Inquest into the death of Adam Trent Ryan

Mr Ryan died on 12 July 2009 by hanging at his home in Charleville. In the days and weeks prior to his death, Mr Ryan received treatment at the Charleville Community Mental Health Service and the Charleville Hospital.

The then Deputy Chief Magistrate Ray Rinaudo delivered his findings of inquest on 18 January 2013.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

Recommendation 1

That the community mental health service in every district provide a full copy of their records and files to the treating hospital whenever a community mental health service patient is admitted preventing a repetition of the information vacuum which occurred in the present case.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

Information from community mental health services is available to hospital clinicians through the Consumer Integrated Mental Health Application (CIMHA). There are processes in place for granting access to CIMHA for all clinicians in Queensland Health. Information includes a state-wide standardised suite of clinical documentation, clinical notes deemed significant by the clinician for consumer continuity of care, and discharge summaries.

In addition, the inclusion of CIMHA as a source feeder system to The Viewer (a read only web based application comprising multiple clinical and administrative systems) in April 2015 has significantly enhanced the overall level and quality of key patient history details that can be instantly accessed by authorised Queensland Health staff. Relevant consumer mental health information now becomes available whenever a patient presents at any non-mental health service, for example an emergency department, and will complement existing key patient data on display sourced directly from other Queensland Health enterprise applications as well as externally from the National Personally Controlled Electronic Health Record System (PCEHR).

The ability of Queensland Health staff to immediately access a patient/consumer's relevant medical history details will enable better informed clinical care and treatment outcomes.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

The chief psychiatrist wrote to all hospital and health services in November 2015 informing them of the coroner's recommendation, reminding services of the need to share clinical information across treatment settings and providing information about developments with the viewer (a read only web based application comprising multiple clinical and administrative systems) and its application.

Recommendation 2

That a requirement be made that the community mental health service advise any treating specialist consultants of the admission of a community mental health service patient as an in-patient of any hospital.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

Statewide models of service provide clear advice about how clinical mental health services should be delivered within hospital and health services. The community care team model of service recommends that all key service providers including any treating specialist consultants are actively engaged in the assessment process with outcomes communicated in a timely manner and considered for inclusion in the care planning and review processes.

This active engagement in the assessment, care planning and review process ensures that treating specialists are aware of the admission of a community mental health service patient as an inpatient of any hospital.

The Department of Health's Mental Health Alcohol and Other Drugs Branch will write to all hospital and health services notifying them of the coroner's recommendation and reinforcing statewide models of service as best practice and requesting they review their current policies and procedures in relation to multidisciplinary care planning and quality of care.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

The chief psychiatrist wrote to all hospital and health services in November 2015 notifying them of the coroner's recommendation, reinforcing statewide models of service as best practice and requesting they review their current policies and procedures in relation to multidisciplinary care planning and quality of care.

Recommendation 3

That nursing staff be specifically instructed to record any reference to any active suicidal behaviour by or depression of a patient from any credible source, in particular, police officers.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health

On 21 January 2016 the Minister for Health and Minister for Ambulance Services responded:

The *Queensland Mental Illness Nursing Documents (MIND) Essentials* resource was released and distributed statewide in 2010. It provides nurses working in general health settings (hospital based and community) with relevant information on different mental disorders, how they may present in a general nursing setting, practical strategies and guidelines for management, screening tools and links to further information. The resource includes sections on caring for a person with depression and a person who is suicidal, and instructs nurses to record details of their interactions with the patient in accordance with record keeping protocols.

Hospital and health services (HHS) coordinate local documentation procedures and resources that support accurate and comprehensive clinical documentation by clinical staff.

The Department of Health's Mental Health Alcohol and Other Drugs Branch will write to all hospital and health services notifying them of the coroner's specific recommendation to record any reference or information in relation to a patient regarding depression and suicidal ideation, or behaviours from any credible source, in particular, police officers. The correspondence will request that hospital and health services to review their current policies and procedures in relation to record keeping for patients with mental health issues presenting in a general nursing setting to ensure ongoing quality of patient care.

On the 3 June 2015 the Minister for Health announced a 12 month project to develop and deliver a new training package to emergency department staff on the recognition, assessment, management and appropriate referral of people at risk of suicide. One component of the project is to review existing clinical resources for generalist nurses including the mental health resource *Queensland MIND (Mental Illness Nursing Documents) Essentials* resource. The coroner's recommendation will be included within the revision.

On 10 May 2016 the Minister for Health and Minister for Ambulance Services responded:

Correspondence was sent out to HHS asking that policies and procedures be reviewed.

