3 March 2016

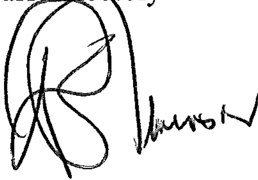
Samuel Barty
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank, VIC
3006

Dear Mr Barty

Re: **Response to the Coroner's recommendations arising from the investigation into the death of Joseph Pezzimenti**
Court reference: COR 2013 002320

Please find attached the written response from Mercy Mental Health to the recommendations arising from the Coroner's investigation into the death of Mr Joseph Pezzimenti.

Yours sincerely



A/Prof Dean Stevenson
Clinical Services Director
Mental Health Services
Mercy Public Hospitals Inc.

Response to Coroners recommendation
Joseph Pezzimenti
Court reference: COR 2013 002320

Recommendation

I repeat the recommendation in *Finding with inquest into the death of Maree Jones* where I adopted Coroner Spanos' recommendation 1 in the finding without inquest into the death of CB and urge Mercy Health to change its current policy that allow as patients in the Low Dependency unit to retain items that are capable of being used as a ligature.

I refer to the Chief Psychiatrist's guidelines Criteria for searches in an inpatient unit which states: *"for patients admitted to an inpatient service dangerous items may also include: ...any object that could be used to assist in a suicide attempt (for example, plastic bags, scarves, belts, shoe laces or headphone cords)'*

Further to avoid confusion it is preferable for Psychiatric Inpatient Units to take a consistent approach on this point and I urge Mercy Health to follow the position adopted by North West Mental Health and St Vincent's Hospital.

[Coroner Spanos made the following recommendation in her finding without inquest into the death of CB: 'I recommend that North West Mental Health change its policy that presently allows patients of the LDU to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrists Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.']

1. Mercy Mental Health's response to the Coroners recommendations is set out below.

Mercy Mental Health recognises the challenge in managing patient and staff safety in an in-patient setting whilst striving to work within the mental health principles in section 11 of the Mental Health Act 2014 and the National Recovery Framework. Mercy Mental has taken the following actions in response to the Coroner's recommendations:

A) 1) The Psychiatric Inpatient Risk and Visual Observations Procedure has been amended and is now known as the Psychiatric Inpatient Visual Observation and Engagement Procedure. The revised procedure highlights that in the case of suicide risk and/or self-harm being rated as medium to high, staff must consider the removal of ligature risks, and document this in the clinical file. The list of possible ligature is recorded in the procedure.

2) The Mercy Mental Health Risk Assessment tools have been reviewed and now comprise the Risk Assessment Mental Health form and the Mercy Mental Health Routine Risk Assessment sticker. The Mental Health Risk Assessment and Management Planning Procedure govern the use of the risk assessment tools. The tools prompt inpatient staff to consider removal of ligature risks if risk of suicide or self-harm is rated medium to high. The

decision to remove ligature from patients in LDU (now known as Recovery Care Area or RCA) is documented in the clinical file as per the prompt on the risk assessment form.

3) A memorandum has been developed to circulate to staff to highlight the Chief Psychiatrists Guideline: Criteria for searches to maintain safety in an inpatient unit. The memorandum is based on the document that NorthWestern Mental Health (NWMH) circulated to staff following the recommendation made by Coroner Spanos in her finding without inquest into the death of CB and has been used with the permission of the Director of Operation for NWMH. The purpose of this is to promote a consistent approach for psychiatric inpatient units as recommended by Coroner English.

4) The Mental Health Patient Search Procedure has been reviewed to ensure compliance with the Chief Psychiatrists Guideline: Criteria for searches to maintain safety in an inpatient unit.

B) Documentation to support Mercy Mental Health's response to the Coroners recommendation.

1) A copy of the Psychiatric Inpatient Visual Observation and Engagement Procedure is attached.

2) Copies of the Risk Assessment Mental Health form and the Mercy Mental Health Routine Risk Assessment sticker.

3) A copy of the memorandum to be forwarded to staff is attached.

4) A copy of the Mental Health Patient Search Procedure

Title: Psychiatric Inpatient Unit Visual Observations and Engagement Procedure

Division: MHVL

Facility or Program: Mental Health Services

Approved by: Program Director – Mental Health Services

Policy Link: Clinical & Quality Governance

Purpose

As part of the risk assessment and management of mental health inpatients, this procedure provides assistance to clinical staff in determining, reviewing and changing the level of visual observations and engagement required.

