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10 October 2019

9(2)(a)

RE Official Information Act request CDHB 10182

I refer to your email dated 11 September 2019 requesting the following information under the Official Information Act from Canterbury DHB regarding external reviews of Specialist Mental Health Services (SMHS). Specifically:

1. 2016 January: Office of Auditor General audit

There was no specific report received from the Office of the Auditor General (**January 2016**) however we have attached as **Appendix 1**, the report that was released nationally by that office (**May 2017**). (Mental Health: Effectiveness of the planning to discharge people from hospital).

2. 2017 March: Ministry of Health certification surveillance audit

Please refer to **Appendix 2** (attached).

3. 2017 May: Christchurch opioid substitution service

Please refer to **Appendix 3** (attached) for Opioid substitution service report.

4. 2017 July: AT&R – quality evaluation report

Please refer to **Appendix 4** (attached).

5. 2017 November: Te Awakura – all wards – Office of the Ombudsman

Please refer to **Appendix 5** (attached).

6. 2018 June: Ministry of Health certification

Please refer to **Appendix 6** (attached).

7. 2018 July: Te Whare Manaaki (forensic service); Te Whare Hohou Roki (forensic service); AT&R; PSAID – Office of the Ombudsman

Please find attached

- Appendix 7** - Te Whare Manaaki Unit **Oct 2018.**
- Appendix 7a** - PSAID Unit **Oct 2018.**
- Appendix 7b** - Te Whare Hohou Roko (Extended Care Secure Unit) **Oct 2018**
- Appendix 7c** - Assessment, Treatment and Rehabilitation (AT&R) Unit **Oct 2018**

8. 2018 November: Child and family service – Office of Ombudsman

Please refer to **Appendix 8** (attached)

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 Canterbury DHB website after your receipt of this response.

Yours sincerely



Carolyn Gullery
Executive Director
Planning, Funding & Decision Support



B.29[17h]

Mental health:
Effectiveness of
the planning to
discharge people
from hospital



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**Mental health:
Effectiveness of the
planning to
discharge people
from hospital**

Presented to the House of
Representatives under section 20 of
the Public Audit Act 2001.

May 2017

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Overview

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata.

Mental health problems affect New Zealanders from all walks of life, with one in five people affected each year. Many people with serious mental illnesses also suffer chronic physical health conditions and many live shorter lives. Mental illnesses can also impact families, friends and care-givers, and communities. The personal, societal, and economic costs are high.

In November 2016, the Ministry of Health's Director of Mental Health reported that specialist mental health and addiction services are experiencing increasing pressure. Numbers have been increasing every year since at least 2003. In 2015, a record number of people, more than 160,000 or 3.5% of the population, used these services.

Of these, about 15,000 people needed to stay in an inpatient unit during 2015. District health boards spent more than \$200 million providing care to mental health patients in hospitals. People who are admitted to a hospital-based inpatient unit for mental health problems are in greatest need of support. Supporting them is difficult and demanding, especially for those directly involved in delivering services, and requires the co-ordination of a wide range of health and broader social services. If the system fails in effectively supporting these people, there are huge implications for them, their families, and the health and other sectors. Getting it right is an investment with significant payback.

International evidence shows that good planning before a person is discharged from hospital to community support services is critical in effectively supporting people with mental health problems. When done well, "discharge planning" brings together a person's health and broader social needs and enables those needs to be met.

This report considers whether discharge planning is completed as intended, whether the needs identified are met after people leave hospital, and whether discharge planning is helping to improve outcomes for people. My staff analysed data for all district health boards, closely inspected practices at three district health boards, and considered the views of a broad range of people directly involved in delivering services.

We focused on people experiencing mental health problems acute enough that they were admitted to hospital. Although they are a relatively small group, their acute and often complex health problems mean that they can need a large amount of care and support from the country's health services.

Overall, the timeliness, quality, and effectiveness of discharge planning (and the associated follow-up work) are impaired by pressures on inpatient and community services and other factors. The extent of these pressures and how well discharge planning is done varies.

Some inpatient units have high occupancy rates – sometimes beyond their capacity – and in some places there is limited availability of community services, such as suitable accommodation, to discharge people to. In these circumstances, discharge planning can be late or incomplete, and may not involve everyone who needs to be included for it to be effective.

This means that people with mental health problems can be discharged from hospital without a plan for their broader needs, such as getting help with housing, their finances, or support from their employer or family.

In my view, improvements are urgently needed for discharge planning to be more effective in enabling better outcomes for people with mental health problems. The pressures on inpatient units and community services need to be addressed.

Most district health boards use a collaborative approach to discharge planning – they seek to involve the inpatient unit and community mental health teams, the person with the mental health problems, and that person's family. However, the extent to which different teams, the individual concerned, and their family are involved is variable and sometimes limited.

Follow-up with people after they had been discharged was also not as timely as expected. Nationally, district health boards follow up with only two-thirds of people within seven days. Their target is to follow up within seven days with at least 90% of people discharged after staying in hospital because of acute mental health problems. There are also barriers to discharge plans being implemented. People, especially those with complex needs, do not always have access to the services they require, including services outside the control of the health sector.

The mental health sector has made progress in recent years in using information to understand service performance and how to make improvements. However, there is more for the Ministry of Health and district health boards to do to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and make service improvements. For example, more work is needed to systematically gather and use feedback from people using mental health services and those supporting them.

The mental health sector has started to take a more people-centred view in how it uses information to understand how well services are delivered. In my view,

it can do more. My staff have been sharing the insights they gained from using the Ministry's data to map when and how people have been in contact with a range of acute mental health and other health care services. We took the concept, developed by people working in the health sector, and refined it to highlight its potential uses, which we have shared with people in the sector.

During the audit, my staff met with many people who are doing the best they can to provide the best mental health support services they can, despite obstacles and hurdles. These people are well aware that the consequences for people with acute mental health problems, their family, communities, and other agencies can be significant if discharge planning is not done well or discharge plans are not acted on.

The increasing demand for acute mental health services and the problems with co-ordinated support in the community are not new. In my view, the Ministry and district health boards need to urgently make demonstrable improvements to deliver better results for people with acute mental health problems.

Since we completed our fieldwork, the Ministry and district health boards have been working on changes to improve mental health service delivery, including to better support people in moving from inpatient units to community mental health services. The effectiveness of these changes is yet to be determined. On this occasion, I have decided to include, as an Appendix to my report, a letter from the Ministry of Health that outlines these changes. This is to provide an update and a reference point to help Parliament and the public hold the Ministry and district health boards accountable for delivering better results for people with acute mental health problems.

I thank the many people in the mental health sector who shared their views, information, and expertise with my staff as they carried out their work.

Nāku noa, nā



Greg Schollum
Deputy Controller and Auditor-General

25 May 2017

Our recommendations

There are clearly pressures on parts of the mental health system and support services that demand urgent attention and, potentially, innovative solutions. In this challenging context, the planning for discharging people dealing with acute mental health problems from hospital needs to be done to a high standard.

We recommend that district health boards:

1. urgently find ways for inpatient and community mental health teams to work together more effectively to prepare and implement discharge plans, ensuring that all those who need to be – the person to be discharged, family, other carers, and all service providers – are appropriately involved and informed;
2. help staff by improving the guidance and tools to support discharge planning (including information systems) so that the information needed for discharge planning can be accessed and brought together easily and efficiently; and
3. regularly review the standard of discharge planning and follow-up work to identify and make improvements.

We recommend that the Ministry of Health and district health boards:

4. quickly make improvements to how they use information to monitor and report on outcomes for people using mental health services; and
5. use the information from this monitoring to identify and make service improvements.

Introduction

- 1.1 In this Part, we discuss:
- the purpose of our audit;
 - what we audited;
 - what we did not audit;
 - how we carried out our audit; and
 - the structure of this report.

The purpose of our audit

- 1.2 Mental health problems affect New Zealanders from all walks of life, with one in five people affected each year. The number of people accessing specialist mental health services has been increasing steadily since at least 2003.
- 1.3 We carried out a performance audit that focused on the relatively few people who are most unwell with mental health problems and require a high level of care, including care in a hospital-based inpatient unit. We looked at whether:
- planning for these people's discharge from an inpatient unit to community care was completed as intended;
 - the needs identified by discharge planning were followed up after discharge; and
 - discharge planning was helping to improve outcomes for people with acute mental health problems.
- 1.4 Figure 1 shows the proportion of the total population that experience mental health problems and that access services at different levels. Most people receive mental health care services in primary health care settings, usually with their general practitioner (GP). However, more than 160,000 New Zealanders (3.5% of the population) accessed specialist mental health and addiction services in 2015. About 15,000 (9%) of these people were admitted to an inpatient unit. These 15,000 people required a high level of care. When they were admitted, many were considered to pose a serious danger to themselves or others as a result of their mental illness. Some of them were admitted under a compulsory treatment order.
- 1.5 Providing inpatient care is expensive. District health boards (DHBs) spend a significant amount of their specialist mental health funding on inpatient units. Sometimes DHBs offer alternatives to inpatient treatment that support people to stay in the community. These can help to reduce the pressure on inpatient units.
- 1.6 It is important that people receive good planning and appropriate follow-up for their discharge from hospital care and transition back to the community. International evidence shows that good planning for the transition from inpatient units to the community is critical in effectively supporting people with mental health problems.

Figure 1
Proportion of New Zealanders who experience mental health problems and access specialist mental health services



Source: Our analysis of available data.

- 1.7 People who need to stay in an inpatient unit often have a broad range of other needs. These can include help with accommodation or finances, or support for their employer or family.
- 1.8 Once a person's needs are identified, prompt access to suitable support is critical. Without this, any benefits gained from treatment during an inpatient stay are more likely to be lost, and there is a risk that the person might suffer a relapse while waiting for help to meet their other needs.

What we audited

- 1.9 Our audit looked at whether:
- discharge planning for people who were leaving an inpatient unit was done in a way that made sure all their relevant needs were identified; and
 - people received support to make sure their mental health and broader needs were met after they left an inpatient unit.

What we did not audit

- 1.10 We did not audit:
- the delivery of primary mental health services;
 - the experiences of people who accessed only specialist community mental health services;
 - services for children and young people or adults aged 65 years or older;
 - forensic mental health services;
 - the experiences of people who accessed only addiction services; or
 - equity of service delivery across ethnic groups or culturally appropriate services.

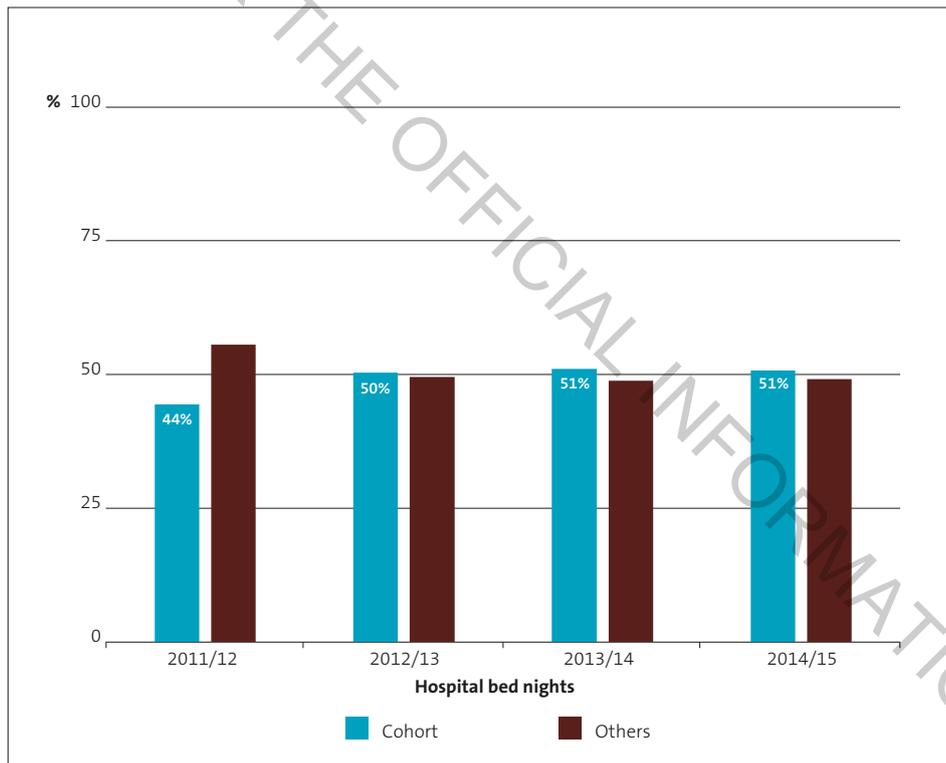
How we carried out our audit

- 1.11 Some parts of our audit looked at national information from all 20 DHBs. We also selected three DHBs to visit and audit in more depth. These visits took place between December 2015 and March 2016. We chose DHBs of different sizes, in different regions, with different demographics.
- 1.12 We also collected data from the Ministry of Health (the Ministry) about people who had used mental health services in 2011/12, 2012/13, 2013/14, and 2014/15. The data did not include people's identities.
- 1.13 About 375,000 individuals received specialist mental health services during those four years. Of these, about 20,000 were aged 20-64 years and had at least one

acute mental health admission to a hospital during the four years. We analysed data for this cohort of 20,000 people.

1.14 Although they made up a small proportion of all those receiving specialist mental health services, these 20,000 people accounted for almost half of all mental health bed nights¹ (see Figure 2) and about 30% of all community contact activities² (see Figure 3).

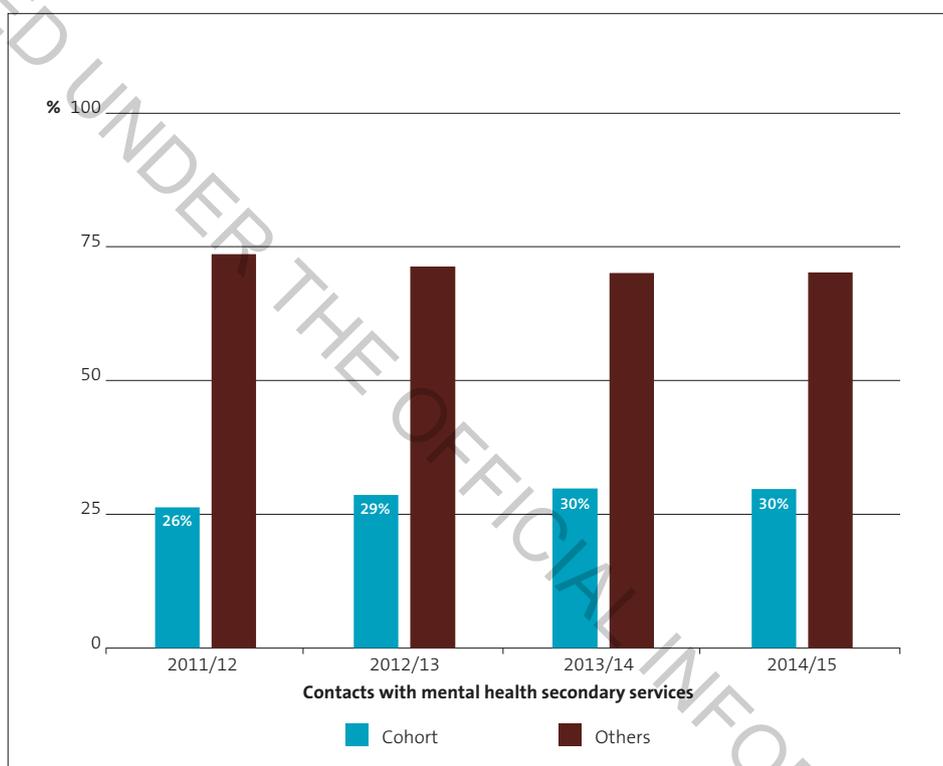
Figure 2
Percentage of bed nights for the cohort as a proportion of all mental health bed nights in all district health boards



Source: Our analysis of Ministry of Health data.

1 Total bed nights includes all types of mental health inpatient and residential care (such as acute, crisis, forensic, and residential) and also includes beds used by people aged 65 years or older.
2 Community contacts include any contact with community mental health services that is recorded in the data we received from the Ministry of Health.

Figure 3
Percentage of community contact activities for the cohort as a proportion of all mental health community contact activities



Source: Our analysis of Ministry of Health data.

- 1.15 We analysed data about the contact the 20,000 people had with mental health services from 2011/12 to 2014/15.
- 1.16 We completed in-depth reviews of case files and clinical notes for 110 people treated in the three DHBs we visited and who were part of our national cohort of 20,000 people. Usually, we looked at the period from the person's admission to hospital to 90 days after leaving. If the person had a pattern of repeat admissions, then we looked at a wider time frame.
- 1.17 We interviewed more than 100 people in about 50 semi-structured interviews. These interviews included a mix of clinical and non-clinical staff, such as independent family, cultural, and patient advisers; staff from inpatient mental health teams; staff from community mental health teams; and staff in non-governmental organisations. Most of these people work for the three DHBs we visited. We also interviewed senior staff at the Ministry. We did not interview

patients directly because we did not wish to potentially cause unnecessary distress.

- 1.18 We structured the interviews around our criteria, with a particular focus on matters raised by our case file reviews and early data findings.
- 1.19 We conducted a survey of just over 900 DHB staff, and achieved a response rate of just over 20%. We received responses from staff in 15 of the 20 DHBs.
- 1.20 We reviewed and analysed documentation and data, including financial information, from all 20 DHBs.
- 1.21 We held one workshop at Canterbury DHB, which was attended by about 16 clinical and non-clinical staff.
- 1.22 We reviewed some of the 500 stories that people submitted to the *People's Mental Health Review*.³ These stories gave us an insight into the views of people with a personal experience of mental health services in New Zealand. This helped us to understand and validate our findings.
- 1.23 We set up an external reference group to provide specialist advice to our audit team. Most of the group were clinicians (psychiatrists and registered mental health nurses) but we also included a patient representative and a Ministry data expert. The representatives on the group came from four different DHBs to the three that we visited.
- 1.24 We have also liaised with the relevant teams in the offices of the Ombudsman and of the Health and Disability Commissioner.

The structure of this report

- 1.25 In Part 2, we provide background information about the provision of acute mental health care, patterns of contact with mental health services, and mental health funding.
- 1.26 In Part 3, we consider how well planning was done before a person was discharged from an inpatient unit.
- 1.27 In Part 4, we discuss whether people received the support and follow-up they needed after they were discharged from an inpatient unit.
- 1.28 In Part 5, we examine the data and information that is currently available about acute mental health services. We explore opportunities for using that information to better understand how people with acute mental health problems are interacting with health services.

³ These stories were analysed to identify key themes that are explored in the *People's Mental Health Report*, which was published by Action Station on 19 April 2017. See www.peoplesmentalhealthreport.com.

Acute mental health care

2.1 In this Part, we describe:

- the organisations with a role in providing mental health care;
- patterns of contact with mental health services; and
- mental health funding.

Organisations with a role in providing mental health care

The Ministry of Health

2.2 The Ministry sets the overall strategy for mental health, including outcome frameworks, high-level standards, and performance expectations. The Ministry also allocates funding to DHBs and monitors their performance.

2.3 The Ministry told us that it is working with other government agencies to consider how government can better respond to mental health needs and support well-being for a range of population groups. This work will have a broad focus and is expected to lead to improvements to a person's mental health and well-being after they are discharged from an inpatient unit.

District health boards

2.4 DHBs provide specialist mental health services. They provide some services directly, such as hospitals' inpatient facilities, and some community-based services. DHBs also contract some services to non-governmental organisations and private providers.

2.5 When people are discharged from an inpatient unit, most are discharged to a community-based mental health service. Each person will receive a different combination of services and care to meet their individual needs. A few people are discharged to another type of service, such as their GP. Occasionally, people do not have any type of follow-on service after their stay in an inpatient unit, based on assessment or by their own choice.

Non-governmental organisations

2.6 Non-governmental organisations also provide community-based services on behalf of DHBs. These services can include respite or residential facilities and day programmes, as well as therapies and other types of support for people living in their own homes.

General practitioners and other primary care providers

2.7 A GP is often the first contact with a medical professional for someone with a mental health problem. Most people will need to receive care only from their GP, but if required a GP will refer someone to more specialised services. A person

can also be returned to a GP's care when they are discharged after a hospital stay. Primary mental health care is also sometimes provided by other types of practitioner such as mental health co-ordinators and nurse practitioners.

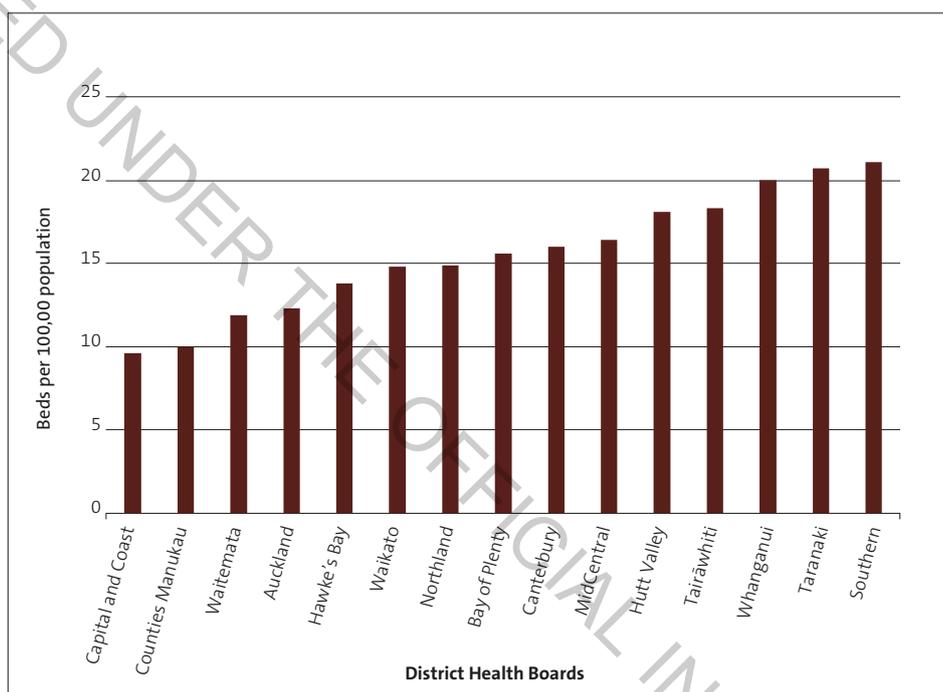
Private providers

- 2.8 Private providers include specialist practitioners, such as psychiatrists, and facilities such as rehabilitation clinics. These are outside the scope of our audit.

Patterns of contact with mental health services

- 2.9 Our audit focused on a relatively small group of people with high and complex needs. Each individual in this group had a unique combination of mental health conditions, general health conditions, and personal circumstances. This means that each person had a unique set of needs and corresponding service requirements.
- 2.10 Each DHB provides mental health services differently, too. We explain these differences in the next few paragraphs. Together, this means that each person had a different pattern of contact with mental health services – we did not expect to see everyone receiving the same services in the same way. Instead, we expected DHBs to deliver services in a way that met the needs of each person with acute mental health problems.
- 2.11 An example of differences in how DHBs organise mental health services is the provision of acute care. All DHBs have a hospital-based inpatient unit for people needing acute care,⁴ but each DHB structures its inpatient unit in a different way. For example, as shown in Figure 4, there is considerable variation in the number of beds in inpatient units compared to population size. There will also be different numbers of secure, intensive care, and non-secure beds in each inpatient unit.

Figure 4
Number of beds in inpatient units for every 100,000 of population, by district health board



Note: Data were available for 15 of the 20 DHBs. Wairarapa DHB does not have an inpatient unit. Data from the other four DHBs were not available.

Source: Our analysis of DHB Key Performance Indicator Programme data.

- 2.12 Beyond inpatient units, DHBs provide different types of services. For example, some DHBs provide a sub-acute unit as a step between the inpatient unit and community-based care.
- 2.13 Each DHB also serves a different population. Some DHBs have a large, ethnically diverse, high-density, urban population. Others have a smaller population spread over large rural areas. This affects the types of services that DHBs need to provide and the best way of structuring their services.

Mental health funding

- 2.14 The total “ring-fenced” funding for the Ministry and DHBs to spend on mental health and addiction services for the last three years was:
- \$1.296 billion in 2013/14;
 - \$1.372 billion in 2014/15; and
 - \$1.407 billion in 2015/16.
- 2.15 This represents around 9% of the total Vote Health budget.

Planning for discharge from an inpatient unit

- 3.1 In this Part, we cover discharge planning and:
- the effect of a high demand for beds;
 - taking people's broader needs into account;
 - involving all appropriate people; and
 - systems and tools to support the process.

Summary of our findings

- 3.2 The Ministry and DHBs expect discharge planning to start between one and seven days after a person's admission to an inpatient unit. This does not always happen. Sometimes people are considered too unwell to start planning in the first few days. High demand for beds also sometimes delays discharge planning.
- 3.3 Most people have at least a partial plan when they are discharged from an inpatient unit. However, many people are discharged without a plan to meet all their needs, including:
- suitable accommodation – in practice, some people are discharged to unsuitable accommodation;
 - finances and support for their employer and/or family; and
 - what to do when arrangements break down.
- 3.4 Some people are discharged at short notice and before they are ready (on a "least unwell" basis, to make space for a "more unwell" person) and before the DHB has had time to set up support in the community. People can also discharge themselves if they are not subject to, or are no longer subject to, the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- 3.5 When there are high occupancy rates in inpatient units, contact and meetings with people outside the inpatient unit (such as community mental health teams, families, and other health professionals) suffer. People can be discharged with no formal handover to the community mental health team.
- 3.6 Families are sometimes unable to attend and contribute when care planning or discharge meetings are called or changed at short notice, or are held at inconvenient times. When the patient and their family are involved, they do not always feel listened to.
- 3.7 The person being discharged and, where appropriate, their family are rarely given copies of discharge plans. Sometimes families are not told, when they should have been, that their family member has been discharged.

- 3.8 Discharge planning is not well supported by tools and systems. Information about a patient is fragmented between different systems, which makes it hard for mental health staff to gain a clear picture of a person and their needs.

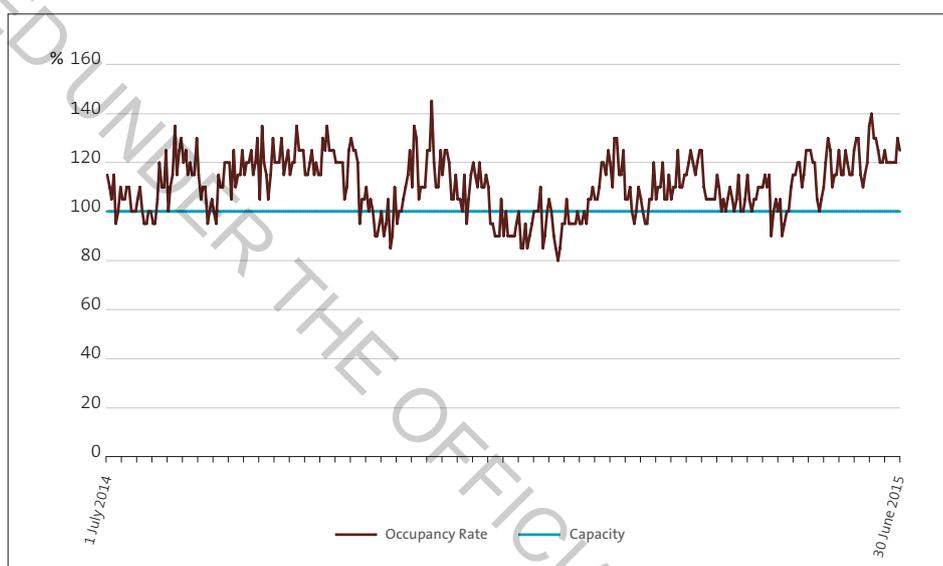
Discharge planning is adversely affected by high demand

- 3.9 Discharge planning does not always start as early as it should and many people leave the inpatient unit without a plan to address their broader needs, such as getting help with a housing situation or their finances, or support for their employer or family.
- 3.10 In line with expectations, most DHBs aim to start discharge planning within the first seven days after someone is admitted to the inpatient unit. Two-thirds of respondents to our survey indicated that planning should start 1-3 days after admission. In practice, this does not always happen.

High demand for beds

- 3.11 Discharge decisions were affected by occupancy pressures on inpatient units at two of the DHBs we visited. One of the DHBs was providing inpatient services for significantly more people than it had beds for (see Figure 5). The inpatient unit occupancy rate for this DHB was particularly high, but our analysis showed that several other DHBs also had high occupancy rates in their inpatient units.
- 3.12 High occupancy rates in inpatient units mean that sometimes people have to be discharged on a “least unwell” basis to create a space for a “more unwell” person. People are sometimes discharged at short notice, and sometimes without the knowledge of community mental health teams or the person’s family.
- 3.13 Demand for beds can also affect the quality of discharge planning. Short-notice discharges can lead to incomplete assessments, which increases the risk that people who are still unwell are leaving the inpatient unit without adequate support in place. We were told that staff had a backlog of paperwork when occupancy rates were high, including preparing discharge plans before people were discharged. Liaison with others outside of the inpatient unit, for example co-ordinating with the community mental health team, also suffered.
- 3.14 The short-notice discharges can also put pressure on other parts of the health service. For example, in one DHB, a sub-acute unit was having to treat people who were acutely unwell when it was not set up for this.

Figure 5
 Inpatient unit occupancy rate per day for a DHB with a high level of bed pressure, year ended 30 June 2015



Source: Our analysis of Ministry of Health data.

- 3.15 We also found that some people could not be discharged because there was nowhere suitable to discharge them to. This reduces the number of beds available for other people. Our data analysis identified about 80 people nationally who have extremely long lengths of stay, which number months or years rather than days.
- 3.16 We looked at whether occupancy rates were lower for DHBs where there were more beds for every 100,000 people in the local population, and did not find a strong indication that this was the case. This suggests that occupancy pressures are about more than the availability of beds.

Discharge planning often fails to cover broader needs

- 3.17 Most people have at least a partial plan to meet their mental health needs when they are discharged from an inpatient unit. However, many people are discharged without a plan to meet their broader needs. Sometimes the planning for broader needs does not happen until after a person has been discharged.
- 3.18 Most DHBs expected a person's broader needs, including needs for services that are not provided by the health sector, to be considered as part of discharge planning. We found a lack of consensus about which needs should be included, and variability in how DHBs assess a person's needs.

- 3.19 In our case file review, we found that broader needs that were identified were not always included in any formal plan. We also found gaps in planning for early intervention and crisis management. Some staff told us that plans did not cover what to do when arrangements broke down.
- 3.20 Accommodation needs were more likely to be assessed than anything else, and we saw from case notes that hospital-based social workers were proactive in this aspect. Staff told us they are not supposed to discharge people who have nowhere to stay. In practice, some people were discharged to tenuous or unsustainable accommodation.

There is scope for better collaboration in discharge planning

- 3.21 All DHBs seek to promote a collaborative approach to discharge planning, involving staff from different disciplines from both the inpatient unit and community mental health teams. Most patients and, where appropriate, their family make some contribution to discharge planning. However, we were told that they could be more and better involved.
- 3.22 In our view, more could be done to involve all relevant people in discharge planning, even when the demands on inpatient units are high. In particular, we found that communication could be improved:
- between health professionals who are part of a multi-disciplinary team in inpatient units;
 - between health professionals and the patient and, where appropriate, their family;
 - between inpatient unit staff and community mental health teams; and
 - in giving copies of discharge plans to the patient and, where appropriate, their family.

Multi-disciplinary approaches

- 3.23 Most respondents in our survey agreed that a range of hospital-based mental health staff, including clinical and allied health staff, should be involved in identifying needs. But there are practical difficulties and tensions that can impede this approach. For example:
- although most inpatient units held weekly multi-disciplinary team meetings where a patient's progress is discussed, not all people who should have been at the meetings could attend;
 - inpatient unit staff in one DHB told us there was a lack of formal process

around multi-disciplinary team meetings;

- notes from the multi-disciplinary team meetings were often not entered into clinical notes; and
- other staff, such as psychologists and occupational therapists, have limited input into a patient's care plan and treatment.

Involving patients and their family

- 3.24 It is generally considered good practice to involve the patient's family in treatment, including forming a discharge plan, but this is sometimes not appropriate – such as when the patient does not want the family involved, the patient is not in contact with their family, or family involvement is considered detrimental to the patient's well-being.
- 3.25 Community mental health teams and families were concerned with inpatient unit staff calling, or changing the timing of, care planning or discharge meetings at short notice. Both groups told us that this affected their ability to contribute and be informed. Both groups also told us that sometimes patients had been discharged without their knowledge. Family members who worked during the day were often unable to attend meetings because these were held during office hours. People who work as advocates or advisors for patients reported that when patients and their family were involved, they did not always feel listened to.

Handing over care to the community mental health team

- 3.26 People were frequently discharged from an inpatient unit without a clearly identified "keyworker" – the person who is responsible for co-ordinating care and support in the community – and without a formal handover to the community mental health team. This increases the risk that people might not receive the support they need after they leave the inpatient unit. In our review of case files, only one-half to two-thirds of people had a clearly identified keyworker. There was no evidence of a formal handover between the hospital and community psychiatrists in one-half to two-thirds of the files we reviewed.
- 3.27 In the three DHBs we visited, keyworkers could be allocated at short notice or after a person was discharged, or not assigned at all. Late allocation of keyworkers means they may not have met the patient before they were discharged, or may not have been at the discharge planning meeting.

Copies of discharge plans

- 3.28 Most DHBs expect that patients receive a copy of their discharge plan. This is in keeping with good practice and a patients' rights under the Health and Disability Act 1994 to be informed and involved in their own care. However, we

heard that plans were not often shared with patients and sometimes not with community mental health teams. The sharing of discharge plans with patients and community mental health teams by inpatient units is generally poor.

- 3.29 In most of the case files from the three DHBs we reviewed, neither patients nor their families received a copy of the discharge plan. Responses to our survey indicated that only about one-half of patients, GPs, community psychiatrists, and social workers, and only one-third of families, received copies of discharge plans.
- 3.30 Some of the reasons we were given for not providing copies of discharge plans to patients and their families included:
- patients would need to make a formal request;
 - it is illegal;
 - it would upset/distress them (patients) to read it; and
 - they (patients) would leave it laying around.
- 3.31 There was uncertainty among staff in one DHB we visited about what information they could and should share with patients, and some reluctance to share discharge plans. We were told that discharge plans are not generally shared with patients and that discharge documentation is often not prepared until after the person has been discharged, partly because of workload.

Systems and tools do not support effective and efficient discharge planning

- 3.32 DHBs have a range of tools (such as forms and checklists) and guidance available to help discharge planning. We focused on:
- processes and forms to support needs assessment;
 - tools to help refer people to the right services; and
 - information systems.

Processes and forms to support needs assessment

- 3.33 Over half of DHBs have a formal process/checklist to help staff complete needs assessments. These include mental health, physical health, education, employment, and addiction issues. However, during our case file review, we found that there were many forms in use, mostly poorly completed, and often duplicating information. One DHB had three different types of risk assessment forms. None of these forms focused systematically on identifying broader needs.

- 3.34 In the three DHBs we visited, forms were not always completed properly. There was also no monitoring of whether and how well risk assessments and other forms were completed.
- 3.35 In our view, forms and checklists for supporting needs assessments could be streamlined and better used. This could help to reduce the pressure on staff and avoid the late or partial completion of discharge plans when occupancy rates are high.

Tools to help refer people to the right services

- 3.36 All DHBs have documented “pathways” for people entering and exiting the mental health service. These pathways describe the requirements for discharge and admission and explain different treatment and care options depending on what each person needs.
- 3.37 Some DHBs had good tools to aid referrals to other services. One DHB uses a central list of all services available in that DHB and how to access them. This was a good example of clear documentation to help staff decide where and how to refer people. In our view, there is an opportunity for DHBs to share these good practices and learn from each other.
- 3.38 Only a few DHBs had tools to help staff refer people to the right services after discharge from the inpatient unit. Few DHBs provided good information about the services available and how to match people to them, based on need.
- 3.39 Some DHB staff told us that they would like better information about service providers and their performance in improving outcomes. This would help them refer people with acute mental health problems to the most appropriate services available.
- 3.40 Without formal processes in place, DHB staff use a range of informal processes to connect people to the services they need. In our survey, most respondents indicated that although they draw on a wide range of resources to help them decide which services to refer a person to, the primary source was local and/or previous knowledge. Care pathways was the second most frequently named source of information.

Information systems

- 3.41 In some DHBs, information about patients was fragmented across different systems, and those systems did not support co-ordinated discharge planning between inpatient units and community mental health teams. For our case file review, we looked at electronic and paper records. On average, we had to look in at least six places to build up a holistic picture of a patient and their needs. A senior

manager told us that having a shared care record is fundamental to seamless service delivery.

- 3.42 One DHB we visited had an integrated computer system that helped the sharing of information between different parts of the mental health service. This DHB was also seeking to improve communication with non-governmental organisations by allowing them access to the DHB's main information technology system.
- 3.43 Systems at another DHB were not as good at sharing information with non-governmental organisations and primary care services. This hampered assessment and referrals. The DHB did have a system that was integrated with two neighbouring DHBs. This helped keep the records for people who move around, and might enter and re-enter the system in different parts of the region, up to date. However, this system was not integrated with some of that DHB's other systems (for example, its electronic medication system).
- 3.44 Some DHBs have found practical ways to help support communication between different parts of the mental health service. Some teams in our fieldwork sites had been co-located, such as the acute and community mental health teams, which helped with integration and continuity of care. One DHB also used video conferencing to facilitate communication between services located in different areas.

Recommendation 1

We recommend that district health boards urgently find ways for inpatient and community mental health teams to work together more effectively to prepare and implement discharge plans, ensuring that all those who need to be – the person to be discharged, family, other carers, and all service providers – are appropriately involved and informed.

Recommendation 2

We recommend that district health boards help staff by improving the guidance and tools to support discharge planning (including information systems) so that the information needed for discharge planning can be accessed and brought together easily and efficiently.

Recommendation 3

We recommend that district health boards regularly review the standard of discharge planning and follow-up work to identify and make improvements.

Supporting people after they leave an inpatient unit

4

4.1 In this Part, we cover:

- expectations for following up with people after discharge; and
- barriers to getting support after being discharged.

Summary of our findings

- 4.2 All DHBs consistently failed to meet the target to follow up with people within seven days of discharging that person from an inpatient unit. The target is for at least 90% of people to receive a follow-up contact but, on average, DHBs manage to follow up with only two-thirds of people within seven days. This is sometimes because of high caseloads for community mental health teams.
- 4.3 Even when follow-up contact is made, there can be barriers that prevent people accessing the services they need, including services that are outside the control of the health sector. Poor availability of suitable accommodation, especially for people with complex needs, is the largest barrier people face, and this can prevent some mental health patients from being discharged.
- 4.4 Some services are not available in all locations. Where they are available, long waiting lists can prevent people from getting timely access to those services.

Follow-up rates are well below expectations

- 4.5 DHBs are not meeting their own expectations that discharge plans will be actioned and followed up. The target that 90% of people are followed up with an initial contact from the community mental health team within seven days of discharge has not been met by any DHBs for at least the last three years. Many DHBs fall well short of the target. Nationally, only around two-thirds of people are followed up within seven days, and we found evidence that some people are not followed up at all.
- 4.6 Expectations for follow-up vary from within two days after discharge to no specified time frame. In our survey, there was clear consensus that the first contact should occur within the first seven days after someone leaves the inpatient unit. However, a few respondents said lack of staff capacity can interfere with this. In one DHB, we were told there is a lack of staff capacity in community mental health teams because of high caseloads.
- 4.7 We found in our case file review at three DHBs that between two-thirds and four-fifths of people with a plan for their mental health needs had a follow-up contact within seven days of discharge. However, we could not see any evidence of follow-up for the other people discharged.

- 4.8 Some of the people who were not followed up may have voluntarily decided not to engage with mental health services. Others may have been followed up by a different DHB. Most DHBs, including the three we visited, have policies and guidance about what to do when people do not show up for appointments or cannot be contacted. However, responses to our survey indicate that there are very few mechanisms for tracking individuals once they have left acute mental health care. The exception to this is those receiving secondary mental health support who have been allocated a keyworker.
- 4.9 Many of our survey respondents and staff we spoke to who work in inpatient units did not know whether people who had left their unit were receiving support. Overall, respondents indicated that there are no particular systems in place to ensure that people received follow-up care.

Barriers make it hard for people to get support after being discharged

- 4.10 We identified several barriers that prevent people accessing the services they need, when they need them. Many of these services are provided by agencies outside the health sector. The most significant of these barriers is a lack of suitable accommodation. There is also limited accessibility for some services in some areas of the country.
- 4.11 Many of these barriers are not within DHBs' control, so improving mental health services is not a challenge for just the health sector. Other agencies also need to be involved in meeting the needs of people with mental health problems. The Ministry recognises this and told us that it is working with other agencies to consider how the Government can better respond to mental health needs.

Accommodation

- 4.12 The most frequently reported service barrier we identified was finding suitable accommodation for people leaving an inpatient unit. The cost of accommodation is particularly a problem in some regions, and there is a shortage of accommodation options for people with complex needs. Workarounds are sometimes put in place, such as discharging people to caravan parks.
- 4.13 In all three DHBs that we visited, staff told us that people are kept in inpatient units when no accommodation can be found for them in the community or their families refuse to take them.
- 4.14 Some people stay in an inpatient unit for long periods (for example, two years) because of problems with access to suitable accommodation, rehabilitation, and other services in the community.

- 4.15 Keeping people in the inpatient unit longer than they need to be there takes up beds so that others cannot be admitted, or are discharged early to make room. As a result, there is a risk that accommodation issues rather than clinical need are influencing some discharge decisions.
- 4.16 The lack of suitable accommodation can mean that vulnerable people are living in loosely regulated and unsupported environments, and sometimes living with several unwell or dependent people.

Accessibility

- 4.17 What services are available can be different depending on where people live. Some services, such as detoxification, are not available everywhere and people have to travel to access them. We were told that, even within a DHB's district, access to services in the community was better in some places than others.
- 4.18 One DHB we visited had a shared care arrangement with neighbouring DHBs, which helped in providing a continuum of care for people moving around the region.
- 4.19 Despite this, that DHB still had some difficulty in arranging drug and alcohol services for people. It also did not have any services available to treat people with both acute mental health problems and other severe health conditions, such as diabetes. Mental health clinicians do not have the expertise to treat all of a person's medical conditions.

Other barriers

- 4.20 Other significant barriers include waiting lists, funding, and eligibility. For two of the DHBs we visited, access to services was problematic in about a third of cases we reviewed, either because of waiting times or entry requirements. In the other DHB, we were told that staff did not have information about waiting times to help them make decisions about referrals.
- 4.21 We were provided with examples of how inpatient unit teams in some DHBs were seeking to work together more closely and share information with other teams providing mental health services, such as with non-governmental organisations and community mental health teams, to be more co-ordinated and provide better continuity of care.
- 4.22 Failing to connect people with the services they need within an appropriate time frame after they have been discharged can make life more difficult for people. This can mean they are re-admitted to hospital sooner than might otherwise have been the case, or increase the demand on other health services.

Using information to assess outcomes

5.1 In this Part, we cover:

- the information that the Ministry and DHBs hold and how they use it;
- efforts under way to improve how information is used; and
- how information can be used better to understand people's experiences and improve services.

Summary of our findings

5.2 The Ministry and DHBs have a lot of data about mental health services. The Ministry uses the data to report mainly on what services are provided and who is providing them. DHBs and other providers use the data to understand service performance through a set of indicators that they have been developing since 2006.

5.3 Both the Ministry and DHBs are seeking to improve how they use information. The Ministry has started to collect information about outcomes for people, and is intending to collect data and improve reporting on the use and quality of discharge planning from 2017/18. DHBs are working to use indicators more effectively to inform improvements to services and outcomes for people.

5.4 There is more for the Ministry and DHBs to do to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and improve their services. More work is needed to:

- establish and use solid outcomes measures;
- systematically gather and use feedback from people using mental health services and those supporting them;
- build capability to use data and information; and
- address some lack of trust and confidence in the quality of the available data.

5.5 In our view, the Ministry and DHBs can gain a greater understanding of how to improve services for people by understanding the patterns and trends in people's experience of services. We show some examples in this Part. We also introduce the concept of viewing a person's contact with mental health services as a timeline of interactions. This is a concept developed by people working in the health sector, which we refined to highlight its potential uses. We have shared this with people working in the health sector.

Using data about mental health services to report on and understand service performance

- 5.6 The Ministry collects mental health data from DHBs and non-governmental organisations providing mental health services. Information about consumer satisfaction with mental health services is also collected by the Ministry and DHBs.

