NorthWestern Mental Health

16 March 2012

Coroners Court of Victoria
Level 11
222 Exhibition Street
MELBOURNE VIC 3000

Dear Sir/Madam

Response on behalf of NorthWestern Mental Health Service to recommendations made by Deputy State Coroner, Iain T West dated 14 October 2011
Court Reference Number: 2384/10 – Inquest into the death of Ms Amanda Kennedy

Recommendations:

1. *That the Northern Hospital examine the level of observation (with a view to harm minimization) that is possible within the Northern Psychiatry Unit, when the patients have full access to their single occupant bedrooms.*

NorthWestern Mental Health (NWMH) has implemented an evidenced based clinical risk assessment and management protocol across all acute adult psychiatric inpatient units. This approach to clinical risk assessment and management includes levels of engagement with and observation of individual patients based on their assessed level of risk *(Clinical Risk Assessment and Management Guidelines, 2011)*. This includes level of access to single occupant bedrooms such that the primary nurse in conjunction with the shift leader may restrict or prevent unsupervised access by the patient to his or her bedroom if relevant risk issues are identified.

2. *That staff remain vigilant in obtaining collateral information from sources such as family, medical records and other health professionals, and that consideration be given to introducing an electronic case note system, to facilitate dissemination of the information.*

A number of local initiatives have been implemented at the Northern Psychiatry Unit that enhance practice to address this recommendation. These include:

- A weekly formulation meeting for each treating team is now in place. This meeting complements and is in addition to the existing weekly clinical review meeting/ward round. The formulation meeting incorporates contributions from all members of the multidisciplinary team within the first 48-72 hours of the patient's admission and includes input from the patient with family/carer involvement as appropriate. The formulation meeting and the clinical review meeting seeks to integrate all available information from as many sources as possible to best understand the patient and the reason/s for presentation to hospital.

- Regular multidisciplinary education sessions and a journal club that increase the awareness of non typical presentations and facilitate discussion around complex clinical presentations.
- A planned pilot in early 2012 trialling the real time use of the electronic case note system on the Northern Psychiatry Unit.

3. *That the Northern Hospital develop and implement protocols aimed at monitoring and or restricting, potentially harmful items being taken into the psychiatry unit.*

At the Northern Psychiatry Unit, local guidelines, aimed at restricting access to harmful items by patients are in place and were reviewed and updated in November *(Northern Psychiatry Unit Guidelines, 2011). All guidelines are formally reviewed on a regular basis.*

NWMH has also introduced hand held "Garrett" type hand held scanning devices into Inpatient Units. Hand held metal detection devices are designed to enable staff to identify any potentially harmful objects that may be concealed on a clients person. A Protocol has been developed that outlines the role of such a device in identifying concealed cigarette lighters, sharps (including needles and cutting implements) or indeed prescription or illicit drugs wrapped in foil without resorting to intrusive searches.

Yours faithfully

Peter Kelly
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Melbourne Health