Visual observation is a prescribed nursing intervention detailing the time period that a person needs to be observed on the ward. Observation involves the purposeful gathering of both objective and subjective information about the patient and is guided by the risk assessment and management

Who Must Comply

All Clinical Staff

Procedure

Determining frequency of visual observation and engagement

- Initial levels of visual observations and engagement for all patients are determined by comprehensive psychiatric and risk assessment on admission. Guidelines for risk assessment are outlined in the Mental Health Risk Assessment and Management Planning Procedure.
- The frequency of the visual observations are determined by the results of the latest risk assessment. Table 1: Frequency of visual observation and engagement provides a guide to the required frequency of observation based on the patient's risk assessment.
- To facilitate this at a minimum, each patient will have an individual session with the contact nurse/treating team where risk and mental state will be reviewed, once in the day shift, once in the evening shift and as required on night shift. This will be documented in the continuation notes and on the Mercy Mental Health Routine Risk Assessment sticker. Ideally this will be conducted as early as practicable within the shift. The result of this review will be discussed with the nursing shift leader.
- The visual observations will take place on all areas of the unit, on all shifts.

Documentation

- The management plan for a patient must include current risk assessment and prescribed level of visual observation and engagement including rationale; this is to be documented within the clinical file.
- Occurrences of visual observations are to be documented according to their required frequency on the Visual Observations form AD2900. Visual observations may constitute a brief interaction with the client to determine the patient's activity level to then document the appropriate arousal level on the form.
- The Mercy Mental Health Routine Risk Assessment sticker and Visual Observations form AD2900, are required to be completed fully by 1300hrs during the day and 1900hrs in the evening by the respective staff. Forms and stickers are to be placed in the visual observations folder, and the previous 24 hours of forms moved and placed into the patient's clinical file.
- The rational for any change in level of observation and engagement must be recorded in the patient's clinical record.

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Reviewing and changing frequency of visual observation and engagement

- Alteration of visual observation levels and frequency will occur in consultation with the shift leader/treating team, following a change in the overall risk level. Review of the patient's clinical file must occur prior to a change in observation level. Refer to the 'Mental Health Risk Assessment and Management Planning Procedure'.
- If a risk assessment of a patient rapidly changes the ANUM can authorise an increase in visual observation urgently. If this occurs the treating team must be notified and a review undertaken as soon as practicable.
- Scores of (2) and above on the level of 'Activity' or arousal for two consecutive sightings should elicit a prompt to the contact nurse to undertake nursing interventions in order to prevent escalation of the client's arousal. This may in turn warrant a change in the risk assessment.

Table 1: Frequency of Visual Observations

Level of observation	Risk category	Definition
1- Routine	The default level of observation for low overall levels of risk for all inpatients	To be conducted at least three times per shift: - At the commencement of shift - At each meal time during the day and mid shift at night - Before conclusion of shift
2- Hourly	Minimum of 60 minute visual observations on all shifts	Patients in RCA deemed Medium risk
3- 30/60	Minimum of 30 minute visual observations on all shifts	Patients in RCA deemed High risk
4- 15/60	Minimum of 15 minute visual observations on all shifts	All Patients in ICA
Specialling	1:1 Continuous observation within arm's length. Refer to 'Specialling a Mental Health Client' procedure	High risk patients requiring continuous observation for safety

Risk category's and level of observation required are a guide only and can be more frequent on direction of ANUM or treating team.

- **Patients in Seclusion**: Seclusion guidelines must be adhered to. Please see 'Restrictive Interventions in a Designated Mental Health Service procedure.'

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- 15 minute visual observations may also be utilised within the Mother Baby Unit and rational must be clearly documented within the clinical notes. Consideration for a nursing special or a transfer to an inpatient unit must also be explored

Environmental checks

- Environmental checks must be completed at a minimum of once each shift in both ICA and RCA units.
- If a patient's risk assessment is indicating a Medium or High risk (regardless whether the patient is being nursed in RCA or ICA), a check of the patients personal belongings and/or an environmental room check may be required to remove any items which may be considered dangerous or inappropriate, these include dangerous items listed below and any other items considered to be a particular risk for the individual patient. This is due to these items having the potential to place the patient, visitors and staff at risk.

