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HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

Interim Bulletin

Provision of mental health care to adults in the emergency department

11 January 2018

Notification of Event and Decision to Investigate

The Healthcare Safety Investigation Branch (HSIB) was made aware of a woman experiencing a mental health crisis who, having presented to her general practitioner, ambulance service and the emergency department of her local hospital, subsequently took her own life. A preliminary investigation reviewed the care pathway of the woman spanning the two years preceding her death. Following an initial investigation, the Chief Investigator authorised a full investigation as it met the following criteria:

Outcome Impact – What impact has a safety issue had, or is having, on people and services across the healthcare system?

When adult patients experiencing a mental health crisis present at an emergency department, their condition, for a variety of reasons, can be difficult to assess. Thereafter, lack of timely access to an appropriately trained mental health professional during the patient's stay may have severe consequences on the outcome and duration of their treatment and may also impact upon the care of other patients.

Systemic Risk - How widespread and how common a safety issue is this across the healthcare system?

A review of national reporting data revealed that this was not an isolated incidence of suicide following access to an emergency department. The commissioning and delivery of mental health care in this clinical area is complex. Despite various initiatives designed to encourage patients to use sources of urgent mental health care other than emergency departments, many patients with mental health problems continue to present at emergency departments. The preliminary investigation identified disparity across the NHS in England in the level of risk assessment for adult patients with mental health problems on presentation at emergency departments and their subsequent care management.

Learning Potential – What is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

This investigation will seek to identify improvements in how the mental health care needs of adult patients can be effectively assessed and then how treatment can be appropriately and safely managed after presentation at the emergency department.

History of the Event

The HSIB preliminary investigation reviewed the case of a woman with a history of mental illness and suicidal thoughts.

The patient was under the care of the local mental health service and was reported to be receiving private psychotherapy. She had been treated at the emergency department of the local district general hospital following self-harm and had attempted suicide on three occasions within the previous 18 months. The penultimate presentation at the emergency department occurred six weeks prior to her death. On that occasion, she reported that she had taken an overdose and had also attempted suicide. The attempt was prevented by a worker at a railway station. She was taken to the local emergency department at midday where treatment was commenced. The patient left the department without notice after five hours. There is no record of a referral to psychiatric liaison or of any subsequent contact with the patient by the mental health services as a result of that visit to the emergency department. A member of the community mental health team made a home visit to the woman two days before her death.

On the day before she took her life, the patient presented to the GP, reporting that she had taken an overdose. She was advised to go to the local hospital emergency department. Following a call to 999 by a concerned relative and a call back to the patient by a clinician, the patient arrived by ambulance at the hospital emergency department at 20:19 on a weekday.

After a wait of just under an hour, she was triaged and treatment started. A set of observations and blood tests were taken and intravenous fluids administered. The hospital had a psychiatric liaison team, available between the hours of 08:00 and 23:00, however no referral was made to that team. The next entry in the electronic patient record notes that the patient left the department without notice in the early hours of the morning. The department attempted to contact the patient without success. At 09:40 the next day the patient presented at her GP practice for a prescription

of medication. The GP who saw the patient was reluctant to prescribe under the circumstances and the decision was deferred in the first instance and reviewed later that day.

In the early afternoon, the patient left a note on the railway station platform before lying in the path of an oncoming train. Following treatment at the scene, she was airlifted to the trauma unit, where she died of her injuries.

National Context

In recent years, effort has gone into raising the profile of the provision of mental health care in the emergency department, and most current initiatives are set against the background of the independent Mental Health Taskforce's *5 Year Forward View for Mental Health* report to the NHS in England in 2016.

There is also work being done to treat mental health close to home in the community and to give patients alternatives when they experience a crisis. Despite this, reports such as the Care Quality Commission's *Right Here, Right Now,* published in 2015, and the National Confidential Enquiry into Patient Outcomes and Death *Treat as One* report, published in 2017, highlight the increasing volume of emergency department mental health referrals and disappointing levels of patient satisfaction with that engagement.

There are National Institute for Health and Care Excellence (NICE) guidelines, as well other tools, to assist healthcare providers when commissioning adult mental health services in the emergency department but fully integrating those services often proves challenging.

Identified Safety Issues

During the HSIB's preliminary investigation the following safety issues were identified and will form the basis of the ongoing investigation:

- The appropriateness of assessment tools to identify patients at risk.
- Difficulties in the sharing of patient information within the emergency department.
- The emergency department may not be a place of safety for a patient experiencing a mental health crisis.
- Access to psychiatric liaison services.

Next steps

The HSIB will continue to investigate the safety implications of adult patients presenting at the emergency department with mental health problems. This will include a comparison of settings with well-established, 24/7 psychiatric liaison against those yet to implement a full-time service. The HSIB will report any significant developments as the investigation progresses and welcomes further information that may be relevant regardless of source.

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