12 December 2016

Consideration of the report on the review of the care and treatment provided to five persons who attended the Mental Health, Addictions and Intellectual Disability Service 3DHB

Background

In April 2016, an external independent case file review and meta analysis of the care and treatment provided to five clients of the Mental Health, Addictions & Intellectual Disability Service 3DHB who were involved in incidents of alleged homicide was commissioned.

The review team comprised Professor Graham Mellsop, Professor of Psychiatry, Waikato Clinical School, University of Auckland (review lead); Dr Helen Hamer, Registered Comprehensive Nurse, Director, Helen Hamer and Associates Limited; and Jason Haitana, Consumer Advisor/Kai Tohutohu, Adult Mental Health Services North, Waitemata DHB.

The review team was asked to investigate and report on the factual circumstances surrounding the clinical care and treatment of these five clients, with the focus being on whether there were factors shared by all or a number of the cases that may have contributed to the adverse outcomes. The review team were asked to make recommendations on any further actions that MHAID Service 3DHB should take as a result of these incidents. A copy of the terms of reference of the review are attached.

A final report was provided by the review team in July 2016. In accordance with our usual process, the report was circulated to staff involved in the review, in order to provide them with the opportunity to comment on the report. Seven staff members provided feedback, which was provided to the review team for their further consideration. The review team responded in November 2016, noting that their review was not intended to be a judicial decision style document; rather, a summary of the material to which they had access to at the time. The review team did not feel that it was their role to consider the feedback, stating that if the feedback led us to "think we have over or under weighted any issues, or earlier been given and recorded any misleading information", our processes could "take such things into account". The review team concluded that they did "not detect anything in them which would lead us to alter our conclusions or recommendations".

Consideration of content of report and feedback from staff

The review team undertook a case file review and meta-analysis of the care and treatment provided to five clients. As part of that review, they interviewed a number of persons they had identified as informing the review in light of the terms of reference. The reviewers also compiled a brief collection of recent literature relevant to the terms of reference.

The feedback from staff mainly related to the summaries of the care provided to the clients as set out in the review report, which were primarily drawn from the review of the clients' clinical files. The feedback was taken into account with respect to the accuracy of the summary of care provided as outlined in the report, and/or as additional information.

Consideration of recommendations

The review team sets out two major recommendations, and six supplementary and/or subsidiary recommendations.

Major recommendations

(a) One record system

The review team recommends that the development of a current, comprehensive overall management plan within the context of one record system.

We refer to the National Health IT Board's work in this space, and in particular, the recent paper released by that Board entitled "Strategic Assessment - Single electronic health record" (August 2016). This paper outlines a strategic assessment for an enabler of the Digital Health work programme, the establishment of an electronic health record (eHR) for New Zealanders.

At a regional level, we are currently implementing new functionality in the recently launched regional Clinical Portal known as "continuous notes". Whanganui DHB is the first of the region's DHBs to be using the new regional Clinical Portal, and will move all their mental health patient records off their current system to this portal.

CCDHB's clinical portal is currently the primary location for mental health patient records for CCDHB, HVDHB, and Wairarapa DHB. We are investigating two options to address the "patient record integrity" issue. Option 1 is to implement the "continuous notes" functionality in CCDHB's portal. Option 2 is to move the Mental Health patient records for CCDHB, HVDHB, and Wairarapa DHB to the regional Clinical Portal and for Mental Health to use the regional Portal.

(b) Service user recovery plans (SURPS)

The review team recommends that the SURP is templated to allow the recording of the changing, comprehensive, up-to-date summary of the extant central care plan, and that it incorporates all that the team considers should be done for that service user.

MHAIDS 3DHB has developed a Client Pathway document which outlines a service user's path through mental health, addiction and intellectual disability services from request for service to service exit. The next stage of the Client Pathway development is to undertake rapid improvement work to establish business rules around the content and use of the electronic clinical documents to ensure consistency and set out minimum standards of practice.

Supplementary and/or Subsidiary Recommendations

(a) Development of education on decision-making around thresholds for compulsory intervention

I have considered the feedback from staff on the review report in which they submit that they have a clear understanding of the criteria for admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA), and that they were not reluctant to use the MHA but rather formed the judgment, based on the client's presentation, the assessment, the information available to them and the discussion with the family, that the client did not meet the criteria for the Act to be invoked.

MHAID Service 3DHB currently provides a range of training on the MHA which are tailored to the varying needs of clinical and administrative staff. Training for clinicians includes:

- Mental Health (Compulsory Assessment and Treatment) Act 1992. This is a core training requirement for all MHAID Service 3DHB clinical staff. Once completed, staff can attend further sessions, as required, to refresh their knowledge.
- Mental Health (Compulsory Assessment and Treatment) Act 1992 Nursing Workbook. The Workbook orientates nurses on the New Entrant to Specialist Practice programme and non-New Zealand trained nursing staff to the most relevant to practice aspects of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Completion of the Workbook is evaluated by a clinical nurse specialist.

