Monitoring in inpatient mental health unit
16HDC01402, 8 March 2019

District health board ~ Inpatient mental health unit ~ Observations ~ Monitoring ~ Right 4(1)

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

After a few days, the man 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.

At approximately 4.15pm, the man's sister arrived to visit, but staff were unable to locate him and it became evident that he had left the premises. It is unclear exactly when or how the man left, 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. A healthcare assistant 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".

The man was found by the Police two days later.

Findings

It was held 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 the man. The district health board 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, it was found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1).

Recommendations

It was recommended that the DHB provide a written apology to the man and his family. It was also recommended that the DHB:

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.