Crown Health Enterprise / Staff Nurse

Report on Opinion - Case 98HDC10973

Complaint

The Commissioner received a complaint on behalf of a consumer. The complaint is that:

- *The mental health services provided by a Crown Health Enterprise to the consumer from mid-June 1997 to the beginning of July 1997 were not of an appropriate standard.*
- *A particular Staff Nurse did not provide an appropriate assessment of the consumer's mental health needs during a home visit the day after his discharge from the Hospital.*

Investigation

The complaint was received on 12 January 1998 and an investigation was undertaken. Information was obtained from:

The Complainant / Consumer's father
The Crown Health Enterprise, Provider/Employing Authority
A Staff Nurse, Provider

Other information obtained and considered by the Commissioner included the consumer's medical records, a report on the internal investigation carried out by the Crown Health Enterprise, and a second report by an external advisor into the care provided to the consumer.

Outcome of Investigation

In early June 1997 the consumer's general practitioner referred him to Psychiatric Services at the Crown Health Enterprise/Public Hospital noting:

> "*Long-standing anxiety symptoms and displays some symptoms that perhaps fit with an obsessive compulsive disorder … He has been in a serious relationship now for some months and while things are going well with this he is obsessed that she may leave him for another man. No other man exists and despite assurances from his partner, he has developed major anxiety and dependency*".

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Outcome of Investigation, *continued*

The consumer was placed on the waiting list to see a psychologist and a letter was sent eight days later informing him about the long waiting list, that no firm date was set for the appointment and that he would be contacted in due course.

In mid-June 1997 the consumer's GP telephoned the Psychiatric Service and asked what was happening about the referral. After speaking with the on-call registrar, the consumer's GP decided to wait for the outpatient appointment. The GP was concerned about the consumer's potential for self-harm.

Four days after this discussion, the consumer was brought to the Mental Health Emergency Services by his father, who was worried by "[the consumer's] *stated intention to kill himself...*" He was seen and assessed by the staff nurse on duty, ("the first staff nurse") who noted the family history of male suicide and "*homicide/suicide*". She recorded "*no suicidal intent... more of an impulsive gesture related to out of control anxiety*". She also obtained an assurance of safety from the consumer and agreed to make contact via phone the next day or that he would present to Emergency Services if this was necessary.

A follow-up Assessment Proforma was completed (dated the same day) giving a full account of the interaction between the first staff nurse and the consumer and his father. This included the consumer's anxiety and agitation and his father's description of the "*absolute hell"* experienced by himself and his wife. The first staff nurse described *"no real rapport"* and "*no understanding as to why his father was so concerned".* She agreed to try to expedite the original referral made by the consumer's GP.

The following day the consumer's parents presented to the Emergency Services at 6.45pm alone as the consumer had driven off in an agitated manner due to his girlfriend requesting that he leave her house. The consumer's mother had then given him two Temazepam tablets and a Clonazepam tablet and he had slept until 2.30am. The Attendance Record recorded that the first staff nurse "*advised re Mental Health Act to go to Police re situation with car*". At 9.15pm the consumer's father rang the Emergency Services to say that they had located their son and would bring him to the hospital Accident and Emergency Department.

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Outcome of Investigation, *continued*

The consumer's father stated that, although the Mental Health Act option was discussed, it was *"never clear"* and that *"if it was put to me that committal was an option, I would not have hesitated…"* He also stated that as he and his wife were at the *"end of their tether"*, they were looking to others to take responsibility for decision making.

