Chief Psychiatrist's Quality and Safety Bulletin 2018/1

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Purpose

The Chief Psychiatrist has undertaken to write two Quality and Safety bulletins each year summarising cases that highlight critical quality and safety themes for the attention of mental health services and mental health community support services. The bulletins cover a range of topics, including recent recommendations from the Coroners Court of Victoria. Services are encouraged to review their local practices and procedures and to take action where necessary to address any gaps.

This edition includes material from the private sector relevant to clinicians in public services. Patients' personal details have been obscured to maintain confidentiality.

Services are asked to share the bulletin with all clinical staff. Copies of the bulletins can be found on the Chief Psychiatrist's website.

1. Ligature point audits

A young woman with a diagnosis of Borderline Personality Disorder was admitted to an inpatient unit. She had history of repeated suicide attempts in context of difficulty in managing her emotions and interpersonal relationships. She had prolonged admissions to hospital in past and her overall care included regular risk assessments. During the most recent admission, she used a door handle in a visitor's toilet as a ligature point to hang herself with her pyjamas.

The Coroner investigated her medical care including management of self-harm behaviours and nursing observations on the inpatient unit and found them appropriate. The Coroner also focused on tools used for audit of ligature points and the training of auditors in application of the tools. The service had conducted a ligature audit previously but the door handle was not considered as a potential ligature point. Following the incident, the service re-audited the inpatient unit and the door handles were replaced with safer options. The service also submitted information to the Coroner about the new suite of audit tools used after the incident.

Coroner's recommendation

To improve the effectiveness of the required ligature point auditing tools, auditor training and their application in acute mental health units, the Department of Health and Human Services work with Area Mental Health Services to develop advice and examples of ligature audit tools that are assessed as being appropriate to the task, and effective in meeting their purpose.

Chief Psychiatrist's comments

The Coroner was concerned about the ligature audit process. Services must use standardised tools for ligature audit of all acute inpatient units at least annually. The audit team must include a staff member who does not work in the unit.

2. Shared care of patients between public and private sector

A middle aged man with a long history of psychiatric illness was under the care of a number of mental health services and clinicians in the years preceding his death. He had diagnoses of Bipolar Disorder and

Borderline Personality Disorder. He remained under the care of his private psychiatrist, psychologist and GP while also simultaneously being under the care of public mental health service. In the weeks and months preceding his death, he had multiple presentations to crisis team and emergency department with suicidal thoughts, violence and threats towards family members, and non-adherence with medications. Subsequently, he died by jumping in front of a train.

The Coroners Prevention Unit conducted a review of his treatment and identified the following issues –

- Difference of opinion among the clinicians regarding the diagnoses resulting in conflicting messages about management.
- Lack of involvement of the patient and carer in treatment decisions.
- Response to his deteriorating mental state with escalating presentations to the emergency department and whether the he should have been admitted to an inpatient unit as a compulsory patient under the *Mental Health Act 2014* especially in light of his repeated presentation with suicidal thoughts, non-adherence with medications and ongoing psychosocial issues.

The mental health service conducted an internal review and made a series of recommendations addressing the issues outlined above. The Coroner commented favourably on these recommendations.

The Coroner concluded that *"viewed separately, each of the clinicians acted reasonably and appropriately in their diagnosis and treatment of the patient".*

Coroner's recommendation

The Office of Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists develop a shared protocol or guidelines to provide guidance for clinicians who share the responsibility for the care of patients across the public and private sector. Matters that should be addressed include communication, transparency of arrangements with patients and carers, clinical responsibility in periods of crisis and negotiated care planning.

Chief Psychiatrist's comments

The Chief Psychiatrist endorses this recommendation. This issue has also been identified as a recommendation in internal reviews conducted by mental health services. The Office of Chief Psychiatrist will collaborate with the Royal Australian and New Zealand College of Psychiatrists to develop guidelines for shared care of patients between public and private sectors.

Elements of good shared care include agreed protocols for contacting various treatment providers within a specified time frame. This includes regular updates about the progress. It should also identify documented responsibilities for each provider besides the frequency and form of the communication between providers.

3. Discharge medications

A young man had repeated presentations with self-harm and suicide attempts over a short period of time. He had a diagnosis of Borderline Personality Disorder and alcohol abuse. He had multiple admissions to hospitals during this time. Following his last admission to an inpatient unit after a suicide attempt, he was discharged into the care of crisis team. At discharge he was prescribed and supplied three months' supply of medications. He died by overdosing on same medication two weeks later.

The mental health service conducted an internal review and identified issues with hospital electronic prescribing system, which was set as a default to order the PBS maximum quantity for any discharge medication. The service implemented changes to prescribing and dispensing of medications to patients on discharge limiting it to two weeks supply on discharge.

