

# **Independent External Review of Mental Health Inpatient Services within ACT Health**

**22 – 23 May 2018**

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**Purpose:**

ACT Health undertook the ACHS re-accreditation process on 19-23 March 2018. In response to the findings from the Australian Commission on Safety and Quality in Health Care (the Commission) Advisory Note A13-01, and the subsequent National Safety Quality Health Service Standards (NSQHS) Standards Survey *Not Met Report*, extreme and significant risks have been identified for mental health in-patient services. An independent external review of all Mental Health Inpatient Units, Alcohol and Drug and Justice Health facilities has been agreed to by Dr Paul Kelly, the Regulator of ACT Health. In addition the *Not Met Report* recommends Canberra Hospital Health Services (CHHS) *commission an immediate external review of all mental Health Inpatient Units, Alcohol and Drug, and Justice Health facilities to assess the level of safety and risk to consumers in the service.*

**Background and Context: Notification of Significant Risk:**

On 26 March 2018 and in accordance with the Advisory A13-01, the ACHS notified ACT Health of the following significant risks:

Standard / Action	Comments	Risk Comments
<p><b>Action 1.8.1</b></p> <p><b>Mechanisms are in place to identify patients at increased risk of harm</b></p>	<p>Significant concern expressed by the survey team regarding a number of issues in Mental Health and the number of suicides in the health service over the past three years which have not had a robust review nor strategies implemented to mitigate the risks.</p>	<p>The delay in immediate actions post suicides and the delay in undertaking regular ligature audits and, the delay in implementing the results and recommendations of the engineers report into ligature points places the patient / consumer at an extreme risk.</p>
<p><b>Action 1.8.2</b></p> <p><b>Early action is taken to reduce the risks for at-risk patients</b></p>	<p>Four deaths in mental health and one death in a general medical ward; no immediate commissioning of any review (internal or external) include no robust RCA. There was some form of general feedback with some suggestions but this failed to make any significant impact. There was a report undertaken by an external architect on ligature points in January 2017 and a Gantt Chart has only been developed to commence in February/March 2018. There appears to be no regular ligature audit undertaken nor was there any action plan done to implement strategies to prevent further cases.</p>	<p>As above.</p>

On 4 April 2018, ACT Health received the *Not Met Report* from ACHS (The Australian Council on Healthcare Standards). Amongst a number of other recommendations, ACHS provided 3 specific recommendations related to their original Advisory Notice to the National Commission of HealthCare Standards during Accreditation week in March 2018;

- Action 1.8.1 Core - CHHS commission an immediate independent external review of all Mental Health Inpatient Unit, Alcohol and Drug and Justice Health facilities to assess the level of safety and risk to consumers of the service;
- Action 1.8.2 Core (1) - Immediate action be taken to reduce the high risk of ligature points; and
- Action 1.8.2 Core (2) - Establish a Mental Health Review Advisory body which incorporates Alcohol and Drug and Justice Health to oversee the review and the implementation of the subsequent recommendations.

#### **Terms of Reference for the Independent Review:**

The independent external review will:

- Conduct site visits to the MHJHADS inpatient units and review the safety aspects of:
  - a. Model of Care;
  - b. Policies and procedures (are we using the existing tools correctly);
  - c. Patient cohort;
  - d. Workforce, skill mix;
  - e. Unique admission criteria to each unit;
  - f. Physical environment; and
  - g. Service demand.
- In accordance with the notification of significant risk by the NSQHS, provide your expert opinion to assess the level of patient safety and risk and application of best practice interventions to admitted people across the specific inpatient facilities.

The independent reviewer/s will provide a preliminary report outlining key findings and recommendations following the site visits to CHHS that:

- Provides relevant descriptive data and current operational paradigms;
- Recommends improvements to the policy framework for service delivery;
- Recommends improvements to the model for service delivery that incorporates clinical need;
- Recommends operational improvements to existing practices; and
- Recommends improvements to oversight and monitoring frameworks.

Noting

- The infrastructure risks have been assessed by external consultant Silver Thomas Hanley in April 2017.
- Should significant risks to patient safety be found, those are to be escalated immediately to the Executive Director of MHJHADS.

#### **The NorthWestern Mental Health (NWMH) Review Team:**

- Dr David Fenn, MBBS, FRANZCP. Interim Director Clinical Governance NWMH
- Mr Peter Kelly, RN. Director Operations NWMH
- Mr Cosimo Brisci, Facilities Manager NWMH

As a means to establishing the credibility of the reviewers, NWMH is a large publicly funded specialist mental health service operating across the north and west of metropolitan Melbourne. A snapshot of NWMH is as follows:

- Annual budget for 2017-18 Financial Year \$207m.
- Is a fully accredited specialist mental health service.
- Employs 1,340 EFT staff or 1,900 headcount.
- Operates 502 beds across youth, adult and aged cohorts and across acute, residential rehabilitation, secure rehabilitation, step up – step down beds.
- NWMH operates a very extensive community based service across youth, adult and aged cohorts. The current Caseload is around 8,400 and we achieve about 50% new registrations per year.
- NWMH is the largest public provider of Electroconvulsive Therapy in Victoria
- NWMH operates across 30 sites.
- Operates sub-speciality programs in the areas of Eating Disorders, Perinatal Mental Health and Neuropsychiatry, Consultation-Liaison Psychiatry, Emergency Mental Health, Dual Diagnosis, and a Fixated Threat Assessment Centre (Clinical Enhancements)
- NWMH is a Division of Melbourne Health. It is a somewhat unique entity in the state of Victoria in that it provides specialist mental health services to Northern Health and Western Health.
- NWMH operates a Mental Health Training and Development Unit (MHTDU) and is auspiced by the state government to operate the Western Education and Training Service (WETS) Cluster which provides training and education to other metropolitan and rural services.

#### **Review:**

NWMH was provided in advance with the following documents:

- A letter of engagement from ACT Health
- A timetable detailing site visits and interviews at ACT Health for the 22<sup>nd</sup> and 23<sup>rd</sup> May 2018
- An organisational chart
- Terms of Reference
- Correspondence to and from the Australian Commission on Safety and Quality in Healthcare (the Commission) relevant to this review
- Background information relevant to this review
- Relevant ACT Health Procedures
- Relevant Operational Guidelines

NWMH was also provided with an outline of the ACT Mental Health inpatient units as follows:

Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) has 5 in-patient facilities within the scope of review. ACT Health is an endorsed health facility under the *Mental Health Act 2015*.

