Waitematā District Health Board

A Report by the
Mental Health Commissioner

(Case 17HDC00632)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. In Month1[1] 2015, Mr A (aged 55 years at the time of events) was admitted to a Waitematā District Health Board (DHB) inpatient mental health unit. He had a history of a major depressive episode with psychotic symptoms, post traumatic stress disorder, and chronic obstructive pulmonary disease. On discharge from the inpatient unit, Mr A remained under the care of the DHB Community Mental Health Service (CMHS).

2. The DHB Needs Assessment Service Coordination (NASC) assessed Mr A's home care needs. He was offered eight hours per week of personal cares, and two hours per week of household management from Organisation 1,[2] and this support commenced in Month2. On 18 Month3, CMHS referred Mr A to Organisation 2[3] for the purpose of obtaining support with personal health conditions and "daily living, community health, being social with others, interacting with other people and environments, and leisure activities". This support was provided for 2.5 hours per week.

3. Organisation 1 advised that from the outset, Mr A demonstrated a marked reluctance to receive support (e.g., for home cleaning, showering, and meal preparation). Organisation 1 raised concerns with NASC about the difficulties in providing support to Mr A in Month4 and Month8, but there is no evidence of further action being taken.

4. On 21 Month13, Mr A was visited by his CMHS key worker. Two days later, Mr A was discussed at a CMHS multidisciplinary team review meeting, and the decision was made to discharge Mr A from the CMHS. The team considered that Mr A's mental health symptoms were stable and he had appropriate supports in place. The discharge was communicated to Mr A's general practitioner (GP) by way of a letter; however, this was not provided to Mr A, his family, Organisation 1, or Organisation 2. At the time of discharge from CMHS, no lead organisation was appointed to oversee Mr A's ongoing care.

5. Organisation 1 and Organisation 2 continued to provide care to Mr A. In Month16, Organisation 1 contacted NASC again advising that there continued to be problems with Mr A accepting help, and that support workers reported that Mr A had no clean clothes or sheets, and often no food. This correspondence was not escalated within the DHB.

6. On 21 Month17, Mr A's sister visited him and took him to see his GP, as he was in a compromised physical state. Mr A was found to have lost 11kg in six months, and he was very short of breath and coughing. Mr A was treated in hospital, but he died from pneumonia secondary to malnutrition and depression.

[1] Months are referred to as Months 1–17 to protect privacy.
[2] Organisation 1 provides home-help support to enable people to live independently within their own home.
[3] Organisation 2 offers local support services to people who experience mental ill health or disability. Organisation 2 has a contract with the DHB to provide mental health residential support, support hours, and peer support.

Findings

7. The Mental Health Commissioner found that the DHB did not provide services to Mr A with reasonable care and skill, and breached Right 4(1)[4] of the Code of Health and Disability Services Consumers' Rights, for the following reasons:

   a) A lead organisation was not appointed upon Mr A's discharge from CMHS, and Organisations 1 and 2 were not invited to attend the CMHS team review, despite the relevant DHB policy allowing for this to occur.

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

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

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

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

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

8. In the circumstances of Mr A's ongoing refusal of care, the Mental Health Commissioner was critical that Organisation 1 did not do more to advocate to NASC for Mr A's needs.

9. The Mental Health Commissioner considered that more attention could have been given to obtaining comments from the other parties involved with Mr A's care when Organisation 2 was forming Mr A's support needs assessment plan. The Mental Health Commissioner reminded Organisation 2 to ensure that its support staff are alert to any general decline in the health of their clients, and vigilant in reporting any concerns.

Recommendations

10. It was recommended that the DHB (a) provide a written apology to Mr A's family; (b) implement policy documentation to ensure that when a person is discharged from the Mental Health and Addictions Service and multiple agencies are involved, a meeting is held to determine the lead agency and confirm the support plan for the person; (c) undertake an audit of compliance with discharge documentation requirements; (d) implement a clear escalation pathway for NASC staff to follow when concerns are raised by contracted

[4] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

providers; and (e) familiarise NASC staff with the Equally Well Consensus Paper, supporting them to enact this in the context of needs assessment and contracting services.

11. It was recommended that Organisation 1 provide HDC with an update on the efficacy of its new system for escalating incidents of missed care, and review its process for accepting referrals to ensure that sufficient information about the client is obtained.

12. It was recommended that Organisation 2 provide HDC with an update on its review of its staff development framework, and review its process for accepting referrals to ensure that sufficient information about the client is obtained.

Complaint and investigation

13. The Commissioner received a complaint from Ms B about the services provided to her late brother, Mr A, by the DHB and two support organisations. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by the DHB in respect of his discharge from the DHB Community Mental Health Services in Month13.*
- *The appropriateness of the care provided to Mr A by the DHB in respect of Needs Assessment and Service Coordination from Month13 to Month17.*

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

15. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's sister
District health board	Provider
Organisation 1	Provider
Organisation 2	Provider

Also mentioned in this report:

Dr C	General practitioner
Ms D	Social worker
Dr E	Medical officer of special scale
Mr F	Consumer's brother
RN G	Senior care manager

16. Information was also received from a medical centre.

17. Independent expert advice was obtained from a psychiatrist, Dr Brenda Brand (Appendix A), and from a social worker, Cynthia Spittal (Appendix B).

Information gathered during investigation

Introduction

18. Mr A had been receiving support from the DHB Mental Health Services since 2014. He had been treated for a major depressive episode with psychotic symptoms and post traumatic stress disorder symptoms. Mr A had a history of cannabis use and was a tobacco smoker. His medical conditions included chronic obstructive pulmonary disease.[5]

19. This report concerns the standard of care provided to Mr A in respect of his discharge from the Community Mental Health Service (CMHS), and in respect of the coordination of Mr A's community support services prior to his admission to hospital with malnourishment and hypoxia.

Background

20. After a hospital admission in 2015, Mr A was assessed by the DHB Needs Assessment Service Coordination (NASC)[6] as requiring seven hours of care at home per week, to assist with showering, dressing, changing his bed weekly, meal preparation, shopping, cleaning, and household management.

21. The support worker visits were stopped for safety reasons, because Mr A was having mental health difficulties and threatened self-harm. Following a mental health assessment, he received care from his general practitioner (GP), Dr C, and from the CMHS.

22. Mr A was assessed by a DHB psychiatrist in Month1, and presented with ongoing depressive symptoms, paranoia, and impaired self-cares. He was admitted to the inpatient mental health unit under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). On discharge from the inpatient mental health unit and the Act, he remained under the care of the CMHS.

23. On 4 Month2, following Mr A's discharge from the inpatient unit, NASC completed a re-assessment of Mr A's home care needs. Mr A was offered eight hours per week of personal care, and two hours of household management, with two carers attending as a safety precaution. Organisation 1[7] was contracted to the DHB to provide this service, with the goal of Mr A "being as independent as possible at home". The contract specified that services were to commence on 7 Month2; no end date was specified.

24. Following the referral from NASC, Organisation 1 prepared a detailed support plan in consultation with the NASC needs assessor and Mr A. Organisation 1 noted that Mr A was referred primarily for physical health conditions (emphysema and back pain), and while a diagnosis of depression is referenced on the referral, Organisation 1 noted that it had no substantive information about Mr A's mental health history.

[5] A chronic lung disease that causes obstructed air flow from the lungs.
[6] NASC is an initial assessment service offered to patients who require home-based support to maximise their independence and self-reliance in the community.
[7] Organisation 1 provides home-help support to enable people to live independently within their own home.

25. Organisation 1 told HDC that at the time of the NASC referral, NASC advised that Mr A might be reluctant to receive help and support. Organisation 1 understood that Mr A was able to make decisions about his own support, and said that there was no reason to believe he lacked capacity to make decisions for himself. The support Mr A was to receive from Organisation 1 included showering, simple home cleaning, and assistance with organising meals and shopping support. The service was provided in five one-hour visits per week by two support workers.

26. Mr A also received telephone support from Organisation 3[8] to assist him to take his medications.

27. On 18 Month3, CMHS referred Mr A to Organisation 2[9] for the purpose of obtaining support for Mr A with personal health conditions and "daily living, community health, being social with others, interacting with other people and environments, and leisure activities". Organisation 2 was contracted to the DHB to provide this service for 2.5 hours per week (including travel time). The contract states that where a service user is referred by the local co-ordination service, Organisation 2 will be required to undertake only "triage/brief assessments" of the service user, to ensure that support hours are used for direct support rather than further assessment.

28. Mr A identified his personal recovery goals to Organisation 2 as keeping healthy and fit, maintaining good health, and being "fully independent towards recovery". Organisation 2 supported Mr A by having one community support worker take him on a trip, usually for grocery shopping but occasionally to attend other places (eg, Work and Income, pharmacy, appointments). Mr A was supported by an Organisation 2 community support worker from Month3 until Month12, when the support worker resigned.

29. On 5 Month7, the community support worker completed a support needs assessment and multi-agency plan (SNAP) in conjunction with Mr A. The SNAP is a DHB document that was developed to improve the quality and consistency of the consumer experience across community mental health settings by having only one collaborative support plan for each consumer. It is completed by the individual non-government organisation providing support, in collaboration with the DHB. Accordingly, Mr A's SNAP also had input from Mr A's CMHS key worker, social worker Ms D. The SNAP listed all agencies providing support to Mr A, including Organisation 1, and set out Mr A's goals. The SNAP stated: "[Mr A] dislikes being pushed and told what to do." It is stated at the end of the SNAP that Mr A and Ms D would receive copies of the SNAP. Organisation 1 did not have a copy of this document.

30. Organisation 1 advised that from the outset, Mr A demonstrated a marked reluctance to receive support, and he was reluctant to have support workers touch his possessions (ie, the washing machine and vacuum cleaner). Organisation 1 stated that Mr A refused to

[8] Organisation 3 is a community support service for people who experience mental illness.

[9] Organisation 2 offers local support services to people who experience mental ill health or disability. Organisation 2 has a contract with the DHB to provide mental health residential support, support hours, and peer support.

shower, and preferred to sponge bath when support workers were not present; he would not allow support workers to prepare meals for him, and often prevented them from entering the kitchen. Organisation 1 told HDC that Mr A was no doubt aware of scheduled visit times, but on many occasions he would not be at home at the scheduled times.

31. Organisation 1 told HDC that the difficulties in providing support to Mr A were reported by its support workers, and these were then raised verbally with NASC in Month4 and Month8. However, there is no evidence of further action being taken by NASC in relation to these concerns.

32. Prior to his hospital admission (outlined further below), Mr A was last reviewed by his GP, Dr C, in Month10. At that time, Dr C recorded: "[D]oing much better in himself compared to last year. Eating much better and has put on weight. On regular medications and gets weekly home help and visit."

