Te Whatu Ora Counties Manukau
(formerly Counties Manukau District Health Board)

A Community Mental Health Service

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00950)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman (aged in her twenties at the time of these events) by Counties Manukau District Health Board (CMDHB) (now Te Whatu Ora Counties Manukau) and a community mental health service (CMHS) in 2016. The woman had a history of non-suicidal injury and life-threatening behaviour and was well known to mental health services. The woman's diagnoses included an eating disorder, attention deficit hyperactivity disorder, partial post-traumatic stress disorder, alcohol use disorder, traits of a personality disorder, anxiety, and depression. The woman was admitted to the CMHS for a seven-day stay. The CMHS was contracted by CMDHB's Mental Health Services (MHS) in partnership with the CMHS to provide a peer-led, acute mental health service based in the community. Throughout her stay, the woman struggled with ongoing low mood and suicidal thoughts. Sadly, the woman was found in her room having died by suicide.[1]

Findings

2. The Deputy Commissioner found Te Whatu Ora Counties Manukau in breach of Right 4(5) and Right 4(1) of the Code for both failing to provide coordinated care to the woman and for failing to provide clinical services to the woman with reasonable care. The Deputy Commissioner was also critical of the CMHS in relation to its processes of conducting wellbeing checks.

Recommendations

3. The Deputy Commissioner recommended that Te Whatu Ora Counties Manukau provide a written apology to the woman's whānau, conduct an audit to ensure that all residents at the CMHS have a collaborative care plan, provide suitably trained staff to provide on-site reviews, and provide training to the Home-Based Team and Intake Team on the diagnosis of a personality disorder and management strategies.

4. The Deputy Commissioner recommended that the CMHS provide a formal apology to the woman's whānau, consider developing policy and procedures to support staff in managing patients with known drug or alcohol misuse, and provide HDC with an update on the recommendations made in its review.

5. It was also recommended that Te Whatu Ora Counties Manukau and the CMHS work together and consider developing a shared copy of the clinical review and adopting the national approach to care for people with co-existing disorders (Te Ariari o te Oranga).

[1] The Coroner found that Ms A's cause of death was self-inflicted and amounted to suicide.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint[2] about the services provided to Ms A by Counties Manukau District Health Board (CMDHB) (now Te Whatu Ora Counties Manukau)[3] and the CMHS. The following issues were identified for investigation:

- *Whether Counties Manukau District Health Board provided Ms A with an appropriate standard of care in 2016.*
- *Whether the CMHS provided Ms A with an appropriate standard of care in 2016.*

7. This report is the opinion of Vanessa Caldwell, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

8. The parties directly involved in the investigation were:

Complainant/consumer's father	
Complainant/consumer's aunt	
CMDHB	Provider
Community mental health service	Provider

9. Further information was received from:

Dr B	Psychiatrist/CMDHB
Dr C	Psychiatrist/CMDHB

10. Also mentioned in this report:

RN D	Registered nurse
RN E	Registered nurse

11. Independent advice was obtained from a consultant psychiatrist, Dr Giles Newton-Howes (Appendix A), and from a registered nurse, Carole Schneebeli (Appendix B).

Information gathered during investigation

Background

12. Ms A, in her twenties at the time of events, had a history of non-suicidal injury[4] and life-threatening behaviour, and she was well known to mental health services. Ms A's diagnoses

[2] This matter was referred to HDC by the Coroner.
[3] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished and Te Whatu Ora|Health New Zealand being established in their place.
[4] The deliberate, self-inflicted destruction of body tissue without suicidal intent.

included an eating disorder, attention deficit hyperactivity disorder,[5] partial post-traumatic stress disorder,[6] alcohol use disorder, traits of a personality disorder, anxiety, and depression.

13. This report discusses the care provided to Ms A by CMDHB and the CMHS when she was admitted to the CMHS in 2016. The report mainly relates to the monitoring and oversight of Ms A during her admission.

CMHS

14. The CMHS was contracted by CMDHB's Mental Health Services (MHS) in partnership with the CMHS[7] to provide a peer-led, acute alternative mental health service based in the community. At the time of events, the CMHS provided 24/7 support for guests with an acute episode of mental illness, as an alternative to a mental health inpatient admission. Usually, guests stay at the CMHS for seven days.[8]

15. The CMHS provides a home-like environment with a focus on supporting people in their recovery and developing wellness strategies. The agreement between CMDHB and the CMHS states that the '[c]are and treatment for people whose mental health is deteriorating should be provided rapidly and in the least restrictive environment'. The CMHS is staffed by peer-support specialists (PSS) who have personal experience of mental illness, addiction, and recovery.[9] A registered nurse is on site daily.

16. The CMHS states that it is not a clinical service, and the clinical treatment plan is delivered by the team at CMDHB, which maintains responsibility for the clients at the CMHS.

Professional and clinical responsibility

17. The agreement between CMDHB and the CMHS provides that PSS will be responsible for the care of the clients admitted to the service, including recovery coaching and facilitating the development of recovery plans. The agreement also states that CMDHB's MHS is responsible for the clinical treatment of the clients using the service. In response to the provisional opinion, the CMHS provided HDC with a copy of its 'Partnership Guidelines' with CMDHB (Appendix F), which stipulate the roles and responsibilities of both CMDHB and the CMHS.

18. Referrals to the CMHS were made through CMDHB's Intake and Acute Assessment (MHS Intake Team) and Home-Based Team (HB Team), which are part of the Acute Mental Health Services. The HB Team also had an ongoing role in the care provided at the CMHS.

[5] A pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.
[6] A psychological reaction to experiencing or witnessing a significantly stressful or traumatic event.
[7] A non-government organisation that provides community-based mental health, addiction, and wellbeing services.
[8] Guests can stay up to 28 days if clinically appropriate.
[9] PSS staff had completed a minimum qualification of DHB-contracted and required Peer Employment Training.

Referral

19. On Day 1,[10] Ms A was referred to CMDHB MHS by her GP. The GP referral noted that Ms A was depressed and had suicidal thoughts with a plan.

20. On Day 1, a nurse telephoned Ms A and recorded in the CMDHB MHS Regional Triage Referral form that Ms A's mood was low and she seemed distressed, and she reported that she was feeling suicidal. Ms A was assigned a triage code of 'C' for an urgent mental health response, and an appointment was made for that evening with a consultant psychiatrist.

CMDHB Mental Health Intake and Assessment Team

Assessment

21. At 6.10pm on Day 1, Ms A and her sister-in-law attended CMDHB MHS and met with consultant psychiatrist Dr C and a nurse.

22. It is documented in the CMDHB MHS Adult Assessment form that Ms A told Dr C that over the previous six months her mental health had deteriorated following a relationship break-up, and in the previous weeks she had had work stressors and financial problems. It is also documented that Ms A reported that she had had a relapse of her eating disorder and had increased anxiety and sleep difficulties. Ms A also reported having drunk alcohol on the previous night to cope with anxiety and thoughts about ending her life. Dr C noted: '[F]requent intoxication and black outs.'

23. Ms A's risk was recorded as: 'Denied having well structured suicidal plans and intentions but has been thinking [of] [method of suicide].' Dr C's impression was that Ms A was depressed, anxious, withdrawing from alcohol, and exhibiting traits of a personality disorder.

24. Under the 'Impression/Formulation' section of the MHS Adult Assessment form, Dr C documented that Ms A had longstanding and chronic ideas of ending her life, escalated by recent events, anxiety, and alcohol and sleep deprivation. Dr C documented:

> 'Although not ideal to use benzodiazepines,[11] given issues with alcohol, if not controlled, levels of anxiety may increase risk. [Ms A] may be at risk of harming self/ attempting suicide impulsively, she will need close monitoring and, most likely, looking at Respite admission as soon [as] a bed becomes available.'

25. CMDHB clarified that on Day 1, during Dr C's assessment of Ms A, he documented the nature and degree of alcohol use, and noted the risk of withdrawal. CMDHB said that Dr C 'medicated to prevent this'.

26. A plan was made for Ms A to stay at her brother's home with family support under the care of the MH Intake Team until a respite bed became available, and for the Multi-Disciplinary Team (MDT) to review her the next day. Ms A was prescribed an antidepressant,[12] anti-

[10] Relevant dates are referred to as Days 1–18 to protect privacy.
[11] Medication to treat anxiety or sleeping issues.
[12] Venlafaxine.

anxiety medication,[13] anti-psychotic medication,[14] and medication to assist with sleeping.[15] Dr C had no further involvement in Ms A's care.

27. Clinical records show that on Day 2, Ms A's care was discussed at an MDT meeting, and a plan was made to hand over her care to the HB Team the following day.

28. It is further documented that on Day 2, a nurse made telephone contact with Ms A. Ms A reported no alcohol use and no signs of alcohol withdrawal, but she continued to have suicidal thoughts. She said that she wanted to be 'knocked out' because she was concerned about feeling distressed and scared. The nurse told Ms A that the HB Team would contact her the following day.

Handover to HB Team

29. The HB Team saw Ms A at home on Days 3 and 4, and it was noted that she continued to have intrusive suicidal thoughts. Ms A's sister-in-law's mother raised concerns about the family's capacity to care for Ms A, and expressed to the HB Team that respite was wanted. A plan for admission to respite care was made with Ms A's agreement and the support of her family.

Admission

30. On Day 5, Ms A was admitted to the CMHS for a seven-day stay.

31. A registered nurse for the HB Team met Ms A at the CMHS and completed an Acute Community Options Crises Resolution Plan. The plan recorded the following detail regarding alcohol use and possible withdrawal:

a) Current acute issues of thoughts of deliberate self-harm, dysphoria,[16] ruminating,[17] and possible withdrawal from alcohol.

b) The section titled 'crises resolution goals' noted the goals as to promote sleep and safety and a low stimulus environment for anxiety, to support alcohol withdrawal with medications as charted, and to manage a daily routine.

c) The plan documented that the CMHS would supervise medication and observe Ms A for alcohol withdrawal.

32. A 'CMHS Respite or Acute Alternative Entry Checklist' was also completed, which records that Ms A was for daily review, and hourly monitoring for sleep, eating, mood, and safety risk of self-harm. However, in contrast to the Acute Community Options Crises Resolution Plan, there was no requirement to monitor alcohol use or withdrawal.

[13] Clonazepam.
[14] Quetiapine.
[15] Zopiclone.
[16] A state of unease and generalised dissatisfaction with life.
[17] The process of continually thinking the same thoughts, which in this context tend to be sad or dark.

33. CMDHB told HDC:

> 'Alcohol consumption was again discussed by the assessing RN on [Day 5], and [Ms A] again reported no consumption and no symptoms of withdrawal. As she was under constant observation by family members during this time [prior to admission to the CMHS], staff were confident the report of her abstinence was reliable.'

34. The CMHS also told HDC that Ms A's problems on admission did not result in monitoring for withdrawal or alcohol use, and that at the time of admission it had been three days since the signs of alcohol withdrawal had been documented in the HB Team's assessment.

35. The Acute Community Options Crises Resolution Plan also had a section titled 'planned acute assessment, treatment, intervention and review', which recorded that CMHS staff would monitor Ms A's sleep, eating, anxiety, and suicidal ideation and safety, and engage her in coping strategies. The registered nurse recorded in CMDHB's clinical notes that Ms A would be reviewed daily by the HB Team. A CMHS medication support plan recorded that all medication would be supervised and administered by CMHS staff.

36. A consent form was completed, and Ms A gave consent for CMHS staff to discuss her care with her brother, a friend, and her GP.

CMHS daily reviews and wellbeing checks

37. The CMHS said that the HB Team was responsible for decisions on wellbeing checks and directed CMHS staff to undertake the agreed checks until the HB Team indicated otherwise. The CMHS stated that any changes to Ms A's requirements for wellbeing checks were recorded in the electronic client management system throughout her stay at the CMHS.

38. The CMHS told HDC that wellbeing checks on guests were provided as general checks for security, and standard wellbeing checks for guests at night time. The CMHS said that the frequency of wellbeing checks was recorded in the Respite or Acute Alternative Entry Checklist[18] and the electronic client management system.

39. Guests at the CMHS were reviewed daily by the HB Team and PSS.[19] When required, a nurse from the CMHS would also attend. CMDHB stated that the role of the HB Team was to 'continue to evaluate the individual and adjust the treatment plan on a daily basis in response to the person's acute needs'.

40. The reviews undertaken by the HB Team and PSS were recorded in their individual systems. CMDHB staff recorded reviews in their clinical notes, and CMHS staff documented reviews in the electronic client management system.

[18] A follow-up to referral and entry to the CMHS.
[19] PSS staff are employed by the CMHS.

Review by Dr B

41. On Day 6, Ms A, a nurse, and a PSS worker from the CMHS attended CMDHB Mental Health Community Services and met consultant psychiatrist Dr B and two nurses from the HB Team.

42. It is documented that Ms A presented as anxious, restless, sullen, abrupt, and reluctant to engage in the interview, and that she focused on medication to 'knock [her] out till suicidal thoughts … subsided'. The PSS said that Ms A reported having relentless thoughts of harming herself but no organised plan.

43. Dr B recorded his impression that Ms A's mood was dysphoric and that her judgement was impaired. He documented a plan (going forward) to include increased monitoring and engagement by CMHS staff through supportive psychotherapy, daily review by the HB Team to assess Ms A's mental state, CMHS staff to monitor risk and support, increased antipsychotic and antidepressant medication, and for Ms A to remain at the CMHS.

44. PSS records from this meeting state that the risk level was changed to high, and that Ms A was to receive hourly wellbeing checks owing to concerns about her safety.

45. Dr B told HDC that he was aware of Ms A's issues with alcohol, having reviewed the previous assessment by Dr C, but that Ms A did not exhibit any symptoms or signs of alcohol withdrawal or delirium.[20] Dr B acknowledged that he did not document this in the clinical notes. He told HDC that the focus was on Ms A's emotional dysregulation and attempts to build a therapeutic relationship and normalise her predicament, and that he left the issue of alcohol withdrawal for consideration at a later date.

46. Dr B told HDC that the ongoing prescribing of clonazepam and zopiclone to treat anxiety and insomnia was reasonable, given that the antidepressant[21] prescribed would take up to four to five weeks to take effect. Dr B said that his plan was to continue clonazepam for the short term until he had a better rapport with Ms A, and her mental state had improved.

47. Between Day 7 and Day 10, Ms A was reviewed daily by the HB Team and CMHS staff. Ms A reported that she was not sleeping well and had strong thoughts of ending her life. On Day 10, Ms A was given an additional dose of quetiapine, approved by a nurse from the HB Team, and it was documented that this had a positive effect.

Further review by Dr B

48. On Day 12, Ms A attended CMDHB MHS and was reviewed again by Dr B. Two nurses from the HB Team, and a nurse and a PSS worker from the CMHS also attended.

49. Dr B recorded that Ms A presented as bright, alert, attentive and appropriately reactive. Ms A reported that she had slept well the previous night and had been visited by family but did not feel ready to trial periods at home. Dr B recorded that Ms A was focused on her need

[20] An acutely disturbed state of mind categorised by restlessness, illusions, and incoherence, occurring in intoxication, fever, and other disorders.
[21] Venlafaxine.

for quetiapine medication and reported that it helped to reduce her anxiety and suicidal thoughts.

50. Dr B's assessment was that Ms A was not pervasively sad or depressed, or experiencing psychosis or mania. His impression was that overall Ms A had improved and was taking steps to engage with friends and family. Dr B documented the plan going forward as being increased antipsychotic and antidepressant medication, increased contact with family, and a referral to psychology. Wellbeing checks on Ms A were reduced from hourly to two-hourly, and her stay at the CMHS was extended.

51. Dr B completed a CMDHB Acute Community Options Extension of Stay form on Day 12. The form recorded that Ms A would remain at the CMHS for a further seven days, and the goal was to complete her Wellness Plan to maximise her recovery.

Day 13

52. A nurse from the HB Team reviewed Ms A and documented that her suicide intent was 'intact' but was low, and that she had enjoyed a social outing while on leave the previous night. CMHS staff notes from the same meeting state that Ms A said that she was not feeling safe and that suicidal thoughts were still there, but she wanted to 'deal with it before taking drugs'.

