Assessment and risk evaluation of a mental health inpatient; discharge planning and systems to ensure continuity of care (09HDC01156, 29 April 2011)

Psychiatrist ~ District health board ~ Mental health services ~ Inpatient services ~ Community services ~ Standard of care ~ Communication ~ Continuity of services ~ Rights 4(1), 4(2), 4(5)

Overview

A man came under the care of a district health board's mental health services having had symptoms suggesting a major mental illness for about two years. The man had ongoing contact with the mental health services, including admission to the inpatient unit. His care in the community was managed by two teams.

Ten years later, the man was admitted to the inpatient unit. The community team was concerned about treating the man in the community on a voluntary basis and felt that the inpatient clinical team should seize the opportunity of informal admission to assess the man and re-establish intramuscular injections. As he would not agree this the community team suggested using the Mental Health (Compulsory Assessment and Treatment) Act to compel the treatment.

He was assessed by a psychiatrist who planned to keep him as an inpatient for a brief stay until accommodation could be arranged for him. The psychiatrist recorded that he saw no evidence of psychosis or disorganisation. At times the man refused to take his medication, but the clinical team considered the man's condition was not such that it was appropriate to apply for a compulsory treatment order.

In the second week of this admission, the man was found smoking and consuming alcohol in his room, and he was advised that he was to be discharged the next day. His family was not consulted or informed of his impending discharge. The man had no fixed address and stated that he intended to travel out of the city. He was given a summary of his admission to present to another mental health unit, if necessary, and a prescription for medication. The man had no further contact with the mental health team (except for a phone call, some weeks later, to the crisis team when he reported being on the street and cold), but there was some contact with his family who contacted the teams, expressing concern about the man's condition. The man was subsequently acquitted of a serious criminal offence on the grounds of insanity.

Breach - Psychiatrist

The psychiatrist was not the man's treating psychiatrist, and the man's care was provided by a multidisciplinary team. However, as the leader of the team, the psychiatrist had a supervisory role, and provided oversight to the rest of the team.

The Commissioner accepted that, during the time the man was in the unit, it was open to the team to conclude that there was insufficient basis to institute compulsory treatment under the Mental Health Act. However, the psychiatrist did not fully explore and set out the risks and benefits of compulsory treatment.

It was found that a reasonable and competent clinician, when confronted with the combination of a patient with a history of violence, medication non-compliance and reluctance to co-operate with treatment plans, would have done a more thorough

assessment and evaluation of risk. The psychiatrist did not adequately assess the man or evaluate the risks of his treatment plan at that time by taking a longitudinal view and identifying that his mental health was deteriorating. In addition, the psychiatrist did not adequately record his assessment, and therefore did not provide services with reasonable care and skill. Overall, the psychiatrist breached Rights 4(1) and 4(2).[1]

Breach – the DHB

Discharge planning

When a patient is to be discharged from the acute inpatient unit to the community, ideally there should be a discharge planning meeting with the relevant providers.

The DHB's protocol stated that the unit staff had a responsibility to maintain contact with the community keyworker and provide information significant to the consumer's progress, and to consult with the keyworker around any planning decisions. There had been some previous discussions with the man's keyworker about his care, but there is also no evidence in the patient notes that the unit staff consulted with him or any other community mental health staff about the decision to discharge.

Decision to discharge

The multi disciplinary team's psychiatric house surgeon, a medical student and a ward nurse met with the man to discuss his pending discharge. The house surgeon noted that the man appeared to be no risk to himself or others, although his safety issues had not been formally assessed. Staff at the unit had encouraged him to arrange accommodation for himself, but he indicated that he wanted to remain in the unit, and made little effort to find somewhere to live. At the time the discharge decision was made the man had only a vague notion of where he would live.

The man's family were proactive in following up with the mental health service staff and expressing their concerns about, and wishes for, their son's ongoing treatment. However, they were not consulted about the proposal to discharge him.

The communication between the ward and the community mental health team was not as good as it should have been. The discharge plan was based on an assumption that the man would continue to take his medication, when it was already evident that he was non-compliant. It was unrealistic to expect that he would keep in contact with the community teams, when he had exhibited a reluctance to interact with his key community worker while in the ward.