The first staff nurse stated that when she initially interviewed the family there were no notes, the old file being stored in the basement. After that day, based on the understanding that the consumer was to be admitted to an inpatient unit, she had sent the file to another ward. She stated that "*I took them through the Mental Health Act and how to apply*". She did not initiate committal herself, as she felt she could not do so on the basis of what she herself had seen. She was aware that the parents were at *"the end of their tether and that they wanted someone else to do it…"*

The next day at 1.45am the consumer presented to the Accident and Emergency Department following a possible overdose. He was referred to Mental Health Emergency Services and was seen by a second staff nurse who completed an Attendance Record. She noted the history of *"stalking girlfriend home after dark…"* and noted *"this young man is suspicious, manipulative and probably more unwell than he presents … manages to hold it together and presents well when interviewed…".* The second staff nurse organised an assessment in the morning at 10.00am, noting *"… would probably benefit from Day Hospital or somewhere (where) he can be observed more frequently".* It was agreed that the consumer would go home with his parents and return at 10.00am that day for a full psychiatric assessment.

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Outcome of Investigation, *continued*

That day at 10.00am the consumer was assessed by a Consultant Psychiatrist. The consumer's presenting complaint was that he wanted to kill himself. The history taken noted that his relationship with his girlfriend ended two weeks prior to presentation after which he experienced lowered mood, suicidal thoughts and reassurance seeking behaviour. Important findings were that the consumer had had no previous convictions for violence and denied past violence to partners. The Consultant Psychiatrist noted a *"flat depressed looking man, close to tears, difficult to engage, who said he wanted to go home and gave reassurances about his safety which does not* [sic] *sound convincing".* In the next paragraph of her notes, the Psychiatrist recorded positive vegetative features of a major depression and stated *"unable to give reassurance for safety".* The Psychiatrist's impression was that of a long-standing anxious obsessional, avoidant personality, currently depressed with risk of self-harm and *"harm to partner"*, and she queried the possibility of *"pathological jealousy".*

After discussing possible treatment options the consumer reluctantly agreed to admission on a voluntary basis. The Consultant Psychiatrist began preparations to admit him to inpatient care. At the time, as there were no available beds, the consumer and his father were asked to return at 2.00pm. The Psychiatrist spoke to a second Consultant Psychiatrist, on the understanding that the consumer would be admitted to a specified ward in the Public Hospital. In fact the consumer was admitted to a ward in a different Hospital in the early evening.

At 4.30pm the consumer presented to the Psychiatry Registrar. She noted his attendance at Mental Health Emergency Services and the first Consultant Psychiatrist's notes and opinion. She completed a physical examination and informed the Consultant to whom she was accountable of the admission.

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Outcome of Investigation, *continued*

The next day that Psychiatry Registrar and her Consultant interviewed the consumer jointly in the company of a registered nurse who worked in the ward where the consumer was admitted. A full history was taken and a diagnosis of *"reactive versus major depressive episode"* was queried, with the additional factor of *"anxiety and/or alcohol/cannabis" use, plus "personality traits of dependency and social sensitivity".* The possibility of the Ward Team supervising the consumer's case for a week was suggested, with subsequent transfer should a longer admission be required. An alternative was for the Ward Team to "keep an eye on things" for a week and then hand the care back to the consumer's GP.

The Psychiatry Registrar returned later to examine the consumer cognitively and noted *"lowish IQ some areas of cognitive deficit".* During that interview the consumer gave assurances that he would be safe, although the Registrar believed that these assurances were largely determined by his dislike of the ward. The treatment plan was to allow him to have unescorted walks during the day with consideration of discharge the following day after discussion with his family.

That morning the consumer's former girlfriend visited him to ensure that he understood that any future contact would be based on friendship only.

It was arranged that the consumer would leave that afternoon with his father and return to sleep in the ward. At 5.00pm the consumer's father called to say that the consumer would not return to the hospital. The Psychiatry Registrar spoke to the consumer on the phone and he assured her of his safety. The Registrar discussed the matter with her Consultant and both agreed that the consumer could remain at home, but return the following morning at 10.30am. The family was advised to contact Mental Health Emergency Services if they had problems. Emergency Services were notified and staff there agreed to ring the consumer in the morning.