The Department of Health (DOH) commenced a project that will undertake a review of the *Queensland Mental Illness Nursing Documents (MIND) Essentials* resource. The review will consider this coroner's recommendation as an opportunity to strengthen the emphasis on accurate and comprehensive clinical documentation.

HHS coordinate local documentation procedures and resources that support accurate and comprehensive clinical documentation by clinical staff. The chief psychiatrist wrote to all HHS in November 2015 notifying them of the coroner's recommendation and promoting the accurate recording of corroborating information provided by non-mental health sources such as Queensland Police Service or other services. HHS have been encouraged to review and update existing policy and procedures in relation to record keeping for patients with mental health concerns presenting in a generalist nursing setting.

The Mental Health Alcohol and Other Drugs Branch are also updating the *Queensland Health Guidelines for Suicide Risk Assessment and Management* to include clinical best practice for emergency departments. The Queensland Centre for Mental Health Learning in conjunction with the Clinical Skills Development Service will develop and deliver a training package using a train-the-trainer model, tailored specifically for emergency department doctors, nurses and allied health staff, to recognise, assess and manage people at risk of suicide.

Advice from this coroner's recommendation will be incorporated into the Department of Health project to review and update the Queensland MIND Essentials resource and the Queensland Health Guidelines for Suicide Risk Assessment and Management. The project is due for finalisation in mid-2016.

On 12 September 2016 the Minister for Health and Minister for Ambulance Services responded:

The Department of Health is progressing the implementation of two projects led by the Mental Health Alcohol and Other Drugs Branch to strengthen the skills of nursing staff in the assessment and management of suicidal behaviour.

The review of the *Queensland Mental Illness Nursing Documents (MIND) Essentials* resource is underway and will provide an opportunity to strengthen the emphasis on accurate and comprehensive clinical documentation. This resource provides generalist nursing staff with information and skills in caring for someone with a mental illness in a generalist nursing setting and

will include recording any reference to any active suicidal behaviour by or depression of a patient from any credible source, in particular police officers.

The Mental Health Alcohol and Other Drugs Branch is undertaking a review of the *Queensland Health Guidelines for Suicide Risk Assessment and Management*. The review will include clinical best practice in the assessment and management of a person with suicidal behaviour, including persons brought into emergency departments by police. The resource will include reference to obtaining collateral information on a person's mental state, including obtaining and documenting information about suicidal behaviour or depression from relevant sources including police officers.

The Queensland Centre for Mental Health Learning, in conjunction with the Clinical Skills Development Service, developed and delivered the first pilot training package using a train-the-trainer model, tailored specifically for emergency department doctors, nurses and allied health staff, to recognise, assess and manage people at risk of suicide.

Consultation is planned on the revised MIND Essentials resource and the revised suicide risk assessment and management guidelines. The project has progressed towards completion of the guidelines and implementation of the train-the-trainer training program for emergency department staff.

On 25 January 2018 the Minister for Health and Minister for Ambulance Services responded:

The Department of Health progressed implementation of two projects led by the Mental Health Alcohol and Other Drugs Branch (MHAODB) to strengthen the skills of nursing staff in the assessment and management of suicidal behaviour.

As part of a review, feedback on the Queensland MIND Essentials resource was sought from Queensland Health nursing workforce and other interested stakeholders regarding content, layout, structure and relevancy. The resource was updated; however negotiations are currently ongoing with the Hunter Institute of Mental Health as the original developer of the resource, regarding finalisation and approval processes. Expected completion is reliant on agreement with the service provider.

Secondly, the MHAODB reviewed and updated the Queensland Health guideline for suicide risk assessment and management. The guidelines highlight the importance of obtaining collateral information on a person's mental state, including obtaining and documenting information about suicidal behaviour or depression from relevant sources such as police officers.

One hundred and sixty-five clinicians across Queensland Health have been trained as facilitators to deliver the suicide risk assessment and management in emergency department settings training package. These facilitators have subsequently trained 204 staff across nine hospital and health services – 93 in the foundational course and 111 in the advanced course. The training is ongoing with the aim to train as many emergency department staff as possible over coming years.

The Queensland Centre for Mental Health Learning will work in partnership with the MHAODB to ensure the sustainable implementation of the training at the hospital and health service level and will include an evaluation of the effectiveness and efficacy of the training.

Recommendation 4

That the handover of patients by one medical officer to another be recorded in writing, including a specific written record of daily medication dose limitations for such patients.

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

Queensland Health supports the need for effective and structured clinical handover appropriate to the circumstances of the patient, staff and facility concerned. However, Queensland Health does not agree that clinical handover between medical officers must always be recorded in writing.

Clinical handover is recognised as a challenging area for quality improvement in healthcare internationally. Clinical handover is actively considered on an ongoing basis across Queensland Health through accreditation processes and a range of other activities.

In relation to handover of medication related information, standard medication charts and medication action plans are available statewide for improved communication of medication related information between clinicians and more comprehensive handover of important medication information. Medical officers or other staff who identify a medication issue can complete a specific 'issues' section. However, completing the form is not intended to replace the need for direct communication between clinicians.

The Australian Commission on Safety and Quality in Health Care developed ten national safety and quality health service standards which form the basis for mandatory accreditation of hospitals and other health care facilities. Standard six 'Clinical handover' describes the range of clinical handovers that can occur, including varying situations of handover (e.g. during shift change or when patients are transferred to another ward or hospital), methods of handover (such as face-to-face, via telephone or via written orders) and venues where handover takes place (e.g. at the patient's bedside or in a common staff area).

Ongoing work to improve clinical handover is being carried out at multiple levels of the healthcare system, locally, statewide and nationally:

- Many hospital and health services are implementing structured clinical handover through participation in the productive ward program, a comprehensive clinical quality improvement program.
- Many hospital and health services have installed electronic patient journey boards which are a visual, interactive tool used to assist with patient flow management, clinical handovers and team communication.
- The Department of Health's Patient Safety Unit has released model policies, guidelines, a checklist, information brochures and other educational resources to support hospital and health services in implementing effective clinical handovers.
- The Patient Safety Unit is working with the in the integrated electronic medical record team for inclusion of clinical handover functionality in the integrated electronic medical record solution that will be progressively rolled out across the state.
- The Australian Commission on Safety and Quality in Health Care provides an implementation toolkit for clinical handover improvement and a range of associated resources for hospitals on their website.
- Queensland has participated in forums led by the national lead clinicians group focused on clinical handover to develop national priorities and strategies for improvement.

Recommendation 5

That a protocol be established in order to ensure that the family member of a person admitted to hospital who then absconds is contacted by the hospital immediately and if necessary, the hospital enlists the assistance of the police service to do so.

Response and action: the recommendation is implemented.

Responsible agency: Department of Health.

The Minister for Health and Minister for Ambulance Services responded:

Queensland Health supports a consumer-centred approach to the meaningful engagement of carers and families and has published information sharing guidelines on the internet for clinicians, consumers, carers and families.

Information sharing between mental health workers, consumers, carers, family and significant others (2011) provides an overview of the legislation that enables the sharing of information concerning mental health consumers and how information sharing can be applied in clinical practice. A key message of the guide is the promotion of good clinical practice through identification and engagement of people who are important to the patient and involved in their care, and encouraging information to be shared at every opportunity between clinicians, patient and those involved in supporting the patient recovery.

The guide is underpinned by a legislative framework that supports the sharing of information while recognising consumers' rights to confidentiality. The *Hospital and Health Boards Act 2011* allows for information sharing in a number of situations. These range from those where clinicians are required by law to disclose information to protect the health, safety and well-being of consumers, carers or the community, to circumstances in which clinical judgement is required in deciding what information should be shared, when and with whom.

In late 2013, the director of mental health issued a policy requirement in relation to the development of absent without permission response plans for patients receiving care under the *Mental Health Act 2000*. Such plans could include contact details of persons who should be notified if the patient absconds.

As far as possible, the expressed views of the consumer are taken into account when sharing information. However, it would not be appropriate to notify family of a consumer's absconding in every case.

In some instances, for example where family relationships have broken down, the consumer might prefer that information is not shared with the family, and alternatively nominates a support person for the receipt of this information.

Recommendation 6

That a protocol be established that nursing staff not return prescription medication to patients in circumstances where the patient's circumstances have changed since the previous prescription by a medical officer and where the patient is unwilling to be reviewed by the medical officer. In other words, where there is any doubt at all about the efficacy of returning medication to a patient, such medication should not be returned without the patient being first reviewed by a doctor.

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

The Department of Health sought advice and is of the view that there is no lawful authority for hospital staff to withhold the property of a patient, including medication the patient has brought into hospital, upon discharge of the patient from hospital. On this basis, the Department of Health is not in a position to implement this recommendation.

However, the department continues to support and encourage communication between clinicians and patients, their families and/or carers about the patient's health condition and the risks and benefits of various treatment options, including the use of medication.

Recommendation 7

That upon the death of a patient who has been treated recently at a hospital in Queensland, the patient's hospital records are to be immediately sealed and secured in order to prevent tampering or interference before the records are provided to the Coroner.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Minister for Health and Minister for Ambulance Services responded:

The Department of Health wrote to all hospital and health services reminding them of the established processes for providing medical records to the police and the coroners. Hospital and health services were asked to review their local procedures to ensure records are collected and secured as soon as possible following a reportable death and provided to the police and coroners in a timely manner.