**The Adult Mental Health Unit (AMHU)** is a 37 funded bed public mental health inpatient unit at the Canberra Hospital. The AMHU provides an environment for people receiving both voluntary and involuntary care for acute mental illness or disorder. The AMHU provides brief individualised care which supports people to safely return back to their community setting. AMHU has three unfunded beds, making the capacity for 40 patients. These unfunded beds are utilised to respond to bed demand from the Emergency Department, other wards in the Canberra Hospital and facilitates direct admissions from the community bed availability allows. The AMHU has a 10 bed High Dependency Unit, a two bed Vulnerable Persons Suite and a 28 bed Low Dependency Unit

(LDU) with four bedroom wings.

**The Mental Health Short Stay Unit (MHSSU)** is a 6 bed public mental health inpatient unit within the Canberra Hospital. The MHSSU is adjacent to the Emergency Department (ED) and provides opportunity for voluntary and involuntary admission for up to 48 hours. Admissions to this unit are generally for the purposes of extended assessment and treatment initiation for people presenting to the ED who may be experiencing mental health crisis or an exacerbation of their mental illness or disorder.

**Brian Hennessy Rehabilitation Centre (BHRC)** is a 30 bed mental health residential facility that aims to provide a recovery focused model of care within a rehabilitation setting. Presently it serves a number of functions including longer long term residential care, medium term rehabilitation services, and an Extended Care Unit which provides an environment for secure care. The Brian Hennessy Rehabilitation Centre and the Adult Mental Health Day Service are currently in the process of transitioning to new facilities at the University of Canberra Hospital due to open in July 2018. The Adult Mental Health Rehabilitation Unit (AMHRU) and Adult Mental Health Day Service (AMHDS) will be located in a purpose built rehabilitation unit based on the University of Canberra Hospital (UCH) campus. The purpose of the AMHRU is to deliver effective recovery based treatment and rehabilitation to people whose needs cannot be met by less intensive community based adult mental health services. The focus is on people with moderate to severe and enduring complex mental health conditions who face challenges living in the community. These people are likely to experience difficulties with living safely and successfully in the community.

**Dhulwa Mental Health Unit** is a purpose built facility providing inpatient services and operating 24 hours a day, seven days a week. Dhulwa supports a person's treatment, care and recovery by responding to the needs of people with moderate to severe mental illness who are or are likely to become involved with the criminal justice system and for those civilian people who cannot be treated in a less restrictive environment. Dhulwa is a 25 bed unit providing care for people with low to medium, secure needs. The 25 beds are configured into an acute wing and a rehabilitation wing. The acute beds cater for people who are acutely mentally unwell and the 15 rehabilitation beds provide a therapeutic environment which provides increased psychosocial rehabilitation, vocational and community integration activities. 10 acute inpatient beds were commissioned in November 2016 and it is anticipated that an additional 7 rehabilitation beds will be opened in late May 2018. These additional secure beds will provide secure long term rehabilitative care for people who have unremitting and severe symptoms of mental illness or disorder with associated behavioural disturbance and are unable to safely or adequately treated in less restrictive settings.

**The Withdrawal Unit** is a 10 bed facility located in Building 7 of the Canberra Hospital. The Withdrawal Service provides a secure and supportive environment for safe medically supervised withdrawal from alcohol and other drugs. The admission criteria requires a person to be low risk and not experiencing suicidal ideation or behaviours. The service is available to any person over the age of 18 who has alcohol or drug dependence.

In completing this review, NWMH undertook the following:

- Met with ACT Mental Health Executive Director, Operational and Clinical Directors and were provided with an overview of the 'in-scope' services.
- Visited the Mental Health Short Stay Unit (MHSSU)
- Visited the Alcohol and Drug Services (ADS)
- Visited the Adult Mental Health Unit (AHMU)
- Visited the Dhulwa Mental Health Unit (DHULWA)

- Visited the Brian Hennessy Rehabilitation Centre (BHRC)
- Visited the University of Canberra Hospital (UCH)
- Met with the CEO from Carers ACT
- Met with the Executive Officer from ACT Mental Health Consumer Network
- Had the opportunity for Question and Answer sessions with relevant service Directors
- Participated in a teleconference call with the Chief Psychiatrist of the ACT

### **General Commentary**

In undertaking this review, the NWMH reviewers will necessarily make reference to, and draw comparisons with the NWMH service system, its policies and procedures and its approach to risk management and incident review.

### **Infrastructure**

The reviewers visited each of the aforementioned bed-based units. The facilities were generally of an excellent standard, with high levels of consumer and staff amenity. The facilities were clean and well maintained. The exception to this was the Brian Hennessy Rehabilitation Centre (BHRC) which, while clean and reasonably well maintained, is nearly 30 years old and is thus at the end of its service life. We understand that the residents of this facility will shortly relocate to a contemporary and purpose built facility and that, according to a Ministerial announcement made during our visit, the BHRC will receive a significant capital redevelopment and be re-purposed for a new patient cohort.