Review on Day 14

53. On Day 14, a planned meeting occurred in the morning with Ms A and an HB Team nurse, with PSS staff also present. CMHS clinical notes document that Ms A expressed that she was in a good mood and had been having 'good sleep' for the past few days.

54. That day, a meeting also occurred with Ms A and her brother, and they discussed the possibility of Ms A staying with her parents following discharge from the CMHS.

55. Later that day, a PSS staff member documented in the clinical notes that Ms A said that she was concerned for her safety and wanted to be admitted to a secure facility. It is also documented that 'she wanted this advocated for her well through staff'. CMHS notes record that this was communicated to the HB Team by one of the CMHS PSS staff.

56. At 3.30pm, it was recorded in the CMDHB clinical record that the HB Team nurse who had visited Ms A that morning received a telephone call from the CMHS PSS staff, who advised that Ms A had reported that she was not feeling safe and wanted to be in a more secure facility. The CMHS staff member requested another review with the HB Team (to occur that day).

57. The HB Team nurse consulted with Dr B (prior to the further review occurring). The CMDHB clinical notes record that Dr B advised the nurse to visit Ms A and 'listen to what she ha[d] to say and inform her that [the CMHS] [was] the best place for her'. It is also documented in the CMDHB clinical record that Dr B advised that CMHS staff should increase checks on Ms A to one hourly.

58. Dr B told HDC that he gave instructions to the HB Team nurse to review Ms A's situation and assess her mental state and safety, and that if there were not imminent safety concerns, to reassure Ms A of the support from the CMHS, which he considered was well suited to her needs. Dr B said that no decision was made at this point (prior to further review by the HB Team nurse) about continuing care at the CMHS (as opposed to transferring her to a secure in-patient facility); rather, it was his recommendation based on his assessment of Ms A two days earlier, during which he had noticed an 'overall improvement in her mood'.

59. At about 4.30pm, two nurses from the HB Team and two CMHS staff reviewed Ms A. The nurse who had received the phone call from the CMHS and discussed Ms A's care with Dr B was not present, and the HB Team nurse who assessed Ms A had not met Ms A previously. The nurse recorded in the CMDHB clinical record that Ms A reported having suicidal thoughts most of the time but was not prepared to discuss these or her plan. Ms A said that she wanted to go to a secure facility. PSS staff said that Ms A was known to mask her feelings and would smile even though she had suicidal thoughts. A plan was made with Ms A's agreement to increase wellbeing checks to hourly, for her to remain with other guests and CMHS staff that evening, and for her to contact the HB Team if required. In addition, the nurse would consult with Dr B the following day. However, this did not occur.

60. The CMHS record of the meeting stated that Ms A said that she was having a very hard time with thoughts of dying and asked to be sedated until her serotonin[22] levels had increased. It was also documented in the CMHS record that a transfer to a secure facility was discussed, and the HB Team told Ms A that her preferred facility was having construction work completed (meaning that it was chaotic at the time).

61. Dr B's view was that the CMHS was the best place for Ms A. He told HDC that he does not recall anyone mentioning construction work at the secure facility as a deterrent to admission. The plan was for quetiapine to be administered at the earlier time of 2pm (because Ms A was usually distressed at 4pm), for a further dose to be given at about 6.30pm, and for Dr B to review Ms A the following day.

62. CMDHB told HDC that the decision not to admit Ms A to an inpatient unit that day was not based on construction work at the inpatient unit. CMDHB stated that decisions regarding where to admit are based on clinical need, risk issues, and the preference of the service user and/or their family/whānau.

63. CMHS records on Day 14 state:

> 'Hourly [well-being] check. Upon every hourly check from 3.30pm to 8.30pm [Ms A] was onsite. Due to [the CMHS] website being down we were not able to document this.'

64. Another set of CMHS notes also records that the website was down at these times.

[22] A chemical produced by nerve cells that helps with sleeping, eating, and digestion.

65. From 9.30pm on Day 14, CMHS staff documented hourly wellbeing checks of Ms A overnight on Days 14 and 15. The CMHS told HDC that the CMDHB MHS Clinical Team was responsible for reviewing and assessing Ms A's mental state and risk on a daily basis. The CMHS stated:

> 'This occurred during daily clinical reviews with [Ms A], the responsible DHB Clinical Team (HBT), PSS staff and the [CMHS] Registered Nurse. This included decisions on well-being checks … The practice at [the CMHS] was that the agreed checks would continue until otherwise informed by the Clinical Team.'

Discussions about discharge

66. On Day 15, Ms A was reviewed by the HB Team and CMHS staff, and a plan was made for discharge the following week. Ms A was to stay with her parents as suggested by her brother. The plan was to contact her brother and request the contact details for Ms A's parents. The CMHS told HDC that the process by which discharge occurs was discussed with Ms A.

67. It is documented in the clinical notes that on Day 16, Ms A told the HB Team on several occasions that she did not want to leave the CMHS because she was concerned that she would not feel supported by her parents. Ms A did not give consent for staff to contact her parents.

68. On Day 17, Ms A told the HB Team that she was leaving the CMHS on Day 19 to stay with her parents, and that her brother had assured her that she had the support of her family. It was documented that Ms A continued to believe that medication would lift her mood and relieve her suicidal thoughts, and she was not receptive to alternative coping strategies. Ms A's mood was low, and she was recommenced on zopiclone. CMHS notes from the meeting state that Ms A was concerned that she had thoughts of taking her life, and that there were opportunities at her parents' place to do so.

69. Dr B told HDC that discharge plans are always a work in progress until the day of discharge. He said that the plan was to review Ms A on Day 19, to decide on a date for discharge and develop a plan. Dr B stated that the HB Team would not have discharged Ms A to her parents without a discussion with them and a referral to mental health services in the region where her parents lived.

70. In response to the provisional opinion, the CMHS told HDC that safeguards for the guest, including the responsibilities for these, would be established during the daily review and planning meetings. The CMHS said:

> 'These critical steps were to be discussed with [Ms A], [CMHS] staff and the CMDHB clinical team at the [Day 19] review. From that review, an updated Wellness Plan which included post-[the CMHS] care planning would be developed.'

71. The CMHS advised that it was not implicit that Ms A was to be discharged, and that guests can have their stay at the CMHS extended to 28 days if it is deemed clinically appropriate.

72. In response to the provisional opinion, the CMHS noted that the Partnership Guidelines outlined that 'planning for the guest's exit occurs from the beginning of service delivery. This is intended so that even at point of entry staff are considering the requirements to safely and effectively support the guest when they leave [the CMHS].'

Incident of alcohol use

73. On Day 17 (two days before her potential discharge to her parents' home from the CMHS), Ms A left the CMHS temporarily to see a friend. She returned later that day around 11.20pm and told staff that she had consumed two cans of beer and wanted her medication. Staff called the HB Team for advice on medication administration following the consumption of alcohol, and initially were instructed to withhold the medication. However, it is documented that Ms A was demanding her medication and expressing that she would leave the premises. CMHS staff again consulted the HB Team (who consulted the on-call medical officer). The HB Team advised CMHS staff to provide Ms A with her night medication, but to withhold the zopiclone. Ms A was not assessed by the HB Team in person.

74. The clinical notes record that the nurse spoke to Ms A about the reasons why zopiclone was being withheld, and Ms A was given her regular medication[23] at 2.25am. RN E recorded that there was no indication of risk to initiate 'the Mental Health Act[24]'. Ms A was monitored by CMHS staff for any adverse effects of her medication. No concerns were noted, and by 4.30am Ms A was asleep. The HB Team escalated Ms A's care to the on-call medical offer, who agreed to review Ms A's notes, and the plan was for Ms A to remain at the CMHS with a review the following morning.

75. CMDHB told HDC that it does not appear that emergency intervention and/or a blood alcohol determination was indicated or would have provided clinically relevant information at that time.

Day 18

76. CMHS notes for hourly checks indicate that Ms A was asleep from 9.30am.

77. At about 1pm, Ms A was reviewed by an HB Team nurse. The nurse was accompanied by a fellow nurse who was also a duly authorised officer (DAO),[25] and CMHS staff. The HB Team's clinical record and the CMHS notes indicate that they discussed the events of the previous night with Ms A, and her reasons for drinking alcohol. Ms A indicated that she was aware that she had made a mistake, but she wanted 'to feel normal'.

78. The HB Team noted that Ms A was 'very subdued' in the meeting, while CMHS notes indicate that Ms A was 'defensive' and that she felt that it was her right to drink. CMHS staff reminded Ms A that the CMHS policy is no drinking, no drugs and no aggression, and of the disruption of having one staff attend to her on the previous night for four hours. The plan

[23] Quetiapine and clonazepam.
[24] The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).
[25] Frontline operators of the Mental Health Act. DAOs are specialist mental health professionals who act as a point of contact for general enquiries about assessment and treatment under the Mental Health Act, and available mental health services.

was for a psychiatrist to review Ms A the following day, and to decide on a plan of care and a date for discharge. Ms A returned to bed and was asleep at 1.30pm.

79. CMDHB told HDC that the nurses who reviewed Ms A were qualified to undertake a psychiatric assessment, and that an out-of-hours medical review was available for support. CMDHB said that it considers that the decision not to seek a further medical review was in keeping with an appropriate standard of care.

80. From 1.30pm to approximately 5.30pm there is no record that hourly checks of Ms A were performed. The CMHS told HDC that a PSS staff member reported that on this afternoon another guest had some intensive support needs, and, because of this, the checks at 3.30pm and 4.30pm could not be completed. The CMHS did not comment on the missed check at 2.30pm.

81. At about 5.30pm, CMHS staff checked on Ms A in bed. She declined dinner or to attend any activities, and she remained in her room.

82. At about 5.50pm, Ms A was found on the floor unresponsive. An ambulance was called, and two CMHS staff attended to Ms A and carried out CPR until the ambulance staff arrived and provided care. Sadly, CPR was unsuccessful, and Ms A passed away on Day 18.

Communication with family

83. CMDHB told HDC that Ms A identified her brother as the principal point of communication for the family. CMDHB said that Ms A did not identify her parents as part of her support system, and it would have been inappropriate and a breach of her privacy to involve them directly. However, CMDHB said that the notes indicate that Ms A's brother was in contact with Ms A's parents concerning her discharge, and they had communicated their support.

Subsequent events

CMDHB Serious Incident Review Process

84. Following Ms A's death, CMDHB carried out a Serious Incident Review Process (SIRP) into the care provided by CMDHB and the CMHS. In summary, the SIRP report was critical that there was no single shared-care plan that identified the actions required and the person responsible for all staff, including respite providers. In addition, CMHS staff raised concerns about a lack of confidence in supporting service users with an emotional dysregulation disorder and alcohol abuse issues. A more detailed summary of the SIRP report is included as Appendix C.

CMHS review

85. Following Ms A's death, the CMHS carried out a high and extreme risk event review and action plan. In summary, the review identified issues and recommended actions in relation to alcohol use, wellbeing checks, leave planning, exit planning, and the use of alcohol whilst on leave. A more detailed summary of the CMHS review is included in Appendix D.

Further information

Ms A's family

86. Ms A's family told HDC that Ms A and the family had been told explicitly that she would be discharged to the care of her parents, and that Ms A was not happy with this arrangement. Ms A's family said that they believe this contributed to her feeling that she had no options. Ms A had already asked to be moved to a higher level of care as she felt unsafe, and the clinical staff had declined this request based on their assessment of her symptoms.

CMDHB

Management plans

87. CMDHB told HDC that the Intake and Acute Assessment Team and HB Team are two components of the same service (Acute Mental Health Services). CMDHB said that the Intake and Acute Assessment Team is responsible for triage, assessment, and initiating the care plan, and that the HB Team evaluates and adjusts a treatment plan on a daily basis in response to an individual's needs.

88. CMDHB told HDC that risk formulation and assessment were captured in multiple places, including the clinical record, the Client Assessment Form, and the clinical notes. CMDHB said that risk information was discussed in the daily reviews with CMHS staff.

Alcohol use

89. CMDHB told HDC that Ms A's alcohol use and signs of withdrawal symptoms were assessed by Dr C on Day 1, and by nurses on Day 2 and Day 5, and that Ms A had reported no consumption of alcohol or symptoms of alcohol withdrawal. CMDHB noted that initially, Ms A was supervised by family until her admission to the CMHS on Day 5, and she did not consume alcohol until Day 17. CMDHB considers that the care provided conforms to the standards for an initial assessment and follow-up mental health care.

90. CMDHB stated:

> '[Ms A] was initially treated at home, where a structured withdrawal scale would not typically be employed, and after four days of abstinence, with no evidence of withdrawal symptoms, there was no clinical indication to pursue this at the CMHS.'

91. CMDHB said that serial blood alcohol monitoring is not regarded as within the purview of community mental health, and, because Ms A was abstinent, it is unclear whether this would have provided any useful clinical information.

92. CMDHB stated that had Ms A developed evidence of alcohol withdrawal, a referral for assessment by the Community Alcohol and Drug Service or the Emergency Department for detoxification would have been arranged. CMDHB told HDC that it considers that the CMHS was responsible for managing Ms A's care in relation to the monitoring and management of her alcohol use.

93. CMDHB told HDC that the short-term use of sedative hypnotics for agitation and anxiety (in order to mitigate risk) is well-accepted practice. CMDHB referred to RANZCP's[26] Alcohol Policy dated March 2016, which advocates for the use of benzodiazepines[27] to mitigate alcohol withdrawal symptoms and indicates that management of withdrawal is likely underutilised. CMDHB said that the sedative-hypnotics were prescribed in accordance with best practice.

CMHS

94. The CMHS told HDC that it offers its deepest condolences to Ms A's family for the loss of Ms A.

95. The CMHS said that the learnings from the SIRP and its internal review have been shared with the CMHS Team.

96. The CMHS submitted that CMDHB was responsible for any assessment and determination of treatment for alcohol use. The CMHS said that had its staff observed any physical symptoms that had indicated alcohol withdrawal, this would have been reported to the HB Team.

97. The CMHS also told HDC that it does not accept that it departed from the expected level of care, either in documentation or in relation to managing potential risks associated with alcohol. The CMHS stated that it followed the direction set out by the HB Team, and CMHS staff shared observations and concerns about Ms A with the HB Team in a timely manner.

98. The CMHS stated:

> 'The use of a checking/sign-off sheet for well-being checks for guests is also not a process supported at [the CMHS] as this has the potential to replicate practice often utilised within acute hospital inpatient settings which is not our model of care or philosophy.'

99. The CMHS told HDC that all staff induction includes orientation to the CMHS Policy and process, including wellbeing checks.

Responses to first provisional opinion

100. Ms A's whānau, Te Whatu Ora, and the CMHS were given an opportunity to respond to relevant sections of the first provisional report. Where relevant, their responses have been incorporated into this report. On receipt of significant further information, a second provisional opinion was written.

CMHS

101. The CMHS submitted that it did not agree with the findings in the provisional opinion and provided HDC with a document titled 'Partnership Guidelines for [the CMHS]' (Appendix E), which outlines the functions and responsibilities of both the CMHS and Te Whatu Ora

[26] The Royal Australian and New Zealand College of Psychiatrists.
[27] A medication used to treat anxiety or sleeping issues.

Counties Manukau. The CMHS advised that this guideline 'underpin[s] the operation of the service at the CMHS'.

Collaborative risk assessment

102. The CMHS submitted that it disagreed with the criticism relating to the lack of an up-to-date risk management plan. The CMHS told HDC:

> 'If CMDHB did not capture important information in an up-to-date risk management plan, [the CMHS] cannot be held responsible for this. CMDHB staff were responsible for capturing information accurately in order to develop it, and [CMHS staff] would work collaboratively with CMDHB to implement the plan to support [Ms A] … [The CMHS] understood the plan to be accurate and up to date.'

Monitoring and management of alcohol risk

103. The CMHS disagreed that there was any lack of clarity about the roles and responsibilities of CMDHB and/or the CMHS in relation to the monitoring of Ms A's alcohol risk. It stated that Ms A received regular clinical review (with CMHS staff present) and peer support, and at no time was alcohol withdrawal identified as an issue for the CMHS to monitor. The CMHS said that there was a 'clear and shared understanding of the needs of [Ms A], and how these would be managed (consistently with the care plan developed with her)'. In addition, the CMHS submitted that when Ms A was away from the CMHS and consumed alcohol, this was immediately escalated by CMHS staff to the clinical team at CMDHB.

Plans for discharge

104. The CMHS told HDC that the Partnership Guidelines highlight that decisions for guests to exit the CMHS require input and communication between the guest and collaborative partners, and that it disputes that there was a lack of communication and cooperation between CMDHB and CMHS staff in relation to this.

Recommendations

105. The CMHS agreed with the recommendation that it provide a written apology to Ms A's whānau.

106. The CMHS also accepted that there is no access to one shared health record that both Te Whatu Ora and the CMHS can access, and that it is supportive of a platform to share records being developed. However, it raised concerns with some of the other recommendations.

Te Whatu Ora Counties Manukau

107. Te Whatu Ora advised that it accepted my recommendations and had no further comments to make on the findings of my provisional report.

Responses to second provisional opinion

108. Te Whatu Ora and the CMHS were given an opportunity to respond to the second provisional report. The CMHS advised that it had no further comments to make in response to the second provisional report.

109. Te Whatu Ora accepted the recommendation that it provide a written apology to Ms A's whānau, and that it reinforce current training in the area of a personality disorder. Te Whatu Ora also accepted the recommendation that it consider developing a shared copy of the clinical reviews, noting that 'maintaining a difference between clinical and peer services is important and shared documentation both resolves and generates risk'.

110. In response to the recommendation that it provide an update on whether it has considered developing a single coordinated care plan and collaborative training with CMHS staff, Te Whatu Ora advised:

> 'As described in the report, Te Whatu Ora Counties Manukau has developed a single care plan (the Regional Collaborative Care Plan) and this is used during all admissions to [the CMHS]. At this stage the focus is not on collaborative training being completed with [the CMHS] regarding those diagnosed with emotion dysregulation and alcohol misuse disorders, and their management — all management plans are completed on a case-by-case basis, often collaboratively with patients and whaanau. Training in this area would be of necessity and would need to consider individual circumstances.'

111. In response to the recommendation that it consider on-site consultant psychiatrist reviews in respite settings, Te Whatu Ora advised that it is not possible for every review to be conducted by a consultant psychiatrist due to their heavy workload and 'increasing acuity being managed by these Acute Community Services'. Te Whatu Ora said that it has added extra senior medical officer (SMO) resource into the teams, but there are ongoing challenges recruiting into the positions. It said that other reviews are performed by appropriately skilled and supported clinicians.

112. In response to the recommendation that the CMHS and Te Whatu Ora collaborate and consider the circumstances, if any, in which the recommendations of my advisor, Dr Newton-Howes, could be adopted, Te Whatu Ora told HDC that formal addiction screening is not appropriate at a peer-led venue and often it is managed more appropriately at emergency care prior to an admission to an acute community facility. Te Whatu Ora said that the use of a breathalyser or physical screening would 'equally not be appropriate in this space given the need for building a therapeutic environment'.

113. Te Whatu Ora stated that clear documentation already exists outlining the proposed length of stay (seven days) as well as further paperwork to outline proposed extensions to this length of stay.

114. Te Whatu Ora accepted the recommendation to discuss and consider adopting the national approach to care for people with co-existing disorders (Te Ariari o te Oranga) within Te Whatu Ora/the CMHS.

Opinion: Introduction

115. In my first provisional report, I found Te Whatu Ora Counties Manukau and the CMHS jointly responsible for the deficiencies in the care provided to Ms A on the basis that there appeared to be a lack of clarity regarding the roles and responsibilities between the services.

116. In response to the first provisional opinion, the CMHS provided HDC with a copy of its 'Partnership Guidelines' with Te Whatu Ora Counties Manukau, which outlined the roles and responsibilities of the two services. I issued a second provisional report in acknowledgement of this further information.

Opinion: Te Whatu Ora Counties Manukau — breach

117. This opinion discusses the importance of robust communication and coordination of care when a conjoint service is being delivered to mental health patients in the community. In order to deliver a shared model of care appropriately, the services must be clear in their respective roles and responsibilities and be able to communicate effectively. The agreement between CMDHB and the CMHS provides that the CMHS will be responsible for the care of the clients admitted to the CMHS service, including recovery coaching and facilitating the development of recovery plans. The agreement also states that CMDHB's MHS is responsible for the clinical treatment of the clients using the service. The 'Partnership Guidelines' also guide the care provided to guests at the CMHS and provide clarity on the roles and responsibilities of both CMDHB and the CMHS.

118. As part of my assessment of this complaint, I obtained independent advice from a consultant psychiatrist, Dr Giles Newton-Howes, and from a registered nurse, RN Carole Schneebeli.

Risk assessment and care planning

119. CMDHB policy[28] indicates that an assessment and review of risk needs to occur on admission to an inpatient unit or respite services.

120. On Day 2, CMDHB's Intake and Assessment Team undertook an initial assessment and completed an 'Acute Community Options Crises Resolution Plan', which identified areas of concern, including that Ms A was thinking of harming herself, although she denied having a suicidal plan. It was also noted that Ms A was more likely to act on her suicidal thoughts impulsively if her anxiety and distress increased, escalated by alcohol and sleep deprivation. At the time of this assessment, Ms A was living with her brother, and had yet to be admitted to the CMHS.

121. Three days later, Ms A was admitted to the CMHS and was under the care of the HB Team. The form used at that time to guide Ms A's management was the 'Acute Community Options

[28] Policy: Risk Assessment and Management in Mental Health Services (see Appendix E).

Crises Resolution Plan', which had been developed by the CMDHB Intake and Assessment Team.

122. However, an up-to-date risk management plan was not completed on admission to the CMHS (as identified in the CMHS review), and the initial assessment undertaken on Day 2 was not updated with any changes to Ms A's care, despite the change of environment.

123. RN Schneebeli advised HDC:

> '[Ms A's] case held complexities including self-harm and suicidal ideation, alcohol misuse, personality issues, and eating disorder. Therefore, a robust collaborative up-to-date risk management plan for any service user with a complex case presentation is a requirement.'

124. On Ms A's admission to the CMHS (an alcohol-free zone) on Day 5, the '[CMHS] Acute Community Options Crises Resolution Plan' contained various references to the monitoring of alcohol use and possible withdrawal. The plan also recorded Ms A's 'current acute issues' as including possible withdrawal from alcohol. The section titled 'crises resolution goals' also included reference to supporting alcohol withdrawal. The plan noted that the CMHS would supervise medication and observe Ms A for alcohol withdrawal. On the contrary, the '[CMHS] Respite or Acute Alternative Entry Checklist' did not include the requirement to monitor Ms A for alcohol use or withdrawal. The CMHS told HDC that at the time of admission, it had been three days since the signs of alcohol withdrawal had been documented in the HB Team assessment.

125. On Day 1, when Ms A was assessed by Dr C (prior to admission to the CMHS), he documented that it was his impression that Ms A was withdrawing from alcohol. However, when Ms A was assessed by nurses on Day 2 and Day 5, she reported no consumption of alcohol and had no symptoms of withdrawal. CMDHB told HDC that after four days of abstinence, and no evidence of withdrawal symptoms, there was no clinical indication to use a structured withdrawal scale. Therefore, by the time that Ms A was admitted to the CMHS, she did not require monitoring for alcohol use or withdrawal.

126. RN Schneebeli considers that the risk information in the initial assessment was relevant and may have supported CMHS staff in understanding Ms A's ongoing suicidal ideation and risk of impulsivity associated with her levels of anxiety and alcohol misuse. However, RN Schneebeli was critical that the assessment was not updated to include information such as the discontinued requirement for alcohol withdrawal monitoring. RN Schneebeli considers that not transferring the relevant information from Ms A's initial assessment into an up-to-date risk management plan for CMHS staff represents a moderate departure from accepted practice.

127. I agree with RN Schneebeli. The reviews that formed the risk assessment and other documentation such as the 'Acute Community Options Crises Resolution Plan' were all conducted by clinical staff at CMDHB, including nursing staff, the HB Team, and Dr C. Therefore, any information that had been gathered by the clinical team (including the discontinued requirement for alcohol use/withdrawal monitoring) needed to be

appropriately and consistently documented by that team in order to assist the PSS staff appropriately in managing Ms A's care. I am concerned that information about Ms A's risk was not updated on admission, given the change in environment and CMHS staff becoming involved in Ms A's care. This meant that important information was not captured in an up-to-date risk plan to provide CMHS staff with a clear understanding of Ms A's risks, so that appropriate management and interventions could be developed.

128. In such a context, with multiple staff from different services involved in a person's care, it is essential that assessments are up to date, recorded accurately, and conveyed in a clear document. Ultimately, as CMDHB was responsible for the clinical oversight of Ms A, it was responsible for ensuring that up-to-date and accurate information was recorded in Ms A's care plans. This should have included the discontinued requirement for alcohol use/withdrawal monitoring. I am critical that this did not occur.

Review on Day 14

129. On Day 14 (following a planned review of Ms A by an HB Team nurse), PSS staff escalated concerns (via a telephone call to the same HB Team nurse) about Ms A's safety and her request to be transferred to in-patient care. A further review of Ms A by the HB Team nurse was requested. The nurse consulted Dr B (prior to a further review of Ms A), and Dr B advised the nurse to visit Ms A and inform her that the CMHS was the best place for her. He also advised that CMHS staff should increase checks on Ms A to one hourly.

130. RN Schneebeli considers that the decision to extend Ms A's stay at the CMHS and not to escalate to an in-patient setting met the accepted standard of care in that this 'would have been potentially counter therapeutic'. I agree. Accordingly, I am not concerned about this aspect of care. However, I am concerned about some aspects of the process that led to this decision.

131. Dr Newton-Howes advised that the decision to continue Ms A's care in the CMHS appears to have been made prior to a face-to-face assessment of Ms A. Although Ms A had already been seen at a planned review that morning, this was prior to her raising concerns about her safety and a further review being conducted. I also note that the HB Team nurse who assessed Ms A that afternoon was unknown to her and was not the nurse who had assessed Ms A in the planned review that morning and taken the concerned telephone call from PSS staff and escalated the concerns to Dr B.

132. Dr Newton-Howes advised that accepted practice would be for a face-to-face assessment to occur prior to a decision being made based on the risks and in respect of Ms A's disposition. Dr Newton-Howes considers that the failure to do so represents a mild departure from accepted standards. I accept Dr Newton-Howes' advice.

133. Following the further review by the HB Team on the afternoon of Day 14, a plan was made, with Ms A's agreement, to increase wellbeing checks to hourly and for her to remain with other guests and CMHS staff that evening, and to contact the HB Team if required. In addition, the HB Team nurse was to consult Dr B the following day. However, this did not

occur. Dr Newton-Howes advised that this omission represented a moderate departure from the expected standard of care. He stated:

> 'I note there does not appear to have been a follow up discussion with [Dr B], or another psychiatrist subsequent to the face to face assessment and that [Ms A] was unknown to [the HB Team nurse] prior to the assessment. As such it is difficult to understand why [the nurse] did not discuss this with a member of the team, ideally [Dr B], following the assessment. I note [the nurse] documents she will follow up with [Dr B] in the morning but the only entry is of a case conference in the afternoon.'

134. I accept Dr Newton-Howes' advice in this regard and am critical that the HB Team nurse did not consult further with Dr B following the face-to-face assessment, given Ms A's increasing concerns.

Conclusion

135. As set out above, I have identified shortcomings in the clinical care provided to Ms A by Te Whatu Ora Counties Manukau. In particular:

- The lack of a face-to-face assessment of Ms A by Dr B prior to making the decision to keep her at the CMHS.
- Failure by the HB Team nurse to consult Dr B following the review of Day 14 when the wellbeing checks were increased to one hourly in light of Ms A's increasing concerns for her own safety.

136. I consider that cumulatively these shortcomings represent a service delivery failure, for which ultimately Te Whatu Ora Counties Manukau is responsible. Accordingly, I find that Te Whatu Ora Counties Manukau breached Right 4(1)[29] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to provide services to Ms A with reasonable care and skill.

137. In addition, I have considered the failure by CMDHB to ensure that accurate information was captured in an up-to-date risk assessment, including the discontinued requirement for alcohol use/withdrawal monitoring. It has been established that PSS staff at the CMHS were not trained clinically and relied on the HB Team at CMDHB to undertake all clinical duties. As CMHS staff were responsible for the day-to-day monitoring of Ms A, it was paramount that they felt supported by the HB Team and were provided clarity on how to monitor Ms A appropriately. Ultimately, as CMDHB was responsible for the clinical oversight of Ms A, it was responsible for ensuring that up-to-date and accurate information was recorded in Ms A's care plans. In my view, the failure to do so represents a failure to ensure cooperation and coordination of care. I therefore also find CMDHB in breach of Right 4(5)[30] of the Code.

[29] Right 4(1) provides that every consumer has the right to have services provided with reasonable care and skill.
[30] Right 4(5) provides that every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Responsibility for monitoring alcohol use — other comment

138. Dr Newton-Howes raised concerns about a lack of clarity about who was responsible for the monitoring and management of Ms A's alcohol use. He advised:

> '[I] continue to have concerns as to the overall approach to alcohol use and the risks of alcohol use in a patient with [Ms A's] psychopathology. It is not clear to me if this responsibility lies with the DHB or [the CMHS], however [I] consider this oversight to be *a moderate departure from the expected level of care*.'

139. As referenced above, there was a difference in the '[CMHS] Respite or Acute Alternative Entry Checklist' and the Acute Community Options Crises Resolution Plan, in relation to confirmation of the requirement to monitor alcohol use or withdrawal. In my view, as this was an issue that was of concern at that time, it would have been important that the plans were consistent in relation to the requirement (or lack of) for the monitoring of alcohol use or withdrawal, and who was responsible for this.

140. Notwithstanding this, it appears that the CMHS and CMDHB agree that it was the role of staff at the CMHS to monitor for symptoms of alcohol use or withdrawal, and that it was the role of clinical staff at CMDHB to assess and determine any potential treatment for alcohol use. I also note that this is consistent with the Partnership Guidelines, and with the understanding that CMDHB was responsible for clinical matters. I have also considered that when Ms A returned to the CMHS having consumed alcohol, CMHS staff appropriately escalated their concerns to the clinical team at CMDHB for guidance on how to manage the situation. Accordingly, whilst the documentation could have been clearer, I am not concerned with this aspect of the care that was provided.

Review on Day 18 — other comment

141. Ms A's emotional state declined from Day 15, and on Day 17 she consumed alcohol while on leave from the CMHS. Overnight on Day 17/Day 18 an HB Team nurse had several discussions with CMHS staff and consulted the on-call medical officer for advice.

142. On Day 18, a nurse and a DAO from the HB Team reviewed Ms A. The notes record that a discussion was had with Ms A about her alcohol use and that she had breached the CMHS rules. A plan was made for a medical review the following day.

143. CMDHB told HDC that the nurses who reviewed Ms A were qualified to undertake a psychiatric assessment, and that an out-of-hours medical review was available for support. CMDHB considers that this care was of an appropriate standard.

144. RN Schneebeli advised that Ms A's complex presentation and breach of the CMHS rules prior to discharge was an indication of the level of distress she was experiencing. RN Schneebeli was mildly critical that the HB Team nurses did not arrange a psychiatric review for Day 18. However, she acknowledged that a medical officer was consulted on the morning of Day 18 and considered this to be a mitigating factor.

145. I acknowledge that a nurse escalated Ms A's care to the on-call medical officer on the night of Day 17/Day 18. However, I agree with RN Schneebeli that given the change in Ms A's presentation, a review by a psychiatrist that day would have been desirable.

Opinion: CMHS — adverse comment

146. As part of my assessment of this complaint, I obtained independent advice from consultant psychiatrist Dr Giles Newton-Howes and from RN Carole Schneebeli.

Wellbeing checks

147. Ms A's wellbeing checks were increased to hourly on Day 14 in response to concerns about her safety. On Day 14, the CMHS notes report issues with the website between 3.30pm and 8.30pm, and the wellbeing checks were carried out but documented retrospectively. I accept that the wellbeing checks were done but not documented contemporaneously, owing to systems issues. Accordingly, I do not consider this to have been a departure from the accepted standard of care.