Discharge from CMHS — Month13

33. Ms D visited Mr A on 21 Month13. Her records indicate that Mr A appeared mostly well, but that he had shortness of breath when getting up to answer the door. Mr A's house was noted to be tidy other than cigarette butts in cans on the table. Ms D recorded that Mr A reported that he was eating well. She noted that he said that he was doing well from a mental health perspective, although he had "ups and downs" related to feeling lonely and wanting company. Ms D planned to discuss Mr A at a review meeting, with a view to discharging him from CMHS. It is not documented in the notes of this visit that Mr A was consulted about the proposed discharge. In response to the provisional opinion, the DHB stated that Mr A had been seen by his allocated psychiatrist in a medical review on 29 Month9. The DHB said that the plan at that review was for Mr A to be seen once more by his key worker before "discharge to GP for further follow up". The DHB noted that the follow-up appointment with his key worker did not occur until 21 Month13 owing to an earlier cancellation.

34. On 22 Month13, Ms D contacted an Organisation 2 support worker by telephone,[10] and Organisation 3 and NASC by email, to advise of the plan to discharge Mr A from CMHS. She advised Organisation 3 and NASC to re-refer Mr A to CMHS if they believed his health was deteriorating and he could use some support. There is no evidence that Organisation 1 was contacted to advise of the discharge plan. In response to the provisional opinion, Organisation 2 disputed that it was informed of the discharge plan, and noted that there is no record in its documents of this having occurred.

35. On 23 Month13, Mr A was discussed at the CMHS team review meeting. The meeting was attended by Ms D, medical officer of special scale (MOSS) Dr E, an occupational therapist, a registered nurse, a psychologist, and a dual diagnosis clinician. The following minutes were recorded from the meeting:

[10] Ms D documented this telephone call in Mr A's clinical records.

"[Mr A] seem[s] to have been doing well … Has good support from [Organisation 2 community support worker]. Is in regular contact with his GP. Complies with medication. In touch with family. [Mr A] is happy to be discharged."

36. The DHB told HDC that the team agreed to discharge Mr A to his GP with support from Organisations 1 and 2. Following the meeting, Dr E recorded a progress note, which stated:

"**Current clinical picture**
[Mr A] has remained stable for many months. The sleep has remained normal and his appetite is good. He has been free of symptoms of depression and psychosis over many months now … there have been no safety concerns. Occasional cannabis continues. Cigarettes 4–5 per day, planning to quit. There is ongoing breathing difficulties which limits his physical activities. He is able to walk up to the letterbox and feels breathless. Sees his GP for his physical issues.

Impression
[Mr A] remains stable with no symptoms of depression, psychosis or anxiety. Ongoing physical issues and significant breathlessness limiting his physical activity. Risk issues remain low. Accepting medications and treatment. Supports are in place.

Plan
… 1. Medications: he will continue Risperidone 2mg nocte, Escitalopram 20mg mane. Physical medications as prescribed by his GP.

2. [Community care — ie, Ms D] will liaise with [Organisation 2 community support worker], [Organisation 3] and [Organisation 1] and inform them about discharge and his ongoing need for support.

3. Discharge to GP …"

37. Dr E's progress note was sent to Mr A's GP, Dr C, in a letter format. However, this letter was not provided to Mr A, his family, Organisations 1, 2, or 3, and the specific involvement of these agencies in Mr A's ongoing support was not identified in the letter.

38. Following the contact from Ms D on 22 Month13, NASC contacted Mr A by telephone to review his needs further. The DHB stated that Mr A advised that he was happy with the support in place and did not require any changes. A plan was made for NASC to contact Mr A to review his circumstances. The DHB told HDC that NASC followed its standard review process when contacting Mr A via telephone.

39. At the time of Mr A's discharge, no lead organisation was appointed. CMHS acknowledged that appointing a lead role/organisation would have provided for better communication between the services, and a more coordinated approach to Mr A's care. The DHB also acknowledged that there was not enough detailed written communication about how each service would continue to provide for the level of care that Mr A required in order to meet his needs post discharge.

Care in community — Month13 to Month17

40. Organisation 1 support workers continued to attend Mr A after his discharge from CMHS. Organisation 1 provided interview transcripts from its staff who supported Mr A. The information in this section is summarised from the transcripts and Organisation 1's responses to HDC.

41. Support workers advised that when they asked Mr A about his food intake, he would state that he had eaten. There was evidence that he ate toast, fruit, and reheated frozen meals and pies, and that he made cups of tea regularly.

42. Support workers noticed that around Month15, there were no frozen meals in Mr A's fridge. Support workers raised the absence of meals with Mr A, who insisted that he was eating. Instead of frozen meals, Mr A requested that staff purchase two pies each day for him, which continued during the last weeks of his care by Organisation 1.

43. Organisation 1 advised that the ability of support workers to purchase food for Mr A was hindered at times by his lack of money. There is evidence that support workers bought some of their own food and food parcels to give to Mr A when he was running out of food, and Mr A would eat biscuits brought in by staff. Support workers would also ask to make meals, but Mr A refused this.

44. Often support workers abandoned attempts to assist Mr A in respect of the food issues because he was clear about what he did and did not want, and he became agitated, and they were keen to maintain rapport with him, as ultimately this would be in his best interests. Organisation 1 advised that having listened to its support workers' concerns about not being able to assist Mr A, it took the view that the support workers would continue to encourage him as much as possible with respect to his choices.

45. The support workers did notice that Mr A was thin. However, as he had a slight build, this did not alarm them unduly that he was malnourished. Organisation 1 stated:

> "His habitual smoking and making himself many cups of tea coupled with his insistence on independence, indicated to the support workers that he was acting in accordance with his own preferences. Staff reported numerous difficulties in getting him to change his clothing and that he refused to remove his jacket or clothes in their presence. In hindsight, this possibly contributed to staff not appreciating [Mr A's] weight loss."

46. Organisation 1 advised that Mr A's brother, Mr F, lived at Mr A's house on two occasions while it was providing support, and said that Mr F moved out for the second time in mid-Month16. The support workers noted that the house was messy and "chaotic" when Mr F was staying there. A support worker brought a mattress for Mr A, as Mr F had moved the mattress from a bed in the lounge, which Mr A had been using as a sofa, to use for himself.

47. Organisation 1 stated:

> "The lack of food items at [Mr A's] home was discussed with [Mr F] who simply said that [Mr A] had a tendency to spend his money on marijuana and cigarettes and that he would wait for [Mr A's sister to arrive] for a proper intervention into [Mr A's] affairs."

48. On 5 Month16, Mr F contacted CMHS and spoke to a social worker. He advised that his brother had not had medication for three weeks because he had a bill with the pharmacy. It is recorded that Mr F advised that Mr A did not appear to have mental health issues and was acting normally. The social worker suggested that Mr A be seen by his GP for support regarding access to medications, as he had been discharged from CMHS.

49. On 10 Month16, Organisation 1's Senior Care Manager, registered nurse (RN) RN G, sent a facsimile to NASC with concerns regarding Mr A. It stated:

> "There continues to be problems with Client accepting help. Support Workers report that he never allows them to help him in the shower. Also that he won't allow them to touch the washing machine. That he has been wearing the same clothes and is very disheveled. They say he becomes quite agitated if they press the matter. They also report he has no clean clothes, clean sheets, often no food."

50. RN G also stated that she had spoken to Mr F, who advised that he would like Mr A to be put into permanent care owing to his mental health state and living conditions. RN G requested that NASC telephone Mr F to discuss this.

51. NASC responded to RN G and advised her to refer these concerns to CMHS or Mr A's GP, "as NASC only provide[d] supports due to his COPD and back pain". There is no evidence that RN G's concerns were forwarded internally to CMHS, or that RN G followed this up further with CMHS or Mr A's GP. On reflection, the DHB advised that it would have been ideal for this correspondence to have been escalated to internal management to allow for follow-up and to ensure that the plan had been actioned.

52. Organisation 1 stated that although there was a general level of concern about Mr A's self-cares, including but not limited to his diet, there was nothing to indicate that he was at imminent risk. Changes to his physical state (ie, swelling of his feet) were apparent to the support workers only in the days immediately prior to his admission to hospital (discussed below). Organisation 1 advised that there was no material change to Mr A's mental state, and no reason to believe that he was no longer competent to make decisions.

Organisation 2

53. After Mr A's regular support worker left in Month12, Mr A received support from six different support workers until Month17.

54. The notes record that Mr A was usually taken to the supermarket for grocery shopping and to the local dairy to purchase cigarettes, along with occasional visits to Work and Income and the pharmacy to pick up medication.

55. Organisation 2 support workers recorded on occasion that Mr A's hygiene was poor and that he was short of breath on exertion. One support worker recorded that he discussed Mr A's smoking habit with him but Mr A responded that he would make his own decision about that and did not want to be told what to do.

56. No records were made of any particular concerns about deterioration in Mr A's condition during the period Month13 to Month17 (inclusive). Mr A's last visit from an Organisation 2 support worker was on 16 Month17. At that time it was noted that he was "relaxed and appreciative", and advised the support worker that he would be going away to another region the following week.

Hospitalisation — 22 Month17

57. On 21 Month17, Mr A was visited by his sister. She found him in a compromised physical state and took him to Dr C. Dr C referred Mr A to the public hospital, noting that Mr A had lost 11kg in six months, was very short of breath and coughing, looked pale, and was not looking after himself. A chest X-ray showed a large left-sided opacity and pleural effusion.[11]

58. Mr A was treated at the public hospital for significant hypoxia and left lung pneumonia. On the morning of 24 Month17, he had an acute deterioration and required ventilation. He was transferred to another hospital, and the impression was that he had suffered an exacerbation of COPD from severe left lung pneumonia, with significant cachexia[12] and malnourishment.

59. A meeting was held with Mr A's siblings and representatives from Organisations 1 and 2, CMHS, NASC and the DHB. During the meeting, Ms B's family expressed concerns that Mr A had been discharged from an inpatient mental health setting without an appropriate support plan in place; that the services did not talk to one another; that the family were not kept informed about Mr A's condition; and that it was not reported adequately that Mr A was refusing care. The DHB noted that Mr A was judged as continuing to have the capacity to appoint an enduring power of attorney while he was in hospital.

60. Mr A died in hospital, with the cause of death identified as pneumonia secondary to malnutrition and depression.

Further information

Case review meeting

61. A meeting was held with representatives from the DHB, Organisations 1 and 2, CMHS, and NASC. The purpose was to discuss the preliminary internal investigations of each service.

- CMHS noted that clients with many services involved in their care are usually flagged for a full multi-disciplinary meeting before they are discharged from CMHS and a lead agency identified. However, this did not happen in Mr A's case.

[11] Fluid build-up between the lungs and chest.
[12] Loss of weight, muscle atrophy, fatigue, and weakness.

