Review of Incident

Whitby Crisis Respite House, 13 March 2017

Review of an incident involving a mental health client at the crisis respite house in Whitby, and the resulting findings and recommended actions

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Introduction

This review was commissioned in response to a serious incident involving a mental health and addiction (MHA) client admitted to the Whitby Crisis Respite House, a Pathways[1]-run respite facility which comprises one part of the continuum of acute care options provided to the Capital and Coast District Health Board[2] (CCDHB) community. The purpose of the review is to investigate and report on the factual circumstances surrounding the clinical and support care provided, leading up to the incident that occurred on Monday 13th March 2017. This includes the assessment and treatment of the client. The aim is to identify any issues in systems of care which contributed to the incident, with a view to identifying opportunities to improve the quality and safety of services provided. This will enable CCDHB and MHAIDS 3DHB to further its commitment to protecting the health and safety both of people using MHA services, and the public. The investigation focussed primarily on finding out and recording what happened from the range of perspectives of those involved, analysing this data to understand the factors which contributed to the event, and making recommendations on:

- Improvements required to address the contributory factors identified;
- Actions to be implemented to operationalise these improvements; and
- Learnings to be shared to minimise future risk of critical incidents.

The investigation was led by Strategy, Innovation and Performance (Mental Health and Addictions) and its primary focus was on systems of care issues, rather than individuals.

The review determined, as far as practicable, the circumstances surrounding the incident. This includes:

- Clinical assessment, including assessment of the client's mental state, and current risk;
- Clinical decision-making process and the information available for this;
- Identifying issues in the care delivery system;
- Handover between services including the information provided;
- Identifying any other contributory factors; and
- Making recommendations and developing an Action Plan.

Acknowledgements

The investigation team would like to acknowledge the input of those who contributed, and that the incident itself has been a difficult time and process for many involved. Both Capital and Coast DHB and Pathways have confirmed they are committed to taking lessons from this incident, to improve not only what they do for clients and families, but also how they respond to community concerns.

[1] Pathways is a national provider of community-based mental health and wellbeing services funded by CCDHB to provide a range of MHA services in the CCDHB region.

[2] Capital & Coast DHB, provides a full range of mental health and addiction services, from crisis, acute inpatient care, intensive psychiatric care, services for the elderly, psychology, alcohol and drug and also specialist services for children and young people, including early intervention, personality disorder and maternal mental health. CCDHB also has a commissioning role funding and monitoring mental health and addiction services with 3DHB MHA provider services (MHAIDS) and non government organisations (NGO) such as Pathways,

The Investigation Team would like to thank:

- The families of the child and the client – we greatly respect their strength and resolve at this difficult time;
- The nominated people from the Whitby community for their contribution to the report and supporting the community concerns;
- The staff involved in this incident for their co-operation and professionalism both during the incident and throughout the investigation process;
- Porirua City Council, particularly Councillor Anita Baker; and
- Those parties from the wider health sector who were co-operative and open with the Investigation Team when information was requested during this process.

The Investigation Process

Interviews were undertaken with those involved before, during and after the event[3]. Those interviewed were invited to describe the incident from their perspective and then provide their views regarding:

- What went well in the care of the client, and wider services provided to the local community;
- What did not work well; and
- What changes and improvements they would make "if they had a blank canvas…".

Common themes were then extracted from the information gathered to inform the review findings and recommendations, via a process of discussion and consensus making between the review team members.

This investigation included:

a) A chronological overview of the clinical care on the day. This was gathered from the diverse perspective of all parties involved:
    - It should be noted that while the client was offered the opportunity to meet the review team, it was openly acknowledged this may be difficult for the client and adversely affect their current wellbeing. The client opted not to speak to us, but is aware we spoke to their father in detail;

b) Reviewing the clinical file and the associated documentation (hard copy and electronic);

c) Gathering supporting information through:
    - Undertaking interviews with:
        - Staff involved in the incident and their management – MHAIDS[4] and Pathways;
        - The father directly impacted by the incident; and
        - The father of the client;
    - Reviewing written submissions from those not participating in the interview process; and
    - Reviewing other documentation and systems relevant to the incident; and

d) Review team's assessment of findings and recommendations, not only relating to the incident, but for MHAIDS and/or Pathways to continue to further their aim to protect both the public and the MHA community.

[3] Biographies of the review team in Appendix 2.

[4] Mental Health, Addiction and Intellectual Disability Service – 3DHB MHA provider - http://www.mhaids.health.nz/

Background

Description of Incident

On 13 March 2017, the client was admitted to the Pathways crisis respite house in Whitby. During the preceding days, the client's parents had become concerned, as the client had stopped taking medication, was not sleeping well, and seemed "not right".

Earlier that day the client left home, scantily dressed and attempted to engage with some children. They were then accompanied home by an adult member of the public. The client's father contacted the Porirua community mental health team (PCMHT), who knew the client well. The case manager spoke first to the father and then the client, and the client agreed to come into the base for assessment.

The client was assessed by the case manager and a senior colleague, who found the client to be experiencing acute psychotic symptoms and to be expressing awareness of being unwell. The client acknowledged stopping taking medication and agreed with the suggested care plan. Based on their assessment the clinicians' decided that a stay in a crisis respite facility was the best option to re-establish medication, provide support, and to give the parents some respite.

The case manager involved phoned the MHAIDS acute response coordinator (ARC) and arranged for a stay at the Whitby crisis respite house. The client and father returned home to pack what was needed. The CMHT case manager and a clinical nurse specialist arranged to collect the client from home at 1 pm. Due to time constraints, they took the documentation with them to the facility, rather than sending it to the facility ahead of admission.

On arrival at the Whitby crisis respite house just after 2 pm the client was admitted and settled in. Over the following 45 minutes in the Whitby house, the client was checked on twice by support work staff (there happened to be two staff present as it was shift handover time), and spoke to staff again at 2.55 pm. The client then left the house without telling staff, climbed over the fence, and walked down the adjoining pathway into the park area behind the house, which leads to a suburban street and a primary school across the park. The client encountered a father and child walking up the path in the opposite direction, towards the fenced boundary of the respite facility, where the path enters the street. The child's father described the client as looking agitated. The client turned and followed them, and when they got to the street outside the respite facility, the client went to take the hand of the child. The father moved his child aside and grappled with the client.

A local woman heard shouting, saw the two individuals grappling near the child, so ran out of her home, picked up the child, ran back inside her home, and locked the door. The client followed and tried to enter the home. Two other men joined the father and held the client in place until the police arrived. A MHAIDS staff member from another mental health team was visiting another client in the Whitby respite facility, came out to leave, and saw the altercation. She went into the respite facility and advised the NGO support staff there was an incident outside. This staff member then called the police and stayed on the line until police officers arrived[5].