  Items that may be dangerous to patients at medium or high risk include but are not limited to the following:

  - Plastic bags and bin liners
  - Equipment that can be potentially fashioned into a noose or ligature such as scarves, pashminas, shawls, wraps, dressing gown or tracksuit cords, belts, cords, shoelaces, phone and headphone cords
  - Boots (steel capped)
  - Lighters/matches
  - Cans, bottles, glass, mirrors
  - Some toiletries (items which are considered flammable, ethanol based or considered toxic)
  - Jewellery (any objects which could be used as harm towards self or others)
  - Mobile phones (may be used under direct supervision only)
  - Items that can be used as a weapon such as scissors
  - Cutting implements such as razors

- In the case of suicide risk and or self-harm being rated as medium or high, staff must consider the removal of any ligature risks, and document this in the clinical file. This is prompted in the Mercy Mental Health Routine Risk Assessment sticker.

The patient's care plan must be tailored to incorporate the highlighted risk and include detailed information around the items considered dangerous or inappropriate for the patient. Staff must ensure that they are checking for any Dangerous items listed when conducting their visual observations.

Handover

- At the change of each shift two staff must complete a round of the unit together and ensure all patients are present.
- The frequency of visual observations and risk assessment must be discussed at each clinical handover as part of the client's overall care plan.

Precautions & Contraindications

N/A

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Title: Psychiatric Inpatient Unit Visual Observations and Engagement Procedure

Division: MHVL

Facility or Program: Mental Health Services

Approved by: Program Director – Mental Health Services

Policy Link: Clinical & Quality Governance

Definitions

Term	Definition
Psychiatric Inpatient Unit	Hospital Unit for mentally ill patients including Acute Unit Recovery Care Areas, Intensive Care Areas, Psychiatric Assessment and Planning Unit and Mother Baby Unit
Visual Observation	Observing a client, their 'Activity' level (arousal), and check for breathing if the client appears to be sleeping.
Contact Nurse	Nurse assigned to a client on a particular shift, who may or may not be the primary nurse.
Shift Leader	Nurse in charge of a particular shift.
Primary Nurse	Nurse assigned to a particular client as co-ordinator of his/her nursing care during an admission.
Shift	Shift times are AM: 0700 – 1530; PM: 1300 – 2130; Night: 2100 – 0730.

Links to Related Documents

- Mental Health Risk Assessment and Management Procedure
- Specialling a Mental Health Client Procedure
- Intensive Care Area Management Procedure
- Mental Health Patient Search Procedure

Key Legislation, Acts, Standards & References

N/A

Acknowledgements

N/A

Keywords

Risk Assessment, Visual Observation

Version History & Author / Contributors

V.	Date Created *(MM/YYYY format)*	Section(s) Changed *(eg procedure / definitions / references)*	Created/Amended by *(position title)*
1	01-07-2006		Nino Di Pasquale
2	07-12-2009		Noel Molloy
3	07/2012	Procedure	Nurse Practitioner Candidate & Forensic Specialist Clinician
4	02/12/2016	Procedure, terms.	NUM – Inpatient Unit
5	21/02/2017	Name of procedure, amended all sections	Quality co-ordinator Nurse Unit Manager

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RISK ASSESSMENT MENTAL HEALTH

UR No: ....

Surname: ....

First Name: ....

DOB: ....

OR Attach Patient Label

AD2890916

Assessed by: (full name) Date:

Team: Time:

