a low Body Mass Index (BMI) and an eating disorder is suspected. These two different cases raised concerns that agencies were not following national guidance, a finding of a recently completed Safeguarding Adult Review – Jennifer. The aim of the review was to consider whether there was any additional learning from these cases and to consider how the safeguarding partnership can ensure and embed the changes in practice and systems that are required.

2. While there are findings from these two cases, the main aim of the review was to consider and compare the learning from the previous reviews.

The previous review

3. The headline issues in the previous review in Bury were in the following areas:
    - Lack of knowledge and use of MARSIPAN[1]/MEED[2] guidelines reduced the quality of care received.
    - Gaps in service provision meant there was no suitable service that could immediately meet Jennifer's needs, as a result Jennifer's care was transferred back to primary care which was not appropriate.
    - Miscommunication and misunderstandings led to delays in Jennifer receiving the care she required with catastrophic consequences.
    - Lack of a comprehensive risk assessment meant there was no comprehensive plan of care.
    - Opportunities to understand Jennifer's lived experience were missed.

[1] Management of Really Sick Patients with Anorexia Nervosa
[2] Medical Emergencies in Eating Disorders – used in patients with a recognised and diagnosed eating disorder

- Indicators that other issues were potentially exacerbating Jennifer's ill health were not fully explored.
- The 'opt – in' model in mental health services demonstrates that the most vulnerable patients may be missed.
- Professional inconsistency due to staff turnover in key agencies and inexperience

4. The consideration of the two additional cases shows that many of the issues continued in the two cases under review, as will be shown below.

The two cases considered

Adult Lisa
Considered at a Case Review Group meeting in October 2022 (and then again in March 2023), following the death of Lisa. Lisa had been admitted on two occasions (September and October 2022) with low BMI and died four days after being discharged. Lisa had been admitted in the past but had no prior diagnosis of an eating disorder. Lisa was of White British heritage. Whilst there is some evidence that MEED was followed initially, however as MEED only applies in its entirety to eating disorders, this was for refeeding and medical checks. The medical cause of death was malnutrition due to self-neglect.
Adult Emily
Considered at a Case Review Group meeting in January 2023, following the death of Emily in December 2022. Emily had two attendances to the ED between October 2022 and December 2022, with similar presenting complaints feeling unwell and vomiting with visible signs of malnourishment and low body weight. In attendance on both occasions was Mum, who reported no history of any underlying eating disorder. There is no evidence that MEED guidelines were followed, however the details of her actual BMI and body weight on admission are unclear. The provisional cause of death was malnutrition and anorexia.

The Process

5. An independent lead reviewer[3] was commissioned to work alongside local professionals to undertake the review and to consider what this told about the current state of practice and systems in Bury, bearing in mind the learning from the previous review. The information provided to the two Case Review Group meetings was considered alongside two SI[4] reports and any additional information requested from individual agencies as required. The report from Jennifer SAR was also considered.

[3] Nicki Walker-Hall is a previous Designated Nurse for Child Protection. She is an experienced safeguarding consultant who undertakes both children and adult safeguarding reviews. Nicki is entirely independent of the BISP.
[4] 243302 and 258231 completed by Northern Care Alliance NHS Foundation Trust

6. Managers of the services involved at the time, came together for a face to face group discussions with the lead reviewer, focusing on practice in the cases and the wider system. The group also considered evidence of progress, in order to identify where continued improvement actions might be required.

Consideration of the learning

7. By considering each of the cases, there was detailed and case specific analysis and the identification of learning.
8. The learning from the Jennifer SAR was compared with the learning in respect of the two cases, in the following areas:

Use of MARSIPAN/MEED guidelines

Previous learning
What was found in the Jennifer review was practitioners did not have full knowledge and understanding of the MARSIPAN guidelines, had no internal policies or guidance based on the guidelines, and had not been trained in their use; GP's were referring to NICE guidance. Those professionals who did have a working knowledge of the guidelines were yet to be leading on Jennifer's care as she had not been admitted to a specialist unit.

9. MARSIPAN Guidelines were superseded by MEED guidelines in May 2022 therefore MEED guidelines would have been in place during the review period for Lisa and Emily. In the MEED guidance, more emphasis has been placed on the risks posed by other eating disorders, including bulimia nervosa, avoidant restrictive food intake disorder, which carries risks due to weight loss and nutritional deficiencies and binge eating disorder, 'other specific feeding and eating disorders' and 'unspecified feeding or eating disorders' in which people have key symptoms of an eating disorder but do not meet full diagnostic criteria.

