Co-ordination of care of man with mental health issues
17HDC00632, 29 July 2019

District health board ~ Community mental health service ~
Support ~ Co-ordination ~ Right 4(1)

A man in his fifties was admitted to an inpatient mental health unit at a district health board (DHB). He had a history of a major depressive episode with psychotic symptoms, post traumatic stress disorder, and chronic obstructive pulmonary disease. On discharge from the inpatient unit, the man remained under the care of the DHB's Community Mental Health Service (CMHS).

The DHB's Needs Assessment and Service Coordination (NASC) service assessed the man's home care needs. He was offered eight hours per week of personal cares, and two hours per week of household management from the first support organisation. CMHS referred the man for support with his personal health conditions and daily living, community health, socialising with others, interacting with other people and environments, and leisure activities. This support was provided for 2.5 hours per week from the second support organisation.

From the outset, the man demonstrated a marked reluctance to receive support (e.g., for home cleaning, showering, and meal preparation). The first organisation raised concerns with NASC about the difficulties in providing support to the man, but there was no evidence of further action being taken.

The man was visited by his CMHS key worker. Two days later, the man was discussed at a CMHS multidisciplinary team review meeting, and the decision was made to discharge the man from the CMHS. The team considered that the man's mental health symptoms were stable and he had appropriate supports in place. The discharge was communicated to the man's general practitioner by letter; however, the information was not provided to the man, his family, or the organisations supporting him. At the time of discharge from CMHS, no lead organisation was appointed to oversee the man's ongoing care.

Two organisations continued to provide care to the man. The first organisation contacted NASC again advising that there continued to be problems with the man accepting help, and that support workers reported that the man had no clean clothes or sheets, and often no food. This correspondence was not escalated within the DHB.

The man's sister visited him and took him to see his GP, as he was in a compromised physical state. The man was found to have lost 11kg in six months, and he was very short of breath and coughing. He was treated in hospital, but he died from pneumonia secondary to malnutrition and depression.

Findings

The Mental Health Commissioner found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1), for the following reasons:

a) A lead organisation was not appointed upon the man's discharge from CMHS, and neither support organisation was invited to attend the CMHS team review, despite the relevant DHB policy allowing for this to occur.

b) It would have been more appropriate for the man to have been reviewed by a psychiatrist at the time of the proposed discharge from CMHS, rather than four months beforehand.

c) Service providers were not given details about a relapse prevention plan or early warning signs for deterioration to be aware of, and the discharge summary was not circulated to all support agencies, despite the relevant DHB policy providing for these things to occur.

d) There were incorrect assumptions made during the CMHS team review about the level of support available to the man, in particular regarding the level of regular contact with his GP, and the reliability of family support available.

e) CMHS did not discuss the man's proposed discharge from its service with the man's family, despite the relevant DHB policy allowing for this to occur, and there was a lack of documentation regarding consultation with the man about the proposed discharge.

f) NASC did not appropriately escalate or address concerns raised by Organisation 1 about the man's refusal of care.

In the circumstances of the man's ongoing refusal of care, the first support organisation was criticised for not doing more to advocate to NASC for the man's needs.

It was considered that more attention could have been given to obtaining comments from the other parties involved with the man's care when the second organisation was forming the man's support needs assessment plan. The second organisation was reminded to ensure that support staff are alert to any general decline in the health of their clients, and vigilant in reporting any concerns.

Recommendations

It was recommended that the DHB (a) provide a written apology to the man's family; (b) implement policy documentation to ensure that when a person is discharged from the Mental Health and Addictions Service and multiple agencies are involved, a meeting is held to determine the lead agency and confirm the support plan for the person; (c) undertake an audit of compliance with discharge documentation requirements; (d) implement a clear escalation pathway for NASC staff to follow when concerns are raised by contracted providers; and (e) familiarise NASC staff with the Equally Well Consensus Paper, supporting them to enact this in the context of needs assessment and contracting services.

It was recommended that the first support organisation provide an update on the efficacy of its new system for escalating incidents of missed care, and review its process for accepting referrals to ensure that sufficient information about the client is obtained.

It was recommended that the second support organisation provide an update on its review of its staff development framework, and review its process for accepting referrals to ensure that sufficient information about the client is obtained.