Chief Psychiatrist's Quality and Safety Bulletin 2017/1

Leave arrangements; ligature safety; heat plans; checking CMI; care transitions; pneumonia

Purpose

The Chief Psychiatrist has undertaken to write two bulletins each year summarising cases that highlight critical quality and safety themes for the attention of mental health services. Four of the six themes selected for this first bulletin for 2017 concern recent recommendations from the Coroners Court of Victoria. Subsequent bulletins might cover a wider range of topics.

Background to this issue

Mental health services must notify the Chief Psychiatrist of all deaths that are reportable within the meaning of the *Coroner's Act 2008,* as well as deaths from any cause while on leave or after absconding from an inpatient unit; within 24 hours of discharge from an inpatient unit; following transfer from an inpatient unit to some other ward; or during an emergency department stay while under the Mental Health Act (including section 351). For more details see *Reportable Deaths: Chief Psychiatrist's Guideline, Summary Version (2016)*.

The Chief Psychiatrist receives coroners' reports of these deaths and is therefore in a unique position to identify emerging themes across the service system. The summaries presented below draw together recent key clinical practice issues to highlight opportunities to improve the quality and safety of the services provided to mental health consumers. Services are encouraged to review their local practices and procedures and to take action where necessary to address any gaps. Personal details have been obscured to maintain confidentiality.

1. Leave from inpatient and residential settings

A young woman, whose history included substance abuse and suicide attempts in the context of interpersonal difficulties, died by suicide from multiple drug toxicity while on leave from an Enhanced Prevention and Recovery Care (E-PARC) facility. Transfer to E-PARC for ongoing treatment and support followed a brief admissions to an inpatient unit and PARC. The risk of relapse was recognised to be high. On the first day at E-PARC, the resident requested and was granted weekend leave after being assessed not to have suicidal thoughts. She was found dead at home the next day.

The service had no procedures regarding leave from PARC or E-PARC at the time of the incident. A procedure was developed soon afterwards detailing leave pre-planning, pre-leave risk assessment, mental state assessment and residents' responsibilities while on leave.

Coroner's recommendation

The Coroner recommended that in the first leave event where the resident will be alone PARC staff encourage the resident to notify family and/or friends of their leave plans or consent to staff notifying them. If this fails, PARC staff should make telephone contact with the resident while on leave to offer support and check safety.

Chief Psychiatrist's comments

The Chief Psychiatrist supports this recommendation. Leave decisions can be complex, especially for voluntary consumers. Services must review their policies and procedures regarding leave from inpatient, secure, residential and PARC facilities to ensure they meet contemporary requirements of engaging the consumer, conducting appropriate risk and mental state assessments and collaborating with carers, family members and/or friends to

support the consumer while on leave. It is also important to discuss planned activities, abstaining from alcohol and other drugs, medication adherence, safety plans and emergency contact details. Leave must be reviewed afterwards with feedback from all relevant parties regarding progress and challenges. All discussions must be documented appropriately in the clinical file.

Services are also reminded to consider the Chief Psychiatrist's guideline, *Inpatient Leave of Absence*, available at www2.health.vic.gov.au

2. Incident scene recording: ward safety checks

A young man committed suicide by hanging in an inpatient unit. The ligature had been secured around the housing of an 'anti-ligature' hook installed behind a bathroom door. The provenance of the ligature remained undetermined (the patient died several days after the incident and the scene had not been preserved or photographed).

The mental health service made a series of improvements after the incident including removing the hooks, upgrading the personal alarm system to locate staff in the unit in the event of an emergency, modifying bedroom doors to allow them to open in both directions to stop consumers barricading themselves in their room, and implementing a new ligature audit tool suitable for mental health settings. The Coroner commented favourably on these improvements.

Coroner's recommendations

Besides a recommendation to remove the hooks, Coroner also recommended that the service develop a procedure that addresses the need for scene preservation and/or recording in circumstances where a serious suicide attempt has taken place in an inpatient facility in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandated or otherwise) and to comply more broadly with their duty of care obligations.

