District Health Board

Registered Nurse, RN B

A Report by the

Mental Health Commissioner

(Case 18HDC00078)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the mental health care provided to a woman by a district health board (DHB) and a registered nurse in 2017. The woman's GP telephoned the DHB and spoke to the nurse asking for an urgent assessment owing to the woman's depression and suicidality, but assessment was delayed and she died by suicide before an assessment was carried out. This report highlights the importance of having adequate processes in place for triaging and managing mental health referrals, and carrying out prompt clinical/risk assessment and quality handover of care.

Findings

2. The Mental Health Commissioner found that the DHB failed to provide a reasonable standard of care and breached Right 4(1) of the Code. He was critical that the DHB had seriously inadequate systems and processes in place at the time of the woman's referral, in particular that there was no formal process for triaging referrals, and e-referrals were managed by administrators, without review by a clinician for up to 24 hours. Clinicians were also unable to access patient medical records easily, and they had to manage crisis calls as well as their usual caseload.

3. The Mental Health Commissioner made adverse comment about the nurse and his management of the referral, which affected the timeliness of assessment provided. The nurse failed to ensure that the woman received same-day clinical/risk assessment, and his handover to a colleague did not convey that the seriousness of the referral required urgent follow-up. In addition, the nurse did not document his telephone call with the GP on the day.

Recommendations

4. The Mental Health Commissioner recommended that the DHB update HDC on its newly developed mental health crisis service manual, and conduct an audit of the current process for the management of incoming mental health referrals, to ensure that the changes made have been effective. The Mental Health Commissioner also recommended that the DHB and the nurse each provide a written apology to the family.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint about the services provided to Mrs A by the District Health Board. The following issues were identified for investigation:

- *Whether the DHB provided Mrs A with an appropriate standard of care in 2017.*
- *Whether RN B provided Mrs A with an appropriate standard of care in 2017.*

6. This report is the opinion of the Mental Health Commissioner, Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

7. The parties directly involved in the investigation were:

RN B	Provider/registered nurse
District health board	Provider

8. Further information was received from:

Dr C	General practitioner (GP)
RN D	Provider/registered nurse

9. Independent expert advice was obtained from a mental health nurse, Dr Anthony O'Brien (Appendix A).

Information gathered during investigation

Introduction

10. Mrs A had a history of depression, post-traumatic stress disorder, and significant mental health issues. She had previously received compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) at the DHB.

11. On Day 1,[1] Mrs A, aged in her thirties at the time of events, was referred by her GP, Dr C, to the DHB's Mental Health Service for assessment, owing to her depression and suicidality. It was determined that Mrs A would be reviewed the following morning but, sadly, Mrs A died by suicide[2] before any assessment was carried out.

12. This report discusses the management of Mrs A's referral by the DHB's Mental Health Service in relation to the adequacy of assessment, handover of care, and documentation.

The DHB

13. The DHB operates an Adult Community Mental Health Service (MHS), located in the public hospital. At the time of these events, during the working day a roster showed who was on duty to take all incoming crisis referrals at MHS, and there was also a back-up duty person on call. Acute/crisis referrals were triaged, and the subsequent intervention provided was dependent on that assessment. MHS also had a crisis respite service that supported individuals who were of low-to-moderate risk and needed more intensive support to maintain their wellness.

[1] Relevant dates are referred to as Days 1–2 to protect privacy.
[2] The Coroner determined that Mrs A died by suicide sometime between about 10pm on Day 1 and 3am the next day.

14. The DHB stated that a patient's history could be accessed by MHS, which held paper files on site. It noted, however, that although the paper files were accessible during the intake process, they were not immediately available for telephone crisis triage calls. At the time, MHS clinicians could not access patient history electronically.

15. New MHS referrals were discussed at intake meetings and then allocated to individual clinicians. The DHB stated that MHS intake meetings occurred first thing in the morning every day, with the exception of Thursdays, when they occurred around 10.30–11am after the multidisciplinary meeting.

16. At the time of Mrs A's care, MHS e-referrals were monitored by administrative staff, and clinicians did not have electronic access to e-referrals.

Day 1

GP consultation

17. At about 11.30am, Mrs A attended a consultation with Dr C, supported by a friend. Dr C documented:

> "Her mood has become lower she no longer enjoys things weepy and low most of the time. She spends most of the day in bed does not really sleep and sleeps poorly at night. She uses alcohol and gets drunk most nights a week to cope. She has not been eating and had lost weight … [Mrs A] does have suicidal ideation … She does not feel as though this is a likelihood [as] she would not want [to] hurt her [son or her husband]."

18. In relation to his assessment and plan from that consultation, Dr C told HDC:

> "I considered [Mrs A] needed the input of specialist Mental Health Services. [Mrs A] was distressed by the discussion as she had been treated under a compulsory treatment order (Mental Health Act) … in the past, and was very fearful of this happening again. Nevertheless, on further discussion with her she agreed that I could refer her to the Crisis Team at the Mental Health Unit."

Telephone referral to MHS

19. At approximately 11.45am, Dr C telephoned the DHB and spoke to duty clinician RN B.

20. Dr C told HDC that Mrs A and her support person were still in the consultation room when the call took place. RN B told HDC that on that day he was taking telephone calls and managing crisis work in addition to his caseload.

21. RN B and Dr C have different recollections of their telephone call.

22. Dr C told HDC that he requested that Mrs A be seen urgently the same day owing to his concerns, which included Mrs A's suicidality, but was advised that Mrs A could not be seen that day "unless she was admitted under the MHA". Dr C documented the telephone discussion contemporaneously as follows:

> "Spoke to [RN B] from the crisis team who advised them they could not see [Mrs A] today and [that] she … needed to be admitted. To do an urgent referral and … get her to be seen to make contact and see her tomorrow."

23. Dr C also told HDC that as the plan was for Mrs A's friend to provide her with food that night, and for Mrs A's husband to be home with her later that day, and because Mrs A had said that she would not want to "put her family through a suicide", he felt "somewhat reassured that she would be okay until she was seen the following day". Dr C further stated that Mrs A, her husband, and her friend all had his telephone number in case they needed to contact him.

24. RN B's retrospective documentation of the discussion at approximately 9.30am[3] on Day 2 noted:

> "Phone call from [Dr C] has concerns [Mrs A] is voicing suicidal ideation. History of [alcohol and drug] issues. I explained currently have someone under [Mental Health] Act awaiting transfer to hospital. Would not be able to [be] seen till later in day. He felt she was not imminently at risk as she had good supports around her. He did feel … she would need assessment by adult team. Suggested he do a referral which would be picked up tomorrow. He agreed that would be appropriate."

25. In response to my provisional opinion, RN B stated:

> "The management of [the patient under the MHA awaiting transfer to hospital] was particularly difficult. A psychiatrist was not available on site as would usually be the case … Not having a psychiatrist available increases the pressure when dealing with a particularly unwell client. My colleague who had been handling the duty telephone that day, given my responsibilities with the MHA client, had not had a break that morning (neither had I) so I briefly left the MHA patient in the Respite Unit with support staff to relieve her so she could take a break. Having to leave a patient so unwell with support staff is not ideal and contributed to the pressure I felt at the time. This was when I took the telephone call from [Dr C]. … By the time I took the telephone call I was feeling overwhelmed and my focus was still on my other patient who needed to be transported to hospital imminently …"

26. As noted above, Dr C documented his understanding that Mrs A could not be seen that day unless she was admitted under the MHA. Dr C told HDC that he did not believe that admission under the MHA was appropriate, owing to the "traumatic nature of [Mrs A's] past compulsory treatment", and, because there was a plan in place to supervise Mrs A, he felt somewhat reassured that she would be safe until the following day.

