West Coast District Health Board

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28 August 2018

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RE Official information request WCDHB 9185

We refer to your email dated 20 July 2018 to the Ministry of Health requesting information under the Official Information Act. The Ministry subsequently transferred the following questions to West Coast DHB on 7 August 2018, regarding the issue of the proper monitoring of mental health patients during breaks and leave.

ii. How do units monitor where patients are at all times?

We follow our General Observation Policy (attached as **Appendix 1**).

iii. Are there sign in/out procedures used at all facilities?

The Daily Recording Sheet is used by staff to sign patients in and out of the unit

iv. What are the definitions for locked, flexi and open wards?

Open ward: free access for patients to come and go.

Locked ward: requires environmental entrances/exits to be locked to ensure the safety of any particular inpatient at the time based on legal status under the Mental Health Act and clinical need.

v. Are these definitions used consistently?

Yes, the unit has a locked door policy from 21.00 to 07.00 hours. Locking of doors outside of this time period requires completion of incident form being completed based on the requirements above.

vi. Can involuntary patients be on open wards?

Yes, we only have one ward and need to provide an appropriate environment for all patients under care. Additionally not all patients under the MHA require a Locked Ward. The decision to change to a Locked Ward is based on clinical assessment of acuity and risks of individual patients.

vii. If patients do not return to the unit when they are supposed to, what is the protocol?

West Coast DHB staff will contact the client's family initially. If the client is deemed a risk the AWOL procedure is implemented. (Please find attached as **Appendix 2** the Inpatient Absence without Leave Procedure Policy). This standardised process covers off risk to self and others, including community, emergency services, family and management is notified.

viii. If patients are on escorted leave and somehow get away from their escort, what is the policy?

The response would be determined by the level of risk the person poses to themselves and or others, and the legal status they may be under. As above the AWOL procedure would be implemented.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website ten working days after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

	Observations In The IPU Procedure	Procedure Number *WCDHB-MHS-0030*	Version Nos: 7

1. Purpose

This Procedure outlines the clinical indicators for increasing the level of observation, and the process of authorising and cancelling any increase in observation within the West Coast District Health Board (WCDHB) Mental Health Service (MHS) Inpatient Unit (IPU).

2. Application

This Procedure is to be followed by all staff involved in arranging and providing special level care in Manaakitanga IPU.

3. Definitions

For the purposes of this procedure

Special care and observation requires that the nurse is fully attentive to the service user while minimising the extent to which they feel that they are under surveillance. The nurse provides a level of increased engagement through an enhanced level of therapeutic intervention.

There are three types of observations:

General Observations	The minimal acceptable level of observation for all in-patients. The location of all patients should, in general terms, be known to the staff at all times. This includes **intermittent observation as part of planned care** where there is concern that an individual may be deteriorating.
Special Care Observations	**The nurse remains with the client at all times**: required when there is direct concern about the risk of self harm, problematic behaviour or harm to others. The individual is kept within sight at all times, by day and by night. It may be necessary to search the person and their property to ensure they have no access to potentially harmful implements.
High Level Observation	**The nurse maintains a physical closeness to the client (within arms length)**: at times of the highest level of risk the person may need to be nursed in extremely close proximity. On rare occasions more than one nurse may necessary. Issues of privacy, dignity and gender need to be considered in allocating staff.

4. Responsibilities

For the purposes of this Procedure:

The decision to place a client on special level care observation is to be made jointly by the responsible psychiatrist and nursing team; except in an emergency. The decision is based upon an assessment of the client's changing presentation and risk profile. Once commenced, any change to the level of special care observation may only occur after consultation between the nursing team and the responsible psychiatrist.

The **Clinical Nurse Manager** is responsible for ensuring staffing levels are adequate to enable the increased level of special care observation. When this is instigated after hours, the shift coordinator (IPU) and/or the Duty Nurse Manager will undertake this responsibility.

The **In-Patient Nursing** Team maintains responsibility for the safety of all in-patients on general observations. The handover between shift changes of staff allows for all involved to be made fully aware of observation requirement and levels.