The reviewers visited the **Mental Health Short Stay Unit (MHSSU)** and met with clinical staff from that program. The MHSSU infrastructure was of a very high standard and afforded consumers a high level of amenity. The consumer bedrooms are of an excellent size and are well configured with a high level of attention paid to ligature safety. Fittings and fixtures comply with anti-ligature design products and guidelines. There was good 'line of sight' observation from the staff base to the main bedroom corridor and to the consumer lounge areas. The balcony area is thoughtfully designed and provides access to fresh air for consumers in a secure area which is free of ligature attachment points. Both the bedrooms and outdoor areas meet or exceed the minimum standard as stipulated in Australasian Health Facilities Guidelines- (AusHFG), Schedule of Accommodation. The MHSSU is designed with two consumer lounge areas which afford an opportunity for consumers to be separated if necessary. We also noted that this unit had good circulation space. Our informed view is that this unit is very safe from a design, finishes, fittings and fixtures perspective. The model of care is consumer centred and clinical staff are very attuned to the risks involved in attending to the needs of this cohort. Specifically, this cohort often present to the Emergency Department (ED) following an act of deliberate self-harm, or are threatening self-harm, or are in a situational crisis, or are drug or alcohol impaired for which the hallmarks are poor impulse control, impaired judgement and a low frustration tolerance. We witnessed clinical staff interacting with this cohort and observed their behaviours to be respectful, non-threatening and engaging. The challenge with SSUs in other jurisdictions is that the focus can be on assessment rather than treatment. In other words the initial assessment may be conducted promptly but active and assertive treatment, including the management of tobacco and alcohol or drugs withdrawal and periodic re-review can be less of a focus, or less achievable, within resource constraints. This can particularly be the case if the SSU is staffed by Emergency Department staff rather than mental health clinicians. This is not the case however in the MHSSU. It is relatively well resourced in terms of staffing i.e. the MHSSU has a fulltime Psychiatric Registrar and two part time Consultant Psychiatrists. Consumers admitted to the MHSSU receive (at a minimum) a daily medical review and more frequently if required. We also observed that the De-escalation Suite was occupied and that ED staff were attending to the two patients being managed in this area. We noticed good cooperation and communication between the

ED staff and mental health staff and it was obvious that the two teams enjoyed a positive collegial relationship.

The reviewers visited the **Alcohol and Drug Services** and met with clinical staff from this program. We noted that the unit appropriately screens, triages and conducts a risk assessment of prospective patients to ensure that there are no acute mental health issues that may preclude admission to this care setting. Specifically, staff are energized to ensure that prospective patients are not psychotic, nor depressed to the extent that s/he is at risk of deliberate self-harm. Accordingly the facility is not subject to the same level of ligature safety as the acute inpatient units. This is an entirely reasonable approach. We did note, that notwithstanding this, the clinical team had identified some clothing hooks in the ensuite bathrooms which may constitute a potential hazard and these fittings had been removed some time prior to our review. If a client is screened, assessed or triaged as at 'high risk' of engaging in deliberate self-harm, or is otherwise vulnerable, his / her care would be appropriately transferred to the acute admissions unit.

The reviewers visited the **Adult Mental Health Unit (AMHU)** and met with clinical staff from this program. During this visit we were joined by Facilities Management and Capital Management staff. We spent some time in this unit and inspected consumer bedrooms including the ensuite bathrooms. We inspected the Women's Corridor, the Vulnerable Persons Suite, the dining area, consumer lounge areas, activity room, spiritual room, sensory room, gymnasium and outdoor spaces. We were very impressed with the level of amenity in this unit. The bedrooms and outdoor spaces were of an excellent size and met or exceeded the minimum standard as stipulated in Australasian Health Facilities Guidelines- (AusHFG), Schedule of Accommodation. There was abundant circulation space, there was very good access to natural light and there were good views to the outside world. It was clear that significant work had been undertaken in this unit to mitigate ligature hazards. We noted the work that has already been completed in terms of removal of door closers and other fittings. We were also briefed on the work that is nearing completion to (a) remove the ensuite doors, (b) modify the ensuite door frames, (c) make good the door frames and (d) then install ensuite curtains on a 'J Track' curtain track. These curtains are designed in such a way that the curtains will 'break away' if subjected to more than 15kg of downward pressure. In addition we were informed of plans to (e) 'box in' the large screen TV in the activity room and (f) remove a door closer from the activity room. In our informed view some of the ligature mitigation works such as the removal of door closing devices in rooms such as the activity room or the sensory room which are access controlled and which consumers cannot use without a staff member being present should perhaps not be removed. This is an example whereby attending to a potential risk creates an actual risk. In this circumstance the door closers have an important safety function in ensuring that the door is always closed (i.e. the default position is that the door is closed and locked) when unoccupied to contain smoke in the event of a fire. Fittings & fixtures comply with anti- ligature design products and guidelines with the exception of the wall mounted soap dispensers (*Microshield*) used in the ensuite bathrooms and we formed the view that these are a ligature hazard and should be substituted with an alternative product or dispenser.

The reviewers visited the Visited the **Dhulwa Mental Health Unit (DHULWA)** and met with senior staff. This facility is very new and built to a high specification in terms of quality, safety and amenity. We noted that the facility is designed to accommodate medium risk patients however it also has the capability in to manage high risk forensic patients. The design of the unit is thoughtful and well considered in terms of access to natural light. Outdoor spaces are necessarily access controlled and supervised by clinical staff at all times. The de-escalation suite is well designed with high grade finishes, fixtures and fittings. We noted that the ensuite bathroom door can be controlled by staff from outside the de-escalation suite and that staff could shut down the water supply from outside the suite should that be necessary. We noted that the unit is furnished with *Norix* brand furniture



which is purpose designed for custody, forensic and acute psychiatry settings. This furniture is devoid of hard and sharp edges and is filled with sand to ensure that these items cannot be picked up and used as weapons or a battering ram. Very good attention to detail has been paid to ligature safety with a couple of minor exceptions (a) the *Microshield* soap dispensers in bathrooms represent a potential ligature hazard and should be removed and substituted with an alternative product (b) the patients and staff toilets in the outdoor area have the wrong signage i.e the staff toilet is designated the patient toilet and vice versa. The issue here is that the staff toilet does not have ligature safe fittings and fixtures and thus, as currently configured, patients will have access to the hand drier, tapware, coat hooks etc that are in the staff toilet. This is easily remedied by reversing the signage. We noted the excellent security systems in place in this unit. Visitors require 100 points of identification to enter this unit and must have digital photographs taken and identification is scanned into a database by security staff. Personal items were x-rayed and no mobile telephones or recording devices were permitted. We were security scanned prior to entering and there was capability for whole body scanning. We understand that 280 CCTV cameras are in place in this unit and that CCTV imagery is viewed by a security officer in a purpose designed CCTV viewing suite. The security officers rotate into this suite on 2 hour stints as a means to avoiding fatigue and inattention. There were 4 security officers on duty and they had various roles including reception, perimeter patrols, responding to code events and checking patients belongings on return to the unit from escorted or unescorted leave. Interestingly, we could see that security staff, via the CCTV monitors, can often observe early signs of escalating patient behaviours such as pacing, hand wringing or other forms of psychomotor agitation and alert staff to this to avoid further escalation. We understand that urine drug screens are routinely sought from patients returning from leave.