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Outcome of Investigation, *continued*

The following day the consumer and his father presented at the ward as arranged and were interviewed by the Psychiatry Registrar and the Registered Nurse. It was agreed that the consumer would be discharged. His father was keen for a follow-up plan to be put into place. It was agreed that the ward would provide ongoing care until he could be placed with the Outpatients Department and that emergencies would be dealt with by Mental Health Emergency Services. An outpatient appointment was given for 2.30pm in two day's time at the ward. It was noted that the consumer was taking Prozac 20mg daily. The Psychiatry Registrar gave the consumer her pager number in case he wanted to speak to her.

The Psychiatry Registrar noted in her report that a further appointment was arranged for two days' time at 2.30pm in the ward. This was discussed later with the Consultant who suggested that Emergency Services be contacted about suitable community based counselling services. A discharge summary was written with copies being sent to Mental Health Emergency Services and the consumer's GP. The Psychiatry Registrar discussed the possibility of counselling the next day with the first staff nurse. A particular counsellor and clinic was mentioned. The Psychiatry Registrar telephoned that counsellor to discuss the case and the counsellor said he would be happy to see the consumer and his family.

The day after the consumer was discharged, his father telephoned Mental Health Emergency Services in a *"very distressed state"* concerned about his son's mental status and safety, stating that the consumer was suicidal. A third staff nurse (the nurse under investigation), received the call and contacted the ward where the consumer had stayed to gather more information, as the consumer's file was still at that ward. This Staff Nurse arranged to visit the house at 7.30pm that evening. Upon arrival at the consumer's house she was greeted by the consumer's mother at the gate. The consumer appeared and after the Staff Nurse entered the house the consumer's father vented his anger "at the system". The Staff Nurse heard the consumer and his mother talking in raised voices and noted that *"[the consumer] looked quite pre-occupied"* with (she thought) dilated pupils. The Staff Nurse was able to hold a brief conversation with the consumer, who made no threats against his former girlfriend.

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Outcome of Investigation, *continued*

The consumer assured the third Staff Nurse of his safety despite the fact that his father had found a paint scraper in his room and some tablets under the telephone book. The Staff Nurse concluded *"[the consumer] did not appear to be mentally disordered at the time of my seeing him ... there was a great deal of anxiety showing in his parents and obvious tension between [the consumer] and his parents. His parents gave the impression of being under a lot of pressure and had reached the point where they were at the end of their tether and could no longer cope".*

While the Staff Nurse was at the house the consumer left. The Nurse noted that the consumer had an appointment with the Psychiatry Registrar the following day which he told the Nurse he would keep, although he had told his father he would not be keeping that appointment. The Nurse then discussed the matter with the consumer's parents and stated that as he was 25 years old, he needed to make his own decisions. After making a phone call the Staff Nurse returned to Mental Health Emergency Services at 8.30pm.

In her written report, the third Staff Nurse stated that she *"went to the [consumer's family] house because of [his] safety, mainly his suicidal thoughts. After talking with [him], I didn't hold any fears for his safety".* Later that evening, the Psychiatry Registrar, who happened to be the on-call Registrar, came to Mental Health Emergency Services. They talked about the call-out.

The Psychiatry Registrar stated that she called in to Mental Health Emergency Services prior to going to bed at 10pm–11pm and overheard a conversation about the consumer. The Psychiatry Registrar confirmed that there had been no request for her to take any action and that she had felt uneasy about the situation. She felt that too many agencies were getting involved in the consumer's care.

Some time during that evening the consumer killed his former girlfriend and was subsequently found guilty of her murder.

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Code of Health and Disability Services Consumers' Rights

The following Rights of the Code of Health and Disability Services Consumers' Rights apply:

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Report on Opinion - Case 98HDC10973, continued

Opinion: No Breach, Crown Health Enterprise

Right 4(2)

In my opinion the Crown Health Enterprise did not breach Right 4(2) of the Code of Rights as follows:

After reviewing the investigations and reports of the internal and external advisors, and conducting my own investigation, in my opinion the care provided by the Mental Health Emergency Services at the Crown Health Enterprise met the appropriate standards required in the consumer's case.