- NASC acknowledged that concerns were escalated to them from Organisation 1 about Mr A's care but noted that these were not followed up.
- Organisation 1 noted that support workers regularly escalated concerns about Mr A's care, and considers that a gap in reporting (e.g., Mr A's refusal of showers) can be attributable to the fact that the issue had been escalated previously. Organisation 1 also found a gap in its clinical notes relating to Mr A's care, which coincided with the implementation of a new electronic record system.
- Organisation 2 advised that its support staff did not notice any significant decline in Mr A's mental or physical state, and it believes that his deterioration was sudden before his hospital admission. Organisation 2 raised at the meeting that it was not clear as to when Mr A was discharged from CMHS.

62. Following the meeting, a letter was sent from CMHS to Ms B. The letter acknowledged that Mr A's discharge plan did not indicate or clearly communicate the level of care required to meet his needs post discharge. It also acknowledged that there was no lead role/organisation appointed at the time of Mr A's discharge. Finally, it apologised that Mr A's family were not fully involved in his care planning.

The DHB

63. At the time of these events, the DHB had in place a "Discharge During Service Delivery" policy,[13] which outlined the process to be followed when discharging a mental health service user. In this policy, "discharge" is defined as "a planned and coordinated process which has been agreed on by the Consumer and the service providers". The policy required a discharge plan that provided information to the GP about re-accessing mental health services, a relapse prevention plan, and details of relevant service providers. It also stated: "[I]f relevant … establish contact with ongoing service provider, provide a discharge summary to ongoing service provider, implement handover process to future service provider." The policy required consideration to be given to family/whānau involvement, and provision of a discharge plan to the consumer/family/whānau.

64. The DHB "Complex Case and Team Review" guidelines set out the circumstances in which a team review should be completed prior to a consumer's discharge from CMHS. The guidelines indicate that non-government organisations and community support workers may be invited to the team review.

65. The DHB informed HDC that following Mr A's case, a number of changes were made to its service; these are summarised below.

66. The DHB has broadened its Complex Case and Team Review guidelines, so that there is a lower threshold for these reviews to occur. The Discharge from Adult and Cultural Services policy has been revised, the Family and Whānau Participation policy has been reviewed, and the Risk Assessment and Safety Planning policy has been updated.

[13] Reviewed April 2010.

67. The DHB advised that it has reviewed the training it provides in respect of risk assessment and safety planning and the relevant documentation. It stated that it has improved multi-agency reviews and discharge meetings, and all agencies involved in a consumer's care are now to be listed in the discharge letter sent to the GP.

68. Feedback was provided to CMHS staff about the HDC complaint, and clinicians have been reminded of the importance of completing referral and discharge documents fully, and to consult with the consumer, family/whānau, and all other agencies prior to discharge.

69. An audit of discharge summaries for clients discharged from CMHS was undertaken to measure the level of compliance related to family involvement during discharge planning and discharge. The DHB identified an area for improvement related to inviting family members to attend discharge planning meetings; it recommended that this be emphasised in staff training.

70. The DHB advised that development of a service agreement between Organisation 2 and the DHB mental health services relating to transition planning is underway.

71. Mr A's case was discussed at the NASC service's monthly training to make staff more aware of the need to ensure follow-up, and staff have been instructed to encourage participation of family members, particularly where there is risk to the client. NASC has also identified that there needs to be a pathway for its staff regarding escalation of declined services.

72. The DHB stated that NASC discusses cases with a multi-disciplinary team (including the DHB, Police, and non-government organisation representatives) in monthly Vulnerable Adult Reference Group meetings, which is an inter-agency forum to discuss persons causing concerns to agencies. Follow-up actions are given to staff to complete, and reports are fed back to the next meeting.

73. NASC has been given approval for a mental health clinician to attend regular meetings with CMHS to provide support and education for NASC staff.

Organisation 1

74. Organisation 1 stated that its role was to provide Mr A support with personal cares and household management, and its role did not include clinical assessment or monitoring, treatment, or management of medications.

75. Organisation 1 told HDC that the support workers assigned to Mr A took into account his preferences and level of needs, which resulted in him being supported by a former nurse and support workers trained up to and including NZQA Level 3 qualification. Organisation 1 said that all support workers undertake pre-employment training, which incorporates training on supporting clients in the home and community setting. The NZQA Level 3 support workers completed unit standards on reporting abuse and neglect, clients' rights, reporting change, and challenging behaviour.

76. Organisation 1 informed HDC that it undertook a comprehensive review of its processes and systems following Mr A's death. The following changes have been made as a result of the review.

77. At the initial client visit, the care manager will identify risk factors and gather more information as required (e.g., from NASC, the GP, and other health professionals and support people). Risk factors for behaviour will be identified clearly and highlighted on the client management system, e.g., on the message board, the details page of the client's file, and on the support plan. Where appropriate, the client will be added to a high-risk register by a care manager, and this will be shared with coordination staff. The register will be maintained and monitored by care managers. Mental health conditions will be included in the support plan (with the client being made aware of this), and support workers will be advised if there is risk. It will be established with the client who should be informed of any concerns (e.g., family members or activated enduring power of attorney).

78. In respect of ongoing care service improvements, Organisation 1 advised that support workers are now to report any incident of missed care owing to client refusal, and coordinators are to document this in a diary note each time. If there are three incidents of missed care in one week, the coordinator will make an entry in the client management system and escalate this to the care manager, with a medium risk level assigned at that stage. The care manager will telephone the client to discuss the refusals, and engage the family if appropriate. The care manager will visit the client if required, and put strategies in place to resolve identified problems that led to the client's refusal of care (e.g., referral to other agencies). The care manager may escalate the situation further if the risk level moves to high or extreme following the visit. If a family member is requested to take any action (e.g., contacting a recommended health professional), a timeframe is put in place for the family to communicate to the care manager that this has been actioned and provide feedback. The care manager will relay to the care coordinator and support workers any new strategies put in place to manage the client's behaviour. If the problem is ongoing following a second visit from the care manager, the care manager will inform NASC and liaise with the relevant health professionals and family.

79. Any client who is deemed by the care manager to be at high risk will be visited on a quarterly basis by the care manager. When the client is due for the review visit, the care manager will perform a quality review of the client's file, to ensure that any issues raised/reported are documented properly and followed up.

Organisation 2

80. Organisation 2 identified that it was not part of a discharge meeting, and it was not informed that a discharge had taken place from CMHS. On review of Mr A's case, Organisation 2 identified that the SNAP did not have a review date. It considered that the plan reflected an allocation of duties, "rather than a co-designed document reflecting shared interest and responsibilities intended to provide the most relevant, responsive care and support to a person with significant support needs".

81. Organisation 2 told HDC that as a result of this case, it would review its policies regarding working alongside multiple agencies, and include an explicit explanation that parties (including the client) are identified to one another and formally meet at least quarterly. Organisation 2 said that it would support its staff to be more active participants in the development of the SNAP, and that it would include discussion of sample SNAPs during staff coaching sessions. It also said that it would review the planning and assessment elements of its staff development framework.

Responses to provisional opinion

82. Relevant sections of the provisional opinion were sent to the DHB, Organisations 1 and 2, and Ms B, and they were given the opportunity to comment. Where appropriate, changes have been incorporated into the "information gathered" section above.

The DHB

83. The DHB stated that while it accepts that a lead organisation was not appointed, Mr A was discharged from CMHS to his GP. It stated that GPs are appropriately placed to be the coordinators of community care, and the DHB believes that this was an appropriate arrangement for Mr A as he no longer required an intensive case management level of service. The DHB submitted that discharging Mr A to GP care was an appropriate and reasonable clinical decision. The DHB accepts that some aspects of Mr A's discharge planning fell below the accepted standard.

84. The DHB stated that it does not accept that the level of support Mr A was receiving in the community was different from that documented at the CMHS team review meeting. It noted that Mr A was receiving support from a community support worker from Organisation 2, medication support from Organisation 3, and household management support from Organisation 1. The DHB stated that Mr A was residing with his brother, who had previously initiated contact with services on Mr A's behalf, and Mr A was seeing his GP, who was prescribing medication on a three-monthly basis. The DHB noted that Mr A's community support worker was fairly new to working with Mr A, but that he was working with Mr A weekly.

85. The DHB stated that steps have been put in place to strengthen NASC capacity to escalate concerns that they become aware of with regard to clients. It stated that further training has been provided to NASC staff regarding the Vulnerable Adults Reference Group, and a liaison process between NASC personnel and mental health services has commenced.

86. The DHB stated that NASC is not a clinical service and, as such, it does not provide or contract clinical services. It stated that it is also not the role of NASC to provide case management. The DHB stated:

> "NASC perform mandated standardised assessments on receipt of referral, and schedule reviews of supports at appropriate intervals or if re-referral is received suggesting current supports are inadequate. If clinical concerns are identified, the process … explicitly directs NASC workers to refer on to other services."

87. In the DHB's view, NASC had an obligation to inform Mr A of the care options available to him, and to make reasonable efforts to put those services in place, but it was up to Mr A himself whether or not he chose to accept them, particularly given he was assessed as retaining legal capacity. The DHB stated that its NASC carried out its intended role in assessing Mr A's care needs and making reasonable efforts to ensure that they were delivered.

Organisation 1

88. Organisation 1 advised that it accepts my proposed recommendations, and noted that following Mr A's death it undertook a comprehensive review of its processes and systems, and, as a result, strengthened its internal policies and procedures.

Organisation 2

89. Organisation 2 stated: "Overall we believe the report is fair and balanced. We note the conclusion and adverse commentary and have taken steps to improve the consistency of our performance in these areas." Organisation 2 told HDC that it considers that any joint planning or review process must allocate an organisation or person to assume a lead role that is agreed to and supported by other stakeholders.

Mr A's whānau

90. Ms B, on behalf of Mr A's whānau, stated: "[W]e were all heartbroken when we read [the "information gathered" section of] this report. If only one agency had stepped up and followed through, [Mr A's] suffering wouldn't have occurred to the extent it did." Ms B said:

> "From all accounts, it appears policies were already in place, but were not followed. Notes were not completed or followed up on. The different agencies involved in [Mr A's] care, with nobody ultimately taking responsibility for him, is unacceptable in our view, as is the fact that no manager of any department or organisation picked up any of the serious flaws in reporting, and ultimately in how [Mr A] was being cared for."

91. Ms B also stated:

> "We cannot have people looking after our most vulnerable, when they are unable to identify someone in distress. I understand these people aren't trained nurses, but as you can see by the photos of [Mr A], all you had to do was open your eyes to see how sick he was."

Opinion — introduction

92. This case highlights the importance of health service providers working together in unison to meet the needs of consumers who are living in the community. My independent social work advisor, Cynthia Spittal, commented that Mr A's care highlights all too common gaps between primary and secondary healthcare services and between physical and mental

health service providers. She also commented that Mr A's care was provided in a parallel, non-integrated manner between agencies, and that there was a serious lack of coordination of his care, which would be considered a serious breach of accepted professional practice.