The reviewers visited the **Brian Hennessy Rehabilitation Centre (BHRC)** and met with clinical staff from this program including the Occupational Health and Safety – Workplace Representative. The fabric of this facility was looking tired and dated as per the introductory comments under *infrastructure* however the patients appeared well nourished, clean, well clothed and were well engaged with clinical staff. The unit program was recovery focused and we noted a range of programs for patients that were both life-skills based (cooking, budgeting etc) and healthy lifestyle based (a gym / activities program with a personal trainer). In a 30 year old building such as this it is very difficult indeed to achieve good ligature safety and in any event there are unlimited ligature attachment points immediately outside the building in the form of pergolas, tree branches etc. Risk management in this unit is predicated on staff engagement with long term patients, a deep understanding by clinical staff of the patient's clinical history and excellent risk assessment. Much like the Withdrawal Unit, a deteriorating patient would be assessed and transferred to an acute inpatient unit. Our informed view was that patients were receiving good quality, recovery focused care in a nurturing and therapeutic environment.

The reviewers visited the **University Of Canberra Hospital (UCH)** which will open in the very near future and accept patients from the BHRC. This is a very well designed contemporary mental health rehabilitation facility which provides a high level of amenity for patients, visitors and staff. It has been designed with amenity and safety in mind, commensurate with the cohort who will receive care in this environment. Again, this is not an acute facility but nevertheless excellent attention has been paid to ligature safety in terms of bedroom and lounge furniture, bedroom and ensuite bathroom design. In particular we noted that ensuite doors have been replaced with a curtain attached to a '*J Track*' curtain track – with 'breakaway' curtains. In doing this, a balance has been struck between achieving amenity, safety, dignity and privacy for the patient.

## **Policies and Procedures Pertaining to Ligature Safety**

The reviewers read the policies and procedures and the models of care relating to each of the bed-based services. We viewed these as thorough, detailed and very comprehensive. Our attention was drawn to the new policy and procedure relating to ligature safety. This was extraordinarily detailed and, in descriptive fashion, made clear the risks associated with potential ligature points, including those below waist level. I draw particular attention to this because potential ligature points above waist level have traditionally been the focus of ligature audits in the United Kingdom and more recently in Australian jurisdictions. MHJHADS attention to this indicates a contemporary approach to ligature safety in what is a constantly evolving area of patient safety. The constant evolution in this area also extends to the suite of ligature safe fittings and fixtures available in the market. Even in the past two years we have seen quantum leaps in product design and a developing knowledge as to how these products have been introduced into new build facilities and into refurbished inpatient units. It was pleasing to see that ACT Health have chosen the most up to date fittings and fixtures supplied by reputable companies which enjoy an excellent reputation for product safety. Examples of these fittings and fixtures include (a) enclosed 'piano type' door hinges (b) door top – weight sensitive strip alarms which connect to *Ascom* Duress pagers worn by staff (c) tapware and bathroom fittings including toilet pans, basins, toilet roll holders, shower roses etc (d) bedroom and lounge furniture. It should be understood that these products are often not available in Australia and have to be ordered from the United Kingdom, the United States of America or Sweden. This necessarily can involve delays of up to 10 weeks from the date of placement of an order until the products land in Australia. The work of ACT Health in this area exceeds the design standards as stipulated by the Australasian Health Facility Guidelines (AusHFG).

We note that MHJHADS has paid particular attention to ensuite bathroom doors. Ensuite bathrooms, and bathroom doors in particular, are over-represented in attempted or completed suicides Australia wide for the following reasons (a) nurses and other health professionals naturally afford patients privacy and dignity as they attend to toileting or showering functions and are thus less inclined to intrude into the ensuite bathroom to conduct visual observations and (b) prior to the most recent ensuite bathroom design evolutions there were, regrettably, the means and opportunity for patients to self-harm in relative privacy in an ensuite bathroom. In this context I am referring to patients being able to utilise tapware and shower rose design, soap holders, toilet roll holders, under sink waste pipes etc as a means to self-harm. Other jurisdictions, including Victoria have responded to this risk by 'topping and tailing' the ensuite bathroom doors however this was far from an ideal fix and patients have indeed found ways to harm themselves using the cut down doors in combination with make shift implements. The cutting down of ensuite bathroom doors caused a multitude of secondary and un-anticipated problems in NWMH inpatient units such as steam (moisture) entering bedrooms and setting off smoke detectors, causing problems with carpet adhesive in bedrooms and causing the growth of mould and mildew in bedrooms.

We note that MHJHADS has established a schedule of 6 month Ligature Audits. NWMH by comparison has established a schedule of annual ligature audits which is based on the NHS methodology. These audits are conducted by senior executive staff, clinical and operational directors, and the local quality co-ordinators. As far as possible, each audit is conducted by "external" staff members from alternative units who are able to bring "fresh eyes" to the unit being audited and thus see items which are essentially 'hidden in plain sight'. Standard auditing protocols are employed that compare the documented results of prior audits with current observations.

The reviewers noted the work undertaken by the MHJHADS in March 2018 to review the clinical operational systems in place across the five mental health inpatient units. The March 2018 review highlights the active management of ligature risk in the inpatient units according to the identification

of *means* - ligature points - in particular locations, the assessment of *motivation* to self-harm and minimising *opportunities* for self-harming behaviours by nursing at-risk consumers in appropriate risk zones within the inpatient units. As may be expected in this model of care, the relative risk of self-harm posed by a particular consumer determines the locus of care and the subsequent intensity of nursing observation and care provided. This approach to assuring the safety of all consumers according to the level of risk identified is familiar to the reviewers and, in our view, is comparable with the operational practices employed across the inpatient units operated by NorthWestern Mental Health.