☐ **INPATIENT RISK ASSESSMENT** ☐ **INTAKE RISK ASSESSMENT**

☐ **COMMUNITY RISK ASSESSMENT** ☐ **DISCHARGE RISK ASSESSMENT**

		PHx *(tick)*	RATING	REASONING *(Mandatory)*
1	**Risk of suicide** ☐ **Risk of self-harm** ☐ **L** = nil ideation or fleeting ideation, no plan/intent **M** = ongoing ideation, no plan or intent OR with plan & intent or immediate / recent past history of attempts **H** = ongoing ideation, plan, intent **and** an immediate / recent past history of attempts Inpatient staff to consider removal of ligature risks if M or H and document in clinical file	☐		
2	**Risk of self-neglect/accidental self-harm** (Homeless, inadequate food/fluid intake, personal hygiene/physical health care) **L** = nil evidence of above risk, currently untreated and may be at risk if untreated **M** = recent or ongoing evidence of self-neglect &/ or accidental self-harm **H** = Ongoing evidence of self-harm with major impact on client's physical and mental health	☐		
3	**Risk of violence/harm to others** **L** = nil ideas of harm to others or fleeting ideation to harm others no plan and intent **M** = ongoing ideation to harm others with no plan or intent or recent past history of violence **H** = ongoing ideation, plan & intent and an immediate or recent past history of violence	☐		
4	**Risk of violence, harm or neglect to infant/child** **L** = nil evidence of harm to infant / not applicable **M** = fleeting or ongoing ideation of harm/neglect to the infant **H** = ongoing ideation, plan & intent or/and an immediate / recent past history of harm/neglect of infant *NB: If rated Medium or High are Child Protective Services involved?* Yes ☐ No ☐ *(why/why not)*	☐		
5	**Risk of vulnerability/harm from others** (Sexual, physical or emotional harassment or financial exploitation) **L** = nil evidence of above risk or currently untreated and may be at risk if left untreated **M** = recent evidence of vulnerability/harm from others **H** = immediate and ongoing evidence of vulnerability/harm from others with major impact on client's physical and mental health	☐		
6	**Risk of absconding/non- adherence with treatment** **L** = nil evidence of above risk, or some ambivalence evident, however willing to accept treatment / attends and allows home visits **M** = reluctantly accepts treatment / attends and allows home visits **H** = refusing treatment and does not attend or allow home visits	☐		
7	**Risk of impulsivity/ level of distress** **L** = nil evidence of above risk or mildly distressed, aware of symptoms and able to control them / no impulsivity **M** = moderately distressed / nil immediate or recent past history of impulsivity **H** = acutely distressed with immediate or recent history of poor impulse control or responding to internal stimuli with plans to act / current impulsivity	☐		
8	**Influence of drugs and alcohol / history of use** **L** = nil evidence of above risk or not under the influence. Infrequent social use, no indication of harmful use, abuse or dependence **M** = intoxicated, alert, orientated and nil behavioural disturbance. Has an immediate or recent history of regular use with evidence of harmful use, abuse or dependence or moderate behavioural disturbance. At risk of withdrawal on discontinuation. **H** = intoxicated with acute behavioural disturbance. Has an immediate or recent history of daily or regular use with intoxication and significant harmful use, abuse or dependence. At risk of complicated withdrawal on discontinuation. *NB: Complete a Substance Abuse History Form if not already done.*	☐		
9	**Physical health risk factors or adverse effects from treatment** (eg diet, physical activity, overweight/obesity, high BP/cholesterol, diabetes, falls) **L**= nil evidence of physical health risk factors/adverse effects or actively treating physical health issues **M**= Physical risk factors/adverse effects identified but not causing significant impact on wellbeing **H**= Physical risk factors/adverse effects identified, impacting on wellbeing and/ or not treated/poor adherence to treatment	☐		

Mercy Health

RISK ASSESSMENT MENTAL HEALTH (Continued)

UR No: ....

Surname: ....

First Name: ....

DOB: ....

OR Attach Patient Label

STATIC RISK FACTORS PRESENT *(please check all applicable):*

☐ Mental Illness	☐ Male	☐ Absent or minimal social supports
☐ Unemployment	☐ Age (16-25, 40-44, 85+)	☐ Homelessness or itinerant
☐ Cultural & Diversity Stressors	☐ Trauma History	☐ Other (specify): ________

DYNAMIC RISK FACTORS *(please check all applicable):*

☐ Acute symptoms of Mental Illness	☐ Financial problems	☐ Recent unemployment
☐ Interpersonal – conflict/loss	☐ Legal/forensic issues	☐ Anniversary of significant event
☐ Morbid jealousy	☐ Lack of appropriate accommodation	☐ Suicide of family member
☐ Child protection Involvement	☐ Recent birth of a child	☐ Family violence
☐ Custody conflicts	☐ Recent pregnancy	☐ Other (specify) ________

TIPPING POINTS (end of relationship, argument at home, abused/bullied, loss of status or respect, death/ suicide of relative or friend, suicide of someone famous or peer group, media reports on suicide methods.