93. I agree with Ms Spittal's comments. I acknowledge that there were difficulties in providing care to Mr A because of his reluctance to receive assistance, and that the staff who saw Mr A regularly during his final months were support workers, not mental health clinicians. However, the services involved in his care had a responsibility to take steps to ensure that Mr A's needs were met, and I am not satisfied that this occurred adequately in this case.

94. In the sections that follow, I outline my opinion about the DHB, Organisations 1 and 2, and their involvement in Mr A's care.

Opinion: Waitematā District Health Board — breach

Discharge planning

95. Mr A was discharged from CMHS on 23 Month13 after a review by Ms D. While the notes from the team review state that Mr A was happy to be discharged, there is no documentation in the notes of the final CMHS visit regarding consultation with Mr A about the proposed discharge. The discharge was agreed upon at a CMHS team review meeting and communicated to Mr A's GP by way of a letter from Dr E. However, the discharge letter was not sent to Mr A, his family, or Organisations 1, 2, or 3. Ms D contacted an Organisation 2 support worker by telephone, and Organisation 3 and NASC by email, to advise of the plan to discharge Mr A. However, there is no evidence that Organisation 1 was contacted.

96. At the time of discharge from CMHS, no lead agency was appointed to oversee the coordination of Mr A's care in the community, and no multi-disciplinary discharge meeting with Organisations 1 and 2 occurred.

97. My independent psychiatry advisor, psychiatrist Dr Brenda Brand, advised that given the complexities of multiple services involved and the multiple co-morbidities identified, it would have been prudent to formulate a pre-discharge plan and then have a multi-service discharge meeting. Dr Brand considered that this would have provided a forum for an integrative approach to on-going service delivery tailored specifically to Mr A. This forum would have allowed identification of the difficulties other providers were likely to encounter in service delivery, and would have provided an opportunity to generate a formulation of the causes for specific obstacles in Mr A's case. Dr Brand considered that failing to appoint a lead organisation significantly impacted on a collaborative service delivery to ensure continuity of care. Dr Brand concluded that the discharge plan and coordination with services were not adequate, and represented a serious departure from accepted standards of care.

98. CMHS has acknowledged that appointing a lead organisation would have provided for better communication between the services and a coordinated approach to Mr A's care. In response to the provisional opinion, the DHB stated that GPs are appropriately placed to be the coordinators of community care, and the DHB believes that this was an appropriate arrangement for Mr A as he no longer required an intensive case management level of service. I note the DHB's comment, but I accept the advice of my expert and I am critical that a lead organisation was not appointed upon Mr A's discharge from CMHS. The DHB "Complex Case and Team Review" guidelines set out that non-government organisations and community support workers may be invited to the team review prior to discharge. I am critical that representatives from Organisations 1 and 2 were not invited to attend Mr A's team review meeting. This would have been an important opportunity to discuss potential issues that could arise during the provision of ongoing support to Mr A. I am also very concerned at the lack of documentation in the notes of the final CMHS visit regarding consultation with Mr A about the proposed discharge.

99. Dr Brand is critical that a psychiatrist did not review Mr A in planning for his discharge from CMHS. She stated that such an assessment could have identified Mr A's high risk for relapse of depressive symptoms given the on-going bio-psychosocial issues of loneliness, medical co-morbidities, and difficult family dynamics. In response to the provisional opinion, the DHB advised that Mr A had been seen by his psychiatrist on 29 Month9, and the plan from that review was for Mr A to be seen once more by his key worker before being discharged to his GP. This review was undertaken approximately four months before Mr A was discharged from the CMHS. While I note that the final key worker visit was delayed owing to a cancellation, in my view, it would have been more appropriate for Mr A to have been reviewed by a psychiatrist at the time of the proposed discharge, rather than four months beforehand.

100. Dr Brand noted that there are no comments in the discharge documentation regarding the impact of Mr A's multi-morbidity (e.g., depression with psychosis) on his capacity to consent, and acceptance of care and the pathway for addressing this. Dr Brand accepts that Mr A had autonomy and presumption of capacity, but noted that his diagnosis of depression with psychosis and multi-medical co-morbidities could have impacted on his capacity in the future. Dr Brand advised that CMHS had the most pertinent information and most relevant expertise to advise other providers in future approaches to capacity issues. She is critical that the initial information made available to the service providers by CMHS was not comprehensive, and lacked detail on crucial issues such as pattern of risks to self, and concerns about self-cares.

101. Similarly, Ms Spittal noted the lack of documentation regarding a crisis or relapse prevention plan, or specific early warning signs of deterioration in Mr A's mental or physical health status. She is critical that there was no specific advice to the GP or community support services about action to take in the event of concerns related to possible relapse, other than a general suggestion to contact mental health services. Ms Spittal commented that a robust system of oversight was required to ensure recognition of early warning signs of relapse and agreed action. She stated:

> "[Mr A] had an identified history of relapse associated with refusal of care by others and difficulty maintaining self-care. In these circumstances it would be reasonable to expect the discharge plan to indicate a clear plan of action should these historical patterns re-occur.
>
> In my considered opinion, the failure to address these issues is a serious departure from accepted standards of practice, and would be viewed accordingly by my peers."

102. I accept the advice of Dr Brand and Ms Spittal. The DHB's "Discharge During Service Delivery" policy required provision of a relapse prevention plan, information on re-accessing CMHS, and information about relevant service providers, to be included in the discharge summary sent to the GP. The policy also specified that, if relevant, the discharge summary should be sent to the ongoing service providers, which it was not. In my view, this was relevant in Mr A's case owing to the number of ongoing service providers involved in his care, and the complexities of Mr A's needs. I am concerned that the service providers were not given details about a relapse prevention plan, or early warning signs for deterioration. I am also concerned that the discharge summary was not circulated to Mr A, his family, or Organisations 1, 2, or 3. I note that the DHB has acknowledged that there was not enough detailed written communication about how each service would continue to provide for the level of care that Mr A required in order to meet his needs post discharge. I am critical that in Mr A's case, the "Discharge During Service Delivery" policy was not followed adequately by the DHB.

103. Ms Spittal noted that the team review documentation suggested that Mr A had regular contact with his GP, and good support from his community support worker, and was in touch with his family. She considered that the change of a key support worker at the time of Mr A's discharge should have been noted and addressed in his discharge plan, particularly because of his reluctance to accept care in the past. Ms Spittal considered that it was not reasonable to have assumed that family contact, community-based supports, and GP care were sufficiently and reliably in place to support safe discharge from CMHS, without collateral information from Mr A's family and GP. She noted that there was contradictory evidence to the view of Mr A being part of a strong and effective support network — in particular, that his familial support was variable owing to his sister living overseas, and perceived conflicts with his brother, and that Mr A was not in regular contact with his GP. Dr Brand and Ms Spittal both noted the absence of involvement from Mr A's family in discharge planning from CMHS.

104. I note that the DHB does not accept that the supports Mr A had in place at the time of his discharge were different from what was documented in the CMHS team review meeting. However, I accept Dr Brand's and Ms Spittal's advice. In my view, CMHS should have made note in the discharge documentation that Mr A's regular support worker had changed recently. I also consider that CMHS should have discussed Mr A's proposed discharge with his family, as recommended by the "Discharge During Service Delivery" policy, and I am critical that it did not do so. I am also concerned that assumptions appear to have been made during the team review about the level of support available to Mr A, in particular

regarding the level of regular contact with his GP, and the reliability of family support available.

Needs Assessment and Service Coordination

105. Ms Spittal considered that the NASC was responsible for ensuring that Mr A's needs in the community were met following his discharge from CMHS, as NASC was "the one agency aware of all the various health and social services providers working with [Mr A]". In response to the provisional opinion, the DHB disagreed with this, and stated that it is not the role of NASC to provide clinical services or case management. Rather, it had an obligation to inform Mr A of the care options available to him, and to make reasonable efforts to put those services in place, but it was up to Mr A himself whether he chose to accept them. I agree with Ms Spittal that NASC was the one agency that had oversight of all of the providers involved in Mr A's ongoing care.

106. Ms Spittal noted that there does not appear to have been any consultation between CMHS and NASC key staff about Mr A's needs assessment following his discharge from CMHS. She noted that the contracted services focused on Mr A's physical and domestic cares, and that there was no specific plan to address symptom management and pain control, strategies to conserve energy when short of breath or fatigued, or access to support for Mr A's mood. She considers that the latter should have been escalated and addressed, as effectively there was no formal oversight of Mr A's mental health — this was left to Mr A's GP, whom he saw only infrequently.

107. I acknowledge the DHB's view that it is not NASC's role to provide clinical service. However, I consider that the further review of Mr A's needs following his discharge from CMHS should have considered specific support for his COPD symptoms and his mental health needs.

108. Ms Spittal also advised that the needs assessment failed to identify a link between Mr A's physical health and his mental health status, and that renewed contact with health services was usually as a result of intervention by family members. She noted that the NASC contracts offer no guidance for contracted service providers or family carers regarding key risk indicators, early warning signs, or specific steps to escalate concerns.

109. Ms Spittal stated:

> "The narrow focus of care is a common practice, but unhelpful, and inconsistent with a holistic approach, particularly in view of the Equally Well consensus paper.[14] Further, it contributed to a delay in escalating concerns and accessing appropriate care in response to [Organisation 1's] Senior Care Manager's email to the [Waitematā] DHB NASC."

110. I agree with Ms Spittal's comments. The DHB has acknowledged that it would have been ideal for the correspondence from Organisation 1 regarding Mr A's ongoing refusal of

[14] https://www.tepou.co.nz/uploads/files/resource-assets/equally-well-consensus-position-paper-september-2014.pdf.

cares to have been escalated to internal management, to allow for follow-up and to ensure that the plan had been actioned. In my view, it was NASC's clear responsibility to ensure that these concerns were escalated and addressed appropriately. I consider that it did not meet this responsibility, as no plan was put in place to review whether the services being provided to Mr A were sufficient to meet his needs.

Conclusion

111. As set out above, the DHB has acknowledged that there was not enough detailed written communication about how each service would continue to provide for the level of care that Mr A required in order to meet his needs post discharge.

112. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. In my view, the DHB did not provide services to Mr A with reasonable care and skill, for the following reasons:

a) A lead organisation was not appointed upon Mr A's discharge from CMHS, and Organisations 1 and 2 were not invited to attend the team review, despite the relevant DHB policy allowing for this to occur.

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

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

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

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

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

113. Accordingly, I find that the DHB breached Right 4(1) of the Code.

Opinion: Organisation 1 — adverse comment

114. Organisation 1 began providing care to Mr A on 7 Month2, under a contract with the DHB for ten hours of support per week. Organisation 1 advised that from the outset, Mr A demonstrated a marked reluctance to receive support, particularly with home cleaning, showering, and meal preparation. These concerns were raised verbally with NASC in Month4 and Month8, and via a facsimile to NASC on 10 Month16. NASC responded to Organisation 1 advising that the concerns should be raised with CMHS or Mr A's GP. However, there is no evidence that any further action was taken by the DHB or Organisation 1.