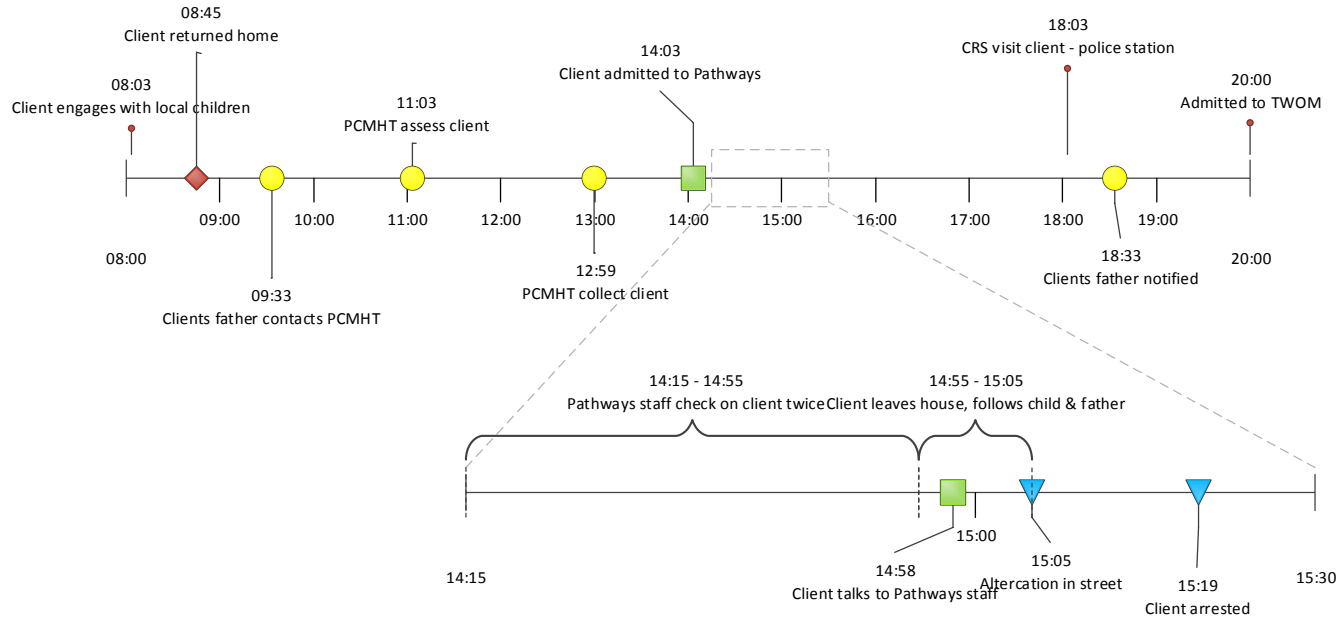
At this stage the NGO staff, having just recently spoken to the client, were not aware that they had left the house. They went outside and discovered their client held down by three men. One NGO staff member tried to get the client's attention and calm the client, while the other called for support from the CMHT (3.02 pm).

[5] The three men thought the staff member was videoing the incident.

The client was taken in to police custody (3.20 pm), was examined by the Crisis Resolution Service at 6 pm and admitted to the acute inpatient ward that evening[6].

While there has been excellent engagement with the family generally, the family was not contacted until 3 hours afterwards. The responsibility for this task was not clear, and it was only later with the involvement of the CRS team that the family was contacted.

Figure 1: Timeline of events on day of incident



As is to be expected, there are different perspectives about some aspects of the event. For instance, the local community described the Whitby staff as watching and filming the incident, rather than providing adequate support, while the Whitby mental health support staff described how they tried to verbally calm the client, attempted to stop the client resisting the physical restraint, and that the DHB staff member rang the police.

Reviewing the clinical file and the associated documentation

The clinical file was reviewed by both the psychiatrist and the clinician on the review team.

The clinical file (paper based) indicated regular recording of contacts and thorough clinical notes, including a mental state exam in the assessment. The notes relating to 2017 were located in the referrals and correspondence section of the file, rather than in the progress notes.

There was evidence of an up to date partnership plan, crisis assessment plan and wellness plan in the electronic health record. The crisis assessment plan and wellness plan were provided to the NGO at the time the client was admitted to the Whitby facility.

[6] Detailed timeline in Appendix 3.

Supporting information

Summary of interviews and written submissions

The key themes from interviews and submissions are summarised below. The incident specific information is first included, followed by system and process information where applicable.

MHAIDS Community Mental Health

Four MHAIDS Porirua CMH clinicians attended interviews with the review team – three together and one at another time, due to availability.

Incident specific:

The clinicians interviewed reported that their clinical assessment was based on interview with the client and father, which included discussion about the earlier events of the day. Assessment indicated the client was psychotic but responding to direction, and agreeable to the planned treatment. The assessment considered prior admissions to crisis respite and the inpatient unit and the option of home based support, as well as the client's response to those earlier treatments.

Clinicians stated they are mindful of what can be managed in the crisis respite facilities and from what they knew, thought the client could be managed with this level of support. They said that even in hindsight their decision for crisis respite care would remain the same. They stated they had checked all the risks and there was no warning that an incident of the kind would occur. Based on this, the client's recovery plan was developed and the process for admission to crisis respite commenced.

System specific:

The clinicians reported a positive relationship with the AR Coordinator and stated that most of the time things operate smoothly; when there are challenges, this is due to resourcing.

They noted they feel like they are fighting over scant resources and described a number of examples where it was difficult to access the most appropriate resources for clients. For example, variable or lack of availability of respite or ward beds, and enhanced packages of care (EPOC). The team stated: "where possible we want to treat people in own community – we want to be able to support people in their homes. There is a resourcing issue; for example, we had someone recently we were able to support at home for a day but they could have done with a full week's worth of packages of care. We could use EPOC more extensively, but also need to recognise that the staff come from a casual pool, and so there is no way of getting continuity of care."

Clinicians clearly stated that in this instance resourcing issues were not the reason for the placement in the crisis respite facility – this was based on clinical assessment. Clinicians stated that they are supported to do the right thing clinically before thinking about resourcing.

Clinicians stated: "people go where they need to go mostly. It can take a few days to get into the mental health ward, especially if the client is already in a medical ward. We can have three people waiting for the ward, even waiting in police stations." They also stated: "The length of time to get people into hospital is a struggle – the community teams are not geared up to manage acutely unwell people – what do we do for six hours while waiting for beds?".

The CMHT noted that the AR coordinator works really hard, and is good at knowing who is where and what is available, but noted the inherent risk in this being a role rather than a service[7]. They considered the incumbent irreplaceable.

Crisis model of care:

Clinicians reported a change to their crisis duty system to accommodate the amount of acute work, as the Crisis Resolution Service (CRS) cannot always meet demand coming through from the community. CMHT reported they have moved from two, to three, duty clinicians per day.

Clinicians described the current model of care, where the CMHT are required to support their clients who present in crisis at ED or Wellington police hub. Porirua clinicians work from 8.30 am to 5 pm, which means the earliest they can assess a client in Wellington ED is 10am. When the community MH team is already managing a local crisis presentation, this creates a stress on resource availability and clinical practice, given the travel time required for teams based in Porirua and Kapiti. Clinicians noted that the current level of vacancies in CRS means the CMH teams are managing a greater numbers of people in crisis

The clinicians thought the following considerations may improve services:

- CRS as part of community team – "when you see them in crisis you get some lovely moments and that gets lost when done by a different team. Continuity of care would be nice.";
- Links to GPs could be done more with a community team;
- CRS currently do both home-based treatment (HBT) and crisis response. Clinicians stated that HBT disappears when crisis response gets busy. This has changed from the original intent for HBT and the community team proposed it may be more effective if they managed the HBT and EPOC allocation.
- Crisis respite – having only one staff member means it restricts what they can provide. It makes them vulnerable. Better matching of the number of staff to the assessed need in the facility at the time would be safer and more effective for clients.

