Care of patient by community mental health services (10HDC00805, 1 October 2012)

Psychiatrist ~ Psychiatric nurse ~ District health board ~ Mental Health Services ~ Clinical documentation ~ Case management ~ Suicide ~ Crisis care ~ Continuity of care ~ Discharge planning and family involvement ~ Rights 4(1), 4(2), 4(5)

This case concerns the psychiatric care provided to a 45-year-old man with a severe personality disorder, by a DHB's Community Mental Health (CMH) service.

In 2010, the man attempted suicide, precipitated by relationship stress and eviction from his partner's house. The Psychiatric Acute Community Team (PACT) staff arranged respite accommodation while he waited for a CMH psychiatric assessment. During the assessment, the man attempted to self harm. He was transferred to the Intensive Care Unit (ICU). Two days later, he was discharged from the mental health service by a psychologist on the psychiatric liaison team and sent to his partner's home without CMH follow-up. There was no communication with the man's partner about his discharge and his GP received conflicting information about psychiatric follow-up arrangements from the ICU medical team and the liaison team psychologist.

Several weeks later, a psychiatrist and CMH nurse saw the man. The psychiatrist understood that the nurse was assigned as the man's case manager. However, the nurse believed he was attending the assessment merely as a "second observer", and that a case manager would be assigned if, on completion of the assessment, the man was considered to be suitable for CMH care. Unfortunately, the assessment could not be completed in the allocated time slot, so a second appointment was made for a month's time, when the psychiatrist returned from leave. The psychiatrist placed his handwritten notes on the man's paper file before going on leave, but he did not communicate with the man's GP or partner. No interim contact was planned, but a crisis plan was made, in which the CMH nurse was to be the man's first point of contact with the service should he go into crisis. This crisis plan was not documented anywhere in his clinical notes or his electronic file. There was also no record of the nurse being present at the assessment or in what capacity.

The man went into crisis within two weeks of the assessment. His partner approached the PACT three times over three days, advising she had asked the man to leave her home and he was threatening suicide. PACT staff were unaware that the man had been seen recently by the psychiatrist or that there was a crisis plan involving the CMH nurse as point of first contact. Despite recognising that the man's relationship breakdown and eviction were risk factors, no arrangement was made to review the man by PACT or CMH staff. The man was found dead from suicide a few days later.

It was held that the psychiatrist's handwritten notes of the assessment were inadequate to inform care and this substandard documentation breached Right 4(2). He failed to communicate with the man's GP and partner, and did not take adequate steps to ensure that the crisis plan was documented on the man's clinical record, which compromised his continuity of care. These failures amounted to a breach of Right 4(5).

It was also held that the failure of the DHB's CMH service to contact and assess the man when informed by his partner of his known risk factors breached Right 4(1). The DHB's failure to take appropriate steps to involve the man's partner in the discharge planning breached Right 4(2), while system failures around role clarity and responsibilities, and in the flow of information and communication between CMH, PACT and the GP impaired the man's continuity of care, and was a breach of Right 4(5).