115. Organisation 1 stated that although there was a general level of concern about Mr A's self-cares, including but not limited to his diet, there was nothing to indicate that he was at imminent risk. Support workers advised that changes to Mr A's physical state were apparent only in the days immediately prior to his admission to hospital.

116. Ms Spittal advised that Mr A met several criteria for at-risk clients under Organisation 1's Service Policy and Procedure.[15] She stated:

> "Apart from requiring two staff to deliver personal care (one male), this does not seem to be adequately reflected in the documentation. I would expect to see a clear plan of action in the event of being unable to provide contracted services — especially if these were being consistently refused by the client.
>
> If this was an enduring, consistent pattern over 15 months, I would expect these to have been flagged and followed up with the [Waitematā] DHB NASC services more actively."

117. Ms Spittal noted that at times support staff exceeded expected standards of care by providing Mr A food, a mattress, and other items from their own personal resources.

118. Ms Spittal stated:

> "In my opinion, the standard of care provided was consistent with usual practice except that identified concerns should have been raised more persistently throughout and followed up to ensure action was taken to address those concerns."

119. I accept Ms Spittal's advice. I acknowledge that Organisation 1's role was to provide Mr A with support with personal cares and household management, and that its role did not include clinical assessment, monitoring, or treatment. I also acknowledge that the care provided to Mr A was undertaken by support workers who were not clinically trained and who, at times, went beyond expected standards to assist Mr A. However, in the circumstance of Mr A's ongoing refusal of care, I am critical that Organisation 1 did not do more to advocate to NASC for Mr A's needs.

[15] The criteria include that the client lives alone, is housebound, and has limited social support/is socially isolated.

Opinion: Organisation 2 — adverse comment

120. On 18 Month3, CMHS referred Mr A to Organisation 2 for the purpose of obtaining support for Mr A with personal health conditions and "daily living, community health, being social with others, interacting with other people and environments, and leisure activities". Organisation 2 was contracted to the DHB to provide this service for 2.5 hours per week (including travel time). This comprised a weekly outing, usually to support Mr A to do his grocery shopping, along with occasional pharmacy and WINZ visits. Mr A had a regular support worker from Month3 to Month12. However, after that time he had six different support workers to assist him. In Month7, a SNAP was completed with Mr A's and CMHS's input.

121. In my view, NASC was responsible for coordinating the services provided to Mr A. Accordingly, I am satisfied that the support care plan requirement of Organisation 2 was to undertake a "triage/brief assessment", according to its contract with the DHB. Ms Spittal advised that the standard of the Organisation 2 SNAP was minimal, but sufficient. However, she noted that this did not include comments from Mr A's family members, other non-government organisations (e.g., Organisation 1), or Mr A's GP. She stated: "This reinforces my view that [Mr A's] care was provided in a parallel, non-integrated manner between agencies." I agree with Ms Spittal's advice, and consider that more attention could have been given to obtaining comments from other parties involved with Mr A's care when forming the SNAP. I note that Organisation 2 has undertaken to support its staff to be more active participants in the development of the SNAP.

122. No records of any particular concerns about deterioration in Mr A's condition were made during the period Month13 to Month17 (inclusive). Mr A's last visit from an Organisation 2 support worker was on 16 Month17. At that time, it was noted that he was "relaxed and appreciative", and advised the support worker that he would be going away to another region the following week.

123. Mr A's condition deteriorated to the point where he was hospitalised on 22 Month17, and he was noted to have lost 11kg in six months. It is understandable that there are concerns that this deterioration was not realised by Mr A's support workers. There is no evidence from the records that Organisation 2 support workers had particular concerns about any deterioration in Mr A's health. I note Ms Spittal's comments that she found this "difficult to reconcile with the reports of refusal of care and general decline noted concurrently by [Organisation 1]". However, I also appreciate that the care provided by Organisation 2 (i.e., a weekly outing as opposed to home/personal cares) was of a different nature to that of Organisation 1, and was for a short amount of time (less than 2.5 hours per week), and Mr A had a number of changes of support worker in the months preceding his hospitalisation. In the circumstances, I remind Organisation 2 to ensure that its support staff are alert to any general decline in the health of their clients, and vigilant in reporting any concerns.

Recommendations

124. I recommend that the DHB provide a written apology to Mr A's family. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding.

125. I also recommend that the DHB:

a) Implement robust policy documentation to ensure that when a person is to be discharged from the Mental Health and Addictions service and there are multiple services involved, a multi-service meeting is held to determine the lead agency and to confirm the support plan for the person.

b) Undertake an audit of compliance with discharge documentation requirements for clients discharged from CMHS. This should focus on the identification of obstacles to future service delivery, and criteria for re-referral to the service. A report back on the audit findings and any action plan as a result of the findings should be provided to HDC.

c) Implement a clear escalation pathway for NASC staff to follow when concerns are raised by contracted providers about a consumer declining services, or other obstacles to service delivery.

d) Familiarise NASC staff with the Equally Well Consensus Paper, and support them to enact this in the context of needs assessment and contracting of services.

e) Provide HDC with evidence of the implementation of these recommendations, within three months of the date of this opinion.

126. I recommend that Organisation 1:

a) Provide an update on the efficacy of its new system for escalating incidents of missed care.

b) Review its process for accepting referrals, to ensure that when a referral is received, sufficient information is obtained to allow a clear understanding of the client's goals and any potential obstacles or risks to service delivery.

c) Provide HDC with feedback on these recommendations, within three months of the date of this opinion.

127. I recommend that Organisation 2:

a) Provide HDC with an update on its review of the planning and assessment elements of its staff development framework.

b) Review its process for accepting referrals, to ensure that when a referral is received, sufficient information is obtained to allow a clear understanding of the client's goals and any potential obstacles or risks to service delivery.

c) Provide HDC with feedback on these recommendations, within three months of the date of this opinion.

Follow-up actions

128. A copy of this report with details identifying the parties removed, except the experts who advised on this case and the DHB, will be sent to the Health Quality & Safety Commission, the Director of Mental Health, the Ministry of Health, the Royal Australian and New Zealand College of Psychiatrists, Te Pou o te Whakaaro Nui, and the Coroner, 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 psychiatrist Dr Brenda Brand:

"**1. Introduction**

I have been asked to provide an opinion on case number: C17HDC00632.

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

I am a Psychiatrist currently working in a private Psychiatric clinic. I specialise in Adult Psychiatry. I was awarded Fellowship by the Australian and New Zealand College of Psychiatrists in 2007 and also obtained the additional qualification of Certificate in Advanced Adult Psychiatry in September 2007. Since gaining my qualifications, I have worked in both community and in-patient adult psychiatry settings in Australia and New Zealand.

2. Instructions from Commissioner

To consider whether the care provided to [Mr A] by the providers involved was reasonable in the circumstances, in specific:

1. The adequacy of the discharge plan by Waitematā DHB in [Month13].
2. The adequacy of the coordination with the other providers.
3. The adequacy of the information provided to the other providers.
4. Any other matters.

For each question, to advise:

a) What is the standard of care/accepted practice

b) If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be

c) How would this be viewed by peers

d) Recommendation for improvement that may help to prevent a similar occurrence in future.

3. Documentation Provided

1. Letter of complaint dated […]
2. [Organisation 2's] response dated [2017]
3. Clinical records from [Organisation 2] covering the relevant period
4. [Organisation 1's] response dated [2017]
5. Clinical records from [Organisation 1] covering the relevant period

6. Waitematā DHB's response of [2017]
7. Clinical records from Waitematā DHB covering the relevant period
8. Clinical records from [the medical centre] (GP) covering the relevant period

4. Disclosure statement

I do not have a personal or professional conflict in this case.

5. Background

[Mr A] (deceased) had been discharged from Waitematā DHB Community Mental Health Services in [Month13]. He was assessed by Waitematā DHB Needs Assessment Services as needing personal cares and home care (provided by [Organisation 1]), and help with grocery shopping and doctors appointments (provided by [Organisation 2]).

On 21 [Month17], [Ms B] (sister and complainant) took [Mr A] to his General Practitioner, and he was taken to [the public hospital] by ambulance for severe malnutrition. [Mr A] died [a short time later]. A Medical Certificate of Cause of Death, dated […] identifies the condition leading to death as pneumonia with malnutrition and depression as antecedent causes.

6. Findings

Providers involved in complaint:

i) Waitematā DHB (Community Mental Health) (CMHS)

Specific Information:

Notes available to me indicate that [Mr A] had been receiving support from Mental Health Services since 2014. It is further stated that prior to this he had no involvement with Mental Health Services and no history of services in place to support him at home.

[Mr A] first came to the attention of Mental Health Services [in] 2014 and [was assessed] after [Mr A] had refused medical intervention (endoscopy) at [Waitematā DHB]. The assessment outcome indicated a 'non identified mood disorder or psychotic disorder'. It is further stated that no clear pathway was identified for compulsory treatment under the Mental Health Act, given the 'absence of mental disorder'. Advice given was to exercise duty of care and explore 'legal' avenues if treatment considered necessary. A second assessment on [date] was requested as [Mr A] continued to present with a 'flat affect' and was voicing suicidal ideation in context of medical unwellness. The outcome of this assessment is not clear from the clinical notes available.

After a hospital admission in August 2015 [Mr A] was assessed by Needs Assessment Service Coordination (NASC) as requiring 6 hours personal care, needing help with showering, dressing, changing his bed weekly, meal preparation, shopping, cleaning

and household management. At that time [an organisation] was the Home Based Support Service provider.

[A doctor] then assessed [Mr A] following putting a knife to his throat and threatening self harm when visited by [a support worker]. This assessment deemed him to be depressed. He received Respite care, care from his General Practitioner and input from Home Base Mental Health Team.

[A doctor] next assessed [Mr A] [in] 2015. [Mr A] presented with ongoing depressive symptoms, paranoia and impaired self-cares. He was admitted to the Mental Health Unit under the Mental Health Act. Upon discharge he was followed up by the Community Mental Health Service (CMHS). NASC completed a re assessment on [date] and [Mr A] was offered 8 hours per week of personal care and 2 hours of household management.

Information supplied by CMHS to Non Government Organisation Service in [Month3], consisted of a Service referral form and a completed Adult Mental Health history template. These documents indicate risks as low, and add 'he doesn't like to be told what to do', on a fax sheet. The Service referral identified the following supports required in the community: support for daily living, being social with others, personal health condition, leisure activities, community health support and medication.

