NorthWestern Mental Health

Coroners Court
Level 11 222 Exhibition St Melbourne Vic 3000
03/03/2014

Inner West Area Mental Health Service – The Royal Melbourne Hospital

'Weratah'
Inner West Area
Mental Health Service
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Services provided:
Primary Mental Health Team
Continuing Care Team
Consultation and Crisis Liaison Service
Mobile Support and Treatment Team
Homeless Outreach Psychiatry Service
Area Service Administration

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Inner West Area Mental Health Service is a provider of services to The Royal Melbourne Hospital

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To the Coroner-

Response to Recommendations made following the investigation into the death of Renee Treen (Court Ref. COR 2010 002062).

Recommendations-

1. To increase the safety of patients, the John Cade Unit should undertake an evaluation of the current system for the allocation and implementation of visual sightings in the Low Dependency Unit. The evaluation should include an assessment of risk associated with a contact nurse with responsibility for co-ordinating the ward round having to negotiate and re-allocate responsibility for the visual sighting of their allocated patients to staff members.

This recommendation was implemented prior to the receipt of the Findings.

In early 2013 the "Clinical Risk Assessment and Management Guidelines" (CRAAM- attached) were introduced into the John Cade Inpatient Unit. In summary, these guidelines prescribe regular and recorded risk assessment and engagement of patients by inpatient nursing staff.

2. To increase the safety of patients in the Low Dependency Unit, the John Cade Unit should undertake an evaluation of all aspects of approved leave under the Mental Health Act 1986 (Vic), including approval, monitoring and recording. The scope of the evaluation is to include the effectiveness of the reliance of staff being available in the reception area and/or staff base to monitor compliance.

This recommendation was implemented after receipt of the Coroner's Findings.

A review of the Melbourne Health "Leave Arrangements from Inpatient Units- policy and procedure" (attached) was undertaken and it complied with all aspects of approved leave covered by the Mental Health Act 1986.

Staff in reception areas or staff bases have no specific role monitoring compliance of patients on leave. The responsibility for monitoring leave compliance is part of staff engagement of patients as outlined in the CRAAM guidelines.

3. The John Cade Unit should review the appropriateness of maintaining minimal frequency of nursing visual observations of a patient who is an involuntary patient under the Mental Health Act 1986 (Vic) and who has absconded from and returned to the Unit in any previous 24 hours and remains in the Low Dependency Unit until when practical, is reviewed by a consultant physiatrist.

This recommendation was implemented prior to the receipt of the Coroner's Findings.

The CRAAM guidelines direct that a patient who has absconded and who has returned to the unit has a revised risk assessment and plan.

4. To improve the safety of patients who are involuntary under the Mental Health Act 1986 (Vic) and who are tobacco dependent and who do have approved leave, the John Cade Unit should:

- Review the available body of evidence-based guidelines regarding withdrawal from tobacco, including best practice in the assessment, prevention, and management of withdrawal symptoms.

- Undertake a program of education with the medical and nursing staff that addresses not only the administration of the rules of a smoke free environment, including staff and patient safety, but best practice in the assessment, prevention, and management of withdrawal symptoms from nicotine as a substance of addiction and prevention or manage the symptoms.

This recommendation is to be implemented.

Although a number of inpatient staff received training through Quit Victoria in the past, it is acknowledged that refresher training is required. A Clinical Nurse Educator who has the relevant Quit training will run monthly refresher training for all inpatient staff. This training will cover a review of evidence based practises to assist with withdrawal from tobacco.

5. To improve out of hours access for patients, the John Cade Unit should install and ensure adequate signage proximate to the intercom at the front doors to the Unit with sufficient information to guide patients who return after 9.00pm on both how to use it and how to contact staff.

This recommendation was implemented after receipt of the Coroner's Findings.

A sign has been made and has been placed proximate to the intercom, which will guide patient access to the ward out-of-hours.

