Waitemata District Health Board

A Report by the
Mental Health Commissioner

(Case 16HDC01402)

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Executive summary

1. On 1 July 2016, Mr A (in his late teens at the time of events) was admitted to a psychiatric intensive care unit (the unit) for assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). He was on 15-minute observations and was noted to be at high risk of going absent without leave.

2. On 6 July 2016, Mr A was informed that it would be appropriate for him to undergo a second period of assessment and treatment as an inpatient. The registered nurses on the afternoon shift attended a meeting between 3.20pm and 4.30pm. The registered nurse providing cover over this time did not receive a formal handover.

3. At approximately 4.15pm, Mr A's sister arrived at the unit to visit Mr A, but staff were unable to locate him and it became evident that he had left the premises. It is unclear exactly when or how Mr A left the unit, but it was thought likely that he had climbed a fence in the enclosed outdoor area, as deep footprints were found in the grass outside the fence. The observation sheet contained four signatures from 3.30pm to 4.15pm, but these were subsequently crossed out. Health Care Assistant (HCA) Mr C explained that he had signed off these times in error, and that he immediately informed the Shift Coordinator of his mistake. He said that he put a line through the signatures, as instructed, but neglected to write "signed in error".

4. Mr A was found by the Police on 8 July 2016.

Findings

5. The Mental Health Commissioner found that there was inadequate monitoring in place within the unit, which was compounded by an inadequate handover. It was noted that the policy for allocation of 15-minute observations was not followed, and there was confusion regarding who was responsible for observing Mr A. Waitemata District Health Board (WDHB) also lacked a comprehensive policy governing access to the unit's outdoor area, including when the doors may be opened, who has the authority to make that decision, and how it is communicated and recorded. Accordingly, the Mental Health Commissioner found that WDHB did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

6. The Mental Health Commissioner recommended that WDHB provide a written apology to Mr A and his family. He also recommended that WDHB: (a) amend its therapeutic observations policy to improve guidance about the handover process, and incorporate the expectation that observation sheets are to be signed as they are completed; (b) consider using a more detailed observation form; and (c) audit compliance with the new observation policy for the enclosed outdoor area.

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Complaint and investigation

7. The Commissioner received a complaint from Mrs B about the services provided to her son, Mr A, by Waitemata District Health Board (WDHB). An investigation was commenced, and the following issue was identified for investigation:

- *Whether Waitemata District Health Board provided Mr A with an appropriate standard of care in 2016.*

8. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

9. The parties directly involved in the investigation were:

Mrs B	Complainant
Waitemata District Health Board	Provider

Also mentioned in this report:

Mr C	Health care assistant
Dr D	Consultant psychiatrist
RN E	Registered nurse
RN F	Registered nurse
Mr G	Health care assistant
RN H	Registered nurse

10. Mr A has not engaged with this Office in the course of the investigation.

11. Independent expert advice was obtained from Mr Toni Dal Din, and is included as Appendix A.

Information gathered during investigation

Admission to inpatient unit

12. On 1 July 2016, Mr A was stopped by the Police for erratic driving. Following Mr A's threats of self-harm, the Police accompanied him to an emergency department for psychiatric assessment.

13. At approximately 8.30pm, Mr A was assessed by a consultant psychiatrist, Dr D. Dr D made a diagnosis of likely substance-induced psychosis secondary to cannabis abuse, depression, and cluster B personality traits. Dr D also determined that Mr A was at high risk of harm to himself and others. Dr D considered that Mr A met the criteria for further assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992

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(the Mental Health Act), and that admission to the inpatient intensive care unit would be appropriate. Police assistance was required to transport Mr A, as he was "shouting … abusive, spitting and trying to fight off staff". It was noted that Mr A became calmer during the journey, and that he was able to engage in superficial conversation with the Police.

14. On admission to the inpatient unit, Mr A was placed on 15-minute observations. Observations are undertaken by HCAs, and there is a signing sheet to confirm that the service user has been sighted. According to WDHB's policy on therapeutic observations,[1] this is the minimum requirement for a service user in the unit. The policy states that time-specific observations (as opposed to being in line of sight or in arm's reach at all times) are appropriate for service users who have been assessed as being at risk of going absent without leave, being at risk of self-harm in the short term, or requiring high physical care and/or assistance. It also outlines that the Clinical Charge Nurse/Delegate is to allocate a staff member to be responsible for observations. The policy further provides that the registered nurse on duty must hand over to the registered nurse coming on shift all information in relation to service users who are under any level of observation.