STRENGTHS / PROTECTIVE FACTORS

Changeability: (Refers to possible change in mental state, personal or environmental factors) ☐ **Low** ☐ **High**

Low Reliability: (Sense of confidence regarding available information to inform the assessment) ☐ **No** ☐ **Yes**

Information Sources Used: Consumer ☐ Consumer Records ☐ Carers ☐ Friends ☐ Other agencies ☐

OVERALL RISK RATING **LOW** ☐ **MEDIUM** ☐ **HIGH** ☐

GUIDELINES TO MANAGEMENT STRATEGIES

LOW:
- Routine Clinical Care
- Crisis Management plan discussed with consumer
- Ensure triage contact details are provided and encourage consumer to call as required.

MEDIUM:
- Initiate/optimise treatment of any mental disorder
- Consider triage alert
- Refer for appropriate Mental Health follow up
- Notify supportive other to stay with consumer
- Crisis management plan discussed with consumer
- Review within one week.
- Discuss treatment plan with specialist staff (e.g. Dual diagnosis).

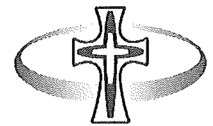
HIGH:
- As identified at medium risk
- Consider admission/ Compulsory treatment if necessary
- If consumer remaining in community discuss management plan with Consultant Psychiatrist
- Review within 24-48 hours

MANAGEMENT PLAN

NAME	**SIGNATURE**
DESIGNATION	**DATE**

MERCY MENTAL HEALTH ROUTINE RISK ASSESSMENT						
DATE: TIME:			**PHx**	**L**	**M**	**H**
1. Suicidality ☐ Self Harm ☐ Inpatient staff to consider removal of ligature risks if M or H and document in clinical file						
2. Risk of self-neglect/accidental self-harm (homeless, personal hygiene, food/fluid intake)						
3. Violence/ harm to others						
4. Risk of violence, harm or neglect to infant/child (consider CPS notification if M or H)						
5. Risk of vulnerability/harm from others (physical, sexual, emotional or financial)						
6. Risk of absconding/ non-adherence with treatment						
7. Risk of Impulsivity/ level of distress						
8. Current substance use, intoxication or withdrawal	**Y**	**N**				
9. Physical health issues or adverse effects from treatment						
10. Other (falls risk, use of restrictive interventions, PRN medication)						
Is the patient's level of risk highly changeable?					Y	N
Is the reliability of this risk assessment low? (poor engagement, conflicting info, etc.)					Y	N
Are tipping points present? (personal stress, recent death, end of relationship)					Y	N
Are there significant protective/ resilience factors present?					Y	N
OVERALL RISK RATING				L	M	H
*** RISK MANAGEMENT PLAN TO BE DOCUMENTED IN CLINICAL NOTES ***						

V2 9/16 P2299



Mercy Health
Care first

MEMO

To:	Clinical Staff
From:	Dean Stevenson, Clinical Services Director
CC:	MMH managers, CSQR committee members
Date:	28 February 2016
Re:	**Removal of Hazardous Items in Inpatient Units**

Staff are reminded to re-acquaint themselves with the Chief Psychiatrists Guideline – Criteria for Searches to Maintain Safety in an Inpatient Unit for Patients, Visitors and Staff, - revised to coincide with the release of the new Mental Health Act in July 2014. This guideline aims to describe search processes that are permissible by law and can ensure clinical safety while respecting patients' rights

Plastic bin liners and neck scarves have been implicated as the means to completed suicides in inpatient units in Victoria and as such these items should be removed from consumers and placed into safe keeping for the duration of the consumer's admission irrespective of the patients (a) legal status, (b) risk assessment or (c) care setting i.e. Recovery Care Area (formerly Low Dependency Unit) or Intensive Care Area (formerly High Dependency Unit). Mercy Mental Health recognises that this intervention is necessary for the safety of the patient being admitted to the inpatient unit as well as other patients already admitted to the inpatient unit.