Yours Sincerely

Dr Richard Yeatman
Director of Clinical Services
Inner West Area Mental Health Services
John Cade Building- Royal Melbourne Hospital
Grattan St, Parkville, Victoria 3050

Cc A/Professor Ruth Vine
A/Professor Peter Burnett
Peter Kelly

PROCEDURE: Leave Arrangements from Inpatients Units			
Category:	Care Planning and Implementation	Ref No.:	NWMH02.02.02
Sub-Category:	Care Planning and Implementation	Version No.:	2.1
Issue Date:	16 May 2012	Expiry Date:	29 Aug 2014
Department:	NorthWestern Mental Health		

NAME OF DEPARTMENT	NorthWestern Mental Health
NAME OF DOCUMENT	Leave Arrangements from Inpatient Units
NUMBER	NWMH 02.02.02
ASSOCIATED MELBOURNE HEALTH POLICY	2. Care Planning and Implementation Policy
DEPARTMENTAL SPONSOR	Director of Clinical Governance, NWMH
FUNCTIONAL GROUP	NWMH Acute Services Managers
IMPLEMENTATION STRATEGY	NWMH Acute Services Managers will be responsible for the review of procedures relating to Leave Arrangements from Acute Inpatient Units across youth and adult. NWMH Acute Services Managers are responsible for the dissemination of information across their local area services, for consumers, carers and staff. NWMH Acute Services Managers will refer all procedures for endorsement to Director of Clinical Governance, NWMH and will provide regular updates.
EVALUATION STRATEGY	All updated procedures will be reviewed within the structures of NWMH All updated procedures will be reviewed within the structures of NWMH Clinical Risk Committee in line with the 3 year MH review process. Review may be completed earlier in response to changes in clinical procedures and/ or legislative requirements. Flagging for identification of this procedure will be in line with the MH iPolicy and the delegated author.
ACHS EQuIP CRITERIA	1.1.1 Assessment ensures current and ongoing needs of the consumer / patient are identified. 1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.
SUMMARY	The purpose of the procedure is to inform staff about the leave arrangements for consumers admitted to an acute mental health inpatient unit and AMHRU. Most if not all, admissions to an acute inpatient unit will involve consumers who are acutely unwell and will have associated risks. The initial policy and this revised procedure are in response to recommendations from a Root Cause Analysis (RCA).

1. ASSOCIATED POLICY

2. Care Planning and Implementation Policy

2. PURPOSE AND SCOPE

2.1. The purpose of the procedure is to inform staff about the leave arrangements for consumers admitted to an acute mental health inpatient unit and AMHRU. Most if not all, admissions to an acute inpatient unit will involve consumers who are acutely unwell and will have associated risks. The initial policy and this revised procedure are in response to recommendations from a Root Cause Analysis (RCA).

3. DEFINITIONS

Consumer	For the purpose of this procedure consumer refers to all persons admitted to an acute inpatient unit irrespective of their legal status

4. RESPONSIBILITIES

4.1. All NWMH inpatient staff including consultant psychiatrists, medical officers, nurses, allied health and administrative staff.

5. PROCEDURE

5.1. NWMH staff will implement and adhere to the National Mental Health Standard 10.3.6 and 10.5.5

5.2. NWMH staff should practice within the Framework for Recovery-oriented Practice, Department of Health (2011) that provides principles, capabilities, practices and leadership that should underpin a recovery-oriented approach to mental health service delivery.

5.3. The decision to grant leave, irrespective of the consumer's legal status, must be made within the context of the treatment objectives and strategies of the treatment plan.

a. Informal/voluntary consumers

i are entitled to discharge themselves from hospital at any time. If there are concerns for a voluntary/informal consumers wellbeing should they decide to discharge themselves, inpatient staff should attempt to persuade the person to stay in hospital until a mental state assessment and risk assessment is undertaken. If the person insists on leaving, it will be necessary to consider whether an involuntary treatment order should be made with respect to the person.

b. Involuntary consumers – provisions are contained within the Mental Health Act 1986

i s.40 the authorised psychiatrist is able to grant involuntary consumers leave of absence from an acute inpatient unit for periods of time and subject to any conditions that the authorised psychiatrist considers appropriate.

ii s.41 The authorised psychiatrist may allow an involuntary patient to be absent from the approved mental health service for the purpose of receiving medical treatment