The reviewers note, that in years gone by, and as recently as the mid 1980s in Victoria, the single biggest protective factor to preventing a suicide in an inpatient unit was shared bedrooms and communal bathrooms. Oftentimes, the sleeping accommodation was 'Nightingale ward' or dormitory style accommodation and in fact there were very few single bedrooms during this period. In the intervening years very significant efforts have been made to improve both the design and the level of amenity provided to patients in contemporary inpatient units. The improvements in design have evolved over time and have resulted in single bedrooms with ensuite bathrooms. This has not always resulted in improved safety. Many jurisdictions in Australia and internationally have subsequently had to retroactively mitigate the unintended consequences of the 'improvements' in design, for example, patient bedrooms were designed with an ensuite bathroom to afford privacy and dignity to patients however retroactive changes have had to be made to the bathrooms to deal with apparent ligature risks with bathroom doors, towel hooks, toilet roll holders, grab rails etc. Similarly, retroactive steps have had to be taken to deal with apparent ligature risks in bedrooms such as bedroom doors, light fittings, ceiling airconditioning grilles, wardrobe doors, wardrobe shelving etc. The reviewers experience has been, and this has been confirmed by patient feedback, is that as fixtures and fittings are progressively stripped out of bedrooms the environment takes on a more custodial feel and in fact the bedrooms are perceived as cold, stark, un-inviting, dehumanizing and counter-therapeutic and, as such, bring to the fore feelings of hopelessness and despair. Clearly, when bedrooms are 'stripped back' to this extent this can only increase the risk for the patient who is depressed and anxious and harbouring suicidal thoughts.

The reviewers noted the attention paid in the development of the MHJHADS procedures to the issue of relational security. As noted above, contemporary models of care are reliant on careful assessment of dynamic risk profiles to identify those consumers who are at high risk of self-harming behaviours at any particular point in time. Dynamic risk assessment and mitigation of risk is dependent on active engagement of consumers at an emotional level and the therapeutic use of the self. Notwithstanding the applicability of these principles to consumer interactions with every staff member, it is most commonly the skills and experience of nursing staff that are called upon to engage consumers and mitigate risk on a shift-to-shift basis. Whereas ACT Health is attending to the mitigation of structural risks by the identification and elimination of ligature points, the simultaneous recognition of the significance of relational security issues is important. NWMH places a similar emphasis on the significance of therapeutic engagement in assessing and mitigating risk in inpatient settings. To expand this point further, about 16 years ago NWMH made a conscious decision to only employ nurses with specialist qualifications in mental health nursing. We have held firm to that decision in the intervening time and we have been able to achieve this aim by (a) Having a very well regarded graduate nurse program that is always over-subscribed (b) having a very well regarded postgraduate diploma in advanced mental health nursing program that is also over-subscribed (c) designing a Division 2 Registered Nurse (Enrolled Nurse) Transition to Mental Health Program and (d) having a very active overseas recruitment program that has seen NWMH recruit over 1000 Registered Nurses from the United Kingdom over the past 12 years. In regard to the training lines, NWMH has a record level number i.e. 82 training lines for the 2018 academic year. These strategies, in combination, have delivered a skilled and enabled Registered Nurse workforce

who understand the value of therapeutic engagement as being of equal importance to the valuable work that is being undertaken in regards to ligature safety.

### **Clinical Governance**

Perusal of the ACT Health governance structure suggests lines of accountability between the clinical governance structure of MHJHADS and the corporate executive structures lack clarity. The reviewers understand that steps are being taken to review the overarching corporate structures that govern MHJHADS. Nevertheless, in the view of the reviewers, it is germane to note the manner in which this lack of clarity has affected incident reviews and the implementation of recommendations arising from the investigations undertaken. The relationship between the Morbidity and Mortality Committee of MHJHADS and the ACT Health Quality, Governance and Risk Division constitutes an important representative example. The nature of the decision-making process and the accountability structures involved in relation to the development of business cases and the identification of financial resources to implement the recommendations of the Morbidity and Mortality Committee was not clear to the reviewers. Confusion about these processes and the lack of a direct line of accountability appears to have delayed the process of improving ligature safety in particular. A second example relates to the compilation and evaluation of service activity data, and the capacity to interpret this data in ways that lead to implementation of service improvement measures. It appears that quality improvement staff with the remit and skills to support these activities are not located within the structures of the mental health service and thus efforts to influence staff on the ground and effect change in mental health service delivery are likely to be impeded. Further, the operational differences between general medical services and mental health services are often under-appreciated by staff that are required to operate across both sets of services from generic quality units.

Medical leadership and the partnership with operational directors are important functional elements in the effective delivery of mental health services. The reviewers were pleased to note the recognition given to these critical elements of clinical governance by the executive and operational leadership of MHJHADS. Discussions with the executive team revealed an appreciation of the commitment of current and past medical personnel to delivering high-quality services, and respect for medical independence in clinical decision-making. Notwithstanding these strongly positive commitments and an ongoing medical recruitment process, MHJHADS is experiencing difficulty attracting and retaining suitably qualified senior medical personnel. Notably, the recent vacancies at the level of the ACT Chief Psychiatrist and the Clinical Director of Acute Mental Health Services of MHJHADS speak to the difficulties frequently encountered. In the experience of the reviewers, training and retaining skilled psychiatrists is a recurring difficulty for Australian public mental health services, and underscores the value of developing national and international recruitment strategies.

### **Investigation of Critical Incidents**

In considering the investigation of the five sentinel events undertaken by the MHJHADS Morbidity and Mortality Committee between January 2015 and July 2017, the reviewers were provided with an overview of each incident and the subsequent investigations, copies of the reports prepared by the Morbidity and Mortality Committee, and the Summary Tables of the review processes that document the recommendations, actions, status of actions, and dates of completion, for each investigation. The reviewers note that these incidents are currently the subject of ongoing coronial investigations and as such the clinical notes were not available for direct perusal by the reviewers.

