

# Risk Watch

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## Lessons from the sentinel event casebook

### Plastic bags in mental health

During the course of the sentinel event program there have been a number of events reported where patients have used a plastic bag to suicide.

Presented below are three case studies which have occurred within the last two years.

**Case 1:** A patient with a history of schizophrenia was admitted to an adult inpatient mental health unit as an involuntary patient. This admission was due to an expression of suicidal ideation. The patient also suffered from paranoia and spiritual/religious delusions.

During the next four weeks the patient occasionally went on day or weekend supervised leave with a parent. The risk assessment for suicide and self harm during this period varied.

Approximately one month after admission the patient was discovered in the toilet with a plastic bag tied around the face and neck.

The patient died in the Intensive Care Unit from cerebral hypoxia and severe brain damage.

**Case 2:** An elderly person, who lived alone, supported by community services, was brought in by ambulance to the Emergency Department after a fall. The patient was diagnosed with a left fractured neck of femur and underwent hip surgery.

During the discharge planning assessment the first instance of suicidal ideation was noted with the patient saying "I have nothing to live for" and admitting to feeling depressed. The patient was transferred for further rehabilitation and discharge planning.

During the medical assessment on admission to rehabilitation the patient remarked that they had lost the will to live after the death of their partner and that they had attempted suicide five years ago (attempted overdose). The patient then expressed suicidal ideation, with an ill defined plan of hoarding tablets. The patient had no access to tablets at the time as they were an inpatient. The RMO noted that the patient still had persistent delirium and counselling for depression was to be arranged. The patient was found deceased with a plastic bag over their head.

**Case 3:** A long standing inpatient in the Mental Health Service, with treatment resistant schizophrenia, was found not breathing and with a plastic bag on their head.

Resuscitation attempts failed. The patient had been assessed as having a low suicide risk.

### How did the health services involved address these issues?

- Removed access to plastic bags for inpatients in the psychiatric unit.
- Ensured that the policies for visual observations and risk assessments were both embedded into the risk assessment tool used by clinicians.
- Updated the Emergency Department admission form to include under the 'Past History' heading Physical and Psychiatric History.
- Education and training to assist staff to develop an appropriate referral threshold for the purposes of psychiatric examination and assessment.
- Investigations to review viable and reasonable alternative linings for inpatient rubbish bins that are air permeable.
- Formal risk assessments for all patients on an ongoing basis and following involvement in a moderate or serious incident.

In February 2009, the Chief Psychiatrist issued a memo to all Psychiatrists, Area Managers and Inpatient Unit Managers recommending:

- That psychiatric inpatient units take steps to minimise patient access to plastic bags on inpatient units wherever possible.
- That all psychiatric inpatient units review the use of plastic bags and where possible, substitute alternative bin liners.

A copy of this memo is available on the website of the Chief Psychiatrist.

<http://www.health.vic.gov.au/chiefpsychiatrist/index.htm>

### Other references

#### South Australian Coroner's court

<http://www.courts.sa.gov.au/courts/coroner/index.html>

#### Queensland Coroner's court

<http://www.courts.qld.gov.au/1680.htm#2006>

## Lessons from the Sentinel Event Casebook continued...

### Medication incident

The patient was admitted following an intracranial haemorrhage and was managed on an acute surgical ward. After some time the patient was transferred to a medical ward following complication of a Deep Venous Thrombosis (DVT).

The treating medical units decided that the patient was to be anticoagulated with an intravenous (IV) heparin infusion to treat the DVT.

The aims for the Activated Partial Thromboplastin Time (APTT), or clotting time, were lower than the usual protocol due to the pre-existing intracranial haemorrhage. Regular monitoring of the patient's APTT indicated that the APTT was sub therapeutic. This was noted by the nurse who contacted the medical officer.

The medical officer wrote an order for heparin 2,000 units stat (immediately). The nurse incorrectly administered 20,000 units of heparin.

The error was immediately recognised by the nurse, who again contacted the medical officer. The patient was immediately reviewed and noted to have a decreased conscious state compared with previous assessment. A MET (Medical Emergency Team) response was called. The patient was subsequently transferred to the Intensive Care Unit and intubated.

Treatment was withdrawn four days later due to a poor neurological outcome. The patient died.

### What did the health service do?

The availability of different concentrations of heparin in the ward environment increased the likelihood that the wrong dose would be given.

The Medication Safety Committee reviewed the need for different concentrations of medications.

A system was implemented to alert staff to the existence of multiple concentrations and physically separate the concentrations within the storage area.

### What is the department doing?

The Victorian Medicines Advisory Committee (VMAC) advises the Department of Human Services and leads the strategic direction and policy development for Quality Use of Medicines (QUM) in Victoria.

One of the projects being undertaken by VMAC is the High Risk Medicines (HRM) project.

HRM's can be defined as those which have a heightened risk of causing significant or catastrophic harm when used in error.

This includes:

- medicines with a low therapeutic index
- medicines that present a high risk when administered via the wrong route or when other systems errors occur.

One of the medications the VMAC HRM working party is focusing on is heparin.

An alert has been issued by VMAC on the storage and use of heparin in the clinical setting.

<http://www.health.vic.gov.au/vmac/projects/hrm.htm>

### Australian Commission for Safety and Quality in Health Care (ACSQHC)

ACSQHC have provided a number of useful resources on their website including protocols on Correct Patient/Site/Side and information on Best Practice for falls prevention.

<http://www.safetyandquality.gov.au/>

### VHIMS update

The department is working through a defined procurement phase in order to identify a vendor to work with them in the design and development of the Victorian Health Incident Management System (VHIMS).

Following development, configuration and testing a three month pilot will be undertaken across representative health service sites towards the end of 2009.

Health services interested in participating in the pilot are asked to contact Ms Theresa Williamson VHIMS Project Manager on 909 67258 or email [theresa.williamson@dhs.vic.gov.au](mailto:theresa.williamson@dhs.vic.gov.au)

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