10. What can be seen in the two cases under review is an inconsistent use of the MEED guidelines and an over concentration on anorexia nervosa without considering alternate eating disorder diagnosis once anorexia nervosa had been ruled out. In Lisa's case ED staff had indicated a likelihood of Lisa's diagnosis being Anorexia Nervosa and that Lisa was at risk of refeeding symptoms and cardiac complications. A plan was formulated to follow the MEED guidelines. Lisa was commenced on fluid monitoring, a food chart, a stool chart and cardiac monitoring. Lisa was referred to the dietician and the Mental Health Liaison Team. A MUST assessment was completed which indicated Lisa was at high risk. Lisa's BMI was 10.88. When seen the following morning by the consultant Lisa denied an eating disorder and a diagnosis of self-neglect, peripheral neuropathy (existing condition), Hypothyroidism (existing condition), and alcohol excess were diagnosed. MEED guidelines continued to be followed and whilst it is clear Lisa was eating and drinking enough to gain some weight, Lisa frequently refused build-up supplements. Lisa was discharged but readmitted within days with not eating, right sided chest pain and feeling tired and

lethargic, Lisa also reported a history of diarrhoea for two weeks. On this occasion there was no evidence that MEED guidelines were followed, Lisa did not have her height and weight measured in ED and although a food chart was commenced this was not fully completed. Following admission Lisa was weighed but not measured. Lisa gave a different height which led to a belief that her BMI was 14.17 when she had lost 1.6kg. Inaccuracies in self-reporting and a lack of review of previous records did not assist practitioners to identify discrepancies. Lisa was being treated as a patient with diarrhoea with limited recognition of the level of risk as a complication of not eating. It is not clear on what basis Lisa was discharged as she was still not eating.

11. In Emily's case there had never been a suggestion of an eating disorder. It was reported that Emily had always been of slight build. Emily presented to the ED on the advice of the GP with vomiting and a BMI of 13.3. Emily was noted to look frail and malnourished, a MEED assessment was completed which recommended admission, referral to the mental health liaison team, and referral to the dietician & nutritional support team. None of these actions were completed as the treating clinician disagreed with the plan having established that Emily had acute renal failure and was diagnosed with viral gastroenteritis.

12. Emily was discharged home the following morning. The GP made contact four-five weeks after discharge and Emily reported she was eating normally and putting on weight. Emily was reviewed in person 2-3 weeks later when a history of dietary intake and a weight and height were measured; these confirmed weight gain and Emily's BMI was 14.48. The following week the GP made a referral to community dietetics.

13. Four days later Emily presented to ED with 'flu' like symptoms. Emily was triaged and whilst a history of being underweight was noted no height or weight measurements were taken. Emily was triaged to the Urgent Treatment Centre. MEED guidelines were not followed and, although a history of being underweight and weakness and muscle wasting were noted, no height and weight measurements were taken. Emily was diagnosed with an Lower Respiratory Tract Infection (LRTI) and discharged with antibiotics. The following day Emily died.

What needs further consideration?*
The two cases show that there remains an inconsistent picture in terms of consideration and use of MEED guidelines. Whilst neither of these subjects had a diagnosed eating disorder both presented with very low BMI's and both were at risk of refeeding syndrome. The possibility of an unspecified feeding or eating disorder needed further consideration. The treatment they received was inconsistent across attendances. On their first presentations to ED there was use of MEED guidelines but on subsequent attendances there was no consideration of following the guidelines and no reassessment to confirm or rule out a diagnosis of an eating disorder. Weight and height checks form a necessary part of assessing a patient and must become routine practice in all patients who appear, or have a history of being underweight.

Neither case met the criteria for anorexia nervosa however both were at high risk due to their low BMI's and associated symptoms. The hospital is introducing Disordered Eating guidance for those patients who present with low BMI but are not diagnosed with an eating disorder to assist medical teams in their management of such patients.

Transition and discharge points

Previous learning
What was learned in the Jennifer SAR was that points of transition and discharge did not go smoothly. Jennifer's care was transferred back to primary care despite Jennifer needing input from the specialist eating disorder unit. Whilst those in primary care regularly monitored Jennifer, they were not able to provide the constant monitoring and support Jennifer required.

14. Both Lisa and Emily were discharged home prior to onward referrals, identified as being required by members of the medical team, being completed. These included referrals to safeguarding around potential neglect/self-neglect, referrals to community dieticians, and in Lisa's case referral to an eating disorder service.

15. Lisa had a number of assessment by multiple disciplines during her first admission but the decision to discharge was taken without further consultation by the medical Consultant. Had this been done on a multi-disciplinary basis, further consideration could have been given to some of the behaviours Lisa was displaying and the previous recommendation for dual and liaison care.

16. Emily was discharged on the basis of a review of her condition in relation to a diagnosis of acute renal failure associated with vomiting due to viral gastroenteritis, anorexia nervosa having been rejected. Emily reported feeling better, having eaten and drank and having had no further diarrhoea. There was nothing recorded in terms of dietary intake, other than glucojuice that had been given when Emily's blood sugar level was assessed as low, for the whole of this attendance. Emily reported her GP had referred her to the dietician which was incorrect.

What needs further consideration?*
The need for greater communication between primary and secondary services. The need to corroborate information that is self-reported in groups of patients who are known to minimise their issues as is often the case in those with eating disorders. The need for decisions to discharge a patient have been involving all disciplines involved in the patients care during an in-patient stay. Consideration needs to be given to ensuring all referrals have been made and signed as complete prior to discharge, whether that is from the ED or a ward.

Information Sharing

Previous learning
Whilst information was shared between services the level and quality of the information shared was not sufficient for the recipient to have a clear understanding of what the issues were and what was required to address the issues. Miscommunication and misunderstandings led to delays in Jennifer receiving the care she required with catastrophic consequences. The sharing of incomplete information between ASC and the Access and Crisis Team meant when the Access and Crisis Team were making their decision as to whether to escalate the case, they made an assumption that Jennifer's physical observations were within the normal range.

17. In the Lisa and Emily cases there were also issues regarding information sharing and delays in referrals meant neither were receiving community dietetic input following their discharges.

18. In both cases there had been concerns raised regarding possible neglect or self-neglect by hospital clinicians however, this was not passed to ASC in the form of either safeguarding referrals or requests for a Care Act Assessment. As a result both subjects were not known to ASC and no assessments were completed.

What needs further consideration?*
Whenever a person is identified as having needs under the Care Act this should trigger a referral to ASC. If concerns relate to neglect these should be reported to the police. Consideration needs to be given to what is impeding staff from completing referrals and considering what partner agencies might be able to offer to patients.

Management of Risk

Previous learning
Whilst practitioners discussed areas where there were risks e.g. low potassium, low BMI, what they didn't do was to complete a comprehensive risk assessment that looked at all the risks and gave a clear understanding of what the risks were and the level of risk; restrictions and changes to the way practitioners were working as a result of Covid-19, impacted. Fully understanding the level of risk and any protective factors is crucial to making a comprehensive plan of care.

19. When Lisa attended the ED on the first occasion with a history of weight loss and poor appetite or 4 months a NEWS[5] score was completed scoring 0 – normal measurements. Over the next 3 hours this was repeated three times and on each occasion another reading fell outside of the normal parameters, so when seen by the medical doctor, Lisa was significantly hypotensive and hypothermic. The medical doctor identified the likelihood of anorexia nervosa and as a consequence Lisa was at high risk of refeeding syndrome and cardiac complications. Whilst alcohol intake was identified as a risk this was not followed through with a referral to the alcohol liaison service. By the following morning when assessed by the Consultant, Lisa's denial of an eating disorder and an impression that Lisa seemed to want to eat and drink, appears to have diminished the concerns. There is no reference to Lisa being at high risk of refeeding syndrome on this occasion, although MEED guidelines continue to be followed. A number of assessments by different doctors, alternate between believing the issue to be down to self-neglect, as Lisa was struggling to look after herself at home, and atypical anorexia nervosa. Lisa initially denied having an eating disorder but later reported she had a past history of bulimia nervosa – this fact was later relayed to the Psychiatrist who had undertaken the earlier assessment who indicated Lisa required the medical team to examine and perform MEED rcpsyc guidelines with dual care and liaison care; this was not followed through.

20. Risk in relation to Lisa's mobility was assessed, however there was no assessment of Lisa's ability to perform personal care and domestic tasks. Lisa was informed that it was important to keep her BMI above 13. Lisa was keen to be discharged and on the last weight before discharge she refused to remove her shoes so when weighed this presented an overly optimistic view of Lisa's progress (BMI 13.06). Misleading weight measurements are common behaviours in patients with eating disorders.

21. In addition, Lisa had started to have some twitching. This was identified as potentially down to recovery from refeeding but could equally have been due to alcohol withdrawal especially as Lisa had been refusing all medication (including medication to reduce the impact of withdrawing from alcohol) in the 48 hours prior to discharge. These factors do not appear to have been taken into full account at point of discharge. Discharge appears to have been based on an overall increase in weight, an improvement in mobility to pre-admission capability, and a normal Potassium level.

22. When Emily attended ED for the first time the department was extremely busy with a RAG rating of Red which had been escalated to Divisional Directors. ED was also short staffed by 1 medical doctor and 3 registered nurses. There is evidence of a NEWS score being completed and scoring for a sepsis screen although the Sepsis Six documentation bundle was not completed. Emily was hypotensive and tachycardic. IV antibiotics in line with treating sepsis commenced until blood results identified renal failure with metabolic acidosis. It was thought the most likely cause was due to acute gastroenteritis. Over the following hours Emily's blood results showed improvement. Emily's height and weight were not checked. Emily had a low blood sugar which was treated via adjustment to the IV fluids being administered. A

[5] National Early Warning Score

MEED assessment and Risk Stratification was completed and as a result of the findings ward admission, referral to the MHLT and referral to the dietician nutritional support team was recommended, none of which happened and Emily was discharged within 24 hours of being brought into the ED.

23. MEED guidance indicates that if a risk factor is present (e.g. 'red risk' on BMI or acute risk of suicide) that would in either condition lead to a recommendation for admission, the patient should be admitted until that risk factor no longer meets admission criteria.

24. When a patient has been classified as high risk, then immediate action must be taken. The patient should be referred to a dietician or a nutritional support team. Goals should be set to improve and increase nutritional intake and this care plan should be reviewed weekly in hospitals and monthly in community settings. Lisa's discharge meant this should be being monitored by the community dietician however Lisa was never seen by community dietetics prior to her death.

25. A number of Malnutrition Universal Screening Tool MUST[6] assessments were completed on Lisa during her admission these were always scored as high risk.

What needs further consideration?*
Significant improvement has been demonstrated in both these cases when MEED guidance has been followed. However whilst risk was assessed, and the initial management of those risks was as expected and demonstrated improvement, as time progressed new risks were not being taken into sufficient account and specified actions were not completed. The question is how do you keep up the momentum, how do you keep risk at the forefront of practitioners minds, and what needs to change in order that prescribed actions have been taken.

Assessments

Previous learning
In general there was a lack of assessment in this case. Concentration on getting Jennifer medically fit meant that no holistic assessment to consider all Jennifer's care and support needs was ever completed. Such an assessment may have identified further concerns around Jennifer's alcohol use that could have led to further referrals and treatment. Whilst assessments took place at points of admission, no further assessments were undertaken during the admission to demonstrate whether there had been progress or deterioration. There was a lack of risk assessment.

[6] MUST is a five-step screening tool that is used to identify whether adults are malnourished, at risk of becoming malnutrition or obese

26. There is evidence of a number of assessments being completed in both these cases, however not all additional assessments identified as being required were completed. In Lisa's case there was a missed opportunity to follow up on concerns regarding alcohol use with a referral to the alcohol liaison team and as a result there was no assessment relating to alcohol. In addition assessments of Lisa's ability to manage her own personal care and domestic tasks were not completed.

27. Lisa when assessed by the psychiatrist on-call did not meet the criteria for an eating disorder and her weight loss was deemed to be as a result of her struggling to look after herself and reduced appetite. Lisa was to be seen by the dietician and a requirement was for social input prior to discharge.

28. In a later assessment, during the same admission, by a non-psychiatric doctor, Lisa indicated a past history of bulimia nervosa. This assessment concluded that Lisa was at high risk to physical health and death and found Lisa met the criteria for atypical nervosa.

29. Lisa was seen by a dietician but there was no social care input prior to Lisa's discharge. The reviewer learned that the lack of social care input was likely to have been impacted by a decision taken during the Covid-19 pandemic, not to complete social care needs assessments whilst patients were in hospital. That decision has not been rescinded since restrictions were lifted. However, in this case no referral was made to ASC for an assessment.

30. This lack of referral meant no social care assessment was completed and if Lisa's physical condition was as a result of her struggling to care for herself or self-neglect this was not clarified – this is a missed opportunity.