27. RN B told HDC that he did not say that Mrs A could not be seen that day unless she was admitted under the MHA, and that he did not decline an assessment. He noted: "It is not

[3] The DHB's serious adverse event review noted that Dr C telephoned the MHS at approximately 9am on Day 2 to say that Mrs A was deceased. RN B told HDC that he made his retrospective note within half an hour of the DHB becoming aware of Mrs A's death.

my role to decide who is admitted … Further, patients need to be seen before it is decided whether the Mental Health Act is necessary." RN B said that he asked Dr C if Mrs A needed to be seen immediately, and as Dr C advised him that she was not in imminent danger and had sufficient protective factors in place, he suggested that Dr C make an e-referral and mark it urgent for consideration the next day.

28. In relation to clinical interactions prior to these events, RN B told HDC that previously he had worked with Dr C on numerous occasions in a range of settings. RN B stated:

> "I valued [Dr C's] skills and knowledge as a health professional. I asked for and accepted his view of the immediacy of risk as I was with another client at the time. Had [Dr C] expressed that he would like [Mrs A] to be seen immediately, that would have been facilitated."

29. However, subsequently RN B told HDC that Mrs A could not be seen immediately, but that she could be seen later in the day, "anticipating a colleague would do an assessment later".

30. RN B also told HDC that at that time, administrative staff managed the referrals, and he was aware that marking a referral as urgent would ensure that it went before one of the duty clinicians. He said that although the process was that administrative staff would monitor e-referrals, it was his experience that "for referrals marked 'urgent', the administrators would usually show the referral to one of the clinicians (usually the duty clinicians) soon after receiving it". RN B stated that he anticipated that when the "urgent" referral was received, it would be placed before the Clinical Nurse Manager, RN D, or another clinician. The DHB also stated that at that time an administrator would have presented any e-referral clearly marked "urgent" to a duty clinician, who would have then informed the administrator if it needed to be put back in the referral tray for the following morning, or if it needed to be actioned that day.

31. It appears that RN B did not inform Dr C of his belief that marking the e-referral "urgent" would mean that a clinician would likely review the e-referral on the same day, and that Dr C understood that Mrs A's e-referral would be reviewed the next morning even if marked urgent.

32. RN B's documentation on Day 2 does not indicate what risk assessment he conducted during the telephone call, nor what enquiry he made about Mrs A's mental health history.

33. Dr C's subsequent e-referral to MHS for Mrs A to receive an urgent assessment is discussed later in this report.[4]

Handover of care

34. RN B told HDC that immediately following his telephone discussion with Dr C, he was required to transport a different patient who was under the MHA to another hospital. RN

[4] See "E-referral" below at paragraph 42.

B stated that there was additional pressure to complete transfers to hospital within designated working hours.

35. In relation to the management of Mrs A's referral, RN B further stated:

> "Prior to leaving [the town], I gave a verbal handover of the phone call with [Dr C] to the Clinical Nurse Manager. I advised … that I had a phonecall from [Dr C], that he had a patient voicing suicidal ideation, that we had discussed whether he felt there was imminent risk, that [Dr C] did not think she was at imminent risk and she had a friend supporting her. I said that we had agreed that an e-referral would be sent which [Dr C] would do. I gave the duty phone to the Clinical Nurse Manager and left to transfer the client. I arrived back in [the town] at approximately 1715 hours and I forgot I had not documented the phone call earlier in the day from [Dr C] …"

36. RN D told HDC that he received a telephone call from RN B prior to midday. RN D said that RN B told him that he had had a discussion with Dr C, who wished to make a referral for Mrs A. RN D stated that at that time he did not know Mrs A, and had never provided her with care.

37. In relation to his discussion with RN B, RN D told HDC:

> "[RN B] described the difficulties he was experiencing during his discussion with [Dr C] and then went into some detail about how he felt it was difficult communicating with [Dr C], who had misinterpreted his initial explanation regarding why he could not assess [Mrs A] straight away, as he was currently involved in an ongoing Mental Health Act process he was undertaking with another patient."

38. RN D stated that RN B then gave a narrative description of Dr C's concerns about Mrs A, the protective factors that Dr C felt were present in Mrs A's case, and that Dr C had agreed that he would forward a referral to MHS for assessment within 24 hours.

39. RN D said that at no time did RN B provide his assessment, or recommendation for triage or follow-up, and stated only the plan agreed with Dr C. RN D said that as it was neither stated nor implied that the referral was being handed over to him, or that any follow-up was required, he did not take any further action.

40. RN B acknowledged that he did not specifically ask RN D to provide further follow-up. RN B stated: "Had [RN D] considered that an assessment ought to be undertaken that day, he could have undertaken that assessment himself or delegated it to another staff member." RN D told HDC that if an immediate assessment had been required, either he or another clinician could have made themselves available.

41. The DHB stated that no handover information about any "pending clients of concern" was provided to the after-hours duty staff.

E-referral

42. At 12.20pm on Day 1, the Mental Health Service received an e-referral from Dr C. Under the "Referral/provisional diagnosis" section of the form, Dr C stated:

> "Please see occasionally has[5] discussed with [RN B] and daily within 24 hours place major depressive illness with suicidality alcohol use to cope and reduced nutritional status. H[a]s support from a good friend … and [her husband] who however works long hours with his business. [Mrs A] is a past history in a teenage years of being major depression and suicidality and was committed under the mental health act. She is extremely fearful of this happening again. [sic]"

43. Dr C also copied his consultation note into the referral form in the "Relevant history & physical examination findings" section, which included details of his concerns. The referral was not marked "urgent".

44. The DHB stated that the e-referral was printed and placed in the administration office tray ready for the next day's intake meeting.

45. As per the DHB's procedures at the time for management of e-referrals, Mrs A's e-referral was allocated to administrative staff to review, and not seen by a clinician. The DHB did not have a formal process for managing the allocation of tasks involving competing acute demands, nor clinical oversight of e-referrals, for periods of up to 24 hours.

46. Early the next day, Dr C learned that Mrs A had died by suicide. At about 9am, Dr C telephoned the MHS and informed it of Mrs A's death.

Further information

The DHB and Serious Adverse Event Review (SAER) report

47. The DHB told HDC that at the time of these events there was no standardised process for triaging incoming referrals. In relation to the telephone referral and RN B's crisis assessment, the DHB's SAER report found:

> "[T]here was no documentation in relation to this call by [RN B] nor was there an adequate triage assessment. This is not aligned to the required standards for the Service."

48. The SAER report noted:

> "The importance of completing a full risk assessment is important, as it is the basis for a formulation of the plan. The review team questioned whether the risk assessment on [Day 1] was sufficient to make a robust clinical decision. One of the key areas is that there was no clinical documentation, which made it problematic to ascertain the

[5] In his response to HDC, Dr C provided the referral form with an additional handwritten correction; he inserted "urgently as" where he had erroneously written "occasionally has". Dr C told HDC that the notes were created using speech-to-text software.

rationale for the clinical decision on [Day 1]. In, of itself, not having any clinical documentation is of concern."

49. The report further stated:

"It is also unclear why there were no other alternatives explored to assist [Mrs A]. Options may have included:

- A review by Duty Person 2.[6]
- A review by the evening shift.
- A discussion with the CNM [RN D] about alternative options for other team members to see [Mrs A].
- A review offered for later in the day."

50. In response to my provisional opinion regarding the options not explored by RN B, the DHB reiterated RN B's recollection that he had been advised that Mrs A was not imminently at risk and had sufficient protective factors in place to wait for a next-day assessment.

51. The SAER report also noted:

"[Patients] referred by a General Practitioner, and declined, could in theory walk into [MHS] and be seen, or at least triaged. In this particular event, [Mrs A] could have chosen to walk over to [MHS]. The duty person would have undertaken a triage assessment … However, this matter turns on the fact that a full triage assessment did not occur during the referral process, and therefore no plan of intervention was undertaken."