The reviewers note that 4 out of the 5 Sentinel Events involved Voluntary patients and that none of the events occurred in a High Dependency Unit (HDU) type setting. Similarly, NWMH has never had a

completed suicide in a HDU environment and it may seem obvious that this could be a consequence of (a) higher quality infrastructure in terms of ligature safe fittings and fixtures (b) a higher ratio of staff to consumers (c) more frequent medical review (d) perhaps more assertive treatment with psychotropic medications (e) better line of sight observation, (f) perhaps more skilled and experienced staff deployed to HDU, (g) less 'nooks and crannies' or blind spots in the HDU where consumers can engage in self-harm out of the vision of staff, (h) Consumers in HDU are likely to always be subject to a more intensive regime of visual observations and checks and (i) HDU is a much more controlled environment and thus it is easier for staff to check items brought into the unit by consumers, visitors and contractors i.e control the introduction of prohibited items into this environment.

The five sentinel events occurred in what may be considered "low dependency" settings where consumers at relatively low risk of self-harm are typically nursed. Given this context, the nature of the findings and recommendations of the incident investigations are unsurprising. That is, the conclusions reported by the Morbidity and Mortality Committee are recognisable as those that in the experience of the reviewers commonly occur in similar settings in other services. For instance, failure to recognise the signs of a deteriorating patient in an LDU setting at a time when relatively junior staff are dealing with high levels of acuity and simultaneous demands, senior staff are on leave, and there is limited access to allied health staff, are themes that resonate with the experience of the reviewers. Similarly, issues related to comprehensive clinical assessment, clinical handover processes at transfer of care, reporting and escalation of significant incidents, the documentation of clinical risk observations, and limited access to supported forms of accommodation are commonly recurring themes in investigations of inpatient suicides. Frank acknowledgment of these service difficulties and the practical actions taken by MHJHADS to address these aspects of service delivery suggests a strong commitment to continuous service improvement activities.

In considering the above factors it begs the question 'do we admit the patient to the care setting most appropriate to his/her needs?' Increasingly, the reviewers note in their own service that HDU beds are sought for the aggressive, violent, drug impaired or floridly psychotic person whereas the agitated /depressed person who is socially withdrawn, not engaging but cooperative and 'compliant' is admitted to an LDU bed. Under these circumstances the agitated / depressed person often ruminates in their bedroom, away from staff, and away from other patients and, left to their own devices, may contemplate acting on their thoughts of hopelessness and despair. At one level it may appear that there is no nexus between the management of occupational violence and the management of the anxious / depressed person however the reviewers believe this nexus to be very real.

### **Management of Occupational Violence (OV)**

In 2016-17, NWMH identified OV as its single biggest priority for the next 20 months. An Executive led working group was established and NWMH sought input from its staff, the unions and carers as to how it could improve safety in inpatient units. This input formed a workplan that has led to \$2.2m expenditure on OV initiatives as a means to reducing the incidence of OV in NWMH inpatient units. NWMH has undertaken a range of initiatives including;

- Installation of CCTV cameras
- Supported the use of 'lapel cams' by Security Officers responding to code events in mental health units or the Emergency Department
- Purchase of *Norix* brand, sand filled furniture
- Construction of airlocks between the LDU and HDU
- Installation of custody suite grade doors to HDUs

- Implemented the use of Saliva Drug testing kits
- Standardised the use of Drug Detector Dogs to search inpatient units
- Developed a protocol between NWMH and Victoria Police for the reporting of OV incidents
- Introduced a principle whereby NWMH would actively seek to prosecute perpetrators of OV
- Introduced rubberised toothbrushes for inpatients
- Our evidenced based and award winning Management of Clinical Aggression (MOCA) program was re-designed to provide more training to front line staff
- Introduced Lone Worker Devices for community clinicians
- Introduced a Security Officer 7 afternoon shifts per week to one NWMH Inpatient Unit
- Introduced a Nurse Practitioner Candidate to one NWMH Inpatient Unit

These initiatives in combination have served to make the inpatient units safer and have allowed NWMH to consider risk in a more thoughtful way and in particular whether we have the patient in the right care setting at the right period in their episode of inpatient treatment.

### **Incident Review**

Perusal of the information provided by MHJHADS prior to this review indicates that the incident investigation times for the 5 Sentinel Events was unreasonably long. The investigation for Incident 1 took 228 days, Incident 2 took 153 days, Incident 3 took 203 days, Incident 4 took 113 days and Incident 5 took 114 days. The average period taken to investigate and close off an incident was 167 days. Clearly, prolonged investigation times such as these represent a lost opportunity to quickly identify modifiable factors such as changes to infrastructure, policies and procedures, staff training etc. – which may not, in and of themselves, be causative factors but nevertheless if implemented may serve to reduce risk.

In the Victorian context, contemporary practice dictates that Root Cause Analysis methodology is utilised to investigate all inpatient suicides. In undertaking these RCAs, NWMH recognises the importance of maintaining a balance of internal and external RCA panel members. A senior panel member from another service ensures objectivity is maintained, and local service members are best-placed to provide a detailed understanding of local processes, and to provide advice about the relevance and application of recommendations under consideration.

NWMH is subject to *Safer Care Victoria* timelines which have recently been introduced in respect to incident investigation. These guidelines require incident investigation to be completed within 30 days and, at the present time, might be considered somewhat aspirational during this period of transition. Prior to the introduction of the *Safer Care Victoria* regime, NWMH was operating on a 60 day deadline to investigate a critical incident. So, whilst we strive to achieve a completed investigation within 30 days, investigations are certainly being completed within 60 days. Over the coming months NWMH will achieve incremental improvements to achieve the 30 day deadline.

### **NWMHs Experience Regarding Completed Suicide in Inpatient Units (or while on leave from an Inpatient Unit)**

In reviewing the summary information regarding the 5 sentinel events at ACT Health there does not appear to be any consistent themes or causal relationships that enabled the deaths to occur. Rather, it appears that a series of events or circumstances may have conspired to create the opportunity where it was possible for the patient to commit suicide. These sentinel events are currently subject to coronial investigative processes and it would be inappropriate to speculate any further at this point about causation. The reviewers did note that there had been no unexpected deaths in ACT Health inpatient mental health units for at least 10 years prior to these events and no deaths in the

18 months since. The reviewers consider that it is incorrect to view the 5 sentinel events as a cluster; rather these events should be viewed as a statistical spike in the context of 16 years, rather than in the context of an 18 month period.