148. However, RN Schneebeli advised that there was a lack of clarity in various aspects of the CMHS's management of wellbeing checks — in particular, the only reference to observations was in the Entry to Respite/Acute Alternative document, which contained a small note on how to conduct night-time checks, and it was unclear when the overnight checks were instigated, for how long they were to continue, and who determined when they were to be discontinued.

149. RN Schneebeli also advised that there appears to have been an inconsistent approach by staff to hourly observations, and a lack of robust recording of the checks. The joint CMHS and CMDHB review also identified this as an area for service improvement.

150. RN Schneebeli considers that the above shortcomings represent a moderate departure from accepted practice. I accept RN Schneebeli's advice in this regard and consider that the deficiencies in the CMHS's management of wellbeing checks was evidenced by the omissions on Day 18, when no wellbeing checks were completed or documented at 2.30pm, 3.30pm and 4.30pm. The CMHS told HDC that the checks at 3.30pm and 4.30pm were not completed because another guest required support at that time. However, the CMHS did not comment on the 2.30pm check. Ms A was not checked again until approximately 5.30pm.

151. RN Schneebeli advised:

> 'This was a time when [Ms A] was at a "risky" period, where the risk of impulsivity due to her setbacks with both teams around her alcohol use and her unsettled night and lack of sleep, were times to be vigilant.'

152. I agree and am concerned that the wellbeing checks were not conducted diligently on Day 18, particularly given Ms A's increased risk at that time.

153. RN Schneebeli also advised that it is unclear how the process of observations, welfare observations or hourly observations are adhered to within the CMHS, and she is concerned that there was no checking or sign-off sheet to record the checks. Further, RN Schneebeli advised that there appears to have been a lack of guidance or policies on wellbeing checks, and that defining this process would have provided clarity to staff. She told HDC: 'Information from the wellbeing checks could be important in client reviews and may guide future clinical pathways i.e planned discharge date/s or a longer negotiated stay.'

154. The CMHS told HDC that all staff received induction on wellbeing checks, and that the process of day and night checks was clearly differentiated. I note that in response to the provisional opinion, the CMHS submitted that the partnership model is reliant on shared information between the clinical team and peer support team to undertake safe planning of care and that this information was communicated between the teams. However, the CMHS has provided no new information to support this assertion, and accordingly I accept RN Schneebeli's advice that the lack of clarity in the process for conducting checks at the CMHS was a mild departure from accepted standards.

155. Ms A's wellbeing checks were increased to one hourly on Day 14 in response to concerns about her safety. I agree with RN Schneebeli that this was a particularly 'risky' time for Ms A. The CMHS's policies and guidance on wellbeing checks should be robust and clear, to ensure that such checks are carried out adequately and consistently. Although I acknowledge that generally the wellbeing checks were completed in accordance with the instructions given by the HB Team, I consider that the policies and guidance for staff in place at the time were not ideal. This is demonstrated by the inconsistent approach by staff to hourly observations, the lack of robust recording of the checks, and the incomplete checks of Ms A on Day 18.

156. It is important to note that the CMHS is a peer-run service that relied on the clinical support of the HB Team. In my view, PSS staff could not have been expected to provide 'checks' in the same manner as nursing/clinical staff, and therefore it is understandable that staff may not have had a clear understanding of what the hourly checks entailed unless instructed by the HB Team. However, in my view, the peer support component of Ms A's care was just as important as the clinical aspects of it, and although not culpable for her clinical assessments, the CMHS had a responsibility to ensure that its staff were provided clarity on how and when to conduct wellbeing checks appropriately.

157. I acknowledge that the CMHS has made considerable changes to its practice of wellbeing checks, as set out below.

Opinion: Te Whatu Ora Counties Manukau and the CMHS — other comment

Communication with whānau

158. On Day 15, a plan was made for Ms A to be discharged from the CMHS the following week to stay with her parents. On Day 16, Ms A reported concerns about leaving the CMHS, and said that she would not feel supported by her family. I note that Ms A did not give consent for staff to contact her parents. However, on Day 17, Ms A reported that her brother assured her that she had their support to stay with them on discharge.[31] Ms A's mood was low, and CMHS staff noted that she had thoughts of taking her life.

159. Dr Newton-Howes advised that he has concerns that staff did not have direct contact with Ms A's parents in the context of the plan to discharge Ms A to their care. However, Dr Newton-Howes noted that Ms A's brother was acting as the family liaison, and that he was in communication with Ms A's parents about the discharge plan. While Dr Newton-Howes considers that this does not represent a departure from accepted standards, he advised that clearer documentation and communication about discharge planning, including the expected lengths of stay, would provide structure for guests and the CMHS and enable early planning to occur.

160. In response to the provisional opinion, the CMHS submitted that the Partnership Guidelines outline the way in which exits are managed between the services. The guidelines include:

> 'Acute community teams [CMDHB] will manage the guest's exit from [the CMHS]. The reason for the guest's exit and their exit destination will be recorded by [CMHS] staff for the purpose of reporting to the CMDHB.'

161. However, the guidelines also state:

> 'Decisions to exit require input and communication between the guest receiving services and the collaborative partners. Safeguards for the guest need to be in place prior to exit and responsibilities for these will be established during the daily review and planning meeting.'

162. Although the Partnership Guidelines suggest that discharge plans are a work in progress, they should be documented clearly to guide the care, and to support the communication with guests and their family. Although the responsibility for exit planning may have sat with CMDHB staff, the Partnership Guidelines also state that it is expected to be a collaborative effort between the services, for which robust communication was required. I also note that Ms A did not give consent for staff to contact her parents. In light of this, CMDHB and CMHS staff should have documented the involvement of Ms A's family, or limitations around this, to improve communication.

[31] Dr B told HDC that prior to discharge, staff would have contacted Ms A's parents to discuss the discharge plan.

Changes made

CMDHB

163. CMDHB told HDC that in 2019, the risk assessment and management policy was revised to address issues of safety, and several new forms were developed. The Regional Client Assessment Form now includes information about risk formulation and assessment, and information about safety planning is documented in the Regional Collaborative Care Plan.

CMHS

164. The CMHS told HDC that after these events it made the following changes:

- It implemented a minimum of hourly wellbeing checks across its respite and acute alternative services.
- It updated its Respite and Acute Alternative Respite Entry Process to include the process for wellbeing checks, and it developed a Welcome Form advising the person about wellbeing checks.
- It held a series of in-service staff training on wellbeing checks and time frames for wellbeing checks.
- It upgraded its mobile devices to support the efficiency of documentation.
- In 2017, it updated the support at respite and acute alternative services to include reference to the hourly wellbeing checks and how these are performed.
- It updated the Entry Checklist form to include a request for clinical referrers to indicate the level of night support required.
- In 2018, it updated the Entry Checklist form to include a section for consultation with the clinical team about the wellbeing checks.
- It updated the Entry Form to include information about drug or alcohol issues. If these are identified, a management plan around the drug or alcohol use is required.

Recommendations

Te Whatu Ora Counties Manukau

165. I recommend that Te Whatu Ora Counties Manukau:

a) Provide a formal written apology to Ms A's family for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

b) Conduct an audit to assess whether each resident at the CMHS (on one selected day) has a single regional collaborative care plan that has been developed in collaboration with all parties, including the resident, their whānau (if applicable) and CMHS staff, and

is readily accessible to, and understood by, all relevant parties. The result of the audit is to be provided to HDC within six months of the date of this report.

c) Provide suitably trained staff to undertake on-site reviews and improve communication between clinical leads and respite staff. Te Whatu Ora is to report back to HDC on the outcome of this recommendation.

d) Provide training to the HB Team and Intake Team on the diagnosis of a personality disorder and management strategies.

166. The information requested in points (c) and (d) above is to be provided to HDC within three months of the date of this report.

CMHS

167. I recommend that the CMHS:

a) Provide a formal written apology to Ms A's family for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

b) Consider developing policy and procedures to support staff in the effective management of patients with known drug or alcohol misuse, particularly in relation to risk management in this area.

c) Provide HDC with evidence of its implementation of the recommendations made in the CMHS review, and any further changes made since these events.

d) Provide training to staff on the diagnosis of a personality disorder and management strategies.

168. The information requested in points (b) to (d) above is to be provided to HDC within three months of the date of this report.

Te Whatu Ora Counties Manukau and the CMHS

169. I recommend that Te Whatu Ora Counties Manukau and the CMHS co-ordinate their response to the following recommendations, and provide the information requested within three months of the date of this report:

a) Consider developing a shared copy of the clinical reviews (incorporating the notes from both CMDHB clinical staff and CMHS staff) undertaken at the CMHS to facilitate communication across the services.

b) Discuss and consider the adoption of the national approach to care for people with co-existing disorders (Te Ariari o te Oranga)[32] within Te Whatu Ora/the CMHS.

[32] See: https://www.health.govt.nz/system/files/documents/publications/service-delivery-for-people-13-04-10.pdf and https://www.health.govt.nz/system/files/documents/publications/te-ariari-o-te-orang-teariari-13-04-10.pdf

Follow-up actions

170. A copy of this report will be sent to the Coroner.

171. A copy of this report with details identifying the parties removed, except Te Whatu Ora Counties Manukau and the advisors on this case, will be sent to the Director of Mental Health and Addiction Services and the Mental Health and Wellbeing Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from consultant psychiatrist Dr Giles Newton-Howes on 13 March 2020:

'Associate Professor Giles Newton-Howes
BA, BSc, MBChB, PhD
MRCPsych, FRANZCP
CCT Adult Psychiatry and Substance Misuse Psychiatry (UK)
Consultant Psychiatrist

9th March 2020

Complaint Name: **Counties Manukau District Health Board (CMDHB)**
Reference: **C19HDC00950**

1. Introduction

1.1 This report is prepared by Associate Professor Giles Newton-Howes, Consultant Psychiatrist. I have a Bachelor of Medicine and Bachelor of Surgery awarded in 1998 and PhD awarded in 2018 from the University of Otago. I have a Bachelor of Science awarded in 1993 Bachelor of Arts awarded in 1999 awarded from Victoria University (Wellington, New Zealand). I have a postgraduate diploma in Cognitive Behavioural Therapy from Royal Holloway, University of London, awarded in 2006. I am a member of the Royal College of Psychiatrists (UK), obtaining membership in 2004 and a Fellow of the Royal Australian and New Zealand College of Psychiatrists. I have my Certificate of Completion of Training (CCT) in General Adult Psychiatry and a Certificate of Sub-Specialty Training in Substance Misuse Psychiatry awarded by The Postgraduate Medical Education and Training Board in the United Kingdom in 2007. I am vocationally registered in Psychiatry by the New Zealand Medical Council. Other than my clinical work I am the deputy Clinical Leader, Community, Mental Health Addictions & Intellectual Disability Service, Te-Upoko-Me-Te-Whatu-O-Ika and Associate Professor at University of Otago, Wellington. I publish regularly and sit on the Board of The Psychiatrist (UK), BJPsych (UK) and Personality and Mental Health. I am an editor of The International Journal of Mental Health and Capacity Law, The Psychiatrist and Deputy Editor of BJPsych.

1.2 I have been asked to prepare a report to the Commissioner on case number C19HDC00950. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

1.3 I am unaware of any conflicts of interest.

1.4 I have been asked to, "advise whether you consider the care provided met acceptable standards in all the circumstances and explain your rationale".

1.5 In completing this report I have had access to the following relevant information:

- Letter of complaint dated 23 May 2019
- Letters from CMDHB dated [2016] and [2018] and response dated [2019]
- Letters from [the CMHS] dated [2016] and [2018] and response dated [2019]
- Clinical records from CMDHB from [Day 1] to [Day 16]. There is no way to confirm this is a complete set (however it appears to be)
- Dealing with distress booklet
- Records from [the CMHS] from [Day 1] to [Day 18]. These are described as "complete"
- Supporting documentation and policies from [the CMHS]
- The SIRP dated [2016]

2. Observations and Preamble

2.1 First I note my condolences for the family for the loss of [Ms A]. The notes provided to me identify [Ms A] had significant psychological difficulties but also significant strengths and a clear place in the world. Death from completed suicide is difficult and distressing and I am aware the family, and others, will have yet to develop a clear sense of closure with various elements of the investigation and reporting (including this report) remaining open.

2.2 The notes provided to me are consistent and describe the matters of fact surrounding the period [Day 1] to [Day 18]. There does not appear to be clear dispute as to the actions of those employed by CMDHB or [the CMHS] in their efforts to support [Ms A].

2.3 The service [the CMHS], where [Ms A] resided as a guest at the time in question, was unknown to me prior to this file review and advice for the office of the HDC. In large part it appears to accord with services that are lauded internationally as more humane and appropriate services within which to support people in mental distress[1]. Such international facilities include: the Heidenheim Mental Health Service in Germany[2] and Trieste in Italy[3]. The focus of these services is about supporting people to develop safe and understandable ways to manage problems distressing to them. These services recognise that inpatient wards may be harmful, frightening, stigmatising, and socially dislocating despite the service's best efforts for this not to be the case. They are also strongly aligned with the recovery model of care, the model supported in New Zealand for mental health services.

2.4 Completed suicide is a rare event that is, unfortunately very difficult to predict and prevent. Some argue that suicide and suicide prevention is largely a public health issue, as opposed to a psychiatric issue[4]. This does not mean appropriate individual assessment and consideration of potential interventions should not occur, rather that

assessment is not prediction[5]. Of particular note is the importance on assessing for potentially modifiable factors, such as psychosis, that may alter individual management.

2.5 In the case of [Ms A] her diagnosis appears to have been unstable, with various elements emphasised as treatment was undertaken. These included externalising disorders, such as ADHD and internalising disorders, such as depression[6,7]. There appears to have been both clusters present at various times, suggesting a predisposition to psychopathology[8]. This adds complexity to psychiatric management and generally suggest both review and specialist input is important in care.

3. Chronological summary of events

3.1 General Comments

3.1.1 As described these are well documented with no material dispute as to the events as outlined in the overviews and in the letters provided to me and by the HDC office itself.

3.1.2 The documentation of these events meets an acceptable level of care. Indeed it surpasses some documentation within DHB notes.

3.2 [Ms A] was well known to mental health services with descriptions of psychopathology from at least the age of 11 years old, when eating disorder symptoms are described.

3.2.1 [Ms A] also had a known history of non-suicidal self-injury (NSSI) and life threatening behaviour. It is recorded she [harmed herself in her teens]. This is recorded as being on the background over very chronic suicidal ideation, which took a waxing and waning course.

3.2.2 Diagnoses of mental disorder over the years include: eating disorder, attention deficit hyperactivity disorder (AHDH), "partial PTSD, alcohol use disorder and [a personality disorder] traits, mixed anxiety and depression".

3.2.3 Treatment for [Ms A's] psychopathology appears to have included psychological and pharmacological interventions. Both appear to have garnered traction prior to a discharge to GP care, the timing of which is unclear.

3.2.4 On [Day 1] the GP re-referred [Ms A] to mental health services with concerns regarding depression and thoughts of suicide … She was seen and assessed by [Dr C], consultant psychiatrist, who undertook a comprehensive assessment and developed a plan taking into account her psychopathology, expressed thoughts of suicide and resource constraints. Of note [Dr C] preferred an admission to [the CMHS] but initial care occurred at home with the support and agreement of family. At this time it was noted pharmacotherapy has been stopped by [Ms A] for approximately three months and an antidepressant and anxiolytics (including quetiapine) were restarted. She was transferred to [the CMHS] on [Day 3].

3.2.5 [Ms A] stayed as a guest of [the CMHS] from [Day 3] until [Day 18] when she was found [deceased] in her room. Whilst in [the CMHS] she was assessed by the [CMHS] workers present at [the CMHS] and the clinical team from the home based treatment team (HBT) regularly. The description of her progress was variable but generally [Ms A] was described as improving. Assessments appear to have been regular and well recorded. Communication between [CMHS] staff and the HBT staff appears to have occurred regularly. Of note there is clear communication between service staff on [Day 17] when [Ms A] was absent from [the CMHS] and over night when altercations between [Ms A] and CMHS staff occurred.