In addition, duly authorised officers (DAO) are required to attend three out of six trainings offered annually to maintain their DAO status.

Further, as of February 2017, there will be compulsory bimonthly education sessions for Responsible Clinicians, led by the DAMHS, Director of Nursing and a Clinical Leader, on the MHA including, in

particular, relating to the Ministry of Health Guidelines "Competencies for the Role and Function of Responsible Clinicians under the Mental Health Act 1992".

(b) Education and guidance on risk assessment and management and family involvement

MHAID Service 3DHB currently provides several training sessions relating to risk:

- MHAID Service Crisis Risk Assessment and Management- this training is provided to crisis staff and addresses how to carry out a clinical risk assessment and formulation within a comprehensive psychiatric/psychosocial assessment and how to formulate this information into a comprehensive treatment plan to guide the appropriate management and treatment for each identified risk.
- MHAID Service FRaMing Personality – this training seeks to develop the skills and knowledge of clinicians working with people who experience personality disorders and includes understanding chronic risk.
- MHAID Service Risk Formulation – this is a core training requirement for all MHAID Service clinician. Training includes risk factors for suicide and violence; formulating risk in clinical work; risk -benefit analysis; use of case studies to practice assessing and managing risk.

In addition, with respect to the issue of family involvement in care, assessment and treatment:

- The family/whānau advisor presentation is an integral part of MHAID Service 3DHB orientation for all new staff.
- Involving Family/Whānau in Practice workshop is a core requirement for all clinical service staff, and included on their learning plans/records on Connect Me.
- The Family Participation Policy has recently been reviewed and we have developed a Framework for Involving Whānau/Families which sets out clear expectations around working in partnership with families at each stage of the service user's pathway through service and maintaining close contact with family and whānau during periods of crisis (see attached Framework). The Framework is due to be implemented in the New Year.

(c) Greater provision of residential accommodation for service users with high and complex needs

The residential accommodation referred to in the report has subsequently closed. The accommodation was not DHB funded.

The MHAID Service 3DHB meets regularly with the Service Integration and Development Unit (SIDU) which is responsible for funding the provision of mental health, addiction and intellectual disability services, including residential accommodation in the community.

We will raise this recommendation with SIDU for its further consideration.

(d) Assessment of service users by a psychiatrist within 2 weeks

The review team recommends that all service users new to a team should be assessed, a formulation developed and a care plan agreed to by a consultant psychiatrist in tandem with the service user's primary clinician within two weeks of the service user's entry to the service.

We agree that if clinically indicated, clients should be seen by medical staff within two weeks of the service user's entry to the service, and this is currently our practice. However, we do not consider that it is appropriate or necessary for all clients to be seen by a psychiatrist within two weeks.

(e) Comprehensive documentation

The review team recommends that "any/every assessment or other intervention by a medical person should be in the electronic record and signed off by them".

Good documentation practices are required to ensure the provision of good quality care. Clinicians are required to meet their professional standards around clinical documentation, as well as the DHBs'

policies and procedures. In October 2015, MHAID Service 3 DHB issued a new Medical Records (Electronic and Hard Copy) Content and Documentation Policy, which sets out expectations around clinical documentation. Establishing business rules for the electronic documents within the Client Pathway will also provide clearer direction to staff around what information should be recorded and where it should be recorded.

(f) Clarification of roles of different services

The ongoing development of the Client Pathway document referred to above will address this recommendation.

Disclosure of report

A copy of the decision relating to the review report, and the report itself will be provided to the clients involved (where appropriate) and/or their families. The report will be provided in de-identified form, and with all clinical detail removed (including staff feedback on the clinical detail which will be annexed to the report) in order to protect the privacy of the clients, their families, and participants in the review. It will be provided to staff in the same format.

It will also be provided in response to any Official Information Act requests (one of which has already been received), although only in fully de-identified form, with all clinical detail removed, to protect the privacy of the individuals involved. I have considered whether the withholding of that information is outweighed by other considerations which render it desirable, in the public interest, to make that information available, and have decided that with respect to the request already received, this is not the case here. In doing so, what has been taken into account is that the clients may be readily identifiable from media reporting at the time of the homicides in question, and that it is not appropriate for third parties to be privy to the clinical details of clients' care.

The decision and the report will also be provided to the MHAID Service 3DHB Advisory Group. The Advisory Group's role is to provide oversight of the Service including service development and service improvement. It also is overseeing the implementation of recommendations from reviews to strengthen the MHAID Service 3DHB.

Finally, a copy of the decision and the report will be provided in the format required by virtue of the respective agencies' statutory powers to the Health and Disability Commissioner, the Coroner and the Ministry of Health.

Nigel Fairley
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MHAID Service 3DHB