5. Resources Required

This Procedure requires no specific resources.

6. Process

1.00 Risk Management

1.01 Special Care and High Level observations are a short-term intervention to aid in managing and reducing actual/potential high risk situations. Once the factors compounding risk are reduced then the level observation should be reduced accordingly.

2.00 Clinical Management

2.01 An increased level of care and observation is an opportunity for the nurse to interact in a therapeutic way, enhancing engagement through one-to-one interactions.
Nursing includes:

- Demonstrating an unconditional positive regard;
- Initiating conversation and conveying a willingness to listen;
- Self-disclosure and the therapeutic use of silence as MH nursing skills;
- Encouraging participation in planned activities that enhance engagement;
- Providing information about the reasons for observations and the possible duration of the increased level of care observation;
- With the service user's permission - discussing with their family and carers about the aims and purpose of observation.

3.00 Special Level Care and Observations

3.01 No period of observations by a staff member should be for longer than 2 hours; Ideally staff undertaking all types of close observations should be relieved hourly.

3.02 Special Care Observations should be reviewed by the Psychiatrist and Nursing Team at least twice a day, 1-2 hours prior to the completion of the shift and at any point where the nursing assessment indicates a significant change.

3.03 High Level Observations should be reviewed at least 3 times during the day (morning review, shift change over, and prior to night shift) and at any point where the nursing assessment indicates a significant change.

3.04 All interventions and decisions regarding special care level observations are recorded in the clinical notes. These records should include:

- Current mental state
- Current evaluation of risk
- Changes to level of observation
- Clear direction regarding the therapeutic approach
- Timing of next review

3.05 Prior to the end of each observation period, the nurse will document their assessments, interventions and specific observations of the service user in the clinical notes

3.06 Both nurses will sign the WCDHB MHS Special Observation Form when starting/ending or temporarily relieving staff.

7. Precautions and Considerations

➔ No period of observation by a staff member should be for longer than 2 hours; ideally staff undertaking close observations should be relieved hourly

➔ No period The nurse is required to document their observations in the clinical notes.

➔ It is mandatory that both nurses shall sign the WCDHB MHS Special Observation in Mental Health Unit Record Form.

➔ Special Care and High Level observations are highly intrusive and should only be used at times when the client's overall safety needs indicate this necessity.

➔ Special Care and High Level observation should never be a part of routine care.

8. References

There are no references associated with this Procedure.

9. Related Documents

- WCDHB MHS Special Observation in Mental Health Unit Record Form
- WCDHB MHS Procedure: Arranging a Mental Health Special in Hospital Services
- WCDHB MHS Special Observation in Hospital Services Form

Revision History		
	Version:	7
	Developed By:	Mental Health QI Co-Ordinator
	Authorised By:	MHS Clinical Governance
	Date Authorised:	July 2002
	Date Last Reviewed:	August 2011
	Date Of Next Review:	August 2013

Inpatient Absence Without Leave (AWOL) Procedure

1. Purpose

This procedure provides direction and guidance to West Coast District Health Board (WCDHB) Mental Health Service (MHS) staff when clients are absent without leave (AWOL) from Manaakitanga (the Inpatient Unit) or do not return from an approved period of leave.

2. Application

This procedure is to be followed by all MHS Inpatient Unit staff. The Clinical Nurse Manager, or after hours the senior nurse on duty will take responsibility for ensuring this process is carried out. After hours, the Duty Nurse Manager will be available to support and assist with decision making.

3. Definitions

For the purposes of this procedure:

Leave is taken to mean a process whereby a client is granted time away from the unit, for a period of time, agreed by the client, the treatment team and their family/ whanau/ caregivers.

Absent without Leave (AWOL) is taken to mean a situation where an inpatient under the Mental Health Act (MHAct) provisions leaves the unit without permission and where any MH Act client fails to return to the unit at the completion of an agreed period of leave.

Missing and of Concern is taken to mean an informal client leaves the unit without notifying staff, or fails to return from an agreed period and there may be risks or concerns.