The Coroner accepted the response from the service and didn't identify any further opportunities for prevention.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the findings of the internal review. Services must have policies about the amount of medication prescribed and dispensed on discharge from the hospital. Further, consideration must be given to risk assessments for further ongoing prescribing of medications in the community. It is also imperative to check what other medications are prescribed for the patient and maintain liaison with other prescribers.

4. Discharge against medical advice

A middle aged woman with depression and suicidal thoughts was referred to public mental health service for assessment and management. Following an assessment, she was offered information about public

and private mental health care. The patient subsequently made an appointment with a private psychiatrist who suggested an admission to private hospital after an initial assessment. After a stay of one week, the patient discharged herself against medical advice from the private hospital on a weekend. The staff at hospital followed the appropriate policy for discharge against medical advice. The patient was not found to have met criteria for assessment under the *Mental Health Act 2014* and was discharged. She went home with a friend. The patient died by hanging herself later that day in her house.

The Coroner referred the case to the Coroners Prevention Unit for a review. The Coroners Prevention Unit identified a number of issues -

- Should the private psychiatrist have spoken to the patient directly, either in person or by telephone, to persuade her to continue treatment as an inpatient?
- Should a follow-up appointment with the psychiatrist have been scheduled soon after discharge?
- Did the clinical file correctly reflect discussions with the next of kin about strategies to reduce the risk of suicide?

The private hospital and the psychiatrist provided further responses about steps taken to address the above queries before the patient was discharged.

The Coroner concluded that the risk of suicide is dynamic in nature. The Coroner identified the importance of good clinical follow up post discharge in reducing that risk. The Coroner also noted the importance of education to next of kin about risks associated with discharge and the safety measures such as follow up appointments and access to psychiatric triage and crisis teams.

There was no recommendation from the coroner, concluding that the patient's suicide may not have been preventable even with onward referral to appropriate community services.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the Coroner's comments. Discharge against medical advice occurs infrequently in public mental health services as well. Services are reminded to have policies and procedures in place to address these issues. Staff should have access to senior staff including Psychiatrists for any patient who is requesting discharge against medical advice. This is particularly important during afterhours and on weekends. Appropriate steps must be taken to ensure ongoing follow up after discharge.

5. Safety checks in residential facilities

A young man with a long history of multiple diagnoses including Borderline Personality Disorder, PTSD and substance abuse was living at a residential program managed by a Mental Health Community Support Service. He had regular reviews with his GP. He was not a current patient of the local mental health service although he had previous involvement with them. A few days prior to his death, he was feeling physically unwell and spoke to his mother. He felt better the next day but did not respond to further telephone calls from her. When she was unable to contact him the next day, she spoke to staff who told her that he had been sighted going out. On the third day, she rang the facility again after failing to reach him by phone. Staff checked his room (but not the ensuite) and found no sign of him. On fourth day, the mother travelled to the facility and asked staff to check his room. He was found dead in the ensuite. The cause of death could not be ascertained.

The Coroner asked a Mental Health Investigator from Coroners Prevention Unit to review the adequacy of the care provided at the facility. It was evident that the facility was not a clinical facility and tracking of residents was not expected. There were no staff on site after 8 pm but patients were provided information about an on call after-hours service for any ill health.

The Mental Health Community Support Service also conducted an internal review of the incident and identified four recommendations –

- Resident safety is to be checked every 24 hours at a minimum.
- Staff rosters are to be reviewed to reduce the hours without staff onsite on weekends.
- A safe is to be placed in each resident's room for storage of medications.
- All staff are to receive first aid training.

The Mental Health Investigator commented that the recommendations will specifically reduce the likelihood of the circumstances of a resident not being located for a number of days. The Coroner also commented that it was not known whether an earlier search of the ensuite would have prevented the death. There was no recommendation from the Coroner.

Chief Psychiatrist's comment

The Chief Psychiatrist supports the initiatives to ensure resident safety in residential facilities, clinical as well as non-clinical. Mental health service providers should ensure that there are systems in place to check residents' whereabouts and that staff know what procedures to follow when residents cannot be located within a reasonable timeframe. This also applies to Community Care Units and Prevention And Recovery Care units.

6. Varenicline (Champix) and suicide

A young man received treatment for a brief psychotic episode. He had a good recovery from the episode and returned back to work. Under the guidance of his treating psychiatrist, he gradually reduced and stopped his medications. He stayed well for more than a year and then had another psychotic episode, which responded well to treatment. Subsequently, the patient was prescribed Varenicline to help quit smoking. Although he was not observed to be unwell or depressed, he died by suicide eight days later. Toxicological analysis revealed the presence of Varenicline. The patient's family wrote to the Coroner concerned that Varenicline may have been a significant contributing factor to the death.