Clinical documentation:

Porirua CMHT reported a system of both electronic and paper files that they consider to be inefficient. While the electronic and paper files do not duplicate information, clinicians must look at both electronic and paper file to gain a complete record. They noted that if Te Haika[8] are contacted by clients and family, Te Haika doesn't have access to the paper file which means current clinical progress notes are not available. They noted there is a current project working on a MHAIDS client pathway which includes clients' clinical records. One clinician with experience in other DHBs considered the current system of paper files and "patchy" electronic files to be unsafe practice and time consuming for staff. It means people can "fall through the gaps as clinicians cannot see exactly what's happening without access to both files".

Acute Response Coordination

The AR coordinator, whose role is to support placement based on the respective team's clinical assessment of the client, received a verbal request for respite care. The request focused on giving the parents and the client some rest, rather than on a psychotic presentation. The AR coordination service provides a further check and balance in the system regarding clinical decision making and placements, based on the information received from clinical teams.

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[7] Cover for leave is currently provided to the role by several staff in CRS.

[8] Te Haika is the central point for all referrals to the Capital & Coast DHB Mental Health, Addictions and Intellectual Disability Directorate (MHAID).

The MHAIDS clinician visiting the facility at the time of the incident noted that the support worker did a good job of trying to calm the client.

NGO staff – Pathways

Five staff were interviewed, including support workers present at the time of the incident and management and clinical director.

Incident specific:

The NGO team reported that they did not receive the client's documentation prior to arrival at the crisis respite facility as is required. NGO staff questioned the decision to place the client in crisis respite, based on earlier events of the day, but was reassured by the attending clinician that it was the appropriate decision. They also noted that the plan indicated the client understood they were not to leave the facility. However, NGO staff also noted that clients enter crisis respite voluntarily and are free to come and go as they please. In this instance, this requirement should have resulted in a request to ARC for EPOC support.

NGO staff identified they had maintained close contact with the client over the 60 minutes that the client was in the facility.

System specific:

Pathways management noted there are more incidents in the CCDHB region than in other DHB areas. However, Auckland also has a higher number of incidents and Counties Manukau, for example, has higher incidents but can respond quicker due to higher levels of staff. Pathways tends to get the higher acuity people over other NGO services. Pathways management indicated they wish to take on high acuity work and there is a good trusting relationship with DHB staff.

Management noted that they understand that decisions will be made that will prove incorrect in retrospect. As such, it is important to have multiple levels of monitoring to catch mistakes early and ensure systems are nimble and responsive to situations. Clinicians need to abide by these systems – the NGO staff must have high trust in the referring clinicians to know the criteria and boundaries. Pathways systems require paperwork and assessment to be with them before a client is brought on site.

It was fortuitous that it was handover time in the facility and two support staff were present, particularly as there was another resident staying at the facility at the time. NGO staff noted they would prefer two staff per shift but recognised that in this case it still would not have prevented the incident. One manager observed that single staffing is not a model used in other regions – the two facilities in this region are the only Pathways facilities with single staffing – facilities in Waikato, Auckland, Counties, Southern, Taranaki, Whanganui are dual staffed.

NGO staff and management highlighted:

- The need for referral information prior to admission to ensure all the needs for the proposed client can be met at the time of admission; and
- The need to consider dual staffing in Crisis Respite services to fully support the presenting client's levels of need.

Whitby Community

The local community nominated three people to provide input to the review. Multiple attempts were made to meet with the selected neighbours on the days the review team were available but as it occurred during school holidays, face to face interviews were not possible with the three people nominated. Input from the three nominated people was

provided by email, at their request, on their perspective of the event, and any other information they considered relevant.

The review panel received two written submissions from three local community members involved in the incident, as they were not able to meet with the review team at the time the review panel was interviewing.

The fathers of both the child at the centre of the incident and the client were interviewed. The families of those involved in this incident (both the child's family and the client's family) talked about the vast impact this incident had on them at the time and continues to have on them.

The submission expressed concern about having a crisis respite house nearby, with people staying a short duration and thus high numbers of different people staying over time. Pathways data shows there are 170 people admitted to the Whitby facility each year, with 72% staying for the first time, and the average length of stay being 6 days.

The local community stated that they are concerned about the acuity of some clients, and they reported repeated instances of police and ambulance vehicles going to and from the site. Information provided by police to the local community through an Official Information Act inquiry shows increased police presence at the Whitby facility over the past 5 years (from 2 visits in 2006 to 7 visits in 2016).

The neighbours perceive that many of the people staying there are of high risk, and are concerned about their children being exposed to unusual behaviour and strong language. Their preference is for the facility to be moved to another location with greater distance from neighbouring properties, schools and older people, to a place where residents can have privacy and peace.

In response to the community concern, DHB and NGO senior management attended community meetings to hear their concerns.

Related systems

Acute Care Facility Options and Utilisation

Most people who need mental health and addiction services are assessed and treated in the community. Community-based acute services (crisis respite and recovery beds) tend to be small and situated in home-like, informal environments in suburban settings. The houses are in ordinary streets and normally provide for fewer than ten people, staying for under three weeks. Crisis houses tend to adhere to the view that mental health crises are a turning point and an opportunity for growth, rather than just risks that need to be managed. They provide a listening ear, personal support, practical advice and complementary treatments, as well as medication. These community based facilities are an important part of recovery of mental well-being (O'Hagan, April 2006).

There are 50 acute inpatient and acute, respite and recovery beds available in the CCDHB region, with an average occupancy of 44 beds (80%) in the six months from 1 October 2016 to 31 March 2017. The MHAIDS Capital and Coast inpatient unit has 30 beds with average occupancy of 88%, and there are also twenty community-based acute respite and recovery beds (five facilities each with 4 beds), and with overall average occupancy of 67%. Over this period the MHAIDS and NGO acute services managed an average of 82 clients at any one time (both in beds and in clients own home).

Respite and recovery beds provide adult crisis respite[9], where the objective is to provide a home based or residential service as an option for people who would otherwise require admission to acute inpatient mental health services. These facilities are to provide:

- staff with appropriate skills to monitor and support the person in crisis;
- short term care in supervised accommodation;
- short term care in a specifically dedicated respite facility; and
- respite care for as short a period as possible during the crisis.

The crisis respite and recovery beds are funded on a bed basis with providers determining how they will provide care within the allocated funding. This funding model is not dissimilar to other DHBs where a variety of models operate, including larger facilities (6 – 10 beds) allowing economies of scale.

On the day of the incident, acute services[10] were managing 83 clients, the inpatient unit had 29 clients, and the crisis respite and recovery houses had 14 clients (68% occupancy). Therefore, it was not markedly different from any other day. The Whitby house had three clients that day (only two at any one time). One was discharged in the morning and the other client remained in the Whitby respite house at the time of the incident.

As such, there were a range of acute care options available to the assessing clinicians.