15. Clinical notes from 2 to 5 July 2016 identify that Mr A was frustrated at being detained in hospital, and was at high risk of going absent without leave. He was noted to state to staff, "OK I'm ready to go now, I'm leaving," and that he did not want to be there, that he "just want[ed] to be out having fun".

16. On 6 July 2016, a psychiatric registrar assessed Mr A and determined that it would be appropriate for him to undergo a second period of assessment and treatment as an inpatient. At 2.30pm, RN F documented that Mr A "became angry and uncooperative" on learning that he was required to remain in the unit under the Mental Health Act, and that he remained at high risk of going absent without leave. At 2.45pm, Mr A declined the offer of a tetanus injection.

17. Following the shift handover, the afternoon registered nurses attended a meeting between 3.20pm and 4.30pm. RN E, who had been working on the main ward during the day shift and had also attended the shift handover, was asked to provide cover while the registered nurses in the unit attended a staff meeting. RN F, who was rostered on the morning shift, stayed in the unit until RN E arrived at 3.45pm. WDHB told HDC that it is usual for a covering nurse to be provided with an update of care appropriate for the extent of the cover period. RN E stated that she did not receive a formal handover, and that the only information she was given was that Mr A had refused a tetanus injection earlier that day. RN F acknowledged that she did not provide a handover to RN E, but stated that she informed both the healthcare assistants and the other nurses that Mr A was elevated and angry about remaining under the Mental Health Act.

18. Two healthcare assistants, Mr C and Mr G, were rostered on the afternoon shift to assist in the unit.

[1] Issued July 2015.

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19. At approximately 4.15pm, Mr A's sister arrived at the unit to visit Mr A, but staff were unable to locate him and it became evident that he had left the premises. It is unclear exactly when this occurred. The observation sheet contained four signatures from 3.30pm to 4.15pm, but these were subsequently crossed out. Mr C explained that he had signed off these times in error, and that he immediately informed the Shift Coordinator of his mistake. He said that he put a line through the signatures, as instructed, but neglected to write "signed in error". Mr C stated that he did not remember seeing Mr A at all; however, both registered nurses on the morning shift recalled hearing Mr A at approximately 3.10–3.15pm. RN E stated that she did not see Mr A in the time that she was providing cover in the unit. She also did not observe whether the 15-minute checks were being undertaken, but said that they were "probably being done".

20. In accordance with WDHB's absent without leave policy, the Police and community mental health team were notified of Mr A's absence and asked to search for him. The situation was escalated to the overnight on-call coordinator for the unit, and Mr A's father was also notified.

21. It was thought likely that Mr A had climbed a fence in the enclosed outdoor area, as deep footprints were found in the grass outside the fence. WDHB told HDC that the outdoor area can be accessed through two rooms, but staff are adamant that the door through the first room was locked, and no one can recall utilising the other door.

22. Mr A was found by the Police on 8 July 2016 and transferred to another inpatient unit.

Interviews with staff

23. The Charge Nurse Manager interviewed a number of staff in relation to the incident. These interviews revealed that there was no clear process for allocating 15-minute checks. RN H, who was on the morning shift, stated that although he could not comment confidently, he believed that the healthcare assistants divided the checks between them, and that it "just evolved" that the healthcare assistants take responsibility for the checks. Similarly, RN F said that "one person will just do it", and that this is organised by the healthcare assistants. Mr G commented that there was no process for assigning tasks, and that on the occasion in question, Mr C had the book for 15-minute observations, so he (Mr G) did other tasks. Mr C told HDC that he could not remember whether he or Mr G was responsible for monitoring Mr A.

24. Mr G and Mr C stated that sometimes they sign the observation sheets retrospectively, as time and duties do not always allow for contemporaneous signing. Mr G said that on rare occasions he would sign off two sets at once. Mr C said that he signed up to an hour after sighting the service user.