Chief Psychiatrist's comments

The Chief Psychiatrist endorses these recommendations. Additional safety measures are addressed in the guideline, *Criteria for Searches to Maintain Safety in an Inpatient Unit for Patients, Visitors and Staff (2014)*, which refers to the need in certain circumstances to remove items that have the potential to place patients, visitors and staff at risk of harm.

Suicide risk will be reduced if inpatients are actively engaged by clinicians and feel supported. Services are asked to check their nursing observation policy against the Chief Psychiatrist's guideline *Nursing Observation through Engagement in Psychiatric Inpatient Care (2014)*. Making purposeful, as opposed to 'tick box', observations informs nursing decisions about how to respond to consumers who may be at risk of suicide, self-harm, aggression or absconding.

3. Heat health plan

A middle-aged woman with psychosis and multiple medical conditions died after collapsing while on approved leave from an inpatient unit. While no precise cause of death could be established, the Coroner's pathologist believed that the very hot weather (temperatures on the day reached 38^{o}C) compounded the effects of hyperglycaemia, hypertension and psychotropic medications.

Coroner's recommendations

The Coroner recommended that:

1. *the Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at the times of extreme weather conditions and*
2. *that services incorporate environmental and climate conditions into their leave policies.*

Chief Psychiatrist's comment

The Chief Psychiatrist recently circulated an advisory notice, *Heat Health Plans for Vulnerable Mental Health Consumers (2016)*, requesting services to develop appropriate policies and procedures to care for highly vulnerable individuals in extreme weather conditions. Strategies might include delaying leave until conditions have improved; arranging or providing transport, or meeting the person's need in some other way.

4. Checking Client Management Interface (CMI) prior to a new assessment

A young man with depression and suicidal thoughts attended a GP who provided counselling and started anti-depressant medication. Four weeks later he presented to an emergency department with ongoing symptoms. After assessment, he was deemed suitable for community treatment with follow up by the GP and was given the triage service's contact details. Two days later he was taken to another hospital after revealing his suicidal thoughts to a friend. The clinicians who assessed him were not aware of the earlier presentation to the other hospital. He was assessed and discharged home with advice to contact the mental health service if required. He died a day later in a motor vehicle accident.

The Coroner while finding the care on both occasions to be appropriate in the circumstances, commented that this incident should serve to remind mental health clinicians to check the CMI database prior to, or as part of, any assessment.

Chief Psychiatrist's comment

The Chief Psychiatrist supports this comment. Mental health clinicians should check the CMI prior to any new assessment in the community or hospital to identify previous presentations and admissions. This allows a longitudinal perspective of the person's presentation and risk assessment and will contribute to a better informed management plan. Clinicians should also review any alerts on the clinical file.

5. Transfer of care to primary care providers including General Practitioners

A number of recent incidents notified to the Chief Psychiatrist concerned the transfer of care from a mental health service to primary care providers of consumers who lacked insight and were reluctant to engage with treatment. A number of consumers had agreed to follow up by their GP but never attended for an appointment. As part of good clinical practice, the service should ensure that the consumer attends an appointment with the GP or other primary care provider before it finalises discharge. The Chief Psychiatrist's *Discharge Planning Guideline (2002)* describes the expected elements for discharge from a mental health service.

6. Pneumonia

Pneumonia has been identified as the cause of death in a number of recently reported sudden deaths. Lifestyle factors associated with an increased risk of community acquired pneumonia include smoking, alcohol abuse, regular contact with children and poor dental hygiene. The presence of comorbid conditions like chronic respiratory and cardiovascular diseases increases the risk by 2-4 fold. Risk also increases with rising age[1]. Further, attributing the symptoms of pneumonia to 'smoker's cough' may lead to a delay in seeking help. Clinicians are encouraged to discuss the benefits of modifying risk factors with consumers and seeking help early from their GP.

1. Torres A, Peetermans WE, Viegi G, Blasi F. Risk factors for community-acquired pneumonia in adults in Europe: a literature review. *Thorax* 2013, *68*(11), 1057-1065.