52. The DHB stated that there were competing demands on RN B on Day 1, which it believes could have influenced why there was no apparent full clinical assessment and subsequent documentation. The SAER report found that the lack of systems and process in place to manage competing demands did not enable or support an adequate response to the crisis call. In addition, the report noted that MHS staff had "significant concerns about how the clinical governance processes operated in the team, and that there was not a safe environment to have robust clinical discussions". The DHB submitted that the management of Mrs A's referral should be considered in the context of the range of significant systemic issues identified by the SAER.

53. In relation to intake meetings for referrals to MHS, the DHB's SAER report found:

"There is no system and process for what occurs in the daily intake meetings … The review team heard that there is a lack of robust clinical discussion during these meetings and that this discussion is not encouraged. This they say significantly compromises the ability to adequately address risks for clients."

[6] A second clinician on duty alongside RN B, allocated to receive incoming crisis calls on Day 1.

54. The DHB told HDC that it is an active participant in the Health Quality & Safety Commission's mental health programme, which helps clinicians to apply current best practice.

RN B

55. In response to my provisional opinion, RN B told HDC:

> "In 2017 the expectation [was] that those on duty would handle all the duty work to allow other staff members to carry on with their core work … It was in this context that I felt an expectation to manage all of the duty work myself and did not make alternative arrangements for someone else to undertake the assessment when I could not."

56. RN B stated that as he is a mental health nurse with considerable years of experience, it is unlikely that he would have said to Dr C that Mrs A could not be seen unless she was admitted under the MHA, because that is "clearly incorrect in law and mental health practice".

57. RN B further stated:

> "There are references [in the patient's mental health history and national event summaries] to [previous attempts at suicide by Mrs A]. I would like to clarify that [Mrs A's] historical clinical files would not have been easily accessible by a clinician and that clinical staff including myself did not have access to that system which recorded national event summaries. Both these pieces of information were not immediately available to use as part of a triage for an acute or urgent situation."

58. In relation to factors that he believes contributed to this incident, RN B told HDC:

> "I believe I had insufficient orientation to the role of crisis/duty work. I was not offered any training in triage and service documentation at that time was inadequate. There was no document to guide an intake/triage assessment and even if the crisis contact sheet had been completed it would not have met the standards I am now aware of since undertaking training. This has changed since the review of the service. I believe the inadequate systems and processes and an absence of clinical leadership at that time were significant contributing factors to the care that was offered on this occasion and these are acknowledged in both the serious event review and the service review completed in 2018."

59. RN B told HDC that although he believes that at the time of these events, "crisis assessment in [the MHS] did not meet expected standards", he accepts that overall, the discussion of risk during his telephone call with Dr C was inadequate, and that Mrs A should at least have been offered either a prompt face-to-face assessment or a telephone assessment. RN B noted, however, that his discussion with Dr C regarding the immediacy with which Mrs A needed to be seen "contained consideration of risk and protective factors".

Dr C

60. Dr C told HDC:

> "Since [Mrs A's] death, we have discussed the scenario at length in our peer review group … In similar situations, we agreed that we would speak directly to the consultant on call and bypass the Crisis Team. This isn't general practice but the concern is that when we call the acute Mental Health line … we are placed in a queue system and have to wait to speak to an on call psychiatrist. It was decided that in certain situations we will call the consultant directly, to ensure patient safety at all times."

Other changes made since these events

The DHB

61. The DHB stated that changes it has implemented since these events include the following:

- Administrators no longer assess incoming referrals. A triage/crisis clinical role has been developed for the management of incoming referrals and triage assessments.
- Triage clinicians are able to focus solely on crisis referrals and not day-to-day case load management. All triage clinicians have completed "Mental Health Telephone Triage Competency Assessment Tool" (MHTT-CAT) training.[7]
- All referrals are now triaged according to the service's "Prioritisation (triage) Protocol", and all MHS staff have had training on the application of the protocol.
- The DHB has developed a mental health crisis service and an operations and procedures manual, which sets out detailed written instructions for staff to follow in the course of their clinical duties, and provides guidance for referral prioritisation and coordinating the most appropriate response. Currently, the manual is awaiting sign-off.
- Performance appraisals that identify areas of development have been completed by all MHS staff. These are repeated annually.
- Caseload reviews for all MHS clinicians are carried out every three months to ensure that the caseload number and acuity is at a safe level.
- All MHS staff have completed a programme focused on patient and staff safety.
- The DHB has introduced a system that standardises processes from patient entry to exit, and includes a patient record, which means that information is immediately accessible to all clinicians, including when triaging is completed over the telephone.
- The DHB has introduced an electronic patient record. This enables the management and audit of referrals into MHS.

[7] MHTT-CAT is a system designed to support competency assessment in telephone-based mental health triage. It provides a framework for assessing the urgency of a presenting issue and the risk for the caller, and formulating a plan to respond in partnership with the caller and the caller's key supports.

62. The DHB also completed a wider review of its Mental Health and Addiction Service. The review's report recommended a number of developments to improve the DHB's services and standards of care.

RN B

63. The DHB told HDC that since these events, a performance improvement plan (PIP) was implemented to address and support RN B in improving his practice in a number of areas. The DHB stated:

- A review of his clinical documentation was undertaken, and RN B was supported to "develop skills and strategies to ensure that his documentation was at the required level. E.g. through strengthening his time management skills, training in the use of ISBAR,[8] Training in Risk Formulation".
- A file review at the end of the PIP period evidenced "significant improvement" in the quality of RN B's assessments.
- RN B completed a competency assessment for the Professional Development and Recognition Programme (PDRP), which found that his practice was at a proficient level. In response to my provisional opinion, the DHB noted that the PDRP requires nurses to maintain ongoing professional development, and to this end noted that RN B attends regular professional supervision and monthly nurses' meetings with the Director of Nursing.
- RN B successfully completed MHTT-CAT training in telephone-based triage and assessment skills.

64. RN B told HDC that since these events he has undertaken considerable training (as noted above) and improved his practice, and is no longer doing on-call work after hours.

Responses to provisional opinion

65. Mrs A's family were given the opportunity to respond to the "information gathered" section of the provisional report, and said that it reflects their understanding of what happened. They told HDC that they believe that Mrs A's death resulted from systemic failings and "multiple actions of many people over time", and that in these circumstances Mrs A "would not want an individual to be blamed for her death". The family said that they are grateful for the efforts and service improvements implemented in the wake of Mrs A's death.

66. The DHB and RN B were also given the opportunity to respond to relevant sections of my provisional opinion, and their comments have been incorporated into the report as appropriate.

[8] ISBAR is a communication tool and acronym that stands for "Identify, Situation, Background, Assessment, Recommendation".

67. RN B stated:

> "I accept that my main shortcoming with respect to handling [Mrs A's] case was failing to organise another staff member to undertake the assessment when I could not. … This incident has remained with me and has affected me personally and professionally. I have undertaken considerable work since this time to improve my practice and have also continued to take steps to limit situations where I become stressed and overwhelmed."

68. The DHB accepted that there was a need for systemic changes and noted that these have since been implemented. The DHB further stated that Mrs A's family provided it with a copy of the family's response to the provisional opinion, and said that it intends to write to the family to address aspects of that response.

Opinion: District health board — breach

69. The DHB is responsible for the services it provides, and must ensure that appropriate systems are in place to support clinicians to carry out their roles. The DHB's SAER found that its system did not support an adequate response to the crisis call from Dr C. In particular, at the time of these events:

- There were competing demands placed on RN B by the system, which meant that he had to manage crisis calls in addition to his regular caseload.
- MHS staff were not able to easily access a patient's medical record or information that could be relevant to their care.
- There was no standardised process for triaging incoming referrals, and no document to guide triage assessment.
- E-referrals to MHS were managed by administrative staff, not clinicians.
- There was no system in place for what occurred in daily intake meetings (where e-referrals were discussed), and the DHB's review found that there was a lack of robust clinical discussion, which compromised the ability to address patient risk adequately.