5.4. NWMH staff need to be familiar with the Inpatient Leave of Absence, Chief Psychiatrists Guideline, Department of Health, (2009) on leave from an inpatient unit:

a. Key principles

i The decision to grant leave of absence must be made within the context of the treatment objectives and strategies of the patient's treatment plan.

ii The granting of leave to any patient whether they are involuntary or informal, requires the treating psychiatrist to give due consideration to the reasons why the patient has requested leave and the likely associated benefits and risks. Such risks include, but are not limited to, the risk of harm to self or others (including any child protection issues), the likelihood and consequences of substance use, absconding from care, and vulnerability. These risks need to be balanced against the benefits of leave such as maintenance of social contacts, attending to family responsibilities, maintaining education/employment or other structured activity and the capacity to assess for less restrictive treatment.

iii A decision to grant leave should include consideration of anticipated activity while on leave, such as use of public transport or private vehicle

iv When deciding whether to grant leave under s.40 of the Act, the authorised psychiatrist or his or her delegate should be mindful of the following principles set out in s.4(2) of the Act which are intended to guide the making of all decisions under the Act:

- that people with a mental disorder are to be given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and the least possible intrusive manner consistent with the effective giving of that care and treatment; and
- that any restrictions upon the liberty of patients and other people with a mental disorder and any interference with their rights are to be kept to the minimum necessary in the circumstances.

v Where possible, leave should be planned well in advance and should occur as a result of discussion and routine treatment planning within the treating clinical team, in consultation with

the patient and carers where this is indicated. If a leave request is made after hours at short notice, or on weekends when the usual treating team is absent, the person responsible should ensure they are familiar with all aspects of the treatment and care provided, and are able to adequately weigh up the risks and anticipated benefits of the requested leave. Where adequate information is not available, a decision should generally be deferred until clinicians familiar with the full clinical picture of the patient are available.

vi Decision making about the purpose and granting of leave should be clearly documented and communicated to the patient, their primary carer (where appropriate), and relevant clinical staff.

vii Newly admitted patients should generally not be granted leave until the treating team has developed sufficient familiarity with the patient to allow a valid mental state and risk assessment to be made.

5.5. NWMH staff need to adhere to the practice procedures (risk assessment, communication and documentation) outlined in the Office of the Chief Psychiatrist program management circular on leave from an inpatient unit.

a. All consumers should have a clearly documented risk assessment and risk management plans that are referenced in leave decisions.

b. The leave plan, approval from the authorised psychiatrist or delegate, communication of the plan to consumer and carer where indicated, the departure and return time should be clearly documented.

c. A consumer's mental state and risk assessment should be reviewed immediately prior to commencing leave.

d. If a request for leave is made at short notice or at other times when the usual treating team is unavailable, a responsible person should familiarise themselves with all aspects of treatment and care of the person and weigh up the anticipated risks and benefits of the requested leave.

e. Where adequate information is unavailable, the decision to grant leave should generally be deferred until clinician's familiar with the consumer is available.

f. Newly admitted consumers should generally not be grant leave until the treating team has developed a full clinical picture of the individual to enable a valid mental state and risk assessment to be made.

g. A Leave of Absence form (MHA21) must be completed for all involuntary consumers. This form is to be used for involuntary consumers who are to be absent overnight or for longer periods and at other times at the discretion of the authorised psychiatrist or their delegate.

h. If a consumer fails to return from an approved period of leave within the expected timeframe, the senior nurse and on call consultant psychiatrist should be notified as soon as possible.

i. The decision to notify police is to be made by senior staff and is dependent on pre-leave risk assessment, legal status of the consumer and duration of leave.

5.6. Leave should be planned well in advance and should occur following discussion amongst the treating team and in consultation with the consumer and carer where indicated and should address the following:

a. The purpose of the leave, its duration and any special conditions should be discussed with the consumer prior to leave being granted. Where appropriate, the consumer's carer should be involved in these discussions. The discussions should also include the provision of a crisis plan in the event that problems are encountered.

b. Any expectations placed on the carer are to be discussed with both the consumer and carer.

c. If the consumer is being considered for leave under the effective supervision of a responsible adult, this must be discussed with both the consumer and carer. If the carer is unable or unwilling to accept this responsibility, any decisions regarding leave should be reviewed.

d. Consideration should be given to the appropriateness of the "accompanying adult", i.e. their ability to exercise appropriate responsibility and effective supervision.

e. Consumers and carers should provide contact numbers for the duration of the leave to assist staff with any concerns they may have during the leave period.

f. Upon returning from leave, an assessment of the consumer should occur. The carer should also be consulted to ensure any issues arising from the leave are identified.

g. Post-leave assessment, collateral from family/carer including any issues arising from the leave must be documented within the clinical progress/continuation notes.

