



MEMORANDUM

Learnings from recent Adverse Event Reviews

From: Dr Alison Masters, Executive Director (Clinical) and the Patient Safety Group
To: All clinical staff, MHD
Date: 07/07/2010

Please find below a number of learnings which have been identified in recent adverse event reviews. These reviews are undertaken as part of routine quality improvement processes and are aimed at understanding what happened, identifying what we can learn from these events and recommending systems and process changes to improve overall standards and reduce the likelihood of a similar event occurring.

Client being left unattended after being seen 'in crisis'.

Incident: A 48 year old female client self-presenting to her care manager in crisis; her mental state described as being unsettled and was voicing suicidal ideation. During the appointment the client was left alone whilst the care manager left the room to arrange for crisis respite. The client left the building during this period and was found dead the next day having drowned.

The clinician in this case would have normally arranged for another staff member to sit with the client whilst she was making the arrangements; however, there was no one was available on this occasion. The clinician also did not feel that there was a high risk of the client leaving; she had brought herself to the planned appointment and the crisis respite that was being arranged had been beneficial to the client previously. She had also presented as being in agreement with management plan.

Since this event the team involved have changed their practice so that clients presenting in crisis are not left alone whilst such arrangements are being made.

The directorate believe that this would be a beneficial action to roll out across Mental Health Services.

Directive: *Clients presenting to Mental Health Services 'in crisis' where there is some evidence of suicidal ideation or thoughts of harming others, should not be left unattended for the duration of the appointment/consultation until follow-up care is provided.*

Common issues noted in clinical file entries when reviewing documentation as part of adverse event reviews.

Generally, documentation in the clinical file is found to be of an acceptable standard. However, it has been noted in a number of adverse event reviews that some basic standards are not always adhered to. CCDHB gives direction on clinical documentation entries in its policy "*Medical Records Management CCP DOC1*". The purpose of clinical documentation is a means by which the healthcare team can provide good clinical care for the patient/client. Clinical entries are a contemporaneous record of events that have occurred, and when made, become a historical account of the patient/client's healthcare for future reference. As such, they are used by this organisation, as well as external organisations, such as the Health and Disability Commissioner's Office, as a primary source of information for an investigation into a complaint or adverse event. It is important that all clinical entries are an adequate and accurate account of events and comply with accepted standards.

Areas that have been highlighted in a number of reviews are the lack of a recorded time of entry in the clinical file, illegible signatures, no recorded designation, and no patient/client identification on both sides of the page (especially important if faxing).

Directive: *Clinical staff are required to follow CCDHB policy with regard to documentation entries, specifically in respect to:*

- Entries must be timed (24 hr clock) and dated (day/month/year), and include a legible signature and a designation (name must also be printed alongside each entry). Name/designation stamps are acceptable.
- Each side of a page of a patient/client's medical record must be clearly labelled with the correct multilith label. When a label is not available, the patient/client's full name, date of birth and hospital number must be clearly recorded on both sides of the page.

A family's concern relating to their perception that CCDHB Mental Health staff lack knowledge of Autistic Spectrum issues and are unaware of the guidelines issued in 2008 by the Ministry of Health.

Incident: A 26 year old man, presenting in crisis with suicidal ideation secondary to depression and social stressors, ran off from his home while Mental Health Act proceedings were being initiated. He was later found dead nearby.

This incident was subject to a CCDHB internal adverse event review, a Coroner's inquest, an investigation by the Health and Disability Commissioner, and a section 95 investigation by the District Inspector.

Though not a finding of the reviews, the family have remained concerned throughout this time about their perception that CCDHB Mental Health staff lacked knowledge of Autistic Spectrum issues and were generally unaware of the Ministry of Health guideline that was published in 2008. The family strongly believe that that their son's problems and depression arose from Asperger's syndrome, which he had previously self-diagnosed.

Without debating this issue, the directorate believe that this is an important document which merits circulation with study by staff.

The New Zealand Autism Spectrum Disorder Guideline was launched in Parliament on 2 April 2008, the United Nation's first World Autism Awareness Day. The guideline is a single, credible source of New Zealand and overseas evidence, experience and practice, brought together by teams from across education, health, disability, and community services.

The full Guideline for Autism Spectrum Disorder can be found here (large document – will take time to load):

[http://www.moh.govt.nz/moh.nsf/pagesmh/7561/\\$File/asd-guideline-apr08.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/7561/$File/asd-guideline-apr08.pdf)

A summary of the guideline can be found here:

[http://www.moh.govt.nz/moh.nsf/pagesmh/7561/\\$File/asd-guideline-summary-apr08.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/7561/$File/asd-guideline-summary-apr08.pdf)

Request: All clinical staff to review the 2008 New Zealand Autism Spectrum Disorder Guideline as part of their professional development educational activities.