Staff should interpret this memo to mean that they should also be vigilant to other items of clothing or equipment that can be potentially fashioned into a noose or ligature to be used in an act of deliberate self-harm. Such items may include, but are not restricted to 'scarves' also includes pashminas, shawls, wraps or other long pieces of fabric such as dressing gown cords, tracksuit cords, shoelaces, belts and headphone cords. These items must be removed from patients in the Intensive Care Area and may be removed from patients in the Recovery Care Area, subject to the patient's legal status and risk assessment that can potentially be fashioned into a noose or ligature to be used in an act of deliberate self-harm.

Notwithstanding the need to be vigilant in regard to other potentially harmful items, the need to undertake a search of the room or belongings of a patient admitted to a mental health inpatient service, or to undertake a physical search, must be based on an assessment of the patient and the level of clinical or environmental risk to the patient, other patients, visitors and staff. Based on this assessment, there will be times when it may be necessary to search a patient or their room and belongings to ensure their safety or the safety of others. This may occur at various points in an episode of care, for example, on admission to an inpatient unit, following any planned or unplanned leave, or prior to an episode of seclusion. While safety is the primary concern, human rights such as respect, privacy, dignity and confidentiality must be taken into account. Searching a patient or their belongings is an intrusive intervention that must only be used when it is the only reasonable and practicable course of action to avoid or prevent a serious risk of harm to a patient or harm to

Mercy Mental Health Saltwater Clinic

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Compassion Hospitality Respect Innovation Stewardship Teamwork

others. When a search is undertaken, every effort should be made to observe the patient's rights to the greatest extent possible under the circumstances.

Please note that Risk assessment forms and stickers have been amended to prompt you at times of assessment. The Visual observations procedure now named "Psychiatric Inpatient Unit Visual Observations and Engagement Procedure" has been amended to reflect these requirements; please familiarise yourself with this procedure on PROMPT.

Managers and clinical staff are asked to please ensure that this information is conveyed to clinical staff employed in the inpatient units who may not have access to email and via staff meetings and staff notice boards.

Dean Stevenson
Clinical Services Director.
Mental Health Services.

[Adapted with permission from a memorandum dated 8 September 2015 forwarded to inpatient staff at NorthWestern Mental Health authored by Mr Peter Kelly, Director of Operations, NWMH]

Title: Mental Health Patient Search Procedure

Division: MHVL

Facility or Program: Mercy Mental Health Program

Approved by: Director of Clinical Services

Policy Link: Care of Patients Policy

Purpose

This procedure will provide clinical guidelines to support clinicians in conducting a search of a patient and their belongings while receiving inpatient treatment in the designated Mental Health Service to ensure safety of patients, visitors and staff while respecting the patients' rights and dignity.

Who Must Comply

All Clinical Staff

Procedure

Mercy Mental Health is required to provide and maintain a safe therapeutic environment that promotes the safety, wellbeing and recovery of patients. Clinicians may at times be required to undertake a search of a patient's room or belongings to ensure the safety of patients, staff and visitors.

The term 'patient' in this procedure refers to a person who is receiving any form of a mental health service or treatment in a designated mental health service, including Mercy Mental Health inpatient units or patients awaiting inpatient admission in Werribee Mercy Emergency Department.

Patient searches are part of a health response and if a patient search is required this must be a clinician lead response, not a security response.

1. When to search:

A search is undertaken when:

- The patient is admitted to a Bed Based Inpatient Unit
- Risk assessment identifies a potential risk to the patient, staff or visitor safety
- A patient returns from leave
- A clinician believes the patient has items that may cause significant harm (I.e. dangerous or inappropriate items outlined over the page)
- An episode of seclusion is required.

Risk factors that should be considered when assessing the need to undertake a search include:

- Risk of suicide or self-harm
- History of violence involving weapons
- History of illicit substance misuse
- Forensic history, for example, arson
- Suspicion of concealing a weapon or a dangerous item/substance
- Risk of vulnerability leading to coercion or manipulation by another person to conceal a firearm, weapon or illicit substances that may cause harm.

Admission to the inpatient unit:

As part of the admission process, staff should routinely review with the patient, any possessions that have been brought onto the unit. The clinician may ask the patient to hand over any valuable items for safe keeping, and any dangerous or inappropriate items for safe keeping or disposal. All items removed should be clearly documented in the clinical file and the Management of Patient Valuables on an Inpatient Unit Procedure must be complied with.