Issues not identified to be of concern were 'alcohol and drugs, family, and keeping safe'. A Waitematā adult assessment, [completed after] his admission to the Mental health Unit in [Month1], was also included in the referral documentation. This template allows for drug and alcohol history but this section was not completed. Risk Assessment identified 'medical risk, no risk to others, and risk to self'. Risk behaviour information stated that he had held a knife to his throat when visited by [support workers]. No information regarding self-neglect or deterioration in self-cares was specified.

An Adult history form was completed by [Ms D], Social Worker, 21 [Month6]. This provided a brief past mental health history, with first presentation circumstances and outcome of this initial assessment as 'non identified depression or psychosis'. Stated that presented with depressive features and Post Traumatic Stress Disorder and required admission to Mental Unit. Self-cares stated 'not good prior to admission to MHU'. Identified previous trauma of home invasion. Physical health issues identified as hyponatraemia, anaemia, head injury in a MVA and Chronic Obstructive Pulmonary Disease. Alcohol and Drug history identified as 'not known'. Risk to self not assessed on this template. Medical risk deemed 'no'. Stated that close to brother [Mr F]. Risk statement identifies low risk. The form further mentions 'good response to supports and beginning to live independently'.

[Ms D], Social Worker, (CMHS) visited [Mr A] on 21 [Month13]. Notes indicate that [Mr A] appeared well. Shortness of breath was noted with activity. [Ms D] stated that he was 'treated by GP'. His environment was reported as tidy with smoke butts in

cans, and he reported eating well and mentally feeling well with just 'few ups and downs'. He identified loneliness as an issue but stated that he felt overwhelmed around others. [Ms D] assessed [Mr A] to be mentally well and planned to discharge him from the Community Mental Health Service (CHMS).

A Multi Disciplinary Team (MDT) meeting occurred on 23 [Month13]. A Medical Officer of Special Scale, Occupational Therapist, Social Worker, Registered Nurse, Psychologist and a Dual Diagnosis Clinician attended this. It was presented at this forum that [Mr A] had been 'doing well' for many months in mental state, that he was in regular contact with his General Practitioner, that he was compliant with medications, was in touch with his family and was 'happy' to be discharged. Risks stated to be low, with no evidence of depression, anxiety or psychosis. The MDT agreed to the discharge of [Mr A] to his General Practitioner with support from [Organisation 2] and [Organisation 1]. Additional discharge instructions were to contact the Mental Health Team if any concerns arose regarding deterioration in mental health. It is stated that verbal and written communication regarding the discharge occurred to [Mr A], the General Practitioner, [Organisation 2] and [Organisation 1].

On 5 [Month16], [Mr F] contacted Mental Health Service, stating that his brother had no medications available as he had a bill with the pharmacy. He advised that [Mr A] did not appear to have mental health issues at this time. It was suggested that [Mr A] be seen by his General Practitioner for support regarding access to medications.

It is stated that MHS had no direct contact with [Mr A] regarding deteriorating mental or physical health following discharge from Mental Health Service on 21 [Month13], until admission to hospital in [Month17].

[The DHB's Chief Medical Officer] report summated that [Mr A] had been treated for a Major Depressive Episode with psychotic symptoms and additionally Post Traumatic Stress Disorder. This report further also states that [Mr A] had a history of cannabis abuse and was a smoker. [Mr A] also suffered from Chronic Obstructive Pulmonary Disease and Benign Prostate Hypertrophy.

Opinion:

I acknowledge the findings from [the multi service meeting] and [the DHB's response to the complaint]. Areas of service development are acknowledged in these documents.

(1)And (2) Adequacy of the discharge plan and coordination with other providers:

It is my opinion that given the complexities of multiple services involved and the multiple comorbidities identified, it would have been prudent to at the time of consideration of [Mr A's] discharge to formulate a pre discharge plan. This would have allowed for the identification of all individual services involved and allowed for planning of a multi service discharge meeting to occur. This would then have provided a forum for an integrative approach to on going service delivery tailored specifically to

[Mr A]. A multi service approach would have further identified the difficulties other providers were likely to encounter in service delivery and would have provided an opportunity to generate a formulation of the causes for specific obstacles in [Mr A's] case. Mental Health Service could further have used this forum to provide guidance to non specialist services on management strategies to address these obstacles and which circumstances would require referral to specialist services for further assessment. Identification of specific roles and responsibilities of services involved could have been addressed in above forum.

It is identified that the lack of appointing a lead organization significantly impacted on a collaborative service delivery to ensure continuity of care.

Waitematā DHB documentation available creates an impression of a lack of identification of the obstacles that could be potentially encountered in service delivery to [Mr A], the reasons why and an approach to productively and safely manage this, e.g. criteria for reassessment with Mental Health Service. [Mr A] had previously presented with refusal of medical intervention and had been admitted to hospital with a lack of self-care. This past history of behavioural pattern would appear not to have been identified as a potential future pattern with a subsequent lack of guidance to services in management of this.

Further in relation to refusal of cares and reluctance to accept care, there are no comments in the discharge documentation from the DHB regarding the impact of identified multimorbidity on capacity to consent and acceptance of care and the pathway for addressing this. It is accepted that [Mr A] had autonomy and presumption of capacity, but the diagnosis of depression with psychosis and multi medical comorbidities could have impacted on capacity in future. The expectation is that the specialist Mental Health Service was not only in possession of the most pertinent information, but also had the most relevant expertise to advise other providers in future approaches to capacity issues.

It is also noted that a psychiatrist did not review [Mr A] in planning for discharge. Such an assessment could have identified [Mr A's] high risk for relapse of depressive symptoms given the on-going bio psychosocial issues of loneliness, medical comorbidities and difficult family dynamics. Additionally no mention is made of any further Post Traumatic Stress Disorder symptoms.

The discharge plan further did not address the issue of cannabis abuse, the impact of this on [Mr A's] recovery and strategies to address this.

It is further noted that family involvement did not occur in the planning of discharge of [Mr A] from care. It is acknowledged that [Mr A] expressed some reluctance for family involvement, but given the complexity of the situation, the involvement of family in planning of discharge from service would have been of utmost importance.

It is further my impression that although the discharge was communicated to other providers, collateral information from other services appeared not to have been taken into consideration to inform discharge planning. This led to a lack of an adequate and appropriate approach to manage complexities in future care delivery.

Given the above issues identified it is my opinion that the discharge plan and coordination with services were not adequate. It is my opinion that there has been departure in the accepted standard of care provided to [Mr A]. Given the number of issues identified it is my opinion that this departure is severe. Even though most centres in New Zealand in the current financial environment would most likely have a lack of infrastructure and resources to establish an Integrative Service Model, it is likely that most colleagues would agree with a finding of departure in care in planning and coordination.

3) Adequacy of Information to other providers:

It would appear that the initial information communicated to Service Providers was a Fax from [Ms D], containing a copy of NGO referral template and Adult assessment template from 3 [Month1]. On this template no alcohol and drug issues were identified, despite later comments on cannabis use issues. Although risk to self identified, no pattern of history of risks is included. It is my opinion that this initial information made available to providers was not comprehensive and lacked detail on crucial issues such as pattern of risks to self and concerns about self-cares. Additionally the template was not satisfactorily completed.

An assessment history template was completed on 21 [Month6] and sent to providers on 21 [Month6]. This was some months after the initial referral. This template provided a brief mental health history with no detail regarding clarifications of outcomes of assessments and nil comments about capacity in the event of refusal to have medical intervention. Again no information was provided on drug use. The brief formulation provided does not adequately inform risk given or behaviours impacting on capacity. No statements on capacity or future indications for reassessment given medical comorbidities were identified. It is my opinion information provided to service providers on risk and risk management are not adequate. I was unable to find evidence of specific discharge documentation provided to service providers.

Given the above conclusions regarding information provided I am of the opinion that adequacy of information provided showed a departure in standard of care of a severe nature.

Recommendations:

- It is my recommendation that the discharge planning process of the Community Mental Health Service be reviewed and the role of the MDT in this process to be strengthened. Although the CMHS may not continue to be involved upon discharge, the plan put together at discharge will form the blueprint for service providers with limited mental health expertise. It would be expected from the team members

involved in the MDT, in conjunction with the patient's Case Manager, to identify the future management plan and seriously consider the appropriateness of this.

- Goals for service delivery to be clearly identified and obstacles identified in the delivery of service. Advice and guidelines to be provided to address these obstacles and criteria for re referral to be clearly documented and communicated to service providers.
- Multi service discharge meetings need to be part of the discharge process when multiple services are involved and the need for clear identification of roles and responsibilities of individual services.
- Identification of a lead agency occurs to ensure integration and collaboration of care. The Care Coordination model has been utilized in multiple Australian Mental Health Services with success and consideration will need to be given to develop a similar model in New Zealand context.
- The documentation provided to services involved provided insufficient background information and an inadequate formulation of risk. Templates have been used but had not been completed adequately. Suggest auditing to encourage comprehensive completion of templates.
- It is further strongly suggested that involvement of family in planning of discharge to be incorporated in discharge processes.
- To address capacity issues when required and identification of surrogate decision makers when appropriate.

[…]

7. Resources:

CARE COORDINATION Model: *Queensland Government*

Exploring interprofessional, interagency multimorbidity care: case study based observational research.

Eileen M. McKinlay, Sonya J. Morgan, Ben V. Gray, Lindsay M. Macdonald, Susan R.H. Pullon. Department of Primary Health Care and General Practice, University of Otago, Wellington, *New Zealand. Journal of Comorbidity* 2017; 7(1): 64–78.

Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians Primary Care Companion. *J Clinical Psychiatry* 1999 Oct; 1(5): 131–141.

I hope that this report is of assistance to the Commissioner in resolving this complaint."

Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from social worker Cynthia Spittal:

"I, Cynthia Spittal, have been asked to provide an opinion to the Health and Disability Commissioner on Case no # 17HDC00632. I have read and agree to follow the Commissioner's guidelines for Independent Advisors (June 2016).

I am a registered Social Worker with 30 + years of practice experience in Mental Health, General and Women's Health, Disability and Social Service Sectors. In addition, I have held roles in team leadership and management, research, policy development, undergraduate teaching, clinical education, professional supervision and workplace coaching. This work experience includes mental health case management and Duly Authorised Officer activities in relation to the Mental Health Act.

I am currently employed as the Learning and Development Manager for a large, nation wide NGO provider of Mental Health, Disability, Peer Support and Social Housing.

I hold a first class honours degree in social work from Massey University (1981) and Postgraduate Certificate in Health Sciences (Mental Health) from Otago University (2009).

I am a member of the Aotearoa Association of Social Workers (Inc) and of the International Coach Federation.

I have been asked to review documentation related to the care of [Mr A] and to consider whether the care provided by Waitematā DHB, [Organisation 1] and [Organisation 2] was reasonable in the circumstances.