Acute Response Coordination

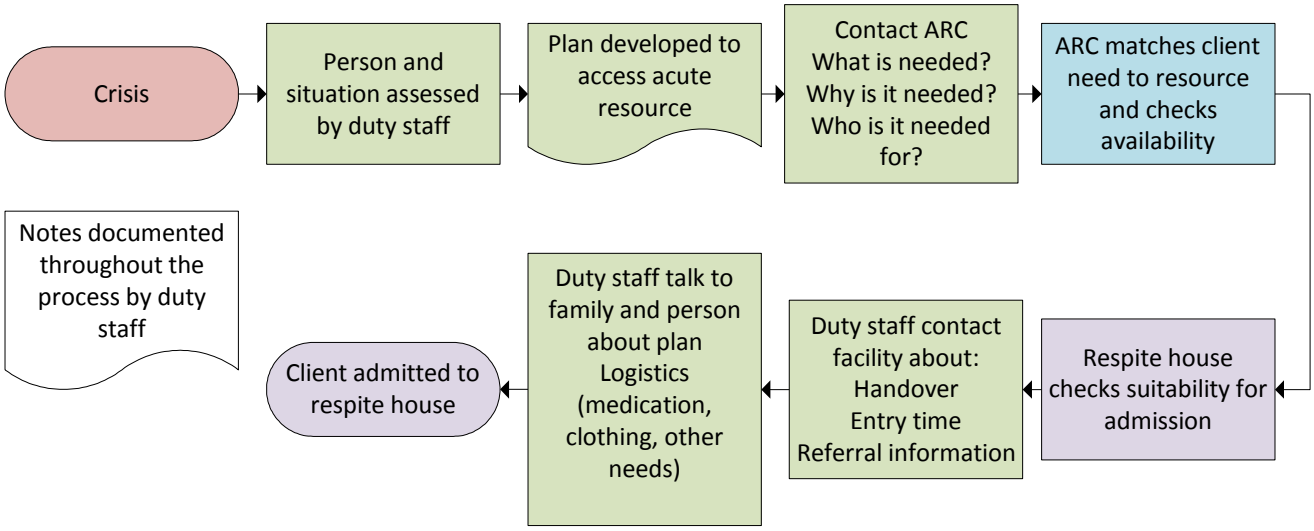
Staff reported that the agreed response to acute presentation during Monday to Friday work hours, of clients known to the CMH teams, is that:

- They are assessed by CMHT duty staff;
- A plan is developed; and
- The duty staff determine whether:
    - Admission to the inpatient unit is necessary,
    - Whether admission to crisis respite would be better or
    - Whether the client can be managed at home, sometimes with an acute package of care.

[9] Purchased under MHA03 using the national service specification.

[10] Includes inpatient beds in hospital and NGOs, crisis resolution service and acute clients in community teams.

Figure 2: Acute assessment process for clients known to CMHT



Once clients have been assessed by their clinical team (duty staff), the duty staff contact the acute response coordination (ARC) service. In addition to finding a placement in a crisis respite facility, the ARC acts as a check in the admission process, by confirming the clients' needs are matched to what is requested by the duty staff. The ARC also works with multiple services to transition clients to other resources, to free up beds where they are needed most. This service works across the acute continuum and is the vital link between determining need and finding resources.

Crisis Resolution Service staffing

MHAIDS 3DHB operates an integrated community crisis resolution and home-based treatment service (Crisis Resolution Service, or CRS), based centrally, but covering the Hutt and Capital and Coast DHB areas. At the time of the review, the MHAIDS service had 1015 full time equivalent (FTE) positions, of which 57 FTE were vacant (approximately 20% (11) of these vacancies were in the CRS team of 50 staff). MHAIDS management reported the service had difficulty filling these vacancies.

The model of care for assessing and treating clients known to MHAIDS is that during Monday to Friday office hours, CMHT staff manage any crisis presentations of clients currently in their care. Clients not known to MHAIDS are assessed and referred on by the CRS. Clinicians reported that with the vacant FTE across the crisis resolution and home-based treatment service (CRS), the CRS team was stretched in responding to crises and so could take on very little home-based treatment. The reduced focus on home based treatment means that clients become very unwell before being seen, with the result that more acute care work falls back on CMHT staff.

In this instance, the model of care and the stress on the acute system meant that the senior clinician had to leave to assess a client in Wellington ED. As the senior clinician had to leave immediately after the assessment on the day of the incident and was not involved in the subsequent care, including conversations with the ARC, this aspect of monitoring and continuity in the patient's care was weakened.

Findings

The review team assessed the information provided from interviews, submissions and other documents, and identified causative factors and areas for improvement grouped under the following headings:

- Incident
- Systems

The findings are summarised under each subheading relating to the incident and to wider systems. Each subheading includes the identified areas for improvement.

Incident findings

Clinical assessment

The review team found the NGO and CMHT services are effective at knowing and working with the person and their family, being responsive to the person and family's needs, and working from a recovery-based practice focus. However, the impression of the review team was that while the clinicians involved in this incident had assessed the client's symptoms of psychosis, they had not appreciated the extent to which those symptoms were having major impact on the client's behaviour.

Previous clinical notes documented the client acting on perceived concerns of children at risk, and that, along with the client's earlier interaction on the day with children, suggests there was risk of the client acting again on psychotic perceptions.

The impression of the review team was that there was documented client behaviour indicating significant, potential risk at the time of the incident and therefore a need to address and manage the acute symptoms within a recovery focused plan.

There was nothing in the clinical documentation viewed to indicate there had been a discussion with the psychiatrist or psychiatric registrar. The Review Team were subsequently informed that the client was discussed with a community mental health psychiatric registrar before the plan was enacted, but this was not documented and neither were the reasons for the decision making.

The Review team consider that in this case, someone with LOW static risk factors quite quickly developed HIGH dynamic risk factors based on the nature of the psychotic phenomena experienced. Nevertheless, the dynamic risk factors were not adequately recognised and integrated into an assessment of current risk and consequent planning to manage the risk. An assessing psychiatrist/registrar would have likely identified the dynamic risk factors, and assessed the client as requiring a level of care higher than that provided in Whitby crisis respite. At a minimum, such an assessment or case discussion would have provided a further check in the system.

Identified areas for improvement

- Review and clarify guidance given for psychiatrist/psychiatric registrar involvement in care planning in acute assessment;
- All clinical staff complete updated training in static/dynamic risk assessment and management ongoing training, and optimal use of MDT care review processes; and
- Handover documentation to go to the NGO facility before the client is admitted.

Clinical decision making

The review team found that:

- The CMHT clinicians' assessment determined Crisis Respite to be the appropriate support for the client's recovery;
- The AR Co-ordinator indicated that if she had been informed of the client's potential risk, additional resources are likely to have been put in place at the facility. The AR coordinator receives verbal requests/communication rather than written documentation, which may not inform fully of the client's situation;
- A contributing factor in this case was that the AR coordinator reported not questioning the case manager as thoroughly as usual, due to the case manager being relatively new in the role, and given assurance of senior clinician involvement in care planning;
- Clinicians on the Review Team have differing views about the right decision regarding level of care in this instance.
    - The psychiatrist from the Auckland region, where acute alternatives are more intensively resourced, would have been comfortable admitting the client to an acute crisis respite service based on the assessment at the time but ONLY if:
        i) There had been a psychiatric assessment and initiation of immediate medication to reduce the client's level of agitation and distress;
        ii) The acute alternative to inpatient care was staffed in a manner fit for purpose, i.e. two support staff at all times, plus accessible nursing presence daily, AND perhaps in this instance some extra support in place via an Acute Package of Care; and
        iii) There had been a plan for the duration of the client's stay, regarding how to actively manage the identified needs and risk that they might again become agitated and act on the client's delusional beliefs re children.
    - However, the local clinician, knowing the limitations of the local crisis respite services, would have requested admission to Te Whare o Matairangi (Wellington Hospital's acute and intensive psychiatric inpatient support unit – TWOM)

Identified areas for improvement

- This case has highlighted a need for training, supervision, and a greater level of input to acute care decisions by the team psychiatrist/registrar, in regards to this aspect of practise.

Model of Care

The review team noted those closely involved in the incident were experiencing residual trauma. Subsequent to this incident, both the DHB and the NGO provider have reflected on their postvention processes.

