Psychiatric clinic did not ensure quality and continuity of services

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The Deputy Health and Disability Commissioner has found Ashburn Hall Charitable Trust in breach of the Code of Health and Disability Services Consumers' Rights (the Code).

Dr Vanessa Caldwell found the clinic in breach of Right 4(5) – the right to services of an appropriate standard. The breach involves the consumers' right to co-operation among providers to ensure quality and continuity of services.

The complaint involves a young woman discharged from Ashburn Hall where she had been treated for over two years. Prior to her transition to her community, the clinic contacted the mental health contact centre at the district health board (DHB, now Te Whatu Ora) regarding a referral for ongoing follow-up.

The woman was discharged from the clinic and her care was transferred to Te Whatu Ora. However, in the weeks following her discharge, the woman failed to receive the support she expected and needed.

Dr Caldwell considered that, "The inadequate discharge planning and handover meant there was a lack of clarity around the woman's needs and expectations at a time of increased vulnerability".

"The clinic had the most in-depth and recent information on the consumer and should have taken more responsibility in her transfer to Te Whatu Ora to ensure quality and continuity of services," she said.

Dr Caldwell was also critical of Te Whatu Ora's management of the referral, as well the as lack of assessment provided at certain times. However, these did not amount to a breach of the Code.

Dr Caldwell made a number of recommendations including:

- For written apologies to be provided to the consumer by both the clinic and Te Whatu Ora.
- For the clinic to consider ways to engage all accepting services and consumer and family/supports in a pre-discharge teleconference to discuss medication and identify strengths and whānau/community supports, risks and early warning signs, coping strategies, patient expectations, and long-term goals.
- For the clinic to ensure that a complete discharge summary is available at the time of, or prior to, discharge, detailing what has been agreed in the pre-discharge meeting, including the specifics of community management and available supports.
- For the clinic and Te Whatu Ora to consider holding a post-discharge review meeting with the consumer, whānau, the referring team and all receiving services to improve communication and coordination of services.

- For Te Whatu Ora to ensure that that service-wide care plans include other relevant services, including the Emergency Department, and are available to both the contact centre and the Emergency Department.

Following this complaint, both the clinic and Te Whatu Ora have made changes to improve their service.

13 February 2023