25. Although the unit's Guidelines (issued January 2013) specified that the enclosed outdoor area was to be supervised at all times, at the time of these events WDHB did not have a comprehensive policy in place governing access to the outdoor area; nor was there any register to record the times at which the doors were unlocked. RN H understood that

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usually the outdoor area was opened in response to requests from service users, and that it was a team decision. He stated that he would like to think that the registered nurses know when the doors to the outdoor area are unlocked. In contrast, Mr C stated that the decision to open the doors was "not really a team one". This view was echoed by Mr G, who stated that he did not always inform others when he unlocked the doors. However, both Mr C and Mr G were aware of the need for a healthcare assistant to supervise the service users in the outdoor area.

Significant incident review

26. On 2 September 2016, WDHB completed a significant incident review. Its key findings were:

- The last recorded sighting of Mr A was at 3.15pm.
- As Mr A could have left only through the unit's outdoor area, there appears to have been a short period where no supervision was provided.
- There was no clear process to guide staff regarding the allocation of 15-minute checks, and staff viewed it as being undertaken collectively by the HCAs.
- The 15-minute checks were being signed retrospectively, up to an hour after the sighting.
- Appropriate shift cover was not provided on the afternoon shift when both registered nurses who were rostered to work in the unit attended the nurses' meeting immediately after attending the handover meeting.
- Full handover was not provided to the incoming nurse at the end of the shift.
- The Clinical Charge Nurse was not aware that the second nurse on the day shift in the unit had left.
- There is no clear line of authority in decision-making as to when the outdoor area will be opened.

27. WDHB told HDC:

> "Overall, [WDHB] accepts that there were a number of service-level failures regarding the standard of care provided to [Mr A] which ultimately allowed his [escape] to occur. [WDHB] takes full responsibility for these failures … Once again, we extend our sincerest apologies to [Mr A] and his family, who were understandably deeply affected by this incident."

28. As a result of the incident, WDHB made the following changes to its service:

- The Clinical Nurse Specialist conducted a weekly audit for six weeks to ensure that the 15-minute observations were being signed at the same time at which they were completed.

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- The unit's registered nurses will have oversight of the therapeutic observations and complete at least one of the 15-minute observations per hour. The other three therapeutic observations may be delegated to a healthcare assistant. At the end of each shift, the Clinical Charge Nurse or Shift Coordinator reviews the therapeutic observation records, which are also audited weekly by the Clinical Nurse Specialist. These results are published on the unit's quality board. Where audits find less than 100% compliance, discussions are held with staff to identify barriers to performing therapeutic observations, and feedback of the results occurs at business meetings.
- An observation policy for the outdoor area was implemented. The policy sets out when it is appropriate to open the area, when not to, who makes the decision, and how this is communicated and recorded. This is in line with the policy in the main ward.
- The Clinical Charge Nurse now ensures that there is always at least one rostered registered nurse working in the unit at all times. This means that only one rostered nurse can attend training or meetings that occur after an afternoon handover.
- Clear safety roof panels were built into the unit's outdoor area to prevent service users from climbing over the top of the walls.
- Currently WDHB is investigating the use of electronic recording systems to enable real-time recording of therapeutic observations. In the interim, staff are directed to sign a therapeutic observations record on sighting the patient concerned.

Responses to provisional opinion

29. Mr A and Mrs B were provided with an opportunity to respond to the "information gathered" section of the provisional opinion.

30. HDC did not receive a response from Mr A.

31. Mrs B stated:

> "We were relying on fully qualified professionals to care for [Mr A] when he was unable to care for himself. This basic need was not provided for …"

32. WDHB was provided with an opportunity to comment on the provisional opinion, and its response has been incorporated into the report.

Opinion: Waitemata District Health Board — breach

33. On 6 July 2016, Mr A left the inpatient unit sometime after 3.15pm. Despite the fact that he was known to be at risk of going absent without leave, and was subject to 15-minute observations, staff were not aware that Mr A was missing until 4.15pm, when his sister came to visit. It was considered likely that Mr A had left the premises through the enclosed

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outdoor area. As detailed below, I consider that WDHB failed to provide Mr A with services of an appropriate standard, and that this failure was caused by organisational issues directly attributable to WDHB.

Allocation and documentation of 15-minute observations

34. WDHB's therapeutic observations policy at the time of the incident specified that the Clinical Charge Nurse/Delegate is to allocate a staff member to be responsible for carrying out observations. However, this process was not followed in the unit, and the registered nurses understood that the healthcare assistants would organise this amongst themselves. On the occasion in question, it appears that there was no clear agreement amongst the healthcare assistants as to who would be monitoring Mr A. Mr G told HDC that he undertook other tasks because Mr C had the book for 15-minute observations; however, when queried by HDC, Mr C was unable to recall whether he had accepted responsibility for monitoring Mr A.

