West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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24 April 2019

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RE Official information request WCDHB 9283

I refer to your email dated 8 February 2019 which was subsequently transferred to us from the Health, Quality and Safety Commission on 21 February 2019, requesting the following information under the Official Information Act from West Coast DHB. Specifically:

1. ***Can I please request under the OIA all the Reportable Event Briefs for the last 3 years for mental health for all the DHBs?***

Reviews of Mental Health Serious Adverse Events at the West Coast DHB for the past 3 years (excluding falls with fracture) have identified the following themes impacting service provision.

Patient Factors:

- Extensive period in the correction environments
- Polysubstance dependence e.g., alcohol, illicit substances
- Recent attempts of suicide
- Recurrent relatively severe but short-lived episodes of depression.
- Lack of engagement with Mental Health Services

Organisation Factors:

- Crisis responsiveness lacked guidelines for psychiatric emergency responses.
- No evaluation of the effectiveness of crisis responsiveness.

Staff Factors:

- High engagement with locum psychiatrists
- Staffing level fluctuation over public holiday periods.
- DHB discharge policies and procedures not implemented affecting the transition of care process
- Risk assessments and management plans lacked rigour, identification of risk management strategies, review or follow through.

- Lack of post assessment follow up with relevant clinicians.
- Differing clinical opinions leading to differing clinical management
- Missed opportunities for face to face engagement or assessment by Mental Health Service
- Failure to respond to the deteriorating Mental Health Patient and admit to acute inpatient services or respite.
- Lack of follow up 23 hours post discharge from Mental Health Services to assess ongoing risk.
- When a patient contacted the service there was no process in place to refer calls to another staff member.

Communication Factors:

- Missed opportunities for meaningful engagement with families/whanau
- Lack of communication/referral between service providers
- Failure to respond to communication from primary service providers.
- Gaps in electronic clinical records and patient risk
- Low compliance of appropriate standard of clinical documentation across services.
- Timely transfer of documentation and communication between DHBs', also affected by staff behaviours.

Environmental Factors:

Isolated locations with limited public transportation services

- Isolated locations with limited access to social environments/entertainment

Recommendations:

- The management of firearms in the presence of suicidal ideation.
- Re-education of staff to the Transition of care processes.
- Education of staff on Involving Families Guidance notes.
- Establishing a Quality Improvement project Connecting Care
- A robust audit tool that is specific to the transition of care between service providers and key stakeholders.
- A detailed operational manual is developed to provide guidelines on psychiatric emergency responses. To include the role of the Consultant psychiatrist in high risk presentations in and out of hours.
- That high risk patients are allocated a case manager
- To enhance the triage and referral process with follow up after 10 days where there is no personal response by the patient to attend/decline and assessment. The referrer or GP to be advised of the lack of engagement.
- A risk Factor 'aide de memoir' is developed to assist phone triage and a Triage code is developed.
- A process of assertive engagement with high risk patients.
- That alternative means of facilitating patient entry to the MHS service before closing a referral.

2. ***Can I also please request under the OIA what information from DHBs are sent to HQSC? (This is in case the previously question doesn't hit the sweet spot)***
3. ***Then I would like to request under OIA the information that DHBs usually send to HQSC and I would like that to cover the last 3 years please.***

The information points provided in answer to Question 1 above is a summary of the matters raised with and provided to the HQSC in regard to reportable mental health events for West Coast DHB over the past three year period. HQSC requires a case event summary in REB part A and recommendations in REB Part B, these are what is **usually** sent for each case, and contains quite specific information around each case. Given the relatively small number of cases involved for the West Coast DHB each year, release of further, more specific detailed information than this could well lead, and in some cases easily lead, to the identification of individual patients concerned. We therefore decline to provide additional information in respect of Question 2 and Question 3 under Section 9(2)(a) of the Official Information Act i.e. *"…to protect the privacy of natural persons, including that of deceased natural persons."*

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support