3.2.6 During the end of her stay conversations between [Ms A] and staff had a focus on discharge. The possible discharge plans were not clear, with [Ms A] undecided on the relative merits of returning to stay with her parents, or remaining closer to home. Stress on [Ms A's brother] is recorded. Notably part of the rationale for admission was stress with [Ms A's] current living arrangements, and possible issues with remaining up to date with her rent.

3.2.7 Notably both CMDHB and [the CMHS] appear to have had [Ms A's] consent to communicate with [Ms A's] brother and a friend. Neither appear to have had explicit consent to discuss the details of [Ms A's] stay and planning options with her parents.

4. Questions asked and opinion

Please comment on:

4.1 The appropriateness and adequacy of [Dr C's] initial assessment of [Ms A], prior to her admission to [the CMHS].

4.1.1 In general I find both the adequacy and appropriateness of [Dr C's] assessment to reach an appropriate standard of care. He notes his interaction with [Ms A] and the fact support people are present in the assessment. He clearly describes the recent circumstances and precipitants to presentation. He notes both biological and psychological stressors. He identifies risks, and triggers for current psychopathology. He notes alcohol use. He describes a clear mental state exam and gives a clinical impression of the situation. He identifies a clear management plan with biopsychosocial considerations. He includes family in the plan. [Dr C] recognises the complexity of [Ms A's] presentation and documents the need for engagement with the multidisciplinary team going forward. As such the essential element of a psychiatric evaluation and management plan are included, with an inference for follow up during the next working day. I note the assessment is after hours, at 6:10pm.

4.1.2 As with any assessment there are some omissions within the documented record. Of note [Dr C] does not: systematically screen for psychopathology, detail past psychiatric history, note medical history or document illicit drug use (or non-use). There is no clear assessment of capacity in regard to agreeing to the plan. The timing of review is not clear, although this is recognised as likely as [Dr C] does refer to the need for MDT assessment that the notes make clear occurred the following morning. It is not clear

that completion of any of these elements within the initial assessment would have changed management, or altered CMDHB planning over the coming days.

4.2 The appropriateness of the clinical management plan put in place for [Ms A] by CMDHB and whether this was adequately adhered to, between [Day 1] and [Day 18].

4.2.1 In considering this broad question I have endeavoured to consider the actions as documented by CMDHB on the basis of the information they would have had at the time of assessment. Generally I consider the clinical management plan put in place to be appropriate and meet the level of care expected by a DHB for a patient with a presentation such as that of [Ms A].

4.2.2 Some elements of the plan appear to be particularly strong. These include: the regular assessments by the senior medical officer [Dr B], the regular nursing assessment of [Ms A] with alterations to the plan on the basis of these assessments (including two assessments at home, two assessment in the HBT base and 18 recorded face to face visits (some by two nurses at the same visit)) and multiple indirect contacts to support the coordination of care, clear prescribing for [CMHS] staff, responses to [CMHS] staff for advice and support and consideration of the use of the Mental Health Act on the night of [Days 16–17].

4.2.3 Some elements of the plan could have potentially been improved on. These largely revolve around acute responses and the advice in regards to alcohol use. Of the former it was clear [CMHS] staff were having some difficulty on the night of [Day 17], when [Ms A] returned apparently intoxicated. At this time it would have been preferable if [Ms A] could have been assessed face to face, ideally by someone with experience in the management of intoxication. This could have provided greater support for [CMHS] staff and would have helped to clarify the nature and extent of the issues at hand. Of the latter CMDHB had documented the diagnosis of alcohol use disorder and potential problems exacerbated by alcohol use. Despite this it does not appear as if any quantitative assessment of alcohol use was undertaken other than [Dr C's] initial assessment. No clear assessment of the degree of intoxication in the night of [Day 17] is given (and would have required clinical review), the ongoing rationale for the prescription of sedative hypnotics (clonazepam and zopiclone) is questionable as generally these medications are contraindicated in alcohol use disorder other than for detoxification. This does not appear to have been the case. I do note however, that [Ms A] was highly focused on pharmacotherapy and a preference for use is repeatedly stated. Further on the night of [Day 17/18] benzodiazepine is withheld in the context of presumed intoxication. It is not clear the degree of pressure the rationing of resources has in these issues.

4.3 The appropriateness of the medication prescribed to [Ms A] and whether medication administration policies were adequately adhered to.

4.3.1 In regard to the prescription of venlafaxine this appears appropriate and exceeded the standard of care required. The medication had a history with [Ms A] of

effectiveness, and the initiation and gradual increases reasonable. This was clearly described to [Ms A] to ensure she was aware of this process.

4.3.2 In regard to the prescription of quetiapine, this is commonly used as a "major tranquilizer" in New Zealand and routinely prescribed in low dose for the management of arousal in various types of serious mental illness. As such its use in [Ms A] over the time in question would be in line with generally accepted clinical practice in New Zealand for a mixed anxiety and depression picture. I note [Dr C] does not document its off label use, however [Dr B] does on [Day 12] at review. He also documents description of side effects and notes [Ms A's] positive experience of this medication. [Dr B] notes, "She insists it was the only medication that took the edge off her anxiety and helped reduce suicidal thoughts." This would endorse the continued use of quetiapine.

4.3.3 The prescription of benzodiazepine and cyclopyrrolone medication is again common in New Zealand as both a sedative and hypnotic and as such its use in [Ms A] in 2016 would be in line with much clinical practice. Having said that, there are well documented concerns about the use of these classes of pharmacotherapies in patients with alcohol use disorder. [Dr C] is mindful of this issue in the initial prescribing of clonazepam and appropriately documents the amounts and pattern of [Ms A's] alcohol use in his initial assessment. He also notes of the clonazepam, "… may need dose reduction or switch to diazepam [an alternative benzodiazepine] if working towards abstinence of alcohol." He prescribes 1–2mg of clonazepam "as directed". The assessments of [Dr B] do not detail consideration of these medications. In the assessment of [Day 6] he does not mention either class of drug in his assessment or plan, however the zopiclone is prescribed at a dose of 7.5mg prn ("as required") and clonazepam is continued. Similarly on [Day 12] both medications are continued and the zopiclone doubled. No in depth consideration to ongoing alcohol use is given. Indeed there is little ongoing monitoring from any clinician with respect to [Ms A's] potential alcohol use. I note that [the CMHS] is described as an alcohol free zone and concerns are not raised (other than on [Day 17]) of alcohol use. As such the inference is [Ms A] was not consuming alcohol or displaying signs of intoxication for the majority of her time there. I note the [CMHS] documentation states [Ms A] took three zopiclone a day and had done for years. It also documents clonazepam 1mg mane and 2mg nocte as routine medication.

4.3.4 The information available to me does not suggest there was any gross divergence in medicines support to [Ms A] from the policies provided.

4.4 The appropriateness and adequacy of [Dr B's] assessments of [Ms A] on [Day 6] and [Day 12].

4.4.1 In general I find both the adequacy and appropriateness of [Dr B's] assessment to reach an appropriate standard of care. I note on both occasions [Dr B] saw [Ms A] at the HBT base, as opposed to [the CMHS] and entered contemporaneous notes. Both reviews included other HBT staff and the first staff from [the CMHS]. [Dr B], in his first review appropriately reviews the notes to provide background and then assesses

progress in his patient. He accesses collateral information as necessary. He makes an assessment of risk and notes impaired judgement. He describes a manageable plan that increases supports of [Ms A] on the basis of his assessment and identifies changes, other than those described above (4.3.3). In his second assessment [Dr B] appropriately notes the change in demeanour, focuses on management and is supportive of a recovery stance, allowing [Ms A] to be an active participant in the dialogue. He describes a clear mental state. He identifies a management plan and rationale for this.

4.4.2 As was the case for the assessment with [Dr C] there are some omissions to the documents that could have been considered in an assessment of a patient in crisis on both occasions. As described above there is no documentation as to alcohol use, or suggestions of intoxication or withdrawal. No consideration appears to be given to routine blood assessment to assist in considering recent alcohol use. The descriptions of alcohol used given to [Dr C] are sufficient to warrant some clinical concern. No assessment of other psychoactive drug use (e.g. cannabis) is undertaken. No clear consideration to family participation is documented, nor [Ms A's] capacity to engage in treatment decisions. I do note, however [Dr B] comments on judgement and this is a proxy for consent. There is no clear documentation as to the process of developing a discharge plan, or how this may have been approached. I note [Ms A] expressed concern about discharge, and the stressors at home leading to admission, that do not appear to have been addressed.

4.4.3 I note that it is unclear that omissions identified above reflect the substance of the clinical interviews, rather the documentation provided. Further it is unclear if systematic issues, such as work volumes or time pressure are an issue in the time available to document clinical interactions. It is not possible to document every element of every interaction. Having said that I would have expected documentation of the above points in 4.4.2 if they had occurred.

4.5 The appropriateness of the decision to continue providing care to [Ms A] at [the CMHS] and introduce hourly checks, after she expressed suicidal thoughts on [Day 14].

4.5.1 From a logical perspective this question makes little sense. [Ms A] was referred for assessment on the basis of suicidal thinking. Further [Ms A] described chronic suicidal ideation/thinking. As such using the notion of "suicidal thinking" as the basis for clinical decision making would be faulty, due to its near continued presence.

4.5.2 Having said this, the decision to continue care on [Day 14] appears to have been made prior to face to face assessment, with [Dr B] suggesting to [RN D] that she remind [Ms A], "… that [the CMHS] is the best place for her". This is somewhat surprising and *is a mild departure from the expected standard of care*. I would expect decisions as to risk and decisions in respect of disposition to be made following a face to face assessment. I note there does not appear to have been a follow up discussion with [Dr B], or another psychiatrist subsequent to the face to face assessment and that [Ms A] was unknown to [RN D] prior to the assessment. As such it is difficult to understand why [RN D] did not discuss this with a member of the team, ideally [Dr B], following the

assessment. I note [RN D] documents she will follow up with [Dr B] in the morning but the only entry is of a case conference in the afternoon. This is also *a moderate departure from the expected standard of care*, despite the fact the assessment is recorded as occurring at 4:30pm.

4.5.3 I note the plan developed on [Day 14] was a safety conscious one with an increase on observations overnight to hourly.

4.5.4 I note in the [review], serious and extreme risk event review and action plan the notes by [the CMHS] indicate the clinical decision to remain at [the CMHS] was based on "chaos at [the inpatient unit]". It is not clear if this information is contemporaneous or recollected sometime later with the knowledge of [Ms A's] death. The veracity of this statement cannot therefore be verified. If contemporaneous, however, a decision to not admit someone prior to assessment based on construction work would fall significantly below the expected level of care and related to both the HBT team and the wider CMDHB milieu.

4.5.5 Lastly I note that the following day [Ms A] appears to have had an upswing in her mood. She is recorded as having chronic problems with emotional dysregulation. As such it is not clear that this decision had a material impact on the outcome of [Day 18].

4.6 Whether consideration should have been given to sectioning [Ms A] under the Mental Health Act during her admission and the reason why.

4.6.1 By the term "sectioning" I presume the office of the HDC means detaining [Ms A] under sections 8–11 of the Mental Health Act (MHA) as a hospital inpatient.

4.6.2 There is no reason to think detaining [Ms A] under the act would have ever been appropriate. Under the principle of least restriction any clinical consideration of inpatient admission should have been initially as an informal patient. Considering the human rights issues with detention using the need to coerce someone into hospital raises the bar on necessity, and harm is clearly being done. [Ms A] asked, from time to time, to be admitted to the inpatient unit and there is no reason to think she would not have accepted this informally, therefore using the MHA would have been both clinically and legally inappropriate.

4.7 Any other matters in this case you consider warrant comment.

4.7.1 I note the difficulty in including all family in discussions related to progress and discharge, in particular parents who are the complainants in this case. Inclusion in planning is important. Balancing this is the right to privacy. Neither parent is listed as someone staff can freely talk to, making independent discussion with parents difficult. I note the plan appears to have potentially included discharge to parents and as such I would have expected them to be involved in discharge planning. A failure to do this (or at least efforts to do this and documenting [Ms A's] refusal) would be expected. *I would consider this a mild departure from the expected standard of care*.

4.7.2 I note [Dr C] undertook a reasonable alcohol use screen but at no time was any effort made by CMDHB staff, or [CMHS] staff, to establish the nature or degree of alcohol use by repeated questioning, use of a structured withdrawal scale or blood monitoring. In a patient with documented alcohol use disorder, and clear history of alcohol use sufficient to increase the likelihood of withdrawal and a recent history of blackouts and intoxication this is a departure from a reasonable standard of care. *This departure is moderate to severe.*

4.7.3 I note [Ms A] was admitted to [the CMHS] for 12 days, with inferences through the notes of discharge and [Ms A's] anxieties around this. I note the predominant proximal cause of distress leading to presentation appears to be the conflict with her landlord and failure to pay the rent. At no time is the issue of discharge to where directly conceptualised. No clear plan existed. It is possible this increased [Ms A's] concerns/ anxiety/impulsivity although this is entirely speculative. This would explain however the worsening emotional dysregulation from [Day 15] and the alcohol use on [Day 17]. As this is a speculation by myself, and it is not clear discharge was set for [Day 20] (or indeed at any time) no departure from an expected standard of care is noted. Nonetheless there is some clinical concern as to this.

4.7.4 Lastly I note the descriptions of [Ms A's] difficulties appear to match those of people with a diagnosis of [a personality disorder]. This would appear to be the case more so than a mental state disorder. Although [personality disorder] traits are noted, this diagnosis was never made. This is important in as far as diagnosis allows management to be evidence based/informed. I note this is speculative from my interpretation of the notes available to me and as such no departure from an expected standard of care is noted. I note too that it is not feasible to document every negative considered.

5 What recommendations for improvement would help prevent a similar occurrence in the future?

5.1 As stated above the evidence strongly suggests completed suicide is a public health issue, and the evidence as to interventions that reduce suicide rates are public health measures, not individual psychiatric ones[9]. Nonetheless [Ms A's] GP and CMDHB appropriately assessed concern and engaged in a strategy to support [Ms A][10,11].

5.2 Notwithstanding this, there are a number of reasonably easy to implement strategies both CMDHB and [the CMHS] could consider to improve the care to guests/ patients such as [Ms A] in the future. They include:

5.2.1 Formal addiction screening and external assessment of risk associated with this. I would recommend a breathalyser at [the CMHS] and physical screen (appropriate blood testing) on admission. Further a urine drug screen for other illicit drugs should be considered as routine bearing in mind the high prevalence of use in at risk populations, particularly if there is a history of any use disorder.

5.2.2 Education for staff as to the diagnosis of [a personality disorder], and consideration of this diagnosis in patients with classic features is of benefit. This enables appropriate evidence informed management strategies to be considered.

5.2.3 It is notable that reviews by [the CMHS] and CMDHB raise concerns about communication, however I consider this to be more than satisfactory almost all of the time. The notable possible exception is the consultant psychiatrist reviews. If these occurred on site at [the CMHS] this would significantly improve communication between the psychiatrist and [CMHS] staff.

5.2.4 Clear documentation as to discharge planning, expected lengths of stay and communication around this would provide structure for guests at [the CMHS] and enable early planning to occur.

5.2.5 Finally I note that many of these issues may well be related to pressure in staff time, staff resources and hospital inpatient beds/building. This is a national issue but one that may have directly impacted on clinical decision making in this case. Noting this to the Minister of Health may help to highlight this issue. I trust this report has been of assistance to you.

Yours truly,

Dr Giles Newton-Howes
Consultant Psychiatrist

The above report is based on the information available to me. It is based on the history and records as provided. If other information becomes available at a later date this may alter or change both the content of the report and the opinions provided. This may require an amendment or new report to be prepared. This report is conducted as an independent psychiatric evaluation at the request of a third party. Decisions regarding further management and interventions are at the prerogative of the referrer. Any legal actions taken as a consequence of this report are solely at the discretion of the referrer. The referring party is responsible to ensure that the report and any detailed documents are dealt within a confidential manner in keeping with the Health Information Privacy Code. The referring party is responsible for safe keeping of these documents as required by the Health Information Privacy Code.