Collection and use of data about provision of mental health services

- 5.7 Data about specialist mental health services are collected by the Ministry in the Programme for the Integration of Mental Health Data (PRIMHD) system. The Ministry uses PRIMHD to report mainly on what services are provided and who is providing them.
- 5.8 The Ministry also collects information through the DHB non-financial monitoring framework. For 2016/17, the Ministry's DHB non-financial reporting framework has three performance measures about mental health services. One of them, *Improving mental health services using transition (discharge) planning and employment*, is about discharge planning.
- 5.9 DHBs and other providers use PRIMHD data to understand service performance through the New Zealand Mental Health and Addiction Services Key Performance Indicator Programme (the KPI Programme). The KPI Programme is a provider-led initiative that began in 2006. It is primarily a benchmarking forum whose purpose is to systematically analyse and use service and outcome data to inform service development and improve the outcomes for people using mental health and addiction services and their families.
- 5.10 Through the KPI Programme, DHBs have designed a framework of key performance indicators and associated stretch targets for adult mental health and addiction services⁵ that represent good performance. The framework includes just over 60 indicators. Results were published in May 2016, covering the three years from 2012/13 to 2014/15. Selected results are also available on the KPI Programme website⁶ for 2015/16 and 2016/17 (year to date).
- 5.11 DHBs also have access to an interactive web-based tool that allows them to examine their own KPI Programme results. Currently 12 of the 60 indicators can be examined using the tool.

5 The KPI Programme also has indicators for children and forensic mental health service users. These are outside the scope of our audit.

6 See www.mhakpi.health.nz.

5.12 Figure 6 shows the results of six of the KPI Programme indicators relating to the discharge of people with mental health problems from acute inpatient units and follow-up contact with them by community mental health services. For each KPI we show, for the three years from 2012/13 to 2014/15, the weighted average value and the highest and lowest value for all DHBs. Our observations from these results are that:

- the average performance of DHBs against the indicators has remained reasonably static in the three years, and the performance of DHBs has varied; and
- the average performance of DHBs did not meet the targets for four of the indicators (see the darker shading in Figure 6), and is well below the targets for percentage of people followed up within seven days of a discharge and the percentage of discharges with qualifying Health of the Nation Outcome Score (HoNOS) assessments (see paragraphs 5.23-5.24).

5.13 Participants from DHBs, NGOs, and their “strategic partners” are involved in benchmarking forums twice a year with the aim of understanding variations in performance, and learning from each other about service improvements and practices to improve outcomes for people using mental health services. For the last 12 months, the KPI Programme has changed its approach to focus on one indicator for all DHBs (and two indicators at a sub-national level, focusing on northern and southern priorities). This approach is intended to increase collective learning on how to improve performance.

5.14 At the DHBs we visited, we heard examples of how information, such as some of the indicators from the KPI Programme and case files of people admitted to an inpatient unit, was analysed to identify trends and service improvements. We also heard examples of how people’s progress, such as length of stay as an inpatient and contact with community mental health services, was monitored.

Satisfaction of people using mental health services

5.15 The Ministry collects and publishes consumer satisfaction information. Since 2006/07, DHBs have been carrying out an annual national mental health consumer satisfaction survey. Survey participants have all received specialist mental health services. In 2014/15, 14 of the 20 DHBs participated in the survey. The Office of the Director of Mental Health reported that 82% of respondents either agreed or agreed strongly with the statement “*overall I am satisfied with the services I received*”.

5.16 In our view, the results that are published do not contain enough information to give a reliable indication of the satisfaction levels of people using mental health services. The response rate for the survey was not provided and there was no breakdown by DHB.

Figure 6
Summary of district health boards' results against six key performance indicators, 2012/13-2014/15

	Year	Weighted average (all DHBs)	Lowest (all DHBs)	Highest (all DHBs)
Average length of acute inpatient stay (Target: 14-21 days)	2012/13	18.2	12.1	29.6
	2013/14	18.1	11.4	27.9
	2014/15	17.4	12.7	28.3
	Average	17.9	-	-
Percentage of discharges with qualifying Health of the Nation Outcome Score assessments (Target: 75-100%)	2012/13	57.9	12.2	90.4
	2013/14	58.1	12.8	94.3
	2014/15	59.0	28.9	94.3
	Average	58.3	-	-
Percentage of discharges for which community mental health contact is recorded in the seven days after discharge (Target: 90-100%)	2012/13	65.6	50.8	85.5
	2013/14	62.5	38.4	80.1
	2014/15	64.1	39.5	80.8
	Average	64.1	-	-
Percentage of discharges re-admitted to acute inpatient unit within 28 days of discharge (Target: 0-10%)	2012/13	15.6	6.3	28.4
	2013/14	14.7	6.4	21.4
	2014/15	15.9	8.7	32.4
	Average	15.4	-	-
Number of community treatment days provided for each person each quarter (Target: 10-20 days)	2012/13	8.5	6.0	11.2
	2013/14	8.3	6.0	10.6
	2014/15	8.1	5.6	12.2
	Average	8.3	-	-
Percentage of community service-user related time with client participation (telephone or face-to-face) (Target: 80-90 %)	2012/13	86.2	72.9	96.8
	2013/14	89.0	73.5	97.9
	2014/15	89.7	68.7	98.6
	Average	88.3	-	-

Source: www.mhakpi.health.nz.

Notes: We have not included data from Lakes DHB because we were told these were incorrect.

One person can have multiple discharges, because each time they are discharged is counted separately.

Efforts to improve how information is used

- 5.17 In our view, the Ministry is starting to collect and report more useful information. DHBs and other service providers, supported through the KPI Programme, have been looking at how they can improve their use of information over time. There is more for the Ministry and DHBs to do to understand what influences outcomes for people, including the effectiveness of discharge planning so that they can improve their services.

The Ministry is starting to collect and report more useful information

- 5.18 From 1 July 2016, the Ministry has started to collect data from some DHBs, in a Supplementary Consumer Records Collection to PRIMHD, on selected social outcomes indicators for people receiving services for mental health and whether they have a wellness plan in place. The social outcome indicators are accommodation status, employment status, and education and training status.
- 5.19 For 2017/18, the Ministry is modifying the discharge planning measure in the DHB non-financial reporting framework to include all age groups and with an expectation that 95% of people have a transition plan⁷ at discharge and 95% of those who have been in the service for a year or more will have a wellness plan.⁸ The measure will also expect DHBs to carry out file audits to determine the quality of the plans and report the results. The Ministry is introducing file audits in response to some of our findings from this audit. We support changing performance measures when doing so makes them more meaningful.

Making better use of information is an ongoing focus for the KPI Programme

- 5.20 In our view, the mental health sector has made progress in using information to improve service performance through the KPI Programme. The *KPI Programme Strategic Plan 2015-2020* outlines how developing how the indicators are used is expected to better inform improvements to services and outcomes for people. The strategic plan focuses on three priorities:
- governance and leadership in the use of information to drive improvement, including through advocating for sector-wide improvement and engaging people using mental health services and their families;
 - collaborative learning and performance improvement, including through focusing on improving a person's experience and sharing lessons and experiences across all those involved in a person's continuum of care; and

7 A transition plan is equivalent to a discharge plan.

8 A wellness plan is another term for a relapse prevention plan.

- increasing data capability to help the sector in improving the range and quality of data and information available for decision-making.

There is more to do to make better use of information

- 5.21 In our view, the Ministry and DHBs need to make better use of information to understand what influences outcomes for people, including the effectiveness of discharge planning, and make service improvements. More work is needed to:
- establish and use solid outcomes measures;
 - systematically gather and use feedback from people using mental health services and those supporting them;
 - build capability to use data and information; and
 - address some lack of trust and confidence in the quality of the available data.

Solid outcomes measures need to be established and used

- 5.22 We acknowledge that data for some social outcome indicators have started to be collected recently, but in our view further work is needed to establish and use solid outcome measures and create a framework to demonstrate how activities such as discharge planning contribute to outcomes.
- 5.23 The sector uses the HoNOS outcomes tool,⁹ completed by clinicians, to assess the health and social functioning of adults with severe mental health problems. HoNOS improvements after admission to an acute inpatient unit are used as one of the qualifying criteria for discharging a person from the unit.
- 5.24 HoNOS has supporters and detractors. At one of the DHBs we visited, we were told that HoNOS did not contribute useful information to service improvements. We were told that it was not used consistently and was seen as a “tick box exercise”, with poor reliability and a lack of training in how to use it. Some staff said they would like to use it better and that steps were being taken to improve its use. Others said they would like to have it scrapped. At another DHB, some staff were not committed to using HoNOS because it was not seen as an accurate representation of the treatment provided.
- 5.25 The Ministry told us that it is moving to outcomes-based commissioning for mental health services. The Mental Health and Addiction Commissioning Framework published in August 2016 provides guidance and direction for those who are responsible for commissioning care to improve outcomes for people with mental health and addiction issues. We support an outcomes-based approach to improving mental health initiatives.

9 Developed in the United Kingdom by the Royal College of Psychiatrists' Research Unit between 1993 and 1996.

Better collection and use of feedback is needed

- 5.26 DHBs seek feedback from people in different ways, but make limited use of this feedback to improve services. In particular, the views of people who have used mental health services and those supporting them, such as their family and GP, about their experiences of discharge planning and its effects are not systematically collected and considered. This means that the Ministry and DHBs do not have a good understanding of how people are involved in discharge planning and how well discharge planning is supporting better outcomes.
- 5.27 Those DHBs that provided us with information about how they seek feedback said that they used means such as surveys and “service user” forums. At one of the DHBs we visited, we heard from advocates that a Whānau hui gave families the opportunity to provide feedback about inpatient unit services. At another, we heard of opportunities for people who had used mental health services to provide feedback and saw an example of a change made as a result of feedback.
- 5.28 However, generally we found that systems to collect and use feedback were underdeveloped. Most DHBs relied on complaints, or the absence of complaints, as a measure of satisfaction.
- 5.29 Because people receiving treatment can be reluctant to complain about the staff treating them, some DHBs have begun to use anonymised real-time feedback by giving people access to an electronic tablet running a feedback application.
- 5.30 We also heard from patient advisors and family advisors that DHBs did not make the best use of them as a resource to bring a user perspective. Nearly every advisor we spoke to or who responded to our survey felt that their involvement was tokenistic. One DHB had not had a patient advisor for nearly two years.

Barriers to using data and information to improve services

- 5.31 Increasing the capability to use data and information is one of the priorities identified in the *KPI Programme Strategic Plan 2015-2020*. For staff in the DHBs we visited, capacity and systems make the effective use of information difficult.
- 5.32 Overall, there was limited use of data and information to inform service improvements at the three DHBs we visited. At one DHB we visited, we were told that there was limited evaluation of what mental health interventions work well because staff lacked the tools, time, and expertise. We also heard that cross-sector evaluation of what works was weak. At another DHB, we were told that there was a lack of capacity to use data to effectively monitor service delivery and make changes.

5.33 During our visit to one DHB, staff said that information systems did not support accurate data collection and that information was held in different places, making it hard for staff to gather data and get a complete picture of outcomes for people using services. Staff said that there was no way of tracking a person's care between services. At another DHB, we were told that information was hard to find. At another, we were told that there was no one place to check whether discharge plans were working.

Addressing a lack of trust and confidence in the quality of the available data

5.34 We heard a range of frustrations – and varying degrees of confidence or mistrust – about the reliability of the available data from the people throughout the sector that we talked to about how information could be used.

5.35 The Ministry and DHBs use data definitions and data quality checking to control the quality of the data in PRIMHD. However, these do not prevent discrepancies occurring. We also heard that some people felt what the KPI Programme indicators showed was disconnected from the reality they experienced.

5.36 For some, these issues devalued the data and indicators, and how they could be used.

Using information better to improve services and understanding

5.37 In our view, looking at the patterns and trends in people's experience of services will provide a greater understanding of how to improve services. In the remainder of this Part, we show this by looking at the data for two of the indicators from the KPI Programme and what these reveal. We also introduce work we have shared with the health sector on viewing a person's contact with mental health services as a timeline of interactions. Our work was based on the innovative thinking of an individual working in the mental health sector.

Patterns and trends in people's experiences

5.38 We looked at two indicators from the KPI Programme and analysed the data. The indicators related to:

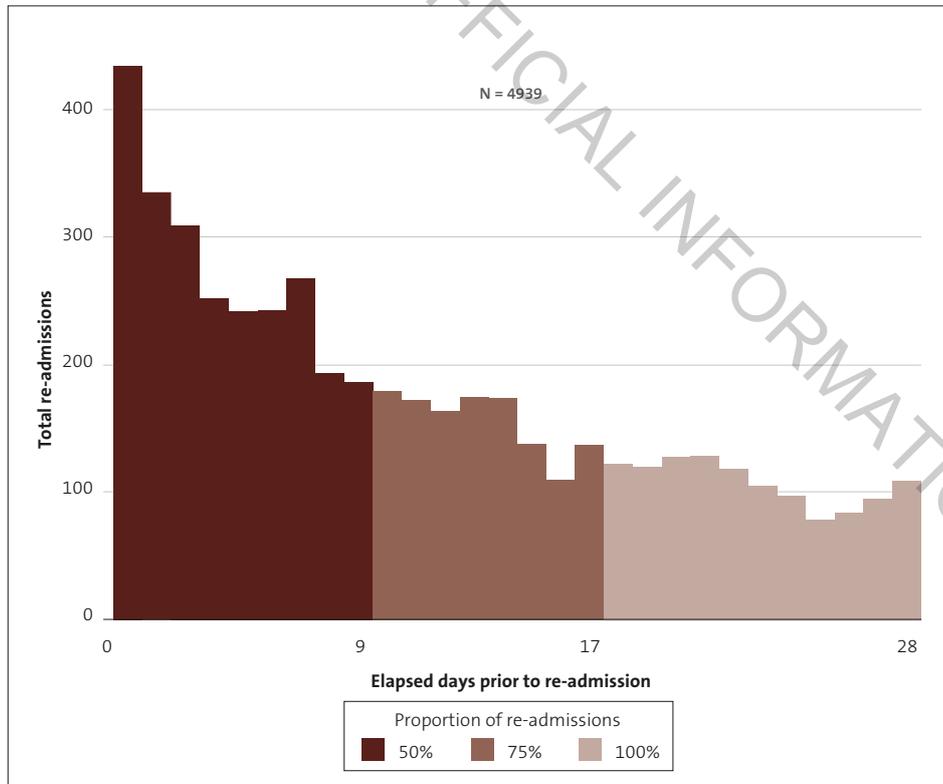
- follow-up contact with people after their discharge from inpatient units; and
- people's re-admission to inpatient units.

5.39 In our view, the patterns and trends we highlight could be useful for the Ministry and DHBs in considering how to improve services.

Patterns and trends in people’s experiences of re-admission to inpatient units

- 5.40 The indicator for re-admission shows the overall percentage of re-admissions to acute inpatient units within 28 days of discharge. We looked at the distribution of all re-admissions that occurred within 28 days of discharge from an inpatient unit, for the period 2011/12-2014/15. Figure 7 shows that almost half of all re-admissions occurred within nine days of discharge, and three-quarters within 17 days. In other words, most re-admissions occurred well before 28 days had passed.
- 5.41 Figure 7 excludes people who were re-admitted on the same day that they were discharged. This often happens when people given day leave from the inpatient unit get counted as a discharge and re-admission on the same day.

Figure 7
Profile of when re-admissions occurred for re-admissions between 1 and 28 days after discharge, 2011/12-2014/15



Source: Our analysis of Ministry of Health data.

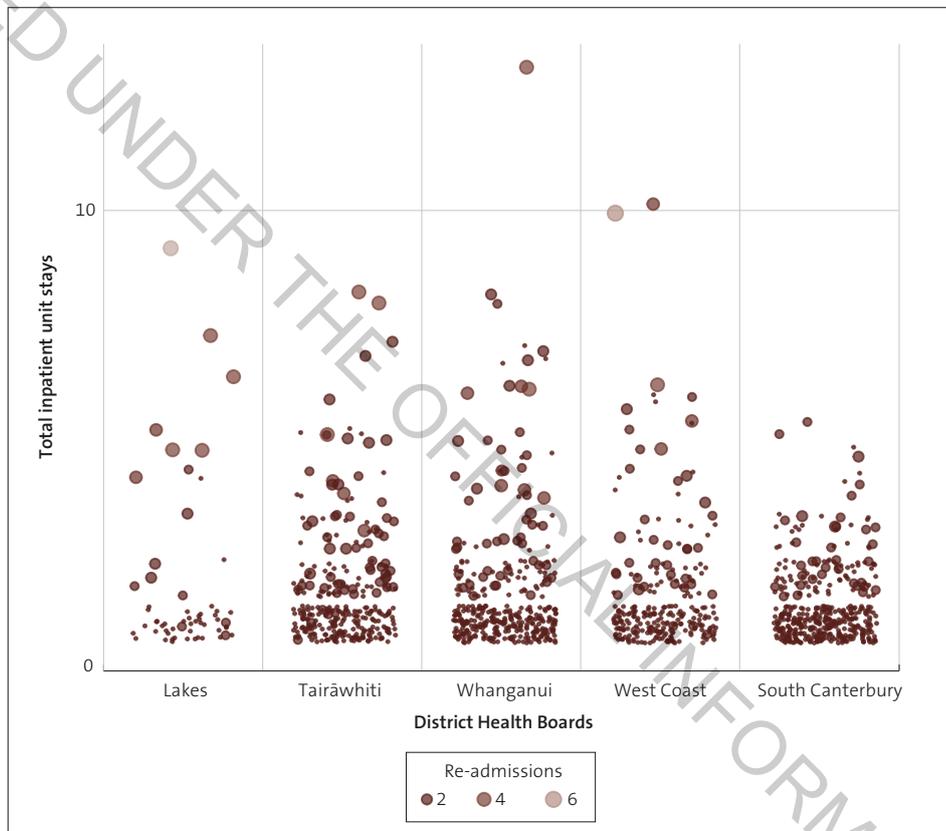
5.42 We also looked at the profile of re-admissions by three-month periods for small, medium, and large DHBs and found that:

- the spread of rates is erratic from one quarter to the next;
- the rates for some DHBs (outliers) is as high as 100% in a particular quarter (meaning every single inpatient stay in that quarter would have been a re-admission); and
- there is no clear pattern of an ongoing decrease (or increase) in re-admission rates.

5.43 Small DHBs (which have the lowest numbers of people using acute inpatient services) are more prone to erratic swings in their re-admission rates than medium or large DHBs. Medium and large DHBs display progressively tighter distributions of re-admission rates from one quarter to the next, with less wide-ranging outliers.

5.44 Focusing in on the cohort of people described in paragraph 1.13 and needing acute mental health services, we looked at re-admissions for each person. Figure 8 shows re-admissions for each person treated in five small DHBs.

Figure 8
Distribution of re-admissions and all inpatient unit stays for people at five small district health boards



Source: Our analysis of Ministry of Health data.

- 5.45 The larger bubbles in the top three-quarters of Figure 8 represent people who have experienced many re-admissions during their inpatient stays. There is a relatively small number of these people. Most people have had fewer inpatient stays and no re-admissions.¹⁰ These are represented by the smaller bubbles at the bottom. We found a similar distribution pattern for all DHBs.

Patterns and trends in people’s experiences of follow-up contact

- 5.46 The indicator for follow-up activity looks at the percentage of people who were contacted by the community mental health team within seven days of their discharge from an inpatient unit. The contact does not need to be in person, but some forms of social media contact are excluded.

¹⁰ An inpatient stay counts as a re-admission when it occurs within 28 days after the most recent discharge and within the same inpatient unit. This means that, for example, a person can have more than one inpatient stay but no re-admissions.

5.47 Our analysis showed that follow-up rates for small DHBs display a similar picture to that of re-admission rates: movement is erratic and highly variable over time. Similar to the 28-day re-admission rates, the follow-up KPI displays a tighter distribution as we move from small to medium to large DHB groups. However, there is no clear observable trend for all three DHB groups.

Viewing a person's contact with mental health services as a timeline of interactions

- 5.48 Building on innovative thinking already happening in the sector, we used the data for the cohort of people described in paragraph 1.13 to construct timelines of people's contact with mental health services. We constructed these timelines for individuals and for groups of people. We took the concept of using visual timelines to understand people's interactions with mental health services, which was developed by people working in the health sector, and refined it to highlight its potential uses.
- 5.49 Currently, it is not always easy for clinicians to form a quick impression of a person's contact history (the details of which might be bundled together as part of various case notes). Timelines show a single picture of a person's contact history, providing clinicians with an intuitive mechanism for rapidly understanding patterns of contact, and can be adapted to focus on different types of contact, groups of people, or areas of the health service.
- 5.50 Viewing data from a person's perspective can also:
- help DHB clinicians and administrators to understand who is using their services and plan to meet their needs, including identifying service gaps; and
 - enable identification and sharing of good practice between DHBs, and enable services between DHBs to be co-ordinated when a person moves, to help with their continuity of care.
- 5.51 Alongside this report, we have made more information available on our website (oag.govt.nz) about the concept of people's timelines showing their different types of contact with mental health services, and potential uses of it.

Recommendation 4

We recommend that the Ministry of Health and district health boards quickly make improvements to how they use information to monitor and report on outcomes for people using mental health services.

Recommendation 5

We recommend that the Ministry of Health and district health boards use the information from this monitoring to identify and make service improvements.

Appendix

Letter from the Ministry of Health



133 Malsworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

5 May 2017

Martin Matthews
Controller and Auditor-General
Office of the Auditor-General Te Mana Arotake
PO Box 3928
Wellington 6140

Dear Mr Matthews

Mental health: effectiveness of planning to discharge people from hospital

I appreciate the opportunity to comment on the issues raised in your report into discharge planning for people in inpatient mental health services. We welcome the report of your audit of the effectiveness of planning to discharge people from inpatient mental health services. It will be a valuable source of information to assist district health boards (DHBs) and the Ministry of Health (the Ministry) in our efforts to continually improve mental health service delivery. As you note in your report, discharge planning is not a separate component of service delivery; rather, it is an integral aspect of good care.

In the period since you commenced your investigation, there are several areas in which considerable work has been done to enhance service delivery across district health board (DHB) mental health services. Some of that work was outlined in a recent address by Hon Dr Jonathan Coleman, at the launch of the Health Quality and Safety Commission's (HQSC) mental health quality improvement initiative.

Some of the work already in progress is being led from the Ministry and others (including the KPI project referred to in your report) are driven by the sector. We recognise that mental health services are under considerable pressure as a result of increased demand. As a result, the Ministry is considering how best to support mental health system pressures and address broader social needs, such as housing. Some of the key actions already under way are outlined below.

Mental health as a priority

The Minister of Health made it very clear that although there are challenges in meeting the demand for mental health services, both the mental health system and the wider social sector is responding. The Minister has included mental health in his recent 2017/18 Letter of Expectation to all DHBs and it is also further reflected in DHBs' Annual Plans. Greater visibility of the ways in which DHBs meet their obligations for discharge planning will also be assisted by including a section on the discharge planning KPI as part of the Annual Report of the Office of the Director of Mental Health.

Mental health strategy and supporting resources

To help guide continued transformation of mental health and addiction services, the Government is adopting a new approach. The Minister of Health has announced his intention to take a paper to Cabinet in the near future, outlining the Government's approach to a new mental health and addiction strategy. This approach recognises that mental health and addiction issues are not simply 'health' problems and that there are significant gains to be made from taking a social investment approach. The development of a new strategy will be informed by other work, including early feedback arising from public consultation on the draft suicide prevention strategy (currently underway) and work being undertaken by the Social Investment Unit. I anticipate that the new mental health and addiction strategy will have an increased focus on prevention and early intervention, as well as building on the gains already made under 'Rising to the Challenge'.

The He Tangata Framework is an analytical tool that identifies critical factors impacting mental health and allows us to identify populations experiencing inequity of mental health and addictions outcomes from the total NZ population. I expect the tool will usefully inform both the national strategy, and DHBs' own annual planning, within the context of the Mental Health Commissioning Framework.

The Ministry's recently-published Mental Health and Addiction Workforce Action Plan 2017–2021 states that New Zealand's health workforce is highly skilled and professional, and acknowledges that the workforce faces staff shortages, as well as that Māori and Pacific health professionals are under-represented in the ethnic distribution of this workforce.

National quality improvement programme

The Minister has recently launch a national quality improvement programme for mental health. This programme has been developed by the HQSC as a result of meetings with the Chief Executive Officers of DHBs and the Minister of Health, and:

- has DHB mandate and ownership and is supported by the sector
- serves as a repository for evidence and best practice for service quality improvement
- establishes standardised, evidence-based processes and practices within MHA services
- begins to generalise best practice across all MHA services and monitors impacts and effectiveness
- employs proven methodologies for service quality improvement
- actively rejuvenates leadership in the sector.

The proposal is endorsed by DHB Chief Executives, and is designed to complement and augment other initiatives in the sector. The programme will focus on a small number of nationally agreed priorities and use the collaborative methodology similar to the Scottish Patient Safety Programme and the Institute for Healthcare Improvement. Assistance and leadership for the programme will also be sought from those services and agencies that have implemented and/or supported successful improvement initiatives, including DHBs, NGOs, PHOs and MHA workforce centres. It will be run for the next five years at a cost of around \$7.5 million, with a review after the first three years.

Proposed priority areas for improvement include a focus on improving service transitions (including from inpatient to community services). Initial steps are in place to implement the programme, with a national leadership group and clinical lead currently being appointed and the programme commencing from July this year. The programme also supports training for quality improvement facilitation, to support DHBs in building their own capability in quality improvement.

Conclusion

In conclusion, there are always opportunities to do better and this includes improvement in the ways in which mental health services support people in moving from inpatient to community mental health services. I am confident that audit report's findings, alongside the processes and activities outlined in this letter, will lead to sustained improvement in the ways in which mental health services support people in need of their care.

Yours sincerely



Chai Chuah
Director-General of Health

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**Central Region's Technical Advisory Services
DAA Certification Audit Programme**

Canterbury District Health Board

Surveillance Audit Report

13-16 March 2017

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HealthCERT Service Provider Audit Report (version 6.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Canterbury District Health Board		
Certificate name:	Canterbury District Health Board		
Designated Auditing Agency:	Central Region's Technical Advisory Services Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Chatham Island Health Centre; Tuarangi Home; Ashburton Hospital; Burwood Hospital; Christchurch Hospital; Ellesmere Hospital; Hillmorton Hospital; Kaikoura Hospital; Rangiora Hospital		
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Children's health services; Dementia care; Hospital services - Surgical services; Hospital services - Maternity services		
Dates of audit:	Start date:	13 March 2017	End date: 16 March 2017

Proposed changes to current services (if any):

Reconfigurations of Ashburton Hospital, Burwood Hospital, Kaikoura Hospital and Rangiora Hospital.

Total beds occupied across all premises included in the audit on the first day of the audit:	1046
-----------------------------------------------------------------------------------------------------	------

Audit Team

Lead Auditor	Raewyn Wolcke	Hours on site	32	Hours off site	30
Other Auditors	Lizelouize Perkins, Tevita Hingano, Zdena Kaspar-West, Christine Davies, Lorraine Proffit	Total hours on site	176	Total hours off site	25
Technical Experts	Click here to enter text	Total hours on site	0	Total hours off site	0
Consumer Auditors	Shaz Picard	Total hours on site	16	Total hours off site	0
Peer Reviewer	Joy Hickling			Hours	4.5

Sample Totals

Total audit hours on site	224	Total audit hours off site	59.5	Total audit hours	283.5
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Number of residents/patients interviewed	17	Number of staff interviewed	182	Number of managers interviewed	10
Number of residents'/patients' records reviewed	80	Number of staff records reviewed	0	Total number of managers (headcount)	21
Number of medication records reviewed	204	Total number of staff (headcount)	7,486	Number of relatives interviewed	17
Number of residents'/patients' records reviewed using tracer methodology	8			Number of GPs interviewed (Residential Disability providers only)	1

Declaration

I, Christine Marsters, Manager Audit & Assurance - DAA/Certification Audit Programme of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Central Region's Technical Advisory Services Limited	Yes
b)	Central Region's Technical Advisory Services Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Central Region's Technical Advisory Services Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Central Region's Technical Advisory Services Limited has provided all the information that is relevant to the audit	Yes
h)	Central Region's Technical Advisory Services Limited has finished editing the document.	Yes

Dated Thursday, 18 May 2017

Executive Summary of Audit

General Overview

The Canterbury District Health Board operates 1390 beds across 14 sites from Kaikoura to Ashburton. This surveillance audit included site visits to the Christchurch hospital campus, Hillmorton, Burwood, Ashburton, Tuarangi, Ellesmere, Kaikoura and the Chatham Islands Health Centre. The audit team was provided with a comprehensive self-assessment and supporting evidence prior to the on-site visit. Eight individual patient tracers and four systems tracers were undertaken during the on-site visit.

The Canterbury District Health Board continues to face challenges from the impact of the Canterbury and more recent Kaikoura earthquakes. Challenges include workforce, infrastructure and the shifts in the population's health profile and health needs. The new builds at Rangiora, Ashburton, Kaikoura and Burwood hospitals have been completed and are suitable for purpose. The new build of the acute services building at Christchurch hospital is underway. The ongoing challenges of managing new building projects and infrastructure are continually risk assessed and mitigated, with weekly meetings with all stakeholders involved.

The Canterbury District Health Board continues to redesign and improve health care delivery through a collaborative 'whole of systems' approach involving health professionals across all sectors. The wellbeing of staff is monitored and support is provided. Patients confirmed they are positive about the care and treatment they receive.

Required improvements closed out from the previous certification audit include nursing assessments and care planning at Tuarangi and restraint committee structure. All partial provisional facility management improvements required at Burwood were verified to be closed out.

Required Improvements remaining from the previous certification audit include document control; corrective actions plans: performance appraisals and credentialing; nursing assessments; early warning scores and medication management (across services audited with the exception of Tuarangi).

There are new required improvements as a result of this audit including informed consent (not for resuscitation and general consent); provider arm clinical governance reporting structures; aged care contract requirements, service delivery practice, and restraint minimisation.

Outcome 1.1: Consumer Rights

All patients confirmed they are provided with sufficient information to make informed choices. There is a computerised system, Safety 1st, in place across Canterbury District Health Board that ensures all complaints are monitored and reviewed within expected timeframes. Staff, patients and families confirmed they are aware of their right to make a written or verbal complaint.

Outcome 1.2: Organisational Management

The executive leadership team and chief executive provide leadership to the organisation. Management decision making is supported by the Canterbury District Health Board's new and improved information systems which provide more real time information.

Risks are reviewed at Board level and mitigation strategies are monitored. Quality and risk management systems support the organisation. The Health Excellence programme has been adopted, and is in the process of being implemented, to provide a coordinated approach to improving systems. This is supported by a central audit library. The leadership and lean projects continue to involve front-line staff in improvement projects. Canterbury District Health Board demonstrates a culture of ongoing quality improvement.

Significant incidents are investigated using a root cause analysis methodology and open disclosure to patients and their families is practiced. Canterbury District Health Board manages all incidents in an open manner. The electronic incident reporting system which is implemented across the organisation, provides improved reporting and analysis of data. Organisational policies and procedures are on the electronic document management system which is controlled centrally and a new framework is being implemented to include health pathways.

The traditional human resource department is currently being redesigned into a contemporary people and capability function, which is centralised and supports managers across the organisation. Canterbury District Health Board has a new credentialing committee.

Inpatient services are provided by a skilled workforce.

Outcome 1.3: Continuum of Service Delivery

Patient journeys were followed through in eight services; medical, surgical, child health, maternity, health of the older person, rest home level services and mental health (forensic and adult acute).

Canterbury District Health Board has achieved their health target for shorter stays in emergency departments, faster cancer treatment and improved access to elective surgery.

Review of patients' journeys and systems tracers evidenced a multidisciplinary team approach to care. There is access to medical staff 24 hours a day, seven days a week.

A falls prevention tracer was undertaken which demonstrated the programme is implemented across Canterbury District Health Board including the long-term care residential facilities and rural hospitals services.

A deteriorating patient tracer was also conducted. This programme is transitioning between a computerised and paper based system.

Canterbury District Health Board has implemented an electronic medication prescribing and administration system which is supported by policies and procedures. This has been rolled out to most areas. A medication management systems tracer was also completed.

There are timely transfers to other health services both externally and internally. Transfers between services follow protocol and standardised communication tools are in use across services.

Outcome 1.4: Safe and Appropriate Environment

The environment for patients and staff is safe. All inpatient buildings have a current building warrant of fitness. A preventative maintenance programme and the environment in the clinical areas is safe for patients and staff. Plant and equipment was compliant with legislation at the time

of construction. There are systems for emergency response and Canterbury District Health Board works closely with other agencies and emergency services in the Canterbury region. Management staff work with the in-house security service to ensure the safety of patients, staff and visitors.

Outcome 2: Restraint Minimisation and Safe Practice

Policies are in place to support practice. Restraint committees/groups oversee monitoring and evaluation of the restraint process. Restraint reviews are conducted and communicated to all concerned.

Specific training in safe management of patients to reduce the likelihood of restraint is implemented in high risk areas. Mandatory restraint training is delivered in accordance with staff roles, specific service environments and specialised needs.

Outcome 3: Infection Prevention and Control

Multidrug-resistant organisms were used as the system tracer for infection prevention and control. The new research based contact precaution guidelines identifies three streams of service delivery for the patient. Staff reported the new guideline and risk assessment policies ensure the process of identification and management was easier to follow. The infection prevention and control team provide education and support as required.

Surveillance programmes are embedded into practice at Canterbury District Health Board.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	10	0	5	3	0	0
Criteria	0	45	0	8	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	39
Criteria	0	0	0	0	0	0	0	85

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.2	Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.	PA Low	Not for resuscitation forms are not completed and general consent is not consistently obtained in Tuarangi, Kaikoura and the Chatham Island Health Centre.	Review not for resuscitation documentation and general consent documentation at Tuarangi, Kaikoura and Chatham Island Health Centre to ensure completion is timely and accurate.	365
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	PA Low	There is a fragmented approach to clinical governance monitoring and decision making across the provider arm of CDHB.	Review the structure and systems for clinical governance monitoring in the provider arm.	365
HDS(C)S.2008	Criterion 1.2.3.4	There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	<ul style="list-style-type: none"> i) Implementing a sustainable system for the management of documents is still in progress, with gaps identified in document control at the service/clinical unit level. ii) Policies and procedures are not readily accessible to staff in the Chatham Island Health Centre. 	<ul style="list-style-type: none"> i) Incorporate all service/clinical unit documents in the organisation wide document control system. ii) Enable access to a current policy and procedure resource to support staff in the Chatham Island Health Centre. 	365

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Follow up on audit results, recommendations and action plans is variable.	Ensure that the system for managing and monitoring corrective action plans are applied across CDHB.	365
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	<ul style="list-style-type: none"> i) Performance appraisals are not completed consistently across services or professional groups. ii) The process to credential medical staff and services is now in progress, however, the timeframe to complete this across all service is five years. iii) The general practice role in the Chatham Islands is not currently credentialed by CDHB. 	<ul style="list-style-type: none"> i) Ensure all staff have a performance review completed as required in the new framework ii) Ensure the implementation of the credentialing schedule is monitored and potential risk mitigated. iii) Review the credentialing process for the general practitioner role in the Chatham Islands. 	365
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	<ul style="list-style-type: none"> i) Aged care service delivery requirements do not comply with all the requirements of the ARC contract and standards. ii) Clinical record documentation and practice (e.g. assessment, care 	<ul style="list-style-type: none"> i) Review the service delivery model at Kaikoura long-term care service to ensure that it meets contractual and standards requirements. ii) Review service delivery practice and clinical record documentation at Chatham 	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				planning, evaluation (discharge planning) at the Chatham Island Health Centre are not consistently recorded.	Islands to ensure consistent implementation.	
HDS(C)S.2008	Criterion 1.3.3.6	The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.	PA Low	Minimal ongoing service provision is available for mental health patients on the Chatham Islands to support relapse prevention.	Review the mental health service delivery model at Chatham Islands in relation to ongoing care and relapse prevention.	180
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Nursing assessments are not consistently completed.	Ensure all nursing documentation is completed in a timely manner	365
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Protocols for the deteriorating patient are not fully understood and implemented.	Ensure that the system for managing the deteriorating patient is embedded and sustained.	365
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		requirements and safe practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	There is inconsistency in practice and documentation in all aspects of medication management.	Ensure practice and documentation of medication management and administration meet policy and legislative requirements.	365
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Moderate	The policy for safe restraint practice and enablers is not being followed at Kaikoura long-term care service and the Chatham Island Health Centre.	Implement policy requirements for safe restraint and enabler use at Kaikoura long-term care service and the Chatham Island Health Centre.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.7 (HDS(C)S.2008:1.1.4.7)

The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5)

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.1.5.1 (HDS(C)S.2008:1.1.5.1)

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:

- (a) Developing effective relationships with Pacific people to support active participation across all levels;
- (b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
- (c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
- (d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.

This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.5.2 (HDS(C)S.2008:1.1.5.2)

The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.7.2 (HDS(C)S.2008:1.1.7.2)

Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.4 (HDS(C)S.2008:1.1.7.4)

The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.5 (HDS(C)S.2008:1.1.7.5)

The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

Attainment and Risk: PA Low

Evidence:

There is an informed consent policy, which is detailed and covers all scenarios in which consent must be obtained. Canterbury District Health Board (CDHB) have consent forms available for staff to obtain consent. The form incorporates a section to ascertain patients' choices concerning keeping body parts. Patients and family members and the consumer auditor confirmed patients and their families were given the opportunity to contribute to their plan of care including the consent process. Staff interviews and training records confirmed staff receive training and education on informed consent during orientation and as part of the mandatory education programmes for staff. Staff reported there has been an increase in the numbers of patients presenting to CDHB with completed advanced care plans as a direct response of the inter-collaboration of primary and secondary services.

The audit team noted in the clinical records reviewed at Tuarangi, Kaikoura and the Chatham Island Health Centre, that general consent is not consistently obtained and there was little evidence of the not for resuscitation (NFR) decision having been discussed with the patient and or their family. This area requires improvement.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: PA Low

Evidence:

General consent in aged care, including consent for treatment; access to information and information sharing; consent for outings and the use of patients' photographs are not consistently obtained in Tuarangi and Kaikoura. Documentation of NFR consent does not consistently show evidence of the NFR decision having been discussed with the patient or family. Informed consent processes were not evident in the clinical records reviewed in the Chatham Island Health Centre.

Finding:

Not for resuscitation forms are not completed and general consent is not consistently obtained in Tuarangi, Kaikoura and the Chatham Island Health Centre.

Corrective Action:

Review not for resuscitation documentation and general consent documentation at Tuarangi, Kaikoura and Chatham Island Health Centre to ensure completion is timely and accurate.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.8 (HDS(C)S.2008:1.1.10.8)

The service has processes that give effect to consumers' requests on the storage, return or disposal of body parts, tissues, and bodily substances, taking into account the cultural practices of Māori and other cultures.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.9 (HDS(C)S.2008:1.1.10.9)

Where a service stores or uses body parts and/or bodily substances, there are processes and policies in place that meet Right 7(10) of the Code.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
 Click here to enter text

Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

Attainment and Risk: Not Audited

Evidence:
 Click here to enter text

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: Not Audited

Evidence:
 Click here to enter text

Finding:
 Click here to enter text

Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

Attainment and Risk: FA

Evidence:

The complaints policy provides guidance to staff on processes for documenting and managing complaints. Information given to all patients on admission explains how to make a complaint. The complaints process is reviewed and monitored by customer services at each site. The introduction of the Safety 1st information technology (IT) system has supported a standard CDHB approach to complaints management.

Complaints reviewed evidenced that the complaints were investigated and managed in compliance with Right 10 of the Code. Reports reviewed indicated the number, type and outcomes of complaints are monitored and reported.

Patients and their families confirmed they were aware of their right to make a written or verbal complaint.

Interviews with staff confirmed the processes in place.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Attainment and Risk: PA Low**Evidence:**

Canterbury District Health Board has adopted and is implementing the Health Excellence programme as a framework for quality improvement. There was evidence of a coordinated approach to improving systems. Progress has been made in standardising systems across CDHB, and a review of quality meeting minutes confirmed that services are active in addressing quality issues and improving practices.

The IT programmes such as Safety 1st, e-medicine, eObservation and patientrack are providing real time information to strengthen and improve outcomes. The organisation has identified there are some risks in transitioning from a paper based system to electronic based systems. Canterbury DHB has a mature risk management system and staff are aware of the risks facing the organisation and mitigation strategies are monitored at an executive and Board level.

Policies and procedures that are organisation wide or corporate, are now all on the electronic document management system and are controlled centrally. Not all local policies are online in the new system. There has been a review and stocktake of policies and processes, and a new framework is being implemented to also include the health pathways and Lippincott for nursing procedures, however, there are improvements required.

A process to manage and monitor audits, supported by a central audit library is now in place. The system does not yet incorporate all audits and there is not consistency in the management of corrective actions although progress has been demonstrated. Canterbury District Health Board clinical board monitors clinical practice and patient safety initiatives across the organisation, and identifies areas where an improvement focus is required. Not all patient safety activities in the provider arm are escalated to the clinical board.

Canterbury District Health Board has access to a range of data and information used to manage the organisation and assist in decision making. Access to data for quality improvement continues to improve. Canterbury District Health Board benchmarks against national targets.

There is an active consumer council involved in a variety of activities across the organisation including participation in the quality committees.

The improvements from the previous audit remain open regarding document control and corrective actions. A new improvement is required in relation to the provider arm clinical governance structure.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: PA Low**Evidence:**

Canterbury District Health Board's clinical board has a broad brief and membership which covers both hospital and primary care. In practice, not all patient safety activities are monitored by the clinical board.

While the service based quality/clinical governance groups function effectively and there has been improvement in standardisation of systems, there is no system that ensures overview of clinical governance across the provider arm.

Finding:

There is a fragmented approach to clinical governance monitoring and decision making across the provider arm of CDHB.

Corrective Action:

Review the structure and systems for clinical governance monitoring in the provider arm.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA**Evidence:**

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: PA Low**Evidence:**

Progress has been made since the last audit and a systematic approach is being taken to reviewing and controlling documents, forms and patient information. A stocktake has been completed. The service/clinical unit level evidenced gaps in document control. There was limited access to CDHB policies and processes at the Chatham Island Health Centre.

Finding:

- i) Implementing a sustainable system for the management of documents is still in progress, with gaps identified in document control at the service/clinical unit level.
- ii) Policies and procedures are not readily accessible to staff in the Chatham Island Health Centre.

Corrective Action:

- i) Incorporate all service/clinical unit documents in the organisation wide document control system.
- ii) Enable access to a current policy and procedure resource to support staff in the Chatham Island Health Centre.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA**Evidence:**

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA**Evidence:**

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: PA Low

Evidence:

A clinical audit library has been developed and an audit plan for nurses implemented. Evidence was provided that shows corrective actions from audits is improving, however, there is not a consistent approach to managing corrective actions that is implemented throughout CDHB.

There is minimal evidence of audits being completed for Tuarangi, Kaikoura sites and the Chatham Island Health Centre.

Finding:

Follow up on audit results, recommendations and action plans is variable.

Corrective Action:

Ensure that the system for managing and monitoring corrective action plans are applied across CDHB.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that

risk;

(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

Attainment and Risk: FA

Evidence:

Canterbury District Health Board has completed a staged implementation of an electronic incident management reporting system (referred to as Safety 1st) to all sites across CDHB, with limited accessibility in the Chatham Island Health Centre. An IT solution to enable improved electronic access to CDHB systems for the Chatham Island Health Centre is in progress. In the interim a manual process is implemented when required to enable entry to be inputted into the Safety 1st system and follow up is required to be manually prompted.

Staff confirmed that they are aware of the reporting and investigating process for incidents. Incidents are discussed at team meetings. There is evidence of staff receiving education and training in relation to the incident and accident reporting processes. Events are electronically reported by staff and reviewed by the immediate team manager (e.g. charge nurse) to ensure appropriate immediate actions have been taken and escalated to the service manager.