While this case had tragic consequences, the providers involved in the consumer's care in the days leading up to his former girlfriend's death did not view him as a risk to others and were attempting to provide appropriate care in light of the mental health problems with which he had presented. The care provided by all clinical and nursing staff appears appropriate given the information they had available to them, and given the consumer's behaviour during their various meetings and assessments.

I believe it is particularly significant that while a number of providers, who were also Duly Authorised Officers, considered the possibility of committing the consumer under the Mental Health (Compulsory Assessment and Treatment) Act, none of the providers felt that they had grounds for the committal. These Duly Authorised Officers discussed the procedures for committal with the consumer's family.

I note that the doctor conducting the external investigation has stated that *"retrospective evaluation has obvious dangers. Tragedies such as this demand us to be highly critical of our decision making and of our service protocols"*. While the death of the consumer's former girlfriend was a tragedy, it is not my role to form an opinion based on the outcome, but rather to look at the particular events around the standard of service. In my opinion the care provided by the Crown Health Enterprise and its employees was not in breach of Right 4(2) of the Code of Rights.

I note that it has been said that the current services being provided to the consumer are significantly improved. However the facts support the conclusion that the Crown Health Enterprise met appropriate standards which were reasonable in the circumstances when first providing services to the consumer in June-July 1997. Care was provided over a number of days during which time the consumer was able to make choices about his care.

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Report on Opinion - Case 98HDC10973, continued

Opinion: Breach, Crown Health Enterprise

Right 4(5)

In my opinion the Crown Health Enterprise breached Right 4(5) of the Code of Rights.

From the outset, the delay in the consumer receiving an appointment following his GP's referral was unacceptable. The Psychiatric Service should have contacted the GP and explained the delay, in order that the consumer's situation could be reassessed.

There were a number of different agencies involved in the consumer's care, and the fact that changes in his care plan were often made without consultation either with other providers or with the family is concerning. Mental Health Emergency Services did not provide evidence of daily clinical meetings between nurses and medical staff. There were no protocols for communication and reporting between nurses and medical staff. While the nurses who staffed the Mental Health Emergency Services after hours were eminently qualified, communication and team meetings are critical from an accountability stand point and to ensure that patients are receiving the best possible care. Nurses must also know when and in what circumstances it is appropriate to refer a case to a medical practitioner.

In a case like the consumer's, where more than one agency is involved, it is important that copies of relevant medical notes and information are available. Management plans should be drawn up for the consumer and be available for all agencies. The situation should not arise, as it did here, where a nurse is required to phone around to find information on a patient requiring emergency help because the file is not available. This is particularly critical given that the only indications that the consumer might have behaved violently were in the notes taken by the first Consultant Psychiatrist, who identified a risk of self harm and harm to the consumer's partner. This information should have been available to all subsequent providers.

Mental Health Emergency Services also did not ensure that its casual employees, such as the third staff nurse, received a clear induction process. New employees, and casual employees, must fully understand where and in what circumstances they are to report to medical practitioners or seek assistance with patients.

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Report on Opinion - Case 98HDC10973, continued

Opinion: Breach, Crown Health Enterprise, ***continued***

In conclusion, while the care provided by various individuals to the consumer met with applicable standards, in my opinion the various agencies and providers within the Crown Health Enterprise did not co-operate sufficiently. This resulted in a breach of Right 4(5) which requires co-operation among providers to ensure quality and continuity of services.

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Crown Health Enterprise / Staff Nurse

Report on Opinion - Case 98HDC10973, continued

Opinion: No Breach, Third Staff Nurse

Right 4(2) and Right 4(5)

In my opinion the third Staff Nurse did not breach Right 4(2) and Right 4(5) of the Code of Rights.

