A 33 year old female patient who had self harmed was presented to an Emergency Department (ED) A medical officer sutured the laceration and referred her to a mental health nurse practitioner (MHNP) for assessment which was completed an hour later and resulted in the patient being discharged.

Five hours later the patient was scheduled under Section 20 of the Mental Health Act 2007 (NSW) by ambulance officers and was returned to ED very distressed. She was delusional and again at risk of self harm. While in ED the patient absconded from the shower with a nurse in pursuit and was later able to exit through the waiting room. The ED was subsequently notified that she had jumped from a 6th floor apartment balcony, sustaining multiple fractures and lacerations.

CASE1

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THE INVESTIGATION

The patient had been assessed by a junior MO, who noted mental illness and liaised with the MHPN. The MHPN talked to the patient after reviewing the medical record, attempted to contact the patient’s psychiatrist, and left a message for him to contact the patient about an appointment. The patient was assessed as suitable for discharge. There was no consultation by the junior RMO or MHNP with the ED registrar about the care plan or discharge.

After the admission process was completed police officers who had been supervising the patient left. Nursing staff in ED had a misconception that an external schedule becomes void on arrival to hospital and they therefore did not enlist the assistance of security personnel to apprehend and restrain the patient. Security officers would not restrain a patient unless he or she exhibited physical aggression, or a schedule was in place. No alternative observation measures were established.

WHAT SHOULD YOU DO

- Ensure ED staff members are trained on their responsibilities under the NSW Mental Health Act 2007.
- Implement effective processes for the timely assessment, management and admission of patients presenting with mental illness, particularly those who are involuntarily held under legislation.
- Base local ED protocols on the “Security Manual” and the “Red Book”. Protocols should require senior ED staff to be informed about the outcome of a patient’s MH assessment and that the patient is reviewed by senior ED staff prior to discharge if a junior doctor has been managing their care.
- Ensure that the seniority of observers and the level of observations are appropriate to patient risk.
- Where a person is awaiting a mental health assessment or is believed to be at risk of absconding, locate the patient in a secure or visible safe environment in the ED.
- Enable ED staff access 24/7 to specialist mental health (MH) input.
- Ensure ED and security staff members know how to manage patients with disturbed behaviour and what to do if they abscond.
- Establish a process to ensure effective briefings are given to security staff about MH patients.
- Have local protocols for nursing and security staff to follow in the event that they are asked to leave a patient unattended.
As the psychiatric registrar was unable to review the patient at that time, he instructed ED staff to uphold the schedule and arrange a nurse special. Staff had had difficulty in achieving psychiatric medical officer review of ED patients for some time.

**ROOT CAUSES**

ED nurses lacked knowledge about the NSW Mental Health Act 2007. In addition, there were no ED policies or procedures in place for dealing with involuntary patients. This led to an incorrect assumption about the validity of the mental health schedule. As a result of this, the security officers did not believe they could use physical restraint when the patient ran from the hospital. No mental health clinicians were present on-site after-hours and there was limited access to psychiatry registrars. No procedures were in place for seeking specialist mental health input through alternative mechanisms such as by video conference or telephoning the State-wide Mental Health Telephone Access Line (SMHTAL). This contributed to a delay in specialist input into the management of a patient in mental health crisis. Junior medical staff did not review the patient’s care plan with senior staff prior to discharge.

**RECOMMENDATIONS**

The RCA team recommended that ED and security staff should complete training programmes on the NSW Mental Health Act and managing the involuntary patient. It also recommended the development and implementation of local policies and procedures for managing the involuntary patient and that systems should be established to ensure adequate mental health specialist medical input is available to support ED staff 24/7.

**CASE2**

Police brought a 45 year old woman under a Section 22 of the NSW Mental Health Act 2007 to the Emergency Department (ED) at 1100 hours after the woman allegedly assaulted two people in her residential accommodation. After triage she was placed between two rooms that were commonly used for scheduled patients. The rooms were already occupied and the ED was full.

ED security staff was informed that the patient was brought in under a mental health schedule.

The patient had a long standing mental health history with a background of schizophrenia and developmental delay. She had no known history of suicidal risk, but had limited insight, a forensic history and was known to have episodes of physical aggression when unwell.

At 15:40 hours, another security officer was performing a safety check on a patient in an adjacent room. He requested his colleague to fetch something for him, and the patient was left unattended. During this time she absconded from the department. The patient could not be located and the police were notified.

**THE INVESTIGATION**

The RCA team determined that the patient had the opportunity to leave the department when the security officer left her room. It was also common practice to seat patients with mental health concerns in the corridor thoroughfare when the ED exceeded capacity. This positioning enabled the established practice of assigning more than one patient to a security officer for observation, increasing the risk of patients absconding and suffering or causing harm.

**ROOT CAUSES**

The absence of clear directions for security officers on what to do in the event that another patient needed attention together with the practice of assigning security officers more than one patient to observe and the positioning of scheduled and unassessed mental health clients in a corridor thoroughfare contributed to the patient being able to leave the emergency department.