Canterbury District Health Board has systems to investigate serious incidents and a core group of staff are trained in managing root cause analysis. The Canterbury serious incident review committee provides oversight and monitoring of incidents, the timeliness of serious adverse event reporting and the Safety 1st system. Serious adverse event reports are presented to the quality, finance, audit and risk committee.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5)

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.2.5.1 (HDS(C)S.2008:1.2.5.1)

The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.2 (HDS(C)S.2008:1.2.5.2)

Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.3 (HDS(C)S.2008:1.2.5.3)

The service assists with training and support for consumers and service providers to maximise consumer participation in the service. This shall include:

- (a) Education and/or training for service providers whose colleagues are consumers working in the services;
- (b) Supervision; debriefing and peer support.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.2.5.4 (HDS(C)S.2008:1.2.5.4)

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:

- (a) Employing consumers where practicable;
- (b) The service assisting with education, training, and support for consumers to maximise their participation in the service;
- (c) Training for service providers in working with consumers as advisors;
- (d) Advisors liaising with consumer groups or networks.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.2.5.5 (HDS(C)S.2008:1.2.5.5)

The service implements processes that involve consumers at all levels of service delivery.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.2.6.1 (HDS(C)S.2008:1.2.6.1)

The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.2 (HDS(C)S.2008:1.2.6.2)

Family/whānau who participate in an advisory capacity have clear terms of reference. This shall include, but is not limited to:

- (a) Advice sought from the family/whānau advisory groups when developing a terms of reference;
- (b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality and conflicts of interest.

Attainment and Risk: Not Audited

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:

- (a) Employing family/whānau where practicable;
- (b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;
- (c) Training for service providers in working with families/whānau as advisors;
- (d) Advisors liaising with family/whānau groups or networks.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

Attainment and Risk: PA Low

Evidence:

Canterbury District Health Board is repositioning a traditional human resources department into a contemporary people and capability function. The recruitment of new staff is centralised and managers across CDHB are supported by the recruitment team in all matters relating to recruitment. The induction and ongoing mandatory education includes a mix of online learning, face-to-face workshops and on the job experience learning. Evidence of completed performance appraisals and documentation of staff attendance at training was sighted in clinical wards visited.

Staff have access to policies and procedures that support people and capability management and ensure this is managed consistently across the organisation. Information is reviewed to identify retention trends and issues. All processes are in line with good employment practice and legislation. Staff have position descriptions and compliance with the requirement for annual performance appraisals is monitored by the division managers. A recent review confirmed there is a 50% non-compliance with annual appraisals. Qualifications are checked at employment and processes to check annual practicing certificates are managed by the professional groups.

Medical staff are credentialed at appointment. A new credentialing governance committee has been implemented. Allied health and nursing services maintain their own competency programmes. Review of data and interviews with clinical staff confirmed orientation and ongoing training is provided. Records of training are managed in a database. Staff are encouraged and supported to develop both personally and professionally. The general practitioner role at the Chatham Islands Health Centre has continued to be modelled on the previous DHB process. There is currently no formally credentialing of this role completed by the CDHB.

The corrective actions from the previous audit remain open for credentialing and performance appraisals.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: PA Low

Evidence:

The iPerform database, which is no longer supported, has 50% of the staff logged as compliant with performance appraisal. The alternative paper based system is not monitored and staff and managers interviewed confirmed that targets for completion of performance appraisals are not met. The proposed new system has yet to be implemented.

A new credentialing governance committee is now functioning. The previous credentialing framework and process has lapsed. A plan to credential all services is developed and implementation is underway. The timeframe to complete all services is five years. Prioritization of services has not been risk assessed. The general practitioner role at Chatham Islands Health Centre is currently not formally credentialed by CDHB.

Finding:

- i) Performance appraisals are not completed consistently across services or professional groups.
- ii) The process to credential medical staff and services is now in progress, however, the timeframe to complete this across all service is five years.
- iii) The general practice role in the Chatham Islands is not currently credentialed by CDHB.

Corrective Action:

- i) Ensure all staff have a performance review completed as required in the new framework
- ii) Ensure the implementation of the credentialing schedule is monitored and potential risk mitigated.
- iii) Review the credentialing process for the general practitioner role in the Chatham Islands.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

Attainment and Risk: FA

Evidence:

There are robust systems in all settings to ensure that all staff are selected appropriately for the roles they are recruited for. Workforce planning is incorporated in CDHB's clinical service planning for the needs of the population. The operations centre ensures the skill mix and staffing numbers are suitable across all services. Planning is supported by the trend care forecasting system and bed capacity management and escalation plan. After-hours duty nurse managers are supported by the clinical team coordinator to ensure the hospitals are appropriately staffed.

All professional groups have different processes for ensuring the competency of staff. The professional development programme for nursing is well established, supervision and competency programmes are used by allied health staff. Doctors have supervision and training programmes depending on their roles and levels of experience. There is always senior clinical staff on call after hours. New graduates have a specific programme and are mentored. In Burwood there has been an increase in bed numbers, with the new Burwood hospital now having 310 inpatient beds. Staff levels and skill mix for the new Burwood hospital was prepared for the Ministry of Health in a documented new facilities workforce transition plan 2013, prior to moving patients into Burwood.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.1.5 (HDS(C)S.2008:1.3.1.5)

To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p>

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p>

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Attainment and Risk: PA Moderate

Evidence:

Individual patient tracers were reviewed in maternity, surgical, health of older persons, aged care (rest home), child health, medical and mental health (forensic and adult acute) services, with their journeys followed through to additional services (e.g. intensive care, emergency department). Incidental sampling was also completed at Burwood, Ellesmere and the Chatham Island Health Centre.

All the patients reviewed had coordinated care provided by competent staff. Interdisciplinary teams work collaboratively together. Clinical records reviewed demonstrated interdisciplinary input of the patients' care. There was evidence in all areas reviewed of documented handover and in some areas bed-side handover is routinely occurring. There is increasing use of the 'about me boards' at the patient bedside. The consumer auditor who interviewed patients and their families verified that care was coordinated and the patients stated they were kept informed.

There are improvements required for assessments and documentation at Kaikoura long-term care and Chatham Island Health Centre.

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: PA Moderate

Evidence:

File reviewed showed there were no general practitioner (GP) three monthly reviews at Kaikoura long-term care services, with acute visits documented only. The service is using five different long-term care plan templates. The initial care plans are not consistently completed on admission. Care plan reviews are not completed within the required timeframes. Risk assessments are not current. Although patients and family confirmed they have opportunity to participate in care planning, there is little evidence of care plans being signed by patients or family.

Clinical records reviewed at the Chatham Island Health Centre did not always evidence completion or consistency in documentation of clinical practice information (e.g. assessment, care planning, evaluation and discharge/transfer).

Finding:

- i) Aged care service delivery requirements do not comply with all the requirements of the ARC contract and standards.
- ii) Clinical record documentation and practice (e.g. assessment, care planning, evaluation discharge planning) at the Chatham Island Health Centre are not consistently recorded.

Corrective Action:

- i) Review the service delivery model at Kaikoura long-term care service to ensure that it meets contractual and standards requirements.
- ii) Review service delivery practice and clinical record documentation at Chatham Islands to ensure consistent implementation.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

Attainment and Risk: PA Low

Evidence:

In the Chatham Islands, patients that are requiring specialist care beyond the capability of the service are flown to Christchurch hospital. Specialist services for patients with acute mental health issues are transferred to Christchurch hospital, often in a crisis state. Police and health staff interviewed stated there are increasing drug and alcohol issues on the Chatham Islands. There are limited services available for people with acute mental health needs in the Chatham Islands to minimise patient relapse or escalation through to a crisis state through the provision of mental health acute care support as the first line of treatment.

Finding:

Minimal ongoing service provision is available for mental health patients on the Chatham Islands to support relapse prevention.

Corrective Action:

Review the mental health service delivery model at Chatham Islands in relation to ongoing care and relapse prevention.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

Attainment and Risk: PA Low**Evidence:**

Across the organisation assessments are individualised, according to the specific patient needs. Allied health staff are involved in the interdisciplinary team and assessments are documented in the patient record. The use of telemedicine has been introduced in the rural hospitals and has resulted in positive outcomes. Patients and families interviewed confirmed they were involved in the assessment process. Improvements are required in the documentation of nursing assessments.

A falls prevention systems tracer was undertaken.

Canterbury District Health Board falls prevention committee through interview demonstrated a clear overview of the falls CDHB prevention programme and outlined the governance structure and systems for the programme. The committee identified improvement opportunities with planned actions and staff members responsible. Community advocates interviewed described their active involvement in the programme, including design of new patient boards and involvement in the feedback processes when these boards were trialled. This programme is being implemented across CDHB with involvement of all services.

Patients, staff (including allied health) and families were interviewed across CDHB during the falls systems tracer and demonstrated an understanding of the programme being implemented. Patient clinical records were reviewed in all areas visited across CDHB during the audit to review falls management. Preventative strategies inclusive of comprehensive assessments on admission and the introduction of the falls risk tools were present in the patient records reviewed. Education is provided to all staff prior to implementation of the falls risk tools being used.

On interview with staff and patients and through observation in areas visited, the releasing time to care process is being implemented and patient bedside boards were visible in the wards visited, demonstrating that services are embracing this preventative programme. The learning and sharing quality activities being adopted in the wards, evidenced improvement activities from some service areas such as medical and surgical care settings having a reduction of falls.

Clinical records reviewed across CDHB evidenced that assessment relating to early warning scores are not consistently completed, protocols followed and interventions documented (refer to 1.3.8.3).

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: PA Low**Evidence:**

Nursing assessments are commenced within the required timeframe. In the medical, child health and the Chatham Island services, the nursing assessments are not consistently completed. The medical and allied health team members' assessments are completed and recorded in the patients' clinical records.

Finding:

Nursing assessments are not consistently completed.

Corrective Action:

Ensure all nursing documentation is completed in a timely manner

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

Attainment and Risk: FA**Evidence:**

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

Attainment and Risk: FA**Evidence:**

Plans for care are specific, integrated, and documented with evidence of involvement with the patient/family. Care is discussed in a variety of settings including interdisciplinary meetings, medical staff rounds, bedside handovers and hourly rounding with the patient. Some wards have 'about me boards' beside the bed and these are used by the patient and staff for documenting plans of care. When required additional processes are put in place to monitor the care of the patient, including a system called patientrack to identify the deteriorating patient. Attention to meeting the diverse range of patient individualised needs is evident in all areas of service delivery. A range of equipment and resources are available, suited to the services provided and in accordance with patient needs.

In the mental health services, the care planning/treatment planning process commences on admission after a comprehensive assessment is completed by the psychiatrist or registrar. In the acute inpatient mental health services, a treatment plan is developed to outline the day to day management of the patients care and a management plan is developed to manage the long-term care. This is the management plan that is reviewed in the interdisciplinary team meeting. Both the treatment plan and management plan are goals orientated with persons of responsibility for actions identified. At the inpatient unit, older person's mental health services at Burwood Hospital, the care plans were set out in the same way, where goals are identified with actions to be completed.

The previous requirement for improvement relating to service delivery plans not being in line with the aged residential care contractual requirements at Tuarangi are now fully implemented.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

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Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/whānau if appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Attainment and Risk: FA

Evidence:

Clinical records reviewed in the patients followed during the tracers undertaken demonstrated plans of care are developed for each patient and appropriate interventions required for individual patients are recorded. Patients confirmed care is discussed with them in a collaborative manner. There is evidence of interdisciplinary involvement where this is required.

There is an increase in the use of pathways with development of hospital pathways complimenting the existing health pathways which are used with primary care. The enhanced recovery after surgery pathway is used in conjunction with pathways in arranged orthopaedic services. In the mental health services, interventions are documented as part of the care/treatment plan to be implemented. These interventions were documented as the actions to be taken to achieve the goals in the care/treatment plan.

Care plans, goals and interventions are documented and aligned with the specific needs of their patients, with the exception of the Chatham Islands service, where documentation was inconsistent (refer to 1.3.3.3).

The falls prevention care plans are still being introduced into all services. Preventative measures are now being documented on the falls prevention care plan for those patients with a risk of falling. This is still being rolled out across all inpatient services. The use of interventions such as the preventing falls measures included the mobility bracelets worn by high risk patients, equipment tags for mobility aids, falls risk magnets, clips and the bed-safe mobility plan signs, which are being introduced for specific areas such as acute care settings, rehabilitation wards, surgical and child health.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;
- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

Attainment and Risk: PA Low**Evidence:**

Care is reviewed on an ongoing basis to monitor progress against goals. Progress is evaluated at interdisciplinary team meetings, ward rounds and clinical handovers and is documented in the clinical record. There was evidence that changes in care were made as a result of the evaluations, the frequency of evaluations is determined by the acuity of the patients and their progress clinically.

Patients in Ellesmere and Tuarangi have six monthly assessments and review of their care plans. Medical reviews occur three monthly or when the condition of the patient changes.

Patients with falls prevention care plans are reviewed/evaluated daily and any changes are made on the plans if required. The bedside mobility plan signs are modified if any changes or if the risk changes for the individual patient. The interventions at a glance, guide staff in their respective care of the individual. Any strategies are also changed in the patient care plan as well to ensure the plan is current and up to date, with the exception of the Chatham Island services (refer to 1.3.3.3).

A deteriorating patient system tracer was undertaken.

The tracer included the review of the system to recognize and respond to patients' clinical deterioration. There is a project steering board (deteriorating patient steering group) in place. Representatives of the steering group on interview provided an outline of the programme. Representation on the group is multi-professional and was established in 2016 to begin alignment with the national deteriorating patient programme to be implemented over the next couple of years. The deteriorating patient steering group links with an implementation team rolling out a computerised early warning score (EWS) system called patientrack. This computerised EWS system has been implemented across the acute adult wards at the Christchurch campus. Other areas continue to use the paper based system. Nursing and medical staff can contact the intensive care unit (ICU) outreach service team directly if they are concerned about a patient's condition, confirmed at staff interviews.

Early warning scores protocols and policies have been in place since 2007 for CDHB, are available to staff online and are included during orientation of new clinical staff. With electronic implementation of the EWS, the EWS protocols and policies are also available to staff in poster format in clinical areas and on lanyards worn by staff. Feedback from nursing staff about the system was positive. However, this was not demonstrated consistently by staff interviewed on audit using the electronic EWS system. Staff interviewed had limited knowledge as to how to access and follow the EWS protocols online, did not have lanyards on the day of audit or visibility of EWS posters to refer to as a reference. As a result of this, staff did not consistently demonstrate understanding and were not consistently implementing the EWS protocols. There was also evidence in some patients' clinical records of variances from the EWS protocol. When a EWS score was explainable and acceptable for a patient based on clinical judgement, the reason(s), acceptable observation parameters and an alternative management plan was documented by medical staff in the patient's clinical record, however, this documentation was inconsistent and requires improvement.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA**Evidence:**

[Click here to enter text](#)

Finding:
Click here to enter text

Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: PA Low

Evidence:

Canterbury District Health Board is in transition from a paper to electronic system for managing the deteriorating patient and this presents risk in terms of staff education and knowledge. Early warning scores are not always actioned. Documentation does not always reflect the medical or nursing management required. The patienttrack system does not include the protocol.

Finding:

Protocols for the deteriorating patient are not fully understood and implemented.

Corrective Action:

Ensure that the system for managing the deteriorating patient is embedded and sustained.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

Attainment and Risk: FA

Evidence:

Discharge planning is initiated on admission to all services. Processes are developed and implemented to support patients from admission to discharge. Discharges are planned in collaboration with the community team, when appropriate, to ensure ongoing support and treatment. Patients and families reported appropriate timely and supportive discharge. Discharge dates are identified at admission and used for bed management and discharge planning.

There was evidence of established links to primary health support in the older person's mental health service for patients' community discharge. Patients are provided with relevant discharge information, inclusive of discharge summary and follow-up appointments, as clinically indicated.

In the Chatham Islands, the transfer/discharge management is a critical process in the delivery of services. When a patient is assessed to be requiring specialist care off the island, a transfer of care is initiated and a Life Flight is organised with staff at Christchurch hospital. While transfer of care is completed when the patient is flown to Christchurch. Documentation in the Chatham Island Health Centre clinical record is inconsistent (refer to 1.3.3.3).

The interdisciplinary team forum, in addition to medical reviews, is the main forum where discharge management is initiated in the mental health services. If the interdisciplinary team meeting finds that the patient is ready for discharge, then the discharge process is initiated and includes the development of a transition plan. Risks are re-evaluated and transfer of care is organised by the primary staff member. Liaison with community services are also commenced to prepare for the handover of care.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.11: Use Of Electroconvulsive Therapy (Ect) (HDS(C)S.2008:1.3.11)

Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner. (Only mental health services that provide ECT need to comply with Standard 3.11)

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.3.11.1 (HDS(C)S.2008:1.3.11.1)

ECT is provided according to legislation and currently accepted best practice guidelines.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.2 (HDS(C)S.2008:1.3.11.2)

There are monitoring processes in place to ensure all assessments, consents, and application of ECT comply with the currently accepted best practice guidelines, legislation, and the organisation's policies and procedures.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.3 (HDS(C)S.2008:1.3.11.3)

Consumers are given specific information on the risks and known side effects of ECT.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.4 (HDS(C)S.2008:1.3.11.4)

The consumer shall be fully informed.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Attainment and Risk: PA Moderate

Evidence:

Canterbury District Health Board has an overarching medicine management policy that outlines systems for reconciliation, prescribing, dispensing, storage and administration of all medicines, however, these are not consistently followed throughout the organisation (refer to 1.3.12.1).

All clinical areas visited (except Ellesmere hospital) showed inconsistencies in all aspects of medicines management throughout the organisation which require improvement.

Medicines are provided as either ward stock or individually dispensed to inpatients. Management of restricted and controlled drugs does not currently comply with legislation and protocols.

The incident reporting system is used selectively to document medication incidents and near misses (refer to 1.3.12.1).

Pharmacists are involved at ward level and this is evident in the patient medication records. Medical staff have access to online and hard copy medication guidelines and protocols. Medical and nursing staff receive medicine management education.

A systems tracer was completed on the safe use of insulin.

Interview with pharmacists identified adverse events relating to insulin use since the implementation of the electronic medication system.

Patient journeys and additional sampling of patient clinical records included sampling of the electronic medication system in the wards/departments at CDHB. Eight patient records throughout the organisation were followed for review of safe and appropriate systems and processes in the management of patients on insulin. All eight records evidenced that the systems for managing this high risk medicine were in line with legislation, protocols, and guidelines. The clinical records reviewed demonstrated that the processes were followed in all wards visited.

The patients stated they received information/education on management of diabetes from medical staff and nurses. Interviews with nursing staff confirmed processes relating to administration of insulin are followed and this was demonstrated when administration of insulin was observed. Clinical staff also confirmed that they are aware of the processes around seeking clinical support from medical, pharmacy staff and a diabetic nurse specialist in respect of diabetes management.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Moderate

Evidence:

Canterbury District Health Board has implemented an electronic medicines management system through the majority of areas, however, there are still areas using a paper based system. Review of drug charts, both electronic and paper, noted inconsistency of documentation of medication management and administration.

At Rangiora a faxed prescription sheet is used as a medication chart for patients discharged from Christchurch Women's hospital. Medications were not stored within required temperatures for safe storage of medication and the emergency drug trolley was not locked. At Ellesmere, Tuarangi and Kaikoura as required (PRN) medication maximum dose and indication for use are not always indicated. There was no evidence that the controlled drug stock take is completed six-monthly at Tuarangi. Subsequently, evidence from Tuarangi was provided of quantity stocktakes being completed. The intensive care unit/operating theatre at Burwood do not document the discarding of controlled drugs. At the Chatham Island Health Centre medication administration processes are not consistently followed or implemented.

There is no ability to change the variance of regular medications prescribed, if the medication is given outside the designated timeframes, on e-med (e.g. six hourly antibiotics). Indications for use is not in e-med and oxygen is not consistently prescribed.

Finding:

There is inconsistency in practice and documentation in all aspects of medication management.

Corrective Action:

Ensure practice and documentation of medication management and administration meet policy and legislative requirements.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

Attainment and Risk: FA

Evidence:

All inpatient facilities have a current building warrant of fitness which are displayed in building entrances. Facilities management includes a preventative maintenance programme and the environment in the clinical areas is safe for patients and staff. Staff understood the risks pertaining to older facilities and mitigation strategies are implemented. There are processes in place to respond to requests for maintenance by the facilities staff. Electrical testing is undertaken and it was noted that all electrical appliances sighted were tagged. Bio-medical equipment is checked. A register is maintained to follow up on equipment not available at the time of testing. All buildings are accessible and there is access to outside areas where courtyards or seating areas are available. All buildings, plant and equipment was compliant with legislation at the time of construction.

New buildings and renovations at Ashburton, Kaikoura, Rangiora and Burwood meet the reconfiguration requirements and are suitable for purpose. The secure external environment at Burwood is completed. The certificate for public use was evidenced at Burwood.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
Click here to enter text

Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:
Click here to enter text

Finding:
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Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:
Click here to enter text

Finding:
Click here to enter text

Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p>

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

Attainment and Risk: FA

Evidence:

Canterbury District Health Board is aligned and prepares for civil defence under the leadership of Environment Canterbury and other supporting agencies. This ensures the CDHB plan fits with the wider community's disaster plans. An annual exercise takes place and lessons learned from incidents and emergencies are incorporated into the plans. Weekly business continuity meetings are held on the Christchurch hospital campus to discuss and plan for risk mitigation relating to all the on-site development projects covering issues such as outages, emergency planning issues, facilities, and security.

All hospitals have emergency preparedness centres which are well equipped with backup telephones and satellite radios, radio contact with civil defence and there are designated areas used to store emergency equipment. All hospitals have backup generators and access to water. All staff receive orientation on Canterbury evacuation schemes. All processes meet the requirements of The Fire Safety and Evacuation of Buildings Regulations 2006 and are approved by the New Zealand Fire Service and CDHB's emergency procedures. This commences with corporate orientation and is followed by divisional orientation. Evidence of staff who have trained is entered into the competency database. Emergency planning processes are also linked to the new build at Christchurch hospital acute services block making sure there are specific protocols in place linking activation of the plan to the construction site as required.

Security is managed in house and has recently implemented a new framework and structure. Systems are in place to monitor incidents related to security. Discussion with security staff confirmed that buildings are locked down after visiting in the evening, with security cameras used to monitor access and grounds. Patrols are undertaken during the night and back up is available from local police. Staff can be escorted to cars after shifts. Security services monitor and collate all incidents and report to the compliance and risk committee.

Clinical emergencies are responded to by a designated team in the hospitals and staff have appropriate training to manage medical emergencies. All clinical staff have cardiopulmonary resuscitation training and there are emergency trolleys in the clinical areas. All clinical areas are fitted with call bells. An approved fire evacuation plan is in place for the new Burwood hospital.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

Attainment and Risk: PA Moderate

Evidence:

The restraint and minimisation programme is managed by the restraint and minimisation group (RAMG) which is a group represented by service leaders throughout CDHB. Two members of this group were from consumer groups outside the CDHB. The RAMG is accountable to the clinical board. There is a CDHB wide policy in place that has been developed to support staff and it is made available to all staff through the intranet system.

The RAMG is guided by its term of references with a purpose to minimise restraints in CDHB. The RAMG is responsible for not only managing restraint and minimisation related incidents but also to develop and review policies, and to approve procedures and products to be used for restraints.

One of the key functions of the RAMG is analysing reports and data from services to design solutions for services. The RAMG, with the professional development unit, developed the 'calm and restrain' training programme that is being delivered for staff.

In the mental health services, one of the initiatives that has been driven by the RAMG is the 'least restrictive environment' programme where seclusions and restraints are proactively minimised. Staff were aware of their responsibilities in their practice and supported this policy.

An improvement is required in restraint minimisation in Kaikoura and the Chatham Island Health Centre.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: PA Moderate

Evidence:

At Kaikoura hospital two patients were using restraints and one patient was using an enabler. A restraint was also being used in the Chatham Island Health Centre. The clinical record reviews identified that there was no evidence of the restraints or enabler having been consented to, monitored or reviewed in each case. Staff interviewed at the Chatham Islands were not familiar with CDHB restraint minimisation policy.

Finding:

The policy for safe restraint practice and enablers is not being followed at Kaikoura long-term care service and the Chatham Island Health Centre.

Corrective Action:

Implement policy requirements for safe restraint and enabler use at Kaikoura long-term care service and the Chatham Island Health Centre.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: Not Audited

Evidence:

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Finding:

[Click here to enter text](#)

Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;

- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

Attainment and Risk: FA

Evidence:

The restraint and minimisation group (RAMG) is responsible for monitoring the restraint minimisation programme. This is done through their regular meeting where reports from various restraint and minimisation committees are received. The RAMG is able to extract information from reports (including trends and issues experienced throughout the hospital). The restraint register, safety1st and the restraint and minimisation committee reports are used for the purposes of monitoring and quality review of restraints. Examples of audits and trend reports were provided with monitoring and quality review occurring in the restraint committee. This information is also used to evaluate and identify training opportunities and improvements in the area of restraint minimisation practice.

Minutes reviewed demonstrated that these reports are discussed by RAMG. The areas of needs identified in these reports, form the basis for solutions and work programmes for the RAMG. Part of RAMGs monitoring responsibility is to inform the clinical governance group of any significant events but also to provide an annual report. Part of the solutions that the RAMG has developed based on reports from restraint and minimisation committees is partnering with the professional development unit (PDU) to design and develop training programmes for staff. Policy redevelopment, supporting best practice and commissioning internal audits have been some of the activities undertaken by the RAMG as part of its monitoring process.

Reporting is completed in real time with identified key members of the restraint committee alerted to new episodes of restraint or to review restraint episodes on an individual and collated level.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 2.3: Seclusion

Consumers receive services in the least restrictive manner.

Standard 2.3.1: Safe Seclusion Use (HDS(RMSP)S.2008:2.3.1)

Services demonstrate that all use of seclusion is for safety reasons only.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 2.3.1.1 (HDS(RMSP)S.2008:2.3.1.1)

The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Criterion 2.3.1.2 (HDS(RMSP)S.2008:2.3.1.2)

Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.3 (HDS(RMSP)S.2008:2.3.1.3)

There exists a legal basis for each episode of seclusion.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.4 (HDS(RMSP)S.2008:2.3.1.4)

Any factors that may require caution must be assessed for each episode.

Attainment and Risk: Not Audited

Evidence:

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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.1.5 (HDS(RMSP)S.2008:2.3.1.5)

The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.

Attainment and Risk: Not Audited

Evidence:
Click here to enter text

Finding:
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Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.3.2: Approved Seclusion Rooms (HDS(RMSP)S.2008:2.3.2)

Seclusion only occurs in an approved and designated seclusion room.

Attainment and Risk: Not Audited

Evidence:
Click here to enter text

Criterion 2.3.2.1 (HDS(RMSP)S.2008:2.3.2.1)

The seclusion room provides adequate lighting, room temperature, and ventilation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.2 (HDS(RMSP)S.2008:2.3.2.2)

The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.3 (HDS(RMSP)S.2008:2.3.2.3)

The seclusion room provides a means for the consumer to effectively call for attention.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:
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Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.4 (HDS(RMSP)S.2008:2.3.2.4)

The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.

Attainment and Risk: Not Audited

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:
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Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: Not Audited

Evidence:
 Click here to enter text

Finding:
 Click here to enter text

Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

Attainment and Risk: Not Audited

Evidence:

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p>

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

<p>Attainment and Risk: Not Audited</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p>

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA**Evidence:**

Surveillance programmes are embedded into practice across CDHB. The Canterbury District Health Board infection prevention and control committee review and approve the annual infection prevention and control programme. Reports reviewed indicated the number, type and outcomes of surveillance are monitored and reported through the CDHB hospital and specialist service, harm and patient experience indicator six-monthly report. The computerised system, ICNet, is configured to identify and alert the IPC operations group of any significant organisms. The infection prevention and control team stated an action plan would be completed if trends identified an increase. This would include increased surveillance in the identified area. The infection prevention and control committee reports to the Health Quality Safety Commission National surveillance programme, including a national orthopaedic surgery report, which reported CDHB rates below the national average. The clinical lead from the national surgical surveillance indicators visited CDHB to gain insight into the low infection rates and found the collaborative approach by the multidisciplinary team, the Burwood hospital theatre design and clinical pathways all contributing to the CDHB low surgical surveillance indicator rate.

A systems tracer was completed on the use of contact precautions with multidrug-resistant organism patients.

There is an overarching strategic infection prevention and control programme that drives service improvement. ICNet is used to generate reports for the infection prevention and control service. ICNet produces 'aTag' result report daily to notify the infection prevention and control team members' patients individual screening results. Meeting minutes verified the service involvement with issues that have impacted CDHB since the earthquake, such as new builds and ongoing maintenance.

The infection prevention and control (IPC) team members stated they had identified an increase in the numbers of patients with multidrug-resistant organism being reported. On review, the IPC team reviewed all policies and developed a research based multidrug-resistant organisms admission assessment flowchart and implemented the extended-spectrum beta-lactamase risk based assessment for patient placement.

The IPC team determined the increase resulted from increased identification and reporting through the implementation of improved screening tools and patient placement. In wards visited with patients placed in low to high risk nursing and medical staff interviewed confirmed the precautions required and that they have received education on contract precautions changes. Further expert advice for staff and patients on infectious disease is available from the infection prevention and control and infectious disease team. Staff were observed wearing protective clothing and taking the required precautions when this was required. Appropriate signage and isolation techniques are available throughout CDHB. The wards visited evidenced staff have resources available to them to guide in the contact precautions procedures. Patients stated they were informed about the need for isolation and all associated requirements relating to isolation.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA**Evidence:**[Click here to enter text](#)**Finding:**[Click here to enter text](#)**Corrective Action:**[Click here to enter text](#)**Timeframe (days):** Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA**Evidence:**[Click here to enter text](#)**Finding:**[Click here to enter text](#)**Corrective Action:**[Click here to enter text](#)**Timeframe (days):** Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.6: Antimicrobial usage (HDS(IPC)S.2008:3.6)

Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Criterion 3.6.1 (HDS(IPC)S.2008:3.6.1)

The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.6.4 (HDS(IPC)S.2008:3.6.4)

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

Attainment and Risk: Not Audited

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Audit report

Audit report executive summary

Canterbury DHB

Audit report date: June 2017

Canterbury DHB's district's population is growing with a faster rate of growth in the Maori population than other DHBs in New Zealand now around 9% , and some growth also in young people and those of Pacific origin . However there is a comparatively low uptake of engagement with the Maori A&D service. Post quake rebuild and increased opportunities for employment and training and apprenticeships have resulted in low unemployment in the area. Like the rest of New Zealand, Canterbury's population structure is also aging with the proportion of people aged 65 and older growing. This is reflected in an increasing number of older OST clients (as seen in most other OST services in NZ and worldwide) who often have more complex health needs. Canterbury also has higher the than average numbers on sickness benefits and those requiring Mental Health and Addictions Services and in prison. CORS has very good links with local prisons and appears to be providing an excellent service to prison clients.

Access is seen as the biggest challenge with the most services provided from Christchurch at the Hillmorton Hospital site and apart from some clinics at Christchurch Womens hospital and Ashburton, all clients are required to travel , some for considerable distance to Hillmorton. The DHB covers from Kaikoura in the north (significant recent quake damage affecting transport and infrastructure) to Ashburton in the south and Lewis Pass to the west. CORS is aware of this as an issue and like many services in Christchurch is looking at how and where to best provide service to their clients.

All members of the audit team were impressed with the strong links between the DHB and the private sector and NGOs and the "one stop shop" approach where all A&D clients are seen for initial assessment at the Canterbury Central Service which is based in the city central area.

CORS (Canterbury Opioid Recover Service) is based at Hillmorton Hospital . The building is typical of an old hospital building with corridors with rooms off both sides but has a large number of rooms available for staff to meet with clients, clinic areas etc. The sign outside the building still reflects the old name of the service "Christchurch Methadone Service" so this should be updated to reflect CORS. There is a good sized waiting area with comfortable seating areas available for waiting clients. Of particular significance was the family area which is well resourced with toys and reading material and is secure for young children. There is also a babychanging area complete with handwashing facilities.

Reception staff observed during the audit were always friendly and welcoming, reading material is available, there is an opportunity for client feedback in the visible suggestions box, and there are information posters displayed in both English and Maori .

The staff are all suitably qualified, although there is a limited range of qualifications with mostly nurses and social workers employed in the key worker role. The inability to recruit to the psychologist role and the subsequent loss of this position is significant.

The audit team made it clear to the service that although we were aware there had previously been a comprehensive review of the service and that the report had resulted in substantial changes, we had chosen to not read the report or look at the previous history but to treat this audit as a snapshot of 2017 and where the service was in relation to the 2014 OST Practice Guidelines. CORS seems confident there is a new and more positive culture and as a result staff may be able to focus more on Recovery Based treatment. The audit team acknowledge there has been significant changes in how the service now operates and encourage CORS to continue looking at Recovery Based Treatment and to continue to move away from the more traditional and risk averse focus on medication alone.

All staff were friendly, helpful and welcoming to the audit team and enthusiastic about the learning opportunity the audit provided.

General overview

1. Opioid substitution treatment
2. Entry into opioid substitution treatment
3. Stages of treatment
4. Safety issues
5. Managing dose-related issues
6. Managing clinical issues
7. Managing OST transfers
8. OST in primary health care
9. OST and the pharmacy
10. The OST workforce and professional development requirements
11. Administrative expectations of specialist OST services
12. Prescribing controlled drugs in addiction treatment (Misuse of Drugs Act 1975, section 24)
13. Interim prescribing
14. Risk (if any)

Audit report

Service context

Service provider:	Canterbury DHB		
Premises name	Street address	Suburb	City
CORS	Sylvan St Hillmorton Hospital	Middleton	Christchurch

Number of funded OST places	Number of clients at date of audit	Number and percentage of clients in shared care	
440 (SMHS)	770	203	
273 (Primary Care)	Plus clients transferred to Pegasus	138	34.8%

Current waiting time	Number of community pharmacies	Number of GPs authorised
4 weeks including DNA	74	172

Staffing roles	Qualifications	Number and % of staff with no professional registration	
Registered Nurses (20.5)	Comprehensive Nursing Registration (BA)	0	%
Social Workers (2)	Graduate Diploma in Social Work	0	%

Alcohol and Drug Counsellor	Bachelor in Alcohol and Drug Studies, Diploma in Health Science endorsed in Mental Health.	0	%
Medical Doctors (4)	MBCHB, MBCHB, RNZGP, BBS, MCRS9/England)	0	%
Psychiatrists (1.5)	MBCHB FRANZCP. 1.-Advanced Certificate in Addictions Psychiatry		
Administration Staff (4.5)	Microsoft Office Packages Word Excel Outlook Publisher Power point.	0	%
Pukenga Atawhai	Diploma is Maori Language, Level 6	0	%

Audit team

Audit team	Name	Qualification
Lead auditor	Nikki Anderson	Senior Addictions Pharmacist/Auditor
Clinical expert	Caleb McCullough	MBChB, FRANZCP
Consumer auditor	Andrew Gifford	

Data collected

No. of clients interviewed	4	No. of whānau interviewed	1
No. of clients records reviewed	8	No. of authorised prescribers/ staff interviewed	1
No. of staff/management interviewed	25	No. of pharmacists interviewed	3

1 Opioid substitution treatment

RELEASED UNDER THE OFFICIAL INFORMATION ACT

Indicators	Evidence	Attainment	Risk
1.1 Objectives of OST			
The service delivery reflects the principles of the Treaty of Waitangi.	Compliance with this requirement is evident in policy documents, and staff commented on the presence of an active and engaging Pukenga Atawhai within the service as beneficial. As well as cultural assessment/support for consumers, she encourages cultural awareness among staff. Staff members talked about including treaty principles of partnership, participation and protection in treatment plan.	FA	NA
The service delivery reflects the principles of recovery and harm reduction	The service certainly appears to be striving for this, and there are good linkages with external Recovery organisations, However risk averse practices as reported by a number of people interviewed, staff, client's and external agencies, may contribute to secondary harms eg - lack of flexibility around takeaway regimes (particularly when patients on very low doses of OST) tie consumer to role of 'patient' thus limiting recovery, and also limit consumer movements (attending family events) which would promote recovery, and the service response to unfavourable UDS results.. One client reported long term staff are stuck in past treatment modes	PA	Mod

<p>The service delivery reflects a partnership approach between the client, the specialist service or primary health care provider and the client's nominated support people.</p>	<p>The staff interviewed universally had a very positive response to this question but the focus was very much on the partnership between the service and primary care rather than the client and or their support people being an important part of the partnership.</p> <p>For example,, it appears that decisions made about doses and takeaway regimes could be more collaborative.</p> <p>One client said they felt distrusted right from the start. This feeling grew until they decided to begin reductions with a view to coming off the treatment. Now they are almost off...not because they are ready but because they felt everything they said was disbelieved.</p>	<p>PA</p>	<p>Mod</p>
<p>1.2 Roles of specialist OST services</p>			
<p>1.3 Recovery-orientated OST</p>			
<p>The service delivery reflects the principles of recovery and wellbeing orientated treatment.</p>	<p>It became clear during the audit that CORS may reduce clients dose (of both methadone and suboxone), sometimes by half, in response to clients providing unfavourable UDS results. This was reported by staff, external agencies and clients interviewed This practice is not consistent with a recovery orientated service and could, without question, increase the harms clients are exposed to.</p> <p>The same can be said of enforcing the use of a particular medication because of perceived noncompliance with service protocols.</p> <p>As stated in the Guidelines “ the guiding factors in choice of medication should always be the preference and goals of the client”</p> <p>And “ Services should be cautious when excluding clients seeking OST because such clients often have poor clinical outcomes if they do not receive treatment”</p> <p>NB: See comments provided by CORS in response to 1.3 in addendum at end of report.</p>	<p>PA</p>	<p>MOD</p>

<p>Recovery is visible to the clients, eg:</p> <ul style="list-style-type: none"> • recovery/recovery capital posters on walls • AA/NA and peer-support group flyers are in reception areas • clients have access to lifestyle information/pamphlets to support social and community resources • the service employees have their own experience and are open about their own recovery <p>the service employs peer-support workers and consumer advocates.</p>	<p>Recovery is visible to clients in the reception area of CORS on the notice board.</p> <p>There is an abundance of lifestyle information available to clients.</p> <p>Especially encouraging is the linkage to various Recovery based organisations through the Christchurch Central Service (AOD Coordination). The latter is doing tremendous work and CORS is doing well to be working closely with them.</p>	FA	NA
•			

Section attainment summary

Indicators (out of 6):

Fully attained 2 Partially attained 4 Unattained Not applicable

Summary of recommended actions

Ensure all staff understand and demonstrate the principles of Recovery and Harm Reduction. This may require more training for staff and primary health providers. Continue to shift the focus for treatment on client centred Recovery and away from the more traditional and risk averse focus solely on medication.

2 Entry into opioid substitution treatment

Indicators	Evidence	Attainment	Risk
2.1 The comprehensive assessment			
The service commences a comprehensive assessment within two weeks of the person presenting to, or being referred to, an OST service or any part of an addiction service seeking assistance for an opioid problem.	Initial comprehensive assessments are predominantly done by other services (CADS or NGOs) clients are then triaged by CORS and given the next available appointment (usually 1-3 weeks) Clients report prompt progress through assessment journey.	FA	NA
Clients accepted for OST meet diagnostic criteria for opioid dependence and indicators of how such criteria are met are clear in the assessment.	Files reviewed reflect compliance	FA	NA
Risk-taking behaviours are documented in the assessment, eg, injecting practices, blood-borne virus transmission, driving.	Files reviewed reflect compliance	FA	NA
The client's strengths and recovery capital are identified in the assessment.	The majority of files reviewed reflected compliance but not all.	PA	Neg
2.2 The treatment plan			

Indicators	Evidence	Attainment	Risk
Comprehensive assessments include an individualised treatment plan that is reviewed and updated at regular intervals.	<p>File reviews demonstrate compliance .</p> <p>However there are mixed responses from some of the clients about their treatment plans.</p> <ul style="list-style-type: none"> • Don't have one-just want to feel normal. • Don't have one • It's fine 	FA	NA
Treatment plans are developed in collaboration with the client and are self-directed and recovery focused.	Mixed. Some of the treatment plan goals appeared somewhat generic and service focussed (eg. achieve a stable dose of methadone)	PA	Low
The expectation and process for transfer to a primary health care provider has been explained to the client and their significant others and engagement with a primary care provider is under way at time of admission.	<p>Yes. Clear focus on this apparent from time of admission.</p> <p>The clients spoken to understood potential shift to primary care and looked forward to it despite some concerns about the potential cost.</p>	FA	NA
2.3 Other treatment options for opioid dependence			

Indicators	Evidence	Attainment	Risk
Alternative treatment options have been discussed and documented.	<p>Clients report being given information on the treatment options however it is clear that on some occasions options are restricted</p> <p>Both staff and external agencies reported that some clients who have been through involuntary withdrawal due to problems on methadone are only offered suboxone at future admissions. Methadone is no longer available. This is at odds with the national guidelines where it states the choice of medications is to be guided by client preference.</p>	PA	
2.4 Decisions not to admit to the OST programme			
The rationale for excluding people who meet the diagnostic criteria for opioid dependence is documented and reflects best-practice principles.	Although there was no specific evidence found during the audit to suggest non compliance with this point there were some concerns expressed that other substance use is precluding some people from accessing OST	FA	
2.5 Contraindications for OST			
2.6 Priority admissions			
A transparent system is in place to determine priority access based on the risks of delaying treatment.	<p>Complies- this is documented clearly in the SPF.</p> <p>One client spoken to was grateful for having been rushed through admissions due to health problems.</p>	FA	
2.7 OST for clients under 18			

Indicators	Evidence	Attainment	Risk
<p>The admission of a client under 18 years old is supported by an opinion from an addiction medicine specialist and/or a child and youth psychiatrist.</p>	<p>No clients under 18 admitted to CORS program, clients of this age group are referred to the Odyssey Youth Program. It appears the service has not given consideration to whether OST could be an appropriate treatment for those under 18 who are opiate dependent.</p>	PA	Neg
<p>2.8 Informed consent and treatment information</p>			
<p>Consent for OST is signed by the client.</p>	<p>There was evidence in all client files audited that an OST consent form was signed by the client.</p>	FA	NA
<p>Before consenting to treatment, clients are informed of and provided with written information on:</p> <ul style="list-style-type: none"> • their rights and responsibilities and the process for making complaints • the benefits, side effects and limitations of opioid substitution medication • the potential effect of opioid substitution medication on activities such as driving and operating machinery • the interactive effects of opioid substitution medication with alcohol and other substances • the possible need for an electrocardiogram before commencing or during OST (if on methadone) to establish QTc interval • the process of making complaints • the availability of consumer advocacy and peer support services. 	<p>Comprehensive written material is available and provided to clients. All clients interviewed reporting having received this information.</p>	FA	NA

Indicators	Evidence	Attainment	Risk
Informed consent is reflected throughout treatment, ie, there is evidence that clients have been fully informed of any changes in service delivery and any proposed changes to their treatment plans.	Not always, the audit team heard examples of decisions being made about treatment plans (dose reductions or takeaway restrictions) that were implemented before communicated to client.	PA	Mod
2.9 Choice of OST medication			
Clients are provided with information on the OST medications available and their choice is guided by their preference and goals.	Clients are provided with good information about different OST medications, however choice is not always guided by their preference and goals, i.e. service will offer limited choice, or none. Concern was expressed about this by clients and others eg MHAPS and Rodger Wright Centre.	PA	Mod

Section attainment summary

Indicators (out of 15):			
Fully attained 9	Partially attained 6	Unattained	Not applicable

Summary of recommended actions

Continue and hone the ongoing process of Quality Improvement with respect to the documents used, particularly the treatment plans, and ensure Recovery Goals/Capital are included. Continue to work on service policy with respect to the treatment options and client choice of treatment.

It is recommended that the service develop a relationship with the Adolescent service to ascertain whether there is a need for OST provision to clients 18 and under.