What needs further consideration? *
There are similar findings across all three cases with assessments being completed initially and then inaction on the recommendations for further assessments. How can this be addressed? There is a requirement to make onward referrals and to involve the right service to meet the identified needs; this is not happening consistently. After initial assessment which acts as a baseline there needs to be continued reassessment of progress in terms of cardiac function, blood chemistry, compliance with diet, fluids and medication, and weighing in patients with low BMIs. Clarity on who is overseeing this, and how frequently this needs to be done should be actioned through a care plan that spans primary and secondary care services.

Mental Capacity Act

Previous learning
There is some evidence that practitioners were considering Jennifer's mental capacity although they were looking to psychiatric colleagues to undertake the assessment rather than complete the assessment themselves. Conducting mental capacity assessments should be part of all practitioners business. Practitioners should be enabled to have a global conversation regarding mental capacity. There are dangers in looking to other specialists to complete mental capacity assessments. In this case insufficient information sharing to the psychiatrist, on one occasion, led to an assessment of Jennifer's mental capacity to agree or not to the discharge and treatment plan. This assessment missed an opportunity to assess Jennifer's mental capacity to agree to a refeeding programme and transfer to a SEDU. Jennifer's partner was thought to be a protective factor but the reviewer has not been provided with any evidence that Jennifer's family and partner were ever contacted to establish whether this was factually correct.

31. Following ED attendance and subsequent admission, when Lisa was seen by health disciplines for the first time there is record that consent to treatment/involvement was sought and there is an initial record that there was no reason to doubt capacity. Whilst an in-patient Lisa refused medication, diet and fluids on twenty-one occasions however this only prompted a recording of her capacity to make that decision on four occasions. During Lisa's admission's there was little contact with Lisa's family to gain their views on Lisa's condition even though her sister was recorded as being Lisa's carer. When staff spoke to her sister, she expressed concerns re Lisa going home too soon and as a result both proposed discharges were delayed.
32. During Emily's ED attendances there is no mention of mental capacity however it is likely that staff in line with legislation assumed capacity as there wasn't a reason to doubt her ability to make decisions. Emily was invariably accompanied during her attendances; it is not known whether her mothers presence may have impacted on her decision making.
33. The hospital has a programme of audit which aligns with the key lines of enquiry of the CQC. Part of this audit considers compliance with the MCA. This halted during the pandemic but has now restarted. The hospital is currently compliant.

What needs further consideration? *
For Lisa there were multiple occasions when practitioners should have been considering whether Lisa had mental capacity to refuse medication, diet and fluids. It appears that some practitioners are either not recognising the need to consider mental capacity in such circumstances, or not recording positive outcomes of assessments. It has been reported that the e-learning training is not sufficiently supporting staff and there is a reticence by practitioners to be the decision maker. The inclusion of Best Interest and Unwise decisions within MCA training is causing anxiety that is acting as a barrier to practitioners completing mental capacity assessments. It is believed that promoting the mental capacity assessment as a tool to be used during every assessment, and using case studies to train practitioners, might be a better way forward. Within some agencies current self-audits are only reviewing cases where a mental capacity assessment has been completed. This is giving a falsely positive view of how well that agency is complying. Random samples of cases would give a more realistic representation of this.

Mental health support

Previous learning
Despite Jennifer's severe eating disorder and anxiety diagnoses, Jennifer received no ongoing mental health support throughout the whole period under review. Had Jennifer been admitted to or under the care of the SEDU, mental health support and care would have been an integral part of the care she would have received. The 'opt – in' model in mental health services demonstrates that the most vulnerable patients may be missed.

34. Neither Lisa or Emily received any ongoing mental health service support.

35. In Lisa's case she was seen in a mental health clinic on the 18th March 2021, when she was not registered with a GP. A history of anxiety, depression and reduced appetite were noted. It was requested that when she did register with a GP that the GP follow her up regarding mental health review and alcohol intake. This would seem to have slipped through the net, as there is no mechanism for checking historic GP electronic referral/recording systems when a patient registers with a new GP. It is not clear why the person assessing Lisa didn't make referrals knowing Lisa had no GP, and unfortunately Lisa did not make an appointment with the GP to discuss her issues. During Lisa's admission there appears to have been a difference of opinion between medical doctors and Psychiatry as to whether Lisa required mental health support. Lisa's self-report that any mental health issues were many years ago and related to work, are at odds with what could have been known if Lisa's records had been accessed.

