

QON LC 5198. Question 3

<b>Status WA State Coroner's Recommendations (Mental Health Services)</b>		
<b>2008/09</b>	<b>Recommendation</b>	<b>Status</b>
	1 The Coroner recommends that in the case of psychiatric involuntary patients a physical examination is conducted at a time when those patients have settled to the extent which would enable such an examination to be meaningfully conducted.	Completed
	2 The Coroner recommends that in the case of psychiatric patients receiving medications which can cause constipation, bowel charts are used to monitor this potential problem.	Completed
	3 The Coroner recommends that the Albany Regional Hospital policies be reviewed to ensure that they clearly define the roles of visiting general practitioners and that steps be taken to ensure that any changes to those policies will be communicated to those practitioners.	Completed
	4 The Coroner recommends that when a psychiatrist grants leave of absence to an involuntary patient who is detained in an authorised hospital and the leave of absence is not to take place immediately, the grant of leave should be subject to there being no perceived change in the risk status of the patient during the intervening period.	Completed
	5 The Coroner recommends that when there has been a grant of leave to an involuntary patient and there is a time lapse between that grant and the taking of the leave, immediately before the leave is actually taken there should be a final review of the risk status of the patient conducted by a mental health professional who is at least a senior member of the nursing staff (a suitably trained registered nurse or a mental health nurse) who is currently involved in the patient's care.	Completed
	6 It is recommended the conclusions of that review should be recorded in the notes and the mental health professional should be required to sign the record so as to clearly accept the responsibility for the clinical judgement.  In the event that there have been no potentially significant changes relevant to the risk issues, the patient may then proceed on leave, but if there are potentially significant changes affecting risk status, the question of the grant of leave should be referred to an available medical officer who should then review the changes in risk status and decide whether leave should be granted or cancelled pending further review by the treating psychiatrist and team.	Completed

7 The Coroner recommends the South Metropolitan Mental Health Services Policies and Procedures Manual relating to missing or suspected missing patients be amended by deleting the section now headed "Involuntary Patient – not considered to be at risk and location known".	Completed
<b>2009/2010</b>	
1 The Coroner recommends that the Health Department conducts a review of the process for providing medications to mental health patients to ensure that patients do receive medications at about the times ordered and the time of the provision of the medications is accurately recorded in the medication charts.	Completed
2 The Coroner recommends that the observations chart be altered so that the time column not contain pre-entered times, but that the nurse should enter the actual time when the patient has been observed.	Being Actioned
3 The Coroner recommends that an additional column be inserted in the observations chart to record actual observations made of the patient by the nurse conducting the observations.	Being Actioned
4 The Coroner recommends that a copy of the nursing guidelines relating to nursing observations be retained at the same location where the observations charts are located on the ward and that the nursing observations chart be amended by adding a brief reference to the importance of ensuring that on close observations the designated nurse must be able to satisfy himself or herself that the patient is safe.	Completed
5 The Coroner recommends that the Health Department review the practicalities associated with conducting high quality observations of at risk patients to ensure that there is consistency in nursing practice in that regard and to reduce unnecessary inconvenience in the conducting and recording of the observations.	Being actioned
6 The Coroner recommends that in all future plans for mental health units there be provision for authorised beds and the construction of the units should be such that staff are able to monitor all persons entering or leaving the ward.	Completed
<b>2010/2011</b>	
1 That Graylands Hospital takes steps to ensure that medication charts accurately reveal the giving of medications and that the Charts not be written up in advance or at a time when medication have not been given to patients.	Being Actioned