3 Stages of treatment

Indicators	Evidence	Attainment	Risk
3.1 Induction			N/A
Admission to the OST service occurs as quickly as possible (ideally two weeks) after eligibility has been established.	Generally appears to happen in about 2 weeks. However reports to Ministry of Health indicate majority of people are waiting 3-4 weeks or longer. Clients reported admission was prompt.	FA	
Clients are informed about how long they will wait for OST and are offered interim methadone or buprenorphine and psychosocial support.	The service explains the process and time frames. Interim methadone or buprenorphine are not offered.	FA	NA
Prescribing and monitoring is consistent with the <i>OST Guidelines</i> sections 3.1.1 and 3.1.2, or a clear rationale is documented where practice is not consistent with the <i>OST Guidelines</i> .	The initial dose is decided by house surgeon at Kennedy Ward, likely with limited knowledge of OST (not part of CORS service or triaging meetings). This evidenced by file review which showed a starting dose of 10mg methadone for a person previously known to service and had been using at least 60mg equivalent/day. First dose adjustment by MOSS was then an increase of 15mg, which while understandable, is again, technically outside of guidelines. NB: See comments provided by CORS in response to 3.1 in addendum at end of report.	PA	Mod
3.2 Stabilisation			
Stabilisation is assessed on an individual basis in relation to the client being on a stable dose without the need for dose review and working toward short-term goals and treatment priorities.	Stabilisation is assessed on an individual basis by establishment nurse and MOSS	FA	NA
3.3 Ongoing OST			
Appointments with the key worker occur no less than three monthly.	File reviews indicate compliance All clients said appointments were monthly and helpful.	FA	NA

Indicators	Evidence	Attainment	Risk
The client is seen by the authorised prescriber, preferably with the key worker, at least once every six months.	Easily met due to 'prescribing clinics' which consist of 15min appointments with prescriber and key worker. Not particularly client centered and leave limited time for recovery focus.	FA	Low
Transfer to a primary health care provider is in place or being pursued.	It is evident right from initial treatment planning that the intended pathway for all clients is from the specialist service to GPSC and then to GP (Pegasus)	FA	NA
Therapeutic doses are generally in the range of 60–120 mg methadone or 12–24 mg buprenorphine.	Ministry of Health reports show generally at least 90% of clients in this dose range.	FA	NA
Doses of methadone above 120 mg or buprenorphine above 32 mg are not prescribed before consultation occurs between the prescribing doctor, the client and the multidisciplinary team.	Complies	FA	NA
Medicines Control have been notified of all prescribing above 120 mg methadone and 32 mg buprenorphine; and the Director of Mental Health has been notified of all doses of methadone above 150 mg.	Unable to confirm this due to lack of response from Medicines Control		
3.4 Transfer methadone to buprenorphine			
3.5 Transfer buprenorphine to methadone			
There is evidence that transfers are well planned and appropriate information has been provided to the client on the transfer process.	In general appears to comply however, one client complained they were made to wait longer than they felt necessary with respect to withdrawal symptoms, during a methadone to suboxone transfer.	FA	NA
3.6 Reviewing progress			

Indicators	Evidence	Attainment	Risk
Reviews occur at least once every six months and involve the client, the authorised prescriber and the key worker.	Case managers have a very handy desktop management tool, which uses a traffic light system indicating when clients are due for 6 monthly review. File reviews reflected compliance.	FA	NA
Key worker monitoring sessions include review of progress in relation to the treatment plan and an updated assessment of risk.	File reviews revealed regular updating of progress and treatment plan. Good risk management tools are utilised, and these generally appear up to date.	FA	NA
Clients are informed in writing about the scheduling of special case reviews and their right to be involved and to have a support person attend. Exceptions to this comply with the <i>OST Guidelines</i> .	Not clear during audit if communicated in writing, or if support person involvement is indicated. Clients and family members interviewed reported being invited to be involved.	FA	NA
Written procedures are available for clients on how to request a treatment review.	Information in 'OST and you' booklet	FA	NA
3.7 Drug screening			
A combination of self-reporting, clinical observation and urine screening is utilised for monitoring drug use; policy, protocol and practices are consistent with <i>OST Guidelines</i> section 3.7.	Extensive facilities available for urine drug screening, case managers certainly elicit self reporting and utilise clinical observation too. Of concern is that it appears nearly all urine drug screening is undertaken as observed urination using the specifically designed facility, observation is appropriate at admissions time or if unstable but not routinely throughout treatment whenever a sample is collected. As stated in the Guidelines " this carries strong connotations of a surveillance agenda being valued over a therapeutic agenda" NB: See comments provided by CORS in response to 3.7 in addendum at end of report.	PA	Low
3.8 Psychosocial interventions			

Indicators	Evidence	Attainment	Risk
Every client has access to case management and psychosocial support, including those receiving treatment from a primary health care provider and those in prison (where appropriate).	<p>Case managers report in general their relationships with clients has become more therapeutic over last 2 years, allowing them to attend to psychosocial support issues more readily. This is backed up by clients also reporting good support to access psychosocial support.</p> <p>Good Primary care and a dedicated prison liaison team ensure provision to those in primary care and in prison also.</p>	FA	NA
Where specialist services or primary health care providers are unable to provide psychosocial interventions, procedures and agreed plans are in place for supporting clients to access appropriate services.	<p>A strength of this service is very good links with various NGOs to provide a wide range of psychosocial interventions.</p> <p>Concerns that Clinical psychologist position has been vacant for 18 months, and is now being disestablished.</p>	PA	Low
Family-inclusive practices are central to the service delivery.	<p>There is an excellent children's play area in waiting room, with baby change facility and a range of toys and books. Client information pack includes information on family-whanau advisors, and promotes family inclusive practice. Clients reported being invited to have family involved in their treatment.</p>	FA	NA
The interventions provided are evidence based, recovery orientated and tailored to individual needs and have defined goals.	<p>Although significant progress towards a more recovery focused service has occurred, there are still occurrences of risk averse practice which limit recovery focus (eg removal of takeaway doses following a stimulant positive UDS - prior to key worker being able to discuss result and reasoning, extensively with client).</p> <p>The perception is that the interventions are service focused rather than individual focused.</p>	PA	Low
Self-help techniques for emotional distress, including sensory modulation, are promoted.	No evidence sighted of self-help techniques and sensory modulation not available except through mental health.	U	Low

Indicators	Evidence	Attainment	Risk
The service has links with other supports, including peer support, employment and housing agencies.	As previously mentioned, the service maintains very good links with a range of supports, including peer support, employment and housing agencies. Especially encouraging is the linkage to various Recovery based organisations through the Christchurch Central Service (AOD Coordination). The latter is doing tremendous work	FA	NA
Clients are provided with information about available psychosocial supports, self-help and family and whānau support groups as well as cultural and spiritual guidance if appropriate.	There is a wide range of information pamphlets in the waiting area and elsewhere available to clients. The presence of an active and engaging Pukenga Atawhai within the service as beneficial. As well as cultural assessment/support for consumers, she encourages cultural awareness among staff.	FA	NA
3.9 Completing OST			
Planned withdrawal is client directed, has a flexible end point and includes relapse prevention, psychosocial, medical and ongoing support, <i>OST Guidelines</i> section 3.9.1.	Generally withdrawal appears planned and client directed and flexible. Clients have easy pathway back into service if required, although key workers expressed further after care provision would be appreciated. All clients report planning towards completing OST being discussed.	FA	NA
Clients who are unable to maintain stability after a planned withdrawal from OST are promptly readmitted to OST, <i>OST Guidelines</i> section 3.9.1.	Clients are offered prompt re-entry for 6 months after treatment completion and only have to phoned their case manager for this to occur. Some concern has been expressed about clients not being offered a choice of treatment on re-entry and suboxone being the only option.	PA	Mod
The client has a discharge plan and after-care plan, <i>OST Guidelines</i> section 3.9.1.	It appears that after-care is usually supplied by NGOs and some staffed expressed they would like to be able to offer further care in this area,	PA	Low

Indicators	Evidence	Attainment	Risk
<p>Involuntary cessation OST is considered and decided by the multidisciplinary team only as a last resort and only after all efforts have been made to resolve influencing issues, <i>OST Guidelines</i> section 3.9.2.</p>	<p>Yes, there are a few instances of this occurring, and do appear to be in response to significant risk issues, such as continued problematic use of other substances and behaviour/security issues. A second opinion is sought prior to decision being made.</p> <p>However clients and external agencies continue to report some concerns in this area. Eg.</p> <ul style="list-style-type: none"> • I was put at risk due to a rapid count down (involuntary) • I was counted down 5mgs (methadone) per unfavourable UDS. • Was count off for relapsing (historic) • Clients counted off or reduced for UDS results positive for illicit drugs. • Clients forced onto suboxone because of past problems on methadone. 	FA	Mod
<p>Decisions regarding involuntarily cessation of OST are supported by an independent addiction medical specialist, or equivalent, <i>OST Guidelines</i> section 3.9.2.</p>	<p>External second opinions sought on these occasions.</p>	FA	NA

Indicators	Evidence	Attainment	Risk
<p>Clients subject to involuntary withdrawal are:</p> <ul style="list-style-type: none"> • given the reasons for the withdrawal in writing • cautioned about risks of driving and operating machinery during the withdrawal process • offered support during the withdrawal process • provided with a future-directed specific treatment plan • informed of other treatment options available • provided with information on the service's complaints procedure and appeal procedure. <p><i>OST Guidelines</i> section 3.9.2.</p>	<p>Unsure if all of these were met as client notes for these clients not specifically reviewed during the audit. SPF contains details that indicate compliance.</p>	FA	NA
<p>The client has a discharge plan, including how they might re-engage in OST, <i>OST Guidelines</i> section 3.9.2.</p>	<p>SPF contains details that indicate compliance</p>	FA	NA

Section attainment summary

Indicators (out of 30):

Fully attained 21 Partially attained 7 Unattained 1 Not applicable 1

Summary of recommended actions

The process of starting OST should more closely involve CORS staff as the specialist service and initial dose should be decided by the CORS MO/triage team/establishment nurse rather than Kennedy House Officer.

Continue to promote and strengthen the work done with Christchurch Central Service (AOD coordination)

Review the need for UDS to mostly be observed.

Work on ensuring clients feel more empowered to be part of their treatment decisions.

4 Safety issues

Indicators	Evidence	Attainment	Risk
4.1 Overdose			
Clients and their support people are provided with relevant information on the risks of overdose and actions to take in an emergency.	'OST and you' booklet provided in client information pack. All clients interviewed reported being given this information.	FA	NA
4.2 Substance-impaired driving			
Before admission, clients are informed of the risks of driving while on OST, in particular during induction, when their dose is increased or decreased or when they are using other substances that could impair or alter the metabolism of the opioid substitution medication.	Risks of driving are made very clear both verbally and in written information. Clients informed not to drive until they reach a stable dose. All clients interviewed reported having been given this information.	FA	NA
Identified risks are effectively managed and documented.	It appears to be the case. Reported actions include removing keys, providing taxi home and or calling the police.	FA	NA
4.3 Methadone and cardiac safety			
Clients are screened for the risk of QTc interval prolongation at entry to, and during, OST as appropriate.	Yes, evidenced in written notes of initial assessments, and progress notes. All clients interviewed reported being given this information and/or being offered regular ECGs,	FA	NA
4.4 Drug interactions	No audit requirements		

Section attainment summary

Indicators (out of 4):

Fully attained 4	Partially attained	Unattained	Not applicable
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Summary of recommended actions

No actions required.

5 Managing dose-related issues

Indicators	Evidence	Attainment	Risk
5.1 Takeaway doses			
<p>The service policy and practices are relevant to takeaway doses of OST medication, support safety and recovery goals and are consistent with requirements, including:</p> <ul style="list-style-type: none"> • provision of takeaways is based on clinical team decision-making • observed consumption of medication occurs on at least three non-consecutive days per week (or the rationale for otherwise is clearly documented and meets safety requirements) • variations to the above are documented and supported by evidence of stability. 	<p>Both Policy and Practice still appear very risk averse in this area.</p> <p>All clients and external agencies spoken to felt the TA policies were too restrictive-this went for those working and also for those living in the country.</p> <p>NB: See comments provided by CORS in response to 5.1 in addendum at end of report.</p>	PA	Low
Safety requirements concerning takeaway doses are specified in writing and provided to clients and pharmacists.	All clients report having been given this information.	FA	NA
5.2 Notice of prescription changes			
Clients are given information on how to request changes to prescriptions.	<p>Clients were asked about this but said they did not have this information and they felt it was impossible to get changes because the service is so restrictive.</p> <p>The service states that this information is provided in "OST and You" and discussed with clients, however clients interviewed did not support this.</p> <p>SPF documents process.</p>	PA	Mod
5.3 Replacement doses			

Replacement of lost or stolen doses occurs at the direction of the prescriber only in exceptional circumstances that are verified.	The policy states lost or stolen doses will not be replaced and clients are aware of this.	FA	NA
5.4 Reintroducing OST medication after missed doses			
The management of missed doses and re-introductory doses complies with <i>OST Guidelines</i> section 5.4.	Complies.	FA	NA
5.5 Split methadone dosing	No audit requirements		
5.6 Measuring methadone serum levels	No audit requirements		
5.7 Travelling overseas with OST medication			
Medication for travel is coordinated in accordance with the requirements of New Zealand and the intended travel destinations.	No specific evidence for overseas travel sighted but “OST and You” is provided to clients. Scripting to other places in NZ is facilitated if sufficient notice given to the service.	FA	NA
5.8 Withholding an OST medication dose			
The rationale for withholding or cancelling OST doses is outlined in the client’s file.	No specific client information sighted but policy states dose may be withheld or reduced if the client is presenting as substance affected.	FA	NA

Section attainment summary

Indicators (out of 7):

Fully attained 5 Partially attained 2 Unattained Not applicable

Summary of recommended actions

Consideration needs to be given to a more flexible view to provision of takeaways and not a “one size fits all” approach of limiting takeaways to all clients under the specialist service.

Please refer to pages 36 and 37 of the OST Guidelines .

6 Managing clinical issues

Indicators	Evidence	Attainment	Risk
6.1 Managing problematic substance use			
The service adopts a motivational approach to engage with and retain clients who continue to use opioids and/or other substances, including alcohol, ensuring consideration of safety and offering assistance.	<p>Treatment occasionally withheld or not offered if other substance use is occurring. The service reports they are managing this area better than they used to, by offering suboxone as a safer treatment and for more intensive case management. Clients are no longer excluded from treatment for use of benzodiazepines but have a clinical treatment review and a reduction plan offered.</p> <p>Compulsory prescribing of disulfiram if alcohol use considered problematic.</p> <p>Clients and external agencies reported that this approach is perceived as a punitive response by the service rather than one designed to engage and retain clients in treatment.</p>	PA	Mod
Clients who are known to use other substances problematically do not receive takeaway doses, and their OST medication consumption is closely observed.	<p>It appears that the service response is to not only remove takeaways but in some cases to reduce the dose considerably (half dose only provided). This was reported by both staff and clients interviewed.</p> <p>This approach could be considered to reduce risk to the service but significantly increase risk to the clients.</p>	PA	Mod
Clients are advised about potential interactions between OST medication and other substance (including alcohol).	<p>A good range of information available to clients.</p> <p>All clients reported being given this information</p>	FA	NA

Indicators	Evidence	Attainment	Risk
Smoking cessation is promoted and offered by both specialist services and GP prescribers.	Yes, several clinicians are qualified to provide NRT service and all clients report having been given the information.	FA	NA
6.2 Managing side effects			
Clients are provided with information on potential side effects and management of side effects.	Written information provided in client pack and all clients report having been given this information.	FA	NA
6.3 Managing intoxicated presentations			
Clear guidance is given to clients and pharmacists regarding the likely outcomes of a client presenting for doses in an intoxicated state.	Yes written information provided to pharmacy and clients.	FA	NA
6.4 Managing challenging behaviour			
6.5 Co-existing medical and mental health problems			
The service routinely assesses for co-existing medical and mental health problems.	2x psychiatrists and 1 psychiatry registrar in team. Examples given of case managers being able to access them easily and assess mental health. Hep C nurse on site once a week.	FA	NA
Frameworks are in place for identifying and treating (or facilitating treatment) of coexisting mental health and/or medical problems.	As above. Clients encouraged to seek GP advice regarding physical health concerns	FA	NA
The service has appropriate systems in place for identifying and supporting clients to manage health issues associated with blood-borne viruses.	Weekly Hep C clinic on site	FA	NA

Indicators	Evidence	Attainment	Risk
All staff are trained in HIV and hepatitis-related issues and are able to provide clients with information about blood-borne virus transmission and treatments, their support people and other health and social service providers.	There is a document to prompt staff and a card for the Hep C clinic in the Admission info pack. Also OST and You All clients report having been provided with this information. Safety information for staff in managing risks associated with BBV also provided.	FA	NA
The service encourages good dental hygiene and facilitates access to dental treatment as needed.	OST and You has information on dental health and the DHB Dental service is adjacent to CORS	FA	NA
Plans are in place to support the management of specific complications experienced by older clients and those who have been on OST for a long period of time.	Staff are aware that their client population is aging but no specific information sighted re management of these clients. Clients are encouraged to see their GP regularly,	U	Low
6.6 Management of acute and chronic pain			
Clear policies and or memoranda of understanding with hospitals are in place for planned and emergency admissions.	There are written protocols and this was confirmed by evidence from staff interviews regarding care of patients when in public hospital.	FA	NA
The service liaises appropriately with medical and surgical services to ensure continuity of OST for clients who are hospitalised.	As above	FA	NA
OST is managed appropriately, in consultation with pain management services, for clients presenting with chronic non-malignant pain problems.	Senior CORS staff report regular liaison with Burwood hospital Chronic Pain specialists.	FA	NA

Indicators	Evidence	Attainment	Risk
6.7 Management of pregnant and breastfeeding women			
Pregnant women have priority access to OST.	Documented in policy documents.	FA	NA
The service implements clear protocols for managing pregnant women.	Excellent MIPS (Methadone in Pregnancy Service), with clinic held in Chch Womens Hospital. MIPS team attend other Obstetrics meetings, encouraging destigmatisation.	FA	NA
Women of childbearing age are given information about the safety of methadone and buprenorphine in pregnancy.	Knowledgeable staff in MIPS Female clients report being given this information.	FA	NA

Section attainment summary

Indicators (out of 18):

Fully attained 15 Partially attained 2 Unattained 1 Not applicable

Summary of recommended actions

Although CORS acknowledge some movement in service attitude consideration needs to be given to a more motivational approach to problematic use of substances. Please refer to page 43 Point 6.1 and 6.1.1 of the OST Guidelines .
Develop service specific information for management of issues related to older clients.

7 Managing OST transfers

Indicators	Evidence	Attainment	Risk
7.1 Transferring between specialist services			
Clients transferring into and out of the service are provided with treatment within their domicile within three months of re-location.	Staff reported able to do this easily in most cases. One 6 mthly MOH report showed a number of clients (4) still being prescribed by CORS but no explanation of why this was happening.	PA	Low
Transfer documentation; including a comprehensive assessment, a current risk assessment, a summary of treatment and a current treatment plan have been provided to the new service.	Process documented in SPF. Yes, seen in file reviews.	FA	NA
Admission to the new service is not conditional on discontinuation or withdrawal of any other (prescribed or illicit) substances.	No evidence of this in documentation. One client reported a much less punitive attitude at the other service.	PA	Low
7.2 Transferring to a prison			
The client's original specialist service authorises the prison medical officer to prescribe for the client when they are in prison.	Documented policy and procedure in the SPF. Prison MO is authorised as required.	FA	NA
The specialist service in the locality has a designated prison liaison role and provides psychosocial interventions to prisoners on OST in prisons in their area regardless of the prisoner's service of origin.	The service has a designated prison liaison person who visits the prison regularly to not only provide ongoing care to existing clients but to identify and offer treatment to clients who may require OST but are not currently in treatment. The audit team was impressed with the comprehensive treatment provided to clients in prison.	FA	NA
Reviews take place at least annually and involve appropriate prison medical and specialist service staff. All out-of-area reviews are conducted by TeleMed.	CORS prison liaison person visits the prisons every 2-3 times per week and has access to the prison medical team and links to their computer system.	FA	NA

Indicators	Evidence	Attainment	Risk
7.3 Transferring from overseas	No audit requirements		

Section attainment summary

Indicators (out of 6):
 Fully attained 4 Partially attained 2 Unattained Not applicable

Summary of recommended actions

These issues are all discussed in the SPF.
 No actions required.

8 OST in primary health care

Indicators	Evidence	Attainment	Risk
8.1 Shared care with the primary health care sector			
All clients have a nominated GP.	Yes, noted in file reviews	FA	NA
The service proactively supports the transfer of clients to their authorised GP as soon as possible after dose stabilisation.	The pathway from specialist service to GPSC and/or GP care is promoted at the commencement of OST and encouraged throughout treatment. All clients reported wanting to progress to this but one of the barriers is the costs associated with the GP.	FA	NA
The specialist service complies with the responsibilities outlined in the <i>OST Guidelines</i> section 8.1.	Appears to comply.	FA	NA
8.2 Requirements of GPs in shared care with a specialist service	NB: Only 1 GP available to interview and he is also a MO at CORS, and authorised prescriber for GPSC and a director at Pegasus.		
Authorised GPs are working within a broader primary health care team.	Yes	FA	NA
Authorised GPs have undertaken training relevant to managing clients receiving OST.	Education meetings provided and the service GP liaison person visits each authorised GP. It was commented that the rigidity of the specialist service makes it easier for GPs to manage clients requests for takeaways.	FA	NA
A formal agreement is in place regarding providing advice and consultation.	Yes and the one of strengths identified is the availability of key staff when required but the limitations of being part of the service as well is that he feels he is expected to know everything.	FA	NA
Clients are provided with access to psychosocial support.	Yes. Plus some free counselling services are available and clients can be referred back to the psychiatrist at CORS	FA	NA

Section attainment summary

Indicators (out of 7):

Fully attained 7	Partially attained	Unattained	Not applicable
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Summary of recommended actions

No actions required.

Note it would have been useful for the audit team to interview more than 1 GP especially as he is also a MO at CORS and Pegasus.

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Indicators	Evidence	Attainment	Risk
9.1 Responsibilities of the pharmacist			
<p>The service provides training and support to community pharmacies and communicates with them regularly.</p>	<p>Pharmacies interviewed reported no specific training provided by the service but that the relationship between them and the service was excellent. They reported the service was organised and consistent in approach, and that everyone involved with the client has clear expectations which allow them to dispense safely.</p> <p>One pharmacist reported feeling a little isolated at times.</p> <p>The service and pharmacists report after hours meetings are held 3 times per year to discuss issues and service updates.</p>	FA	
<p>The service provides pharmacies with accurate information as to which GPs are authorised to prescribe OST.</p>	<p>Copies of up to date Authorities are provided to the relevant pharmacy who checks the details match their own information.</p>	FA	
<p>The pharmacist notifies the prescriber when a client:</p> <ul style="list-style-type: none"> • has missed collecting more than one dose • presents as intoxicated • exhibits abusive or threatening behaviour • diverts or makes a serious attempt to divert their OST medication • exhibits withdrawal symptoms • deteriorates in their physical, emotional or mental state. 	<p>All pharmacies reported good communication with the service and that the service responds in a timely manner.</p>	FA	

Indicators	Evidence	Attainment	Risk
Pharmacists inform specialist services when they receive OST prescriptions for unknown prescribers.	Yes	FA	
9.2 The administration and dispensing process			
Pharmacists are consulted as part of the multidisciplinary team, in particular, before making significant changes to a client's treatment plan that affect dispensing.	One pharmacist reported only being consulted if there are issues but the frequency of contact was appropriate and another said they should be consulted more often as they see the client more often than clinic staff.	PA	Low
The service is accessible to the community pharmacist, eg, has the contact details of the key worker for each client, and an afterhours contact number.	Contact with key workers and GPSC staff is appropriate. However several pharmacists reported concern with lack of after hours support with a mixed response as to much assistance is provided by the staff at Kennedy Unit.	PA	Low
9.3 Managing other aspects of OST provision			
The service communicates clearly with the pharmacist when a client's new prescription differs from the previous one (eg, dose change, new takeaway regimen, split dose, early start date).	Complies	FA	
Written confirmation (a fax) is received following any telephoned request for script changes, <i>OST Guidelines</i> 9.3.4, and faxed prescriptions are received in a timely manner, <i>OST Guidelines</i> Appendix 16.	All communication is received in writing	FA	
The service notifies the pharmacist when a client has transferred to a new pharmacy.	Yes	FA	

Indicators	Evidence	Attainment	Risk
The service has systems/policies for documenting and responding to errors in a community pharmacy.	Yes- this is documented in the SPF	FA	

Section attainment summary

Indicators (out of 10):
 Fully attained 8 Partially attained 2 Unattained Not applicable

Summary of recommended actions

Although there is a policy that outlines the relationship between the service and community pharmacy and the respective roles and responsibilities, Pharmacists would encourage more involvement with the service with respect to clinical decision making and would be grateful for more access to an after hours service.

10 The OST workforce and professional development requirements

Indicators	Evidence	Attainment	Risk
10.1 The OST team			
The OST team includes a range of disciplines and roles.	The OST team has a full range of roles and key workers are a mix of disciplines: nurses, social workers, counsellors, OT. A number of staff expressed concern that the psychologist role was not filled and has now been lost to the service.	PA	Low
Clients are able to access peer support and consumer advocacy from within or outside the service.	Peer support and advocacy services are available and promoted by the service.	FA	NA
OST staff demonstrate knowledge, skills and attitudes appropriate to their role.	Yes	FA	NA
10.2 Workforce training and professional development			
Clinical staff members receive appropriate orientation, mentoring and supervision and ongoing in-service education.	The service attempts to fill positions quickly so there is a crossover period for orientation and training. Some staff reported that supervision was very difficult to obtain, others not. All staff are encouraged to participate in supervision.	FA	NA
Clinical staff have completed or are enrolled in relevant tertiary addiction education.	Yes	FA	NA
Clinical staff are members of a relevant professional body.	Yes	FA	NA
Lead clinicians and senior staff members are supported to attend specialist sector meetings and networking opportunities with OST providers.	Yes	FA	NA
Staff in leadership/management positions and medical officers are supported to attend at least one NAOTP meeting per year.	Yes	FA	NA

Indicators	Evidence	Attainment	Risk
Senior medical staff are supported to attend the majority of NAOTP meetings.	Yes	FA	NA

Section attainment summary

Indicators (out of 9):			
Fully attained 8	Partially attained 1	Unattained	Not applicable

Summary of recommended actions

Continue to advocate for a psychologist role within the service.

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11 Administrative expectations of specialist OST services

Indicators	Evidence	Attainment	Risk
11.1 Record keeping			
Comprehensive records are held for all clients.	Comprehensive records are maintained and these are a mixture of paper files and electronic records.	FA	
11.2 Reporting requirements			
The service fulfils regular reporting requirements, eg, to PRIMHD and to the Director of Mental Health.	Complies, recent reports to Ministry of Health viewed.	FA	
11.3 Rights of clients receiving OST			
<p>Clients are provided with information about:</p> <ul style="list-style-type: none"> • their rights under the HDC Code of Health and Disability Services Consumers' Rights Regulation 1996 • peer support and consumer advocacy contacts • limits of confidentiality under the Health Information Privacy Code 1994 • the range of treatment options and psychosocial interventions available • the service's policies and procedures, including the complaints procedure. 	<p>All clients report either being given this information or knowing it is in the various pamphlets available. This information is clearly visible in patient information kits and waiting area of clinic.</p>	FA	

11.4 The complaints procedure			
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<p>The service has a complaints management system that is easily accessible to clients and complies with legislation and is linked to the service's quality and risk management system.</p>	<p>Yes. There is a suggestions box in the waiting room and information displayed for clients who wish to make a complaint. There appears to be a robust system for recording and managing complaints.</p> <p>The service reports a reduction in the number of complaints about staff in recent years.</p> <p>One suggestion is to post the responses to complaints received, in the waiting room to demonstrate responsiveness and to encourage dialogue with the client group.</p>	<p>FA</p>	
<p>Records of complaints are not kept in clinical files.</p>	<p>No evidence of complaints on client files.</p>	<p>FA</p>	
<p>11.5 Safety requirements of specialist services</p>			
<p>The service has safety protocols that address the personal safety of clients and staff, as well as safety in prescribing and dispensing OST doses.</p>	<p>The service has good policy and procedures in this area.</p>	<p>FA</p>	
<p>11.6 Local protocols in specialist services</p>			
<p>Local protocols are consistent and do not conflict with the <i>OST Guidelines</i> or with relevant legislation, codes of practice or accountability requirements.</p>	<p>Local protocols such as some returning clients only being offered suboxone treatment conflict with OST Guidelines P11 “ when choosing which medication to prescribe the guiding factors should always be the preference and goals of the client”.</p> <p>Also only providing a Half Dose to a client with a positive UDS could be seen to conflict with the Guidelines P43 “ client not achieving or maintaining stability the aim should be to optimise treatment by increasing the intensity of OST rather than reducing it”</p>	<p>PA</p>	<p>Low</p>
<p>11.7 Civil defence emergencies</p>			

Management plans are in place for civil defence emergencies.	Comprehensive management plans in plan.	FA	NA
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Section attainment summary

Indicators (out of 8):			
Fully attained 7	Partially attained 1	Unattained	Not applicable

Summary of recommended actions

Consider reviewing and amending protocols that appear to be inconsistent with the OST Guidelines as outlined above.

12 Prescribing controlled drugs in addiction treatment (Misuse of Drugs Act 1975, section 24)

Indicators	Evidence	Attainment	Risk
12.1 Operation of MODA, section 24			
12.2 Protocol: designation of specialist services			
12.3 Protocol: designation of lead clinicians			
12.4 Departure from appointment protocol			
12.5 Criteria for appointment of lead clinicians			
12.6 Operating a specialist service in compliance with MODA, section 24			
The service complies with provisions of the Misuse of Drugs Act 1975, section 24 (or other relevant legislation) relevant to approval to offer OST.	Complies	FA	
Master copies of the Misuse of Drugs Act 1975, section 24(2)(b) authorisation forms are contained in the service's authorisation folder.	Complies	FA	
The Misuse of Drugs Act 1975, section 24(2)(d) authorisation forms are evident in clients' files.	Yes	FA	
12.7 Supporting consumers in primary health care in complying with section 24 MODA – authorising medical practitioners working in primary care			
12.7.1 Authorising medical practitioners working in primary care			
Correct authorisation is given to each GP and prison medical officer for named clients, the Misuse of Drugs Act 1975.	Complies	FA	

Indicators	Evidence	Attainment	Risk
Copies of each GP authority are sent to the dispensing pharmacy and to Medicines Control, the Misuse of Drugs Act 1975.	Complies	FA	
The lead clinician ensures that authorised prescribers comply with the sector standards and practice guidelines and have regular clinical supervision and access to relevant training, the Misuse of Drugs Act 1975.	Difficult to confirm as the only GP interviewed also works for the service, however appears to comply.	FA	
The service ensures that all health professionals authorised to prescribe have information on how to: <ul style="list-style-type: none"> • discuss management problems • request reviews • transfer clients back to services. 	Yes, Reported the process of transferring back to specialist service if there are issues with the client, works well and that this is a wakeup call to clients to “change their ways”. GPs can struggle to get clients stable again. CORS is known as rigid with things like UDS tests/results and Takeaways but this makes it easier for the GPS to manage.	FA	
12.7.2 Period of GP authority			
A prescribing authority is updated at three-monthly intervals, or longer only with approval from the Medical Officer of Health, Medicines Control, the Misuse of Drugs Act 1975, section 12.7.2.	Complies	FA	

Section attainment summary

Indicators (out of 8):

Fully attained 8 Partially attained Unattained Not applicable

Summary of recommended actions

No actions required.

13 Interim prescribing

This section applies only to those specialist OST services that offer an interim methadone prescribing programme. The indicators below are set out in *National Guidelines: Interim methadone prescribing* (Ministry of Health 2007).

Indicators	Evidence	Attainment	Risk
13.1 Eligibility			
Interim methadone treatment prescribed by an authorised GP is offered to clients when OST is clinically indicated (following comprehensive assessment) and there is a longer than two-week waiting list for OST.	Service not provided	NA	
Clients receiving interim methadone treatment are retained on a waiting list for the full OST programme.	Service not provided	NA	
13.2 Consent to interim methadone prescribing programme			
The Consent to Treatment form sets out the following treatment terms: a. The client will pay for all GP or alternative prescriber consultations where appropriate. b. The client will attend all review sessions as required on the programme. c. The maximum daily dose on the programme is 60 mg of methadone. d. Split dosing is not possible. e. There are no takeaway doses of methadone (or buprenorphine) on the programme.	Service not provided	NA	

Indicators	Evidence	Attainment	Risk
13.3 Induction and prescribing			
<p>Induction and prescribing practices for methadone are as set out in the National Guidelines: Interim methadone prescribing (Ministry of Health 2007) or Appendix 18 of the <i>OST Guidelines</i> (Ministry of Health 2014). This includes prescribing relevant to missed doses.</p> <p>If the interim medication is buprenorphine, induction guidelines should be followed as outlined in the <i>OST Guidelines</i>.</p>	Service not provided	NA	
13.4 Ongoing support			
The specialist service provides information to the client and their support people regarding available psychosocial support.	Service not provided	NA	
13.5 Interim buprenorphine prescribing			
Where buprenorphine is prescribed as an interim OST medication, the same requirements as per methadone (above) apply. The maximum dose should be 32 mg.	Service not provided	NA	

Section attainment summary

Indicators (out of 6):			
Fully attained	Partially attained	Unattained	Not applicable6

Summary of recommended actions

Not Applicable

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Addendum: Comments on draft report from CORS

1.3 Recovery-orientated OST

Choice of Medication.

This is primarily guided by the client's preference but not solely determined if there are significant clinical reasons why a specific medication would not be used.

Where there are known risk factors that are linked with the key differences between buprenorphine and methadone, this influences the choice of OST medication (see table under /section 2.9 page 12 OST guidelines). Examples include: significant physical health complications (e.g. chronic obstructive pulmonary disease, prolonged QTC) extensive use other substances known to contribute to mortality (e.g. extensive benzodiazepine use +/- COPD) in combination with methadone. If these factors are modifiable and change once in treatment then Suboxone can be changed to Methadone at a later date.

Decisions are based on the benefits/risks of OST medications and patient preference. The audit report lists decisions being based on perceived non-compliance with service protocols.

Exclusion of clients from treatment

The statement (in indicator 1.3) is that services should be cautious when excluding clients seeking OST because such clients often have poor clinical outcomes if they do not receive treatment.

- Our response is that clients are excluded from OST only if they do not meet the CORS admission criteria. Admission criteria was determined by the Christchurch Methadone Steering committee which included a number of stakeholders and services following the review. (See attached acceptance criteria document) .
- Other substance use does not prevent admission to the programme.
- The numbers of clients declined OST and the rationale for doing so are reported in the 6 monthly OST MOH report.

Reduction is OST dose

OST Guidelines Section 6.1.2 Benzodiazepine use - recommends a "review of dose" as part of the treatment plan in relation to benzodiazepine use.

- This is usually in the situation of high dose Methadone and significant ongoing hazardous substance use (benzodiazepines and/or stimulants) combined with community reports of intoxication.
- A dose reduction is not done in response to a positive urine drug screen with no other reported concerns.
- Recent examples of reduction in Methadone dose have been due to prolonged QTc and advice from cardiology.
- Doses are not halved except when clients miss consecutive doses (as per Section 5 OST guidelines) or there is persistent and ongoing reports of diversion that has not ceased despite other interventions e.g. increased volume, previous small dose reductions due to reduced opioid tolerance.

3.1 Induction

The establishment dose of OST is determined when the client attends Kennedy and information obtained about their recent substance use. As there can be a delay of 2-4 weeks between assessment, triage and establishment, a client's substance use can dramatically change over that time. This is often related to a number of factors (e.g. lack of supply of opioids, clients wanting to reduce before coming onto OST in an effort to "not be on too much") or the opposite where clients have a binge before coming on to the programme.

The initial dose is determined after the updated information is obtained and made following discussion with the client, senior nursing staff and the Psychiatrist of Kennedy. The house-surgeon does not make this decision in isolation.

3.7 Drug screening

Case managers are encouraged to use "the one cup" which is unobserved, and from where the test is taken.

Routine Quality Audit for the Ministry of Health on Canterbury District Health Board Assessment Treatment and Rehabilitation Unit
Report Date 1 August 2017

Canterbury District Health Board

General

- **Date evaluation completed:** 19,20,21 July 2017
 - **Date evaluation report sent to the provider:** 2 August 2017
 - **Date evaluation report signed off:** 24 August 2017
 - **Names of evaluator / report writer:** Suzanne Win/ Sue Gates
-
- **About the provider:** Canterbury District Health Board (CDHB) covers the geographical area from Kaikoura to the North, to the Waitaki River in the South and to the East of the Alps. The Canterbury DHB is the second largest DHB in the country by both geographical area and population size - serving 558,000 people and covering 26,881 square kilometres and six Territorial Local Authorities.
 - **Provider address:** Hillmorton Hospital, Private Bag 4733, Christchurch 8140
 - **Evaluation venue:** Hillmorton Hospital
 - **Provider contact person:** Toni Gutschlag, General Manager, Specialist Mental Health Services (SMHS)
 - **Brief description of service:** This is a Regional Intellectual Disability Secure Service and an Assessment, Treatment and Rehabilitation Service. The service provides 24 hour secure support for people who have been assessed as requiring compulsory care and treatment under the Intellectual Disability Compulsory Care and Rehabilitation Act (IDCC&R) or under the Mental Health Act (MHA). From time to time there may be patients without legal reasons for secure care who require short term treatment. The service also provides a Consult Liaison Team who work both with individuals in the unit on short term admission and work to raise the capacity of Regional Intellectual Disability Support Services in the Canterbury Region.
 - **Number of clients:** 7 in the unit and 2 in Te Whare Manaaki. The seven men in the unit are aged 24, 23, 17, 25, 36, 26, and 25
 - **Brief description of clients:** There are 9 men who are receiving support across two units in the SMHS. Seven are resident in the AT&R Unit and another two are being supported in another unit. This evaluation concentrated on the AT&R Unit. The men all have clinical needs and characteristics that require this level of service.
-

Outcome Focus Evaluation Tool for and Core Standards Regional Intellectual Disability Secure Services May 2014
Confidential to the Ministry of Health and Canterbury District Health Board subject to the provisions of the Official Information Act 1982

- **Findings**

- **Total number of requirements:**
- **Total number of recommendations:**
- **Summary of findings:**
 - **Section One – 0**
 - **Section Two – 0**
 - **Section Three – 0**
 - **Section Four – 1**
 - **NZ Government Standards for Accreditation:**
 - **Standard No 1-0**
 - **Standard No 2-0**
 - **Standard No 3-0**
 - **Standard No 4-0**
 - **Standard No 5-0**

- **Information about this report**

Methodology

The routine quality audit with issues utilised the Ministry of Health evaluation tool approved 13 June 2013 for Regional Intellectual Disability Secure Services May 2014 and the New Zealand Government Standards for Accreditation 1-5 (also known as Business Viability Standards).

Definitions

1. Requirement

Requirements are made where there is a concern(s) about the quality of the service that pose risk to people. Each requirement has a risk rating and an attainment rating.

Risk rating			Attainment rating		
Risk to people		Timeline for action	Attainment		Achievement of standard or criteria
Low	Minimal	As soon as possible within one year	CI	Continued improvement	Achievement beyond the full attainment
Moderate	Moderate	As soon as possible within six months	FA	Fully attained	Full attainment and meets the requirements
High	Significant	As soon as possible within six weeks	PA	Partial attainment	Partial attainment and improvement required
Critical	Extreme	As soon as possible within 24 hours	UA	Unattained	Not met
			NA	Not applicable	Standard or criterion not audited as it does not apply

2. Recommendation

Recommendations are made where there is no immediate concern about the quality of the service, or where developments are already under way towards meeting the requirements in the existing contract.

Executive Summary

The Canterbury District Health Board (CDHB) is currently discussing with the Ministry of Health (MoH) wider sector issues regarding the overall IDDC&R service and there has been a call for an independent review from senior clinicians/managers in three DHBs.

It is in this wider context that this routine quality evaluation was conducted although the evaluators made it clear that their role was to address the service against the service specifications and Government Accreditation Standards. In that regard there were no findings apart from the need to better survey patients and families about their level of satisfaction.

There are issues with the environment and because of that the incompatibilities cannot be easily managed leading to the view of managers as initiating the level of incidents in the Unit.

A presentation was made to the evaluators at the opening meeting regarding the service and concerns about the compatibility of patient groups and the suitability of the environment. This presentation also provided information about the changes the service has made to ameliorate the presenting issues to the extent possible. It is appreciated that there is a moratorium on admissions due to the concerns raised but that is an issue that is a matter for the MoH and CDHB and is being worked through cooperatively between the parties as well as the National Disability Care Agency (NIDCA).

In particular the presentation indicated that there had been consistently high numbers of assaults occurring within this environment. AT&R has the highest rates of incidents and assaults of any unit in CDHB that is 40% of all incidents

From 1st June 2015 to 31st May 2017 there have been a total of 442 reports of assault. 187 assault events have occurred as a result of peer conflict. Patient on patient assault is very high, and assaults on staff often occur when staff attempt to intervene, de-escalate and physically separate individual patients.

There have been 255 reports of assaults on staff/ visitors/ others. One patient in particular has been involved in more than 40% (83 of 187) of assaults on consumers and over 35% (93 of 255) of assaults on staff. Injury to staff or consumers occurs on average in half of these incidents.

For much of the last 2 years there has been at least one staff member off on work related ACC. The majority of those off were as a result of assault from one patient and a number have involved head injuries.

A graph was provided showing that since February 2015 of the physical assault incidents 34% were in the corridor, 14% in the Foyer and 19% in the lounge area.

Risk management strategies which are being used or are being considered are

- Changes in model of care
- Use of 1-1 staffing observations, Allied Health Assistant resourcing for a patient.
- Minor alterations have been made to the building over the last few years including additional doors between ends of the corridor and a safe area for staff to retreat to in the OT/ Activities room
- 'Crisis response'-escalation process and placement in forensic unit (now exhausted) and increase staff resource as able
- Regular H&S meetings involving staff, organisational support, unions
- Contingency planning for staff shortages
- Proposal for High Care Area as a priority action to mitigate risk of assault and injury

There are a number of Specialist Mental Health Service (SMHS) priorities for 2017 which are reflected in the overall work on the Unit, being quality and patient safety, workforce wellbeing and facilities development and integration with NGOs.

There are Service Cluster priorities for the Regional Intellectual Disability Secure Services/ Assessment and Treatment Unit (the Unit) being associated with the issues raised.

The CDHB in 2014 adopted a model of support based on Applied Behaviour Analysis, (ABA), O'Briens Five Essential Accomplishments and the Good Lives Model for people who are offenders. This model involved converting nursing positions into behavioural support and occupational therapy positions which are incorporated into the day to day support on the unit and within the community work. There are also two Clinical Nurse Specialists positioned in the service. The model had been implemented in part through a variety of pilot initiatives which introduced behavioural and occupational modalities more intensively than previously, when there was part time availability, but not within the unit setting.

There has been some recent challenges to this model due to behaviour support facilitators' positions being vacant and the psychologist resigning, although the psychologist had just left the week prior to the evaluation. The Occupational Therapy position is also part of the hands on staff with some supernumerary time, but this does get reduced when staffing is tight or issues emerge on the Unit.

The last evaluation in November 2015 remarked on the much improved and reduced statistics for incidents of restraint and seclusion. This improvement has been maintained but has plateaued which is unacceptable to the senior managers as the impact on staff has been concerning.

During the evaluation staff on the unit were busy which limited capacity to talk to a more than four “hands on” staff.

Observation of the interactions indicated that staff were positive in their approach to patients, the Charge Nurse is a strong presence and very responsive to staff needs and the programme for patients being implemented to the extent possible.

Staff were knowledgeable about the individuals in their care. They were respectful and interacted with individuals in a considered and considerate way. They were well trained and used current proven behaviour management techniques. They acknowledged they worked in a stressful environment but felt well supported, particularly by management, and their colleagues. They were aware of the Employee Assistance Programme (EAP). All had a good or high level of satisfaction, one person said that the reason she couldn't give a higher score was that the staffing sometimes limited ability to do her role to her level of satisfaction.

The Unit and IDPH service is well supported by the wider DHB processes. The SMHSMangers have presented to the Hospital Advisory Committee and Disability Advisory Committee about the Unit, their work and staff issues. The Unit has input from Pukenga Atawahai, Consumer and Family Advisory staff and the Wellbeing Health and Safety Service, Infection Control staff, Quality & Patient Safety staff, Nurse Consultant and Medical staff.

The CDHB and SMHS policies and procedures are comprehensive and robust. Staff recruitment, training and support systems are implemented.

Relationships with the wider sector are maintained with staff at the IDPH seeing a good part of their role to support sector capacity.

Families, were mostly grateful that there was a service that could meet their family members' needs. They acknowledged that staff were involved in difficult work and they appreciated their dedication to the task. There was mention of the building and how crowded it was. There was also some concern about the “mix” of patients in the Unit and the propensity for conflict amongst them.

The patients interviewed expressed their unhappiness at being in the facility and were eager to move on.

The Internal Audit programme for the Unit includes documentation, assessment treatment and planning, review and discharge. Individual files are audited against the criteria.

Number of people interviewed

	NIDCA	Individuals	Families	Staff/ Clinicians	Management
No	1	3	5	16	5

Introduction/ Background/ Observations

This routine evaluation was conducted over a total of 5 days between two evaluators. The programme covered all aspects of the AT&R as well as the wider corporate functions that support the service delivery. Observations are documented in the Executive Summary.