35. Both healthcare assistants on that shift mentioned that they do not always sign the observation chart when they sight the service user, and will occasionally back-sign. WDHB's policy on therapeutic observations does not specifically state that observation charts should be signed contemporaneously.

36. My expert advisor, RN Toni Dal Din, commented that the unit's processes "seemed inconsistent and unstructured", particularly around the delegation and direction of observation checks. He considers that back-signing of observations is not consistent with best practice. He likened the observation chart to a "tick box exercise", as it required only a signature to confirm that the service user had been sighted at a particular time, and had no room for descriptions of the service user's location or activity. He noted that "tick box" observations are not productive and preventative, and that it becomes more of an administrative task than a means of therapeutic engagement.

37. RN Dal Din stated:

> "I find that overall the processes for allocation and monitoring of 15/60 minute observations are a moderate departure from expected standards and that it would be adversely viewed by my peers."

38. I accept this advice. Although the therapeutic observations policy specified that it was the role of the Clinical Charge Nurse (or a delegate) to allocate staff responsibility for 15-minute observations, this did not occur in practice. I consider that confusion caused by the lack of familiarity with this process contributed to circumstances that allowed Mr A to go missing unnoticed for up to an hour. I am further concerned that, had Mr A's sister not visited the unit, Mr A's absence may have remained undetected for longer.

Oversight of outdoor area access

39. WDHB's significant incident review identified that there was no policy governing when it is appropriate to open the doors to the outdoor area, who makes the decision, and how it is

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communicated and recorded. The unit's Guidelines mentioned only that the outdoor area was to be supervised at all times. The significant incident review referred to the need to replicate the main ward's existing process. RN Dal Din noted that it is difficult to understand why the process in the unit was "different and less stringent", as the service users in the unit are more acutely unwell and in need of more intensive monitoring. He viewed the comparatively diminished safety and security requirements in the unit as a moderate departure from expected standards.

40. I agree that it makes little sense for the unit to have more relaxed processes than the main ward, and I am seriously critical that WDHB did not have a formal policy detailing processes about access to the outdoor area.

Handover and staffing of the unit

41. As acknowledged in the significant incident review, there was inadequate handover to the registered nurse covering the unit from 3.20pm to 4.30pm. RN Dal Din agreed that this is an area of concern. He advised:

> "[The unit] is for service users who are acutely unwell. There needs to be clear and consistent staffing guidelines in place to manage the risks posed by this population of service users.
>
> …
>
> Current literature explains that the handover of care is a very important process as breakdown in communication is one of the leading causes of serious events and … was one initiative recommended by the [World Health Organization] to increase patient safety."

42. RN Dal Din advised that there should be a system in place that outlines how clinical handovers are undertaken, and that such handovers should include a summary of the events of at least the last three shifts, including the service user's treatment plan, risk, vulnerability, suicide risk, violence and aggression, medication, progress, current assessment of needs, multidisciplinary interventions, mental state examination updates, and other health and social care information.

43. I accept RN Dal Din's advice. It is important for patient safety that handover is detailed and occurs consistently, and that the unit is staffed appropriately. I acknowledge that WDHB now ensures that there is always at least one rostered registered nurse working in the unit at all times, and consider that this is a step in the right direction in facilitating continuity of care.

Conclusion

44. The fact that Mr A, a service user who was under 15-minute observations, was absent for up to an hour before he was noted to be missing, is compelling evidence that there was inadequate monitoring in place within the unit. As set out above, there was some

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confusion as to who was responsible for sighting Mr A every 15 minutes, and this was compounded by an inadequate handover.