A review of 9 years data 2006-07 to 2014-15 has enabled NWMH to quantify the frequency of a completed suicide occurring in each care type setting across NWMH and unsurprisingly the greatest frequency was in an acute youth unit and the lowest frequency was in aged residential. There was a ten-fold increase in risk between youth acute inpatient beds compared to aged acute inpatient beds. These are extremely rare events and sometimes, for no explicable reason, grouping of these rare events can occur.

In reviewing these deaths consideration was given to the following:

NorthWestern Mental Health (NWMH) operates 532 (in 2014-15) beds across a range of care types including;

- Youth, adult and aged acute inpatient units
- Adult residential rehabilitation
- Adult secure extended care
- Adult Eating Disorders
- Adult neuropsychiatry
- Adult prevention and recovery care service
- Aged residential care
- Aged hostel

The table below identifies the frequency of these events in NWMH over a nine year period and in a range of care settings.

Care Type Setting	Frequency of Completed Suicide
Youth Acute IPU	1 suicide every 17,520 beddays
Adult Acute IPU	1 suicide every 31,207 beddays
Aged Acute IPU	1 suicide every 177,390 beddays
Secure Extended Care IPU	1 suicide every 28,470 beddays
Aged Residential Care IPU	1 suicide every 542,025 beddays

### External Benchmarking

Eight years ago, NWMH convened a group of 8 metro and rural mental health services to engage in an external benchmarking process which continues to function with the cooperation of all 8 participants. NWMH serves as the secretariat and its senior Health Information Manager collates data and this is presented back to the group at quarterly meetings. The data is closely protected and is always presented in a format in which individual services cannot be identified. This has proven to be an excellent quality assurance activity and has provided comfort to the NWMH Executive, the Melbourne Health Mortality and Morbidity committee, and indeed to the Melbourne Health Board that NWMH is not an outlier in the statewide system. ACT Health may find similar value in joining an external benchmarking group of peer organisations in NSW or Victoria.

## **Carers ACT**

The reviewer's met with Ms Lisa Kelly, CEO of Carers ACT. Ms Kelly has a clinical background in psychology and has had professional appointments at *Lifeline* and *headspace* prior to her current role. Because of this background she is acutely attuned to suicide and she has done a lot of work in this area. Her work at *headspace* in particular gives her a deep understanding of the contagion effect and clustering of suicides that can sometimes occur in school communities. Ms Kelly shared her view that the 5 sentinel events in ACT Health did not represent a cluster as the term is generally understood in healthcare.

Carers ACT represents 48,000 carers – not just mental health carers, across southern NSW and the ACT and has a role in disbursing brokerage funding, policy development and supporting carers networks. Ms Kelly sits on the Mortality and Morbidity committee and as such she is privy to committee papers including Riskman reports and incident investigation reports.

Ms Kelly characterized the relationship with ACT Health as productive and healthy. She reports a high level of trust and respect for the Executive of the organization. She opined that she had a very good relationship with ACT Health Executive Director Ms Katrina Bracher who was proactive at raising issues with her, particularly adverse events. She considered that she had good access into the service and that ACT Health viewed the relationship with Carers ACT as an important partnership. By way of constructive criticism she opined that (a) the investigations into adverse events had been unnecessarily lengthy (b) there was a convoluted and somewhat confusing governance structure in place to deal with such matters and (c) it was somewhat difficult to understand what the investigative process was and what timelines were applicable to these.

In terms of a wish for the future, Ms Kelly said she would like to see better collaboration around suicide postvention strategies including bereavement care for affected carers.

## **ACT Consumer Network**

The reviewers met with Ms Dalane Drexler, Executive Officer from the ACT Mental Health Consumer Network. Ms Drexler conveyed that the ACT Consumer Network was well engaged with the service and had been involved in user groups for the design of new facilities and also the development of models of care. She described a collegial and productive relationship with MHJHADS and she had good access to ACT Health Executive Director Ms Katrina Bracher. She, or other consumer consultants were involved in most ACT Health committees including the Mortality and Morbidity and also the Seclusion and Restraint committees. By way of constructive criticism she opined that (a) the Seclusion and Restraint committee had been cancelled multiple times – Ms Drexler had raised this formally with Ms Bracher and a commitment had been given to re-convene the meetings in the near future and (b) the perennial observation that nursing staff in the acute unit are burdened with reporting tasks and are thus undertaking such tasks in the staff base or 'fishbowl' at the expense of engaging with patients out in the open spaces of the ward.

## **Service Context**

The reviewers noted a chronic skills shortage across all craft groups but most notably in nursing and medicine. These shortages are 4.2% for medical, 14.1% for nursing and 14.1% for hotel and allied health staff and consequently the service has a reliance on VMOs, locum medical staff and agency nurses. At particular times, such as over Christmas and New Year, these staff shortages are inevitably more pronounced as agency nurse supply dries up. The skills shortage needs to be seen in a broader context that could be considered to be a 'perfect storm' that, if not attended to, could contribute to organizational risk and a decrease in patient safety. The broader context includes:



- (a) Budget constraint – with a savings and efficiency target of 9% over 2 years
- (b) Steadily increasing demand for mental health services via the ED. Canberra Hospital ED growth in presentations is increasing year on year - from 2015-16 to 2016-17 there was an increase in the order of 8.5%.
- (c) A steadily reducing average length of stay (ALOS) – which is directly related to the increased demand for beds. In 2014-15 the ALOS was 10.4 days, 2015-16 the ALOS was 9.9 days, in 2016-17 the ALOS was 9.1 days and in 2017-18 the ALOS was 8.6 days – but sometimes as low as 6 days.
- (d) Occupancy rates consistently higher than 100% in the acute mental health unit and,
- (e) As ‘carve out’ options are pursued such as MHSSU, SUSD etc this has the effect of concentrating more and more acuity into the inpatient unit.