There was an opening meeting which was attended by Senior Managers from the CDHB Corporate Office as well as the Executive Team from the SMHS. The Closing meeting had representation from the Corporate Office and the SMHS Executive.

Rosters

Monday to Sunday

	AM Shift	PM shift	Night Shift
RNs	3	3	1
ENs or HCA	2	2	1

From Monday to Friday the Charge Nurse/ Manager, Clinical Nurse Specialist, Nurse Consultant and Occupational Therapist and Psychologist are on the Unit. The Charge Nurse and Psychologist are supernumerary. The other staff have supernumerary time but from time to time dependent on the situation will have to be present on the "floor".

The Charge Nurse/ Manager is the Care Manager for the patients on the Unit. When absent she delegates to other clinicians. There are 1.5 Care Managers in the IDLT

When required for any crisis staff are available from neighbouring units and will also respond to alarms from other units.

Outcome Focus Evaluation Tool for Regional Intellectual Disability Secure Services

1. DSS Philosophy

1.1 Disability Services promote a person's quality of life

Evidence:

The O'Briens Principles in Guiding the IDPH Service
You Have Rights 2004
Direction of Change Paper, Model of Care, AT&R Unit, Hillmorton Hospital 2014
Discussion with staff, patients and families
Introduction to AT&R

Field Notes:

The DSS philosophy is promoted within capacity of the people's clinical risks, legal orders, acuity and environment. The ability to make decisions is fostered primarily around the day to day activities within their plans. Linkages are fostered and maintained. One external commentator said that there is a strong staff commitment to disability rights and philosophy.

There is a Unit based informed consent process for people to be in the Unit if they have no legal status or are informal patients. This is based on a pictorial booklet which describes the various parts of the unit in photographs. It tells people that they can go out the locked front door but that sometimes staff will go with them. Staff show people and family/Whanau the booklet and work with them to understand. If there is no level of understanding the consultants are contacted. The discussions and outcomes are documented.

There are external and internal activities accessed. Activity programmes in the Unit centre around the services users' interests. A very popular activity in the Unit for everyone is cooking and baking. They are fully involved in the whole process from making shopping lists to eating the food they have prepared. Service users are taken outside the Unit for various activities, for example, walking in Hillmorton grounds, outside the hospital grounds, walking, shopping, cafes and visiting places of interest to the patient. One young man works in a café when he is able to.

2. Definition

1.1 The Regional Services defines the assessment, triage and longer term stay components of this service

Evidence:

Organisational Chart
Processes and procedures related to the patient journey
Discussion with the Intellectual Disability Liaison Team (IDL)
Discussion with NIDCA
Referral and admission process
Admission Pathway IDPH Inpatients Unit Referral Presentation IDCC&R Care Recipient

Field Notes:

The service receives a written referral from NIDCA. In some circumstances this may not be comprehensive, particularly if it is from the Courts. There will be a broad interpretation of what needs to be looked at, description of target offences and then there is a meeting with NIDCA to discuss the person.

The NIDCA have the accountability for the IDCC&R beds contracted by the MoH. NIDCA try and give notice and keep the Unit and IDLT informed of the possible entries to service. Generally there is an awareness of the people in the system but there are others who are emergent and not known to the service. The admission pathway delineates between during business hours and out of hours. There is a fast track service for people known and under RIDSAS. This provides certainty for RIDSAS staff in a crisis and is not often used.

There are eight beds, one assessment and seven for secure care. Currently there are 7 people in the Unit, three are under the IDCC&R Act, and four are under the Mental Health Act, two of these four are civil patients under the RIDSAS. There are two men in another unit, one under ID(CC&R) Act and one under the Mental Health Act .

The level of service for patients is dictated by the Care and Rehabilitation Plan, the plan for people under the Mental Health Act and those who are civil patients.

There was clear documentation about the process of exiting the service.

2 Service Objectives

2.1 AT&R Regional hospital level intellectual disability Services will provide 24 hour supervision and active support and short term assessment and planning
Including service users, exclusions, interface with Mental Health, interregional transfers, service exit

Evidence

- 5 Individual files
- Journey Board
- Behaviour support plans and "brochures"
- Discussion with staff
- Discharge process

Field Notes:

AT&R is staffed and supervised 24 hours/ 7days a week. There is close supervision of the patients. Each service user has a key staff person on each of the AM and PM shifts who supervises and provides a wide range of activities and therapies. The overnight shift has 2 awake staff.

There is a detailed daily therapeutic plan for each patient. All plans are based on current assessment data. The therapeutic plan will only stop if an individual's behaviour deteriorates. Because patients can become de-stabilised very quickly it is essential that staff and management follow all plans and protocols.

There is a large "Journey Board" on display in the nurses' station that has daily up to date information pertaining to each individual, including their shift nurse, current risks and alerts, observational data, legal status and leave status. This board is easily accessible to all staff. In addition there are individual weekly planners and individual, current behaviour management plans – also easily accessible.

Mental Health services are provided through the psychiatrist assigned to the IDPH.

Interregional Transfers are managed through the NIDCA. There are specific AT&R Unit protocols for entry, review and discharge from the Unit.

Exit is organised working alongside NIDCA. The RIDSAS Provider works with the Unit to effect a smooth transition including RIDSAS Staff working on the unit alongside the Staff who know the patient. The intention is to reduce possibility of a readmission.

2.2 Natural supports, providers include natural supports during assessment, support service planning and implementation

Evidence

Discussion with families/Whanau
Individual files

Field Notes:

There was some involvement by families involved in assessment, service planning and review. It was clear that some families were more involved than others. This was their choice.

Two families were particularly appreciative for the Psychologist and Psychiatrist's consistent involvement. It was clear that some families found the whole progression of their family member's entry, stay and future exit from the Unit, the legal processes, and the assessments and planning confusing, and acknowledged their gratitude for the staff at the Unit and the wider system.

2.3 Assessment Beds: The provider will facilitate assessment process necessary to determine appropriateness of the Court Application

Evidence:

Discussion with the Intellectual Disability Liaison Team (IDLT)
Discussion with NIDCA
Referral and admission process
Admission Pathway IDPH Inpatients Unit Referral Presentation IDCC&R Care Recipient
Sensory modulation protocol June 14

Field Notes:

There are a number of assessment tools which are used by the organisation. If there is a person having assessment for the purpose of Court Application the Specialist Assessors are engaged by the NIDCA.

The Sensory Profile Checklist (SPCR) is a checklist for parents or caregivers to complete for children with autism. Normally 2-3 individuals complete this. The results are pulled together and compared. Followed by a report with recommendations/ sensory diet.

The Adolescent/ Adult Sensory Profile has an in-depth look at taste/ smell processing, movement processing, visual processing, touch processing, ones activity level and auditory processing. Again, this assessment is scored, followed by a report with recommendations/ sensory diet in order to support one with sensory challenges.

Sensory groups are also part of the therapeutic programme where education is provided, hands on experience, opportunities to ask questions etc.

Personal Sensory Assessment tool. This assessment looks at triggers, early warning signs, and strategies “what helps you feel ‘just right’ by exploring all of the sensory modalities; movement, touch, temperature, hearing, vision, smell, taste, distractions, people etc. Please note: this assessment tool is only used sometimes and is completed by the patient’s individual case manager in consultation with community providers and family/ whanau.

2.4 Hospital Level Secure: To provide inpatient care in a secure environment for eligible service users within the level of security required

Evidence

Observation
Discussion with Charge Nurse Manager
Seclusion Policy 28/ 4/ 17
Observation including specialising 12/ 11/ 14

Field Notes:

The AT&R Unit is escape proof, with locked single point entry. Windows are fixed and external doors apart from the single entry door only egress into two courtyards. The Unit has two doors to get through to obtain entry to the unit and one must be closed prior to the other being unlocked. Windows meet the criteria apart from being alarmed. All doors are locked and are opened with a swipe card or key. Bedroom doors have alarms on them to alert staff when people are leaving their rooms.

There is a seclusion room and de-escalation area which has been adapted to design and standard for seclusion. The CCTV system (view only, non recording) covers the common areas, with more now placed on the corridors due to the number of incidents. Cameras are not in bedrooms or seclusion due to the need for privacy. Staff are assigned to specific people and where required are on 1:1 watches in the unit. This requires the client risk to be identified and various strategies relating to that risk implemented. Staff are always on the floor with patients and always hand over to another staff member. All patients require constant visual or frequent observation.

Seclusion rooms have visual and auditory observation. All staff are required to wear a duress alarm when on the unit. There are no personal staff items on the unit. Fire alarms are linked to the fire service and the unit has internal sprinklers

CDHB provides the hotel services such as food and cleaning. There is a Pharmacy at SMHS which provides an imprest system for medication. The personal health care needs are met through a visiting General Practitioner. Advocacy is provided via the District Inspectors or legal representation. Handovers are conducted on each shift to ensure continuity of support.

The Multidisciplinary team includes Allied Health, Psychiatrist, [Pukenga Atawhai](#) and Nursing input. Where the IDLT have been working with a patient in the community they will continue to have contact and be involved while the person is an inpatient.

2.5 Key Processes: Service users can expect to access advocacy, assessment, case management, discharge planning, hotel services, legal compliance, management of risk, peer support, service handover, therapy, treatment and rehabilitation

See Core Government Accreditation Standard 4: Health and Safety

Individual files
Journey Board

Behaviour support plans and 'brochures'

Discussion with staff

Staff training records

Patient clinical files

Risk Management Guidelines and Procedures

Incident Management Policy June 2017

IDPH Incident and security Meeting Minutes 13/ 7/ 17

Clinical Risk Assessment and Management

Restraint Minimisation and Safe Practice Policy 21 April 2015

Restraint Minimisation Committee ToR and Minutes 29/ 6/ 17

Incident Triage and SIRT processes 6 January 2016

Field Notes:

Management of risks is paramount in this service. Each patient has their own specific Risk Management Plan on file. The use of accessible information about risks is on display in the Nurses Station including the Journey Board, Behaviour Management Plans and weekly planners - very easy to quickly read. The use of SPEC – the Safe Practice and Effective Communication Programme - a new de-escalating and calming procedure that is prone free and pain free and focuses on a series of holds, is practised by all staff.

Staff wear alarms that can be activated quickly. When an alarm sounds all staff go immediately to the scene, to provide assistance where needed.

Staff work as a multi-disciplinary team. All know each other's strengths and professional skills.

Shift handover is a documented process that is closely followed at the end and beginning of every shift.

Therapeutic and treatment and rehabilitation plans are in patients' files. The CARP (Care and Rehabilitation Plan) is very detailed and user friendly. Crisis plans are current and changed when the need arises.

There is an audit of seclusion rooms which is monitored by the Director of Mental Health Services Coordinator.

2.6 Support Services: Access to Support Services

Evidence

5 Patient files

Weekly programmes

Observation of programmes

Field Notes:

All patients have access to an Occupational Therapist, a Psychologist, a Psychiatrist and a Behaviour Support Specialist in addition to all Nursing staff and Health Assistants and Management. All the specialists have input into the treatment plans for the individual. There are specialist reports on patients' files.

Unfortunately the Unit has recently lost their Behaviour Support Facilitators and Psychologist some to a Behaviour Support Service. However, the Unit does have access to specialists from other units, should the need arise. The Unit is currently advertising to fill these vacancies.

The patients' files contain recent evidence of the Behaviour Support Specialists and Psychologist's work within treatment plans and assessments.

There is a visiting General Practitioner and at other times there is access to the SMHS on-call house surgeon. Patients have access to CDHB oral health services as required.

Deleted: p

Documentation was well managed, the clinical files are well structured and have complete and current information.

3 Service Linkages: Providers are required to maintain effective linkages with a number of services

Evidence

Discussion with NIDCA
Discussion with IDLT

Field Notes:

The organisation has service linkages across the DHB and externally including

- Regional Forensic Services
- NIDCA through MDT and meeting as well as individual client reviews
- Court Liaison Forensic Nurses
- Specialist assessors through reviews
- The relationship with District Inspectors who visit and are available to those under the Mental Health Act and IDCCR
- Community Probation and Sentence planner
- Relationships with Te Roopu Taurima and Emerge through the IDLT and directly particularly during the transition period. There are quarterly meetings between the NIDCA/ RIDSAS/ IDLT to address issues.

4 Quality requirements

4.1 Service user and family/ whanau involvement: Patients, family and Whanau members and advocates should be central to service delivery

Evidence

Discussion with Pukenga Atawhai
CDHB Website re Nga Pukenga Atawhai
Maori Health Action Plan 16-17

Field Notes:

The Maori Health Action Plan covers the Maori population in Canterbury, national and local priorities and strategies.

The CDHB website indicates Ngā Pūkenga Atawhai (Specialist Māori Mental Health Workers) work as members of multidisciplinary clinical teams to provide cultural support to the Tangata Whaiora, their Whānau, the clinician and service. Te Korowai Atawhai is translated as "The Cloak of Care and Nurture". This personifies the service as a fine cloak, metaphorically woven with the strands of traditional Māori values and beliefs. These values and beliefs of aroha, manaakitanga, āwhinatanga, whānaungatanga, wairuatanga and te whakakoharangatiratanga underpin and inform much of the Māori life experience.

The service aims to improve the delivery and quality of health service to Tangata Whaiora who are in pursuit of wellness, primarily through the mahi of Pūkenga Atawhai employed in a number of multidisciplinary clinical teams.

The philosophy of the service is Whānaungatanga – a concept which not only acknowledges that our work is not done in isolation but as a member of a whānau; whānaungatanga also acknowledges the importance of Tangata Whaiora being a member of a Whānau, Hapū, Iwi and Waka.

The AT&R Service has the involvement of a Pūkenga Atawhai on a part time basis which provides access and capacity for patients who identify as Maori.

The Pūkenga Atawhai attends multidisciplinary meetings. She also talks with Maori patients regarding Tikanga and will support interests such as Waiata and Maori drawing. She is involved with Whanau when required. A more formal process for involvement is being developed. There is involvement in assessments when identified.

Families could be involved in the Unit as much as they wished. Some families commented they would like more communication from the Unit - a frequent newsletter was suggested. Others expressed they would like to be contacted at other times, other than when their family member had been involved in an assault or was in seclusion.

4.2 Complaints and feedback Systems: The provider will have a set of documented policies/ procedures for a range of service delivery

See Core Government Accreditation Standard 2 for Complaints Management

Evidence

Administration of Medicines Policy 8/ 10/ 12
Medication Error 21/ 4/ 15
Patients' money/ valuables policy 5/ 13
Patient Funds Account (CDHB): SMHS procedure 29/ 11/ 16
Opening a private bank account 11/ 16
Seclusion Policy 28/ 4/ 17
Observation including specialling 12/ 11/ 14

Field Notes:

Medication systems are electronically managed through EMED with each staff member having a unique log on. Monitoring of medication occurs through a display in the nurse's station noting remaining PRNs available etc. Each patient's medication is on an individual screen with the list of current medications. All allergies, descriptors and any special instructions are on screen. Medication accountability for each shift is assigned by the shift lead. The pharmacist attends all MDT meetings with a lap top so that medication changes can be made on the spot. Controlled and registered drugs administration is done by two staff.

PRN medication can only be dispensed up to the daily allowance and that prescribed by the clinicians.

The CDHB has a Trust Fund which is available to patients. People bringing money or valuables are encouraged to send them home with Family, although they can be held for 48 hours in the office locked desk or safe.

Within the SMHS Intranet within the Clinical Support section there is a section on consumer finances and welfare.

This information is intended to aid staff in assisting consumers to learn skills and promote their welfare whilst an inpatient and in making the transition to community care.

The page provides links to policy, procedures, resources and information on important aspects of consumer welfare.

This guidance section is accessible to all SMHS staff via the intranet link

4.3 Additional quality requirements includes reporting to Ministry of Health, client feedback and residents meetings

Evidence

Discussion with Charge Nurse Manager and NIDCA
Reporting formats
Weekly Patient Meetings Protocols
Minutes of three Patient meetings

Field Notes:

Reporting to the Ministry of Health is through NIDCA and uses the Safety First methodology. The NIDCA said that the reporting is mostly appropriate. The Charge Nurse said that reporting is wide ranging and that NIDCA can sift what it needs but thinks it's important to inform the NIDCA.

When talking to staff they indicated that they don't always complete an electronic incident form if the behaviour in particular is low level, usual for that patient, and not harmful.

There was no evidence of patient surveys and feedback from the patients about the service they were receiving. It is understood that the CDHB is awaiting the outcome of the Ministry of Health work on surveys. However in the meantime a process to engage with patients and families could be implemented at the time of review or focus group run by consumer advisors.

There is a clearly stated protocol for "Weekly Patients Meetings". It included

1. Meeting time 30 minutes,
2. Discussions to be related to the unit and patients e.g. changes of routines, introduction of new ways of doing things,
3. Not a forum for individual clinical matters,
4. Action points or issues arising from patient meetings to be discussed at staff communication meetings,
5. Urgent matters to be addressed immediately, otherwise feedback to patients at next week's meeting.

The protocol also stated that,

A minimum of 2 staff, one of whom should be nursing staff are to attend the meeting. All patients are encouraged to attend and attendance and apologies are recorded. Minutes are to be kept and there is to be respect for all attendees, with ample opportunity for everyone to have their say.

It was clear from the minutes that these meetings focussed on the running of the Unit including events coming up, the 'comings and goings' of old and new staff, new equipment, maintenance in the Unit, food and meal preparation, and hand hygiene.

Findings

Number of findings at a glance

	Low	Mod	High	Critical	Total
No of requirements	1				1
No of recommendations					

Recommendations

Specific requirement if any

Criteria	Attainment rating	Risk rating	Finding	Requirement	Required evidence for verification of compliance	Due date
Contract reference 9	PA	low	That there is no formal mechanism to assess levels of satisfaction	That a system to seek satisfaction of patients and families is implemented	Written confirmation of the system	30 September 2017

NZ Government Standards for Accreditation

CORE STANDARD 1: FINANCIAL MANAGEMENT AND SYSTEMS

The organisation is financially viable and manages its finances competently.

1. The organisation is solvent.
2. The organisation has financial management systems appropriate to the size and complexity of the organisation.
3. The organisation has an appropriate accounting system that produces accurate and timely financial statements.
4. The organisation has arrangements for the regular independent audit, or in some cases review, of financial accounts.
5. The organisation undertakes forward financial planning (forecasting) to show that it will remain financially viable.

Evidence

CDHB Board agendas and financial reports
Discussion with SMHS Financial Accountant
ATR budget information

Field notes

The CDHB finances are subject to Ministry of Health and Government scrutiny. Given that there is dispute about the forecast deficit it is not useful for this evaluation to make comment as to solvency except to say that the ATR is getting the resources it requires.

The organisation uses Oracle and is currently migrating to Oracle 12. This is consistent with DHB financial systems across the Country.

The DHBs have a consistent insurance arrangement through Marsh.

The accounting system provides a monthly budget outcome to the 55 cost centres in the SMHS. Each Cost Centre Manager provides feedback as to variances and report fortnightly on staff vacancies, FTEs etc. The ATR budget is ringfenced. There is a high level of awareness about budget pressures and while the budget holders are looking for savings this is not easy due to staffing pressures. The Nursing Director IDPH monitors the relevant budgets.

Audit New Zealand undertake the annual financial audit. The budget indicates the actual against budgeted expenditure and forecast.

Exceptions

Criteria	Findings	Type of Finding
1	No exceptions to this standard were identified at this review.	N/A

CORE STANDARD 2: RESOLUTION OF COMPLAINTS RELATED TO SERVICE PROVISION

The organisation uses an effective process to resolve complaints about service provision.

1. The organisation has a formal process for receiving, considering and resolving complaints that is soundly based in law and is consistent with the principles of natural justice, and ensures the support and safety of the complainant throughout the process.
2. The organisation ensures its patients and staff are aware of the formal complaints process.
3. The organisation maintains records of all complaints, the formal application of the complaints process and improvements that arise.

Evidence

Patient and Whanau Information on Complaints procedure
Complaints Policy and Procedure
Complaints Management Flowchart
CDHB Website
Complaints Register relating to the Unit
Individual Complaints
Complaints Review Committee Terms of Reference, minutes of meetings 11 and 18 July 2017
Discussion with Consumer Services Manager
CDHB Your Rights Brochure
You have rights booklet
Discussion with Families
Discussion with Managers, Unit Staff and Consumer Services/ Privacy Officer

Field notes

The CDHB SMHS has a Customer Services and Privacy Officer who receives and acknowledges all complaints. Complaints are logged and sent to the Service Manager, a copy to the Senior Leadership Team for action with appropriate timelines. The Divisional General Manager is also copied in to any complaints so that she is informed of issues.

There is a weekly Complaints Review meeting which has a high level involvement including heads of departments, quality team member, family and consumer advisors and complaints are discussed at this meeting. The objectives of this committee is to

- Ensure proper and fair decision making and taking account of the CDHBs vision and goals as well as appropriate advocacy for consumers and their families
- Identify matters to be addressed in the response letter
- Review response letters where provision of care is a concern, to determine if further investigation and / or remedial action is required

The CDHB Website has information on the complaints process as below

Complaints from consumers provide us with an opportunity to continually assess and improve our service.

Your complaint will be acknowledged to you within five working days of receipt.

We will endeavour to investigate your complaint within 20 working days from the date of acknowledgement. You will be informed if this will take longer and the reasons this is necessary.

Where extensive investigations are required, you will be kept informed in writing at monthly or at agreed intervals until the matter is resolved.

If you require independent support to assist you during the complaint process, you may wish to use the free advocacy services available.

Health and Disability Advocacy services

Phone: 03 377 7501

Health and Disability Commissioner's Office

Phone: 0800 11 22 33

Postal Address:

PO Box 11934,
Wellington 6142,
New Zealand.

The CDHB document "Your Rights" provides information about the Health and Disability Consumers' Code of Rights in plain English, how to make a complaint and privacy information. Information relating to some aspects are in a variety of languages and also provides information about interpreters. The Brochure is made available to all new patients in the Consumer and Family/ Whanau pack.

The HDC Code of Rights is displayed in the Patients Lounge in the Unit and for those people under the IDCC&R Act a Brochure called "You Have Rights", is provided by the Care Coordinator/ Care Manager. The right to make a complaint is clear including access to the District Inspector.

There have been 5 complaints from 1 June 2015 to 30 June 2017, 4 from patients and 1 from an NGO. These complaints were about a variety of issues, no specific trends were observed but in all cases actions were implemented including an apology to the complainant and where needed systems were amended to limit possible reoccurrence of the matters under complaint. The Consumer Services Officer said that all complaints are considered and taken seriously.

The Consumer Services Officer attends staff inservice training to instruct staff on the process and philosophy of complaints. Staff are encouraged to document complaints for people who do not have the literacy skills to do so. Staff on the Unit understood the system and their obligation to support a person to make a complaint.

All families interviewed were well aware of the complaints process but none had used it. One family stated they would not use the complaints system because they were worried it might affect negatively on their family member's stay in the Unit.

Complaints are managed through the Safety First database which has capacity to record recommendations.

Exceptions

Criteria	Findings	Type of Finding
2	No exceptions to this standard were identified at this review.	N/A

CORE STANDARD 3: STAFFING

The organisation has the staffing capability and capacity to deliver services safely.

1. The organisation has sufficient, qualified and competent staff to deliver its services.
2. The organisation's staffing and staff relations policy and procedures comply with the relevant legislation.
3. The organisation includes in its definition of staff anyone the organisation relies on to deliver its services. This includes caregivers, volunteers, and contractors, as well as paid staff members.
4. The organisation uses a clear, transparent and open process for recruiting and vetting suitable staff, including as members of the organisation's governance body. The process leads to an appropriate decision in response to all vetting. Vetting of staff is to include, but is not limited to, a police vet.
5. The organisation does not employ any person in a paid or voluntary capacity, including members of the organisation's governance body, who has a conviction for sexual crimes or for any offence involving the harm or exploitation of children.
6. All staff have a written agreement of service.
7. The organisation provides adequate induction, training, professional development and support for all staff.
8. The organisation uses an effective performance management system for all staff.

Evidence

- Unit Management, and Staff Discussions
- Rosters
- 15 Staff files
- Turnover Statistics
- Induction and Orientation Programmes
- Training plan
- Individual Training Records
- Mandatory Training Record
- Position Descriptions for all Staff Categories
- Appraisal record
- Individual Employment Agreement Standard Terms and Conditions
- Letters of appointment
- Annual Performance Review/ Plan template
- Position descriptions
- Staff file review and file index
- Interviews with Human Resources Manager SMHS

Field notes

Outcome Focus Evaluation Tool for and Core Standards Regional Intellectual Disability Secure Services May 2014
Confidential to the Ministry of Health and Canterbury District Health Board subject to the provisions of the Official Information Act 1982

The SMHS has staff shortages of up to 25% across the acute services. The AT&R have vacancies for two Behaviour Support Facilitators and a Psychologist. Staff are expected to be shared across all units in case of a shortage although AT&R is seen as a priority area.

PSAID which is adjacent, share staff with RIDSS/ ATR and the Charge Nurses meet to on a weekly basis to assess what gaps exist and how to manage them. Staffing is a constant juggling act, as the Charge Nurse tries to maintain morale. Any overtime is monitored by the Charge Nurse to ensure work life balance. The Charge Nurse works on the ward when required. There is a 6 week roster which is broken down to weekly rosters. Staff are aware of the shortages and impact, but remain committed to the service.

From time to time there are staff surpluses in which case they may be reassigned to other wards. There are staff shortages approximately 1 shift a fortnight. Staff indicated that they understood the need to share across the wider SMHS.

Staff are assigned on a daily basis according to skill and gender. A team nursing approach is the model utilised. There is an assigned nurse for each patient. Registered Nurses are assigned as Case Managers and their role is to oversee the service to meet the Care and Rehabilitation Plan. Staff are obliged to work within their delegations and scope of practice. Nursing agency staff are employed to fill gaps and are normally familiar with the service.

There is now polytechnic nursing students being assigned to the service which has the benefit of attracting nursing graduates. The Unit based staff work hard to make them feel comfortable in the Unit. There are also New Entry to Speciality Practice Mental Health and Addiction Nursing Programme (NESP) staff through the Unit.

There are no volunteers working in the service although there is capacity for non-employed people to be honorary staff such as university appointments.

Turnover rates for the Unit for the last two years are 15% although when taking out planned retirements and a staff member who died the rate is down to 11%.

There were clear processes for recruiting suitable staff and Vulnerable Children's Act Checks and driver licence checks were in place. The CDHB recruits electronically throughout NZ and overseas particularly Canada, UK and Ireland. Interview panels include Maori health, consumer advisors, management and clinical staff. There are minimum of 2 referee checks. Professional qualifications are verified.

Staff files are being migrated to an electronic platform and this impeded the capacity to fully review staff files although some had considerable information in the hard copy.

All staff have access to supervision, additional professional development and Training. Mandatory training includes Safe Practice/ Effective communication, CPR, Emergency Fire, hand Hygiene, ABC Stop Smoking annually and Risk a three yearly refresher. Health of the Nation Outcome Scales (HoNOS) is required to be refreshed biannually. Most staff are fully compliant with mandatory training and a small number are booked to complete the required training.

Additional training is provided based on staff roles. Weekly inservice training had included presentations, however this is under review as it is increasingly difficult to ensure sufficient attendance to support guest speakers. Other training is individualised to patients specifically interventions and behavioural approaches. The SMHS is sending 15 staff including 5 from AT&R to Applied Behaviour Analysis training with Gary LaVigna. Some of the staff spoken with were attending this training and looking forward to the opportunity.

Staff are encouraged to embark on post graduate study and receive organisational support with fees and study days. Other training is opportunistic such as an example of recent in-service from the National Advisor NIDCA on cognitive therapy.

Staff training records reviewed showed staff were completing their mandatory training requirements as well as a range of other opportunities.

The annual performance review are current or due. Clinical supervision is available to staff and 10 staff access this through the DHB supervisors system. It is not compulsory but encouraged. Staff spoken with are aware they can access supervision but do not feel they need it. It is a close knit and professional team and staff have peer support.

Staff feedback was that orientation is thorough and well managed. They appreciate that debriefs and clinical supervision is available and they feel well supported by the organisation.

Exceptions

There are no exceptions to this standard

Criteria	Finding	Requirement	Required evidence for verification of compliance	Due date
3				

CORE STANDARD 4: HEALTH AND SAFETY

The organisation ensures that clients, staff and visitors are protected from risk.

1. The organisation ensures that its premises, and any premises it uses or relies on for service delivery, comply with all legal and regulatory requirements.
2. The organisation provides and maintains a safe physical and emotional environment for all who enter its premises and any other premises that it uses for service delivery.
3. If applicable, the organisation ensures the safety of any children being supervised on the premises while their parents or caregivers receive services.
4. The organisation ensures the safety of any client being supervised.
5. The organisation has safety and emergency plans for the evacuation of its premises and any other premises it uses for service delivery.
6. The organisation maintains a register of accidents and incidents and occasions of serious harm to staff, visitors and others in the workplace.
7. The organisation notifies the Ministry of Business Innovation and Employment, WorkSafe as soon as possible of any incident which falls within the definition of serious harm, as defined in the Health and Safety in Employment Act 1982, and provides written confirmation of the incident within seven days.
8. The organisation ensures that where an intervention is required, staff use appropriate methods that protect the physical and emotional safety of clients.

Evidence

Discussion with Manager Wellbeing, Health and Safety
Discussion with Infection Control Staff Member
Discussion with Unit staff
Health, Wellbeing and Safety Policy 3 August 2016
SMHS Health and Safety Committee Agenda and minutes 12 July 2017
AT&R Unit Staff meeting minutes 25/ 5/ 17 and 1/ 6/ 17 and 30/ 6/ 17
Staff orientation programme including Wellbeing Health and Safety and Induction Checklist Unit Orientation Checklist
Position Descriptions includes obligations for Health and Safety
AT&R Health and Safety/ Union Meeting minutes 17 January, 21 February, 21 March, 23 May and 4 July 2017
Wellbeing Health, and Safety Report to Quality, Finance, Audit and Risk Committee 2 May 2017
Wellbeing Health, and Safety Dashboard SMHS June 2017
Health and Safety Risk Register for AT&R
Safe Staffing report data
Risk Management Guidelines and Procedures
Incident Management Policy June 2017
IDPH Incident and security Meeting Minutes 13/ 7/ 17
Clinical Risk Assessment and Management
Restraint Minimisation and Safe Practice Policy 21 April 2015
Restraint Minimisation Committee ToR and Minutes 29/ 6/ 17
Incident Triage and SIRT processes 6 January 2016
Gerbuster newsletter
Infection Prevention and Control Link Group Meeting SMHS Agenda 13 July 2017
Infection Prevention and Control Link Group Meeting Minutes 14 June 2017

Infection Prevention and Control Annual Programme July 2016 to June 2017
Body and Blood Fluid Exposure Report June 2017
Influenza and Respiratory Pathogens Report weekly report 13 July 2017

Field notes

There is a keen interest and commitment of the Board and Executive in staff wellbeing. At the Corporate level there is a Wellbeing, Health and Safety Governance body with representation from Executive Director Nursing, General Manager People and Capability, senior staff from West Coast District Health Board, a Legal representative and the General Manager SMHS. Each Division has a Wellbeing, Health and Safety Committee which meets monthly and has union involvement. In an attempt to include as many staff as possible the meetings are held in or near the Units.

All buildings have current warrants of fitness.

The Wellbeing Health, and Safety Policy covers all staff, visiting staff, volunteers, students and contractors. The purpose of the policy is

- to enable staff to be safe and well so they in turn can improve the health and wellbeing of people living in Canterbury
- to comply with the Health and Safety at Work Act
- to comply with the Hazardous substances and New Organisms Act
- to comply with the Health and disability Service Standards

The procedures of the Wellbeing, Health and Safety policy covers
Continuous improvement through review planning and implementation

- Management commitment to promote shared responsibility
- Employee and union participation
- Risk management through identification documentation and control of hazards and providing a health monitoring programme for identified staff
- Accident reporting and investigation
- Staff rehabilitation
- Wellbeing programmes
- Emergency Planning
- Contractor management
- Training for managers and staff
- Acting in good faith
- Fulfilling responsibilities

Staff spoken with have an awareness of their obligations to the Wellbeing, Health and Safety of themselves, fellow staff and the people they support. They understand their obligation to report incidents and hazards.

The CDHB Staff Wellbeing Survey had a response of 4200 out of an overall staff of 10,000 which was the highest response to date. From that came 12 focus groups from across the DHB specific to site as well as nursing and medical staff categories. There is an acute awareness about the specific areas of concern for the ATR and there has been advice and consultation about how to limit the number of physical assaults. The CDHB has set up groups on request for staff to do yoga, physical activities and financial planning workshops.

Review of the Unit Health and Safety/ Union meeting indicates a range of discussion relating to patient safety, health and safety, emergent issues, unit update, staffing and updates on building alterations, incidents and limiting potential for incompatibility between patients.

The Unit staff communication meetings agendas discuss Health and Safety as a regular item

It is not recommended that children visit the Unit as it would not be deemed appropriate given the impulsivity of the patients, however this can happen with prior arrangement.

There have been no notifications to Worksafe from the Unit as the incidents as staff injuries have not met the threshold for serious harm, although the Manager Wellbeing, Health and Safety will contact Worksafe for advice.

There is a fire safety training module for all staff. The buildings have sprinklers and are wired into the Fire Service. An evacuation plan is displayed.

The Wellbeing Health, and Safety Report to Quality, Finance, Audit and Risk Committee covers an update, occupational health, injury management and current projects. A comprehensive dashboard for the overall DHB is attached including loss of days due to injury, frequency of lost time, mechanism of harm, Worksafe notifiable events, and workplace support contacts, combined injury frequency, paid leave compared to accrued leave, and EAP clients. Each category has an explanation and actions.

The CDHB infection control programme is active in the Unit. Given the client group there is an emphasis on personal hygiene and handwashing. Hand sanitisers are used prior to meals and available in all staff areas including at the front door. Universal precautions are practised. In an attempt to engage people with limited literacy there are some engaging posters to remind patients to wash their hands.

Staff have Hepatitis B testing on entry to employment and this is retested at required intervals. Staff are actively encouraged to have flu injections. Any blood or body fluid exposures are followed up by the infection control staff member. There is a monthly report on antimicrobial use from the pharmacy. The cleaning services have a three monthly environmental cleaning audit. Sharps containers are monitored. The Unit was described as having minimal infection control issues.

There is an electronic register of incidents and accidents through the Safety first system. Incidents are reviewed at fortnightly meeting of PSAID and AT&R including the Charge Nurse, Nurse Consultant, Psychiatrist, and Clinical Nurse Specialist. The Agenda includes number of incidents, staff wellbeing, and significant events including use of seclusion, emergency procedures/ duress alarms, emergency trolley and other business.

The Restraint Minimisation Committee ToR has a wide representative including clinicians, managers, Maori, restraint coordinator, consumer advisor and family/ whanau advisor and the nurse coordinator patient quality and safety. Among the objectives is to advance least restrictive practice including the reduction of all forms of restraint within SMHS. Meetings are held fortnightly or more frequently as required. This meeting examines policies, practices, audit findings and monitors reviews of incidents. There are specific Serious Incident reviews when the incident reaches a certain threshold.

The Health and Safety Risk Register is reviewed at least monthly or as emergent issues arise. The Hazards Register indicates the date notified, with initial and residual consequences and risk control plan.

CDHB have moved to using SPEC– the Safe Practice and Effective Communication Programme - a new de-escalating and calming procedure that is prone free and pain free and focuses on a series of holds. It is practised by all staff and there are frequent refresher sessions to ensure staff are using the SPEC method correctly.

Exceptions

Criteria	Findings	Type of Finding
4	No exceptions to this standard were identified at this review.	N/A

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CORE STANDARD 5: GOVERNANCE AND MANAGEMENT STRUCTURE AND SYSTEMS

The organisation has a clearly defined and effective governance and management structure and systems.

1. The organisation has a defined and current legal status.
2. The organisation is governed and managed by people with appropriate skills, qualifications and personal attributes.
3. The organisation has appropriate and clearly defined governance and management structure, the written record of which shows authorities, delegations, responsibilities and accountabilities.
4. The organisation has a process for identifying and managing perceived, actual or potential conflicts of interest including between governance and management roles.
5. The organisation's management systems, policies and procedures are consistent with:
 - 5.1 its legal status, constitution, rules, charter or Act of Parliament
 - 5.2 the aims, philosophy and scope of its activities
 - 5.3 its management structure
 - 5.4 relevant legislation
 - 5.5 contractual obligations
6. The organisation has a business continuity and disaster recovery plan in place.

Evidence

Organisational Chart
Position Descriptions
Policies and Procedures
Audited accounts for year end 2016
Board agendas and meeting minutes

Field notes

The CDHB is a Crown Entity which operates under the New Zealand Public Health and Disability Act 2000.

The District Health Board follows requirements set by the Minister of Health on an annual basis. There are seven elected and four appointed Board Members who are required to adhere to Government Policies and requirements.

The General Manager SMHS reports to the Chief Executive. Within the SMHS the Senior Leadership Team reports to the General Manager.

There are systems and processes to ensure that the staff are selected, trained, certified as competent and managed in accordance with required outcomes. As a public Crown organisation standards are expected in line with all legislative and contractual obligations. There are written delegations according to the level of management within the structure.

The board has a Conflict of Interest Policy and it was noted that at Board meetings all potential or actual conflicts of interest are recorded. As an example the Quality Finance audit and Risk Committee of the Board Terms of Reference states "Legislative requirements for dealing with conflicts of interest will

Routine Quality Audit for the Ministry of Health on Canterbury District Health Board Assessment Treatment and Rehabilitation Unit
Report Date 1 August 2017

apply to all Quality, Finance, Audit and Risk Committee members and members will abide by the Canterbury DHB's Media Policy, its Probity Policy and with its Standing Orders".

Business continuity and disaster plans are in place but were not reviewed

Exceptions

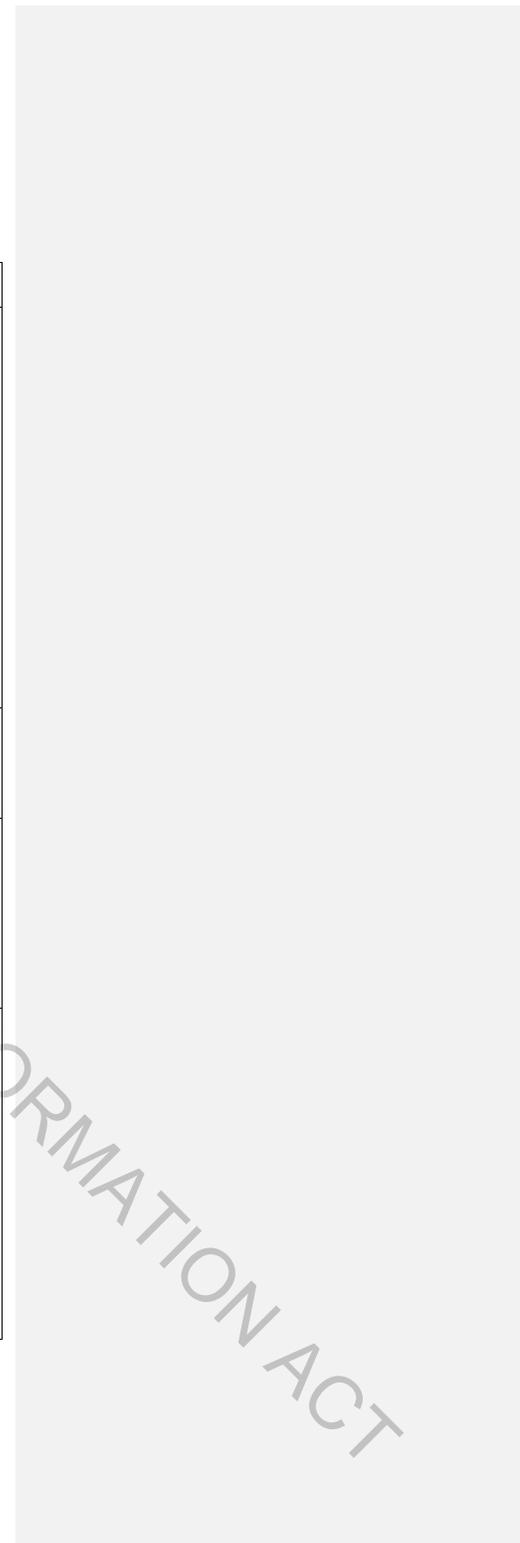
Criteria	Findings	Type of Finding
5	No exceptions to this standard were identified at this review.	N/A

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Secure matrix

Lines of responsibility

Requirement	Evidence
Management resources Clear lines of accountability	<p>The IDPH service sits within the wider DHB structure which is ultimately accountable to the District Health Board through the CEO. The management at the IDPH level is through a triumvirate consisting of the Nurse Consultant, Nursing director and Clinical Director. They report to the Divisional General Manager Mental Health. The line accountability is clear. Clinical governance is provided through the directorate meetings, which are held fortnightly, participants being senior clinicians and managers from all disciplines, the Consumer Advisor, Family Advisor, Pukenga Atawhai, Quality & Patient Safety and the Service Manager. There are also two dedicated Clinical Nurse Specialists (CNS) and wider organisational health and access to wider safety and infection control services.</p> <p>Evidence: Interviews with staff, organisational chart and meeting minutes</p>
Weekly monitoring (Admission and discharge data)	<p>The Multidisciplinary Team meets weekly to discuss all clients, their progress, incidents and issues relating to their care and rehabilitation.</p> <p>Evidence: minutes of MDT meetings</p>
Legal compliance (policy and legal)	<p>There is full understanding of the legislative requirements associated with the IDCCR Act, the Mental Health Act and other legislation relating to provision of health and disability services. There is currently work being done on the legal status of people in the Unit who do not fall under the IDCCR or Mental Health Act.</p> <p>Evidence: discussions with staff and training evidence</p>
<p>Inter-agency relationships (maintenance and enhancement of boundaries and relationships)</p> <p>Specialist assessors</p> <p>RIDCA</p> <p>District inspectors</p> <p>Clinicians</p>	<p>Interagency relationships with specialist assessors and the NIDCA are described as positive, evidence by involvement in MDT meetings by the Care Coordinators and their verbal feedback. A comment was made that that “we need each other”</p> <p>There are quarterly meetings with RIDSAS and NIDCA.</p>



Relational security

Requirement	Hospital secure	Evidence
Staff Ratios Face to face time	Ability for awake night staff Adequate to meet challenging behaviours and requirements of CARP	Nursing and Support Staff are rostered across the 24 hour period in three shifts and in the weekends the Activities assistant is also available to support programmes. During the week the staff also includes the MDT normally including behaviour specialists although they are not currently on staff, OT, Psychology and Psychiatry and Care Managers. Staffing levels meet the needs for ability to escort on 2:1 basis and also sufficient to meet the requirements of the CARP recognising that the CARP does not normally dictate numbers unless off site. Staffing has been impacted by the wider SMHS shortages although AT&R have priority for staff. Evidence: Rosters, CARP, Interviews with staff
Qualitative	Ability to form therapeutic relationships with client group essential Immediate access to predominantly professional nursing and medical care staff Ready access to full scope of MDT	Staff allocations are made to balance continuity and consistency with staff capacity particularly trying to get teams who can work effectively with individuals due to their acceptance of staff members. The varying client cognitive capacity can impact on ability to accept and participate in therapeutic programmes. Registered nurses are on each shift and a GP is contacted for personal health needs with house surgeons as needs dictate. The unit psychiatrist is available Monday to Friday and wider mental health services are available. The MDT is on site Monday to Friday
Restraint	Training in calming and restraint and use of seclusion	Staff training is based on a system of core subjects which are compulsory and includes CPR, restraint, breakaway, fire and emergency training, risk, health and safety, hand hygiene, code of conduct and communication, de-escalation and interpersonal skills. Evidence: Rosters, Training records, use of SPEC
Reviews	Daily by staff	Nursing staff are required to complete notes on each client on all three shifts. There is a whiteboard in the staff office which is updated daily with all relevant details, assigned staff, daily activities and risk

	<p>Weekly by MDT</p> <p>Monthly by MDT and CLT and NIDCA 6 monthly</p>	<p>management. Handovers between shifts are documented.</p> <p>The MDT meets weekly satisfying the criteria for the weekly and monthly reviews and the NIDCA Care Coordinators meet with MDT regularly as well as on a formal basis relating to each care recipient reviews on a six monthly basis.</p> <p>Evidence; CARP reviews on clinical files</p> <p>Progress notes, MDT meeting minutes</p> <p>Interviews with staff</p>
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Environmental Security (Buildings and Fixings)

Requirement	Hospital Secure	Evidence
	<p>Escape Proof</p> <p>Locked/ limited opening windows</p>	<p>The AT&R Unit is a locked unit, with locked single point entry.</p> <p>Windows are fixed and external doors apart from the single entry door only egress into two courtyards.</p>
	<p>Single point controlled</p>	<p>The Unit has two doors to get through to obtain entry to the unit.</p>
	<p>Windows unbreakable</p> <p>Limited opening</p> <p>Alarmed</p>	<p>Windows meet the criteria apart from being alarmed.</p>
	<p>Doors Robust lockable</p>	<p>All doors are locked and are opened with a swipe card or key. The bedroom doors are now all alarmed</p>
	<p>Seclusion</p>	<p>There is a seclusion room and de-escalation area which has been adapted to design and standard for seclusion.</p>
	<p>Designed to allow observation and interaction at all times if required</p>	<p>The CCTV system covers the common areas but is not in bedrooms due to the need for privacy. Staff are assigned to specific people and where required are on 1:1 watches in the unit. This requires the client risk to be identified and various strategies relating to that risk implemented. Staff are always on the floor with clients. The corridor has proven to provide opportunities for incidents of assault and have had</p>

		<p>cameras installed, additional doors halfway down and the OT room has had a safe area for staff to go to with observation provided.</p> <p>All observation levels require constant visual or frequent observation</p> <p>Seclusion rooms have visual and auditory observation.</p>
	<p>Staff personal alarms</p> <p>Fire and smoke alarms</p> <p>Sprinklers</p>	<p>All staff are required to wear a duress alarm when on the unit. There are no personal staff items on the unit.</p> <p>Fire alarms are linked to the fire service</p> <p>The unit has internal sprinklers</p>
	Enclosed courtyard	There are two small courtyards which clients can access under staff observation.
	Perimeter	There is no perimeter fence to the wider campus but there is a high fence in the courtyard

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SIGN OFF FORM FOR QUALITY EVALUATION

Name of Facility Assessment, Treatment and Rehabilitation Unit, Hillmorton Hospital, Canterbury District Health Board

Date of Evaluation 17, 18 and 19 July 2017

I received the ROUTINE AUDIT WITH ISSUES REPORT from the Team Leader

On Tuesday 1st August 2017.