45. In my view, adequate systems and procedures are necessary to support staff in their duties and to facilitate the delivery of safe and appropriate care. It falls upon WDHB, as the service provider, to have in place clear policies that guide individual staff in the operation of the unit, and to ensure compliance with these policies. Although WDHB's therapeutic observations policy at the time of the incident specified that the Clinical Charge Nurse/Delegate is to allocate a staff member to be responsible for carrying out observations, this did not occur in practice, and neither the registered nurses nor the healthcare assistants on the afternoon shift were able to identify who was responsible for monitoring Mr A. WDHB also lacked a comprehensive policy governing access to the unit's outdoor area, including when the doors may be opened, who has the authority to make that decision, and how it is communicated and recorded. Accordingly, I find that WDHB did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

46. I acknowledge that since this incident WDHB has implemented an observation policy for the unit's outdoor area, and has stipulated that the unit's registered nurses will have oversight of the therapeutic observations and complete at least one of the 15-minute observations in every hour.

Other comment

47. Mr C stated that he accidentally back-signed Mr A's observation chart from 3.30pm to 4.15pm. RN Dal Din commented:

> "If this was a genuine mistake that would be acceptable as mistakes in documentation do occur in busy [psychiatric units] … however if [Mr C] deliberately signed off in advance [t]his would be a serious departure from expected standards."

48. On the information available, I do not consider that I am able to make a finding either way. However, I would be extremely concerned if observations were being signed off in advance. This would defeat the purpose of implementing time-specific observations for vulnerable service users who are at risk of self-harm.

Recommendations

49. I recommend that WDHB provide a written apology to Mr A and his family for the breach of the Code identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr A and his family.

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50. I acknowledge the changes implemented by WDHB to improve its monitoring of service users on time-specific observations, access to the unit's outdoor area, and staffing. I recommend that WDHB complete the following additional actions, and provide evidence of such, within three months of the date of this report:

a) Amend its therapeutic observations policy to improve guidance about the handover process, with reference to my expert advisor's advice that handovers should include a summary of the events of at least the last three shifts, including the service user's treatment plan, risk, vulnerability, suicide risk, violence and aggression, medication, progress, current assessment of needs, multidisciplinary interventions, mental state examination updates, and other health and social care information.

b) Incorporate into its therapeutic observations policy the requirement that observation sheets are to be signed as they are completed.

c) Give consideration to utilising a more detailed observation form that includes a description of the service user's location and activity when sighted.

d) Audit compliance with the new observation policy for the outdoor area.

51. In response to a recommendation in my provisional opinion, WDHB provided the results of an audit of 15-minute observations over six weeks. These showed weekly compliance rates of 99% and 100%.

Follow-up actions

52. A copy of this report with details identifying the parties removed, except the expert who advised on this case and WDHB, will be sent to the Director of Mental Health, the Mental Health Foundation, Te Ao Māramatanga New Zealand College of Mental Health Nurses, and the Health Quality & Safety Commission, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to Commissioner

The following expert advice was obtained from RN Toni Dal Din:

"**Preamble**

I have been asked by the Commissioner to provide an opinion on case number 16HDC01402. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my nursing career as a Psychopaedic Nurse in 1982. I completed a general and obstetrics-bridging programme for comprehensive registration in 1987. I hold a postgraduate certificate in Forensic Psychiatric care. I completed my Master of Arts degree in nursing at Victoria University of Wellington in 2006. I am currently a Fellow of Te Ao Maramatanga College of Mental Health Nurses and a Fellow of the College of Nurses Aotearoa (NZ).

Over the last 30 years I have undertaken various clinical and leadership roles within general health, intellectual disability, and mental health including the forensic psychiatric area. I am also gazetted as a Director of Area Mental Health Services and have undertaken this role both on a permanent and relieving basis.

The purpose of the advice requested is to enable the Commissioner to determine whether the care provided to [Mr A] by Waitemata District Health Board (WDHB) in July 2016, was reasonable in the circumstances and why.

Background

[Mr A] was stopped by the Police for erratic driving on the evening of 1 July 2016. Following his reports of suicidal ideation, the Police accompanied [Mr A] to [an] Emergency Department (ED). [Mr A] was assessed by Consultant Psychiatrist [Dr D], who diagnosed [Mr A] with likely substance induced psychosis secondary to cannabis abuse, depression, and cluster B personality traits. [Dr D] also determined that [Mr A] was at high risk of harm to himself and others.

Consequently, [Mr A] was admitted to the Inpatient Unit (IU) pursuant to section 11 of the Mental Health (Compulsory Assessment and Treatment Act) 1992 (MH Act). Clinical records from 2 July 2016 to 5 July 2016 identify [Mr A] as being at high risk of leaving the unit and becoming Absent Without Leave (AWOL), and refer to [Mr A's] frustration at being detained in hospital, as well as his desire to leave.

