GUIDELINES FOR REPORTING AND REVIEW OF INCIDENTS IN MENTAL HEALTH SERVICES

REVISED VERSION

DECEMBER 1995

MINISTRY OF HEALTH
MANATU HAUORA

This revision of the 1993 Guidelines for Reporting and Review of Incidents in Mental Health Services has been developed by the Mental Health Section of the Ministry of Health, following widespread consultation.

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Published with the permission of the Director-General of Health.

ISBN: 0-478-09435-3

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Guidelines for Reporting and Review of Incidents

1. Background

The working party for improving the management of High Risk Mentally Ill Patients (1991) recommended that "Area Health Boards should develop and implement comprehensive critical incident recording and reporting systems".

In June 1993 the then Department of Health prepared and issued "Guidelines for Reporting and Review of Incidents" to provide a framework for the development of incident reporting and review systems. This was one of a number of Quality Guidelines produced for mental health services in New Zealand.

In the last two years, mental health services throughout the country have developed and refined their own systems for reporting and review of incidents.

The revision of the Guidelines aims to build upon the progress which has been made and provide a framework for the continuing development of good systems, essentially as a "minimum standard" for incident reporting and review. The revision is based on feedback from services, and the collective experience of the members of the current working group.

2. Purpose

The purpose of reporting and reviewing incidents occurring in mental health services is to improve the quality of the service, both for the individual client and at the level of the service system as a whole, by identifying and correcting problems which arise.

It is important to emphasise that incident reporting is a quality improvement tool, and is not a defensive device to protect the service from blame when problems arise.

The ideal system pre-empts and prevents the occurrence of incidents; and minimises the harm that arises when an incident does occur.

Because of the nature of mental illness and its effects on behaviour, it is inevitable that incidents arise as part and parcel of the illness and its treatment. It is important that reporting and review of incidents is able to be integrated into the overall clinical management plan of the individual client*, as well as providing feedback for system improvement.

There are, therefore, particular requirements of incident reporting systems in mental health services. In general it is preferable to develop specific incident reporting and review systems for mental health services to meet these needs, rather than using a "generic" system developed for general health service use.

* The term "client" is used throughout this document to indicate the individual who is the recipient of the service (eg "patient", "consumer", "resident").

3. Definition of an Incident

An incident is when an event occurs that is physically, psychologically, spiritually or culturally harmful or potentially harmful to a client or other person.

There may be events of a more minor nature occurring, that may have some harm potential, but which it would be inappropriate or impractical to record as incidents. Clinical judgement must be used in making a decision about whether an event is subject to incident reporting. It is useful to take into consideration antecedents to the event in making such a judgement.

All incidents are important and should be handled in the same way, with analysis of the incident and review of clinical management. A service may choose to have additional reporting systems for incidents above a defined threshold.

Categories of incidents for which reports are required should be defined and specified and should include:

(a) suicide
(b) self harm attempts

(c) homicide
(d) injury to self or others
(e) violent behaviour towards fellow clients, staff or others
(f) serious threats of violence towards self, others or property
(g) arson
(h) damage to property, including theft
(i) occurrence of client-specific indicators of dangerousness (identified in the care plan)

(j) sudden death
(k) medical emergency including adverse reaction to medication
(l) injury by staff
(m) medication errors
(n) injury by another client
(o) client accident (whether or not there is obvious injury)
(p) restraint, either personal or mechanical

(q) sexual harassment, intimidation, assault

(r) unauthorised absence/ cancellation of leave/ breach of leave conditions
(s) abuse or illicit possession of drugs/ alcohol

(t) specific complaints/ allegations (including sexual allegations) against staff or others
(u) allegations of loss or damage of personal effects
(v) unauthorised media involvement with client, family, service
(w) intruder activity or breach of security
(x) error of legal status, including incorrect MHA papers

(y) breaches of cultural needs or protocols, including lack of access to translators. The threshold and circumstances for inclusion as an incident must be defined very carefully.

Seclusion is recorded independently. There may be an incident, in the mentioned categories, prior to seclusion, which requires reporting. The report should indicate that seclusion was used.

Use of Sections 110 & 111 of the Mental Health (Compulsory Assessment & Treatment) Act 1992, may also be the result of an incident. Again the incident should be *reported* and the use of the Act should be *recorded*.

4. Aims for Incident Reporting and Review

The focus of incident reporting is to ensure high quality care of the individual client by integrating individual client information (including incidents), review of clinical management and review of the care system.

The aims are:

to improve quality of client care
to contribute to the care of the client, to minimise occurrence of similar incidents
to initiate further action to minimise or prevent harm, including training
to provide a verifiable account of the event, and of actions taken so that legal rights and personal well-being of both clients, staff and others are protected
to provide records that can be individually and collectively analysed to identify areas of concern and develop successful strategies to minimise future incidents
to provide an opportunity for the client to feed back on the outcome of the report and review of any incident in which they were involved or to initiate any further action.

5. Quality of Reporting

(1) The rationale for reporting incidents must be clearly communicated to all staff and reinforced by the approach used in the management and review of the incident reporting process. Feedback should be constructive, helpful and supportive of staff expressing their views on client management. Debriefing should emphasise lessons learnt and positive approaches to the management of such incidents (ie "what can we do differently next time?").

(2) The preparation of good reports is a skill that has to be learned and maintained. Training should be provided to all staff, to ensure timeliness, accuracy, objectivity, adequacy and legibility of reports. Effective formatting of reporting forms is helpful in ensuring this occurs.

(3) Reports should provide a clear outcome of each incident which will include assessment of the impact of the incident on the individual and their understanding of this impact. A copy of every incident report involving any individual client should be placed in the individual's clinical file.

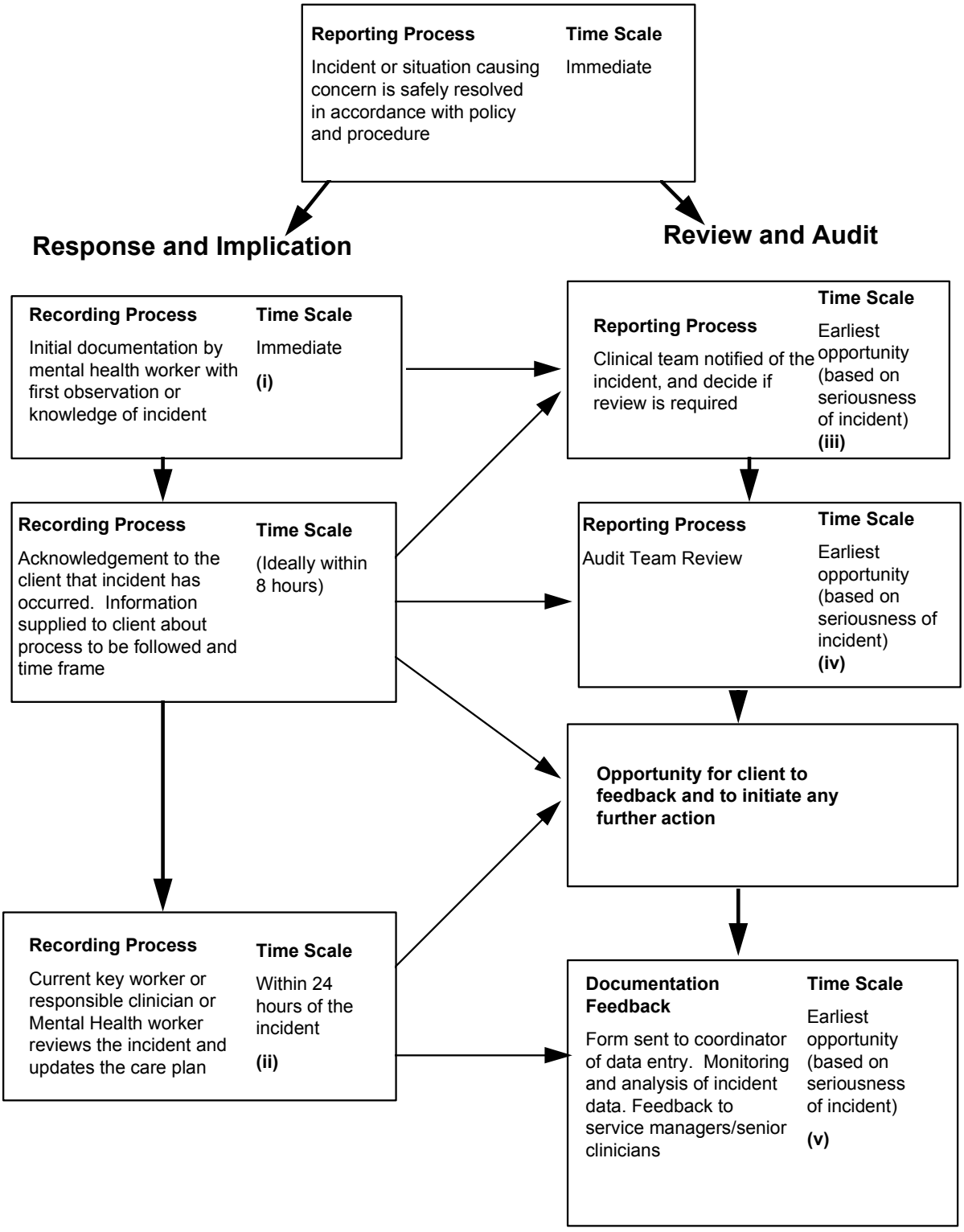
(4) Reports should be written, wherever possible, in such a way that the client can fully understand what happens.

All documentation should be clear. Corrected errors must be initialled by the writer. No correction fluid should be used and unused lines must be crossed through.

Flow Chart of the Incident Reporting and Review Process

The storing and handling of forms must protect client confidentiality and meet requirements of the Health Information Privacy Code and Privacy Act 1993.

Dealing with the Immediate Situation



Notes to Flow Chart

(i) Initial Documentation

After the immediate intervention, the first mental health worker to observe or be contacted about the event should complete the initial documentation.

This will include:
Name(s) of those involved
Date/Time of Incident
Current domicile of the client
Client's Legal status
Name and designation of writer
Date/time form completed

Description of event, including:
Correct chronological sequence
Location of incident
Client's activity at time of incident
Injuries sustained, psychological state
Witnesses and participants
Perceived contributing and precipitating factors

Recorded action taken should include notifications relevant to the event, eg. manager, Police, Victims' Support, legal advice, Ministry of Health, advocacy service, family, District Inspector. A note should be placed on the clinical file, flagging the incident.

The Unit Manager/Charge Nurse/Community Manager must check all documentation details and ensure that the form is seen by current key worker/responsible clinician/duty worker within 24 hours. (Ideally within the shift or 8 hours.)

(ii) Review by Key Worker/Responsible Clinician/Duty Worker (if out of hours)

The current key worker/responsible clinician/duty worker reviews the incident and updates the client's care plan, considering the following:

Legal status of the client:
Contributing and precipitating factors
Past related or similar incidents
Confidentiality

Consultation with client/ community/ advocate
Service guide-lines
Safety of client, staff and others

The updated care plan should incorporate lessons learnt from the incident.

(iii) Clinical Team Review

The current key worker/responsible clinician must ensure the clinical team is informed of the incident. The clinical team should decide if full review is necessary. If so the clinical team should review the incident, its management and the client's care plan. They should ensure that the revised care plan reflects experience gained from the incident, and an entry recording outcome made in the clinical file.

(iv) Audit

These are independent reviews conducted by a team which represents client advocacy, Maori/cultural advisors, senior clinical advisors and management of the service. Each member must sign the report and make any necessary comments. Members may request further inquiry or specialist advice. Feedback (which may include written documentation if appropriate) should be supplied to the client, clinicians, and to managers and District Inspector where appropriate.

The audit team is responsible for identifying the data that should be entered for monitoring purposes and for returning the form to the client's file.

(v) Data Entry and Monitoring

After the audit, the identified data for the purposes of monitoring should be entered in the system.

Anonymous general data and individual specific data should be recorded for each incident.

Regular summaries of incident report data should be conducted to identify patterns, trends and interventions. Results should be communicated regularly to service managers. Service managers and clinicians should be directly involved in the evaluation of summaries and the implementation of strategies to improve quality of care delivery.

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