Comments

The IDPH Senior Leadership Team thanks the auditors for the opportunity to present the ATR and related service, and for their helpful feedback during the audit.

Corrections to the written report have been written into the document using the track changes function.

Comments made by Warren Campbell-Trotter, Nurse Coordinator Quality & Patient Safety, on behalf of the Senior Leadership Team IDPH service.

On 24.08.2017

 **Ombudsman**

Fairness for all

.....
OPCAT Report

Report on an unannounced visit to
Te Awakura Inpatient Unit
(Canterbury District Health Board)
Under the Crimes of Torture Act 1989

5 January 2018
.....

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of service users in New Zealand secure hospitals.

On 1 to 3 November 2017, Chief Inspector Jacki Jones and Inspectors Tessa Harbutt and Sue Silva (to whom I have delegated authority to carry out visits of places of detention under COTA)¹ visited Te Awakura Inpatient Unit in Hillmorton Hospital grounds. They were assisted by contractor, Sal Faid.

Summary of findings

The Inspectors' findings may be summarised as follows.

- There was no evidence that any service users had been subject to anything that could be construed as torture, or cruel, inhuman or degrading treatment in the six months preceding the visit.
- Generally, service users were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns. Inspectors observed good service user/staff relationships with respectful interaction taking place.
- Files contained the necessary paperwork to detain and treat the service users in the Unit.
- Access to the complaints process was readily available for service users, family/whanau and visitors. The District Inspectors details were accessible to service users.
- Service users had their own bedrooms which they could lock, access to clean bedding and showers daily.
- Service users could easily access fresh air in the external gardens and courtyards.
- There were no complaints about the food, access to the telephone or access to family or friends.
- Cultural support services could be easily accessed by all service users.
- Staff were complimentary about the management. Leadership was visible, supportive and positive.

The issues that needed addressing were as follows.

- Service users requiring a period in seclusion had to be moved through a public area (usually under restraint), which was not appropriate.

¹ Acting under delegation of the NPM Chief Ombudsman Peter Boshier.

- There was no signage in place to explain the process to enter and exit the Unit and wards when the doors were locked.
- When bed occupancy across the service was above capacity, staff moved service users between units and wards to accommodate new admissions.
- Not all service users received a copy of their treatment plan.
- Consent to treatment forms were missing from some files.
- Service users did not routinely attend their multi-disciplinary team (MDT) review.
- There was limited programmes and activities available in the wards.
- The family/whānau room was not fit for purpose.
- Not all nursing staff had a good understanding of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Recommendations

I recommend that:

- a. Access to the seclusion area for clients in East, South and West wards should be reviewed.
- b. Notices detailing the process for entry and exit into the ward should be displayed in prominent areas when the doors are locked.
- c. The service develop a plan to reduce the number of sleepovers.
- d. Service users receive a copy of their treatment plan.
- e. Consent to treatment forms should be completed and filed appropriately.
- f. Service users be invited to attend their MDT meeting.
- g. Privacy issues in North ward be addressed.
- h. Worn and damaged soft furnishing be replaced.
- i. The Unit, in conjunction with service users, should review the activities and programmes on offer in the wards. Service users should be able to access a gym.
- j. The Unit should identify a more suitable family/whānau room.
- k. The Nurse Coach should work with nursing staff on the application of the Mental Health Act.

Follow-up visits will be made at future dates as necessary to monitor implementation of the recommendations.

Housekeeping issues

The DHB's *Seclusion and Restraint* policies and *Complaint Management* policy should have review dates.

Service users in seclusion should be orientated to time and date.

What was working well

The service was working hard to reduce seclusion and restraint.

Good leadership was evident across the service.

Staff were visible on the wards. They were helpful and pleasant.

Clients spent a considerable amount of time off the wards and made use of the extensive hospital grounds.

Advocacy services were actively engaged in the wards.

Multi-disciplinary team meetings were comprehensive and had a positive approach to assessing clinical risk for each service user.

Feedback meeting

A feedback meeting took place prior to the conclusion of the inspection. The Chief Inspector outlined the initial findings of the inspection and provided an early opportunity for the Acting Nursing Director to offer any corrections or clarifications as deemed appropriate.

Consultation

A draft copy of this report was forwarded to Te Awakura Inpatient Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

Te Awakura Inpatient Unit Comments

The Acting Nurse Director confirmed the service has accepted all recommendations.

Te Awakura had no specific comments on the report.

Facility Facts

Te Awakura Inpatient Unit

Hillmorton Hospital is the main site for Specialist Mental Health Services in Canterbury. Some mental health services are also based at Princess Margaret Hospital and in the community.

Te Awakura (Adult Acute Inpatient Service) is a four ward complex at Hillmorton Hospital providing assessment and treatment by a multidisciplinary team for adults with acute mental illness when 24 hour nursing care is required. The four wards work in collaboration with the community mental health teams and other agencies.

Te Awakura wards:

- North (16 beds) plus 3 seclusion rooms separate to the main ward
- South (16 beds)
- East (16 beds)
- West (16 beds)

Region

Canterbury

District Health Board (DHB)

Canterbury District Health Board

Operating capacity

64

Unit Manager

North – Roy Magno (acting)

South – Rebecca Wright

East – Michelle Phelan (acting)

West – Erin Dellaway

Acting Nursing Director

Patrick McAllister

DAMHs

Dr Peri Renison

Last inspection

Announced inspection – February 2014

Scoping visit – September 2008

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The Visit

The visit of Te Awakura Inpatient Unit took place on 1 to 3 November 2017 and was conducted by Chief Inspector Jacki Jones and Inspectors Tessa Harbutt and Sue Silva. They were assisted by contractor, Sal Faid.

Visit methodology

The Acting Nursing Director (adult services) provided the following information during and after the visit.

- a list of service users and the legislative reference under which they were being detained (at the time of the visit);
- policies/procedures on use of mechanical restraint, environmental restraint and seclusion;
- the seclusion and restraint data for the previous six months;
- restraint minimisation committee meeting minutes for the past three months;
- a list of all staff trained in use of restraint and reasons for those not up to date;
- the number of complaints for the previous ten months and the complaints policy;
- average length of stay, admission and discharge numbers for last 12 months;
- staff list including number of vacancies;
- information for service users on admission;
- visits policy;
- activities programme.

At the commencement of the visit the Inspectors met with the Acting Nursing Director, before being shown around the wards. On the day of the visit there were 61 service users in the four wards comprising of 31 males and 30 females.

The following areas were examined to determine whether there had been anything that could be construed as torture, or cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on detainees.²

Treatment

- Torture, or cruel, inhuman or degrading treatment
- Seclusion facilities
- Seclusion policies and incidents

² Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, available at www.ap.t.ch.

- Restraints
- Environmental restraint
- Bed occupancy
- Electro-convulsive therapy (ECT)
- Service users' and visitors views

Protective measures

- Complaints process
- Records
- Cultural services

Material conditions

- Accommodation
- Food

Activities

- Leisure activities
- Outdoor exercise

Communications

- Access to visitors/telephone

Personnel

- Staffing levels

Evidence

In addition to the documentary evidence provided during the visit, Inspectors spoke to the Managers of the wards, service users and staff.³

Inspectors also reviewed a sample of health records from across the four wards, were provided with additional documents upon request by the staff, and observed the facilities and conditions.

Service users' visitors were also interviewed during the course of the inspection.

³ See Appendix 1.

Treatment

Torture, or cruel, inhuman or degrading treatment

There was no evidence that any service users had been subject to anything that could be construed as torture, or cruel, inhuman or degrading treatment in the six months preceding the visit.

Seclusion

Seclusion facilities

Te Awakura had three seclusion rooms and a small de-escalation suite adjacent to North ward. The rooms serviced all four wards. If service users from South, East and West required a period in seclusion they were moved (often while being restrained) through the reception area, a public thoroughfare, to seclusion, which was not appropriate. Staff informed Inspectors that they ensured the corridors and reception area were clear before taking service users though to seclusion.

Seclusion rooms, all with en-suite facilities, were clean and ready for use. Rooms had a drinking fountain, privacy blinds and a means of raising the alarm. There was a clock located in the seclusion area for service users to orientate to time, but not the date.



Figure 1: Seclusion room



Figure 2: Seclusion courtyard

Inspectors noted a small supply of stitched clothing in the linen cupboard. Managers and staff informed Inspectors that stitched clothing⁴ was not routinely used for service users although the DHB's *Seclusion Policy* did make provision for its use in rare circumstances. The Restraint Minimisation Committee reviewed all seclusion and restraint incidents and were mindful of the traumatic effect placing someone in stitched clothing could have.⁵

Inspectors spoke to one service user who had experienced a period in seclusion. They reported there was always a nurse outside the seclusion room, they had access to food and water and the

⁴ An anti-rip gown used to reduce the risk of suicide.

⁵ Minutes from 19 October 2017.

en-suite bathroom facilities were unlocked. They reported it could sometimes get hot in the seclusion room. They had worn their own clothing while in seclusion.

There was a small lounge area and courtyard that could be accessed by service users, when appropriate to do so.

There were no service users in seclusion over the course of the inspection.

Seclusion policies and incidents

An up to date copy of the DHB's *Seclusion Policy* was provided (V16 dated, 28 April 2017; Ref: 23337). There was no written indication of when the seclusion policy would next be reviewed.

For the period November 2016 to October 2017 there was 66 episodes of seclusion involving 54 service users and a total seclusion time of just over 908 hours. The average length of time in seclusion was 16 hours 50 minutes.

Table 1: Seclusion hours (by ward)

	Nov 2016	Dec 16	Jan 2017	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Total hours
North	7.12	0.30	0	0	30.0	0	0	0	0	16.18	121.30	0	175.50
South	0	1.12	1.06	2.12	0	0	4.24	26.18	44.42	0	0	58.48	138.42
East	35.42	21.42	15.12	44.48	42.06	35.54	0	0	0	29.48	55.48	10.24	291.40
West	11.42	3.48	84.30	41.18	7.12	8.30	0	9.0	73.48	27.48	0	36.24	304.00

Staff emphasised that all alternative means to de-escalate and support services users were exhausted before seclusion was considered (least restrictive environment).

Active oversight of seclusion was evident from reviewing the *Restraint Minimisation* minutes. Meetings were well attended and the minutes were comprehensive.

Well-placed sensory modulation rooms were situated in each wing and used to good effect. Rooms were open and accessible.

The service was culturally responsive and mindful of seclusion events involving Māori. Staff were required to consult with Pukenga Atawhai⁶ regarding the removal of culturally significant items following a clinical assessment. Cultural items were positioned in places where service users could easily observe them.

The clinical team undertook a full review of the pre-seclusion event and the seclusion episode. The service users' allocated nurse undertook a debrief with the service user when it was safe to do so. Debriefs often involved a peer advocate, peer support or Pukenga Atawhai. The service user's perspective was incorporated into the full evaluation/review and incorporated into the updated treatment plan. This process was audited by the Nurse Coach and fed back to the Restraint Minimisation Committee.

Restraints

A copy of the DHB's *Restraint Minimisation and Safe Practice Policy* was provided (Issue 7, 19 Sept 17; Ref: 231490). There was no written indication of when the restraint policy would next be reviewed

Ward staff carried duress alarms (on their wrist) which could be activated across the service or on individual wards. Responders were allocated on each shift with the shift leader being part of the response team. It was reported to Inspectors that male staff were the first responders for incidents/alarms if they were on the ward. It was also reported by some staff that de-briefs after incidents did not consistently occur. The Inspectors were unable to verify this.

There were five hundred and ten personal restraint incidents involving 140 service users for the period November 2016 to October 2017. Four individual service users accounted for 160 restraint incidents (31 percent). North wing had the highest number of restraint incidents, 182 and South the least, 102. The average number of restraint incidents each month was 42.5.

Table 2: Personal restraint (by wing)

	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Total
North	6	7	3	11	9	27	25	30	16	23	22	3	182
East	11	4	13	4	5	8	5	2	13	31	6	6	108
South	0	11	1	6	2	6	8	28	12	9	8	11	102
West	13	18	12	3	13	1	9	18	9	4	8	10	118
Total	30	40	29	24	29	42	47	78	50	67	44	30	510

⁶ Pukenga Atawhai - Māori Consumer Advisors.

Over 80 percent of staff were in date with their Safe Practice and Effective Communication (SPEC) training. Training was ongoing and it was hoped that all staff would be fully trained in the foreseeable future.

Environmental restraint

Environmental restraint is when a staff member intentionally restricts a consumer's normal access to their environment. For example, locking devices on doors or denying their normal means or independent mobility (wheelchair).⁷

Generally, Te Awakura was an open unit. The main entrance doors are open between 7am and 8pm in summer and 7am and 6pm in winter. Public entrance and exit from each ward is via the main entrance and is overseen by the reception staff.

To prevent the departure of high risk service users from the Unit, nursing staff could lock the ward doors, for the minimum amount of time necessary to maintain the safety of service users, visitors and staff. Reception staff were made aware of a small number of pre-specified service users; their unescorted approach to the reception led to the front door being locked and the relevant ward contacted.⁸ When the entrance to a ward was locked the clinical team were required to assess the situation and ensure any restrictive practice was conducted for the shortest period of time. Alternatives to locking the ward were 1:1 observations or nursing staff observing service users in high care areas (with the doors open). Inspectors noted the doors to North ward were locked when they arrived. There was no information displayed on how to enter or exit the ward for service users (and visitors) not subject to the emergency locking protocol.

Environmental restraint was actively monitored and recorded. Environmental restraint was applied 718 times between November 2016 and October 2017. West wing accounted for 43 percent of all environmental restraints (310 events). South accounted for 15 percent (107 events), North accounted for 20 percent (144 events) and East accounted for 22 percent of environmental restraints (157 events).

Each ward had a high-care area that could be secured and managed separately from the main ward. This was the most common form of environmental restraint reported on each ward. Each high care area had three bedrooms, bathroom facilities, a courtyard and a TV lounge with kitchenette. Once a service user no longer posed a clinical risk the environmental restrictions were removed and the high care area unlocked.

Bed occupancy

The average bed occupancy rate for the service for the period October 2016 to September 2017 was 93 percent. July had the lowest level of occupancy, 87 percent and January the highest, 98 percent.

⁷ DHB Restraint Minimisation and Safe Practice Policy. Sept 2017

⁸ Protocol for emergency locking of Te Awakura main entrance doors (undated).

The service worked hard to ensure sufficient beds were available for emergency admissions. Unfortunately, this often resulted in service users having to move to other units to sleep (sleepovers); returning to their ward in the morning.⁹ The number of sleepovers per month for the period October 2016 to September 2017 were as follows:

Table 3: Te Awakura (number of sleepovers) - October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Sleepovers	48	15	24	87	40	43	40	15	26	25	32	22

It was reported to Inspectors that sleepovers were taking place to meet the needs of the service, not the service user. Several service users who had experienced a sleepover stated they found it unsettling and frightening. They reported that moving to a different unit made them feel uncomfortable with the different service users and staff in that ward.

Electro-convulsive therapy (ECT)

There were no service users (in the Unit) undergoing ECT at the time of inspection; clients were community based. The ECT suite was clean and well maintained. Staff were friendly and responsive to client's needs.

Service users' and visitors views on treatment

Service users and family/whānau provided positive feedback in relation to staff and service user interactions. Inspectors observed staff interacting with service users in a positive and respectful manner. Staff routinely knocked on bedroom doors before entering and were seen to ask service users if they would like to speak in a private space. A small number of service users believed they should not have been admitted to the Unit. Others spoke of feeling safe and being listened too. Service users were generally very complimentary about staff and felt they were treated with respect.

Inspectors received varied reports from service users in relation to receiving information packs on admission. Most reported that they had not received one. Not all staff were able to locate an admission pack when asked by Inspectors.

Discussions with service users, carers/family/whānau and staff showed that service users were actively involved in their treatment. Examples were sighted by Inspectors of family inclusion with regard to treatment planning and discharge. Not all services users spoken to by Inspectors reported having a written copy of their treatment/crisis plan.

A twice weekly pharmacy group was held where service users could ask questions or raise concerns regarding medication. Inspectors received favourable service user feedback regarding how they were able to raise and discuss issues in this forum.

⁹ Inspectors noted service users moved to the Seager Clinic - a 24 bed extended treatment unit, Tupuna Clinic - a 15 bed extended treatment unit and PSAID – a 15 bed psychiatric unit for adults with an intellectual disability.

A lack of activities on the ward was a common message from service users, and staff.

Recommendation – treatment

I recommend that:

- a. Access to the seclusion area for clients in East, South and West wards should be reviewed.
- b. Notices detailing the process for entry and exit into the ward should be displayed in prominent areas when the doors are locked.
- c. The service develop a plan to reduce the number of sleepovers.
- d. Service users receive a copy of their treatment plan.

Protective measures

Complaints process

Inspectors were provided with an out-of-date copy of the DHB's *Complaints Management* policy (Issue date: 25 June 2009. Review date: 25 June 2012). A notation on the documents states that printed copies may not reflect the most recent updates.

At the time of the visit, Inspectors were advised that a new complaints database had just become operational. Complaint forms were readily available in the reception area and on each ward. Complaints were responded to in a timely and comprehensive manner. The Complaints Review Committee, which met weekly, reviewed all complaints.¹⁰

Service users that were interviewed were aware of how to make complaints. Staff were able to detail the process and explain how the service users were supported to make a complaint. Low level complaints were dealt with at ward level. The Consumer Advisor and Ward Manager's met on a regular basis to discuss complaints that had been raised by service users.

Contact details for District Inspectors were displayed in areas easily accessible to service users. It was reported to Inspectors by both staff and service users that the District Inspector had a regular presence on the Unit.

Records

There were 61 service users (31 females and 30 males) in the Unit on the day of the visit.

Thirty-three service users were being detained under the Mental Health (Compulsory Assessment and Treatment) Act and twenty eight were informal clients.

¹⁰ A sample of minutes from 26 September 2017 to 31 October 2017 was provided.

Inspectors reviewed a sample of files (23) from across the four wards. All files contained the necessary paperwork to detain [and treat] the service users in the Unit.

Service users either reported they could not remember signing consent forms or were unsure about the consent they gave. Staff provided an understanding of consent for voluntary service users, however they were unsure regarding consent for those under the Mental Health Act. Inspectors note consent forms were missing from some files.

There were daily multi-disciplinary team (MDT) meetings in each ward. Service users did not attend their MDT meetings. Follow-up appointments with service users were arranged to discuss any changes to their medication or care plan.

The specialist Māori mental health service - Te Korowi Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health services for Māori. Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori service users. Their role was specific to providing cultural assessments that sat alongside the clinical assessment and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work. Māori Hauora plans were discussed with the service user and their whānau if appropriate. Service users received a copy of their plan.

Records indicated that physical examinations were undertaken and that there was ongoing monitoring of service users' physical health.

With the exception of consent to treatment forms, paperwork was completed to a reasonable standard; up-to-date and stored appropriately. There was good administrative support located in North ward.

Recommendations – protective measures

I recommend that:

- e. Consent to treatment forms should be completed and filed appropriately.
- f. Service users be invited to their MDT meeting.

Material conditions

Accommodation

The Unit, consisting of four 16 bed wards, was generally clean and free from clutter. Each ward had allocated domestic staff that cleaned the wards on a daily basis. The lay out of the wards did not allow staff to observe all parts of the ward and there were blind spots. Soft furnishing in some wards were worn and shabby; this was particularly noticeable in North ward which also required some redecoration.

Bedrooms (non with en-suite facilities) were reasonably spacious, with adequate storage and natural light. Service users on North ward lacked privacy in their bedrooms because viewing panels on doors were only covered on the outside. Bedroom doors could be locked from the inside. However, service users require staff to unlock their bedroom door to gain access. This was raised as a potential reason for personal property going missing from rooms.

There was adequate bathroom facilities for the number of service users. Each ward had a three bed high care area that could be locked off from the main ward.

There was limited communal space and quiet areas in each wing.



Figure 3: Typical bedroom

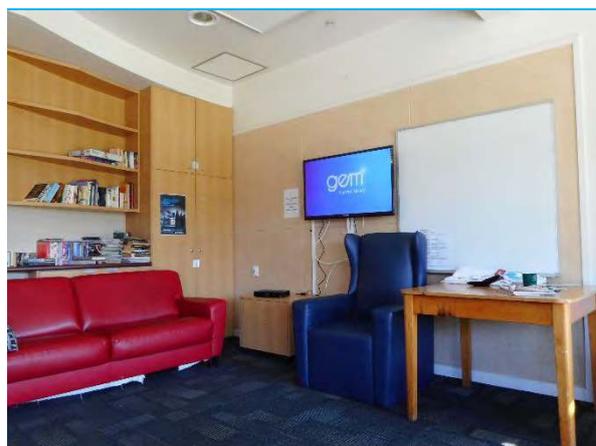


Figure 4: Lounge

Food

Meals were prepared in the main hospital and bought to the wards on a trolley. Service users had a choice of meals from a daily menu. The quantity and quality of the food over the course of the inspection was satisfactory. Special diets, such as vegan meals were provided. There were no formal complaints from service users about food.

Breakfast was scheduled between 7.30 and 8.30am, lunch from 12.45 to 1.30pm and dinner was served at 6.00pm.

There were facilities to make hot food and snacks throughout the day, although, at times, access was observed to be restricted, particularly in North ward.

Service users reported that food was good.

Recommendations – material conditions

I recommend that:

- g. Privacy issues in North ward be addressed.
- h. Worn and damaged soft furnishings should be replaced.

Activities

Leisure activities

A limited programme of activities was available on each ward, however service user uptake appeared low. Activity rooms, particularly on North ward were not always accessible due to a number of vacancies in the Occupational Therapy team. Inspectors noted the games cupboard in North ward was locked during the course of the inspection. A service user computer with internet access was located in the reception area.

Nursing staff regularly offered and organised activities throughout the week and at weekends. However, at times, escorts and service user observations limited the number of activities that could be offered.

Although not strictly adhered to, there were signs in the TV lounge prohibiting its use between the hours of 9am and 3pm Monday to Friday.

Multi-faith chaplains visited regularly and service users could request specific spiritual advisors. Service users provided examples of being supported to attend church.

A lack of activities and access to a gymnasium was a common message from service users, and staff.

Inspectors noted a considerable number of service users being escorted around the hospital grounds either individually or in small groups.



Figure 5: Art room



Figure 6: Vegetable garden

Outdoor exercise

All wards had open access to outside areas. A small basketball court was available for service users on North and West wards, although the hoop needed to be replaced on West. Service users told Inspectors they enjoyed outdoor activities such as playing football. There was an attractive outside garden space which had recently been established by one of the service users.

Each ward had a courtyard which was open until 6pm; and for 15 minutes every hour until 10pm.



Figure 7: Garden area



Figure 8: Quiet/games room

In line with national requirements the hospital had a smoke-free policy. Nicotine replacement therapy was available to service users. The service took a pragmatic approach to smoking.

I recommend that:

- i. The Unit, in conjunction with service users, should review the activities and programmes on offer in the wards. Service users should be able to access a gym.

Communications

Access to visitors/telephone

Visiting hours were from 10am to 8pm daily, including weekends. Te Awakura ran a wellbeing programme during the day and evening that family/whānau and friends could attend. The wards were flexible if people needed to visit outside of the set visiting times.

Inspectors observed, and spoke with, a number of visitors over the course of the inspection. All visitors and service users interviewed reported that family/whanau could visit without any difficulty.

Children were welcome under adult supervision. A small family/whānau room was situated in the reception area. Visitors and service users reported that it was unsuitable for children, particularly during the summer when temperatures became unbearable when the door was closed.

Service users could make telephone calls in private. Hand held telephones were available for service users to use; many had their own mobile device.



Figure 9: Family room



Figure 10: Reception

Recommendations – communications

I recommend that:

- j. The Unit should identify a more suitable family/whānau room.

Personnel

Staffing levels

The Unit had a full time equivalent of 108 nurses (registered and enrolled). There were 6.5 nurse vacancies at the time of the inspection; four on South ward.

The Unit had a large number of newly qualified nurses¹¹ (40 percent). New staff (and student nurses) were orientated in to the Unit and a Nurse Coach was available on the afternoon shift to provide mentoring and support. Clinical Nurse Specialists (CNS) and Clinical Nurse Managers (CNM) were also available for support and guidance.

Most staff Inspectors spoke with had limited understanding of the Mental Health Act. Nurses, including student nurses, reported little training in this area. Many nurses were unsure of the District Inspectors role.

¹¹ Employed for twelve months or less.

In 2012, Adult Mental Health Services introduced a new in-reach model of care for allied health care staff - *Direction for Change*. Inpatient based Social Workers and Occupational Therapists were relocated to the adult community teams from which an in-reach service was provided to the four wings. There was much discussion with the Inspectors as to the effectiveness of the new in-reach model. Staff raised their concerns with the new model and generally felt service users had been disadvantaged since its implementation. Inspectors were informed that the new model was in the process of being reviewed.

Recommendations – staff

I recommend that:

- k. The Nurse Coach should work with nursing staff on the application of the Mental Health Act.

Acknowledgement

I appreciate the full co-operation extended by the manager and staff to the Inspectors during their visit to the Unit. I also acknowledge the work involved in collating the information sought by the Inspectors.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people spoken with by Inspectors

Team Leader

Director of Area Mental Health

Psychiatrist

Director of Nursing

Clinical Director

SPEC Trainer

Māori Consumer Advisor

Allied Health Manager

Occupational Therapist

Social Workers

Customer Services Coordinator and Privacy Officer

Nursing Students

Nurse Coaches

Health Care Assistants

Cleaner

Receptionists

Family/Whānau/Relatives

Registered and Enrolled Nurses

Chaplin

District Inspector

Community case managers

Consumer Representative

Consumer Advocate

Appendix 2. Overview of OPCAT – Health and Disability places of detention

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT. Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

- (d) a hospital*
- (e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - a. for improving the conditions of detention applying to detainees;
 - b. for improving the treatment of detainees;
 - c. for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector’s (COTA). This is to ensure that there is a clear distinction between the Ombudsmen’s preventive monitoring function under OPCAT and the Ombudsmen’s investigation function under the Ombudsmen.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;

3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

RELEASED UNDER THE OFFICIAL INFORMATION ACT



**Central Region's Technical Advisory Services
Certification Audit Programme**

Canterbury District Health Board
Certification Final Audit Report
Health and Disability Service Standards
18-22 June 2018

RELEASED UNDER THE OFFICIAL INFORMATION ACT

HealthCERT Service Provider Audit Report (version 6.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Canterbury District Health Board		
Certificate name:	Canterbury District Health Board		
Designated Auditing Agency:	Central Region's Technical Advisory Services Limited		
Types of audit:	Certification Audit		
Premises audited:	Hillmorton Hospital; Lincoln Maternity Hospital; Kaikoura Hospital; Chatham Island Health Centre; Oxford Hospital; The Princess Margaret Hospital; Tuarangi Home; Rangiora Hospital; Ashburton Hospital; Burwood Hospital; Waikari Hospital; Christchurch Hospital; Darfield Hospital; Ellesmere Hospital		
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Children's health services; Dementia care; Hospital services - Surgical services; Hospital services - Maternity services		
Dates of audit:	Start date:	18 June 2018	End date: 22 June 2018

Proposed changes to current services (if any):

None

Total beds occupied across all premises included in the audit on the first day of the audit:

1164

Audit Team

Lead Auditor	Raewyn Wolcke	Hours on site	43	Hours off site	26
Other Auditors	Lizelouize Perkins, Zdena Kaspar-West, Lorraine Proffit, Christine Davies, Tevita Hingano	Total hours on site	176	Total hours off site	26
Technical Experts	Nicola Pereria, Jacqui Wynne-Jones, Carolyn Coles, Annette Van Zeist, Mikaela Shannon, Carole Schneebeli, Claire Jennings	Total hours on site	104	Total hours off site	0
Consumer Auditors	Shaz Picard	Total hours on site	24	Total hours off site	0
Peer Reviewer	Joy Hickling			Hours	4

Sample Totals

Total audit hours on site	347	Total audit hours off site	56	Total audit hours	403
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Number of residents/patients interviewed	27	Number of staff interviewed	288	Number of managers interviewed	9
Number of residents'/patients' records reviewed	165	Number of staff records reviewed	0	Total number of managers (headcount)	21
Number of medication records reviewed	314	Total number of staff (headcount)	10228	Number of relatives interviewed	21
Number of residents'/patients' records reviewed using tracer methodology	15			Number of GPs interviewed (Residential Disability providers only)	0

Declaration

I, Christine Marsters, Manager Audit & Assurance DAA/Certification Audit Programme of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Central Region's Technical Advisory Services Limited	Yes
b)	Central Region's Technical Advisory Services Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Central Region's Technical Advisory Services Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Central Region's Technical Advisory Services Limited has provided all the information that is relevant to the audit	Yes
h)	Central Region's Technical Advisory Services Limited has finished editing the document.	Yes

Dated Monday, 17 September 2018

Executive Summary of Audit

General Overview

Canterbury District Health Board's Annual District Plan describes how health services are provided to the people of Canterbury. The whole of system approach to healthcare is in collaboration with other health agencies in the region. This approach has enabled health services to continue efficiently despite the continued aftermath of the earthquake.

There are 1459 inpatient beds. The audit team visited services at Christchurch, Christchurch Women's, Burwood, Lincoln, Darfield, Waikari, Tuarangi and Ashburton hospitals and the mental health services at Princess Margaret and Hillmorton.

The new acute services building adjacent to Christchurch hospital is due for completion late 2019 and a master plan for the site is awaiting approval.

Continued improvements and a culture of safety and patient centred care was demonstrated across the services.

The audit team received a self-assessment and supporting evidence was available pre-audit and on site. The audit team met with staff, patients and their families during the audit. Fifteen patient tracer journeys were completed across Canterbury District Health Board in medical; surgical; child health; maternity; mental health; geriatric and long-term aged residential care. Two systems tracers were completed for medicines management and infection prevention and control.

There are 11 required improvements arising from the audit. These relate to consent, document management, corrective actions, performance plans, mandatory training, nursing assessments, goal setting, planned activities, medicine management and restraint.

Outcome 1.1: Consumer Rights

Safe Services that comply with consumer rights legislation are provided in a respectful manner. 'Your Rights' leaflets and posters ensure patients and their families are informed. Assessment of patients identify individual needs and this forms the basis for appropriate care planning. A Māori Health Action Plan provides the framework for provision of health services to Māori and cultural support is provided to Māori and Pacific people during service provision. Policies and expectations ensure patients are not discriminated against. Staff are professional and are guided by the code of conduct and professional requirements. The Canterbury District Health Board encourages good practice. There is an emphasis on education, professional development and research. Health pathways, clinical audit and clinical protocols and pathways support clinical best practice.

Patients confirmed they are involved in their care, treatment and decision making. Survey results confirmed that patients are positive about the care and service provided by the organisation. The complaints process is advertised and accessible. The process complies with Right 10 of the Health and Disability Code of Consumer Rights.

Outcome 1.2: Organisational Management

The Board and management provide governance and leadership to the organisation. They receive advice from both the Consumer Council and the Clinical Board. The values of the organisation and the planned direction are communicated to staff and the community. The organisation is led by experienced managers. Performance measures show the District Health Board is efficient and, despite the increasing numbers of patients attending the hospitals, patient flow and beds are effectively managed. The quality and safety programme supports staff to provide safe care and the structure supports an integrated quality management system. Policies and procedures guide staff in their practice and the Safety 1st recording and file management system is used for incident, complaints and risk management.

There are documented strategies in place to provide the right skill mix of staff based on acuity. Recruitment and appointment processes are documented and used. All medical staff are credentialed. All staff attend orientation and there are ongoing professional and personal development training programmes offered with an increasing use of online training. The people and capability strategy is progressing.

The District Health Board is moving from a paper based clinical record to a digital record. Currently the record is a hybrid record to ensure all information about the patient is available for care and treatment.

Outcome 1.3: Continuum of Service Delivery

Canterbury District Health Board has processes in place to support standardisation of inpatient care systems and processes where possible, including the development and implementation of emerging technology advances that support patient care.

The review of patients' journeys and incidental sampling demonstrated a multi-disciplinary team approach to patient care. All members of the multi-disciplinary team document patient care and treatment in the patient's clinical record. There is timely access to allied health services staff when this is required. Access to medical and nursing staff is 24 hours a day, 7 days a week. Evaluation of patient care and changes to patient care planning when this is required was evidenced. Patients and family members interviewed confirmed they have input into care planning and are consulted on their and their family members' treatment and care, where appropriate.

Continuity of care is facilitated through handovers at the change of each shift and appropriate sharing of information between staff was demonstrated. Daily rounds and 'huddles' provide a forum for planning the day in the wards noting patients for discharge, assessment and/or referral to other services. Patient transfer to other services, internally and externally, are clearly documented in the patient record following a referral process used throughout Canterbury District Health Board. Transfers between services follow a newly introduced computerised handover system that facilitates detailed information about the patient and allows for transfer timeframes to be adhered to.

The electronic medication prescribing and administration system is supported by policies and procedures.

The patients interviewed were positive about the food services which is managed by a contracted service provider with dietitian input into menus and special diets.

Outcome 1.4: Safe and Appropriate Environment

Systems are in place to support the provision of a safe environment to patients, staff and visitors. All buildings have a current warrant of fitness. The organisation is still managing the effects of the earthquake on its buildings and infrastructure, however, risk management processes remain strong. Waste, including recycling, is managed effectively with education provided to staff. Mechanisms for disaster and emergency response, including fire safety, are established. Staff are trained and plans are practiced. Amenities are provided to meet the needs of the specific patient groups including areas for recreation, dining, playroom in paediatrics and outside areas.

Outcome 2: Restraint Minimisation and Safe Practice

The restraint minimisation and safe practice policies and procedures are used across the organisation with specific policies to inform practice with identified groups of patients, such as paediatrics, psychogeriatric and mental health.

There is a range of approved restraints and enablers for general use listed in the policy document to guide staff.

Mandatory training is delivered to staff within the organisation. There are clear policies for safe seclusion use.

Outcome 3: Infection Prevention and Control

The infection prevention and control committee is multidisciplinary. A review of the Canterbury District Health Board infection prevention and control programme was undertaken and as a result, a number of improvements are being implemented.

Surveillance activities were reviewed and these include audits and surgical site infection surveillance. Canterbury District Health Board participates in the Health Quality and Safety Commission surgical surveillance programme.

Antimicrobial stewardship is in place with prescribing benchmarked against the other South Island District Health Boards. Infection prevention and control programme training occurs, including gold auditor training for all staff in regional hospitals to monitor compliance of hand hygiene.

The infection prevention and control system tracer focused on management of patients with known and suspected norovirus. The Canterbury District Health Board norovirus outbreak guidelines provide guidance for staff to prevent and control cross infection of norovirus gastrointestinal disease.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	0	3	6	0	0
Criteria	0	130	0	4	7	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	i) Variable documentation of informed consent in the acute mental health unit. ii) At Darfield and Waikari hospitals there is no evidence that general consent is obtained from all patients.	Ensure that informed consent is obtained and consistently documented.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.3.4	There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	i) The new software to manage documents on the SharePoint has not yet been implemented. ii) Not all policies and procedures are up to date.	Ensure software implementation is completed, all documents are reviewed in a timely manner and control of the documents is maintained.	365
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	i) Follow up on recommendations is variable across the DHB. ii) The DHB does not have the ability to overview the completion of recommendations until planned software is implemented. iii) Different mechanisms are used across the DHB to document corrective action plans.	Develop and implement strategies to improve the management of corrective action plans and the monitoring and oversight of recommendations.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	Staff development plans are not completed consistently across the DHB.	Ensure all staff participate in development planning as required in the people and capability framework.	180
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Current information systems do not support an organisation view of training compliance. Discussion with staff within the divisions and review of available data shows a variable compliance rate.	Ensure that all staff complete their mandatory training as required by policy.	180
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis	PA Moderate	Documentation of nursing assessments is variable across CDHB.	Ensure documentation of nursing assessments is completed in a timely manner.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		for service delivery planning.				
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	i) Multi-disciplinary team treatment plans in the Hillmorton hospital West Wing acute adult mental health are not goal orientated or consistently completed. ii) Patient goals in the general inpatient acute services are not individualised, patient orientated or documented consistently. iii) Cultural and spiritual aspects of care are not included in the long-term care plans for the aged residential care long-term care patients. iv) Short-term care plans as required by the ARRC contract for the management of acute problems are not always completed for patients in long-term care at Waikari	i) Ensure all treatment/care plans across the organisation include patient centred goal statements. ii) Ensure that care planning, as required under the ARRC contract, is completed for Waikari and Darfield Hospitals.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				and Darfield Hospitals.		
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	At Darfield and Waikari Hospitals there are no formalised activity programme in place.	Implement a formal activity programme for long-term care patient's resident at Darfield and Waikari hospitals under the ARRC contract.	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine	PA Moderate	<ul style="list-style-type: none"> i) As required (PRN) medication indications for use are not consistently documented. ii) The requirement for oxygen is not prescribed consistently. iii) Completion of IV fluid chart 	Ensure all medication management and practice meets requirements of policy, guidelines and legislation.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		reconciliation in order to comply with legislation, protocols, and guidelines.		documentation is variable. iv) The management of controlled drugs does not always meet the CDHB policy requirements.		
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	Currently staff, excluding mental health staff, are not receiving regular training on the use and documentation of enablers and restraint.	Ensure staff receive appropriate training (relevant to service requirements) in restraint and enablers to meet the requirements of the standard and current practice.	180
HDS(RMSP)S.2008	Standard 2.2.1: Restraint approval and processes	Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	PA Moderate			
HDS(RMSP)S.2008	Criterion 2.2.1.1	The responsibility for restraint process and approval is clearly	PA Moderate	At Darfield Hospital restraint practice does not meet the restraint	Implement changes of practice to ensure patients safety in	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		defined and there are clear lines of accountability for restraint use.		minimisation safety standards.	restraint and enabler use.	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

RELEASED UNDER THE OFFICIAL INFORMATION ACT

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

Attainment and Risk: FA

Evidence:

Staff at Canterbury District Health Board (CDHB) receive training on the Code of Health & Disability Services Consumers' Rights. Staff demonstrated in interviews their understanding of the requirements and their role in ensuring services are provided within the legislation. Patients and families interviewed confirmed their involvement in care and treatment decisions and that they were kept informed. Policies and procedures guide staff on all aspects of the legislation and audits are undertaken to confirm compliance.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

Attainment and Risk: FA

Evidence:

Posters are displayed and 'Your Rights' leaflets are included in patient information packs. The leaflet includes information on CDHB's values and tells patients how to make a complaint. Information about patient's rights is also on the Canterbury DHB website. Feedback from patients included whether information was received. Patients interviewed by the auditors confirmed they were given information about their rights. Sections of the leaflet 'Your Rights' is available in different languages and interpreters are used where required. The availability of an advocacy service and how to access it is advertised throughout the facilities.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

Attainment and Risk: FA

Evidence:

The auditors observed that patients interacting with staff are treated with dignity and respect. The age and design of some buildings results in difficulty in maintaining visual and auditory privacy, however, staff are aware and take care to minimise potential issues. Each patient is assessed and plans of care are developed to meet individual needs values and beliefs. Cultural and spiritual aspects of care are not always documented for long-term aged residential care patients (refer to criterion 1.3.5.2). Review of clinical records demonstrated that assessment and resultant care planning also includes strategies to encourage independence and reflect the wishes of the patient. Policy and procedures provide guidance to staff on the identification and management of elder abuse, child protection and family violence. There are no complaints or incidents relating to abuse or neglect of patients by staff.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: FA

Evidence:

There are a range of initiatives undertaken by CDHB to ensure the needs of patients who identify as Māori are met. This includes Māori health workers available to support staff and patients.

At the time of audit, the Māori health team reported an increase in demand for their service and a review is underway of Māori health services in some services.

At an operational level, a staff member of the Māori health team is allocated to support service areas, such as older person's health and mental health services. The Māori health team can converse in te reo Māori and provide organisational training as required. Policy and procedures cover tikanga safe practice requirements.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4.7 (HDS(C)S.2008:1.1.4.7)

The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.

Attainment and Risk: FA

Evidence:
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Finding:[Click here to enter text](#)**Corrective Action:**[Click here to enter text](#)**Timeframe (days):** Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5)**

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: FA**Evidence:**

Canterbury District Health Board has policies and procedures in place to support the needs of the Pacific community. Responsiveness to Pacific health needs are currently sourced from external providers should this be required. Currently there is no Pacific capacity in-house, however, staff within the Māori health team provide support by linking up with Pacific non-governmental organisations in the community. It was evident in the mental health services that this is being implemented consistently and a Pacific patient confirmed support was available.

Staff interviewed were familiar with how to access external provider support should this be required.

Criterion 1.1.5.1 (HDS(C)S.2008:1.1.5.1)

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:

- (a) Developing effective relationships with Pacific people to support active participation across all levels;
- (b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
- (c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
- (d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.

This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

Attainment and Risk: FA**Evidence:**[Click here to enter text](#)**Finding:**[Click here to enter text](#)

Corrective Action:[Click here to enter text](#)**Timeframe (days):** [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.1.5.2 (HDS(C)S.2008:1.1.5.2)**

The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

Attainment and Risk: FA**Evidence:**[Click here to enter text](#)**Finding:**[Click here to enter text](#)**Corrective Action:**[Click here to enter text](#)**Timeframe (days):** [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

Attainment and Risk: FA**Evidence:**

All patient needs are assessed and care includes inclusion of cultural, ethnic and spiritual values and beliefs. Interviews with patients and review of clinical records confirmed this occurs and is documented. There is policy and guidelines in respect to culturally safe service provision.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA**Evidence:**[Click here to enter text](#)

Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

Attainment and Risk: FA

Evidence:

Canterbury District Health Boards policy on discrimination is clear in its expectation on ensuring patients are not exposed to any form of discrimination. Service information provided to consumers in the mental health services included information protecting consumers from discrimination. Advocacy services are made available to provide further support. Patients interviewed were satisfied that service provision is free from discrimination.

Criterion 1.1.7.2 (HDS(C)S.2008:1.1.7.2)

Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.4 (HDS(C)S.2008:1.1.7.4)

The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7.5 (HDS(C)S.2008:1.1.7.5)

The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

Attainment and Risk: FA

Evidence:
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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

Attainment and Risk: FA

Evidence:

The health service and the university work closely together and research is encouraged and supported. Information systems such as Patienttrack, Cortex, FlowView, InterRAI assessment tool and E-meds are all enabling safer best practice as do processes such as ISBAR handover and transfers, releasing time to care programme, participation in national programmes such as falls prevention, pressure injury prevention and the deteriorating patient project.