At 1pm on 6 July 2016, [a registrar] assessed [Mr A] and extended his admission, having determined that he was unlikely to engage in treatment without use of the MH Act. [RN F] noted at 2.08pm that [Mr A] 'became angry and uncooperative when the MH Act was extended' and that he remained at high AWOL risk.

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At approximately 4.15pm, [Mr A's] sister visited IU; however, staff were unable to locate [Mr A], and it became evident that he had gone AWOL. [Mr A] was on 15 minute documented observations, and the observation record shows that [Mr A] was last sighted at 3pm.

A search for [Mr A] was initiated, and it was thought likely that he escaped by climbing [a] fence in the [enclosed outdoor area].

A significant incident review was undertaken by Waitemata District Health Board. It noted that:

a. There was no clear process to guide staff regarding the allocation of 15/60 checks and the 15/60 checks were being signed retrospectively.
b. There is no policy governing when it is appropriate to open the [door to the enclosed outdoor area], who makes the decision, and how it is communicated and recorded when it is opened.
c. There was not appropriate shift cover on the afternoon shift, as both registered nurses who were rostered to work in [the unit] attended the nurses meeting immediately after attending the handover meeting.
d. Full handover was not provided to the incoming nurse at the end of the shift.

The following documents were reviewed:

1. Letter of complaint dated 14 September 2016
2. Waitemata DHB's responses dated 6 December 2016, 18 September 2017 and 14 December 2017
3. Clinical records from Waitemata DHB covering the period 1 July 2016 to 8 July 2016
4. Serious Incident Review Triage Form and Significant Incident Review Form
5. RiskPro Incident Report and Mental Health AWOL form, dated 6 July 2016
6. Interviews with [RN E], [RN H], and [RN F], dated 6 July 2016
7. Interview with Health Care Assistant [Mr C], dated 11 July 2016
8. Interview with Health Care Assistant [Mr G], dated 1 July 2016
9. Policies and procedures relating to suicidal patients, namely 'Risk Management During Service Delivery', 'Therapeutic Observations — Adult MHS', Model of Care Acute Mental Health Inpatient Units', 'Service User/Tangata Whaiora Pathway DMHS Adult Inpatient Units — Entry & Assessment', 'The Adult Mental Health Services AWOL Policy'
10. [The unit's] floor plan

Expert advice requested

I have been asked to comment on the systems issues identified in the significant incident review, the adequacy of the policies in place at the time of [Mr A's] admission, and any other concerns I may have.

For each question, I have been asked to advise:

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a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Firstly I would like to acknowledge how difficult an event such as this can be for family and clinical staff and in this case how fortunate it was that a more serious outcome did not occur for [Mr A] and his family.

The document bundle I received included a significant incident review that was undertaken by Waitemata District Health Board. As stated above it noted that:

a) There was no clear process to guide staff regarding the allocation of 15/60 checks and the 15/60 checks were being signed retrospectively.

I have reviewed the policy for therapeutic observations and agree there is an absence of detailed guidance for staff about the allocation of 15/60 observations. However there is some guidance in the policy. The 15/60 observations are described as time specific observations. The definition states

> 'The service user is located and observed at intervals of up to 15 minutes apart. Registered Nurse and Clinical Charge Nurse (CCN)/Clinical Coordinator (CC) can implement 15/60s and discontinue same. Not all service users will require 15/60s.'

The policy describes in the indications that observation levels must be based on regular clinical assessment of individual service users. Service users assessed as:

- AWOL/AWOCA risk
- Transitioning from [the unit] to [the main] ward
- Risk of self-harm in the short term
- Requiring high physical care and/or assistance

There is a flow chart that has some broad indications including the requirement for the CCN to allocate a staff member to be responsible for observations but did not appear to be followed.

The DHB policy states that [the] Registered Nurse must hand over to the Registered Nurse coming on shift all information in relation to service users being under any level of observation. From the documents I reviewed, this was not followed.

Best practice guidelines clearly direct that handover must include observation levels. I searched for guidelines that would help provide advice for this case and I was able to find a number of recent guidelines. The most recent and useful guidelines are the New

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South Wales Health Procedure: Observation and Engagement in Mental Health Inpatient Units 2017. On page 4 it states that:

> 'Nursing clinical handover for each consumer must include the level of observation and engagement and assessments undertaken to ensure a safe transfer of care and clear understanding of the plan for the receiving nurses.'