The DHB's policy, which was intended to provide staff with guidance on discharging a consumer who is known to the service to have no accommodation, was not sufficient. The DHB also did not have appropriate procedures, or take appropriate action to ensure that the protocol for liaison between the inpatient unit and community mental health services regarding discharge was being followed by staff. This contributed to the man being discharged into the community without adequate liaison and consultation with his keyworker (or other staff), and without definite accommodation and appropriate plans in place for action should he make contact after discharge.

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill." Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Follow-up after discharge
The follow-up arrangements were that, should the man require readmission owing to relapse or non-adherence to the treatment plan, consideration was to be given to restarting his compulsory treatment. The man was discharged into the care of the community team that assists homeless people. Patients under care of this team are always likely to be difficult to follow up. Yet there was no plan of what to do should an "elusive" patient such as this man make contact. A clear plan for his future care and the involvement of community mental health services should have been agreed upon, and activated, before he was discharged. There was a missed opportunity when the man made contact stating that he was on the street and cold, and that he wanted medication, somewhere to sleep and some warm clothing. He was told these could not be provided. His family unsuccessfully attempted to raise concerns about the man's condition. The DHB lacked appropriate systems to ensure co-operation between its teams to achieve the appropriate quality and continuity of services for consumers.

For these reasons the DHB did not provide services of an appropriate standard to the man in relation to his discharge, continuity of care and the follow-up in the community, and this amounted to a departure from the accepted standard. Accordingly, the DHB breached Rights 4(1) and 4(5)[2] of the Code.

The DHB conducted external and internal reviews of its adult mental health services as a result of these events, and took steps to steps to address the recommendations arising from these reviews. These actions include: improvements in the processes between community mental health services and Court liaison; improved interface between general and forensic mental health services; implementation of staff training regarding dual diagnosis; and the establishment of a restructured community service.

It also took steps to improve communication between the mental health service and families. The DHB restructured the position of family advisor, undertook an audit of practice, and improved consultation policies and accountability.

Recommendations
District Health Board
It was recommended that the DHB apologise in writing to the families involved for its breaches of the Code. The written apologies were to be sent to the Commissioner for forwarding to the families.

It was also recommended that the DHB take the following actions:

1. Develop clear performance criteria and processes for review of performance of the unit's Clinical Director and all mental health service medical staff.
2. Develop a clear mechanism to resolve any disagreement between and within the community and inpatient teams in relation to proposed treatment or discharge plans, including when clinicians have markedly different views.
3. Develop a system whereby a "red flag" appears in the electronic record when a patient comes to the attention of one of the mental health services because of

[2] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

a relapse or non-adherence to treatment, and whose historical pattern and clinical records indicate a history or risk of violence.

4. Contract an independent reviewer to critically appraise the appropriateness of the changes made to the DHB's mental health services as a result of the recommendations arising from the reviews undertaken, in particular the:
    - discharge protocol;
    - interface between the adult acute inpatient unit and Agency 1 regarding discharge planning;
    - interface between mental health and addiction services;
    - inpatient management model;
    - observation procedures;
    - criteria for triggering a complex case review;
    - training for senior medical and nursing staff regarding diagnosis, assessment and management of clients with comorbid substance use disorders; and
    - adult acute inpatient unit leadership.
5. Provide evidence that internal auditing and monitoring processes have been introduced to audit compliance with the DHB's mental health services policies and procedures.

Ministry of Health

The DHB has made service changes to its mental health services. It was recommended that the Ministry of Health monitor the DHB's progress with these changes, and the recommendations above, and provide an update to HDC.

Follow-up actions

- A copy of the full report will be sent to the Coroner and the Medical Council of New Zealand.
- A copy of the report with details identifying the parties removed, except the expert who advised on this case and the DHB, will be sent to the Royal Australian and New Zealand College of Psychiatrists, and it will be advised of the psychiatrist's name.
- A copy of the report with details identifying the parties removed, except the name of the expert who advised on this case and the DHB, will be sent to the Ministry of Health, the Mental Health Commission, the Mental Health Foundation, and the Schizophrenia Fellowship, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.