# Quality improvement themes from coronial recommendations received by the Chief Psychiatrist in 2005

**Chief Psychiatrist** Information

## Purpose

This information is a summary of themes from the coronial recommendations over the 2005 calendar year. It is intended to inform quality improvement activities and assist services to focus on key practice improvement areas.

## Introduction

Under the provisions of the *Mental Health Act 1986*, mental health services are required to notify the Chief Psychiatrist of the death of any patient that is a reportable death within the meaning of the *Coroner's Act 1985*. The Chief Psychiatrist registers an interest with the Coroner in relation to the findings arising from any coronial inquest or inquiry into such deaths. The Chief Psychiatrist is in a unique position to review these finding and to identify emerging themes across the service system. Currently, the Chief Psychiatrist publishes regular summaries of Coronial findings for the mental health sector – these summaries draw together the key clinical practice and standards issues for a given period and highlight areas for ongoing quality improvement action. Services are encouraged to review their local practices, policies and procedures and implement action plans in relation to the issues identified.

## Management of patients on clozapine

Following the deaths of a number of patients on clozapine, the Coroner highlighted that all psychiatric facilities, clinicians and case managers involved in offering inpatient or outpatient clozapine treatment should be alert to the possible side effects of the drug including the development of myocarditis. They should insure complete compliance with the drug manufacturer's clinical guidelines and ensure frequent monitoring of patients.

**Chief Psychiatrist's comments**

The Chief Psychiatrist endorses the Coroner's recommendations in relation to compliance with the drug manufacturer's clinical guidelines for clozapine. Each service should have local policies and protocols in place in relation to the management of patients on clozapine, including staff training and patient monitoring.

## Review of patients by psychiatrists

The timely review of both inpatients and community patients by consultant psychiatrists is also an issue raised by the Coroner, for example:

- All patients entering community psychiatric services should be seen by a consultant psychiatrist within a reasonable time following admission and also have periodic reviews by the consultant psychiatrist.
- Patients admitted to an acute inpatient unit should be seen by a consultant psychiatrist within a reasonable period of time.
- Involuntary patients and patients admitted following revocation of a Community Treatment Order (CTO) should be reviewed by a consultant psychiatrist within 24 hours of admission.

**Chief Psychiatrist's comments**

It is good clinical practice for all patients to be seen by a consultant psychiatrist within a week of commencing treatment with a community mental health service. They should be reviewed by a psychiatrist as required at least once every three months. The recommendations in relation to review following admission as an involuntary patient is in keeping with the requirements of the *Mental Health Act 1986*. The recommendation regarding review following revocation of a CTO is consistent with the standards set in the *Chief Psychiatrist's guideline on Community Treatment Orders, November 2005* (CPG01111)

State Government Victoria

## Deaths in seclusion

Though infrequent, deaths in seclusion do occur and they are very traumatic events for all concerned. There were two deaths related to seclusion in Victoria in 2005 and the coroner made several recommendations in relation to these deaths. Both deaths occurred following the administration of high doses of medication. The Coroner's recommendations included:

- Twelve monthly audits to check compliance with the development of local policies and procedures governing the use and management of seclusion, including the usage, times and reasons for seclusion.
- Guidelines to clarify circumstances that can be regarded as 'emergency' for the purpose of secluding a patient. (*Under the Mental Health Act 1986, the senior nurse on duty can authorise seclusion only in an emergency. This is, however, the most common means of authorising seclusion with little clarity of what the term 'emergency' means*.)
- Audits of nursing staff as to their knowledge and understanding of both the Chief Psychiatrist's guidelines and hospital policies in respect to the management of patients in seclusion.
- That DHS in conjunction with the Chief Psychiatrist and other relevant stakeholders investigate ways in which the use of seclusion can be reduced with appropriate bio-psychosocial interventions.
- That DHS in conjunction with the Chief Psychiatrist and relevant mental health services develop a professional development program for the training of nurses in relation to seclusion practice.