I noted that on the DHB observation chart staff only sign that they have sighted the service user, there is no indication of where the service user was and what they were doing at the time, this seems to be a tick box exercise. My understanding of best practice guidelines is that this is not considered to be best practice, the service user's location and activities should also be recorded.

The New South Wales Health Procedure: Observation and Engagement in Mental Health Inpatient Units 2017 P1 states that:

> 'Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making.'

It also states that 'Observation is not passive nor does it predominantly include watching consumers at a distance.'

On page 5 of the same guidelines it states:

> 'Tick box observation forms must not be used because they do not adequately document the consumer's level of risk or record the observation.'
>
> 'The observation form must allow the nurse to document the actual time the observation took place and clearly identify the nurse completing the observation.'
>
> 'Minimum observations documented on the observation form must include the consumer's location and activity at the time of being seen.'

This is further reinforced in a position statement from the New Zealand Director of Mental Health Nurses Group 2013. This position paper links therapeutic engagement and observation together as a recommended way of working with people who are a risk in mental health facilities. The paper aimed to inform those who create working policies in the mental health sector of safe practices with regard to procedures for observing and relating with people who are unsafe. National and international literature on observations in the mental health sector was reviewed in this paper.

Common themes from the literature with regard to planning care are:

1. To consider the connection between observations and therapeutic engagement
2. To allow treatment to occur in the least restrictive environment
3. To consider the implications for patient's privacy and staffing resources.

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Recommendations include but are not limited to the following points:

- Levels of engagement through observations need to be productive and preventative and not merely existing to meet the needs of the organisation/ service. For example, a tick box exercise that becomes an administrative task rather than therapeutic engagement.
- It is essential that levels of observations are determined by the needs of the person at risk and include consultation with them and their family/whānau.
- The model of care will inform enhanced engagement and observations.
- Observations must include practical measures to ensure that the person is alive at the time they are being observed.

I noted in HCA [Mr G's] report that processes seemed inconsistent and unstructured, particularly around delegation and direction of observation checks, he commented that there was no process for assigning tasks and they don't always inform others that the [outdoor] doors are open.

[Mr C] said that the process around 15/60 checks was 'hit and miss'.

Both HCAs mention that observation checks occasionally get back signed and [Mr C] states that he accidentally started signing off checks between 1530 and 1615 after [Mr A's] absence. He stated that he immediately informed the shift coordinator he had made the error and was advised to put a single line through his signature and write signed in error, however he updated the checklist by crossing out his signature. There is inconsistent recollection of this between [Mr C] and [the shift coordinator].

I have been asked by the Commissioner to comment on inconsistencies in information by providing alternative comments.

In this case I will need to comment that if [Mr C] accidentally signed the observations sheets in advance, he should have followed the advice that was provided to him to put a single line through the incorrect recording and write signed in error. He did not do this. If this was a genuine mistake that would be acceptable as mistakes in documentation do occur in busy [units] and that would be taken into account when determining whether this was an acceptable standard of care or not.

However, if [Mr C] did not accidentally sign off the observations in advance and deliberately signed them off in advance, this would be a serious departure from expected standards and would be adversely viewed by peers. With the documentation available it is impossible to ascertain the accurate description of this so I am not able to provide any further comment.

Both HCAs also explained that they back sign observations at times. I don't consider this practice is consistent with best practice and should only be a rare occurrence. Waitemata DHB SIR Report action plan recommends that staff need to ensure checks are signed as they are completed. This is to be audited by the CNS weekly for 6 weeks.

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I would recommend that it is audited further and specific instructions added to the policy as a specific point of note.

I find that overall the processes for allocation and monitoring of 15/60 observations are a moderate departure from expected standards and that it would be adversely viewed by peers.

b) There is no policy governing when it is appropriate to open the [door to the outdoor area], who makes the decision, and how it is communicated and recorded when it is opened.

This was identified in the Waitemata DHB SIR Report and I agree that it was an area of weakness.

The DHB SIR Report describes that the process utilised in the [unit] was different and less stringent than the main ward. This is hard to understand as the service user group that require care in [the unit] are more acutely unwell and have increased needs for security and safety as well as more intensive monitoring.