6. ASSOCIATED PROCEDURES

6.1. 02 Care Planning and Implementation Policy

6.2. NWMH 01.01.02 Request & Recommendation for an Admission

6.3. NWMH 01.01.04 Access to Acute Mental Health Inpatient Beds

6.4. NWMH 13.01.01 Statutory Documentation – Mental Health Act

7. REFERENCES

7.1. Framework for Recovery-oriented Practice, Department of Health (2011)

7.2. Department of Health and Ageing (2010), National Standards for Mental Health Services

7.3. Inpatient Leave of Absence, Chief Psychiatrists Guideline, Department of Health, (2009)

7.4. Working together with families, Chief Psychiatrist Guideline, Department of Health (2005)

7.5. Mental Health Act 1986 with Amendments

8. FURTHER INFORMATION

8.1. Director of Clinical Governance, NWMH

8.2. Director of Operations, NWMH

8.3. Directors of Clinical Services, NWMH

9. DOCUMENTATION

9.1. Clinical Risk Assessment and Management (CRAAM)

9.2. CRAAM Safety Plan

9.3. NWMH Intensive Care Area (ICA) Treatment Plans

9.4. Clinical progress/continuation notes

9.5. Daily Bed Return Sheets

9.6. Schedule 1 - request for a person to receive involuntary treatment from an approved mental health service

9.7. Schedule 2 - recommendation for a person to receive involuntary treatment from an approved mental health service

9.8. Schedule 3 - authority to transport without recommendation

9.9. Schedule 6 - involuntary treatment order

9.10. MHA1 - examination of involuntary patient by authorised psychiatrist

9.11. MHA4 - treatment plan a4 size

9.12. MHA5 - appeal to the mental health review board

9.13. MHA6 - community treatment order

9.14. MHA8 - variation of community treatment order

9.15. MHA9 - extension of community treatment order

9.16. MHA10 - revocation of community treatment order

9.17. MHA11a - restricted community treatment order

9.18. MHA16 - discharge from involuntary patient status

9.19. MHA26 - informed consent to major non-psychiatric treatment

9.20. MHA27 - substitute consent to non-psychiatric treatment

9.21. MHA32 - annual examination of patient a4 size

9.22. MHA33 - notice of death of person undergoing treatment or care for a mental disorder

9.23. Form 4B-Certificate of Psychiatrist for restricted involuntary treatment order

9.24. Form 5B - Report of authorised psychiatrist for restricted involuntary treatment order

9.25. MHA3 - Examination of security / involuntary / forensic patient by authorised psychiatrist

9.26. MHA12A - Progress report on restricted community treatment order

9.27. MHA13A - Variation of restricted community treatment order

9.28. MHA15A - Revocation of restricted community treatment order

9.29. MHA17A - Discharge from restricted involuntary treatment order / assessment order / diagnosis, assessment and treatment order

9.30. MHA18 - Discharge of security / involuntary patient

9.31. MHA20 - Transfer of a security / involuntary / forensic patient by chief psychiatrist

9.32. MHA34 - Certificate of psychiatrist

9.33. MHA35 - Report of authorised psychiatrist

10. REVISION AND APPROVAL HISTORY

Date	Rev No	Author and approval
September 2005	0	Director, NWMH
January 2010	1	Acute Services Managers Committee, NWMH Continuous Improvement Commitment, Authorised by Peter Burnett, Director of Clinical Governance, NWMH
August 2011	2	Peter Kelly, Acute Services Managers Committee, NWMH Continuous Improvement Commitment, Authorised by David Barton, Acting Director of Clinical Governance, NWMH
May 2012	2.1	Minor changes – numbering and authoriser