70. My expert advisor, mental health nurse Dr Anthony O'Brien, advised that it is inappropriate for e-referrals to be managed by a member of administrative staff. He stated that the accepted standard of care is that all referrals are managed by a clinician, so that a decision can be made about the urgency of response time.

71. Dr O'Brien advised that workload issues appear to have contributed to this adverse event, and further noted that easier access to Mrs A's historical records in this case may have helped in the triaging of her referral.

72. Dr O'Brien stated:

> "In this case there were systemic failings within the DHB, and also departures from the accepted standard by [RN B]. Clinicians practise within a service context … that impact[s] on clinical practice and clinical decision making. … My impression is that the service model followed by [the DHB] at the time of this adverse event made it more likely that such an event would occur, and left [RN B] vulnerable to making the unsafe decision to decline an urgent assessment for [Mrs A] on [Day 1] in favour of a more routine assessment the following day."

Conclusion

73. I accept Dr O'Brien's advice. The DHB had seriously inadequate systems and processes in place at the time of Mrs A's referral. There was no formal process for triaging referrals, e-referrals were managed by administrators without review by a clinician for up to 24 hours (although it appears that there was an informal process whereby e-referrals marked "urgent" were reviewed by a clinician on the day of receipt), clinicians had to manage crisis calls in addition to their usual caseload, and clinicians were unable to access patient medical records easily. This contributed to the poor standard of care provided in this case, with the result that opportunities to assess Mrs A with the urgency required were missed. Accordingly, I find that the DHB failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[9]

Subsequent actions

74. In relation to changes implemented since these events, Dr O'Brien advised that the DHB's separation of crisis and case management roles will help clinicians to focus fully on their specific roles, and should prove helpful in providing timely and effective crisis responses. He advised that the introduction of continuous electronic notes since these events should enable better access to patient information and help clinicians to make informed decisions. Dr O'Brien believes that these and additional changes implemented as a result of the SAER "will help make similar adverse events less likely". He further advised:

> "A significant improvement is that all referrals are triaged by a clinician, not by an administrative staff member as happened with the electronic referral in [Mrs A's] case. The … Prioritisation (Triage) Scale has been adopted and this provides very clear guidance to staff on levels of urgency, response times and actions. This … will greatly assist staff in managing referrals. The new Client Pathway more clearly links intake triage with triage codes and with responding within the required timeframes."

75. Dr O'Brien considers that the new procedures put in place by the DHB have "strengthened the referral management process".

[9] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

76. I acknowledge that the DHB has implemented a number of substantial changes since these events, which should improve its service quality. I have taken those changes into account in making my recommendations.

Opinion: RN B — adverse comment

77. This section discusses RN B's management of the telephone referral from Dr C, as well as his handover and documentation of Mrs A's care.

Telephone referral and assessment

Telephone call with Dr C

78. On Day 1 at about 11.45am, Dr C telephoned MHS and asked RN B for an urgent assessment of Mrs A, owing to her suicidal thoughts. Dr C understood from that telephone call that Mrs A could be seen that day only if she was admitted under the MHA. Dr C contemporaneously recorded (and copied into the e-referral):

> "Spoke to [RN B] from the crisis team who advised them they could not see [Mrs A] today and [that] she … needed to be admitted. To do an urgent referral and … get her to be seen to make contact and see her tomorrow."

79. In contrast, RN B stated that he did not tell Dr C that Mrs A required MHA admission. Shortly after RN B learned of Mrs A's death, at around 9.30am on Day 2, he documented retrospectively that he told Dr C that he was busy with another patient, and that Dr C felt that Mrs A had good supports around her and was not imminently at risk. For these reasons, RN B suggested that Dr C send an e-referral to be reviewed the next day. Dr C agreed to this plan.

80. Due to the different accounts, I am unable to make a finding on what was said in the telephone call between RN B and Dr C, in particular whether the MHA was given as the reason needed to provide an assessment of Mrs A on Day 1. However, it is clear that Dr C's understanding from the call was that the MHA was a key consideration in the management of Mrs A's referral, and the outcome of the telephone call was that Dr C would send an urgent e-referral, and that Mrs A would be reviewed the following day.

81. At 12.20pm, Dr C sent through an e-referral, which was placed in the administration tray ready for discussion at an intake meeting the following day. Dr C noted in the e-referral for Mrs A to be seen "occasionally" (instead of "urgently"), and the form contained details of Dr C's understanding from his discussion with RN B.

Failure to arrange risk assessment

82. RN B told HDC that had Dr C expressed that he wanted Mrs A to be seen immediately, that would have been facilitated. Subsequently, RN B stated that Mrs A could not be seen immediately, but he anticipated that because the e-referral was to be marked "urgent",

the referral would promptly be brought before one of his colleagues, who would then assess Mrs A later that day.

83. There is no evidence to suggest that RN B informed Dr C of his understanding that marking an e-referral "urgent" would mean that a clinician would be likely to review it the same day. RN B told Dr C that the e-referral would be picked up the next morning.

84. The DHB's SAER report stated that it was unclear why RN B did not explore options for Mrs A to be reviewed either (1) by Duty Person 2, (2) by the evening shift, or (3) later in the day.

85. RN B acknowledged that while his telephone discussion with Dr C contained consideration of risk and protective factors, the discussion of risk in that call was inadequate, and Mrs A should have been offered a prompt in-person or telephone assessment.

86. RN B told HDC that he received insufficient orientation to his role, and was not provided training in triage. He stated that there was no document to guide triaging of incoming referrals, and that had he completed the crisis contact sheet it would still not have met the required standard, owing to inadequate service documentation. He said that the inadequate systems and processes in place at MHS were contributing factors to the care he provided to Mrs A, and the DHB has agreed that its lack of appropriate systems did not enable or support an adequate response to the crisis call.

87. In relation to Mrs A's telephone referral and subsequent care, my expert advisor, mental health nurse Dr Anthony O'Brien, advised:

> "When a consumer is referred from primary care to a community mental health service, especially where there is some urgency and suicidal thinking, there should be an initial triage of the consumer to determine the level of priority and the level of risk. If pressure of work makes it difficult to offer a prompt (same day) face to face assessment there should at least be a telephone triage to help the consumer engage with the service, and to gain an initial understanding of their needs, and any risk issues."

88. Dr O'Brien advised that "one of the reasons for requesting assessment is to obtain an expert opinion on clinical needs and risk", but in this case there is no evidence that any clinical assessment or risk assessment took place.

89. Dr O'Brien advised that even though Dr C felt that an assessment the next day was a safe option for Mrs A given the noted protective factors, nevertheless Mrs A should have been offered a face-to-face or telephone assessment by RN B. Dr O'Brien advised that there was sufficient information available to offer an assessment, at which point relevant history could have been explored.

90. Dr O'Brien said that notwithstanding the organisational issues present at MHS at the time of these events, it is his opinion that the lack of risk assessment conducted by RN B (or

requested by RN B of another MHS clinician) was a severe departure from the expected standard.

91. Dr C had telephoned the MHS crisis team for an urgent assessment of Mrs A, owing to her suicide risk. As noted by my expert, one of the reasons Dr C contacted MHS and spoke to RN B was to obtain his opinion on clinical needs and risk. Dr C was concerned about Mrs A's suicidality and lack of self-cares. RN B explained that he was busy with another patient, and asked Dr C if Mrs A needed to be seen immediately. This led to Dr C outlining some protective factors for Mrs A. RN B then suggested that Mrs A could be assessed the following day. Owing to the very serious concerns that Dr C had raised, I consider that RN B should have given the referral greater priority and offered Mrs A a prompt assessment.