Lippincott, nursing evidence-based practice procedures, are used across CDHB. Good practice is encouraged and promoted through the use of specialist services such as diabetes nurse specialists, pain control team and wound care specialists. Example of good practice observed during the audit relates to staff huddles at the beginning of a shift and bedside handovers ensuring a patient centred delivery of care.

Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

Attainment and Risk: FA
Evidence:
Patients and family members stated they were kept well informed about any changes to their status and were advised in a timely manner about any changes. Staff understood the principles of open disclosure, which is supported by policies and procedures.
Staff interviewed know how to access interpreter services. Records reviewed identified if an interpreter was required, this was completed in all records reviewed at audit.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA
Evidence:
[Click here to enter text](#)
Finding:
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Corrective Action:
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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

Attainment and Risk: PA Low

Evidence:

There are policies and procedures around informed consent. Staff were familiar with and could articulate the CDHB philosophy around informed consent. Staff described the informed consent policy, including what they would do if there is no consent able to be provided.

Consent is an ongoing process in the patients' journey that requires a formal documentation process at specific times. Documentation around this was inconsistently completed in the acute mental health unit, Darfield and Waikari hospitals.

There is a process to document advance directives with these acted upon where provided. Resuscitation status must be completed at registrar or senior medical officer level. If there is an existing written document, a copy is to be placed in the patient's record. A planned initiative will see advanced care plans and directives attached to the regional electronic patient management system (Health Connect South), to ensure patients' wishes are adhered to.

Canterbury District Health Board has a policy on the management of body parts and there is a process in place to ascertain patients' choices around this. Staff confirmed the process for storage, return or disposal of body parts.

Patients' and family interviewed confirmed they receive information that enables them to give informed consent.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: PA Low

Evidence:

Canterbury District Health Board has policies and systems to guide staff to support informed consent management. There is an organisation philosophy which promotes consent 'not being a single point in time' and as an ongoing process. In acute services, paediatrics and maternity services documented informed consent was evident.

General consent processes as required by the aged related residential care (ARRC) contract are implemented at Tuarangi, however, Darfield and Waikari hospitals do not always document all components of required consent.

Informed consent forms in forensic rehabilitation, older person's mental health (ward BG Burwood) and child and adolescent mental health services (The Princess Margaret hospital) informed consent documentation was evident. Informed consent was not completed consistently in the acute mental health wing (Hillmorton).

Finding:

- i) Variable documentation of informed consent in the acute mental health unit.
- ii) At Darfield and Waikari hospitals there is no evidence that general consent is obtained from all patients.

Corrective Action:

Ensure that informed consent is obtained and consistently documented.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.8 (HDS(C)S.2008:1.1.10.8)

The service has processes that give effect to consumers' requests on the storage, return or disposal of body parts, tissues, and bodily substances, taking into account the cultural practices of Māori and other cultures.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.10.9 (HDS(C)S.2008:1.1.10.9)

Where a service stores or uses body parts and/or bodily substances, there are processes and policies in place that meet Right 7(10) of the Code.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

Attainment and Risk: FA

Evidence:

Patients are informed of their right to advocacy and to have support people with them. Information on how to access an advocate is in the patient information given to patients. Discussion with the advocacy service confirmed they are contacted and are supported to advocate for patients. Staff confirmed at interview that support persons were welcome and staff knew how to access advocates.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

Attainment and Risk: FA

Evidence:

Nursing, medical and midwifery staff stated visitors and support persons are welcome. Documentation shows planned involvement of and access to community services where applicable. The DHB has a policy on visiting and visitor hours are advertised on the internet. Staff confirmed that after hours visiting is flexible and family are encouraged to be involved. Mental health services are able to offer accommodation to families from out of town.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

Attainment and Risk: FA

Evidence:

The complaints policy and the process for management of complaints, which complies with right 10 of the Code of Health and Disability Services Consumers' Rights, is understood by all staff. Complaints are registered on Safety 1st recording and file management system (Safety 1st) and progress in the resolution of the complaints is now

documented on this system. Patients confirmed they are told about how to make a complaint. Review of the system and discussion with staff confirmed that complaints are managed with involvement from the complainant and are managed in a timely manner. Meetings are held with the patient and/or their family if wanted.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

Attainment and Risk: FA

Evidence:

Discussion with the CDHB Board chairperson confirmed they are well informed and are provided with the reports and data required to give them assurance about safe care delivery. The Board monitors performance and clinical governance is supported by the Clinical Board. The DHB is led by a qualified experienced executive team. The organisation's vision and goals are visible and focus on an integrated health system using a 'whole of system approach'. The Annual District Plan (DAP) sets out the strategies and performance measures for the year. A consumer council for the DHB ensures there is consumer input into planning and other activities across the DHB.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

Attainment and Risk: FA

Evidence:

In all facilities there are arrangements for 24 hour management coverage. The delegations policy provides clarity on accountability and responsibilities. The 'hospital at a glance' electronic board provides real time data which enables efficient management of patient flow. All performance targets are met. The 9 am operations meeting at Christchurch hospital is held daily or more frequently if required and this enables a whole of hospital approach to bed management and patient flow. Beds across the DHB can be used for service delivery. Business planning at operational level is linked to the DAP and the strategic direction of the organisation. Performance indicators are measured and management reports monthly to the Board through the chief executive.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Attainment and Risk: PA Moderate

Evidence:

Quality improvement principles underpin the quality and safety focus of the organisation. The systems continue to improve. Each division has a quality structure and the quality managers work collaboratively to have standardised systems across the DHB. A review was recently undertaken of the clinical governance framework. The establishment of a new clinical governance committee for the provider arm of the DHB will complement the work of the Clinical Board and strengthen the monitoring of quality and safety in the divisions. Key policies were reviewed pre-audit and it was noted that documents were not all current.

Review of minutes show that the quality management system is linked to service delivery, as are national targets and Health Quality and Safety Commission (HQSC) programmes. The organisation collects a range of data and staff confirmed that access to information is being continually improved. Performance indicators are monitored and benchmarking occurs. The DHB has an internal audit programme (viewed). Review of the risk register and discussion with staff demonstrated that the risk management system is used with effect. Board and management understand the risks facing the organisation and all risks are mitigated. There is a structured health and safety programme. Health and safety representatives discussed their role and confirmed they are supported in the workplace. Strategies are implemented to minimise risk of harm to staff, however, violence and aggression towards staff remains an increasing problem.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: PA Low

Evidence:

A document control system on SharePoint is proposed which will enable greater visibility, accessibility and ease of management of policies and procedures. Lippincott provides an easily accessible resource for nursing procedures. On review of the policies and procedures on the intranet it was noted that these have not been reviewed, are not up to date and are difficult to access.

Finding:

- i) The new software to manage documents on the SharePoint has not yet been implemented.
- ii) Not all policies and procedures are up to date.

Corrective Action:

Ensure software implementation is completed, all documents are reviewed in a timely manner and control of the documents is maintained.

Timeframe (days): 365 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p>

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: PA Moderate

Evidence:

The new Safety 1st recording and file management system has been implemented successfully. The division quality teams investigate and manage the complaints and incidents with robust but variable processes. The audit register is not kept current and recommendations from audits are not completed in a timely manner. A central repository for all recommendations from the outcomes of these reports, is proposed but needs to progress so it will make monitoring and the analysis of trends more visible.

Finding:

- i) Follow up on recommendations is variable across the DHB.
- ii) The DHB does not have the ability to overview the completion of recommendations until planned software is implemented.
- iii) Different mechanisms are used across the DHB to document corrective action plans.

Corrective Action:

Develop and implement strategies to improve the management of corrective action plans and the monitoring and oversight of recommendations.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

Attainment and Risk: FA

Evidence:

All incidents are reported on Safety 1st recording and file management system (Safety 1st) and are investigated. Staff confirmed their understanding of the incident management system. Reports are provided to staff and management. Review of the management of Severity Assessment Codes (SAC) 1 and 2 incidents showed thorough review was undertaken with documented involvement of the patient and family. Follow through on recommendations is not always timely (refer to criterion 1.2.3.8). Open disclosure education is provided. Documentation of open disclosure is now made in Safety 1st (system viewed). Evidence was provided of improvements made as a result of incidents.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5)

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: FA

Evidence:

One of the values of the model of care for mental health services is ensuring that consumers and their families are involved throughout their care. Consumer participation is encouraged on entry to the service. In the mental health service it was evident in the review of clinical records and interviews with patients that they have input into care plans and the multi-disciplinary meetings where decisions are made. The consumer auditor met with consumer representatives and patients and there was evidence across all aspects of service delivery of consumer participation.

Criterion 1.2.5.1 (HDS(C)S.2008:1.2.5.1)

The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.2 (HDS(C)S.2008:1.2.5.2)

Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.3 (HDS(C)S.2008:1.2.5.3)

The service assists with training and support for consumers and service providers to maximise consumer participation in the service. This shall include:

- (a) Education and/or training for service providers whose colleagues are consumers working in the services;
- (b) Supervision; debriefing and peer support.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.5.4 (HDS(C)S.2008:1.2.5.4)

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:

- (a) Employing consumers where practicable;
- (b) The service assisting with education, training, and support for consumers to maximise their participation in the service;
- (c) Training for service providers in working with consumers as advisors;
- (d) Advisors liaising with consumer groups or networks.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Criterion 1.2.5.5 (HDS(C)S.2008:1.2.5.5)

The service implements processes that involve consumers at all levels of service delivery.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: FA

Evidence:

It was evident in the mental health services that family members are encouraged to participate in service provision processes. Staff however were clear that this process is only undertaken when it is appropriate to do so. Family members are involved in the multi-disciplinary team meetings where the patient's care plan is developed and reviewed. Family members of patients in the mental health service interviewed were satisfied that they are involved in service provision as much as possible.

Criterion 1.2.6.1 (HDS(C)S.2008:1.2.6.1)

The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.2 (HDS(C)S.2008:1.2.6.2)

Family/whānau who participate in an advisory capacity have clear terms of reference. This shall include, but is not limited to:

- (a) Advice sought from the family/whānau advisory groups when developing a terms of reference;
- (b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality and conflicts of interest.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:

- (a) Employing family/whānau where practicable;
- (b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;
- (c) Training for service providers in working with families/whānau as advisors;
- (d) Advisors liaising with family/whānau groups or networks.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

Attainment and Risk: PA Moderate

Evidence:

Good employment practice and legislation requirements guide human resource management. The people and capability strategy being implemented is changing some of the systems supporting and developing staff. Progress is being made and staff discussed some of the latest developments for identifying and developing talent, developing leadership skills, streamlining recruitment processes and developing and supporting staff. Review of policy shows there are processes for validating professional qualifications and practicing certificates. Staff confirmed this occurs. The credentialing programme has been re-launched and individual credentialing completed in the clinical units is up to date. Service credentialing is now in year two of a five-year plan. Twelve services have been credentialed to date. Nursing could include their credentialing register on Share point with the medical register so the information with regard to credentialing and scopes of practice is transparent. The strengthening of the medical leadership is assisting clinical engagement. Orientation is provided to all staff (programme viewed). Staff confirmed the range of education and training programmes available to staff and the support given to staff for their professional and personal development.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: PA Moderate

Evidence:

Processes for recruitment and appointment are established. The People and Capability strategy provides clear pathways for staff development, however, individual staff success and development plans are not consistently completed across the organisation. There is also no organisational view of the wider DHB compliance to the requirements within the People Strategy.

Finding:

Staff development plans are not completed consistently across the DHB.

Corrective Action:

Ensure all staff participate in development planning as required in the people and capability framework.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Moderate

Evidence:

A range of education is provided across the organisation. Staff report that they are well supported with the provision of education opportunities. However, there is a mandatory requirement for a range of courses and data is collected on completion of these at a local level. There is no visibility at an organisation wide level of capability development (mandatory training) to ensure monitoring of compliance.

Finding:

Current information systems do not support an organisation view of training compliance. Discussion with staff within the divisions and review of available data shows a variable compliance rate.

Corrective Action:

Ensure that all staff complete their mandatory training as required by policy.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

Attainment and Risk: FA

Evidence:

Models of care are clearly defined and staff are rostered to ensure skill mix is appropriate and new staff are supported. There is a specific programme for nursing new graduates. Registrar and house surgeon levels are decided annually for each service and this is then linked with training needs. A documented process is used for the assessment of patient acuity and staff skill mix levels is included in unit/ward profiles. The management and clinical expertise available after hours ensure safe staffing is maintained.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Attainment and Risk: FA

Evidence:

The CDHB is moving towards a digital clinical record. This transition results currently in a hybrid record, however, clinical information is available for care either through the electronic system or the paper record. Clinical records staff confirmed they continue to maintain the record with documented procedures to ensure confidentiality and security of the record is maintained. Processes are in place to respond to requests for access. There is a governance process for the transition which is identifying and mitigating risks. Documentation audits are undertaken. Data accuracy is monitored and duplicate records identified and merged.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
Click here to enter text

Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:
Click here to enter text

Finding:
Click here to enter text

Corrective Action:
Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

Attainment and Risk: FA

Evidence:
The Health Pathways is the main source of information on referral pathways for both acute and outpatient referrals. There are multiple entry points to inpatient services and a number of fast track pathways in place via the emergency department.
The CDHB website contains information about the services provided. There is additional information for patients and family members on access to services via publications, patients' GPs and specialists. Entry screening processes are in place. The electronic flow view system supports entry to services and interdepartmental transfers. Interviews

with patients and family confirmed information is communicated relating to admission processes and entry to services is facilitated in a timely manner. Entry criteria is clearly documented. Waiting lists are both outsourced and insourced which enables access to surgical services in a timely manner. There are systems in place to prioritise entry to all services.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.1.5 (HDS(C)S.2008:1.3.1.5)

To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

Attainment and Risk: FA

Evidence:

Processes are in place to manage declined services where patients do not meet entry criteria as indicated. This includes referral to other services as appropriate, with reasons for decline documented and communicated to the referrer as required.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Attainment and Risk: FA

Evidence:

Fifteen patient journeys were followed through individual patient tracers in: medical, surgical, maternity, paediatric, mental health, and aged care services.

The patient tracers and additional incidental sampling of patient records confirmed that each stage of service provision is completed by a suitably qualified person. This includes nurses, allied health staff and medical staff. Patients' and family interviews confirmed they were satisfied with the care and treatment and were consulted and able to participate in the planning of their and their family members' care.

Nursing assessments using standardised risk assessment tools were not consistently completed in the clinical records reviewed (refer to criterion 1.3.4.2). Clinical records review also demonstrated that medical staff and allied health professionals complete assessments at initial consultation and reassessments thereafter.

Continuity of service delivery is maintained through: progress notes; family meetings; interdisciplinary meetings; medical rounds; written and verbal handovers; patient bedside boards; bedside handovers and 'huddles'. There was evidence of nursing, medical and allied health staff participating in planning the day in the wards noting patients for discharge and or assessment or referral to other services. The patient status communication boards aid communication across the multi-disciplinary team (MDT) with regard to the patients' current status in their journey towards discharge or transfer. In some services the electronic tool 'FlowView' has replaced the patient whiteboards to support patient flow. The electronic flow view ensures transferring of a patient to an appropriate service in a timely manner. The implementation of the Cortex electronic message system enables interactive communication in a timely manner between health professionals in some services.

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA

Evidence:

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Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
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Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
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Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

Attainment and Risk: PA Moderate

Evidence:

Patients' medical assessments are completed and recorded in a timely manner. Allied health staff assessments are documented in patient's clinical record or on specific forms related to the allied health professional services. The nursing assessments are not consistently completed and recorded in the patients' records reviewed. Assessments reviewed included input from the multidisciplinary team and were managed in a timely manner. Patients are assessed prior to transfer to other services.

All patients (or their families) whose care was reviewed confirmed they had been involved in the assessment process and were kept informed about their care and treatment.

Privacy is respected during the assessment process.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: PA Moderate

Evidence:

There are systems and processes available to document assessments. The medical and allied health staff assessments are completed and recorded in the patients' progress notes and/or allied health forms.

The initial nursing assessment forms that are required to be completed within a designated timeframe are not always completed, excluding aged residential care long-term care patients, maternity, paediatrics and mental health.

Finding:

Documentation of nursing assessments is variable across CDHB.

Corrective Action:

Ensure documentation of nursing assessments is completed in a timely manner.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

Attainment and Risk: PA Moderate

Evidence:

Patients' medical plans of care are recorded in the patients' progress notes and communicated to relevant staff verbally at handovers and at MDT team meetings. There is a process to follow when a patient is requiring medical review after hours and during weekends. The patients and family interviewed confirmed staff keep them informed about their progress and ongoing care needs.

Patients' progress notes are updated by nursing, medical and allied health staff each shift, when the patient's condition alters or reassessment occurs. There was evidence of updates recorded in the patients' progress notes reviewed. Patient clinical records reviewed were legible and document communication between health professionals that are involved with patient care and treatment. Nursing care plans reviewed demonstrated that nursing staff have completed relevant entries on the care plan to guide individualised care and treatment, however, the patients' goals were not always individualised or consistently recorded.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: PA Moderate

Evidence:

Medical and allied health plans of care are documented in patients' progress notes. Maternity, brain injury rehabilitation ward at Burwood Hospital, forensic rehabilitation inpatient mental health and child and adolescent inpatient mental health evidenced documentation of individualised patient goals in treatment/care plans.

Patients' goals are not always individualised or completed in the acute inpatient adult and older adult mental health services and general inpatient acute services. There was not always recorded evidence that patients' goals were discussed with patients. Templates, systems and processes for the documentation of ARRC contractual requirements, associated with long-term aged residential care was not always available or evident.

Finding:

- i) Multi-disciplinary team treatment plans in the Hillmorton hospital West Wing acute adult mental health are not goal orientated or consistently completed.
- ii) Patient goals in the general inpatient acute services are not individualised, patient orientated or documented consistently.
- iii) Cultural and spiritual aspects of care are not included in the long-term care plans for the aged residential care long-term care patients.
- iv) Short-term care plans as required by the ARRC contract for the management of acute problems are not always completed for patients in long-term care at Waikari and Darfield Hospitals.

Corrective Action:

- i) Ensure all treatment/care plans across the organisation include patient centred goal statements.
- ii) Ensure that care planning, as required under the ARRC contract, is completed for Waikari and Darfield Hospitals.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/whānau if appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Attainment and Risk: FA

Evidence:

In observations, interviews and review of patients' clinical records, there was evidence that patient care and treatment was conducted by the nursing, medical and the multi-disciplinary staff members. There are systems in place for referral to allied health professionals and staff reported this is managed in a timely manner. The staff interviewed were able to consistently describe the required interventions for their allocated patients.

The medical plans of care and interventions are documented in patients' progress notes and on handover documents. Patient interviews confirmed satisfaction with care and treatment received. Nursing care plans include listed nursing interventions. Multi-disciplinary team meetings are held to discuss ongoing care of each patient.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;
- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

Attainment and Risk: PA Low

Evidence:

Services provide activities relevant to individual goals and to settings of each service. This includes rehabilitation focused activities for those patients requiring this, activities to regain independence and life skills to promote activities of daily living. In mental health patients are offered a programme that includes individual and/or group activities to support their identified needs.

In child health services activities are provided that are educational and contribute to the wellbeing of the children. The play specialists provide a variety of educational activities from Monday to Friday in the activities room located between the two paediatric wards. Resources available are age appropriate and this is taken into consideration when planning the activities for each individual child or adolescent.

Patients and family in the maternity services state they are supported to maintain their independence and that their learning regarding early parenting is supported by staff and by the environment. Allied health professionals provide structured treatment activity plans for individual patients as required on a case by case basis.

A formalised activity programme was not evident in all long-term aged residential care services.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: PA Low

Evidence:

In child health services the play therapist programme enables assessment and provision of play therapy where this is required. Allied health services deliver programmes and activities specific to patient needs and identified outcomes. Activities in mental health services are planned and implemented consistently.

Activity programmes were not always evident for long-term care patients under the ARRC contract. Activities for patients under the ARRC contract are limited to four hours per week. Patients at Darfield, Waikari and Tuarangi Hospitals are assessed by activity coordinators/diversional therapists and current abilities are identified. Review of activities showed that there are no documented activities programmes confirming planned activities for patients.

Finding:

At Darfield and Waikari Hospitals there are no formalised activity programme in place.

Corrective Action:

Implement a formal activity programme for long-term care patient's resident at Darfield and Waikari hospitals under the ARRC contract.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

Attainment and Risk: FA

Evidence:

Patients' care and treatment is evaluated on an ongoing basis. Patients' clinical records reviewed demonstrated evaluation occurring by those health professionals involved in the individual patient's care. Evaluation is clearly documented either as part of the nursing care plans or in the progress notes by medical and allied health professionals. The frequency of evaluation and reassessment of patients is based on acuity and progress of the patient.

Adult services, with the exception of maternity services, within the CDHB use the New Zealand Early Warning Score tool. Where progress is not as expected there is timely assessment and changes made to the patient's care and treatment.

Ongoing evaluations in paediatrics, and primary and tertiary maternity care settings occur to monitor progress. The maternity early obstetric warning scores system is used in Christchurch Women's hospital. In the mental health services the review and evaluation of patient progress against their treatment plans is undertaken in a comprehensive and timely manner.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

Attainment and Risk: FA

Evidence:

The electronic tool, FlowView, used in some services within the DHB, enables staff to see details of patients that are expected to be transferred and manages the patient progress through this model of care. This assists in enabling the healthcare team to share a joint view of the patient's status and their entire pathway of care. Patient referrals to other health and disability services, specialists and/or clinics are facilitated by the appropriate health professional when required. Transfers are facilitated by handovers that allow the staff members receiving the patient to access all relevant information and respond to the ward transferring the patient in timely manner. A copy of the referral information is retained in the patient's clinical record.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

Attainment and Risk: FA

Evidence:

The electronic patient at a glance system, FlowView, requires the patient estimated date of discharge entry and this facilitates appropriate length of stay. The patient's discharge is discussed by the health professionals involved with the patient's care and the patient and where appropriate the family. The discharge plan is completed to ensure all support is available at the time of discharge. Every week day active case management meetings are attended by multi-disciplinary members of the ward to discuss patient progress towards meeting discharge goals to determine the expected date of discharge for each patient.

The electronic nursing handover processes are in place from the emergency department to the wards.

The electronic FlowView screens and the whiteboards document patients' proposed discharge or transfer dates. The whiteboard is updated at the daily active case management meetings.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.11: Use Of Electroconvulsive Therapy (Ect) (HDS(C)S.2008:1.3.11)

Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner. (Only mental health services that provide ECT need to comply with Standard 3.11)

Attainment and Risk: FA

Evidence:

Electroconvulsive therapy (ECT) remains a common treatment procedure for some service areas of CDHB mental health services. Electroconvulsive therapy is more commonly used in the acute, long-term adult mental health services and forensic mental health services, than in older person's mental health services or young person's mental health services. During the audit, there were 14 ECTs being carried out in the adult mental health services for the week. The procedure is supported by a policy to ensure that processes are in place that meet current best practice. A clinical nurse specialist is in place to coordinate and manage the process.

Criterion 1.3.11.1 (HDS(C)S.2008:1.3.11.1)

ECT is provided according to legislation and currently accepted best practice guidelines.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.2 (HDS(C)S.2008:1.3.11.2)

There are monitoring processes in place to ensure all assessments, consents, and application of ECT comply with the currently accepted best practice guidelines, legislation, and the organisation's policies and procedures.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.3 (HDS(C)S.2008:1.3.11.3)

Consumers are given specific information on the risks and known side effects of ECT.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.11.4 (HDS(C)S.2008:1.3.11.4)

The consumer shall be fully informed.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Attainment and Risk: PA Moderate

Evidence:

The service currently has two systems for medicines management. The electronic system (MedChart) is in place in acute services and the paper-based system is used in the long-term residential aged care services. Although the electronic medication system is used in acute services, this does not include the charting of oxygen and intravenous (IV) fluids, as this is completed on hard copy medication charts.

The review of medication charts (both electronic and hard copy) showed that medicines prescribed as needed (PRN) did not consistently record the indications for use. Where patients were using oxygen, the oxygen charting was not always evident for those patients. The completion of IV fluids were not always documented on the IV chart.

Medication management systems tracer:

A medication management tracer was completed on controlled drug management processes and systems including disposal of controlled drugs. This systems tracer included review of implemented medicines management processes across CDHB.

Medicines management policies provide guidelines for staff for appropriate prescribing, dispensing, administration, review and reconciliation of medicines. Medicine management errors are continuously being reviewed and CDHB uses this information to identify trends.

Canterbury District Health Board has a steering group to oversee medication management practices and reduce medication errors. An electronic medicines management system is used to support safe medicines management processes.

Review of incidents and accidents, physical checks and interviews with staff across the organisation showed that there are inconsistencies in the medication management processes. Incidental sampling of patients' clinical records of patients with prescribed controlled drugs included review of medication charts and evidenced that storage and disposal processes are not consistently implemented according to policy. Practices do not consistently meet legislative requirements and/or guidelines. Return of unused controlled drugs to the pharmacy and disposal of medicines (including controlled drugs) are not consistently following policy, guidelines and/or legislative requirements. The systems tracer review confirmed staff are using different systems and processes around disposal of controlled drugs that do not meet safe medication practice, policy, guidelines and legislative requirement.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Moderate

Evidence:

Two medication systems are currently in place including hard copy medication charts and an electronic medication management system. There is an additional process for the charting of oxygen and IV fluids in separate hard copy forms.

Mental health services were managing their medication using an electronic system MedChart. Controlled medications were observed to be managed safely with proper storage and monitoring processes such as the reconciliation and discarding process. The review of the MedChart system showed consistent prescribing to include indication

for PRN medication. The mental health services are supported by a group of pharmacists who are not only checking and monitoring the medication room but also actively participating in the management of consumers' medication.

Review of medication charts (both electronic and hard copy) evidenced the PRN indication of use were inconsistently completed. Oxygen charting was not always evident for patients being administered oxygen therapy. The IV fluid prescription and administration were documented, however, the completion of IV fluids was not always documented. Quantity stocktakes and weekly stocktakes of controlled drugs are completed. Discarding of controlled drugs is not always recorded.

Finding:

- i) As required (PRN) medication indications for use are not consistently documented.
- ii) The requirement for oxygen is not prescribed consistently.
- iii) Completion of IV fluid chart documentation is variable.
- iv) The management of controlled drugs does not always meet the CDHB policy requirements.

Corrective Action:

Ensure all medication management and practice meets requirements of policy, guidelines and legislation.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:
 Click here to enter text

Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

Attainment and Risk: FA

Evidence:

Food services are provided by a CDHB subsidiary business. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with New Zealand Food control plans legislation and guidelines. Food control plans have been completed for all major hospitals, with three of the rural hospitals planned for completion in August 2018.

The service is managed by a dietitian and a chef, to ensure all patients dietary needs are met. Dietitian input is evident ensuring nutritional needs of patients are met.

Patients verified the quality of the food.

A quality system relating to food services is in place including separate patient satisfaction surveys and regular audits (as per food control plan) are undertaken.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:
 Click here to enter text

Finding:
 Click here to enter text

Corrective Action:
 Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

Attainment and Risk: FA

Evidence:

The waste management policy is current and staff described the processes that are followed for the different waste streams including recycling. The contracts for waste removal and disposal are monitored. Incidents are managed through the Safety 1st reporting system and staff training on waste management (programme viewed) is provided. The auditors observed the availability of protective equipment and clothing in the clinical areas and staff confirmed correct use is included in training. All chemicals and hazardous substances are registered and all staff have access to Chemwatch on the intranet. Safety Data Sheets are in the areas where chemicals are used. There was no evidence of incorrectly stored chemicals or hazardous substances. The waste management system is monitored and meets legislative requirements.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

Attainment and Risk: FA

Evidence:

All buildings have a current warrant of fitness. The DHB is still managing the building and infrastructure issues related to the earthquakes and until a new master plan for the Christchurch site is completed and approved there is not clarity about the eventual outcome for some buildings. The new outpatients building and new education and research building are soon to open. The new acute services building will be ready for occupation late 2019. The delays have impacted on other planning. Business continuity on the Christchurch site, where service delivery is continuing as the new hospital is built beside it, is comprehensive and focussed on clinical safety. Discussion with staff confirmed that risks are understood and managed.

There is a planned maintenance programme for all buildings, utilities and equipment. Contingency plans are in place to manage any utility failure.

Some mental health and older persons health services remain on the Princess Margaret hospital site. The buildings are old but generally well maintained although interiors may need redecorating if planned moves are delayed.

All medical equipment is monitored and maintained. All equipment sighted in the clinical areas was tested and tagged. All imaging equipment is tested and radiation safety is monitored across the DHB.

Consumables are stored correctly and staff confirmed there is clinical input into the procurement of consumables and capital expenditure on equipment.

The audit team observed that facilities with longer term patients have outside areas that meet the needs of each specific group.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Attainment and Risk: FA

Evidence:

All newer buildings are designed with ensuite arrangements. The number and design of toilets and bathroom facilities in the older wards in Christchurch hospital will be improved with the opening of the new building and then the upgrading for those services not moving to the acute services block. Currently staff manage the use of facilities to minimise risk.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

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Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

Attainment and Risk: FA

Evidence:

The older buildings do not provide the space for each patient that is provided in the newer facilities, however, models of care are adapted to ensure there is adequate room for equipment around the bed where required and safe mobilisation can occur. All corridors and lifts allow for safe transportation of beds. The new Christchurch hospital design will give each patient better personal space and bed area as has been provided in the new building at Burwood hospital.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

<p>Attainment and Risk: FA</p> <p>Evidence: In the mental health specialist services, Burwood hospital services, Princess Margaret hospital and the rural hospitals it was observed that there are areas set aside that are used for recreation, entertainment and dining. The age and design of the different areas does mean there is variation in what is available. In the acute services on the Christchurch hospital site where length of stay is shorter there are small lounge areas available for patients and the paediatric area has a well-equipped playroom.</p>

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p>

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

Attainment and Risk: FA

Evidence:

Cleaning services are currently contracted to an external cleaning service provider. The manager confirmed how the contract is monitored and concerns escalated. Regular internal environmental audits are undertaken to ensure the service meets its contractual requirements. The manager discussed additional cleaning requirements at Christchurch hospital related to the ongoing building alterations and city council road works being undertaken around the facility. Cleaning trolleys and cleaning chemicals are stored in locked cupboards.

The laundry service is provided by a CDHB subsidiary company. The company provides services for the CDHB and a number of external customers. The releasing time for care project has resulted in a new initiative in the way linen is delivered in acute services. The new pod system sees linen delivered six days a week, in designated amounts and on specially designed trolleys. All aspects of the laundry service comply with current legislation and guidelines.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

Attainment and Risk: FA

Evidence:

Planning for response to both internal and external emergency situations is undertaken across the DHB with practice scenarios adding to the knowledge of staff and providing opportunity to improve the plans. The health emergency plan links to the national plan and the local civil defence. The DHB uses the Coordinated Incident Management System (CIMS) framework for emergency management. A contingency plan is in place on the Christchurch site during the building process and staff meet daily to assess risks and manage these effectively.

All staff receive training in fire safety and disaster response, however, compliance with fire training requirements is not high although the data is not currently reliable (refer to criterion 1.2.7.5). Flip charts with response instructions were visible in the areas visited by the auditors and staff discussed response processes; including earthquake response.

Evacuation plans are currently under review to meet compliance with new regulations.

There is an established mechanism for response to clinical emergencies which includes medical emergency teams (MET) teams in the hospitals and ambulance in the more rural settings. Staff are trained in basic life support and advanced training where required. All clinical areas have access to emergency equipment and evidence was sighted to show emergency trolleys are checked. The deteriorating patient programme has resulted in standardised management of patients and observation data is now monitored electronically.

Alternative systems of energy and utilities are in place. Backup generators are regularly tested. The water tank for Christchurch hospital is being replaced and currently there is reliance on water tankers and bottled water in the event of water supply disruption for that site.

Call bell systems function in all areas except at Hillmorton hospital which has never had a call system and staff use individual risk assessments and observation where required to minimise risk. Benchmarking of other facilities prior to any new builds will ensure contemporary practice is followed in relation to call bell systems for the mental health service.

Security systems are comprehensive with security personnel, cameras, lighting, duress alarms and staff education combining to manage risks. Security personnel are on site 24/7 in the main hospitals and provide escort to staff on late shifts. The potential risk for staff walking to cars at Christchurch campus now that parking is restricted is understood by the DHB and discussion with the auditor included the strategies that are in place to manage the risk.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
[Click here to enter text](#)

Corrective Action:
[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
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Corrective Action:
[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
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Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
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Corrective Action:
[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:
[Click here to enter text](#)

Finding:
 Click here to enter text

Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

Attainment and Risk: FA

Evidence:

Heating and ventilation is monitored by building services and where required improvements have been made to ensure patients are in ventilated and heated building. The medical assessment unit and surgical progressive care unit in Christchurch hospital have limited natural light. Patients in these units are short stay and the facilities will move to the new hospital when it is opened. There are clear criteria in place on the use of these two areas.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

<p>Attainment and Risk: FA</p> <p>Evidence: Click here to enter text</p> <p>Finding: Click here to enter text</p> <p>Corrective Action: Click here to enter text</p> <p>Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

RELEASED UNDER THE OFFICIAL INFORMATION ACT

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

Attainment and Risk: PA Low

Evidence:

Canterbury District Health Board is committed to actively reducing restraint use. The CDHB restraint minimisation and safe practices policies and procedures documents are used across the organisation with specific policies to inform practice with identified groups of patients such as: paediatrics; psychogeriatric and mental health.

Processes to recognise potential risks for patients is part of the admission and ongoing assessment process (refer to criterion 1.3.4.2). Where there is an identified risk, efforts are made to involve a family member to assist and sit with the patient, or a patient watch is instigated.

Specific training in safe management of patient symptoms including interpersonal communication strategies are used to de-escalate and distract patients where necessary rather than use restraint and facilitate safe holds is implemented in the high-risk area mental health. Limited restraint and or/de-escalation training was noted in clinical areas, other than mental health services, to meet the organisations requirements and ensure safe patient and staff care.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: PA Low

Evidence:

Canterbury District Health Board have policies and procedures in place to guide staff in restraint minimisation. There is a restraint minimisation organisational drive across CDHB. The restraint committee and stakeholders provide oversight to restraint minimisation practices.

Staff understanding, implementation of policy and practice for the use of enablers and restraint, did not consistently meet the restraint minimisation standard and current best practice.

Finding:

Currently staff, excluding mental health staff, are not receiving regular training on the use and documentation of enablers and restraint.

Corrective Action:

Ensure staff receive appropriate training (relevant to service requirements) in restraint and enablers to meet the requirements of the standard and current practice.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

Attainment and Risk: PA Moderate

Evidence:

The restraint policy defines the responsibilities for ensuring the requirements of the restraint standards are adhered to.

Restraint episodes are recorded on Safety 1st recording and file management system (Safety 1st) and in the restraint register, documenting a detailed account of the restraint episode. The restraint register provides opportunity to reassess and review each episode of restraint use. Auditors noted at Darfield hospital the restraint practice did not meet the CDHB policies and procedures.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: PA Moderate

Evidence:

In the mental health services restraint use is clearly defined, minimised, with approval processes in place. Restraint use in the wider CDHB service areas are minimised in accordance with the standard, with the exception of aged residential care long-term care patients.

Finding:

At Darfield Hospital restraint practice does not meet the restraint minimisation safety standards.

Corrective Action:

Implement changes of practice to ensure patients safety in restraint and enabler use.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

Attainment and Risk: FA

Evidence:

Approved restraint guidelines and procedures are available for staff via the CDHB intranet to guide practice. Incidental audit sampling throughout the organisation demonstrated a uniform approach to minimising restraint by using strategies such as additional one to one staffing to help at risk patients.

Documentation of restraint episodes occur in the patients' clinical records. Each episode is recorded in the electronic incident system Safety 1st and recorded in the restraint register.

Systems are in place for responding to emergencies requiring de-escalation and restraint.

The mental health service providers interviewed are aware of the process that is required when restraint is necessary (refer to criteria 2.1.1.4 and 2.2.1.1).

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

Attainment and Risk: FA

Evidence:

Approved restraint guidelines and procedures are available for staff via the intranet to guide practice. Canterbury District Health Board hospital divisions have specific restraint procedures that are relevant to the services provided, such as child health and mental health services to help manage any risks. Incidental audit sampling throughout the organisation demonstrated a uniform approach to minimising restraint by using strategies such as additional and one to one staffing (refer to criterion 2.2.1.1).

Systems are in place for responding to emergencies requiring de-escalation and restraint. Partial or full physical restraint is seldom used. The mental health service providers interviewed are aware of the process that is required when restraint is necessary. Documentation of the restraint episode occurs in the clinical notes and is reflected in the plan of care in the clinical record, the Safety 1st recording and file management system and updated on the register by the restraint coordinator.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;

- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

[Click here to enter text](#)

Finding:

[Click here to enter text](#)

Corrective Action:

[Click here to enter text](#)

Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

Attainment and Risk: FA

Evidence:

The evaluation of each restraint is completed by the charge nurse manager of the ward. Episodes of restraint are reviewed by staff to consider future options that the care plan is followed, review the event to ensure that the least restrictive measure was used and to review the impact of the restraint on the patient.

Reporting is completed in real time with identified key members of the restraint committee alerted to new episodes of restraint or to review restraint episodes on an individual and collated level.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

Attainment and Risk: FA

Evidence:

The restraint committee is able to extract information from the restraint register for the purposes of monitoring and quality review of restraints. This information is also used to evaluate and identify training opportunities and improvements in the area of restraint minimisation practice (refer to criterion 2.1.1.4).

Key staff in each area of the organisation are able to review information and to have input into the future training and processes.

Reporting is completed in real time with identified key members of the restraint committee alerted to new episodes on an individual and collated level.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 2.3: Seclusion

Consumers receive services in the least restrictive manner.

Standard 2.3.1: Safe Seclusion Use (HDS(RMSP)S.2008:2.3.1)

Services demonstrate that all use of seclusion is for safety reasons only.

Attainment and Risk: FA

Evidence:
 Canterbury District Health Board has developed and implemented a restraint minimisation policy to include striving for zero seclusion. Each area of mental health inpatient services have seclusion rooms. Mental health services have designed the seclusion facilities to encourage staff to use seclusion only as the last resort after using other measures to de-escalate the situation as early as possible so that seclusion is not needed. It was clear in the interview of staff and review of the seclusion policy that this is a strength area of the organisation where staff are united in doing everything possible to minimise seclusion. Seclusion areas were dedicated and catered for appropriately to include safety equipment and natural light. Monitoring processes of seclusion are in place with documentation evidenced by staff.

Criterion 2.3.1.1 (HDS(RMSP)S.2008:2.3.1.1)

The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.1.2 (HDS(RMSP)S.2008:2.3.1.2)

Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.1.3 (HDS(RMSP)S.2008:2.3.1.3)

There exists a legal basis for each episode of seclusion.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.1.4 (HDS(RMSP)S.2008:2.3.1.4)

Any factors that may require caution must be assessed for each episode.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.1.5 (HDS(RMSP)S.2008:2.3.1.5)

The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.3.2: Approved Seclusion Rooms (HDS(RMSP)S.2008:2.3.2)

Seclusion only occurs in an approved and designated seclusion room.

Attainment and Risk: FA

Evidence:

The mental health services use approved seclusion rooms in their respective areas as sighted by the audit team. No other rooms are used for seclusion purposes. Each seclusion room has adequate lighting, controlled temperature and basic comfort measures such as mattresses and sheets. Patients have access to water and toilet facilities while in seclusion. All seclusion rooms that were sighted by the audit team have a clock visible to patients.

Criterion 2.3.2.1 (HDS(RMSP)S.2008:2.3.2.1)

The seclusion room provides adequate lighting, room temperature, and ventilation.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.2 (HDS(RMSP)S.2008:2.3.2.2)

The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.3 (HDS(RMSP)S.2008:2.3.2.3)

The seclusion room provides a means for the consumer to effectively call for attention.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2.4 (HDS(RMSP)S.2008:2.3.2.4)

The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

Attainment and Risk: FA

Evidence:

There is an infection prevention and control management document and implementation guideline which supports an environment to minimise the risk of infection to patients, staff and visitors. The infection prevention and control committee sets an annual infection prevention and control programme that includes: objectives; actions; timeframes; audits; blood body fluid exposure; staff screening; immunisations; education; policies and procedures; surveillance and antimicrobial prophylaxis. The infection prevention and control programme has been reviewed with the new programme coming into effect in July 2018.

The infection prevention and control committee is a multi-disciplinary committee that meets at least five times a year. The infection prevention and control operational group consists of the clinical director of infection prevention and control and clinical nurse specialists (CNS) as divisional representatives.

The CDHB recently completed an independent review on the current governance and operational structure of the infection prevention and control service, by external infection prevention and control experts. A new position of nursing director of infection prevention and control has been created and is currently advertised.

There is a transmission-based precautions guideline and the infection prevention and control facilitator described precautions for multi-drug resistant organisms. Standard precautions are in place. A cleaner was observed washing hands and putting on an apron and gloves before cleaning a room. In the sluice rooms throughout the hospital and theatre there is personal protective equipment signs that state equipment as well as a picture. Gloves, aprons, masks/visors were present in all the sluice areas visited. Alcohol based hand rub is available throughout the hospital and sighted on patients' bed ends, throughout clinical areas and is accessible to visitors.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

Attainment and Risk: FA

Evidence:

The CDHB provides resources to implement the infection prevention and control programme and is managed by a clinical director, a clinical microbiologist, and IPC CNS. There are infection prevention and control representatives at departmental level. The infection prevention and control committee reports to the clinical board at governance level. Reporting includes outcome data and an annual report showing achievement against the infection prevention and control plan.

Training for infection prevention and control CNS is planned annually and ensures attendance at both national and international conferences and workshops.

The laboratory information system is used to alert the CNS of significant infection prevention and control patient results. The team responds to patients' infection prevention and control needs regarding multi-drug resistant organisms (MDRO) and other potentially infectious conditions.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

Attainment and Risk: FA

Evidence:

There are key infection prevention and control policies and procedures that reflect current accepted good practice, and these are available to staff online. Processes to improve turnaround time for reviewing policies and supporting documents has been identified as an improvement objective for 2018.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

Attainment and Risk: FA

Evidence:

Infection Prevention and Control is included in the online orientation programme for new staff with Healthlearn education providing continual education on infection prevention and control for all staff. The infection prevention and control CNS interviewed stated managers monitor compliance.

Regular infection prevention and control link representative meetings are held, confirmed by meeting minutes.

New CDHB infection prevention and control link representatives receive an introduction letter that outlines, terms of reference, role description and meeting and education schedule. Patients are provided with relevant information.

Gold auditor hand hygiene training is provided by the CDHB. Department quality boards advertise the departments five moments compliance. The overall rate for the CDHB is 81.5% as at March 2018.

The Gernbuster newsletter is distributed to all departments bi-monthly and includes information on infection prevention and control for all staff. The May/June newsletter contains information on multiple respiratory viral infection, including the average length of hospitalisation of adult patients.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

An infection prevention and control tracer was undertaken and included the review of isolation management.

The infection prevention and control CNSs reported there was one confirmed and a number of suspected patients in one medical ward with signs and symptoms of norovirus at the time of the audit.

The CDHB norovirus outbreak guidelines guide staff as to patient isolation and specimen collection requirements. An outbreak definition is defined as two or more cases of suspected or confirmed norovirus within a defined location. In the event that a patient presents with or develops symptoms, the patient is placed in a single room with ensuite bathroom. Contact precautions are activated with a change to contact and droplet precautions if the patient is actively vomiting. The infection prevention and control service was notified of the norovirus patients by ward staff, with results available on the electronic infection prevention and control ICNET and alerts recorded on the patient flow white board.

The audit team observed patients placed in isolation. The CDHB norovirus guidelines were activated when the first patient presented with signs and symptoms. Appropriate signage and isolation trolleys were strategically placed outside the rooms. Staff reported when there is an outbreak, it significantly reduces the number of toilets and vital sign monitoring equipment for both symptomatic and non-symptomatic patients. Dedicated commodes can be allocated, if required. Staff were observed wearing protective clothing and taking the required precautions when this was required.

Staff interviewed across the organisation confirmed the precautions that are required and training records demonstrated that staff have received education on contact precautions and norovirus management. Patients stated they were informed about the need for isolation and all associated requirements relating to isolation. Further expert advice for staff and patients on norovirus management is available from the infection prevention and control team. Canterbury District Health Board policy and guidelines for isolation were observed to be implemented as required.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.6: Antimicrobial usage (HDS(IPC)S.2008:3.6)

Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.

Attainment and Risk: FA

Evidence:

Canterbury District Health Board antimicrobial guidelines align with the other five South Island DHBs. Antimicrobial guidelines are incorporated into the infection prevention and control manual and published in an accessible manner for prescribers.