The Coroner stated that "*while the investigation was unable to identify any definitive link between the prescription of Varenicline and patient's death, I note that Victorian coroners have observed an increasing number of deaths by suicide where Varenicline is present in the results of the toxicological analysis performed on the deceased".*

The Coroner also commented that the evidence base for Varenicline's association with suicide is still very limited[1].

Chief Psychiatrist's comments

Mental health patients have high rates of smoking and psychiatrists may prescribe Varenicline as part of a smoking cessation plan. Although Varenicline is mostly prescribed by GPs, it is important that staff are aware of this association and discuss this with the patients and carers where appropriate.

1. Wu, Q., Gilbody, S., Peckham, E., Brabyn, S., and Parrott, S. (2016) Varenicline for smoking cessation and reduction in people with severe mental illnesses: systematic review and meta-analysis. Addiction, 111: 1554–1567. doi:10.1111/add.13415.

7. Patients leaving from Emergency Departments

A number of instances have been reported to the Chief Psychiatrist of patients leaving from an emergency department and subsequently meeting with an adverse outcome.

It is suggested that services take steps to prevent absconding by patients on Assessment Orders who are awaiting admission to an inpatient unit, as well as patients brought to the emergency department by police under section 351 of the *Mental Health Act 2014*. These steps include -

- Conducting a prompt mental health assessment, including an assessment of absconding risk.

  Locating the patient's bed in a safe location within the department.
- Providing 1:1 nursing.
- Calling a Code if the person tries to leave the department.

8. Deteriorating patients

Issues about escalation of care were identified in services' internal reviews of a number of deaths notified to the Chief Psychiatrist. These issues included the availability of senior staff and psychiatrists for discussion about patients who were deteriorating or difficult to engage. In many instances, junior staff were uncertain when to escalate concerns. Most of these incidents related to patients receiving care in community.

Recognition that a patient is deteriorating is critical. Besides changes in mental state, other indicators that a patient is deteriorating include repeated cancelled appointments or 'no shows' and repeated presentations to emergency departments or crisis teams. In such circumstances it is vital that staff are encouraged to discuss these issues with senior staff or in other forums like clinical reviews or handovers.

From the internal reviews, it was recommended that -

- Guidelines should be provided to staff about when and how to escalate concerns, deal with cancelled appointments and when to consider a home visit.
- Home visits must sometimes be preferred to phone contacts to help clarify clinical urgency.
- Information should be sought from a nominated person, family member, next of kin or carer to help clarify the reasons for deterioration and facilitate early assessment, including a home visit.

- There should be clarity about the frequency of face to face reviews with medical staff and other clinicians.
- For those who present repeatedly to emergency departments in a short time frame, further discussion should be undertaken with senior staff to identify more effective solutions.

9. Clinical handover

Clinical handover, information sharing and documentation standards continue to be highlighted as major issues in some Coronial investigations and many services' internal reviews. Although not necessarily identified as direct causative factors in the incidents, they remain issues of significant concern. A number of reviews recommended review of clinical handover procedures and information sharing between –

- Inpatient and community teams during admission and prior to discharge
- The emergency department and community teams after patient attendance at emergency department
- Area mental health service and primary care providers including GPs, psychiatrists and psychologists especially during transition from one level of care to another, e.g. discharge or refusal to accept care.
- The recommendations also include timely and appropriate documentation of clinical handover process.

In situations where a referral is not accepted, clear communication is critical with the parties who initiated the referral, for example family members or the police. These discussions must be recorded in the clinical record.

10. Clozapine and constipation

A patient who had been on Clozapine for several years was admitted to hospital with a relapse due to non-adherence. He was recommenced on Clozapine with good response. Complaints of constipation were treated appropriately but unsuccessfully. The medical team suspected that worsening abdominal pain was due to faecal impaction but their treatments also failed to help. Rapidly progressive abdominal distension culminated in a Code Blue a few hours later. Bowel obstruction was suspected and an exploratory laparotomy was undertaken, but the patient died during the procedure. The Forensic pathologist conducted an autopsy and identified cause of death as "complications of large bowel pseudo-obstruction" due to faecal impaction. The Coroner concluded that his medical care and management was reasonable and appropriate. There was no recommendation from the coroner.

The service, following a review of its own care, undertook to maintain bowel charts for all patients prescribed Clozapine in an inpatient setting, and to educate staff in the management of constipation. Community clinicians should also regularly enquire about bowel function for people taking Clozapine.