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The following further advice was obtained from Dr Newton-Howes on 20 March 2020:

'**4.4.2 and 4.4.3** — You note that there is no documentation regarding [Ms A's] alcohol use or suggestions of intoxication or withdrawal. No consideration appears to be given to routine blood assessment to assist in considering recent alcohol use and no assessment of other psychoactive drug use is undertaken. There is also a lack of documentation regarding consideration of family participation and development of a discharge plan. You comment that it is unclear whether these omissions in documentation reflect the full extent of clinical interactions. **In light of this, please advise the level of departure from acceptable practice if the above clinical interactions did occur, but were not documented. In the event that lack of documentation is indicative of omissions in the care provided, please advise the level of departure from acceptable practice.**

If these did occur and were not documented this is a moderate departure from the expected level of documentation practice.

If these did not occur it is very challenging to identify the degree of "departure from acceptable practice" as the facility in question is unique. There appears to be a systems issue as to who would hold responsibility for this (although I am certain [the CMHS] would say the DHB). Overall I am unnerved by this omission and it concerns me, however I suspect this sort of departure of what I would consider acceptable occurs reasonably frequently. It is clearly significant. The terms the HDC uses are vague and there is very little science to guide this sort of judgement. Overall I would consider them serious, but I note I am an addictions psychiatrist and a general crisis psychiatrist may not be as concerned as I am. Personally I think we do not pay sufficient attention to A&D issues in our patients (or society) and so "acceptable practice" nationally would definitely benefit from improvement in this regard.

4.5.4 — You note that in the serious and extreme risk event review, it is documented that the clinical decision for [Ms A] to remain at [the CMHS] was based on "chaos at [the in-patient unit]". You advise that it is not clear if this information is contemporaneous or recollected some time after [Ms A's] death. **If this information is contemporaneous, please comment on the level of departure from acceptable practice. If this information was recollected after [Ms A's] death, please advise if this was a departure from acceptable care and quantify the level of departure.**

If the information was collected contemporaneously it is a moderate departure from an acceptable level of care. Care should never be decided solely on the basis of difficulty in the appropriate care facility.

If the information was recollected, and bearing in mind this is a [CMHS] report, then I would put the information aside as significantly prone to recall bias and unlikely to be helpful.

4.7.3 — You note that there is some clinical concern regarding conceptualisation (or lack thereof) of [Ms A's] discharge from [the CMHS] based on the clinical documentation. **Could you please advise what best practice would be with regard to planning discharge for a patient in [Ms A's] circumstances?**

Again this is difficult as the care facility in question is unique. Nonetheless a "signal" is apparent on careful reading of all the information that an unspoken view was being formed that [Ms A] would be discharged in 2 weeks, that would have been two days after her death. It is clear discharge would have likely been stressful bearing in mind the circumstances surrounding the admission (conflict with landlord, unable to pay the rent). I would have expected early planning for discharge (possibly as early as admission), open discussion as to the difficulties with this and management strategies to mitigate these. A clear plan to support [Ms A] in the discharge plan would be expected. An "estimated date of discharge" provides certainty notwithstanding the

need to be clinically oriented and flexible. None of this is clear from my recollection of the file.'

The following further advice was obtained from Dr Newton-Howes on 18 November 2020:

'Associate Professor Giles Newton-Howes
BA, BSc, MBChB, PhD
MRCPsych, FRANZCP
CCT Adult Psychiatry and Substance Misuse Psychiatry (UK)
Consultant Psychiatrist

18th November 2020

Complaint Name: **Counties Manukau District Health Board (CMDHB)**
Reference: **C19HDC00950**

Thank you for your email of 16th November where you forward me the 11 page response from [the CMHS] and the 193 page response of Counties Manukau to the assessment of the above complaint. You have asked if either of these documents change my previous advice in any way.

I have also reviewed my report to the HDC dated 9th March and this report should be read in conjunction with it. I have consulted, anonymously, with expert colleagues in regard to the expected level of care from a principles (not patient) perspective. This is to ensure my views in this matter are not idiosyncratic. I have not seen the report of Carole Schneebeli, Mental Health Nursing Advisor, and have not reviewed the extensive initial packet of documents provided.

I note, in large part due to the nature of the way the HDC is set up and operates the focus of the HDC is on omissions, deficits and problems. Although this is unavoidable (and hopefully improves services) it overlooks the positive elements of the care provided in this case. In my view there was much positive, supportive and occasionally excellent in the care provided to [Ms A]. This includes the individual work in this case, and much of the policies, procedures and communication between [the CMHS] and the DHB. This in no way ameliorates the tragedy of her death.

For ease of use I list my areas of concerns from my initial report below and any amendment on the basis of the additional information provided. The numbering below is directly lifted from the report of 9th March to facilitate overview.

I was asked to comment on:

4.1 The appropriateness and adequacy of [Dr C's] initial assessment of [Ms A], prior to her admission to [the CMHS].

I described this as meeting the standard of care and continue to do so. Some elements of this care exceeded the standard expected. I note, in 4.1.2, some omissions but did

not and do not consider these to be below the standard of care expected. I noted inclusion of these elements would have been unlikely to have changed management and accept [Dr C's] comments in the correspondence provided.

4.2 The appropriateness of the clinical management plan put in place for [Ms A] by CMDHB and whether this was adequately adhered to, between [Day 1] and [Day 18].

I describe this as meeting the standard of care and continue to do so. Some elements of this management plan exceeded the standard expected as described in 4.2.2. I note, in 4.2.3, some omissions but did not, and do not consider these to be below the standard of care expected.

4.3 The appropriateness of the medication prescribed to [Ms A] and whether medication administration policies were adequately adhered to.

I describe this as meeting the standard of care in respect to the prescription of venlafaxine (indeed exceeding it) and continue to do so.

I describe this as meeting the standard of care in respect to the prescription of quetiapine, noting a minor omission with respect to off label use, but did not, and do not consider this to fall below a common standard of care in New Zealand (although it probably should).

I do not describe the prescription of sedatives as meeting the standard of care but do describe it, "… in line with much clinical practice". I did not describe it as falling below the standard of care expected. The information provided both [Drs B and C] clarify the prescribing, that would fall within an appropriate standard of care within New Zealand.

I note there is not a divergence from the policies provided in the prescribing practice.

4.4 The appropriateness and adequacy of [Dr B's] assessments of [Ms A] on [Day 6] and [Day 12].

I described this as meeting the standard of care and continue to do so. I note, in 4.4.2, some omissions but did not, and do not consider these to be below the standard of care expected.

4.5 The appropriateness of the decision to continue providing care to [Ms A] at [the CMHS] and introduce hourly checks, after she expressed suicidal thoughts on [Day 14].

I did not consider this question to make logical sense and continue not to do so. The additional information provided by [Dr B] contextualises their comment with respect to the discussion with [RN D] and in doing so make clear this was not coming to a premeditated decision as to level of care. As such *I no longer consider this to be a mild departure from the expected standard of care.*

The follow up after the assessment of [RN D] is described in the additional correspondence as possibly occurring within the morning MDT context (in which a doctor would have been present) but I am left uncertain if this occurred (or if a doctor was present). [Dr B] cannot recall a 1:1 meeting and none is documented (by recollection or report). On review with colleagues such morning meetings meet an accepted standard of care and are not always documented. As such this may have occurred and there may be no documentation of this (and this would be an acceptable standard of care in New Zealand). I note [RN D] appears not to have followed up with her SMO as is written she would and as would be a usual standard of care. Mitigating this is the description of the additional follow up provided by [RN D]. I am not a Mental Health Nurse Advisor to the HDC but considered this, and continue to consider this *to fall below an acceptable standard of care. This departure remains moderate* from the perspective of a consultant psychiatrist. The perspective of a Mental Health Nurse Advisor may also be of assistance to the HDC here.

I note in my initial report the plan developed was, however, a safety conscious one and continue to consider that to be the case.

4.6 Whether consideration should have been given to sectioning [Ms A] under the Mental Health Act during her admission and the reason why.

I did not consider this question relevant and continue not to do so.

4.7 Any other matters in this case you consider warrant comment.

In 4.7.1 I expressed some concern as to the failure of discussion between the treating team and parents, in the context of [Ms A's] plan to be discharged to their care. In the additional information provided it is stressed that family was involved, and that [Ms A's] brother was acting as the family liaison and reported positive responses from parents. I continue to have concerns about discharge to the care of family the treating team cannot talk to, in the light of conflict with said family members, *but no longer consider this to be a mild departure from the expected standard of care.* Clearer documentation would have clarified this.

In 4.7.2 I raise concerns about [Ms A's] alcohol use disorder, the presentation with recent intoxication and a failure to monitor this in any way other than a general impression of no withdrawal (a finding by omission of documenting withdrawal as opposed to actively examining for it and documenting its absence). In their response [the CMHS] considers this a responsibility of the DHB describing a peer support, non-hospital environment that would make this counter to their responsibilities. This is, however, inconsistent with their response of hourly monitoring which is clearly clinical in the same manner. In the response the DHB stress the observed failure to see a withdrawal state, the expertise of the staff to monitor this and statements of the patient to not be drinking. On balance I accept [Dr B's] statement of not considering this as "pressing" but continue to have concerns as to the overall approach to alcohol use and the risks of alcohol use in a patient with [Ms A's] psychopathology. It is not clear to

me if this responsibility lies with the DHB or [the CMHS], however consider this oversight to be *a moderate departure from the expected level of care.* Please note this is not about long term addictions management, rather shorter term monitoring and management of alcohol related problems and the potential issues of intoxication.

I raise concerns around discharge in 4.7.3 and the diagnosis of [a personality disorder] in 4.7.4 neither of which reach, to my mind, a departure from the standard level of care.

I have no further comment as to the recommendation raised in 5 and consider them all to remain valid.

I trust this follow up report has been of assistance to you.

Yours truly,

Dr Giles Newton-Howes
Consultant Psychiatrist

The above report is based on the information available to me. It is based on the history and records as provided. If other information becomes available at a later date this may alter or change both the content of the report and the opinions provided. This may require an amendment or new report to be prepared. This report is conducted as an independent psychiatric evaluation at the request of a third party. Decisions regarding further management and interventions are at the prerogative of the referrer. Any legal actions taken as a consequence of this report are solely at the discretion of the referrer. The referring party is responsible to ensure that the report and any detailed documents are dealt within a confidential manner in keeping with the Health Information Privacy Code. The referring party is responsible for safe keeping of these documents as required by the Health Information Privacy Code**.'**

Appendix B: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Carole Schneebeli on 26 May 2020:

> 'I have been asked to provide expert advice to the Health and Disability Commissioner concerning the above complaint. The Commissioner has sought my opinion on the care provided by Counties Manukau District Health Board to [Ms A] between [Day 1] and [Day 18].
>
> I have read and agree to follow the Guidelines for Independent Advisors.
>
> My qualifications include: My current role is Nurse Leader for Auckland Regional Forensics since January 2016. Prior to this I was from 2012 the Clinical Nurse Advisor for Regional Forensics, and CADS (AOD Services). I have an ongoing role oversight of Auckland Forensic Psychiatric Services DAO competency. I completed my Masters in Philosophy in 2013 from AUT. Prior to this I completed my Post graduate diploma in Health Sciences — Auckland University.
>
> Other areas of education and expertise include: Professional supervision, Quality Health Surveyor, Portfolio assessor, WDHB Coach, was previously in a role as the Undergraduate Coordinator of Mental health papers at Auckland University School of nursing.
>
> My current role is one of nursing leadership in regional forensics with key accountabilities in: pathways for nurses, quality improvement, strategic planning, service user safety, and service interface (primary health, district mental health and NGOs). I have an ongoing involvement in the credentialing of practice nurses around mental health and addictions care, in the wider Auckland area.
>
> **Referral instructions:**
>
> The Health Commissioner has outlined the following areas they wish to seek my opinion
>
> 1. Whether the clinical management plan put in place for [Ms A] by Counties Manukau DHB was adequately adhered to by nursing staff, between [Day 1] and [Day 18].
> 2. The adequacy and appropriateness of reviews carried out by registered nurses involved in [Ms A's] care and whether her care should have been escalated at any point during her admission.
> 3. Whether medication administration policies were adequately adhered to by nursing staff during [Ms A's] admission.
> 4. The appropriateness of the decision to introduce hourly checks, after she expressed suicidal thoughts on [Day 14] and whether this plan was adequately adhered to by nursing staff.
> 5. Any other matters in this case that you consider warrant comment.

Each question

What is the standard of care/accepted practice and what are the relevant guidelines?

Has there been a departure from accepted practice? If so, what degree: mild, moderate or severe?

What recommendations for improvement would help prevent a similar occurrence in future?

The information reviewed in order to give an opinion was:

1. Letter of complaint dated 23 May 2019
2. Letters from Counties Manukau DHB to the office of the Coroner, dated [2016] and [2018].
3. Letters from [the CMHS] to the Office of the Coroner, dated [2016] and [2019].
4. Counties Manukau DHB's response dated [2019].
5. [CMHS] response dated [2019].
6. Clinical Records from Counties Manukau DHB covering the period [Day 1] to [Day 18].
7. "Dealing with distress" booklet provided to [Ms A] by Counties Manukau DHB.
8. Complete record printout for [Ms A] from [the CMHS] covering period of [Day 1] to [Day 18].
9. Supporting documentation and policies for [the CMHS].
10. Joint Serious Incident Review Process, dated [2016].

Summary of events collated from documents supplied for review:

[Ms A] was a [woman in her twenties] who passed away on [Day 18]. She had longstanding mental health issues of anxiety and depression complicated by underlying personality issues, and alcohol use problems. She had had two documented previous suicide attempts … [Ms A] was referred by her General Practitioner to Counties Manukau on [Day 1] for assessment of depression and associated suicidal ideation, whereby she had persistent thoughts of [harming] herself. She was assessed as suffering from anxiety, emotional dysregulation, and suicidal ideation. Precipitating factors for this deterioration in her mental state included stopping her mood stabilizers and other medications, three months prior, a breakup of a relationship, and stressors at work leading to financial challenges. On [Day 1] she was assessed by the Consultant Psychiatrist [Dr C] from Intake & assessment in CMH and diagnosed with a mixed anxiety and depression complicated by personality issues and alcohol use. The risk assessment concluded that [Ms A] was experiencing chronic suicidal thoughts with an obsessional quality which had intensified due to the recent setbacks in her personal and professional life. She was triaged the same day by a RN as "cat c" on the triage scale as being high risk for self-harm in the 24 hour period. This indicated that nursing care required was one of close monitoring for risk of impulsive suicidal behaviors. Counties Manukau intake and assessment crisis team initially managed her care in the

community at her brother's house but this was not sustainable due to her poor sleep, persistent suicidal ideation and intermittent use of alcohol.

She was admitted to [the CMHS] on [Day 3], an acute alternative to inpatient setting, to offer her 24 hour care utilising a peer lead model of care. The CMH, Home based treatment (HBT) team led her clinical care and [the CMHS] implemented the plans set up by the CMH DHB. During her stay in [the CMHS], it appears that [Ms A] did at times engage in some of the groups and meaningful activities offered by this service to support her. However, it is clear from her [CMHS] notes that her suicidal ideation was pervasive, and she was constantly reporting this posed a significant distress for her. In her DHB notes, the daily reviews by the HBT clinical team, indicated a theme of medication requests. [Ms A] was reported to be very focused on medication as a means to reduce her ongoing challenges of distress and associated anxiety leading to suicidal ideation. During the week of [Day 13], it was decided to extend her one week respite care in [the CMHS] to [Day 20], where she would then return to her family home in [another region]. It was reported that she was ambivalent about discharge and wanted to stay longer. The condition of her staying longer at [the CMHS] was to increase her engagement in groups and activities offered and to complete a WRAP (wellness and recovery action plan).

On [Day 17], [Ms A] returned from a planned leave, later than agreed, and appeared to be under the influence of alcohol, which is a breach of the rules in respite care. Not all her regular medications were administered that night, under direction of the HBT clinical team, due to concerns of contraindications associated to mixing medications and alcohol. She had a poor sleep and the following day was reinstituted with hourly checks due to concerns around her mental state. At around 6.10 pm on [Day 18] [CMHS] staff found her [dead by suicide]. They were unable to successfully resuscitate her and she was pronounced dead by the paramedics who attended the scene.