Identified areas for improvement

- This incident has highlighted the need for community engagement processes to be built on, clearly identifying when postvention support is required, and developing processes to support those impacted by incidents such as this one.

Other contributing factors

The NGO team management had carried out its own review and identified a number of contributing factors to the event, and ways that they can improve their service going forward.

The PCMHT clinicians that were interviewed identified ways to improve the current acute care system and were aware of the independent review. Their team leader indicated the team would be actively engaged in responding to the report recommendations.

Identified areas for improvement

- Emphasis on a culture of learning from incidents such as these is essential to continue to further the aim of providing effective and appropriate care for members of the MHA community.

System findings

Clinical record system

Within MHAIDS, there is a system of paper files and patchy electronic files. This means risk assessment and crisis plans are not easily accessible. This is considered by the review team as unsafe practice, time consuming for clinical staff looking for information and means people can fall through the gaps. Clinical staff report spending time looking for paper files that they sometimes do not find. The team was informed that an MHAIDS electronic shared health care record is a core component of the client pathway currently in the process of being implemented. Implementation of the client pathway is planned for December 2017 and the review team were informed this should help to address this issue.

Identified areas for improvement

- The review team recommended that the development of a standardised, integrated, accessible mental health client record across the 3DHB MHAID needs urgent prioritisation[11].

Clinical decision making

Awareness of level of care provided in crisis respite houses

Those referring to the acute facilities need an awareness of the level of care available in the crisis respite facilities and of the limitations in terms of facilities not intended to be secure, staffing limited to one support worker, and often no clinical presence. The crisis respite facility at Whitby has a pre-admission checklist that provides a further check in the system to ensure that there are appropriate admissions, and that alternative arrangements can be made for inappropriate referrals that have made it through the other checks and balances (the first being the referring clinical team, and the second being the AR coordinator).

Several instances were reported where clients that may present with high risk to themselves or the community were referred to crisis respite, but the checks and balances in the system meant alternative arrangements were made.

Inappropriate referrals reaching the crisis respite facilities may be due to CMHT and replacement ARC staff not being aware of the capability of the crisis respite and recovery houses to manage acutely unwell clients. They may not be

[11] Shared Care Records are a tool for allowing wider access to health information by health professionals for the purpose of care.

aware that these houses have only one staff member present at any one time, and do not have the time to closely manage or oversee clients. The crisis respite and recovery houses may be seen as acute alternative inpatient care, and indeed with the right staffing mix and levels they could be providing this level of care for acutely unwell clients. However, at the current level and type of staffing they are not able to provide the level of support and clinical care required to operate as an alternative to inpatient acute care.

Identified areas for improvement

The review team suggested that it would be useful to:

- Identify a clear process that supports informed decision making about placement for people requiring acute support – including responsibility for placement decision; and
- Ensure all clinical and NGO staff are informed of the process.

Acute Response Coordination

Presently there is only one person performing acute response coordination and as such, the system is totally reliant on their ability to capably undertake this role and manage the acute system. The review team found this reliance on one person for the system to work safely and effectively to be a significant potential risk. Mitigating this risk is that in the AR coordinator's absence, cover is provided by CRS clinicians trained in the ARC function. However, clinicians and NGO staff reported the service was less effective in the current ARC's absence. There is an urgent need to begin adequate training and succession planning for this service.

The review team also noted that requests for beds are only via verbal discussion with the ARC coordination service, and they were not made aware of formal documentation supporting the bed request. In the review team's opinion, a documented process should be in place. While the verbal system continues, the decision about care planning for a person's support needs and placement remains with the assessing clinician/team, rather than with the ARC service.

Identified areas for improvement

- The Acute Resource Coordinator service is currently a key "check and balance" in the acute care system, but this service relies on one person. A second equally capable and senior clinician needs to be trained and mentored by the current ARC to provide continuity of the service, with the service potentially extended to provide increased hours in the evenings and weekends.

Model of Care

When clients currently under the care of the CMHT present at the Emergency Department (ED) during normal working hours, the client's case manager assesses them at ED. For the PCHMT this means at least an hour's travel, in addition to the time assessing their client and planning their care. While this provides continuity of care for the client, it can be very disruptive to planned workloads and care of other clients. In this instance, the senior clinician overseeing the assessment was called away to ED to assess a client, leaving the newer staff member to complete the assessment with no reference to senior staff support/consultation.

Identified areas for improvement

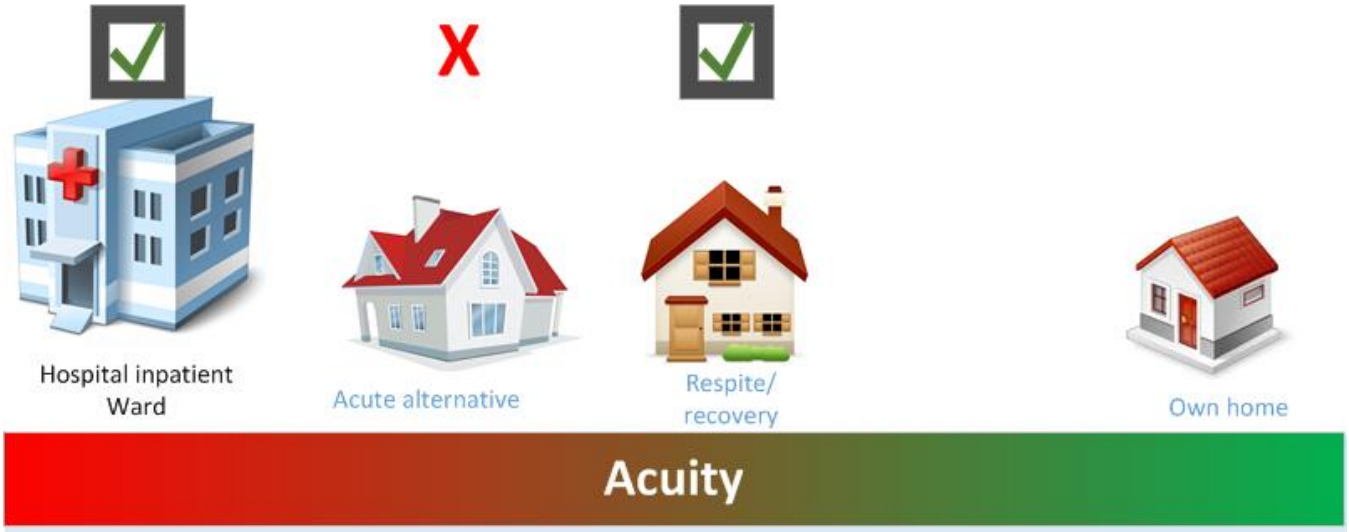
- There is no perfect solution to this complex issue, but the review team would like to stress that travelling long distances for assessment is an inefficient use of time that may further compromise both patients and the ability of clinicians to make the most informed recommendations. The current system of CMHT clinicians travelling to ED to assess existing clients should be reviewed.

Acute Care Continuum

The Journey Forward 2005-2011 identified a separation between the delivery of acute services and the community in which service users live their lives. The adult acute inpatient ward, (TWOM) was consistently at over 100% of its intended occupancy, resulting in a crowded and less therapeutic environment. At that stage, it was resourced to provide 29 beds but often accommodated up to 36 people in poorly designed spaces. Since then, TWOM has had a $7.8 million-dollar makeover. It is currently funded for 20 acute beds and nine intensive beds, can accommodate 30 people, and routinely accommodates 27 mental health clients.