**Chief Psychiatrist's comments**

Partly in response to these recommendations, the project 'Creating Safety – addressing seclusion practices' is being jointly undertaken by the Chief Psychiatrist's Quality Assurance Committee and the Victorian Quality Council. This project aims to address some of the issues involved in the project with seclusion practice and to reduce the use of seclusion. Services will be informed and involved in the project at various stages. Your attention is also drawn to the current *Chief Psychiatrist's guideline on Seclusion, October 2006* (CPG06052)

## Potential hanging points in inpatient units

Following a number of inpatient suicides by hanging, the Coroner felt that facilities providing treatment to people who are at a risk of self-harm should examine the facilities for potential hanging points. This is best done by a proper audit with a risk assessment tool.

**Chief Psychiatrist's comments**

The current DHS design brief for new facilities provides guidance for services developing new units or undertaking significant modifications or refurbishment. Services considering any modifications or refurbishment should also bare these guidelines in mind. I am aware that Australian Council on Healthcare Standards (ACHS) are also paying particular attention to risk management and potential hanging points during in-depth accreditation reviews, in some cases proposing physical fabric changes which are inconsistent with existing building codes and design guidelines. This matter is currently the subject of discussion with ACHS at a national level and services will be advised of the outcome of these discussions.

## Observation of high-risk patients

The observation of high-risk patients is another important area of nursing care and standards of clinical practice. Documentation of observations varies significantly between services. 'When 15 minute observations are recommended, these observations must occur within the 15 minutes since the last observation, instead of every 15 minutes as previously applied. Staggering these observations is intended to prevent patients creating plans because they are unable to work out when a staff member may return to check again.' With respect to a number of inpatient suicides, and suicides following absconding from inpatient units, the coroner made the following recommendations:

- Documentation of observations is an important nursing clinical tool. It also serves as a means of communication between health care professionals about a patient's status at particular designated times. Documentation must be accurate to be reliable and in order to be reliable there must be certainty that the observations will, in face, be done when they are required. Unless there is certainty as to who is responsible for the taking and recording of observations, it is difficult to place much faith in accuracy. Despite the best intentions of a 'team', designated observation times may be overlooked in the absence of a roster, which allocated the responsibility to a specific staff member. (*The Coroner recommends that services implement a designated roster of responsibility for the taking and recording of patient's observations*).

**Chief Psychiatrist's comments**

In response to previous coronial recommendations, the Chief Psychiatrist has alerted clinicians to the importance of accurately recording the time an observation is made (rather than using a preset checklist and staggering observations within the 15 minute intervals.) The Coroner's recent comment regarding the staggering of observation intervals is consistent with this view.

## Involuntary patients in general hospitals

The Coroner raised the important issue of the management of mentally ill patients (especially involuntary patients) in general hospitals. Some of the recommendations made by the Coroner in relation to this matter include:

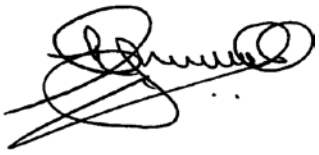
- That health services and health professionals develop holistic models of care that meet the multiple needs of patients.
- That the disciplines of psychiatry and general medicine develop a working relationship that results in better management of complex patients and, in particular, avoid compartmentalising patient care.
- The development of specific policies and procedures for addressing the mental health issues of patients in general hospitals who are subject to involuntary orders under the *Mental Health Act 1986*.
- Proper procedures for the transfer of legal responsibility for and communication about patients between community mental health teams and Consultation and Liaison psychiatry teams in general hospitals.
- Procedures for ensuring that both the legal status of acute medical patients subject to involuntary psychiatry treatment orders, and the psychiatric consultant who is legally responsible for supervising their orders is clearly indicated and updated in the general hospital medical files.
- Education and information sessions to raise awareness of the role of consultation liaison psychiatry services and the responsibilities of the authorised psychiatrist in relation to patients on an Involuntary Treatment Order in general hospitals.

**Chief Psychiatrist's comments**

The Chief Psychiatrist encourages the development of clearer protocols and procedures regarding the management of mentally ill patients in general hospitals. Where the patient is involuntary under the Mental Health Act, the authorised psychiatrist retains responsibility for the patient's mental health treatment and care.

## For further information

For further information about the **coronial recommendations and the Chief Psychiatrist's comments** please contact the Chief Psychiatrist on (03) 9096 7571 or 1300 767 299 (toll free)



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