The National Association of Psychiatric Intensive Care Units (NAPICU): National Minimum Standards for Psychiatric Intensive Care in General Adult Services. United Kingdom 2014; P5 defines Psychiatric Intensive care as:

> 'Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or a less secure mental health ward.'

Given this definition, there should not have been less stringent rules around opening and monitoring of the [outdoor area] doors in the [unit]. Safety and security is a priority within the [unit], from my review of the documents this seemed to have been diminished.

I find this to be a moderate departure from expected standards and something that would be viewed adversely by peers.

c) There was not appropriate shift cover on the afternoon shift, as both registered nurses who were rostered to work in [the unit] attended the nurses meeting immediately after attending the handover meeting.

Again the Waitemata DHB SIR Report identified this as an area of concern and I agree with the findings. As stated previously [the unit] is for service users who are acutely unwell. There needs to be clear and consistent staffing guidelines in place to manage the risks posed by this population of service users.

It is however important for nurses to have dedicated protected time to be able to get together to discuss and plan care for the overall unit, to discuss complex cases and to undertake peer review. If this is to happen, a balance between service user safety and

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staff requirements must be struck. This is an area of difficulty or tension within acute inpatient mental health units and the recommendation of ensuring there is always one rostered [for the unit] registered nurse working in [the unit] at all times in the action plan from Waitemata DHB SIR Report will assist in managing this risk.

d) Full handover was not provided to the incoming nurse at the end of the shift.
I agree again with the Waitemata DHB SIR Report, clinical handover is an essential part of the overall risk mitigation strategies that [inpatient units] must undertake in order to maintain a safe environment for service users.

Current literature explains that the handover of care is a very important process as breakdown in communication is one of the leading causes of serious events and was one initiative recommended by the WHO to increase patient safety.

The National Association of Psychiatric Intensive Care Units (NAPICU): National Minimum Standards for Psychiatric Intensive Care in General Adult Services. United Kingdom 2014; Page 20 states:

> 'The handover of clinical and operational information is a key function in a [psychiatric intensive care unit] due to the potentially rapidly changing clinical presentations of patients. Therefore, a system should be in place which outlines how clinical hand-overs between all professionals are undertaken.
>
> A formal handover between shift staff should be undertaken at shift changes. This should include details of all current patients in relation to:
>
> - A summary of the events of at least the last three shifts
> - Treatment plan
> - Risk
> - Vulnerability
> - Suicide risk
> - Violence and aggression
> - Medication
> - Progress
> - Current assessment of needs
> - MDT interventions
> - Mental state examination (MSE) updates
> - Other health and social care information (e.g. activity goals).'

Waitemata DHB have acknowledged this as an area of deficit and should work to strengthen current policies in order to address these.

I agree that these areas are at the heart of the failings and I also note that the DHB have accepted failings as a result of this review.

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Conclusion

From the review of the documents provided to me, it is clear that this was a situation that could have had tragic consequences had [Mr A] not been found as quickly as he was. A situation that no family should have to go through.

It is understandable that [Mr A's] family have asked questions about how this could have happened.

From my experience this sort of situation happens and one moment of inattention can be catastrophic.

It appears that processes were inconsistent and somewhat unstructured and staff appear to have become complacent about the risks posed in a [psychiatric intensive care unit].

Handover was not consistent especially around the process of observation checks and delegation and direction of HCAs. The observation process is just a tick box exercise and not consistent with best practice.

The inconsistency in enforcing a systematic approach to direction and delegation of the tasks associated with observation and engagement in the existing policies appeared to be clear and accepted by Waitemata DHB. The DHB appear to have implemented some changes that will help mitigate the risk of a similar situation happening in the future.

Recommendations:

Waitemata DHB review the Therapeutic Observations — Adult MHS Policy to include best practice guidance, particularly around the handover process, allocation of levels of observation, delegation and direction and documentation.

References

- New South Wales Health Procedure: Observation and Engagement in Mental Health Inpatient Units 2017.
- Position Statement New Zealand Director of Mental Health Nurses Group 2013.
- The National Association of Psychiatric Intensive Care Units (NAPICU): National Minimum Standards for Psychiatric Intensive Care in General Adult Services. United Kingdom 2014.

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