92. In the event, Dr C had the impression that same-day assessment was not possible, owing to his understanding about MHA criteria, and it appears that this understanding may have played a part in his reasons for agreeing to Mrs A being assessed the next day. I agree with my expert that there was sufficient information available to warrant a same-day assessment, and that in the presence of known suicide risk it is reasonable to expect that RN B would have at least discussed with Dr C options for how assessment could have been conducted that day.

93. I accept my expert's advice, and find that while there were work pressures and system issues present when Dr C made the telephone referral, RN B did not take certain steps that were open to him (such as offering a face-to-face or telephone assessment) that would have enabled Mrs A to receive an assessment on Day 1, even if he was not able to provide that assessment himself. I acknowledge RN B's submission that he had anticipated that an e-referral marked "urgent" would be reviewed by a clinician on the day of receipt. However, in my view, RN B should have considered other options to enable a colleague to assess Mrs A, given the risk information available.

Handover to Clinical Nurse Manager

94. Shortly after his telephone call with Dr C, RN B was required to attend to another patient, and handed over details of Mrs A's care to RN D. The handover was not documented. RN B handed over details of his discussion with Dr C, and did not ask RN D to follow up on Mrs A's care.

95. The DHB's SAER report stated that RN B could have explored with RN D the alternative options for other team members to see Mrs A that day, and that it is unclear why this was not done.

96. In relation to the standard of handover between RN B and RN D, Dr O'Brien advised:

> "In a busy service a handover might be brief and provided verbally. Ideally there would be documentation, especially if there was an expectation of some specific further action to be taken by the nurse receiving the handover. A handover, whether verbal or written, would include all the information the receiving nurse needs to provide the care that the consumer needs. If there were issues of risk they would

> need to be adequately addressed. In particular a handover should include a statement of [what the nurse] receiving the handover is expected to do over the next period of care. In the case of [Mrs A] that could mean … arranging for [Mrs A] to have a phone or face to face assessment."

97. Dr O'Brien advised that it was open for RN D to initiate an assessment if he thought that was needed. Dr O'Brien also said that "[RN B] may have anticipated that [RN D] would conduct an assessment", but that such an expectation "needs to be made explicit in the handover". Dr O'Brien advised:

> "[B]ased on the information available I don't think it is reasonable to expect [RN D] to have initiated an assessment as there is no suggestion that [RN B] communicated that expectation to [RN D]."

98. Overall, Dr O'Brien advised:

> "My assessment of the [handover] is that it was certainly not adequate if there was an expectation that [RN D] initiate an assessment of [Mrs A]. It is somewhat concerning that, according to [RN D's] statement, there was capacity for the service to provide an assessment for [Mrs A] on the day she was referred."

99. I accept Dr O'Brien's advice. I find that although RN B conveyed his telephone discussion with Dr C to RN D, again RN B failed to take appropriate actions to ensure that Mrs A could have an assessment on the day of the referral. In my view, given the seriousness of the referral, RN B should have asked RN D to ensure that Mrs A received an assessment the same day, especially given that RN B has stated that he in fact anticipated that the e-referral would be seen by RN D or another clinician soon after it was received that day. No such request was made, and this meant that RN D was not given the expectation that he was required to take any further action.

100. While it may have been open to RN D to diverge from RN B's plan by providing Mrs A with a same-day assessment, I agree with my expert that it is not reasonable to expect that RN D should have done this. The handover to RN D was RN B's second opportunity to put in place steps to ensure a same-day assessment for Mrs A.

Documentation of telephone referral

101. On Day 2 — after he had learned of Mrs A's death — RN B retrospectively documented his interaction with Dr C regarding the care of Mrs A.

102. Dr O'Brien advised that RN B's retrospective clinical note of the discussion with Dr C the previous day is "scant", and does not mention any enquiry about Mrs A's mental health history. Dr O'Brien said that retrospective notes, especially when there has been a serious adverse event, are of limited value as a record of what took place. Dr O'Brien advised that RN B's documentation is "not at the expected standard for a consumer referred because of an experienced general practitioner's concerns about suicidality".

103. I accept this advice. RN B should have documented relevant aspects of his telephone discussion with Dr C and any assessment of Mrs A on the same day these events occurred, particularly in light of the serious nature of the concerns raised by Dr C. Adequate and timely documentation is crucial for continuity of care.

Conclusion

104. In summary, RN B did not undertake the following actions in his management of the referral:

- Clinical or risk assessment.
- Adequate steps to arrange for Mrs A to have a same-day face-to-face or telephone risk assessment with himself or a colleague.
- Communication to RN D that the seriousness of the referral and associated risk required him to follow up on the matter when possible that same day.
- Documentation of his telephone call with Dr C on the same day it took place, so as to provide an accurate record of what occurred.

105. It is apparent that situational factors may have contributed to the above omissions. In particular, RN B acted on the understanding that Mrs A had sufficient protective factors in place to wait for a next-day assessment and he had competing demands at the time. The DHB's inadequate systems and processes also contributed significantly to the poor standard of care Mrs A received.

106. Notwithstanding these mitigating factors, I am mindful that RN B was a mental health nurse with many years' experience, and as such was reasonably equipped to manage the situation better. I am critical of the care that RN B provided, but consider it appropriate to view his management of Mrs A's referral in light of significant systemic issues at the DHB that contributed to the overall poor handling of the crisis call.

107. I acknowledge and support the steps taken by RN B since these events to develop his clinical and documentation skills, as noted at paragraphs 63–64 of this report.

Recommendations

108. I note the further training and supervision completed by RN B since these events. I recommend that RN B provide a written apology to Mrs A's family. The apology is to be sent to HDC within three weeks of the date of this report.

109. Following consideration of the significant changes the DHB has made to improve its mental health services following these events I further recommend that the DHB:

a) Provide a written apology to Mrs A's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report.

b) Provide an update on the newly developed mental health crisis service manual, within six months of the date of this report.

c) Provide evidence of caseload reviews carried out for Mental Health Service clinicians in the last three months, and report on the effectiveness of these reviews. This is to be sent to HDC within six months of the date of this report.

d) Conduct an audit of the current process for the management of incoming referrals at MHS, to ensure that the changes made have been effective. The results of the audit are to be sent to HDC within six months of the date of this report.

Follow-up actions

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

111. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

112. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, the New Zealand College of Mental Health Nurses/Te Ao Māramatanga, the Director of Mental Health, and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from mental health nurse Dr Anthony O'Brien:

"Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

Preamble

I have been asked by the Commissioner to provide expert advice on case number C18HDC00078. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my training as a nurse in 1974. I qualified as a registered male nurse in 1977 (later changed to registered general nurse) and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. I am a duly authorised officer under the Mental Health (Compulsory Assessment and Treatment) Act (1992). My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mrs A] by [the DHB's] mental health service on [Day 1]. I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Mrs A] by [the DHB] was reasonable in the circumstances, and why.

In particular please comment on:

1. The risk assessment of [Mrs A] by the Service, in response to [Dr C's] phone call and e-referral.
2. The management of [Dr C's] e-referral.

3. The adequacy of the recommendations made by [the DHB] in their Serious Adverse events Review Report.
4. Any other matters in this case you consider amount to a departure from expected practice.