When the third Staff Nurse visited the consumer's family home, she placed herself in a difficult and stressful situation where the family was upset, and where the consumer was largely unresponsive. In the brief time she had to speak with the consumer, the Staff Nurse formed the view that the consumer would not harm himself. In her response to the Commissioner's investigation officer, the Staff Nurse stated:

> *"I should add that at all times the concern regarding [the consumer] was that he would do harm to himself, rather than anyone else, with no indication at any time that he would do harm to any other person and certainly it was never suggested in any of the information given to me, or in my assessment of [the consumer], that he would do harm, or had ever done harm, to his former girlfriend".*

The Staff Nurse found no basis on which she could summon a Duly Authorised Officer with a view to having the consumer compulsorily treated, a view which was consistent with the other providers who saw him in the preceding weeks. She was paged by a colleague while at the family home. Given her assessment of the situation she did not see the need to seek further assistance. She completed an Attendance Record as required and discussed the matter with the Psychiatry Registrar.

In my view, the Staff Nurse completed her job in accordance with the procedures she was used to, and had no cause for alarm. As noted above, the Crown Health Enterprise needs to have protocols in place to assist employees such as this nurse to know when communication is required. However nothing in my investigation has indicated that had these protocols been in place this nurse would have consulted further with other providers.

In my opinion this Staff Nurse provided an appropriate standard of care to the consumer and co-operated as necessary with other providers involved in his care.

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Report on Opinion - Case 98HDC10973, continued

Actions

I recommend that the Crown Health Enterprise implement the recommendations made in the reports of both the internal and external investigations, summarised as follows:

Internal Report:

- *Referrals from doctors outside the Mental Health Emergency Services for a psychiatric opinion* [are to] *be allocated, as soon as possible after receipt, by a designated medical member of each team, to a named doctor's out-patient clinic for an appointment within three weeks.*

- *Patients referred to Mental Health Emergency Services who are not already under the care of one of the four GST catchment area teams, and who are thought, after initial assessment, to require on-going care,* [are to] *be referred to the appropriate team on the day of presentation at Mental Health Emergency Services.*

- *All ward admissions, discharge plans and follow-up should be determined by members of the relevant multidisciplinary catchment area care team. These teams should include clinical staff working on the wards.*

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Report on Opinion - Case 98HDC10973, continued

Actions, *continued*

External Report:

- *That upon receipt of a referral, telephone contact should be made with the referrer to determine the acuity and extent of the problem and that further assessment should be made within 3 weeks by a member of the multidisciplinary team who will then triage the case according to need.*

- *That all assessments must make a statement as to not only risk to self but risk to others.*

- *Any change in a patient's management plan between consultants should occur in consultation and agreement between them.*

- *That consideration be given to clinical meetings between staff nurses and medical staff on <u>every</u> day of the week and that protocols governing communication and decision making between staff nurses and doctors be agreed upon.*

- *That service induction protocols and procedures be instituted to ensure that new staff fully understand the system.*

- *That when multi agency care is inevitable, a summary of clinical issues and a management plan* [is to] *be available to all parties.*

- *That emphasis be given (in training) to consider both the current mental status and collateral information in making an assessment.*

- *That all clinicians should be acquainted with the "Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992", published by Mental Health Services, Ministry of Health, June 1997.*

- *Consideration* [is to be] *given to protocols to refer or to recommend parents to (patient) advocates, who may be of assistance in times of high stress and who might take the initiative in committal application.*

- *That consideration be given to a policy of "assertive follow-up" of such patients under treatment.*

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Crown Health Enterprise / Staff Nurse

Report on Opinion - Case 98HDC10973, continued

Actions, ***continued***

I further recommend that the Crown Health Enterprise takes the following actions:

- Apologises in writing to the consumer and his family for breaching Right 4(5) of the Code of Rights.
- Focuses on the improvement of protocols for inter-agency communication. It is critical that the Crown Health Enterprise improve the provision of information among agencies where a mental health patient may be seen by a number of providers.
- Reviews its Mental Health Emergency Services internal procedures to allow for daily meetings between nursing and medical staff.
- Puts in place clear and comprehensive protocols for situations in which nurses are to consult with a medical practitioner for further assistance.