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Return from day leave:

When there is a significant risk of a patient returning from leave with items not permitted on the unit, or with items that present a risk to the safety of patients, staff or visitors, consideration should be given to making a "search on return" part of the conditions of leave.

2. How to search:

Before the search:

- Discuss the proposed search with the shift leader
- Identify two clinical staff to conduct the search; ideally be the same gender as the patient
- Give the patient an adequate explanation of why the search is necessary and ask them to consent to the search

Seeking Consent:

A patient's consent must be sought before a search is undertaken. If the patient gives consent, the search should be conducted to ensure maximum privacy and dignity to the patient. The person conducting the search must ensure that patient being searched is informed that the search is voluntary and that consent can be withdrawn at any time.

All patients must be presumed to have capacity to give informed consent unless it can be demonstrated that the person lacks capacity at the time the decision needs to be made.

A person has capacity to give informed consent if they:

(a) Understand the information they are given that is relevant to the decision; and
(b) Is able to remember the information that is relevant to the decision; and
(c) Is able to use or weigh information that is relevant to the decision; and
(d) Is able to communicate the decision that is made (speech, gestures or any other means)

If a patient does not consent, the search must not occur unless there is a lawful reason.

If consent is refused:

If a risk assessment indicates that the search of a voluntary mental health patient is necessary in order to maintain safety in the inpatient unit or Werribee Emergency Department and safety of patients, visitors or staff, and the patient concerned refuses to consent to a search:

1. Proceed with the search if there is a lawful reason to do so

   When patients refuse, are unable or lack the capacity to consent – and discharge from hospital or refusal of service is unreasonable = a search may be authorised without that persons consent provided the need for a search is indicated by the risk assessment (providing a lawful reason) and provided the treating clinician, another senior clinician, authorises the search. Any search must also be proportionate to the level of risk.

2. Consider discharging the voluntary patient from the unit where there are safety concerns

   Any suggestion to discharge a patient should only be considered after consultation with the authorised psychiatrist/delegate and the treating team.

   Any suggestion to discharge a patient because of safety concerns would have to be weighed against duty of care considerations. The patients family or carer should also be consulted to ensure that adequate support arrangements can be put in place should the patient be discharged.

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Discharging a voluntary client because of their refusal to consent to being searched should be the last resort.

Respecting patient privacy and dignity:

Staff must ensure the patients right to privacy, dignity, safety and confidentiality is preserved during the search. This can be achieved by ensuring the following:

- Do not undertake the search in a public place, except in case of emergency.
- Do not undertake the search in the presence of other patients.
- Do not discuss the search outcomes with other patients.

Consideration must be made prior to conducting a patient search:

- Gender and gender sensitive search practices
- Cultural and religious issues
- Language barrier and if an interpreter is required
- Trauma history

Mental Health Act 2014:

The Mental Health Act 2014 (Section 354) outlines that search powers apply to a person who is required under the Act to be taken to or from a designated mental health service or any other place.

An authorised person may search a person before the person is taken to or from a designated mental health service or any other place if the authorised person reasonable suspects that the person is carrying anything that –

(a) Presents a danger to the health and safety of the person or another person; or

(b) Could be used to assist the person to escape.

The MHA (section 354) defines search of a person or of things in the possession or under the control of a person that may include -

- Quickly running the hands over the persons outer clothing or passing an electronic metal detection device over or in close proximity to the persons outer clothing; and
- Requiring the person to remove only his or her overcoat, coat or jacket or similar article of clothing and any gloves, shoes and hat; and
- An examination of those items of clothing; and
- Requiring the person to empty his or her pockets or allowing his or her pockets to be searched.

Search Types:

Type of Search	Description	Authorisation	Reporting/review
Search of a patients belongings and room	Search of room and belongings only	Nurse Unit Manager or Associate Nurse Unit Manager	Document in the clinical file and review within the multidisciplinary team
Non-contact search of a person	Requiring the person to remove items of clothing such as a jacket, hat or shoes. Emptying pockets or allowing pockets to be searched	Nurse Unit Manager or Associate Nurse Unit Manager	Document in the clinical file and review within the multidisciplinary team
Contact search of a person	Quickly running hand over the persons outer clothing or use of a metal	-Consultant Psychiatrist -Psychiatric Registrar/Medical Officer	Document in the clinical file and review within the multidisciplinary team

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	detector	-Nurse Unit Manager -On Call Manager -After Hours Coordinator	*Incident report must also be completed.*

Please Note: In the case of an emergency code grey the senior nurse on shift may authorise a contact search of a patient and must report to an authorised person as listed above.