In relation to the above issues I have been asked to advise on:

a. What the standard of care/accepted practice is;
b. If there has been a departure from the standard of care or accepted practice, how significant a departure it is.
c. How the care provided would be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I have had the following documents available to me for the purpose of writing this report:

1. Letter of complaint […]
2. A letter from [the] Chief Executive of [the DHB] to [the] Office of the Health and Disability Commissioner.
3. Report of [the DHB's] Serious Adverse Event Review, including a timeline of events.
4. Terms of Reference for review of [the DHB's] Mental Health and Addiction Service.
5. Terms of Reference for a review of [the DHB's] Mental Health and Addiction Services.
6. Letter from [Dr C] to [the] Office of the Health and Disability Commissioner, dated 3 May 2018.
7. Primary care clinical records of [Mrs A] from [the time of these events], including e-referral sent to [the DHB's] Mental Health and Addiction Service.
8. Document with
   a. e-referral sent by [Dr C], GP, on [Day 1]
   b. a summary of [Mrs A's] health service contacts ('Patient national event summary') and
   c. notes written by members of the mental health service on [Day 2].

Outline of events

On [Day 1] [Mrs A], together with [a friend] attended her GP ([Dr C]) and reported low mood, heavy alcohol use and suicidal thoughts. At 1145am [Dr C] phoned [the DHB's] Mental Health to request an urgent assessment. [Dr C] was told by [RN B] that it was not possible to see [Mrs A] unless she was seen under the Mental Health (Compulsory Assessment and Treatment) Act (1992). [Mrs A] was not seen by a mental health services clinician, and there was no phone contact with [Mrs A]. There is no documented assessment or risk assessment. [Dr C] was asked to send an e-referral

and mark it urgent. The e-referral was sent at 1220hrs and placed in a tray in the administration office, by an administrative staff member, for discussion at an intake meeting the following day. The e-referral was apparently not read by a clinician from the mental health service. [Mrs A] died by suicide sometime between 10pm on [Day 1] and 3am on [Day 2].

The following section of this report responds to the Commissioner's questions.

1. **Question 1. The risk assessment of [Mrs A] by the Service, in response to [Dr C's] phone call and e-referral.**

The standard of care/accepted practice

When a consumer is referred from primary care to a community mental health service, especially where there is some urgency and suicidal thinking, there should be an initial triage of the consumer to determine the level of priority and the level of risk. If pressure of work makes it difficult to offer a prompt (same day) face to face assessment there should at least be a telephone triage to help the consumer engage with the service, and to gain an initial understanding of their needs, and any risk issues. In the case of [Mrs A] there is no evidence of a clinical assessment taking place, and no evidence of risk assessment. In saying this I note (from [Dr C's] letter to the Commissioner) that [Dr C] had explored [Mrs A's] thoughts of suicide and protective factors, and felt that an assessment the next day was a safe option. Nevertheless it is my opinion that [Mrs A] should have been offered a face to face or phone assessment. One of the reasons for requesting assessment is to obtain an expert opinion on clinical needs and risk. I note that [Dr C] was told that [Mrs A] could only be seen if she was assessed under the Mental Health Act. In my opinion that advice is wrong, and if followed as a service policy would severely limit access to mental health services.

The clinical note, written retrospectively by [RN B] to record the telephone conversation with [Dr C] the previous day, does not mention any inquiry about [Mrs A's] mental health history.

The e-referral was sent at 1220hrs and placed in a tray in the administration office, by an administrative staff member, for discussion at an intake meeting the following day. Mental health services take a wide range of referrals, from requests for advice to referral of people with high levels of risk. The accepted standard of practice for referrals, whether they are e-referrals, telephone referrals or some other type of referral, is that on receipt they are reviewed by a clinician so that a decision about urgency and response time can be made. Response to the e-referral is also discussed below.

In my opinion there was a severe departure from the accepted standard of care in the management of this referral. The initial decision to decline an assessment meant that there was no opportunity to identify and consider [Mrs A's] clinical needs, clinical history and risks.

How the care provided would be viewed by your peers?

I believe that my peers would regard the initial decision to decline an assessment as a severe departure from the accepted standard of care. In relation to the management of the e-referral my peers would regard the care provided as representing a moderate departure from the accepted standard of care.

Recommendations for improvement that may help to prevent a similar occurrence in future.

I note that the service has undergone a major review following this incident, and that many points addressed in the review have a direct bearing on how referrals to the mental health service are managed. This offers the opportunity to put in place policies and protocols that ensure that consumers are assessed in a timely way. My recommendation is that any policy on initial triage and assessment for urgent referrals is very specific about establishing contact with the consumer on the day of referral. This policy could be strengthened by putting in place an escalation process to be followed if pressure of work makes a same day response difficult. There also needs to be a policy that all referrals are triaged by a clinician on the day they are received.

2. The management of [Dr C's] e-referral.

Some matters relating to the management of [Dr C's] e-referral have been discussed above. The DHB in their Serious Adverse Event Review noted that it is inappropriate for e-referrals to be managed by a member of the administrative staff. The appropriate standard of care is that referrals are managed by a member of the clinical staff. In [Mrs A's] case it was already known that [Dr C] was concerned about suicide risk, so I would expect that the staff members who knew the referral had been made would actively pursue it, rather than waiting for it to make its way through an administrative system. The reason for having a clinician review the referral can be seen from the clinical information provided about this case. The Patient National Event Summary mentions [two previous episodes of attempted suicide][1]. Previous suicide attempts are a risk factor for suicide, so it is critical that this information is seen by a clinician.

The adequacy of the recommendations made by [the DHB] in their Serious Adverse Event Review Report.

The Serious Adverse Event Review examined the specific issues involved in [Mrs A's] referral, but also took a wider view of the mental health service to consider systemic issues. Reading the report I am left with the impression that the service model of the crisis service was unclear at the time of this event. Even the language of the Serious Adverse Event Review report is inconsistent in the way it refers to the service, using terms such as 'crisis response', 'crisis response service' and 'crisis response and recovery service'. Page 4 of the report states that 'The [mental health crisis service]

[1] The Patient national event summary was provided to me with a number of other documents in a single pdf, so it is not clear if this information came with the e-referral.

supports individuals who are of low to moderate risk who need more intensive support/intervention to maintain their wellness'. But it is evident that the [mental health crisis service] is focussed on individuals with high levels of risk, for example those subject to the Mental Health Act.

The Serious Adverse Event Review makes a number of comments about the service provided to [Mrs A], specifically that there appears not to have been a full triage assessment with the GP during the phone conversation, and additional options for providing an assessment were not considered. Comment was also made about the retrospective recording of the phone conversation. My impression is that the Serious Adverse Event Review gave adequate consideration to the events in question. The report also identified a number of issues such as an unclear handover process, uncertainty about who triages referrals, non-completion of core documents related to crisis assessment, allocation of clients, and management of daily team meetings.

The report makes recommendations for a dedicated crisis response function — separate from the provision of continuing care — and this may go some way to better managing crisis presentations. There appears also to be additional staffing resources allocated to the crisis response service and this too could contribute to improved responsiveness. However the report stops short of recommending a minimum standard for crisis response, specifically whether consumers referred for urgent assessment, with identified suicide risk, should be assessed on the day of referral. In my opinion a commitment to a policy of same day response would go a long way to address the issue of service responsiveness. In addition, the Serious Adverse Event Review did not make a recommendation about the management of e-referrals and as I have noted above this an area of clinical service that requires a clear policy.

In view of the many systemic issues identified by the Serious Adverse Event Review the recommendation for a full and comprehensive review of the service is sound.

The questions of standard of care, departure from standard of care, the view of peers and recommendations do not seem relevant to this area of the report.

Any other matters in this case you consider amount to a departure from expected practice.

One of the features of this case is that on critical matters such as phone conversations with [Dr C] there was no record made at the time and there are different perspectives about what was discussed. Under most circumstances, clinical records should be made on the day, not retrospectively. In this case the phone call was received early in the day so there seems to have been time to make a brief written note. Retrospective notes, especially when there has been a serious adverse event, are of limited value as a record of what took place.