The Journey Forward also proposed that CCDHB develop community-based 24-hour crisis houses staffed partly by clinical and partly by NGO staff, as part of providing an extended range of acute care options. These community crisis houses (which were to be called STAR – short term assessment and recovery – centres) for people with acute mental health and addiction issues, were to be located in each territorial local authority area and accessible to people with physical disabilities. The STAR centres were to take people who were either in the earlier stages of an acute episode and required 24-hour support and clinical care but not the higher intensity of acute inpatient care, and also people who after a short time in inpatient care were no longer very acutely ill, but needing some intensive support and treatment for a longer period.

Figure 3: Current availability of facilities to address differing levels of patient acuity



This incident has highlighted the fact that the current crisis respite options are not providing the level of care and expertise required to safely and effectively provide an "acute alternative to inpatient care" service. The nature and staffing of the services is in reality, more consistent with a non-acute planned respite level of care.

The move to reduce hospital based inpatient beds and provide more recovery-focussed community based acute alternatives has gained a lot of support internationally. There are some exemplar models (such as Soteria House), BUT they are not a "cheaper" option, and they rely on adequate staffing, AND excellent clinical support. In seeking to provide alternatives to inpatient acute care in the current crisis respite facilities CCDHB have risked undermining what is in fact an ideal model of acute care if implemented in the manner intended.

There is also a balance to be made between running a cost-effective facility with higher bed numbers (6+ beds) and maintaining a home like environment with fewer bed numbers (4 beds). All crisis respite and recovery beds in the Wellington region are 4 bed houses and future commissioning may want to consider the clinical and cost effectiveness of dual staffing of 4 bed facilities compared to larger facilities.

There are mixed views from the local community about the placement of a crisis respite house in suburbia – the house has been utilised by many local residents over the 12 years it has been there, providing a quiet place for time out from life's pressures. Over time the community reported a number of lower level incidents, and this has contributed to growing concerns, and likely increased stigma. For instance, a gentleman mistakenly entering a similar looking neighbour's house caused concern to the neighbour, and unusual behaviour has been witnessed by neighbours concerned about the impacts of this behaviour on their children.

Identified areas for improvement

- A review of the 3DHB community based respite services was completed early 2016. Benchmarking was undertaken at the time but was limited by the acute pathway of care not being fully documented. Work on the acute pathway of care continues and should be broadened to include the wider components of acute care and should be informed by DHB strategic planning for MHA services.
- The acute pathway work should establish a reasonable continuum of care and acute care options, including levels and types of staffing for acute alternative to inpatient care facilities.
- MHAIDS, the mental health commissioning team and local NGO leaders have subsequently continued to progress commissioning changes to the acute care continuum and this work is progressing with some urgency.

Collaboration and clinical communication between services

The NGO has standard documentation they require completed prior to accepting clients into the crisis respite service. In this case the information arrived with the client, the support worker noted the information received with the arrival of the client and questioned the risk level, but was told by the CMHT clinicians present there were no risk concerns and accepted this.

Crisis respite and recovery houses report routinely receiving information about clients as they come through the door. At times, they find information is inaccurate, meaning that when clients arrive at the facility, they are found to have higher levels of need than anticipated.

The prior handover information from the assessing clinical team is vital as the assessing clinicians do not always travel with the client – this is sometimes only a driver with no clinical knowledge of the client.

At the level of service provision, NGO and clinical staff interviewed during this review highlighted that overall, despite a stressed system, people work well together, collaborate and ensure service transitions and boundaries work. The services involved all seem to work well from a recovery-based practices perspective. Almost without exception, those interviewed spoke highly of the relationships that exist between services (both NGO and MHAIDS) and there was mutual respect for the work that others do.

However, there are opportunities to improve the level of collaboration, so that across the clinical-NGO boundary there is more of a sense of working as one MDT (e.g. collaborative reviews in crisis respite) with consistent input from crisis respite staff.

The crisis respite facility identified that while they generally have good collaborative relationships with the CMHT, the Maori and Pacifika teams could improve their collaboration a little, with improved accuracy of information for handover and in some of their one to one relationships.

Identified areas for improvement

The review team emphasised that:

- For NGO crisis respite and recovery services to safely and effectively receive clients into their services, they need to receive the required documentation prior to admission, to allow them to make a decision regarding whether to accept the admission; and
- While the current level of collaboration is good, it could be improved, so that across the clinical-NGO boundary there is more of a sense of working as one MDT (e.g. staff suggested collaborative reviews in crisis respite).

Other contributing factors

Crisis respite house staffing

The review team considers staffing at the Whitby crisis respite house is below a safe level for provision of an "acute alternative to inpatient care" service. This view is also supported by the increased police call outs to the facility over the past 5 years.

In this instance, it was fortuitous that it was handover time and there were two support workers present to enable the other client to be cared for. These crisis respite facilities are sometimes used as an alternative to acute inpatient care and the level of support/clinical staffing required to safely and effectively deliver inpatient-alternative care is not present.

Identified areas for improvement

- Good practice would suggest levels of staffing should be based on the risk assessment and are appropriately matched to the assessed needs of clients in the acute alternative to inpatient care respite facilities at the time. There should be access to a registered mental health nurse for a minimum of 8 hours daily. This will have implications for the size (i.e., bed numbers) of such facilities.

MHAIDS vacancies and staff shortages create a crisis cycle

Vacancies in the specialist mental health service (MHAIDS) and staff shortages across the sector are compromising acute capacity and the ability to manage acute care both in the community services and the crisis services. This in turn means that other parts of the service are dealing with clients of higher acuity, with their CMH teams at times operating as a mini crisis team. The home-based treatment function, alongside the crisis assessment and treatment function, forms the crisis resolution service (CRS). With the vacancies in this team, the HBT component takes a lower priority with the function reduced to crisis resolution only AND as a result more crisis work spills onto the community teams. This in turn draws the community teams away from their planned work, meaning patients are less likely to get planned needs met, more likely to relapse, and thereby driving up acute demand.

Identified areas for improvement

- The current level of vacancies in the Crisis Resolution Service/Home Based Treatment service, is compromising the capacity to provide Home Based acute clinical care, and is also pushing a greater level of acute care onto the CMHT clinicians. These roles need to be filled as a priority to ensure the acute care continuum is able to function as intended.

Conclusions

The client was assessed by the local CMHT who had a skilled team available. During the assessment, the more experienced member was called to attend another client, and made the decision to leave the less experienced staff member to complete the assessment. Some risk factors were not given enough weight in the assessment process and consequently, the client was placed in a facility not suitable for their needs.

There are no winners from this incident, which has negatively impacted the lives of a number of people – the child and family, the client and family, the community who live nearby, and the staff involved.

The review has highlighted a number of factors related to mental health and addiction systems, local CMHT and NGO services, clinical service delivery and commissioning that contributed to this incident. However, the review team believes we can learn from this incident, and recommend and implement changes to address the issues identified in the following section.

Summary Recommendations and Actions

The findings of this review map to areas of focus for the impending Health Quality and Safety Commission sponsored Mental Health and Addictions Quality Improvement Project (MHAQIP):

- Learning from adverse events; and
- Improve service transitions.

To ensure the recommendations of this review are implemented in a way that results in sustained improvement in quality and safety of MHAIDS and local NGO services, it is strongly recommended that:

- MHAIDS and local NGOs prioritise these recommendations in the local implementation of the MHAQIP initiative. The MHAQIP initiative means utilising a trained Improvement Advisor (IA), resourcing of IA and project support time to work with clinical and support teams to use the collaborative methodology to implement recommendations, and convening a collaborative team to overview the implementation process;
- The findings and recommendations of this are synthesised into a series of areas for focus of work for that collaborative team using the MHAQIP methodology of Co-design with consumers/family, and using Improvement Science to test and implement improvements to quality and safety of services; and
- The work of this collaborative needs to also actively encourage a culture of reflection and learning in all clinical and support teams.

While all recommendations relate to this incident, some have application to the wider system that incorporates NGOs and the commissioning of services across the whole system. The recommendations below are separated into two levels – recommendations relating to this incident and those relating to the wider service system. However, it is likely that many of the findings related to the wider service system and this incident, may not be unique to this case. It is for this reason that we recommend that the findings of this review are used to help identify the priority areas of focus to integrate into the current MHAIDS MHAQIP collaborative

The three main considerations are:

- Improvements required to address the contributory factors identified;
- Actions to be implemented to operationalise these improvements; and
- Learnings to be shared to minimise future risk of critical incidents.

Recommendations Relating to this Incident

1. While the recovery focus evident in the PCMHT staff interviewed is to be lauded, there is insufficient awareness of the need when acute symptoms intervene to shift into a different mode of practise, focussed on detailed assessment of psychiatric phenomena (i.e. symptoms and what they mean), and assessment of risk. This is required to then develop a management plan to address the person's acute care needs at that point in time. This case has highlighted a need for training, supervision, and a greater level of input to acute care decisions by the team psychiatrist/registrar, in regards to this aspect of practice.
2. This incident has unfortunately evoked a high level of distress and concern in the local community, and resulting resistance to continuance of the Whitby crisis respite service. Engagement with community concerns needs to be made, including acknowledging failings, and potentially either downgrading the function of the facility to a more "planned respite" level of care, or to ensuring the resources in the facility are appropriately matched to the assessed needs of clients in the facility at the time.
3. Alongside this engagement, those involved consider postvention support as a core component of any future serious incident follow up.

System Wide Recommendations

1. The Pathways requirement for information about potential clients for crisis respite must be sent PRIOR to the client arriving, so the crisis respite house team can make a decision regarding their ability to safely provide care. This must be upheld at all times, and implemented in all crisis respite facilities.
2. Any consumer presenting acutely, who is being placed into an acute alternative to inpatient care level of respite, is ideally assessed by a psychiatrist/psychiatric registrar prior to the decision around placement being made, or at the least the case should be discussed with a psychiatrist/registrar.
3. The process of consumer review while in respite needs to be amended to ensure this is a collaborative process between the DHB and NGO clinical and support staff providing care.
4. The acute model of care, particularly with regard to community staff assessing known clients presenting with an acute episode in ED, needs reviewing to ensure the right staff are supporting the right people at the right time with the right resources.
5. Implementation of a standardised, integrated, accessible mental health client record across the 3DHB MHAID is being progressed as a matter of urgency. This should include a single comprehensive assessment, identification of any risks, and a single comprehensive care plan, which is readily available to all providing care to consumers, and is a living document able to be updated over time.
6. A review of the 3DHB community based respite services was completed early 2016. Benchmarking was undertaken at the time but was limited by the acute pathway of care not being fully documented. Work on the acute pathway of care continues and would benefit from being broadened to include the wider components of acute care and should be informed by DHB strategic planning for MHA services. The acute pathway work (completed for CRS and underway for crisis respite) should establish a reasonable continuum of care and acute care options, including levels and types of staffing for acute alternative to inpatient care facilities. MHAIDS funding and planning, provider arm, and local NGO leaders then need to be convened to agree required changes to the acute care continuum and implement these collectively. Work to close the gap in the community based acute continuum is progressing with some urgency.
7. Good practice would suggest levels of staffing should be consistent with services in other similar DHBs and based on the risk assessment of clients, with resources in the facility appropriately matched to the assessed needs of clients in acute alternative to inpatient care respite facilities. There should also be access to a trained

mental health nurse for a minimum of 8 hours daily. This will have implications for the size (i.e. bed numbers) of such facilities.

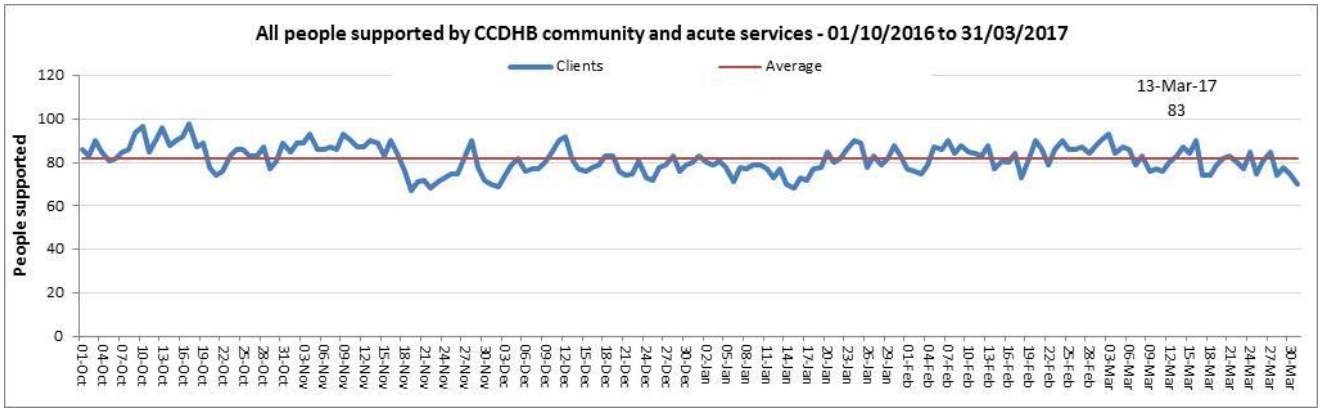
8. The Acute Resource Coordinator is currently a key "check and balance" in the acute care system, but this service relies on that one coordinator, with back up from CRS when on leave. To reduce the vulnerability of this function and ensure consistent service provision, a second equally capable, senior clinician trained and mentored by the current ARC would provide continuity of the service, with the service potentially extended to provide increased hours in the evenings and weekends.
9. The current level of vacancies in the Crisis Resolution Service/Home Based Treatment service, is compromising the capacity to provide Home Based acute clinical care, and is also pushing a greater level of acute care onto the CMHT clinicians. These roles need to be filled as a priority to ensure the acute care continuum is able to function as intended.