### **Acting Chief Psychiatrist ACT**

The reviewers engaged in a teleconference with the ACT Acting Chief Psychiatrist Dr Mandy Evans who has been acting in the role for the past year. A Chief Psychiatrist has been recruited and will commence in the role in August 2018. We discussed medical recruitment and retention. The service has been bedevilled by high turnover in senior medical staff roles. This has been compounded at times by provisions in the ACT Medical award which allows for a two week notice period on resignation – (compared to a three month notice period in Victoria) under these circumstances the Acute Mental Health Unit (AMHU) recently lost two senior medical staff in a four week period. This obviously makes it nigh impossible in the ACT to recruit to a vacant position prior to the incumbent vacating their post. The AMHU currently has vacant senior medical staff roles. A recent recruitment process saw three people apply, only one of which was appointable. In the past 12 months 12 senior medical staff have left the service out of a workforce of 33. There has been a heavy reliance on overseas trained doctors who tend to stay for relatively short periods. Dr Evans opined that the worst seems to be behind them and there is plenty of cause for optimism in the short to medium term in regard to recruitment and retention. Three locally trained registrars have gained fellowship over the past 12 months. One of these has been appointed at Calvary Hospital and the other two have accepted positions at the AMHU. Another four trainees are likely to gain fellowship in the next 12 months. The training program is regarded as excellent and candidates are achieving fantastic pass rates. We discussed governance and we understand that in the normal course of events MHJHADS has a structure in place similar to NWMH whereby a program is co-managed by a Lead Consultant and a Program Manager however consistent senior medical staff shortages over the past 18 months or so have made this difficult to achieve. We discussed the investigative process in relation to sentinel events and a view was expressed that these processes have been slow and cumbersome to the extent that the findings or recommendations lose their meaning or usefulness by the time they are tabled. Dr Evans commented that after a year in the role it was still very difficult to understand the reporting lines and connections between various service committees.

### **Summary**

The reviewers consider the bed-based mental health and drug withdrawal programs of MHJHADS to be safe and very competently managed by a skilled and experienced senior management team. The reviewers do not consider that the 5 sentinel events are representative of an unsafe service system. These events, while deeply regrettable, and no doubt tragedies for the 5 bereaved families, need to be seen in the context of 13-14 years of service history rather than the 18 month period in which these deaths occurred. We noted that there were no inpatient deaths for at least 10 years prior to these events, nor in the 18 months that followed.

The quality of the infrastructure is excellent with the exception of the Brian Hennessey Rehabilitation Centre – which is on the cusp of refurbishment. The Ligature safety program is superior to that undertaken by NWMH in terms of frequency, i.e 6-monthly, compared to annual audits conducted by NWMH, and MHJHADS is using state of the art ligature safe products to mitigate the risk of inpatient suicide.

Key service partners in Carers ACT and the ACT Consumer Network view the organization and their relationship with the service as positive and productive with high levels of confidence and respect for the senior management team including the Executive Director.

Notwithstanding the above, there are always opportunities for improvement and in that context the reviewers make the following 11 recommendations.

## **Recommendations:**

### **1. Workforce**

- MHJHADS should consider a sustained program of national and/or international recruitment for nurses and senior medical staff as a means to ensuring regular supply throughout the year. If recruiting nurses from overseas, MHJHADS should preference nurses with specialist mental health qualifications.
- MHJHADS should consider increasing both the number and the percentage of nursing staff who have specialist mental health qualifications as a means to ensuring that an appropriate balance is struck between attending to ligature safety risks in infrastructure vs mitigation of the risk of patients deliberately self-harming by enhancing the nursing skills that support therapeutic engagement with patients in inpatient settings.

### **2. Governance**

- MHJHADS should participate in the current review of corporate governance structures being undertaken across ACT Health with a view to clarifying the reporting relationships and explicating the accountability processes. MHJHADS should adopt clear criteria and timelines for the investigation and reporting of critical incidents and sentinel events.
- The reviewers recommend that a RCA be undertaken for all sentinel events and that ideally these be completed within 30 days but definitely within 60 days. The service should also seek to ensure external participation on RCA investigative panels.
- MHJHADS should consider adopting a governance model at team/unit level which has a Lead Consultant and a Program Manager heading up each program. Under this model both partners have equal power and authority and work together to manage the program. Under this model the Lead Consultant is responsible for managing junior and senior medical staff, medicolegal matters, legal responsibilities in regard to patients treated under the Mental Health Act and standards of care; the Program Manager is responsible for managing nursing, allied health and administrative staff, oversight of systems and processes and the operational management of the Program.

### **3. Quality Managers**

- MHJHADS should consider embedding quality improvement staff with the remit and skills to support quality improvement activities within the structures of the mental health service as a means to positively influence staff on the ground and effect change in mental health service delivery.

#### 4. Occupational Violence (OV)

- MHJHADS should undertake further work in the area of OV as a means to improving safety in the acute inpatient unit and to ensure that the High Dependency Unit is not consumed with providing care for the aggressive, violent patient at the expense of the vulnerable, passive and agitated depressed patient.
- We noted that AMHU does not have an internal CCTV system in place. In addressing the key issues of Occupational Violence and Ligature Safety consideration should be given to introduce CCTV in patient areas such as reception, lounge areas, courtyards etc as a tool to aid and support identification of incidents that may be attended to prior to escalation. In addition CCTV can assist observation of any prohibited substances or potential weapons brought into the Unit. With a total foot print of approximately 7,800 sq metres the AMHU is an extensive area to monitor and retain vigilance of internal and external activities. In addition, CCTV cameras serve to deter malicious property damage and occupational violence and CCTV cameras greatly assist the investigation of critical incidents and also supports the prosecution of individuals who engage in malicious property damage and interpersonal violence.

#### 5. External Benchmarking

- MHJHADS should consider convening, or joining an external benchmarking group for mortality and morbidity to gain an ongoing understanding as to how it performs in this regard against peer services.

#### 6. Ligature Safety

- MHJHADS should remove *Microshield* brand soap dispensers from patient areas such as ensuite bathrooms, activity rooms and circulation spaces in inpatient units. These dispensers are firmly attached to walls and constitute a ligature attachment risk.
- MHJHADS should correct (swap) the signage for the staff and patient toilets in the external area of the Dhulwa unit because as things stand currently, patients have access to a number of ligature hazards in the incorrectly designated 'patient toilet'.

Dr David Fenn



Mr Cosimo Brisci



Mr Peter Kelly