The two previous suicide attempts mentioned above also appear to have occurred when [Mrs A] was a patient of [the DHB], but there is no mention of old records being accessed when [Mrs A] was referred. Similarly, it is not clear that [DHB] clinicians were

aware that [Mrs A] had previously been treated under the Mental Health Act. This is concerning as previous history is an important component of clinical and risk assessment.

General comment

This incident has triggered a review of the issues surrounding [Mrs A's] care, and a wider, wide ranging review of [the DHB's] mental health and addiction service. The DHB has acknowledged shortcomings in the care provided to [Mrs A]. There has been an apology to [Mrs A's] family and an apology is to be made to [Mrs A's] GP, [Dr C]. Good clinical care needs to be supported by sound systems and governance, and it appears these issues are to be addressed in the current review of the mental health service. My only concern about the review already undertaken and the one currently in progress is that it is already clear that there needs to be a policy of same day response to urgent referrals.

Documents consulted

Flewett, T. (2010). *Clinical risk management: An introductory text for mental health clinicians*. Elsevier Australia.

Mental Health Commission. (2012). *Blueprint II: How things need to be.* Wellington: Mental Health Commission.

New Zealand Guidelines Group and Ministry of Health. (2003). *The assessment and management of people at risk of suicide. For Emergency Departments and Mental Health Service Acute Assessment Settings.* Wellington, New Zealand Guidelines Group and Ministry of Health.

Te Ao Māramatanga, New Zealand College of Mental Health Nurses (2012). *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition) Auckland, Te Ao Māramatanga."

Dr O'Brien provided the following further expert advice on 16 April 2019:

"Case number C18HDC00078 ([Mrs A]). Additional report prepared by Anthony O'Brien, RN, PhD, FNZCMHN

I have been asked to provide further expert advice on this case. This request follows my initial report on 14 August 2018, and is in relation to additional documents received by the Commissioner, including [the DHB's] response to my report, various DHB policy and procedure documents, a statement from [RN B] which comments on my initial report, and [Mrs A's] full clinical record from [the DHB].

My report responds to each specific area of request.

1. Whether [RN B's] explanation on why a clinical assessment was not undertaken at the time, and that he did not decline an assessment of [Mrs A], changes my opinion

that management of the referral represented a severe departure from the accepted standards.

My comment in my original report that [RN B] told [Dr C] that it was not possible to see [Mrs A] unless she was seen under the Mental Health (Compulsory Assessment and Treatment) Act (1992) was based on [Dr C's] statement, in his letter to [HDC] on 3 May 2018, that he [Dr C] '… was advised [by RN B] that they were not able to see [Mrs A] that day unless she was admitted under the MHA'. A similar statement is recorded in the Patient Medical History from [the medical centre] which states: 'Spoke to [RN B] from the crisis team who advised them they could not see you today and (sic) unless she would need to be admitted'. It is also noted in [the DHB's] Serious Adverse Event Review report ([2017]) that the general practitioner recalled Duty Person 1 saying that unless Client 2 [Mrs A] was unwell enough to need the Act they could not be seen that day. [RN B's] statement states that he did not decline assessment, but also that [Dr C] agreed that the assessment could be deferred until the next day (because an assessment could not be provided on the day in question). It therefore remains my opinion that an assessment on the day of [Day 1] was declined. There may be some difference about the exact language used, but it appears use of the MHA was a key consideration. I accept [RN B's] comment that it is not the role of the DAO to decide who is admitted (under the MHA) but that is the point of an assessment. [Dr C's] referral is for 'urgent assessment' and the content of the referral reflects a sense of urgency. It remains my impression that in the context of a busy service, the criteria of the MHA was used to make a decision on whether [Mrs A] was assessed that day. However as I noted in my original report, consumers should not need to be assessed under the MHA in order to be provided with an assessment. It remains my opinion that the management of the referral represented a severe departure from the accepted standards.

2. Whether [RN B's] statement that [Mrs A's] historical file and the patient National Event Summary were not immediately available as part of triage for an acute situation changes my opinion.

Easier access to [Mrs A's] historical records may have helped [RN B] in his triage of the referral from [Dr C]. However the main issue in this case was the telephone triage of [Dr C's] referral. I believe there was sufficient information available to offer [Mrs A] an assessment at which the relevant history could have been explored. The phone call also provided an opportunity to inquire about relevant history, which [Dr C] was aware of. The lack of immediate availability of [Mrs A's] historical records does not change my opinion that there was a severe departure from the accepted standard of care in the management of [Dr C's] referral.

3. Please comment on [RN B's] statements on page 3 of his response regarding factors that he believes contributed to the adverse event and further training he has completed since that time.

Many of the issues raised by [RN B] were reflected in the [DHB's] Serious Adverse Event Review and have been addressed in the subsequent Improvement Action Plan and in revised policy and procedure documents. It does appear that workload issues and crisis

management systems contributed to this adverse event. Separation of crisis and case management roles will help clinicians to focus fully on their specific roles, and that should prove helpful in providing timely and effective crisis responses. [RN B] also mentions lack of training in the crisis role, and outlines training subsequently undertaken, with competency assessment. Training in the new triage model should prove a useful way of supporting [RN B's] professional development, specifically in relation to crisis triage and assessment. I do think factors of workload, training, and the service model of the time contributed to this adverse event, and that the changes made, and the professional development undertaken by [RN B] will help make similar adverse events less likely.

4. The steps taken by [the DHB] in relation to staff development as outlined on page 3 of their response.

The [DHB] lists eight steps taken in relation to staff development. These are all positive steps and should be of benefit to the DHB and to individual clinicians.

5. The new Client Pathway and introduction of electronic continuous notes.

The new Client Pathway sets out a clear protocol for crisis responses. The steps in the pathway address many of the issues identified in the adverse event. In particular, linking the Client Pathway to [the] Triage Scale is helpful as that scale is very clear in stating level of acuity and response times. One specific aspect of the Triage Scale is its statement that assignment of a triage code must always be based on the person's presentation, not the service's capacity to respond. This guideline addresses an issue at the centre of the adverse event: the need to respond promptly when there is a high level of risk. Introduction of continuous electronic notes addresses another issue identified in the review, that of documentation, including access to previous records. Having continuous electronic notes should be very helpful in communicating clinical information and helping clinicians to make informed decisions.

6. The adequacy of the policies and procedures in place at [the DHB] at the time of the events, and changes to policies and procedures since that time.

Since this adverse event [the DHB has] undertaken a Serious Adverse Event Review and a wider review of mental health and addiction services. A significant improvement is that all referrals are triaged by a clinician, not by an administrative staff member as happened with the electronic referral in [Mrs A's] case. The [Mental Health and Addictions Prioritisation Scale] has been adopted and this provides very clear guidance to staff on levels of urgency, response times and actions. This is a timely and welcome innovation which will greatly assist staff in managing referrals. The new Client Pathway more clearly links intake triage with triage codes and with responding within the required timeframes. The guidance on documentation within the 2018 Operations & Procedure Manual is more explicit that the guidance contained in the 2010 (updated 2017) … Manual. The 2018 Desk File provides further guidance with appropriate linkages to wider policies. There is some wording in Appendix I of the Desk Manual which could potentially be confusing. The response times for codes 1–4 are different to

those given in the [Mental Health and Addictions Prioritisation Scale]. My impression is that at the time of the adverse event in 2017 the policies related to management of referrals should have been sufficient to ensure that [Mrs A] was offered a same day assessment, however the new procedures have strengthened the referral management process.

7. In light of the information received, please advise on whether the departures from accepted standards I have identified represent systemic failings with the DHB, or if they can be attributed to individual staff.