Appendices

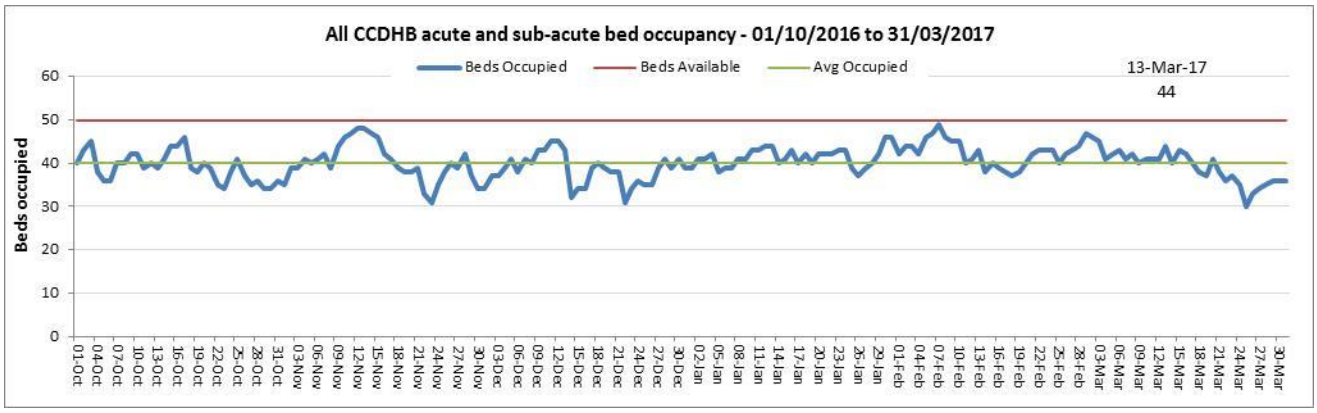
1. Service utilisation

The graphs below show utilisation of services from 1 October 2016 to 31 March 2017.

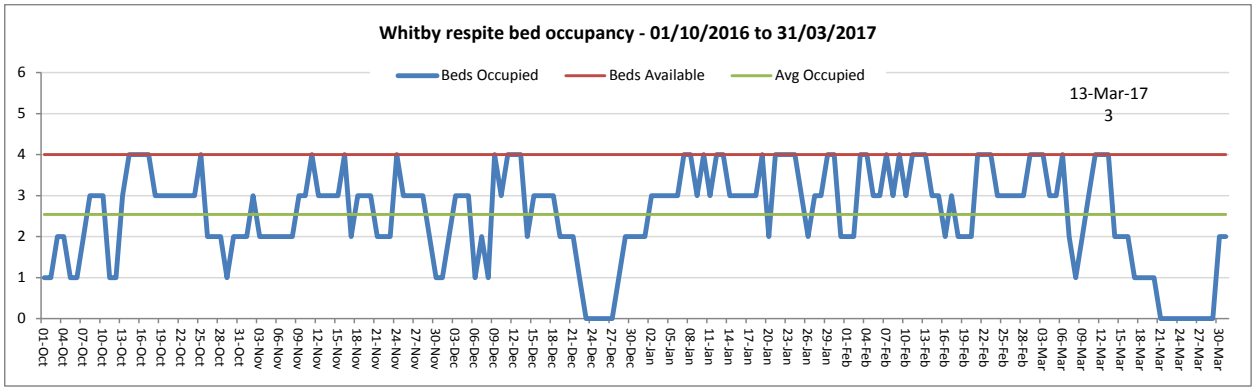
There were 83 people supported by CCDHB community and acute services on 13 March 2017 and while busy this was close to the average day and no different from many other days.

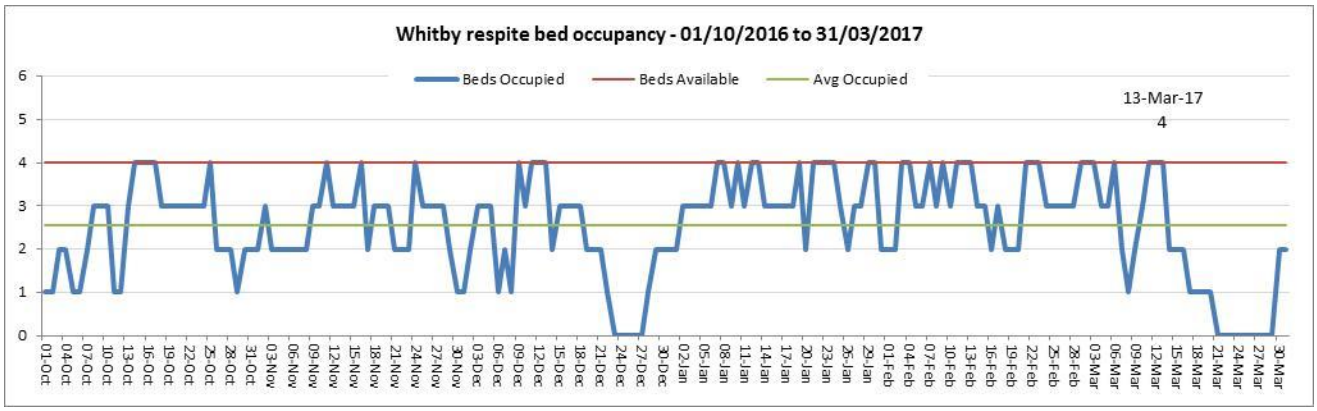


On 13 March, 44 acute and sub-acute beds were occupied, and again while slightly higher than average, this was not dissimilar to many other days over that 6-month period.



Two beds were occupied on 13 March, half of the 4 beds available.





2. Review Team

David Codyre is a psychiatrist based in Auckland with 30 years' experience working in the community mental health sector in New Zealand, in a range of clinical and leadership roles.

Helen Moroney has worked in Mental Health for many years both within NGOs and the DHB. Helen has worked as a social worker on Te Whare O Matairangi, CATT/CRS and Community Mental Health Team where she currently is a Team Leader. Helen is committed to continuous reflection on practice and learning. She is also committed to upholding the vision of community development within Mental Health and to develop strong working relationships within both primary and secondary services.

John Tovey brings to the team many years of experience working in community based NGOs and has also contributed a consumer perspective to the development of services at local, regional and national levels. His works part-time as an advisor to the MHAID Intensive Recovery Sector. John is committed to enhancing opportunities for consumers to contribute positively to continuous quality improvement and to increasing the utilisation of Peer Support.

Helen Mitchell-Shand is an independent health contractor with extensive experience in mental health quality systems and auditing.

Marion Thomas is an independent contractor with 30 years' experience in the health sector, both as a clinician and in health management and review.

3. Follow up actions post incident

Date	Who	What
13 March	NGO management	Travelled to site, notified DHB, arranged for double staffing on site, met with clients father
14 March	NGO & DHB	Visited Whitby house, visited neighbour, contacted family of child
17 March	NGO & DHB	Meeting with local mayor and MP, DHB senior management, and NGO regional manager
20 March	NGO & DHB	Meeting with neighbours, full apology to family
21 March	NGO & DHB	Public meeting with media in attendance
24 & 29 March	NGO	Follow up meeting offered on two occasions
30 March	Neighbours	Meeting agreed for 5 April, and list of questions
31 March	Neighbours	Neighbours seek written answers before next meeting
3 April	NGO	Purpose of meeting restated (problem solve and continue neighbourly engagement) -written answers not to be provided
4 April	Neighbours	Venue confirmed
5 April	NGO & DHB	Meeting cancelled & email to neighbours outlining reasons, meeting with mayor, deputy mayor and city council, email to neighbours seeking representatives to participate in external review
11 April	Neighbour	OIA seeking written response to questions
12 April	NGO & DHB	External review process initiated
14 April	NGO	Neighbours advised that FAQs to be released next week
21 April		FAQ sent to mayor and neighbours, request from Mayors office to attend facilitated meeting with neighbours
26 April		Updated FAQs, facilitated meeting with neighbours at Porirua City Council
27 April	NGO & DHB	3rd bed reopened at Whitby house with other conditions remaining in place
1 May	DHB	New communication group with contact details set up
2 & 6 June	NGO	Face to face meeting sought with neighbour about incident several years ago
7 June	DHB	Monthly update to group, and response from neighbour setting meeting date
19 June	Neighbour	After some to'ing and fro'ing, neighbour advised NGO a meeting after independent review has been completed