Lessons from the sentinel event case book

Case 1

Inpatient suicide on approved leave

A patient was admitted to a mental health unit for treatment of psychiatric illness and suicidal ideation. On admission the patient was assessed as moderate risk for suicide / self-harm. Over the admission period, the patient demonstrated improved mental health and was granted supervised leave as part of a therapeutic plan. Risk assessments were completed routinely in the ward and during each pre/post planned leave period. Throughout the course of their admission the risk assessment was amended to low risk as a reflection of the patient's improved mental health status.

During weekend leave at home with their family the patient was found deceased; due to hanging.

What were the contributing factors in this case?

- The decision for leave was granted based on the risk assessment which focused on the patient alone without consideration of the wider family or environment context.
- The service did not provide standardised information to the patient and the carer(s) before going on leave, or implement a formalised assessment of the carer's capacity to supervise during leave.
- The service did not have a process for active communication between the health service, patient and carer/family while on leave.

How did the health service address the identified issues?

Developed and implemented a standardised and structured leave process and risk assessment tools for gathering and recording information that include:

- Risk assessment for patient and interpersonal relationships, the carer’s capacity to provide care, and the leave environment.
- Leave event information recorded from carer/patient (i.e. activities, level of supervision, compliance with medication) in order to develop a greater understanding of the safety of the patient during leave.

Developed and implemented a process for provision of information to the patient, the supervising carer and staff about:

- The level of supervision required, medication administration instructions, early warning signs and advice on action for carer, contact numbers for escalation process, and organisational accountabilities for staff in the event of a crisis.


Case 2

Suicide in an in-patient unit

A patient was admitted to a mental health facility following an acute deterioration in mental state and several months of intermittent suicidal ideation. They had previously been admitted for attempted overdose and self-harming behaviour. During the admission assessment, the patient revealed they had been researching ways to commit suicide.

On admission to the inpatient unit the patient was placed in an area to facilitate containment, close observation and to enable further assessment. On day three the patient was reviewed by the medical team. During this assessment they denied any thoughts of self-harm and guaranteed their own safety if transferred to the ward.

On day four, the patient was re-assessed as low risk and transferred to the ward on 15-minute visual observations. Five hours later, the patient was found asphyxiated, having placed a plastic bag over their head and a ligature around their neck.
While a thorough search was conducted on the patient’s belongings on admission and during transfer to the ward, they may have had access to potentially unsafe materials/items from an unknown source leading to the adverse event.

**How did the health service address the identified issues?**

- Updated consumer information resources regarding safety and developed Safety Awareness posters for display at the unit entrance.
- Revised its policy to include the requirement for clinical staff to undertake regular checks of consumer bedrooms and all clinical areas to minimise the presence of any prohibited materials.
- Reviewed the Consumer Search Policy and checklist to include that all consumer searches are to be conducted when leaving the high dependency area.
- Escalated capital work plans for the redesign of the reception area to improve consumer safety and monitoring abilities of reception staff.

In November 2013, the Department of Health released a guideline for health service providers regarding the role of, and best practice approaches to, the conduct of nursing observation of people receiving care in Victorian mental health inpatient units. To access this document visit:


**Case 3**

**Clinical handover in ED**

A middle aged patient with multiple co-morbidities, history of pulmonary and cardiac disease presented to the emergency department (ED) with severe abdominal pain. The patient was given IV fluids, pain relief and received a surgical review. A provisional diagnosis of acute renal failure was made. Pathology was requested and the surgical registrar suggested insertion of an in-dwelling catheter which the patient refused.

Two hours following the provisional diagnosis a medical registrar accepted the patient for admission and discussed treatment with ICU and the renal team. A treatment plan of inotropes and dialysis was recommended. As there was no available ICU bed the patient remained in ED for stabilization and treatment, with regular review by the ICU registrar.

In the evening the patient was reassessed by the medical registrar and deemed appropriate for admission to a ward bed overnight if they remained stable.

At the ED clinical handover between evening and night shifts the patient’s ‘stable’ condition was communicated to the oncoming ICU and medical registrars. Overnight the patient was transferred to a general ward with the plan to have dialysis the following day.

Overnight staff noted the patient was febrile and obtained a phone order for blood cultures. Two hours later the patient was found unconscious. Resuscitation attempts were unsuccessful and the patient died.

**What were the contributing factors in this case?**

- Care coordination in ED between treating, admitting and consulting teams resulted in the fragmentation of responsibility and lack of accountability for the patient’s treatment plan.
- There was no clinical handover policy or requirement for a structured process, resulting in miscommunication of important information between clinicians.
- The decision to transfer to the ward was decided without medical team involvement. There was no requirement to notify medical units when ED patients are transferred to inpatient units.

**How did the health service address the identified issues?**

- Developed a policy to define responsibility of care in the ED.
- Established a Clinical Handover Policy.
- Developed a clinical handover education and training program and implementation plan.
- Published a procedure on how high acuity patients are to be managed when ICU/HDU beds are not available.

The National Safety and Quality Health Service Standards developed by the Australian Commission on Safety and Quality in Health Care include **Standard 6 Clinical Handover**. Implementation tools and resources for health services specific to **Standard 6 Clinical Handover**, such as the **Ossie Guide to Clinical Handover Improvement** are available at: