KEEPING MENTAL HEALTH PATIENTS SAFER
BY IMPROVING SYSTEMS

Category
Suicide within 7 days of contact with a health service

What was the error?
A patient was granted leave to spend time with family but absconded from the family home after going outside to have a cigarette. He was found dead the following day. The cause of death was found to be suicide.

How did this happen?
- The patient had a chronic mental health condition and many hospital admissions.
- The hospital had no formal processes in place to assess risk prior to granting leave.
- The psychiatrist was not consulted in regard to the decision to approve leave.
- The family was not well prepared before the leave.
- The hospital team did not talk to the community team prior to the leave being taken.

What normally happens?
1. No formal processes existed at the time for the granting of patient leave, which meant that a junior doctor was permitted to discharge the patient on family leave without consulting a senior doctor.
2. There was no process for ceasing leave, which was documented in the health record by use of a sticker.
3. There was no requirement to have formal contact with family or community mental health teams when leave was granted.

What harm was done?
The patient died.

What happened then?
- A thorough investigation took place to determine cause.
- Recommendations were made and put into action.

What changes have been made as a result of the error?
1. Strict processes for leave approval have been developed, including the need for a senior doctor to review a case prior to granting leave.
2. Audits occur to ensure there is a valid sticker in the clinical record.
3. A checklist has been developed and implemented for the approval of leave. The checklist is now completed before patients are granted leave and included in the medical record. Items on the checklist include:
   a. completing a risk assessment
   b. discussion with family members or the primary carer responsible
c. consultation with the treating psychiatrist

4. Classroom based training on clinical documentation specifically targeted at inpatient staff has now been run on a monthly basis for over 6 months focussing on assessment, care plans, risk assessment and review modules.

5. When patients require more than three doses of PRN (per required need) medication, a medical review will occur. This will be audited to ensure compliance.

6. Community Mental Health teams will be involved in reviews of inpatient care.

Further Information
The NSW Ministry of Health has issued a policy on the Transfer of Care from Mental Health Inpatient Units Policy Directive. Link: