Importance of following the legal process designed to protect vulnerable mental health patients

19HDC01201

A consultant psychiatrist and Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral (formerly MidCentral District Health Board) (Te Whatu Ora) have breached the Code of Health & Disability Services Consumers' Rights (the Code) for not following the legal process designed to protect vulnerable mental health patients.

Deputy Health and Disability Commissioner Deborah James found, "This case highlights the importance of following the legal process designed to protect vulnerable mental health patients and of effective mental health care within the community, including the effective coordination of care".

Serious administrative errors in 2017 meant the patient, a man in his thirties, did not receive an appointment letter from Te Whatu Ora and a treatment plan was sent to his former GP instead of his current GP. This resulted in a lack of support, frustration and confusion concerning conflicting direction over the man's medication. Te Whatu Ora breached Right 4(5) which states every consumer has the right to co-operation among providers to ensure quality and continuity of services."

In 2018 the man presented to the Emergency Department at Te Whatu Ora seeking assistance and treatment for his mental health condition. The assessing psychiatrist arranged for the man to be admitted to the High Needs Unit and detained as an inpatient to undergo further assessment and treatment. However, a lack of communication and inadequate handover, including no doctor-to-doctor handover, resulted in the man being placed in seclusion, using a process which did not comply with the process required under the Mental Health Act.

"Te Whatu Ora was also in breach of Right 4(2) which states every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

"I find the psychiatrist in breach of Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable care and skill. She did not provide an adequate handover of care, or follow the legal requirements under the Mental Health Act."

Ms James made a number of recommendations, including Te Whatu Ora and the psychiatrist providing written apologies to the man and his family, further training

for staff involved in the man's care, and that the Medical Council of New Zealand consider whether a review of the psychiatrist's competence is warranted.

Since the complaint, Te Whatu Ora said that it put in place important improvements in its processes to ensure that an incident of this nature does not occur again in the future, which has resulted in a significant reduction in the use of restrictive practices, including seclusion. It has also implemented a "client check-in form" where, upon attending appointments, patients will be asked to confirm their correct contact details and details of their current GP at their appointment.

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Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).