NorthWestern Mental Health

North West Area
Mental Health Service

Services based at:
130 Bell Street
Coburg Vic. 3058
Tel: 03 9355 9700
Fax: 03 9355 9701
☐ Administration
☐ Mobile Support and Treatment Service
☐ Moreland Continuing Care Team
☐ Shared Care Program
Tel: 03 8371 9800
Fax: 03 9354 8014

Services based at:
12-20 Talgano Street
Broadmeadows Vic
☐ Broadmeadows Community Care Unit
Tel: 03 9301 7777
Fax: 03 9301 7700

Services based at:
Broadmeadows Health Service
35 Johnstone Street
Broadmeadows Vic. 3047
☐ Broadmeadows Continuing Care Team
Tel: 03 8345 5611
Fax: 03 8345 5610
☐ North West Crisis Assessment and Treatment Service
Tel: 03 8345 5305
Triage: 1300 768 073
☐ Broadmeadows Acute Inpatient Unit
Tel: 03 8345 5725
Fax: 03 8345 5811

www.mh.org.au
ABN 73 892 706 972

4 May 2012

Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne VIC 3000

Court Reference: 5605/08

Re - Simon Macqueen (deceased)

I write this letter in response to the Coroner's recommendations following the Coronial Inquest into the death of Mr Simon Macqueen who was a client of North West Area Mental Health Service (NWAMHS). This response is in my capacity as the Director of Clinical Services of NWAMHS. The response to the recommendations has been prepared in consultation with senior medical and managerial staff working across the service where these recommendations are applicable. The recommendations have also been discussed in appropriate forums to learn from the investigation and consequently improve the delivery of our services.

Since the death of Mr Macqueen in December 2008, a number of initiatives have already been undertaken by NWAMHS to improve on the issues identified in the recommendations. I will go through each of the recommendations separately.

Recommendation 1 - At every first contact with MCCT there must be a telephone call with the General Practitioner with whom care is shared.
NWAMHS acknowledges the importance of ensuring immediate contact with General Practitioners (GP) or other service providers with whom care is shared. Since the passing of Mr. Macqueen, the service has attempted to address this issue with the development of protocol agreement with partner GP networks. These protocols have been reviewed in November 2011. Central to this agreement is collaborative practice with GPs. Included in this agreement are actions requiring our Community programs to invite our GPs to case conferencing and also to make telephone contact with the respective GP to advise of treatment changes. Further, Continuing Care Teams (CCT) including Moreland CCT has implemented a policy and procedures manual, "the Gold Series". A component of these procedures pays particular attention to the need for both initial and ongoing contact with GPs. Guidelines are provided to staff to indicate timelines for contact as well as template proformas to optimize the transfer and communication of clinically relevant information. The procedure referred to above, provides guidelines to staff to ensure transfer of written clinical information. It is an acknowledgement on behalf of our service, that phone contact directly with

GPs immediately upon entry, is not always feasible due to various factors including availability of the respective GP and their workloads. The service will undertake to amend these procedures, to improve in all facets of communication with GPs. The amendments will include the requirement for a phone call upon first contact with our service.

Recommendation 2 - Clinicians must be provided an opportunity to make important notes prior to commencing subsequent consultation.

All clinicians working NWAMHS are guided by a documentation procedure to help them appropriately document their clinical interactions. This procedure places emphasis on timely documentation of information. Documentation audits are carried out annually to identify and address any issues related to documentation. The next such audit is to be carried out in May 2012. Since the death of Mr Mcqueen there has been further dissemination of this requirement to all staff. Besides this, staff is encouraged to ensure they keep time between appointments to document their previous clinical interaction. A Clinical Risk Management Bulletin addressing this was released in December 2008 and distributed electronically to all staff in NorthWestern Mental Health.

Recommendation 3 - Discharge summaries contain all relevant information in respect to treatment and medication plans, provision of medication to the patient and circumstances of discharge and confirmation with co-sharing professionals in the community are contacted by telephone and with follow up discharge plan.

Producing timely and quality discharge summaries following admission to Broadmeadows Inpatient Unit (BIPU) remains an issue, albeit one partially addressed via the electronic medical record. Problems contributing to this are multifactororial. Attempts to address this issue over the last several years have been sporadic and ad hoc. BIPU had undertaken a project to improve the quality of discharge summaries by pre populating the initial assessment on discharge summaries, which is helpful for the treating team avoiding duplication of data entry. This is now incorporated in routine practice. This has improved both the timeliness and quality of discharge summaries. Further to this, BIPU is currently undertaking a project to identify further improvements in consultation with the Health Information Manager at NWAMHS using a Lean Sigma Six type methodology. We will have outcomes from this project within 6-12 months.

Flow of information between the BIPU and outside service providers is an issue being addressed on many levels. Since the death of Mr Macqueen, the service has introduced an electronic medical record. This means that medical and nursing entries made by the treating team within BIPU can be accessed directly, upon discharge, by all arms of the NWAMHS including MCCT. There is a Key Performance Indicator (KPI) set for the speed of scanning post discharge and the speed is currently above 90% (recently between 92 and 100%) within 24 hours of discharge i.e. community teams have direct access to the inpatient episode of care including drug charts and

file notes post scanning usually well before the clients first appointment in the community. The role of a Discharge Co-ordinator has been established and is currently being filled by a senior nurse within BIPU. One of their primary roles is to liaise with outpatient services including MCCT and GP's to ensure follow up appointment times are made. Contact is subsequently made by the Discharge Coordinator with the patient post discharge to ensure follow-up arrangements have been adhered to. This is also monitored by a post discharge contact KPI established by the Department of Health, which NWAMHS has consistently met.

Recommendation 4 - MCCT creates a Crisis/Emergency plan at the first consultation. Ideally to encompass a crisis pathway for families.

The Service acknowledges that developing a crisis plan for the consumer and carers at the initial review is an extremely important measure in managing risk and safety. Since Mr Macqueen's death, CCT has introduced a process of providing a 'Consumer and Carer Pack' at each initial meeting with consumers and carers. This pack includes a range of information, including accessing emergency and after hours care such as Psychiatric Triage and Crisis Intervention Teams. In addition CCT will introduce a process whereby each initial contact with a new consumer will be of 90 minutes duration; to allow for adequate time for clinicians to develop a crisis plan, make contact with relevant carers and services involved in the Consumer's care and enable adequate documentation in the clinical file.

Attachments-
1. GP Protocol
2. CCT "Gold Series" procedures pgs: 25-27
3. Documentation procedure
4. Clinical Risk Management Bulletin 2

Signature .....

Dr Vinay Lakra

Witness

Acknowledgment made and signature taken by me at (time) 12:54..

on this 14th day of May, 2012 at (place) NWAMHS....

Signature .....

Print name: