Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Adequate systems needed to coordinate the transfer of patient care between regions
19HDC02053

The Deputy Commissioner, Dr Vanessa Caldwell, has found Counties Manukau District Health Board (now Te Whatu Ora Counties Manukau) in breach of the Code of Health and Disability Services Consumers' Rights (the Code) for mental health services provided to a man in his thirties who died of suspected suicide.

Following discharge from hospital, the man's care was intended to be transferred to a Te Whatu Ora district he had recently moved from. However, inadequate transfer of care from Te Whatu Ora Counties Manukau contributed to a delay by the receiving service in establishing prompt therapeutic contact with the man. This was critical in light of the importance of follow up after an inpatient admission.

Dr Caldwell found Te Whatu Ora Counties Manukau in breach of Right 4(1) for not providing services with reasonable care and skill and Right 4(5) for lack of co-operation between providers to ensure quality and continuity of services.

"I consider that the onus was on Te Whatu Ora Counties Manukau as the transferring service to initiate and complete the transfer of the man's care appropriately and within accepted guidelines," Dr Caldwell said.

"The National Transfer of Care Guidelines are clear and concise and in this instance transfer of care did not adhere to the guidelines. I am critical that, particularly in the context of mental health care, more was not done by Te Whatu Ora Counties Manukau to transfer the man's care safely. Overall, this led to a poor standard of care at the point of discharge," said Dr Caldwell.

Dr Caldwell had a number of concerns about Te Whatu Ora Counties Manukau's patient discharge and transfer process.

Engagement with the man's support person was inadequate and the man was permitted to travel alone on the day of his discharge without a person organised to go with him or pick him up. There was no aftercare plan issued to the man or his whānau which would have included emergency contact numbers or contact for the follow-up mental health team. There was a lack of timely communication initiated by Te Whatu Ora Counties Manukau to the receiving service and limited referral information was sent.

The report highlights the importance of having adequate systems for the co-ordination of the transfer of a patient's care from one region to another, and of ensuring that the handover is clear, and that the receiving region has accepted

responsibility for the patient's care. It also demonstrates the importance of providing timely and responsive services.

Dr Caldwell made a number of recommendations for Te Whatu Ora Counties Manukau including to:

- Provide a written apology to the man's family for the breaches of the Code.
- Provide HDC with an update on the changes implemented in response to these events, and report on any further changes that occurred following implementation.
- Consider developing a guideline about transport and supervision when a patient is to be transferred within Te Whatu Ora to a different district.
- Consider a review of the work pressures on staff in in-patient units.

Since this event, Te Whatu Ora Counties Manukau has undertaken work to improve the assessment and management of risk through a comprehensive safety assessment, and increased the involvement of family in safety planning. It has also been reviewing its existing discharge procedures, and said that the new procedures would include family/whānau participation in discharge planning; documented discharge plans for patients; and a telephone-based handover between treating and receiving senior medical officers for transfers between regions.

15 May 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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