Dangerous and inappropriate items:

Dangerous and inappropriate items are objects or substances that are seen as unacceptable possessions for patients receiving treatment and care, because they have the potential to place the patient, staff or visitors at risk of harm.

Dangerous Items include (during admission):	Inappropriate items include:
fluids that can induce toxicity such as alcohol	Chemicals and other hazardous substances
Prescription and over-the-counter medication	Illicit substances and associated paraphernalia
Explosives (including aerosols)	Tobacco (non-smoking policy)
Lighters/matches	Equipment that can be potentially fashioned into a noose or ligature such as scarves, pashminas, shawls, wraps, dressing gown or tracksuit cords, belts, cords, shoelaces, phone and headphone cords, jewellery
Weapons, potential weapons or firearms	Plastic bags/bin liners
Steel capped boots	Cutting implements such as scissors, razors Cans, bottles, glass, mirrors or Jewellery
Any item or objects that could be used to damage the facility	

- This list is not exhaustive and some degree of discretion should be exercised with regards to other objects not listed.
- NOTE: In the case of suicide risk and or self-harm being rated as medium or high (regardless whether the patient is being nursed in RCA or ICA), staff must consider the removal of any ligature risks, and document this in the clinical file. This is prompted in the Mercy Mental Health Routine Risk Assessment sticker.

Illicit substances and associated paraphernalia, weapons and other dangerous items seized in a search must be handled in accordance with the Removal of Harmful Substances Procedure and given to police as soon as practicable.

Documentation:

Once the search has been completed the following information must be documented in the clinical file:

- The reason for the search/ the risk that was assessed
- If consent was obtained/ or not
- Full name of all staff involved in the search
- Actions taken (description of the search)
- The outcome of the search; and
- Arrangements for storing or disposing of any objects or substances found.

An incident report must be completed into VHIMS under notification type Clinical Incident where indicated

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Visitors:
If staff believe there is a reason to search a visitors bags, staff must not touch the content, but request the visitor remove the contents for inspection. The visitor can be refused entry to the inpatient unit and, if necessary, asked to leave the facility.

Precautions & Contraindications

If the patient is 16 years old or younger then the search must be conducted in the presence of a parent, if it is not reasonably practicable for the parent to be present then another adult must be present (MHA 2014 - section 355)

Definitions

Term	Definition
MHA	Mental Health Act
Authorised person	A police officer, an ambulance paramedic, a registered medical practitioner employed or engaged by a designated mental health service, a mental health practitioner or a member of a class of prescribed persons.
Designated Mental Health Service	A health service that may provide compulsory assessment and treatment to people in accordance with the *Mental Health Act 2014*.

Links to Related Documents

- Compulsory Patient Procedure
- Mental Health Visitors to Adult Inpatient Unit Procedure
- Advance Statement Procedure
- Prohibited Items Procedure
- Removal of harmful Substances Procedure

Key Legislation, Acts, Standards & References

- Victorian Mental Health Act Victoria 2014
- NSQHS Standard 1- Governance for Safety and Quality in Health Service Organisations
- National Standards for Mental Health Services 2010
- Occupational Health and Safety Act 2004
- Crimes Act 1958
- Chief Psychiatrist's guideline – Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff

Acknowledgements

- Mental Health Act 2014, Section 354-356
- Chief Psychiatrist's guideline – Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff

Keywords

n/a

Version History & Author / Contributors

V.	Date Created *(MM/YYYY*	Section(s) Changed *(eg procedure / definitions /*	Created/Amended by *(position title)*

	format)	***references)***	
1	04/2005		Noel Molloy, WMPU Manager
2	03/2008		Noel Molloy, WMPU Manager
3	08/2014	Reviewed entire procedure	MHA Implementation Project Manager Inpatient Unit
4	02/2017	Statement relating to risk assessment amended to reflect both RCA and ICA	Quality Coordinator