36. In Emily's case, she had been signed as unfit for work for many years due to anxiety and depression. There had been little input or face to face contact with the GP, although the GP had referred Emily to mental health services. However it is not clear whether Emily had engaged. In the ED, Emily was referred to and assessed by the MHLT and whilst she was identified as anxious and a query was raised regarding possibly needing a mental health review, the treating medic didn't feel she had an acute mental illness to warrant in-patient psychiatric input or an ED mental health referral, therefore no further review was sought.

What needs further consideration? *
Health staff do not have access to each other's records, and this is leading to an over reliance on self-report. How can information known to other health services e.g. GP's and Mental Health Services be obtained in a timely manner so it can inform assessments. Some services are looking to GP's to make referrals they have identified as being required. Why? Consideration needs to be given to whether the 'opt-in' mental health model is a sufficiently robust model to meet clients mental health needs.

Professional curiosity and escalation

Previous learning
Opportunities to understand Jennifer's lived experience were missed. Indicators that other issues were potentially exacerbating Jennifer's ill health were not fully explored. When gaps in service provision meant there was no suitable service that could meet Jennifer's needs this should have led to escalation to commissioners, this did not happen. When frontline practitioners did raise their concerns with managers, no solutions that would address Jennifer's needs were forth coming.

37. In Lisa's case there is evidence that deterioration in Lisa's vital signs was escalated by nursing staff to medical staff and that did lead to more timely review. There was a difference of opinion regarding LISA's diagnosis and whilst both a nurse and a doctor challenged the senior doctors opinion, rationalised that, although anorexia nervosa had not been diagnosed, MEED guidelines were being followed. It is positive that the nurse challenged the doctor although this did not change the opinion of the doctor. Historically there is little evidence that nurses would challenge doctors; the culture was that a doctors opinion would outweigh that of a nurse. The nurse could have, but did not, escalate the concern to their own senior for an independent opinion.

38. The reviewer learned that there has generally been a cultural expectation that managers have the solution; this is not always the case. It could be argued that the practitioner in this case had considered and rejected the need to escalate. Whilst nurses do tend to collaborate this is not the same for medics who are often the final decision maker. What is required is a problem solving approach.

39. The Integrated Therapy Team were not sufficiently curious to establish whether there was a physical barrier to Lisa preparing her own food. An assessment of this could have triggered a referral to ASC and might have led to greater clarity as to whether the underlying cause of Lisa's low BMI was physical or mental, which would have been helpful moving forward.

40. In Emily's case issues relating to staff shortages and overload in the ED department were escalated to senior managers. When Emily's blood sugar was outside normal parameters this was also escalated. Emily required cardiac monitoring but because of a lack of cubicle this was not possible, this was escalated but remained unresolved for a significant time.

41. Emily's mother was either present during all attendances and consultations. No consideration appears to have been given as to why that might have been or whether that might have impacted on the information Emily was giving. Both Emily and mother denied anorexia nervosa although mother did agree Emily was malnourished.

42. Emily had been too unwell to work for many months however, there was not sufficient curiosity to establish what her lived experience was either at the time or in the past. Emily required regular 'fit notes'. This gave the GP an opportunity to learn more information about her day to day. Little was established regarding the dynamic in the relationship between mother and Emily and the roles they had. There was no consideration as to whether Emily's mother may have been eligible for a carers assessment. It is known that Emily refused some routine health screening, Emily indicated her mother had deterred her; it appears Emily was living a very constrained life. Although Emily was off work on health grounds there was very little health input.

43. It was good practice for the GP to verify Emily's food and alcohol intake however, they just accepted Emily's word.

44. The discharge letter to the GP asks for repeat of bloods and asks the GP to consider a Psychiatric referral, but doesn't provide any reason why the GP might need to consider this. Further clarification was not sought and no referral to Psychiatry was made.

What needs further consideration? *
There is a need to enhance professional curiosity. Practitioners need to exploit opportunities to carry out holistic assessments that help them understand more about a clients lived experience. Practitioners need to explore and make use of history in considering the needs of clients Does the culture with the ED support challenge of doctors by nurses or does the opinion of the doctor always outweigh that of a nurse? Practitioners across all disciplines need to be supported by managers to adopt a problem solving approach in circumstances where there is professional disagreement.

Conclusion and recommendations

45. It is clear from consideration of these cases that there remain a number of areas of practice that require improvements, despite the efforts of partner agencies and the Partnership to ensure that the learning from reviews is disseminated and that recommendations have been implemented.

46. The following recommendation is made:

Recommendation 1

That consideration is given to how to implement all of the suggestions included in the analysis sections of this report entitled ‘what requires further consideration’ (see*) in order to improve practice in and between partner agencies.