AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Chief Executive's Office
Level 1
Building 37
Auckland City Hospital
PO Box 92189
Victoria Street West
Auckland 1142
Ph: (09) 630-9943 ext: 22342
Email: ailsac@adhb.govt.nz

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[redacted]

Dear Corinda

Re Official Information Request – Reportable event briefs

I refer to your Official Information Act request of 8 February 2019 to HQSC and subsequently transferred to the Auckland DHB on 21 February 2019 for information about the following:

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?***
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 you have requested is enclosed below:

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?***

This information is best understood in the context of Auckland DHB's Incident Review process. An Incident Review is routinely undertaken following a serious incident/ adverse event related to a patient of the Auckland District Health Board Mental Health and Addictions Directorate. Such reviews are primarily a clinical quality improvement process. The purpose is to review the care that has been provided in relation to the specific serious event and, through this review, identify any opportunities to improve the service. Care delivery issues may or may not be identified by a review. Identifying opportunities to improve practice (Care Delivery Issues) does not mean that the presence of these Care Delivery Issues contributed to or caused the adverse event.

All adverse events are rated by a Severity Assessment Score (SAC) from 1 to 4. All SAC 1 and SAC 2 adverse events are reported to the Health Quality and Safety Commission (HQSC) via Adverse Event Briefs (formally Reportable Event Briefs). A Part A Adverse Event Brief is sent to HQSC shortly after an adverse event, and this describes the nature of the adverse event. Following the completion of a review a Part B Adverse Event Brief is sent to HQSC which provides a summary of the findings of the

review and recommendations. For privacy reasons it is not appropriate to provide the Reportable Event Brief documents. To answer your question we have instead summarised the findings and recommendations in the tables below.

Auckland District Health Board has reviewed a total of 64 serious adverse events in Mental Health and Addictions between 2016 and 2018. Of these 56 have been completed and eight remain in progress. Of the 56 completed, 28 identified no care delivery issues. The other 28 may be summarised as follows:

Summary of findings and recommendations

Falls:

Incident	Findings summary	Recommendations summary
1	Patient choice Inappropriate footwear	• Encourage service user to use lift
2	• Falls prevention information not in admission packet. • Post-fall huddle did not occur. • Lying-standing blood pressure not obtained on admission. • No physiotherapy leave cover. • Only using red colour wristband.	• Falls prevention information included in admission packet. • Post-fall huddle to be held after each incident. • Lying-standing blood pressure to be obtained on admission routinely for all clients. • Arranging physiotherapist cross cover. • Implementing different colour wrist band on the ward.
3	• No routine post fall huddles review on the ward. • No wrist band use on the ward • Question of uneven surface in patient's bedroom.	• Routine post fall huddles. • Wrist band use. • Floor vinyl and underlay need to be replaced.
4	• Patient's age. • Patient's frailty with anaemia. • Olanzapine depot injection. • Clothing, large slippers for footwear.	• Contact with external team – to make aware of risks of falls and to address issues of ill-fitting footwear. • Falls prevention plan in place. • Explore potential for patients to attend adult community service clinic. • Record necessary documents in electronic clinical record.
5	Patient factors. Suboptimal equipment available. Room allocation and level of observation assessed as required. No physiotherapy available.	• Replacement of beds. • Establish and implement guidelines for High Dependency Unit. • Discussion with Physiotherapy of alternative arrangements available.
6	No physiotherapy available. Equipment not adequate.	• Physiotherapy cover to be established. • Close monitoring of patients at high risk of falls.

7	No physiotherapy available. No protocol to decide suitability for physical activities. No Patient Status At a Glance (PSAG) board and wrist band used on the ward. No routine post fall huddle on the ward.	• Physiotherapy cover to be established. • To develop protocols deciding suitability for physical activities. • To implement Patient Status At a Glance (PSAG) board and wristbands.
8	Lack of orientation due to communication issues. Fewer staff available at handover.	• Early involvement of interpreter where needed. • Increased observations for patients at high risk of falls.
9	Family education. Measuring postural hypotension. More detailed physiotherapy assessment.	• Falls prevention information for patients and family on admission. • Monitoring postural hypotension closely. • On-going assessment and education of gait tolerance.
10	• Falls assessment not performed. • Room blackboard too high.	• Falls assessment to be completed on every admission. • Review and movement of blackboard.

Suicides:

Incident	Findings summary	Recommendations summary
11	Delay in communication with another service.	• Clarification from other service regarding the process for admission.
12	Receiving service saw service user before contact with discharge team.	• The 2013 Transfer of Care between District Health Board Mental Health Services Memorandum of Understanding be followed in all cases of transfers of care to DHBs outside of Auckland. • A memorandum to this effect to be sent to all staff.
13	Insufficient documentation	• The Regional History form be used and kept current. • Clinical decisions to be explicitly documented.
14	Lack of clarity of roles and responsibilities between multiple teams. Insufficient documentation	• Develop a shared pathway. • Ensure an approach to crisis management planning and documentation with inputs of involved clinicians, client and family. • Ensure clear documentation of team discussions and reviews. • Ensure periods of elevated risk are discussed with clinical team. • Address duplication and quality of regional client history forms.
15	Lack of interpreter Insufficient documentation Lack of multi-disciplinary team planning	• Early involvement of interpreter and adherence to interpreter policy • Ensure robust planning and documentation when changing level of intensity of intervention. • Establish a new system whereby service users transferred external teams are reviewed by the multi-disciplinary team. • Regular clinical and caseload reviews are held and

		documented.
16	Insufficient risk assessment Lack of escalation	• All staff need to have up to date training in risk assessment and management. • Develop a consistent and documented approach to manage risk escalation.
17	Unclear process for referral to GPs Insufficient triage process	• Review referral pathway and ensure clarity. • Clarify triage process when mental health risk factors are identified. • Review triage and allocation system.
18	Lack of consistency for service user Lack of an integrated cultural model Staffing and capacity issues.	• Shift model of staffing to be reviewed. • Review provision of Maori cultural support within Mental Health Services.
19	Insufficient triage process	• Develop a structured approach for decision making on triage outcomes.
20	Lack of clarity of roles and responsibilities between multiple teams.	• External team to review the Duty person system.
21	Insufficient risk assessment Insufficient access to documentation Lack of communication between teams.	• All staff complete Mental Health Services risk training. • Feedback on issue of cross-sectional risk assessment fed back through appropriate meetings. • Client History form containing longitudinal risks must be kept up to date. • Review the Adult Mental Health Transition Pathway and clarify responsibilities. • Close communication between multiple treatment providers. • Develop principles for collaboration with other providers.

Other:

Incident	Findings summary	Recommendations summary
22	Lack of multi-disciplinary team planning Lack of shared understanding	• Improvements to multi-disciplinary team planning and documentation with an audit to monitor compliance. • (Re) orientation of staff around key policies and guidelines.
23	Delay in external assessment	• Review the referral pathway with external Trust.
24	Lack of escalation Lack of supervision for unregulated staff High demand on service Difficulty raising alarm due to another issue being dealt with in the same area Observation not in line with policy	• Review and improve the shift coordinator and duty manager processes for escalation. • Confirm and ensure all RNs understand role in supervision of Mental Health Assistant and unregulated staff. • To review and further develop the personal alarm system to align with the TWT unit alarm system. • Review and monitor staff practice when completing Category B observations patients.

25	Insufficient documentation Sole escort and police not included in planning	• Utilise existing pre-admission folder for patient clinical notes on electronic clinical record. • Summary of discussions to be recorded in clinical file. • Consideration given to use of a second escort. • Where possible, police to be involved early in pre-admission and planning.
26	Reliance on family support Delay in external assessment	• Review the referral pathway with external team.
27	Lack of clarity of roles and responsibilities. No discussion around staff safety.	• Discuss with interpreting service about the importance of following instructions of clinical team. • Explicit appointment of a leader and adaptation of plans when acute risks arise. • Staff en route to an acute event should telephone ahead to check on developments.
28	Suboptimal transition pathway. Suboptimal contact with patient's family. Unclear process for involving Police.	• Review and update transition pathway. • Communication and education around involvement of family. • Development of clear protocol for Police involvement.

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)***

As we have provided a comprehensive response to the first question no further response is required to this request.

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***

See the answer to question one.

I trust this information answers your questions.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

op Ailsa Claire

Ailsa Claire, OBE
Chief Executive