1. **Whether the clinical management plan put in place for [Ms A] by Counties Manukau DHB was adequately adhered to by nursing staff, between [Day 1] and [Day 18].**

A thorough review of [Ms A's] clinical notes indicated that the care provided by registered nurses was in three areas — Intake Mental Health Clinicians, Home Based Treatment (HBT) clinicians and [the CMHS] nurses over the period of [Days 1–18].

[Ms A's] first contact was with the mental health intake team of CMH on [Day 1]. She remained with the team till [Day 3]. The nursing team made one face to face contact on [Day 1] with the Consultant Psychiatrist, and then daily phone contact till [Day 3] whereby the HBT team took over her care. During this time, the documentation indicated the nursing team engaged with the family, who were her protective factor, and worked collaboratively with [Ms A], prior to handing over her care to HBT. *The nursing team in MH intakes' practice was of an accepted standard of practice.*

From [Day 5] HBT team then took over her care. This included an updated MH smart (HoNOS) (outcomes measure). The HBT RN and Consultant Psychiatrist completed a face to face assessment and review that included plans to

- Admit her to respite care.
- HBT daily visits to assess mental state, risk and support CMHS staff.

On the same day she was admitted to [the CMHS] and had a joint assessment with the HBT clinical staff and [CMHS] staff. [Ms A] was reported by the HBT Consultant to present with *relentless thoughts of [harming] herself but no clear plan.*

The initial clinical plan developed by DHB MH intake RN, was the Acute Community options referral form [Day 1]. Then on [Day 2] the MH intake RN created the Acute Community Crisis Resolution plan. The crisis goals outlined in the document indicated that the reason for acute care alternative in [the CMHS] was to; *promote sleep and safety, low stimulus environment for anxiety, support alcohol withdrawal monitoring with medications as charted, maintain a daily routine*. Additionally, there is a section for [CMHS] staff that outlined their role was to *monitor her sleep, eating and anxiety, and to support her with her suicidal ideation monitoring her safety and engaging her in coping strategies*. The [CMHS] admission checklist added more details of interventions required including, visits allowed with family/friends or staff, hourly monitoring overnight for sleep, hourly monitoring for mood and safety, daily updates from DHB team.

From [Days 5–18] there was a shared care between two services, HBT clinical team and [the CMHS] team. A review of the clinical notes in both areas indicates the nursing staff were following the plans as outlined. There were daily face to face reviews that were documented and reflected mental state and risk assessment. [The CMHS] also documented their care reflecting her ongoing suicidal ideation and the psychological supports offered to her. Leave was negotiated by both teams to be with family and/or friends only and nursing staff adhered to this directive during the stay. Medication management was an occurring theme throughout the stay and this was increased as assessed and prescribed by the Consultant Psychiatrist. [CMHS] staff administered the medications in accordance with their policies and utilized blister packs which are the approved practice in NGO settings.

One area of care management that became apparent in the review of all clinical notes and the [CMHS] review is the use of the care management plan by the HBT clinical team that had been developed by another team, the Intake Mental health team, who are a different service. This is *a moderate departure from standard of practice*. The document adult assessment, although relevant at the time of intake mental health service assessment, did require updating. Areas such as discontinued requirement for alcohol withdrawal monitoring and an updated risk management plan needed to be included. Of note, the adult assessment document provided a risk formation section outlining the areas of concern such as *… thinking of [harming herself].* This information captured in the adult assessment document also outlined that she denied having a suicide plan. The

assessment indicated that she was more likely to act on her suicidal thoughts impulsively if her anxiety and distress increased. The impression formed by the assessing intake team clinician indicated that the likelihood of her acting impulsively on the suicidal ideation would have been greater if she was using alcohol. This information was relevant and may have supported [CMHS] staff in understanding her ongoing suicidal ideation and risk of impulsivity associated to her levels of anxiety and alcohol misuse. The process of utilising care plans from other parts of services does occur, particularly if they are in the same DHB and processes are the same. *The main departure from accepted practice is the lack of updating of the document* and lack of inclusion of relevant information from her initial assessment, being transferred into a risk management plan for [CMHS] staff to follow.

Recommendations:

Collaborative documentation processes that are transparent and accessible by both services involved in an episode of care.

When reviewing the different sets of clinical notes between the HBT clinical team and the [CMHS] team the documentation reflected different focuses. The HBT clinical team addressed mental state and risk assessment in context of [Ms A] being in a safe and contained environment. The assessments indicated that medication regime was a factor in supporting her through the crisis. [The CMHS] team often wrote about her intense persevering suicidal ideation and the psychological support and group processes she engaged in as well as her access to prn medication. Both sets of clinical notes were relevant to her care management, however it would have benefited both teams to have a shared copy of clinical reviews to aid in a shared understanding of the how risk was assessed by the clinical team. Effective communication between clinicians and across teams is essential to ensuring safe, continuous, and coordinated care, (Australian Commission on Safety and Quality in Health Care, 2017). As it was, there remained a reliance on daily reviews and verbal handover between the teams which has a significant place in handover but is one element of handover and shared understanding of care management. Nursing literature indicates that verbal face-to-face communication directly between caregivers increases accuracy and efficiency of handover information, (Johnson, Maree & Sanchez, Paula & Suominen, H & Basilakis, Jim & Dawson, Linda & Kelly, Barbara & Hanlen, Leif. 2013). However, to augment a shared understanding, the process of checking the accuracy of key information is best addressed with reference to shared written care documents, and clarifying gaps or uncertainty further enhance the quality of handover communication.

Updated relevant to context — collaborative risk management plan

The other aspect of care delivery and management that could be improved was the risk management plan. Clear up-to-date information available to the team accepting a transfer requires the documentation to be current, relevant, accurate and complete at the time of the transition. I note this was addressed in shared DHB/[CMHS] [review], where the admitting team [the CMHS] accepted an admission without a collaborative up-to-date risk management plan. [Ms A's] case held complexities including self-harm

and suicidal ideation, alcohol misuse, personality issues, and eating disorder. Therefore, a robust collaborative up-to-date risk management plan for any service user with a complex case presentation is a requirement, (Firth, Spanswick, & Rutherford, 2009).

2. The adequacy and appropriateness of reviews carried out by registered nurses involved in [Ms A's] care and whether her care should have been escalated at any point during her admission.

The review by CMH provided a print out of all the contacts and associated reviews by RNs and other key health professionals from CMH clinical team, of [Ms A's] care from [Days 5–16]. The dates missing on the print out of [Days 11, 12, 13, 17 and 18], were located in the clinical notes. Her care was reviewed daily by the HBT DHB clinicians over the initial 7 day plan of admission and treatment, which was then extended on [Day 12], a further 7 days to support her ongoing recovery and engagement in planning for relapse prevention (WRAP).

The review by Counties Manukau dated [2019], gave the rationale for placing [Ms A] into acute psychiatric alternative setting, on the basis that this was a least restrictive intervention, whilst maintaining her safety, enhancing her independence, and avoiding long-term dependency on institutional care. The initial admission note indicates that [Ms A] was not required to be under the mental health act, she agreed to treatment, and her level of risk was associated to a transient down turn of her mood, which could be, with regular medication regime and support, effectively managed in [the CMHS] service.

During her stay she continued to work with the clinical staff and [CMHS] staff, even when her suicidal ideation persisted. There was no evidence indicated in the reports or notes during her stay that she was experiencing any form of psychosis or mania. Indeed, it appeared she was insightful of her treatment and health issues and was effectively engaged with the staff. It is reported that [Ms A] often sought support from [CMHS] staff when distressed through her stay.

Oversight of her clinical care included daily reviews from the DHB HBT team which was predominately nursing staff and one visit recorded from a HBT clinician who was a social worker on [Day 10]. She had two medical reviews with a Psychiatrist on [Days 6 and 12], which is in keeping with the requirements of the [the CMHS] and DHB agreement of planned care. There was a Multi-Disciplinary Team (MDT) review on [Day 15], where there would have been a review of her ongoing progression and support of the decision to extend her time for a week. There were recorded periods of her stay where her suicidal ideation fluctuated, often in context of specific stressors and particularly her pending discharge. On all occasions, [the CMHS] team sought support from the HBT clinical team.

On [Day 14] she expressed her fears around pending discharge to family [home] and plans to act on her suicidal ideation. This was reviewed by the HBT clinical team (Nurse) and [the CMHS] team and the HBT clinical team, who then escalated this to the Consultant Psychiatrist with the plan she should remain in [the CMHS]. The decision to

keep her for an extended period in [the CMHS] was an *accepted standard of practice* and did not at this point of her stay, require any escalation to an inpatient setting or require mental health act process. [Ms A] had built relationships with her [CMHS] care team and was generally engaged with the groups and 1:1 care offered to her. The extended time gave her opportunity to work in collaboration with the [CMHS] team towards her discharge planning and development of her wellness recovery action plan, (WRAP). To address her increased anxiety and associated distress she was placed on hourly checks, and prn medication was used appropriately, as outlined in her clinical notes.

On [Day 17] [Ms A] returned to [the CMHS] at 2300 and was noted to smell of alcohol, which was a breach of her agreed behaviours in [the CMHS]. This resulted in withholding her nocte medication as advised by the HBT clinical team. Overnight, CMHS staff rang [RN E], HBT team to seek support around [Ms A's] persistent request to have her medication. She was advised to take only one of her medications. [RN E] consulted with the on-call medical officer and they were in agreement that this was the right course of action. [Ms A] also agreed to stay at around 0330, after speaking to [RN E]. She had an unsettled night and poor sleep. According to the clinical notes, [RN E] had escalated the situation and his decision making to the [on-call medical officer] who was to review the notes. *This is in keeping with standard of practice* and the decision to keep her at [the CMHS] at this time was due to her agreement to stay and her willingness to settle to sleep with a review planned for [Day 18].

On the morning of [Day 18], [Ms A] was reviewed by the HBT RN who was accompanied by a fellow RN who was also a DAO. The DHB HBT clinical notes do not indicate if the accompaniment of a DAO was for the provision of a joint assessment to determine if [Ms A] required mental health act process. However, the DHB clinical notes did indicate at the conclusion of the interview, that the plan was to proceed with discharge planning and medical review on [Day 19].

Both the [CMHS] notes and the DHB clinical notes indicate that the teams had a difficult conversation with her. Specifically, around her drinking, which was against the policy of the setting and around her disruptive behaviours overnight that procured a large amount of staff time. Indeed, the DHB/[CMHS] [review], indicated that this was an area that CMHS staff could improve on in regards to managing their own values and responses to people who engage in alcohol mis-use when it is against the policies. Both sets of notes indicated she was defensive around the collaborative review with both CMHS staff and HBT clinical staff. The message implied in both clinical notes was that she was to be discharged the following day post the medical review.

It is my impression that [Ms A] may have perceived the difficult conversations and feedback from staff as distressing. This can be confirmed in the DHB clinical notes where she was reported to be defensive and withdrawn. Literature indicates that in the face of failure or stressors such as described above, rejection sensitivity and fear of abandonment is often the response for people who suffer from personality issues (Berenson, K.R., Gregory, W.E., Glaser, E. et al. 2016).

Her complex presentation and breach of [the CMHS] rules prior to discharge was an indication of the level of distress she was experiencing. The team should have considered escalating this for a medical review that day. *To leave her review to the next day was a mild departure from practice.* It is my impression that her presentation and behaviours of concern warranted a review that day by a Consultant Psychiatrist. It could be debated the HBT nurse overnight had consulted with the on call medical officer, as documented in the DHB clinical notes dated [Day 18], at 0225, who was to review the notes and address any concerns assessed in the clinical documentation. There is no documentation to confirm if this review occurred.

Recommendations

CEP — co-existing problems

Both sets of notes from the DHB clinical staff and [CMHS] staff indicated the difficulty there was in managing her care when she engaged in the use of alcohol on [Day 17].

The joint DHB and [CMHS] [review] indicated that this was an area of care that CMHS staff and peer support workers could continue to develop competencies in when dealing with people who have co existing issues of drug and alcohol and mental health. The joint review indicated changes the service was going to put in place around more training on co existing problems (CEP)and in particular how to deal competently with alcohol misuse. I also note that the training calendar for [CMHS staff] has training associated to risk and risk management and CEP. It would benefit the training to be enhanced by policy and procedures on [the CMHS] site, which support staff in how to effectively manage situations where the risks increase associated to alcohol or drug misuse. This may be in place but could not be located in the documents supplied.

3. *Whether medication administration policies were adequately adhered to by nursing staff during [Ms A's] admission*.

A review of all [Ms A's] clinical documentation by [the CMHS] indicates the team adhered to her medication regime in accordance with the policies. It was well recorded in the HBT clinical notes and [CMHS] notes that [Ms A] was quite focused on medication as a means of helping her manage her intense suicidal ideation and she was very aware of her regime and fully informed of the intended effects that medication would have as an intervention. She was on a supervised administration plan and her medications were blister packed and monitored by HBT clinical team. Regular medication reviews were addressed with her and her clinical team and an increased titration of anti-depressant regime was implemented. She also had an increased PRN prescription over her time to support her ongoing anxiety.

A review of the medication administration record indicates that the staff adhered to policy around signature recognition. Her medications were signed off daily and times indicated on the signing sheet. As with all handwritten documents it can be difficult to decipher the comments.

The PRN quetiapine was captured in a separate document and signed off accordingly. The clinical notes for [the CMHS] indicate the team monitored her prn usage and reported this to the clinical team each day. The practice of medication administration by [the CMHS] and DHB clinical *staff is within accepted standard of practice*.

The clinical notes from [Day 5] to [Day 17] by CMHS staff indicate that the key area of medication negotiation between [Ms A] and the nursing staff was PRN. The use of PRN (as needed), is a frequent clinical intervention for the management of agitation, aggression and distress. It can be either psychotropic medications or benzodiazepines (Usher, Baker, & Holmes, 2010). The administration of PRN requires a collaborative process between the service user and the nurse as well as clinical decision making with regard to the rationale for use. All shift notes of any use of PRN was documented, and reasons for giving indicated around her levels of distress. *This is in keeping with accepted practice for use of PRN.*

4. The appropriateness of the decision to introduce hourly checks, after she expressed suicidal thoughts on [Day 14] and whether this plan was adequately adhered to by nursing staff.

On [Day 14] [Ms A] expressed her fears around pending discharge to the family [home]. She also spoke of plans to act on her suicidal ideation should she leave [the CMHS]. This was reviewed by the HBT clinical team (Nurse). Both the [the CMHS] team and the HBT clinical team followed up with the Psychiatrist who supported the premise she should remain in [the CMHS]. To address her increased anxiety and associated distress around pending discharge, she was placed on hourly checks and prn medication was used appropriately. *This is in keeping with standards of practice.* The use of observations is not uncommon and is usual for Registered Nurse to initiate the observation procedures, (Rooney, 2009). The implementation of welfare checks or observations involves the increased monitoring of mental health service users who are at an increased risk of harming themselves, or absconding the care facility to engage in self-harm behaviours. The practice involves staff being assigned to engage with the service user therapeutically and monitor their well-being (Lambert et al., 2018). It involves the provision of compassionate care while managing risk until the intensity of the risk subsides. *This approach is in keeping with best practice*. The Clinical team that included HBT Nurse and Consultant Psychiatrist supported this approach, as [Ms A] had a therapeutic rapport with the [CMHS] team, who could engage her in effective coping strategies. It is my impression that to have placed her in an inpatient setting at this point, would have been potentially counter therapeutic.

However, when reviewing all the clinical notes it is unclear as to how the process of observations, welfare observations or hourly observations is adhered to within [the CMHS]. The documents supplied did not include a procedure or process around observations. Nor did there seem to be a checking sheet or sign off sheet. *This is a mild departure from practice*. The only reference to observations was in the Entry to Respite/Acute Alternative document, with a small note on how to do night checks. A review of the clinical notes on [Day 14] for [CMHS] Staff it is unclear if overnight the hourly observations were adhered to. The notes on the clinical notes on [Day 15] hourly

checks are recorded in clinical notes. It is unclear, when the overnight checks were instigated, for how long the checks were to continue and who determined when they were discontinued. *This is a moderate departure from standard of care.* Indeed, as the DHB/[the CMHS] [review] indicated, the inconsistent approach by staff to hourly observations and lack of robust recording was an area that the service intended to improve.