I have been asked to comment on:

a) The adequacy of the discharge plan by Waitematā DHB in [Month13], in particular, regarding [Mr A's] needs assessment.

b) The appropriateness of the care provided by [Organisation 2] and its care staff, including whether concerns about [Mr A] were appropriately escalated and managed.

c) The appropriateness of the care provided by [Organisation 1] and its care staff, including whether concerns about [Mr A] were appropriately escalated and managed.

d) The adequacy of co-ordination of services provided to [Mr A].

e) In your view, which organisation was responsible for ensuring [Mr A's] needs were met?

f) Any other matters in this case which you consider to warrant comment.

In considering my opinion I have consulted the following documents:

1. Ms B's letter of complaint dated [...]
2. Ms B's additional letter of complaint received by the HDC [...]
3. [Organisation 2's] response dated [2017]
4. [Organisation 2] — selected records
5. The Service Agreement between Waitematā DHB and [Organisation 2] for Mental Health Residential Support, Support hours and Peer Support [2015–2020]
6. Waitematā DHB — [Organisation 2] Support Needs Assessment and Multi-agency plan for [Mr A] dated 05 [Month7]
7. [Organisation 1's] response dated [2017]
8. Clinical records from [Organisation 1]
9. The Service Agreement between Waitematā DHB and [Organisation 1] [2010–2011]. There was no subsequent contract provided, so my opinion is based on a presumption that this contract had been extended, with substantially the same content, to include the time-frame in which [Organisation 1] provided services to [Mr A].
10. Policies from [Organisation 1]:
    a. Home Healthcare Services Consumer Policy and Procedures — 1A Informed choice/informed consent, 6 Consumer and staff safety, 10C Consumer service — monitoring consumers at risk, 12 Managing challenging behaviour, 17 Reportable serious and sentinel events
    b. Home Healthcare Services Human Resource Policy and Procedure — 7 Workplace accidents/incidents
    c. Homecare Services — Service policy and procedure — 10A Quality improvement and risk management system
11. 10d. Home Care Support Worker Handbook, 2017 (8th Ed.)
12. Waitematā DHB response dated [2017] including [clinical notes and letter to Ms B]
13. Waitematā DHB response dated 10.04.2018
14. Waitematā DHB Needs Assessment Coordination (NASC) and Mental Health records provided by the office of the Health and Disability Commissioner
15. Clinical notes from [Dr C], [Mr A's] General Practitioner
16. NZ Social Workers' Registration Board Ten core competence standards
17. NZ Social Workers' Registration Board Code of Conduct
18. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

19. Community Liaison Committee Royal Australian and New Zealand College of Psychiatists. (2000). *Involving Families guidance notes.* Wellington, New Zealand: Ministry of Health.

20. Te Pou, (2014). *Equally well — take action to improve physical health outcomes of New Zealanders who experience mental illness and/or addiction. A consensus position paper.* Wellington, New Zealand: Author.

21. Evans C. Humberstone, F. et al, (2006). *Assessment and management of risk to others: Guidelines and training toolkit.* Wellington, New Zealand: Ministry of Health.

Summary of facts

[Mr A] had been under the care of the Waitematā Mental Health Services from 2014 until he was discharged to the care of his General Practitioner (GP) in [Month13].

The GP notes indicate [Mr A] had last seen his GP in [Month10], and was not seen again until his sister initiated a GP appointment on 21 [Month17].

His GP care was supplemented by contracted community based services to provide personal cares, household assistance, grocery shopping, assistance with attending appointments and medication monitoring. These services were provided by three different Non Govermental Organisations (NGOs). His GP care was provided on a fee-for-service basis and community services were at no cost to [Mr A]. His need for community support was assessed by Waitematā DHB Needs Assessment (NASC) Service, and initiated accordingly.

For a period of time whilst receiving community support, [Mr A's] brother, [Mr F], resided with him. There are several references to [Mr F's] claim to be his brother's Welfare Guardian, but this is not evidenced.

On 21 [Month17] [Mr A] was visited by his sister, [Ms B]. She found him in a compromised physical state and escorted him to the GP for urgent review. He was taken from there to [the public hospital] by ambulance and transferred to [another hospital] three days later. He was initially found to be malnourished, with hypoxia, tacypnoea and abnormal lung sounds. A mental health assessment completed on 23 [Month17] found [Mr A] to have problems with orientation to time and date, lapses in attention and concentration and unable to give a clear history of his deteriorating physical health.

Whilst in hospital steps were taken to have [Ms B] appointed as her brother's Welfare Guardian. He was found to be able to understand the nature of this proposal and to be legally able to give consent.

[Mr A died in hospital] with the cause of death identified as pneumonia secondary to malnutrition and depression.

[Mr A] is described as having a long history of co-morbid mental and physical health issues including depression with psychotic symptoms, post-traumatic stress disorder, cannabis abuse, heavy nicotine use (dependence status not clarified), chronic obstructive pulmonary disease (COPD) and benign prostatic hypertrophy. He had previously been assessed under the Mental Health (Compulsory Care and Treatment) Act (2015). The notes available to me do not clearly indicate when he was discharged from compulsory assessment or treatment.

Clinical notes and carer documentation indicate that [Mr A] strongly valued his privacy and independence and, at times, exercised his right to refuse treatment.

The adequacy of the discharge plan by Waitematā DHB [Month13]

The notes available to me indicate that the formal discharge documentation associated with [Mr A's] discharge from Waitematā DHB Mental Health Services ([CMHS]) in [Month13] consisted of:

- Clinical notes made by his key worker, [Ms D] from her home visit of 21 [Month13]
- Phone liaison with [Organisation 2] Community Support Worker 22 [Month13]
- Email from [Ms D] to [Mr A's] WDHB [Needs Assessor] dated 22 [Month13]
- Multidisciplinary team review notes 23 [Month13]
- Clinical note by [CMHS] MOSS, [Dr E] 23 [Month13] based on MDT discussion and verbal report from [Mr A's] key worker
- Reference to medication scripts being sent to [Mr A's] regular Pharmacist
- Letter to [Mr A's] General Practitioner, [Dr C], from [Dr E], dated 24 [Month13], advising of [Mr A's] discharge from [CMHS] to GP care.

There does not appear to have been any updated documentation regarding a crisis or relapse prevention plan, or specific early warning signs of deterioration in [Mr A's] mental or physical health status. There is no specific advice to the GP or community support services about action to take in the event of concerns related to possible relapse other than a general suggestion to contact Mental Health Services.

It is generally accepted best practice to involve family or significant others at times of transition or proposed changes in health care. If this was done, it was not documented.

Further, the MDT review documents [Mr A] being in regular contact with his GP, having good support from his community worker, and being in touch with his family. This assertion makes the lack of documented MH Service contact to obtain collateral information from [Mr A's] family and his GP at the time of discharge even more at variance with accepted practice.

There is some contradictory evidence to the view of [Mr A] being part of a strong and effective support network.

[Mr A's] GP notes indicate that [Mr A] had last been seen in [Month10], for review and medication scripting, three months prior to discharge from [CMHS]. This is substantiated by [Mr A's] three month script for medications 'running out' at the time of discharge, requiring a script from [CMHS]. Hence the view that [Mr A] was in regular contact with his GP cannot be substantiated.

GP, Community Support and WDHB notes from 2015 onward describe primary familial support coming from [Mr A's] brother [Mr F], with intermittent advocacy by [his sister] in relation to [Mr A's] health care. Familial support is variable due to the geographical distance from his sister, perceived conflict with his brother, and estrangement from his [children]. Given this, in my opinion, at the time of [Mr A's] discharge from [CMHS] in 2016, it was not reasonable to assume that [Mr A] had regular family contact, without collateral substantiation from the family.

General Practice, Mental Health, Needs Assessment and Community Support notes from August 2015 onward all paint a picture of [Mr A] as a man with chronic, relapsing mental illness and poor physical health. There is consistently documented difficulty with [Mr A's] own attention to personal care and hygiene, financial management, low mood, physical health and social isolation. Any accepted support required considerable persuasion.

His assessment under the MH Act in [Month2] followed this pattern, as did his previous compulsory assessment in [2015], following [...] refusing home cares. [Mr A's] mental health assessment [in 2014] followed his refusing medical treatment for physical health concerns.

From late [Month2] onward [Organisation 1] was contracted to provide personal care and housework four times per week. There were initial difficulties with obtaining [Mr A's] permission to proceed with this. Notes consistently document difficulties with support workers being able to deliver contracted services due to [Mr A's] refusal re same. There are notes missing from [Month7] onward, although timesheet notes confirm three support worker visits in [Month10]. It is difficult to confirm whether [Mr A] was reliably receiving the contracted level of support at the time of his discharge from [CMHS].

In [2015] [Organisation 2] [was] similarly contracted to provide 2½ hours week shopping assistance, and assistance to attend clinical reviews and doctor appointments. I received a copy of the WDHB/[Organisation 2] Needs Asessment/ Support plan dated [Month7] and accompanying documents related to a recovery plan dated June and [Month10] along with a WHO Quality of Life questionnaire dated 15 [Month11]. I did not receive other community support documentation, so again cannot verify the level of support [Mr A] was actually receiving in [Month13]. [Organisation 2's] own review indicates thar [Mr A] received regular support with grocery shopping as planned. However, his regular support worker finished in

[Month12], one month prior to his discharge. He had five different support workers between then and late [Month16]. Given [Mr A's] known distrust of others and difficulty accepting care, the change of a key support worker at the time of his discharge should have been noted and addressed in his discharge plan — perhaps delaying discharge until continuity of care could be confirmed. The [Organisation 2] review of [Mr A's] care and support dated [after Mr A's death] notes that neither [Organisation 2] personnel nor [Organisation 3] had been consulted regarding his discharge from [CMHS], nor had they been advised of same. Lack of collateral consultation with [Organisation 2] at the time of discharge is even more significant in this context.

I received no documentation regarding the telephone based medication oversight provided by [Organisation 3], so accordingly, cannot determine whether this was being provided in an effective manner at the time of discharge.

Given the factors outlined above, it is not reasonable to have assumed that family contact, community based supports and GP care were sufficiently and reliably in place to support safe discharge from Mental Health Services. Although [Mr A's] mental state was noted to have been much improved, a robust system of oversight was required to ensure recognition of early warning signs of relapse and agreed action.

[Mr A] had an identified history of relapse associated with refusal of care by others and difficulty maintaining self-care. In these circumstances it would be reasonable to expect the discharge plan to indicate a clear plan of action should these historical patterns re-occur.

In my considered opinion, the failure to address these issues is a serious departure from accepted standards of practice, and would be viewed accordingly by my peers.

I note Waitematā DHB letter of [2017] and response to the Mental Health Commission of 04 April 2018.

The updated broadening of Complex Case and Team Review Guidelines and improved Discharge Policy address the issues raised in this review. In particular, the requirement to hold a review where there are mutiple agencies involved and significant un-addressed physical health issues alongside mental health treatment, would have triggered a full review of [Mr A's] care.