In this case there were systemic failings within the DHB, and also departures from the accepted standard by [RN B]. Clinicians practise within a service context, which includes guidelines and protocols, staffing arrangements, staffing levels, caseload management and other components that impact on clinical practice and clinical decision making. The DHB Serious Adverse Event Review identified a number of service issues that have been addressed through changes to staffing, greater clarity of roles, improvements to the triage model, and support for professional development of staff. [RN B] in his response has identified areas of his practice that were problematic at the time of the adverse event and has identified measures taken to develop his practice. Since the event, [RN B] has undergone training in triage, risk assessment and documentation, and has had a competency assessment. My impression is that the service model followed by [the DHB] at the time of this adverse event made it more likely that such an event would occur, and left [RN B] vulnerable to making the unsafe decision to decline an urgent assessment for [Mrs A] on [Day 1] in favour of a more routine assessment the following day.

8. Any other matters that you consider warrant comment.

There are no other matters that I wish to comment on.

Anthony O'Brien RN, PhD, FNZCMHN"

Dr O'Brien provided the following further expert advice on 4 November 2019:

"Further report: C18HDC00078 ([the DHB]; [Mrs A])

I have provided advice about this case previously, on 14 August 2018 and 15 April 2019.

I have been asked to provide further advice about this case following receipt of new information by the Commissioner. The new information comes in the form of five documents:

1. A letter from [an NZNO lawyer] providing a response to the Commissioner on behalf of [RN B], dated 6 June 2019.
2. An email from [an NZNO lawyer] to the Commissioner, on behalf of [RN B], responding to the statement by [RN D], dated 24 October 2019.
3. A letter from [the manager of a mental health service] dated 11 June 2019.

4. A letter from [Dr C], [Mrs A's GP], dated 12 July 2019.
5. A statement by [RN D], Clinical Nurse Manager at [the DHB's] Mental Health Services on the day of [Mrs A's] referral to that service ([Day 1]), dated 9 October 2019.

I have been asked whether the new information alters my previous advice in any way. In addition, I have been asked, in light of the different accounts of the interaction that occurred between [RN B] and Clinical Nurse Manager [RN D] when they discussed [Mrs A's] referral and assessment plan on [Day 1], to comment on what the ideal handover would have been and what should have happened when [RN B] and [RN D] discussed [Mrs A's] care.

In considering the new information I have also reviewed my two previous reports and the relevant documents provided earlier by the Commission.

The main issues that are addressed in the new information are

1. Questions raised by [the NZNO lawyer] about whether [RN B's] practice in response to [Mrs A's] referral amounted to a severe departure from the accepted standard.
2. [RN D's] recollection of a discussion between himself as Clinical Nurse Manager and [RN B] on [Day 1], as [RN B] left to transport a patient to hospital.

I have responded to each of these issues below.

1. Whether [RN B's] practice in response to [Mrs A's] referral amounted to a severe departure from the accepted standard.

This question refers to my opinion on 14 August 2018. In that advice I was asked whether the risk assessment of [Mrs A] provided by ([the DHB's] Mental Health Service) was at the accepted standard, and if not, how significant a departure did I consider that to be. I am aware, as [the lawyer] says, that there are different recollections of whether [RN B] declined an assessment for [Mrs A] in response to [Dr C's] telephone referral. In particular there is a difference in the recollections of [RN B] and [Dr C] about whether assessment could only be provided if [Mrs A] were to be admitted under the Mental Health Act. I acknowledge [the lawyer's] comment that [RN B's] recollection is that assessment under the Mental Health Act was not the reason for not providing an assessment that day, and that [Dr C's] recollection is that he was told by [RN B] that [Mrs A] could only be assessed if she were to be admitted under the Mental Health Act. Both clinicians are very experienced and had worked together on previous cases involving assessment under the Mental Health Act. My reasoning that there was a severe departure from the expected standard does not turn on this point. The question I was asked to address was whether there was an adequate risk assessment at the time. There is no new information about the risk assessment provided. The documentation provided by [RN B] is scant and retrospective, and not at the expected standard for a consumer referred because of an experienced general practitioner's concerns about suicidality. As I noted in my original advice, no clinician from [the DHB's] mental health service spoke to [Mrs A], despite [Dr C's] concerns about her suicide risk. The

significance of the risk assessment is that it enables appropriate care to be planned, in [Mrs A's] case in relation to safety. Risk assessment would also allow [RN B] to decide if other measures were indicated, such as interim support by phone until a face to face assessment could be provided.

[The lawyer] makes an additional point about the service issues that I commented on in my original opinion, and whether an individual practitioner should be accountable for the standard of service provided in the context of organisational issues. That is a fair point. However I was asked to comment on the risk assessment provided and that is the responsibility of the clinician managing the referral. In this case there is very little evidence of a risk assessment being conducted by [RN B], or requested by [RN B] of another clinician in the service. My opinion remains that this represents a severe departure from the expected standard.

2. What the ideal handover would have been and what should have happened when [RN B] and [RN D] discussed [Mrs A's] care?

'Handover' is a somewhat informal term, and there is no standardised definition or process. However a reasonable definition of a handover is that it involves the transfer of responsibility and accountability for some or all aspects of nursing care from one nurse to another. In a busy service a handover might be brief and provided verbally. Ideally there would be documentation, especially if there was an expectation of some specific further action to be taken by the nurse receiving the handover. A handover, whether verbal or written, would include all the information the receiving nurse needs to provide the care that the consumer needs. If there were issues of risk they would need to be adequately addressed. In particular a handover should include a statement of what the nurse receiving the handover is expected to do over the next period of care. In the case of [Mrs A] that could mean anything from responding to any new developments like a further phone call from the GP or from [Mrs A], to arranging for [Mrs A] to have a phone or face to face assessment.

It is not clear what the content of [RN B's] handover was. [RN D's] recall is that a certain amount of clinical information was provided, together with a brief statement of a plan to assess [Mrs A] the next day as agreed with [Dr C]. [RN D] does not recall being asked to take any follow up action, such as to review [Mrs A's] records or provide the assessment [RN B] had not had time to provide. The Serious Adverse Event Review notes only that [RN D] was given an 'update on the phone call' but not that there was any request to take any action. [RN D's] account is consistent with the account provided in [RN B's] statement to the Commissioner on 5 February 2019, which refers to some clinical information being passed on. [RN B's] account of his handover does not suggest he was requesting [RN D] to take any follow up action. The handover does not appear to have been documented.

Both the letter and email from [the lawyer] state that it was open for [RN D] to initiate an assessment if he thought that was needed. That is correct. However based on the information available I don't think it is reasonable to expect [RN D] to have initiated an assessment as there is no suggestion that [RN B] communicated that expectation to [RN

D], or that [RN B] thought an assessment needed to be conducted that day. I accept that [RN B] may have 'anticipated' that [RN D] would conduct an assessment, but that needs to be made explicit in the handover. In fact the information suggests the opposite, that [RN B] did not think there was a need for [Mrs A] to be assessed that day. [The lawyer's] letter of 6 June 2019 refers to [RN B's] statement, contained in his letter to the Commissioner of 5 February 2019, that he advised [Dr C] that '[Mrs A] would not be able to be seen until later in the day, anticipating that a colleague would do an assessment later'. That expectation is not apparent in [Dr C's] clinical note made on the day, or in his letters to the Commissioner. The statement is also not supported by [RN B's] account of his handover, or [RN D's] recall of that handover. The statement conflicts with the statement in the following paragraph of [RN B's] letter to the Commissioner stating that he had asked [Dr C] to make a referral and it would be picked up the next day.

My assessment of the adequacy of the handover is that it was certainly not adequate if there was an expectation that [RN D] initiate an assessment of [Mrs A]. It is somewhat concerning that, according to [RN D's] statement, there was capacity for the service to provide an assessment for [Mrs A] on the day she was referred. [Dr C's] letter of 12 July states that [Mrs A] would have attended an assessment.

I am happy to respond to further questions.

Anthony O'Brien, RN, PhD, FNZCMHN"