Recommendation

Policy and procedures on observations

There appears to be a lack of guidance or policy on this process. Review of clinical notes and policies/procedures supplied for [the CMHS], indicates there is no policy/procedure defining and outlining the process of welfare checks. The joint DHB and [CMHS] [review], dated [2016], indicated clearly that there were periods on [Day 18] where there is no record of hourly checks. This was a time when [Ms A] was at a "risky" period, where the risk of impulsivity due to her setbacks with both teams around her alcohol use and her unsettled night and lack of sleep, were times to be vigilant.

Indeed it is important that when engaged in the process of checks there is clarity around what this entails such as therapeutic engagement, review of mental health status and review of level of risk as well as knowledge of where the person on checks is located or what they are doing i.e. a resident has not left the service without the team's awareness or engaged in self-harm behaviours.

5. Any other matters in this case that you consider warrant comment.

It must be noted that *… the management of patients with personality disorder is one of the most challenging and sometimes controversial areas of psychiatry* (Paruk & van Rensburg, 2016). [Ms A's] persistent thoughts of suicidal ideation were noted to be a theme that was quite challenging for the staff at [the CMHS], even when they were essentially able to effectively engage with her and support her through it. The review of relevant documentation supplied indicates that both teams worked hard to keep her engaged and supported during her stay in [the CMHS]. The issue of whether [Ms A's] care should have been escalated to a hospital setting during her stay is inconclusive. Literature indicates that inpatient hospitalisation as an option for people who present with personality issues should be used cautiously to minimise unintended, unproductive consequences i.e enhanced risk taking, institutional dependency leading to longer periods of hospitalisation (Czelusta, Idicula, Laney, Nazir, & Udoetuk, 2020).

The rationale to admit [Ms A] in [the CMHS] and keep her there instead of escalating her to an inpatient was detailed in the CMH review by the General Manager report. [The CMHS] is designed as an alternative to inpatient care, which offers 24 hour care and support for service users in a home like environment. The principle of these settings to offer shared decision-making, least restrictive practice for people who experience personality issues has been identified as important in promoting better health outcomes, (Warrender et al, 2020). This environment was centered on recovery principles of collaborative planning with service user to encourage hope, self-

determination, and empowerment through partnership. The use of peer support workers is valued as they can bring their lived experiences to the care environment that reinforces resilience and hope.

References:

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The following further advice was obtained from RN Schneebeli on 28 October 2021:

'28th October 2021

Independent advisor response to [the CMHS] review 19 October 2020

To Assessor Health and Disability Commissioner,

I have been asked to respond to the letter by [the General Manager (GM) of the CMHS].

Background:

The Commissioner has sought my opinion on the care provided by Counties Manukau District Health Board to [Ms A] between [Days 1 and 18].

I have read and agree to follow the Guidelines for Independent Advisors.

My qualifications include:

Associated Director of Nursing for Auckland Regional Forensics and CADS since November 2020. From 2016–2021, Nurse Lead for Regional Psychiatric Forensics Services. From 2012–2016 Clinical Nurse Advisor for Regional Forensics, and CADS (AOD Services). I have an ongoing role oversight of Auckland Forensic Psychiatric Services DAO competency. I completed my Masters in Philosophy in 2013 from AUT, this was grounded theory on the provision of mental health care in primary health. I completed my Post graduate diploma in Health Sciences — Auckland University. Other areas of education and expertise include: Professional supervision, Quality Health Surveyor, Portfolio assessor, WDHB Coach, was previously in a role as the Undergraduate Coordinator of Mental health papers at Auckland University School of nursing.

The initial briefing from the health commissioner asked key questions that required specific answers based on the information supplied for the review.

The information provided for the review was:

- clinical notes
- service reviews
- policies — associated to the time range of the incident in 2016.

I have had opportunity to review the comments made by [the GM of the CMHS] and will now respond to this.

The incident occurred 5–6 years ago, and as an independent reviewer I acknowledge that practice and service delivery processes may have evolved.

The review did indeed take into account the service delivery model of peer support service as an alternative to a hospital setting, that offers peer support engaging in practices of partnership, recovery coaching and crisis prevention within the context of a homelike setting, and with limited restrictive practices.

The areas I was initially asked to respond to were:

a. The appropriateness of the decision to introduce hourly checks, after she expressed suicidal thoughts on [Day 14]

b. and whether this plan was adequately adhered to by nursing staff

The response letter by [the CMHS] [GM] set out a definition of the wellbeing checks, pg 2, "wellbeing checks on people we support at [the CMHS] were provided as general checks for security and standard wellbeing checks for guests". This is also my understanding and premise when reviewing the documents. Additionally, any checks would be recorded in the notes for the purpose of supporting the process of accountability around security and physical wellbeing, and any other cares that arose when checking.

A further review of documentation from [the CMHS] and DHB, regarding the decision to introduce wellbeing hourly checks indicates it was instigated by the clinical team in consultation with [Ms A], and [CMHS] staff on [Day 14] in the pm. Reference DHB clinical notes (page 14 of 19) and [CMHS] notes (page 21 and 72 of 111). [Ms A] had a therapeutic rapport with the [CMHS] team, who could engage her in effective coping strategies. I still support my initial impression that to have placed her in an inpatient setting at this point, would have been potentially counter therapeutic. The decision to keep her at [the CMHS] is in keeping with usual standard of practice.

When attempting to review if [CMHS] staff did follow the plan, my initial review indicated this was not clearly documented. However when reviewing the two sets of notes for [Days 14–15] (overnight) in two different parts of the 111 page document, it appears there was a problem with the website reducing the ability to document the hourly checks in the [CMHS] notes. This was recorded by [the CMHS] named staff member on pg 21, however, page 72 it is not clear which staff member documented this, as the name was not easily identified in the notes. Both sets of notes indicated the website issue was from 1530–2030. This suggests that the situation was an exception not the rule in respect to usual practice of documenting hourly wellbeing checks as requested by the clinical team. Therefore, wellbeing checks for [Day 14 to Day 15], overnight were recorded hourly from 2130 onwards once the website issue was resolved.

The variation in the way in which the wellbeing checks are captured across all the documentation reviewed, is still in keeping with my initial review. There were occasions

in the notes where the recording for [Ms A's] wellbeing checks was not always recorded regularly. In recognition of [the CMHS GM's] suggestion an observation chart is not in keeping with the service, my opinion is that whatever the form the recording takes — it must be completed in a manner that is regular and aligned to the agreed documented request, by the clinical team, on the clinical referrer's entry form. The partnership model between the DHB and peer support is reliant on shared information between the clinical team and the peer support team to undertake safe planning of care. Information from the wellbeing checks could be important in client reviews and may guide future clinical pathways i.e. planned discharge date/s or a longer negotiated stay.

Serious Incident Review Process, dated [2016]. [Reference number]. Paragraph 1 on page 6. This was indeed a [CMHS] review as indicated by [the CMHS GM]. The assumption made was it was a joint DHB and [CMHS] review based on the attendees list, where the CD was involved. The documented phrase was "these checks were not documented in the record base regularly and not always completed for [Ms A]". My interpretation of this review comment is that it isn't consistent nor is it a robust way of record keeping. The issue of regular, consistent documentation of welfare checks was also addressed in the [CMHS] team discussion in the same review — "challenges discussed with documenting this information in a timely way without disruption to programmes and supports during the day".

It would seem that the solution to consistent practices around wellbeing checks in this review was to look at mobile devices which could assist with regular and timely documentation of wellbeing checks. From the response letter by [the CMHS GM], it appears this action has been implemented.

In addition to the implementation of mobile devices, it was notable in the response letter to be informed of the changes to the respite and alternative service process. This indeed is a step towards clear communication between clinical DHB team and PPS on expectations and standard of practice around wellbeing checks. From the timeline it appears that in 2017, reference to hourly wellbeing checks and how they are practised were included in changes; then in 2018 the entry checklist was changed to include a section to consult with the clinical team around wellbeing checks. In 2018 there was a national approach implemented by [the CMHS] to a minimum of hourly wellbeing checks, with a welcome form advising the person receiving the service of the checks. These quality improvement changes are examples of enhancing safe practice and accountability for all stake holders.

The final paragraph of expert nursing advice or reference to delegated duties, I'm not sure what is meant here however, I will outline my understanding that would have underpinned my review.

I do understand the collaborative agreements between a DHB and [the CMHS] or any NGO, is built on shared understandings of model of care, and the subsequent service delivery model and workforce aligned to this. The Peer support facility [the CMHS] has RNs and PPS who are an unregistered workforce on site. The NZ Nursing Council

direction and delegation guidelines only relate to health care assistants and enrolled nurses. The nursing council competencies for nurses, domain one, Professional Responsibility — 1.3 references accountability for directing, monitoring and evaluating nursing care provided by ENs and others. The others could be loosely applied to the peer support facility. These competencies are easily incorporated into secondary health settings, but harder to align to NGOs such as [the CMHS] where a RN is not necessarily leading the care on site, but rather a partner in care, with the peer support worker, and client.

In conclusion, it was pleasing to note the response letter outlined that the internal review by [the CMHS] and the DHB joint review/s, have given opportunity to share the learnings with [CMHS] staff and nationally across [the CMHS].

Yours Sincerely

Carole Schneebeli
Associate Director of Nursing, Regional Forensic and CADS services WDHB.'

Appendix C: Serious Incident Review Process (SIRP) Report

CMDHB completed a SIRP Report in 2016.

The section on incidental findings states:

> 'Incidental Finding 1
>
> There was no single shared care plan which identified the actions required and the person responsible for all staff including respite providers.
>
> Incidental Finding 2
>
> Feedback from [the CMHS] was that some of the peer support staff were not comfortable, nor confident in, supporting or caring for service users with Emotional Dysregulation Disorder and alcohol abuse issues.'

The SIRP made the following recommendations in relation to the above findings:

> 'Incidental Finding 1
>
> A single coordinated care plan is being developed by Regional MHS.
>
> Incidental Finding 2
>
> Acute Community Services will organise collaborative training with [CMHS] staff to improve the skills and knowledge in the joint management of service users with Emotional Dysregulation Disorder and alcohol abuse issues.'

Appendix D: High and extreme risk event and action plan

The CMHS completed a high and extreme risk event and action plan that identified the following issues and actions:

> '7 **Alcohol use**
>
> Referral information indicates [Ms A] was experiencing withdrawal from alcohol. Entry meeting indicates that no monitoring related to alcohol was required by [the CMHS]. No further information or support plans were provided to [CMHS] staff by the clinical team. No alerts were in place that [Ms A] was withdrawing from alcohol, how to respond if [Ms A] did choose to consume alcohol, or how to support [Ms A] to cope without alcohol.
>
> Establish if staff had asked the clinical team if there were any physical effects for [Ms A] relating to alcohol withdrawal.
>
> Establish if staff understood how to respond to and support [Ms A] if she consumed alcohol. Provide AOD training for all staff (planned for December).
>
> Consider adding information to respite checklist about drug and alcohol use or withdrawal and whether any support planning is required. Request [CMHS} review this as an improvement suggestion.
>
> **8. Wellbeing checks**
>
> [Ms A] and clinical team had requested PSS provide hourly well-being checks. These checks were not documented in recordbase regularly and not always completed for [Ms A].
>
> Understand how team at [the CMHS] ensure well-being checks are completed and documented. Recommend refresher for team on importance of documenting well-being check information in [the electronic client management system].
>
> …
>
> **10. Exit planning**
> [Ms A] was due for exit from the service and was worried about leaving [the CMHS]. Had PSS staff reviewed [Ms A's] goals of stay and effectiveness of the support provided? What did the PSS staff do to explore how to support safe options for [Ms A] and place to go to following her stay at [the CMHS]?
>
> Review how we can better advocate for guests who have anxieties or concerns about leaving the service and develop support plans to address these concerns.
>
> …
>
> **11. Use of alcohol whilst on leave**
> Response to [Ms A] going out and consuming alcohol appeared to be primarily rule driven by PSS. What did PSS do to understand why [Ms A] had gone out and why she had chosen to use alcohol?

Explore with staff at interview other approaches that they might have used to explore this behaviour with [Ms A].] Evaluate if further CEP training would be helpful.

…

Communication

…

The initial risk assessment provided by the admitting clinical team was out of date and written for another environment and should not have been accepted by [the CMHS] team on entry as adequate. The panel noted that despite these problems that the [CMHS] team did have a good understanding of the known clinical risks affecting [Ms A] during her stay as a guest and how to respond to them. This was not viewed as contributory.'

Appendix E: Policy — Risk Assessment and Management in Mental Health Services

The policy provides:

> 'All Service Users will have risk and safety concerns identified and documented on entry to services. A risk assessment will be undertaken as part of the initial comprehensive assessment. Following that the identified risks will be added to the Regional History Form in HCC. This will include the identification of Patterns of Risk Behaviour and enable clinicians to work with Service users and their partners in care to develop plans to minimise risk behaviours. Historical risk can be viewed in any previously completed Risk Assessment and Management plans.
>
> …
>
> Critical Risk Assessment Events:
>
> Risk assessment is an integral part of every clinical observation or assessment by all mental health staff, and is an ongoing process. Routine and regular review to occur at least three monthly.
>
> Risk and safety needs to be comprehensively assessed and summarised to enable a management plan to be reviewed to incorporate findings of the assessment.
>
> Assessment and review of Risk needs to occur when there is:
>
> On entry to services at Initial Assessment.
>
> On Admission to an inpatient unit or respite service.
>
> Change in level of observation.
>
> Change in treatment setting or transfer of care.
>
> Significant change in mental state or presentation causing concern.
>
> After a serious incident or event.
>
> During any crisis period.
>
> Significant situational changes that are likely to impact.'

Appendix F: Partnership Guidelines

- 3.5: Entry: Entry to [the CMHS] is through CMDHB acute community team, including Home Based Treatment Team (HBT). A collaborative discussion will occur between the community acute clinicians, [CMHS] staff and the person concerned about the ability for that person to have their acute needs met safely within [the CMHS].
- 4.0: Working in collaboration: Working alongside each other and the guest, the clinical and peer support services are responsible for meeting the clinical treatment and support needs of the person receiving services. Acute community team members and PSW staff will each be responsible for their specific aspects of service and will base their work on the aspirations and preferences of the person receiving services.
- 5.3 Responsibilities:

  [CMHS] Peer Support Workers: The PSW will be responsible for the care of the guests in the service, including recovery coaching, daily support, facilitating and completing the development of the [CMHS] Wellness Plans and the delivery of, and access to, appropriate programs delivered both within and outside of, the service. Communicating progress and issues with other partners involved in the guest's care.

  [CMHS] Registered Nurse: The [CMHS] RN will be responsible for monitoring the clinical well-being of guests using the service, assisting community acute clinicians with the implementation of the Clinical Goals for [the CMHS] Plan, administering medication, monitoring the effectiveness of medication and communicating with the acute community team and the PSW about urgent or crisis issues.

  CMDHB Provided Acute community team: Remain responsible for the guest's clinical care needs whilst in [the CMHS] and during post-[CMHS] care planning. They will monitor the clinical well-being of guests using the service by daily review and ensure that the Clinical Goals for [the CMHS] plan is implemented.

- 6.2 Information sharing: The guideline stipulates that there is an acknowledgement that the purpose of notes will differ between [the CMHS] and the clinical services and the clinical risk assessment will be stored within [the CMHS] electronic client record system — Record Base. Requests to access the clinical risk assessment are to be directed to the relevant DHB clinical service.

- 8.0 Exit: Decisions to exit require input and communication between the guest receiving services and the collaborative partners. Safeguards for the guest need to be in place prior to exit and responsibilities for these will be established during the daily review and planning meeting. Guests will exit services when:

  1. They no longer require the level of support provided by [the CMHS]; or
  2. They require more support than that provided by [the CMHS]; or
  3. They no longer wish to receive services and/or do not agree to stay in [the CMHS];

As a good practice principle the planning for the guest's exit occurs from the beginning of service delivery. This is intended so that even at point of entry staff are considering the requirements to safely and effectively support the guest when they leave [the CMHS]. The guest will leave [the CMHS] with an updated Wellness Plan that involves post-[the CMHS] care planning.

Acute community teams will manage the guest's exit from [the CMHS]. The reason for the guest's exit and their exit destination will be recorded by [CMHS] staff for the purpose of reporting to the CMDHB.