The specified requirement for the person and family/whānau to be partners in discharge planning is consistent with Royal Australian and New Zealand College of Psychiatry Guidelines (2000) and long established best practice in social work.

The formal re-assessment of risk prior to discharge is consistent with the Ministry of Health 2006 guidelines for the Assessment and Management of Risk to others, as is the updated WDHB Risk Assessment and Safety Planning Policy.

The added requirement for discharge planning to include the agreement of, and preferably, face-to-face meetings with other agencies involved and the GP, would significantly reduce the breakdown in communication and shared care which occured for [Mr A].

I am satisfied that these improvements, if followed, would address the issues raised by [Mr A's] care.

The adequacy of the Needs Assessment by Waitematā DHB

Waitematā DHB Needs Assessment and Service Coordination (NASC) plans dated [2015] and 04 [Month2], are essentially the same, except the latter notes [Mr A] was 'having some support from mental health providers'. There is a change from [a single provider] to two separate providers ([Organisation 1] and [Organisation 2]).

The Needs Assessment does not appear to have been updated at the time of [Mr A's] discharge from [CMHS]. There does not appear to have been any consultation between MH & NASC key staff about his Needs Assessment apart from an email from [Mr A's] MH Key worker to his previous [NASC Co-ordinator] alerting her to [Mr A's] discharge and requesting a review of his personal support. [The Co-ordinator] then forwarded the alert to current NASC staff.

A file note dated 20 [Month16] noted that [Mr A's] NASC review was again completed on 21 [Month13], but the details are not provided.

The Needs Assessment identified needs remain the same on both 2015 documents, and these appear to have remained current at the time of his discharge.

The contracted services focus on [Mr A's] physical and domestic cares. There is no specific plan to address the following identified needs:

- Effective symptom management and pain control
- Strategies to conserve energy when short of breath or fatigued
- Access to support for your mood
- Support for your carer to manage their role as your caregiver

At the point of discharge from [CMHS] these latter two needs should have been escalated and addressed as there would be no formal oversight of his mental health — left to his GP whom [Mr A] rarely saw.

[Mr A's] history also indicated that renewed contact with health services was usually as a result of intervention by family members. This should have been recognised at the point of discharge.

There is no identified link between [Mr A's] physical health and his mental health status.

The mental health workforce development agency, Te Pou, has been actively working on behalf of the Ministry of Health to raise awareness of the increased risk of adverse physical health outcomes among people who experience mental illness. The 2014 'Equally Well' consenus paper has been widely promoted and discussed in the mental health sector. It would be reasonable to expect clinicians involved in [Mr A's] care to be familiar with this and to take particular care to address the interface between physical and mental ill health in any treatment and discharge planning. This is especially so, when poor health and chronic co-morbidity is already identified.

In my opinion, [Mr A's] Needs Assessment and Care Plan focuses on his physical health concerns to the deteriment of a holistic approach.

In the case of people with similar situations to [Mr A] this narrow approach leads to an additional layer of complexity in trying to provide adequate care.

Was [Mr A] of consistently sound mind following his discharge from [CMHS] to be regarded as being capable of exercising his free will to accept or reject care/treatment or was his decision making capacity affected by his deterorating mental state or vice versa?

The NASC contract requisition offers no guidance for contracted service providers or family carers regarding key risk indicators, early warning signs, or specific steps to escalate concerns.

In my view, the narrow focus of care is a common practice, but unhelpful, and inconsistent with a holistic approach, particularly in view of the Equally Well consensus paper. Further, it contributed to a delay in escalating concerns and accessing appropriate care in response to [Organisation 1's] Senior Care Manager's email to the WDHB NASC dated 10 [Month16] and phone call of 20 [Month16].

I note the WDHB has taken steps to educate staff and improve liaison between NASC and Mental Health services regarding ongoing care. (Response dated 06.04.2018).

I recommend staff be made familiar with the Equally Well Consensus Paper, and be supported to enact this in the context of Needs Assessment and the contracting of services.

Appropriateness of care by [Organisation 2] and its care staff, including the escalation and management of concerns about [Mr A].

As noted previously, I do not have copies of [Mr A's] case notes made by support workers, and my observations reflect that.

The [Organisation 2's] Brief Review of the care provided to [Mr A] notes that regular grocery shopping occurred as planned between [2015 and 2017]. As previously noted this was consistently provided by one support worker until [Month12], and by five different workers subsequent to that.

I note the referral from [Mr A's] [CMHS] Keyworker [2015] indicates the need for being social and interacting with others, leisure activities, personal health and non-clinical community health. Despite this contracted services via NASC were for grocery shopping and GP/clinical appointments only.

There is a partially completed Wellness Plan dated 26 [Month15] and a Personal Recovery Plan and Living Skills Profile dated 03 [Month16]. Unfortunately the general early warning signs section is not completed which compounds this having been missed from the WDHB discharge and NASC documentation.

A partially completed Support Needs Assessment and multi-agency Plan (SNAP) and Strengths Assessment dated 05 [Month7] show a level of collaboration between [CMHS], [Organisation 2] and [Mr A]. It does not include comments from family members, although [Mr A] had signed permission for [Organisation 2] staff to contact his brother and sister (26 [Month15]). The SNAP document also omits comments from other NGOs and [Mr A's] GP. This reinforces my view (and the findings of others) that [Mr A's] care was provided in a parallel, non-integrated manner between agencies.

His support worker notes on 03 [Month10] that [Mr A] had been 'doing well, maintaining personal cares and working with support'. There is no specific evidence related to this.

The WDHB/[Organisation 2] Health and Disability Services Agreement dated [2015] was in operation at the time of [Mr A's] care. There is a clearly stated expectation that staff employed in the non-regulated workforce (e.g. Support Workers) are expected to hold, or be working toward, a NZQA level 4 or higher Mental Health or Addiction qualification. Therefore, it is reasonable to expect that [Mr A's] support worker had some basic skills in monitoring mental state, care planning, recovery focussed rapport building and intervention, family inclusive practice and inter-agency liaison.

Pages 16–20 of the Agreement set out the service specifications which include a single care plan led by the Service Provider where less than fours hours support/week is provided.

[Organisation 2] provided less than four hours, but [Mr A's] overall care package was for more, in which case the Co-ordination service would have lead responsibility if seen as a whole package of care.

If [Organisation 2] was to lead the care plan, the standard of that agency's documentation regarding [Mr A's] plan is not of an acceptable standard.

If the local NASC service was the lead agency, then the Agreement states that the Service Provider would only undertake brief assessment/triage. If this was the case, the standard of the [Organisation 2] care plan was minimal, but sufficient.

There do not appear to be any specific concerns raised about [Mr A's] wellbeing which I find difficult to reconcile with the reports of refusal of care and general decline noted concurrently by [Organisation 1].

In the absence of other documentation regarding support worker contact with [Mr A] I am unable to comment further.

Appropriateness of care by [Organisation 1] and its care staff, including the escalation and management of concerns about [Mr A].

As noted in the NASC referral, and in the [Organisation 1] response of [2017], [Organisation 1] was contracted to provide personal cares and household assistance of up to 10 hours per week in total, with a Support Package Allocation (SPA) at a high level. [Organisation 1] was involved in providing this care from [Month2] until [Month17]. This length of contact allowed staff to get to know [Mr A] reasonably well. It is reasonable to assume that given this level of care, [Organisation 1] was the agency with the most contact with [Mr A] during this time.

There is much reference to [Mr A's] ambivalence about receiving assistance and consistent refusal to allow support workers to assist with personal cares, meal preparation and domestic chores. This is evident from the time of the initial referral ([Organisation 1] fax to WDHB NASC dated 15 [Month2]). The [Organisation 1] response indicates that agency concerns about [Mr A] were raised with NASC staff in [Month4] and [Month8], and again in [Month16]. Apart from the recommendation that [Organisation 1] contact [Mr A's] GP to arrange re-referral to WDHB MH Services (20 [Month16] — 10 days after the concerns were raised), I cannot find information about NASC Services' response to earlier flagging of concerns.

I have access to selected excerpts from [Organisation 1's] [case] notes [...]. 14 excerpts date from 18 [Month2] to 04 [Month7] and all indicate problems with being able to deliver contracted care. There is then a lengthy gap in documentation until 31 Month15 and a note regarding an alert to WDHB NASC on 10 [Month16] following contact from [Mr A's] brother, [Mr F] on 07 [Month16]. Notes from [this time] mainly pertain to family concerns about [Mr A's] care and historical recall by support workers about the difficulty of providing contracted care due to [Mr A's] reluctance re same.

It seems to me that [Mr A] met several criteria for 'At risk' clients under [Organisation 1's] Service Policy and procedure (10C), although apart from requiring two staff to deliver personal care (one male), this does not seem to be adequately reflected in the documentation. I would expect to see a clear plan of action in the event of being unable to provide contracted services — especially if these were being consistently refused by the client.

If this was an enduring, consistent pattern over 15 months, I would expect these to have been flagged and followed up with the WDHB NASC services more actively.

Having said that, there are reports that at times support staff exceeded expected standards of care — providing [Mr A] food, a mattress and other items from their own personal resources.

From their documented accounts, staff also found [Mr F] did not always act in his brother's best interests, adding to the complexity of family involvement in care.

In my opinion, the standard of care provided was consistent with usual practice **except** that identified concerns should have been raised more persistently throughout and followed up to ensure action was taken to address those concerns.

The adequacy of coordination of services provided to [Mr A].

As described throughout this report, there was a serious lack of co-ordination of [Mr A's] care. In my view this constituted a serious breach of accepted professional practice and would be regarded likewise by my peers.

In your view, which organisation was responsible for ensuring [Mr A's] needs were met.

In my view this responsiblity remained with the WDHB NASC services who were the one agency aware of all the various health and social services providers working with [Mr A].

For the period of time [Mr A] was being treated by the WDHB Mental Health Service his care manager or key worker also had a responsibility to liaise with [Mr A's] family, the various agencies involved and his GP, to ensure coordinated care, gain collateral information and to identify any gaps in care which could impact on his successful recovery.

Given the fee-for-service nature of Primary Health General Practice, infrequent contact, and the need for contact to be initiated by the client, a GP is unlikely to be successful in assessing [Mr A's] needs in any consistent and reliable way.

Any other matters in this case which you consider to warrant comment.

[Mr A's] care highlights all too common gaps between primary and secondary health care services and between physical and mental health service providers.

Further, the major provision of care following [Mr A's] discharge from mental health services was by the non-regulated health workforce. Expected standards of care are therefore dictated by the agency's own guidelines and contracts for service, rather than any independent professional body.

In this case, the situation is further compounded by the tricky balance between [Mr A's] right to self determination (including the right to refuse treatment regardless of outcome) and a duty to care on the part of health and social service providers. I note that the community support services believed [Mr A] to be of sound mind and able to make informed choices. The support workers acted accordingly, in good faith."