4. Responsibilities

For the purposes of this Procedure:

The **Case Manager** is responsible for;

- Identifying with each client (& their family whanau) and recording in the client's Treatment and Recovery Plan the appropriate number of planned respite days/hours (if any)
- Making application on the Mental Health Application for Crisis and Planned Respite Form to the relevant budget holder for Planned Respite on each occasion (for accounting purposes)
- Co-ordinating suitable accommodation (or service) to provide a safe and caring environment
- Monitoring the effectiveness of the planned respite in accordance with the resources allocated
- Developing an annual plan for planned respite care based on the needs of their client base, and communicating this to their Clinical Manager/District Manager

The **Clinical Manager/District Manager is** responsible for:

- Co-ordinating suitable accommodation (or service) to provide a safe and caring environment
- Monitoring the effectiveness of the planned respite in accordance with the resources allocated
- Maintaining awareness of budget resources

5. Resources Required

- Clinical file
- Report of Unauthorised Absence of a Mental Health Inpatient (Police notification form)
- Safety 1st electronic reporting system

6. Process

FAILURE TO RETURN FROM LEAVE – or AWOL/MISSING CLIENT FROM THE INPATIENT UNIT

5.0.0 When client fails to return from a period of agreed leave, the shift coordinator will attempt to contact them by telephone to explore reasons for the delayed return.

5.0.1 If unable to contact the client, telephone the family/ contact person and discuss the situation/risk with them.

5.0.2 Ensure the contact person knows how to contact the service should they become aware of the consumer/tangata whaiora whereabouts.

5.1.0 If the client is safe but delayed- ensure they have sufficient medication and find out when they are able to return.

5.2.0 If the client indicates they do not intend to return, or the team is unable to contact them, ***or an inpatient has been confirmed as missing from the IPU.***

5.2.1 Contact the on duty Psychiatrist to inform and review as to AWOL status: discuss current risk evaluation and likelihood of risk behaviour
5.2.2 All clients under the MH Act ***must have an AWOL notification to the Police***
5.2.3 In the case of an informal client refusing to return from leave: consider extending the leave period- for an additional 24hours
5.2.4 In the case of an informal client consider discharge from inpatient care – or arrange for client to return at set time the next day for review pre discharge
5.2.5 In case of concerns with an Informal client, consider whether use of the MH Act is indicated- commence Section 8 processes if needed and contact TACT team.
5.2.6 Revoking of Section 31 Leave if already under the Act
5.2.7 Consider, in discussion with the duty Psychiatrist, whether a Missing and of Concern notification to the Police is required for the informal client

5.3.0 **In-hours**: Notify the CNM of the IPU and Operations Manager MHS and Care Manager of CMHT (if known to a CMHT).

After hours: Notify the Duty Nurse Manager who may notify the Hospital Manager and notify them of the AWOL event and of any risk concerns.

5.4.0 Notify the Police by emailing southcomms@police.govt.nz Report of Unauthorised Absence of a Mental Health Inpatient (form) outlining the actual risk concerns.

5.5.0 Complete all relevant documentation including update of risk assessment, clinical notes, and an incident report in Safety 1st system.

5.6.0 Once the client is located, organise/ assist with transport, if needed to the IPU for treatment.

ON RETURN TO THE UNIT

5.7.0 When a client returns or is returned to the unit, advise the Psychiatrist and discuss the necessity for immediate risk management procedures (for example, additional support and engagement, observation needs, securing the environment).

5.7.1 Notify all other parties previously notified as AWOL of the persons return.

5.7.2 Document in the clinical notes and update treatment plan and risk assessment documentation.

5.7.3 At next Team review meeting discuss and review the clients Treatment plan, update the changes.

7. Precautions and Considerations

Nil.

8. References

Mental Health (Compulsory Assessment and Treatment) Act 1992 and amendments.

9. Related Documents

Mental Health (Compulsory Assessment and Treatment) Act 1992 and amendments.
Inpatient Unit (IPU) Leave Policy.

Revision History	Version:	6
	Developed By:	WCDHB Mental Health Service
	Authorised By:	Senior Manager – Mental Health Service
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