Canterbury District Health Board participates in the Health Quality and Safety Commission surgical safety programme on orthopaedic and cardiac surgery. This includes audit on prophylactic antibiotic dose time and length of prophylaxis. The antimicrobial pharmacist attends the infection prevention and control committee meetings quarterly to report back to the committee on audits and outcomes.

Criterion 3.6.1 (HDS(IPC)S.2008:3.6.1)

The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.6.4 (HDS(IPC)S.2008:3.6.4)

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

Attainment and Risk: FA

Evidence:
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Finding:
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Corrective Action:
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Timeframe (days): Choose an item (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

 **Ombudsman**

Fairness for all

.....
OPCAT Report

Report on an unannounced inspection
to Te Whare Manaaki Unit
(Hillmorton Hospital)
Under the Crimes of Torture Act 1989

30 October 2018
.....

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of patients in New Zealand secure hospitals.

From 23 to 27 July 2018, two Senior Inspectors and a Specialist Advisor (to whom I have given authority to carry out visits on my behalf) visited Te Whare Manaaki Unit (the Unit), which is located in Hillmorton Hospital grounds.

Summary of findings

- There was no evidence that any patients had been subject to torture, or other cruel, inhuman or degrading treatment or punishment.
- All patients had the necessary legal documentation to be detained and treated in the Unit.
- Members of the multi-disciplinary team (MDT) appeared to work collaboratively and effectively.
- Interactions between staff and patients were respectful, constructive and appropriate.
- Accommodation was clean and tidy.
- There were adequate bathrooms and laundry facilities for the number of patients.
- There was a broad range of activities and programmes for both individuals and groups.
- Patients were able to communicate freely with family and friends, either during a visit or through the telephone/mail.

Issues that need addressing were as follows:

- The inappropriate placement of patients with an intellectual disability in the Unit.
- The complaints process and the contact details of District Inspectors was not readily available in the Unit.
- The lack of a designated area on the Unit for female patients.
- Not all patients could access fresh air daily.
- Patient's privacy was compromised when using the patient telephone.
- Not all staff were up-to-date with mandatory training.
- Staff retention was problematic.

Recommendations

I recommend that:

1. Patients with an intellectual disability should be accommodated in facilities which meet their needs.
2. Details of the complaints process and the contact details of District Inspectors are displayed in the Unit.
3. Accommodation and facilities are provided for female patients that ensure their need for privacy and safety are met.
4. All patients are able to access the outdoor area for at least one hour per day.
5. Arrangements be made to ensure greater privacy for patients when using the telephone.
6. All staff complete the Unit's appropriate mandatory training and the required refresher sessions.
7. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection to the Charge Nurse Manager (CNM), Clinical Nurse Specialist, Nurse Consultant and Occupational Therapist (OT) and sought any corrections or clarifications. Prior to this meeting, the Manager OPCAT provided high-level feedback of Inspectors' initial findings for the four units inspected at Hillmorton Hospital to the General Manager (Mental Health Services), Director of Nursing and the Quality Manager.

Consultation

A draft copy of this report was forwarded to Te Whare Manaaki for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

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Facility Facts

Te Whare Manaaki (the Unit)

Built in 1991, Te Whare Manaaki is a 15-bed medium secure unit. It is part of the Canterbury Regional Forensic Psychiatric Service and is one of two secure forensic units on the Hillmorton Hospital grounds. The Unit receives referrals from the Courts, Prisons and other Forensic Services. Occasionally, patients are admitted from the community on the advice of the Forensic Community Team.

The Unit provides inpatient assessment and treatment in a secure environment for people experiencing acute episodes of mental illness.

Region

Canterbury

District Health Board (DHB)

Canterbury District Health Board

Operating capacity

15 (plus three seclusion rooms)

Last inspection

Announced visit – July 2014

Announced inspection – May 2010

The Inspection

The inspection of Te Whare Manaaki Unit (the Unit) took place on 23 to 27 July 2018 and was conducted by two Senior Inspectors and a Specialist Advisor (the Team).

Inspection methodology

At the commencement of the visit the Team met with the Charge Nurse Manager before being shown around the Unit. During the inspection, there were 14 patients in the Unit comprising 12 males and two females.

Inspectors were provided with the following information during the inspection:

- a list of patients and the legislative reference under which they were being detained (at the time of the visit);
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in use of restraint and reasons for those not up-to-date;
- the number and a sample of complaints for the previous six months and the complaints policy;
- information for patients on admission;
- the activities programme;
- visits policy;
- staff sickness and retention data;
- staff orientation information (in the Unit);
- workforce development framework – mandatory courses 2017/2018; and
- community (patient) meeting minutes for the past three months.

Inspection focus

The following areas were examined on this occasion to determine whether there had been torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on patients:¹

¹ Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, available at www.apt.ch.

Treatment

Torture, or cruel, inhuman or degrading treatment or punishment

Seclusion/de-escalation

Restraint

Restraint training for staff

Electro-convulsive therapy (ECT)

Sensory modulation

Clients and relatives' views on treatment

Protective measures

Complaints process

Records

Material conditions

Accommodation/sanitary conditions

Food

Activities and programmes

Outdoor exercise/leisure activities

Programmes

Cultural/spiritual support

Communications

Access to visitors/external communications

Health care

Primary health care services

Staff

Staffing levels/ staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to a number of managers, staff and 12 patients. Family and whānau were also spoken with.²

Inspectors also reviewed patient records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

Recommendations from previous report

Inspectors followed up on the sole recommendation made following a visit in 2014, namely:

The seclusion rooms should not be used as long-term accommodation (bedrooms) for those difficult to manage, or difficult to place patients. The DHB, in conjunction with the Ministry needs to find alternative accommodation for the highly complex individual currently accommodated in seclusion.

This recommendation will be addressed in the body of the report.

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any patients had been subject to torture, or other cruel, inhuman or degrading treatment or punishment. However, I have serious concerns about the location on the Unit of two patients with intellectual disability (ID).

Patient A was admitted in June 2004 and as at 27 July 2018 had spent 5,152 days at Hillmorton Hospital. Patient A is the patient referred to in the recommendation from my 2014 inspection report and is now located in the general area of the Unit rather than in seclusion. Patient A was observed by Inspectors to spend most of his day in his bedroom and nursed on a 1:1 basis when in the communal areas of the Unit. At times, his behaviour can be volatile; on one evening during the inspection he became disturbed and threw dining chairs around the room. The situation was de-escalated by staff, who escorted him back to his bedroom.

Inspectors who knew Patient A from previous inspections to the Unit were pleased to note the progress made in managing his integration in to the Unit. Various sensory modulation techniques are used by staff to ameliorate his unsettled behaviour and he is able to enjoy a weekly visit to the local swimming pool.

² For a full list of people spoken with by the Inspectors and Specialist Advisor see Appendix 1.

Patient B was admitted to the Unit on 11 July 2018 and at the time of the inspection was being nursed in the de-escalation/admissions area. He slept in the de-escalation lounge and had access to a shower in one of the seclusion rooms, none of which were occupied at the time of the inspection. Patient B was considered a '*...high risk of violence and sexual violence. He is a large gender safety risk and is a risk to those he believes are vulnerable*'.³ Because of the risk to female staff, Patient B was nursed by male staff only. Staff visited him periodically during the day and he was observed via a CCTV monitor in the nurses' station. Patient B could contact staff through an intercom system.

Patient B spent most of the time alone in the de-escalation area watching television and DVDs. He informed Inspectors that staff were helpful to him and, despite being offered some activities, he preferred to watch television. He said that he had enjoyed a visit from the Ngā Pūkenga Atawhai, who had shared lunch with him.

Patient B informed Inspectors that he would like to move into the Unit; the MDT had implemented an incremental progression system by which he is introduced to the Unit gradually. During the inspection, he had begun to use the gym.

Whilst commending staff for their work in attempting to improve the lives of Patients A and B, Inspectors consider that the Unit is not a suitable facility for patients with an ID. Such patients often have complex needs, which require the attention of staff with the necessary experience and expertise to ensure that they are able to live as full a life as possible while in hospital.

Patients with an ID sometimes display unsettled and disruptive behaviour, which can have an adverse impact on the wellbeing of other patients. Staff informed Inspectors that this was often the case on the Unit.

The circumstances of Patient B highlight the demand on staff resources that are sometimes made by patients with ID, particularly if they are a potential risk to others and have to be nursed by same sex staff.

The CNM summed up the situation when he explained to Inspectors '*Manaaki is a forensic mental health unit and it is detrimental to ID patients and other patients because of the staff resource required for ID patients. It can cause tensions between patients because of the ID patients' behaviour*'.

In its 2007 Strategic Plan,⁴ the South Island Regional Forensic Working Group identified as one of its High Level Principles: '*Consumers should be accommodated in facilities that match their*

³ Safety First restraint notes, 22 July 2018.

⁴ South Island Regional Forensic Working Group (2007). South Island Regional Forensic Strategic Plan and responses to the Ministry of Health's Future Directions document.

need'. Inspectors consider that this principle is not being met currently for those patients with an ID resident on the Unit.

Inspectors observed staff interacting with patients in an engaging, respectful and caring manner. Discussions about patients between MDT members were constructive and sought to identify positive treatment journeys and outcomes for patients. Inspectors were impressed by the compassionate attitudes of some staff towards the patients. For example, two staff who spoke with Inspectors explained that many patients who enter the Unit lack a sense of hope and that it was the responsibility of staff to assist them to regain hope in order to enter a journey of recovery.

Inspectors attended a MDT meeting in which staff discussed the clinical progress of patients' and reviewed and updated care plans. All members of the team were actively involved in the discussion. The patients' input to the MDT process involved a discussion with their case manager prior to the meeting to discuss the clinical review to be presented to the MDT. Whilst patients can request to attend the MDT, staff informed Inspectors that few do so.

Inspectors observed two effective shift handovers, which discussed patients' behaviour, risks and care.

Seclusion

Seclusion facilities

The Unit has three seclusion rooms located within the low-stimulus/admissions area. All rooms were clean, tidy and well maintained. Although basic, each room had en-suite toilet and shower facilities, natural light, access to drinking water and a small clock to enable patients to maintain orientation to time. Two of the rooms contained an intercom to enable patients to access staff. The CNM informed Inspectors that he is currently obtaining quotes for the installation of an intercom in the third room.

Since the last inspection in 2014, the environment directly outside the seclusion rooms had been enhanced. In particular, the Occupational Therapist (OT) facilitated a project, Whakapaipai,⁵ which, following consultation with patients, resulted in new furnishings and artwork for the area. The OT has also created sensory kits for the area comprising items such as lavender, herbal tea, soft balls and laminated cards of soothing images. Inspectors commend the environmental improvements to this area.

⁵ To decorate, adorn, tidy up, beautify, enhance. Māori Dictionary. Downloaded from <http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=whakapaipai>

A de-escalation lounge, with en-suite toilet, leads from the low-stimulus area and can also be accessed through the main unit.

A small, vehicle access area doubles as an exercise yard for patients located in the seclusion rooms. While the surroundings are blank concrete walls, there is shelter and seating available.



Figure 1: Seclusion room



Figure 2: De-escalation with art work

Seclusion incidents and policies

A copy of the DHB's *Seclusion Policy* (dated 28 April 2017) was provided to Inspectors. The policy did not include a review date.

Data provided by the DHB indicated that between 1 January 2018 and 30 June 2018 there were 74 episodes of seclusion involving 14 patients. The total seclusion time for this period was 918.94 hours. This is broken down as follows:

Table 1: Seclusion episodes 1 January - 30 June 2018

Month	Events	Patient numbers	Hours	Average hours
January	18	8	211.03	11.72
February	18	4	215.32	12.00
March	12	3	75.92	6.33
April	3	2	4.16	1.40
May	10	5	124.16	12.42
June	13	3	288.35	22.18
Total	74	Actual = 14	918.94	12.42

The data indicates a significant reduction in the use of seclusion since the inspection in 2014. Comparable data for the period 1 January to 30 June 2014 shows 299 episodes of seclusion, totalling 4,153 hours. Inspectors commend this reduction in the use of seclusion.

Inspectors spoke to three patients who had previously been placed in seclusion, all of whom reported that their personal needs had been met.

No patients were in seclusion at the time of the inspection.

Restraints

The DHB provided Inspectors with a copy of its *Restraint Minimisation and Safe Practice Policy* (dated 19 June 2018). The policy did not indicate a review date.

Data supplied by the DHB showed that for the period 1 January 2018 to 30 June 2018, there were 123 episodes of restraint involving 14 patients. Three patients accounted for 80 of these episodes (65 percent).

A breakdown of the use of restraints is set out below:

Table 2: Restraint incidents 1 January - 30 June 2018⁶

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint	Seclusion
Patient 1	7	00	00	2	5
Patient 2	3	00	00	00	3
Patient 3	9	00	1	00	8
Patient 4	4	00	00	4	00
Patient 5	29	1	11	9	8
Patient 6	3	00	00	00	3
Patient 7	33	00	3	11	19
Patient 8	1	00	00	00	1
Patient 9	1	00	00	00	1
Patient 10	4	00	00	3	1
Patient 11	6	00	00	2	4

⁶ Inspectors note that restraint data provided by the DHB is incomplete in that the number of seclusion events recorded is fewer than those provided for seclusion episodes in Table 1.

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint	Seclusion
Patient 12	2	00	00	00	2
Patient 13	3	00	00	00	3
Patient 14	18	00	00	5	13

This data indicates a significant reduction in the use of restraint since the inspection in 2014. Comparable data for the period 1 January to 30 June 2014 showed 333 restraint episodes involving 14 patients, although one patient accounted for 228 of the episodes during this period.

A note on the door to the low-stimulus/admissions area read *'if patient is NOT secluded.....write: "Patient nursed in the admission area, unsecluded in S1/2/3" DO NOT WRITE nursed in open seclusion!'* The CNM explained to Inspectors that this instruction related to those instances when a patient is located in the de-escalation lounge/admissions area and the door to the main Unit remains open. However, were the patient to attempt to enter the Unit staff would attempt to persuade them not to. In such circumstances, if the patient is prevented from entering the Unit, by whatever means, Inspectors consider this environmental restraint and should be recorded as such.

Restraint training for staff

All Unit staff were up-to-date with Safe Practice Effective Communication (SPEC) training, with the exception of five staff for whom the training was scheduled for August 2018.

Electro-convulsive therapy (ECT)

There were no clients undergoing a course of ECT in the Unit at the time of the inspection.

Sensory modulation

The CNM informed Inspectors that patients' had used the Unit's sensory modulation room infrequently as, in accordance with the DHB's protocol,⁷ they were required to seek permission from staff to use it. Adopting a pragmatic approach, the CNM converted the room to a Comfort Room,⁸ which enabled patients' to have open access to the facility. Inspectors observed the Comfort Room in frequent use by patients throughout the inspection period and one patient reported to Inspectors the 'huge benefit' of having easy access to the room in order to 'calm down'. Inspectors endorse the approach adopted by the CNM, which has provided much benefit to patients.

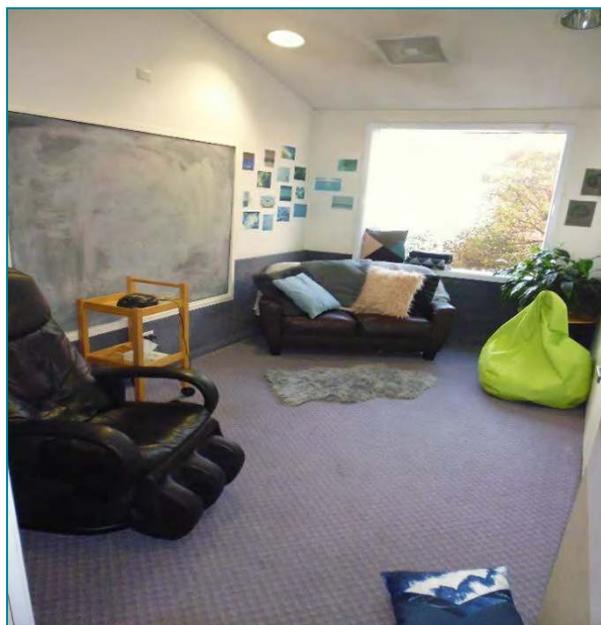


Figure 3: Comfort room

Patients' views on treatment

Patients informed Inspectors that staff treated them with kindness and respect and were interested in their wellbeing. They felt that they could approach staff if they had any concerns. Inspectors observed respectful interactions between patients and staff.

Patients' reported that staff were open and approachable when they wanted to discuss their legal status, and information is provided to them in a way that was easy to understand.

Staff were described by patients' as showing regard for their privacy, and Inspectors observed staff knocking on patients' bedroom doors before entering.

Some patients commented that they would like more to do on the Unit and have easier access to the outdoor area.

Inspectors attended the weekly patients' community meeting, facilitated by the OT. Patients were observed to be actively involved and minutes from previous meetings indicate a broad range of topics discussed, including: menu planning; bedroom maintenance issues; choice of Sky channels to purchase; and, the establishment of new therapeutic groups and activities.

⁷ Canterbury DHB. Sensory Modulation Protocol.

⁸ 'A therapeutic environment equipped with a range of furniture and sensory based resources that can be used with safety by the individual in an unsupervised manner'. Canterbury DHB. Sensory Modulation Protocol.

Recommendations – Treatment

I recommend that:

1. Patients with an intellectual disability should be accommodated in facilities which meet their needs.

Te Whare Manaaki comments

Accepted recommendation 1.

Recommendation 1 response:

The Forensic Service agrees with this recommendation. The inability to access the National Secure Intellectual Disability beds results in consumers with intellectual disability being admitted to the Forensic Service, which is unable to provide their rehabilitation needs.

Protective measures

Complaints process

Information about the complaints process⁹ is provided to patients in their admission pack and those patients to whom Inspectors spoke said that they knew how to make a complaint and felt supported by staff when assistance was sought. Inspectors spoke to a number of staff in relation to patient complaints and all were familiar with the process.

A copy of the complaints process was not displayed in the communal areas of the Unit. Inspectors consider that this would be a helpful addition to the general information on display for patients, particularly as some nurses informed Inspectors that the information given to patients on admission is often discarded.

Copies of the consumer response form ‘*Suggestions, Compliments and Complaints*’ were located alongside the complaints box and easily accessible by patients.

There were four recorded complaints, one of which included a compliment, in the six months preceding the inspection. All complaints were responded to in a satisfactory and timely manner. One patient informed Inspectors that she had been happy with the response she received to her complaint and with the process in general.

Contact details for District Inspectors, while on display in the staff office, were not displayed in an area easily accessible for patients. While all patients to whom Inspectors spoke said that

⁹ Canterbury District Health Board. Complaints Management Process: Patient and Whānau Information.

they had met with a District Inspector during their stay, Inspectors consider that it would be helpful for patients to have their contact details on display in the Unit.

Posters for the Health and Disability Commission's 'Code of Rights' were displayed in the Unit and contact details for the Health and Disability Advocacy service was provided in the patients' admission pack.

Records

There were 14 patients in the Unit during the inspection and the Inspectors checked all their files.

Nine patients were detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and five patients were detained under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

All files contained the necessary paperwork to detain [and treat] the patients in the Unit.

All patients have a Case Manager and an Associate Case Manager who developed a treatment plan with the patient. All files contained a signed copy of the patient's treatment plan and a copy was given to the patient.

Copies of patients' weekly clinical reviews written for the MDT were also contained in the files.

Recommendations – Protective measures

I recommend that:

2. Details of the complaints process and the contact details of District Inspectors are displayed in the Unit.

Te Whare Manaaki comments

Accepted recommendation 2

Recommendation 2 response:

Contact details of district inspectors are now displayed in the unit.

NPM further response:

I am pleased that the contact details for District Inspectors are now displayed in the Unit. However, details of the DHB's complaints process should also be displayed in the Unit.

Material conditions

Accommodation/sanitary conditions

The Unit was clean and tidy but somewhat tired in appearance. Some parts of the Unit had recently been repainted.

A large, combined lounge and dining room provided comfortable furnishings, a good level of natural light and a television. The Unit also contained two smaller lounges, which provided quiet spaces for patients and each had a computer. Containing a selection of books and board games, one of the small lounges also functioned as a library.

Inspectors had concerns about the lack of specific facilities for female patients and little flexibility in the building for creating any sense of separation from male patients. The two female patients residing in the Unit at the time of the inspection occupied bedrooms in the same corridor as male patients and used one of the general purpose shower rooms, albeit the facility had been set aside for their sole use. One of the small lounges had also been designated a 'Women's only lounge' between 1.00pm and 4.00pm daily.

Staff had identified one of the female patients as being particularly vulnerable and at risk from some of the male patients. The lack of a designated female area in the Unit placed an additional burden on staff because, in order to ensure the patient's safety, her allocated nurse was required to maintain line of sight observation when she was out of her bedroom.

Inspectors consider that the lack of specific accommodation and facilities on the Unit for female patients leaves this group of women with limited privacy and creates a potential risk to their safety.



Figure 4: Patient lounge and dining area



Figure 5: Smaller lounge/library with computer

Patients had their own bedroom with an integral toilet and hand washing facility, privacy screening, and sufficient storage for personal possessions. There was no night seclusion in the

Unit and patients could enter and exit their bedrooms at any time of the day or night. Inspectors commend this practice.

There was a sufficient number of showers in the Unit for the number of patients, and a laundry facility was available for those wanting to launder their own clothes.

Food

Meals were prepared in the hospital kitchen and transported to the Unit in a trolley. Patients had a choice of meals from a daily menu and special dietary needs were catered for. The quality and quantity of the food over the course of the inspection was satisfactory and patients were generally happy with the standard of the meals. Patients had not submitted any formal complaints about the food in the previous six months.

Breakfast was scheduled for 8.00am, lunch at 12.00pm and dinner was served at 5.30pm. Hot drinks and snacks were prepared for patients on two occasions in both the morning and the afternoon and once again during the evening. Patients did not have access to facilities to make their own hot drinks during the day, but were able to do so in the evenings in the OT room.

Recommendations – Material conditions

I recommend that:

3. Accommodation and facilities are provided for female patients that ensure their need for privacy and safety are met.

Te Whare Manaaki comments

Accepted recommendation 3.

Recommendation 3 response:

The Forensic Service agrees that this is a significant shortcoming.

If it is deemed that a female consumer is vulnerable or at risk from other consumers, a special 1:1 nurse will be allocated to the female consumer.

When the number of female consumers who do not need medium secure level of security are sufficiently high, a wing in Te Whare Hohou Roko is designated female only.

Activities and programmes

Outdoor exercise/leisure activities

A large outdoor area with adequate seating and shade is available for patients but it can only be accessed when two staff are available to supervise. This resulted in patients having restricted access to outdoor exercise and fresh air. With the exception of organised activities such as volleyball, the outdoor area was open only once during the inspection.

A weekly Hīkoi¹⁰ is organised for patients from the Unit and Te Whare Hohou Roko involving going out for a drive, walks and, occasionally, having lunch.

Some patients have leave privileges and are able to leave the Unit to undertake activities (both escorted and unescorted).

Two part-time Occupational Therapist's (OT) provide a structured programme of daily activities, which includes both individual and group work. Activities such as arts and crafts were available in the OT room, which also doubles as a drop-in centre in the evenings where patients and staff can get together. During an evening visit, Inspectors observed the room to be well attended.

A small kitchen is also available for patients in which the OT organises cooking sessions. Patients using the kitchen can do baking and cook meals, which they are able to share with another patient.



Figure 6: Occupational therapy room

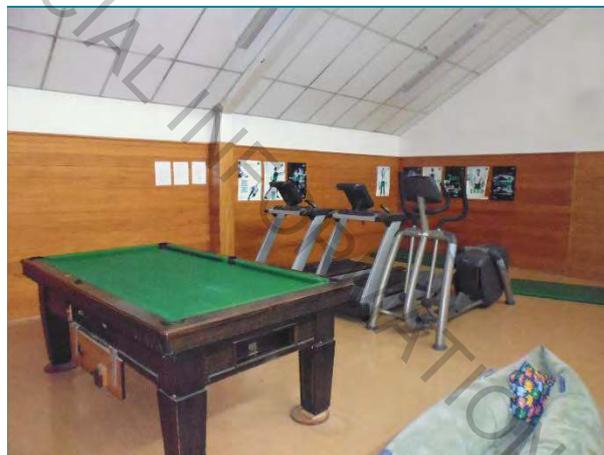


Figure 7: Patients' gym

Exercise equipment, table tennis and pool are available to patients in the Unit's gym.

¹⁰ To step, stride, march, walk. Māori Dictionary. Downloaded from:
<http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&keywords=hikoi>

Programmes

Several individual and group therapeutic programmes were organised by the Unit's social worker, OT and clinical psychologist. These included Anger Management, Violence Prevention and an Emotion Group.

Patients could attend a weekly adult education group on the Unit, facilitated by a tutor from Hagley College. Activities included scrabble, spelling and number games.

Cultural/spiritual support

A hospital chaplain attends the Unit weekly.

The Ngā Pūkenga Atawhai visits the Unit regularly to provide Māori cultural and spiritual support to patients and is involved in a number of activities such as orientation of new patients, the Hīkoi and meeting with patients in seclusion.

Recommendations – Activities and programmes

I recommend that:

4. All patients are able to access the outdoor area for at least one hour per day.

Te Whare Manaaki comments

Accepted recommendation 4.

Recommendation 4 response:

Staff aim to provide access to outdoor areas. Consumers identified risk and sufficient staff to support adequate safety of each consumer and staff is required for outdoor activity.

A proposed rebuild will incorporate an internal courtyard for consumers in high secure areas.

Communications

Access to visitors/external communication

There is a designated room for both domestic and legal visits located at the entrance to the Unit. The room is clean and tidy with adequate seating and good natural light.

Supervised visits take place between 10.00am and 3.00pm; unsupervised visits are from 10.00am to 8.00pm. Patients can have an unlimited number of visits but, owing to the limited availability of space, visits must be prearranged. For patients able to have unsupervised visits, the family room on Te Whare Hohou Roko is sometimes used. Patients told Inspectors that the appointment system worked well and they were able to have visits regularly.

There was a patients' telephone on the Unit. However, its location (just off the main corridor, opposite the nurses' station) offers little privacy for patients.

Patients are generally able to send and receive mail, unless otherwise directed by the MDT for clinical reasons or to protect members of the public.

The DHB has published a procedure¹¹ for the use of the internet by patients located in the forensic psychiatric service. The OT informed Inspectors that the MDT had approved 11 patients for supervised access to the internet. A computer is available for patients in both the small lounges and they can access the computer in the OT room. Patients use the internet for activities such as checking emails, online shopping, accommodation searches and obtaining song lyrics. Inspectors observed two patients using the internet during the inspection and commend the implementation of this facility for patients.



Figure 8: Visitors room



Figure 9: Patients' phone

¹¹ Procedures on Chromebook and Internet use within Secure Forensic Inpatient Units. Canterbury DHB

Recommendations – Communications

I recommend that:

5. Arrangements be made to ensure greater privacy for patients when using the telephone.

Te Whare Manaaki comments

Accepted recommendation 5.

Recommendation 5 response:

This is being addressed with the staff. Consumers can be given access to cordless phones and provided with private areas for phone conversations. On a case by case basis, risk management may result in supervised phone calls.

Health care

Primary health care services

On admission, all patients receive a physical examination by a House Surgeon and can access an on call House Surgeon for acute physical health needs at any time. For more long-standing health issues a General Practitioner (GP) attends one-day per week, and patients can obtain an appointment by first notifying the Unit staff. The patients that Inspectors spoke with commented that they were satisfied with the physical health care they received.

Patients' electronic records contained details of health interventions and there was evidence of routine health screening and dental checks occurring.

The hospital has an onsite dentist, who will review patients on the Unit but all treatment is completed in the dental unit.

A shared emergency trolley, containing oxygen and the defibrillator, is located on Te Whare Hohou Roko.

Recommendations – Health care

I have no recommendations to make.

Staff

Staffing levels/staff retention

Data provided by the DHB showed the Unit to have a multi-disciplinary staff complement (excluding medical staff) of 47.71 full time equivalent (FTE). The CNM informed Inspectors that there were no vacancies at the time of the inspection.

Nursing staff worked to a three-shift roster with a designated staffing level on each shift. However, the CNM informed Inspectors that for the previous two years he had rostered additional staff onto two of the shifts to manage effectively the acuity of the patients on the Unit and to ensure the appropriate balance of male and female staff. The CNM has submitted a business case to the DHB to increase the FTE by one nurse on both the A and the D shifts.

Table 3: Nursing staff shifts

Shift	Hours	Funded staffing (FTE)	Actual (FTE)
A shift	10.45pm to 7.15am	3	4 or 5
B shift	7.00am to 3.30pm	8	8
D shift	3.00pm to 11.00pm	5	6 or 7

The CNM informed Inspectors that the Unit does not currently employ Health Care Assistants but he may do so in the future to address the staffing shortage and need for more male staff.

All new nurses received a two-day orientation to the Unit, which included the allocation of a 'buddy'. Nurses Inspectors spoke with were positive about the orientation they had received.

The Clinical Nurse Specialist informed Inspectors that all staff are encouraged to participate in clinical supervision. In the case of new entrant registered nurses, they undertook 20 hours of supervision during their first year of practice.

The DHB has published a list of mandatory training for staff.¹² Training data for the Unit indicated that the majority of staff had undertaken the required mandatory training or have it scheduled in the near future. However, Inspectors observed this was not the case for some staff. In particular, the data indicated that six members of the control room staff were not up-to-date with their fire training. Staff said that this was because they were unable to leave their post for this training.

¹² Workforce Development Framework – Mandatory Courses 2017/2018

During the period 2016/17 to 2017/18, staff turnover on the Unit increased from approximately 22 percent to 40 percent. Whilst the CNM was able to offer some potential causes for this increase such as the loss of some older nurses, no systematic evaluation of the reasons for the increase in turnover had been undertaken.

Coupled with an increase in staff turnover, staff sickness levels had risen from 77.87 hours per FTE in 2015/16 to 111.13 hours per FTE in 2017/18, an increase of 42.71 percent. While casual nurses covered staff shortages, the CNM informed Inspectors that nurses were often required to work overtime or double shifts to ensure full staffing on the Unit. Inspectors observed first-hand the impact of staff sickness on the Unit. On day one of the inspection, three staff were off sick and this, combined with the running of the MDT, resulted in fewer staff on the Unit. Staff, at times, appeared to Inspectors to be under pressure.

Recommendations – Staff

I recommend that:

6. All staff complete the appropriate mandatory training and the required refresher sessions.
7. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

Te Whare Manaaki comments

Accepted recommendations 6 and 7.

Recommendation 6 response:

The Forensic Service Leadership team is addressing this recommendation.

Recommendation 7 response:

The Forensic Service Leadership team is addressing this recommendation.

Acknowledgement

I appreciate the full co-operation extended by the Clinical Nurse Manager and staff to my Inspectors and Advisor during their inspection of the Unit. I also acknowledge the work involved in collating the information requested.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 4: List of people who spoke with Inspectors

Senior Managers	Unit Staff	Others
General Manager	Patients	Chaplain
Director Area Mental Health Services (DAHMS)	Charge Nurse Manager	Ngā Pūkenga Atawhai
Clinical Director, Canterbury Regional Forensic Service	Consultant Psychiatrist	General Practitioner
Clinical Director, Intellectually Disabled Persons Health Services	Clinical Nurse Specialist	Quality and Patient Safety Team
Nursing Director, Forensic and Intellectually Disabled Services	Registered Nurses	Consumer Advisor
Director of Allied Health	Enrolled Nurses	NZNO Local representative
Quality and Improvement Manager	Housekeeper	NZNO Regional Officer
Pou Whirinaki	Occupational Therapists	Customer Services Coordinator - Complaints
People and Capability Advisor	Clinical Psychologist	
	Social Worker	

Appendix 2. Overview of OPCAT – Health and Disability places of detention

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT. Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

(d) a hospital

(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - a. for improving the conditions of detention applying to detainees;
 - b. for improving the treatment of detainees;
 - c. for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector’s (COTA). This is to ensure that there is a clear distinction between the Ombudsmen’s preventive monitoring function under OPCAT and the Ombudsmen’s investigation function under the Ombudsmen.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

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 **Ombudsman**

Fairness for all

.....
OPCAT Report

**Report on an unannounced inspection to
Psychiatric Service for Adults with an
Intellectual Disability (PSAID) Unit
(Hillmorton Hospital)
Under the Crimes of Torture Act 1989**

.....
30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of consumers in New Zealand secure hospitals.

From 23 to 27 July 2018, two Inspectors and a Specialist Advisor (to whom I have given authority to carry out visits on my behalf) visited the Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit) (the Unit) which is located in Hillmorton Hospital grounds.

Summary of findings

- There was no evidence that any consumers had been subject to torture, or other cruel, inhuman or degrading treatment or punishment.
- Positive feedback was received from family concerning the level of care provided to their family members.
- Staff and consumer relationships appeared respectful and positive.
- Leadership in the Unit was visible and staff feedback was positive in regards to the accessibility of senior staff.
- There was good attendance and representation at the Unit Multi-Disciplinary Team (MDT) meeting, and Clinical Review meetings.
- Consumers had their own bedroom and access to showers daily.
- Generally, consumers felt the food was good.
- Consumers could receive daily visits.

Issues that need addressing were as follows:

- The entrance door was regularly locked over the course of the inspection to prevent an informal consumer from leaving the Unit.
- An informal consumer was subjected to mechanical restraint when being transported to and from school.
- Seclusion and restraint data appeared inaccurate.
- Information on the complaints process was not readily available on the Unit.
- Informal consumers did not have consent to treatment documentation on their files.
- Advocacy services were unavailable to consumers and their family/whānau.

- The building was not fit for purpose and not able to adequately accommodate the mobility and physical issues faced by some consumers.
- Access to drinking water was problematic for some consumers.
- Consumers could not access fresh air daily.
- There were limited activities/programmes available in the Unit for consumers.
- Consumers did not have free access to the telephone.
- The referral process on admission to see the Pukenga Atawhai was not always followed.
- Staff retention was problematic.

Recommendations

I recommend that:

1. The practice of detaining informal consumers by locking the Unit doors should cease.
2. The practice of using mechanical restraint for the transportation of consumers without the legal authority to do so, should cease.
3. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.
4. The DHB's complaints process should be visible in the Unit and more accessible for consumers, taking in to consideration the specific needs of the population group.
5. Informal consumers have consent to treatment documentation on file.
6. Advocacy services should be available to consumers and their family/whānau.
7. The building is upgraded as a matter of urgency.
8. Consumers need to be able to easily access drinking water.
9. Consumers can freely access fresh air daily.
10. Opportunities for consumers to participate in activities and programmes are improved.
11. Consumers should be able to freely access the telephone.
12. The referral process to the Pukenga Atawhai is maintained and followed.
13. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

Suggestions for improvements

- Clean linen should be made available to consumers without the requirement to access it through staff request.

PSAID comments

The suggestion for improvement was not raised with staff during their unit visit.

Follow up visits will be made at future dates, as necessary, to monitor implementation of the recommendations.

What was working well

There were ongoing and close relationships with consumer's community providers.

Multi-disciplinary team (MDT) meetings were comprehensive and well attended. There were innovative approaches to providing integrated pathways of care that involved other service providers, particularly for people with multiple and complex needs.

Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection and provided an early opportunity for the Charge Nurse Manager (CNM) to offer any corrections or clarifications. Prior to this meeting, the Manager OPCAT provided high-level feedback of Inspectors initial findings for the four units inspected at Hillmorton Hospital to the General Manager (Mental Health Services), Director of Nursing and the Quality Manager.

Consultation

A draft copy of this report was forwarded to the Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

Facility Facts

Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit

The Unit is a 14-bed facility providing sub-acute and rehabilitation services to those consumers with a suspected and/or confirmed intellectual disability (ID) who experience mental illness.

The Unit uses a MDT approach to provide a comprehensive psychiatric assessment, monitoring and treatment of diagnosed or suspected mental illness in a person (aged 18 years and above) with an ID.

Referrals to PSAID are usually via the outpatient service however, the Unit does accept transfers from other inpatient units within the District Health Board's Specialist Mental Health Service and after hours' admissions come via the Crisis Resolution Service. Length of stay varies significantly. Duration of stay can vary from a few days to a number of months depending on factors that have contributed to the admission. The age, and level of physical and intellectual disability of consumers can vary greatly. Many consumers admitted to PSAID have limited or no verbal communication.¹

Region

Canterbury

District Health Board (DHB)

Canterbury

Operating capacity

15 (14 operational)

Last inspection

Announced visit – June 2009

Announced inspection – February 2014

¹ Information provided by Charge Nurse Manager.

The Inspection

The inspection of PSAID (the Unit) took place on 23 to 27 July 2018 and was conducted by two Inspectors (the Team).

Inspection methodology

At the commencement of the inspection the Inspectors met with the Charge Nurse Manager, before being shown around the Unit. During the inspection there were six consumers in the Unit, comprising three males and three females.

Inspectors were provided with the following information during the inspection:

- a list of consumers and the legislative reference under which they were being detained (at the time of the visit);
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in use of restraint and reasons for those not up-to-date;
- the number of complaints for the previous six months and the complaints policy;
- information for consumers on admission;
- visits policy; and
- activities programme.

Inspection focus

The following areas were examined on this inspection to determine whether there had been any torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on consumers.²

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

Seclusion/de-escalation

Restraints

Electro-convulsive therapy (ECT)

² Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, available at www.apt.ch.

Consumers' views on treatment

Family/Whānau views on treatment

Protective measures

Complaints process

Records

Material conditions

Accommodation

Food

Activities

Outdoor exercise/Leisure activities

Cultural/spiritual support

Communications

Access to visitors

Access to the telephone

Health care

Primary health care services

Staff

Personnel

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of managers, staff and consumers. Inspectors also spoke with family and whānau.³

Inspectors also reviewed records, were provided additional documents upon request, and observed the facilities and conditions.

³ A full list of persons spoken to over the course of the inspection can be found in Appendix 1.

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any consumers had been subject to anything that could be construed as torture, or other cruel, inhuman or degrading treatment or punishment.

Seclusion

Seclusion facilities

There was one seclusion room and one de-escalation room. Both rooms had en-suite facilities, privacy blinds, heating and ventilation, natural light and a means of raising the alarm. The clock in the seclusion room window was partly obscured meaning there was no adequate way for a consumer to remain oriented to time.

The de-escalation room (a decommissioned seclusion room) was used to accommodate consumers requiring a period of de-escalation rather than seclusion. The de-escalation lounge, which was clean and tidy, had soft furnishings and natural light, provided a low stimulus space for consumers to access. The entrance to the de-escalation area was difficult as it was through the staff corridor. There was no evidence to suggest that the seclusion room or de-escalation room were being used as consumer bedrooms.

During the inspection a consumer was observed by Inspectors in the de-escalation room following a period of unsettled behaviour. The consumer was accompanied in the area by a Health Care Assistant providing one to one care, thus ensuring the consumer was not left alone.



Figure 1: Seclusion room



Figure 2: De-escalation area

Seclusion incidents and policies

A copy of the DHB's 'Seclusion' policy was provided (April 2017). The policy did not include a review date.

Data provided by the DHB indicated that from 1 January to 20 June 2018 there had been 16 episodes of seclusion involving six consumers and a total seclusion time of 128 hours and 17 minutes. However, errors in reporting were noted by Inspectors, and attempts to clarify the data were unsuccessful.

The data indicates a significant reduction in the use of seclusion since a previous inspection in 2014. Comparable data for the six month period prior to the 2014 inspection showed 91 seclusion episodes involving 13 consumers and a total seclusion time of 278 hours.

There were no consumers in seclusion during the course of the five day inspection.

Table 1: Seclusion episodes 1 January - 20 June 2018

Month	Events	Number of consumers	Duration (hours/minutes)	Average duration (hours/minutes)
January	0	0	00:00	00:00
February	1	1	14:15	14:15
March	3	1	70:54	23:38
April	0	0	00:00	00:00
May	8	3	36:11	04:31
June	4	3	06:57	01:44
Total	16	Actual = 6	128:17	08:01

Restraints

An up-to-date copy of the DHB's 'Restraint Minimisation and Safe Practice' policy was provided (June 2018). The policy did not include a review date.

From January to June 2018 there were 70 episodes of restraint involving 15 consumers.

Night safety orders were not in use in the Unit. Consumers were able to exit their rooms freely, and could lock their doors from the inside if they chose.

Environmental restraint

PSAID is an open unit. Over the course of the inspection the entrance door was locked regularly to prevent an informal consumer from leaving the Unit.

The DHB's *'Restraint Minimisation and Safe Practice'* policy stated that:

'Locking an internal or external door, whereby it restricts a consumer's normal access to their environment, is defined as environmental restraint and is a reportable event'.

Staff on the Unit were aware of the practice of locking the entrance door to detain the informal consumer; the practice appeared to have become normalised.

The DHB's *'Locking Doors in Open Units'* policy stated that:

'Each single continuous episode of locked doors requires one Safety First Restraint Register form to be submitted for each consumer for whom environmental restraint has been deemed necessary'.

A blanket restraint form was submitted at the beginning of each month to capture all episodes of environmental restraint. The form was inaccurate.

Inspectors also noted that the doors to the Unit were regularly locked during the course of the inspection to prevent formal consumers from exiting. Inspectors enquired as to why the doors were locked. On one occasion, staff reported the door was locked as a consumer (who had leave) was reluctant to have his depot medication.

Mechanical restraint

Over the course of the inspection, Inspectors observed an informal consumer being restrained in a harness for daily transportation to school. The practice involved the key to the locked harness being given to the driver (out of reach of the consumer in the back seat). The arrangement had not been initiated by the Unit⁴ however, he was under their care, and therefore, responsible for his treatment. Inspectors could find no documentation relating to the approval of the application of the harness.

The consumer was not subject to any form of legislation, however given the nature of his illness and intellectual functioning his ability to consent to this form of restraint was questionable. Inspectors were unable to find evidence of welfare guardianship or enduring power of attorney in place with respect to consent to treatment being made on behalf of the consumer. Inspectors were concerned by this practice and the serious health and safety implications for the consumer, particularly if an accident were to occur.

Restraint training for staff

The Safe Practice Effective Communication (SPEC) training programme was launched in November 2016. It has been designed with service users' input, and has service users as

⁴ This transportation arrangement had been set up by the consumer's school.

trainers and members of the programme's governing body. The new initiative aims to provide national consistency and best quality, evidence-based therapeutic interventions for effectively reducing restraint and seclusion.⁵

Six staff were not up-to-date with their SPEC training. However, four staff had been booked to attend training in the coming weeks, one staff member was seconded elsewhere and Inspectors were advised the remaining staff member had resigned.

Electro-convulsive therapy (ECT)

No consumers were undergoing ECT at the time of inspection.

Clients' views on treatment

Inspectors spoke with a number of consumers. General feedback was that consumers were bored and did not have enough to do in the Unit.

Consumers were not familiar with the complaints process and access to the District Inspectors was via staff. When wanting to contact the District Inspectors a consumer said they asked staff who would phone on their behalf.

Consumers did not have any complaints about the food and confirmed they chose their own meals from the daily menu.

A consumer advised when wanting towels or clean bedding they ask staff as the doors to the lined cupboard are locked.

Family/whānau views on treatment

A family member spoken with by Inspectors described being, overall, impressed by the staff at PSAID and felt the family were generally kept included and informed in matters pertaining to their family member's care while in hospital. The family were invited to the three monthly clinical review meetings where in-depth discussion and treatment planning was undertaken, as observed by Inspectors.

Recommendations – Treatment

I recommend that:

1. The practice of detaining Informal consumers by locking the Unit doors should cease.

⁵ Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016*. Wellington: Ministry of Health.

2. The practice of using mechanical restraint for the transportation of consumers without the legal authority to do so, should cease.
3. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.

PSAID comments

Accepted recommendation 1 and neither accepted or rejected recommendations 2 and 3.

Recommendation 2 response:

The safety restraint is used in Special Education Services taxi only. It has been prescribed by a Special Education Services Occupational Therapist and agreed to by the consumer who uses it for his safe transport to school. The Special Education Services have been asked to provide the legal authority for this.

The Ministry of Health Guidelines website <https://www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/equipment-and-modifications-disabled-people/vehicle-modifications-disabled-people> provides the following: An occupational therapist can help you to find the best way to get around the community including driving a modified vehicle, being a passenger in a modified vehicle or other options.

- *“If you’re caring for a disabled child who lives with you their safety needs as a passenger will be assessed. This may include seating, safety restraints, ramps or hoists and safe ways of transporting wheel chairs”.*

NPM further response:

I remain concerned at the significant safety issues for a patient restrained in the back seat of a van without the means to extricate themselves in the event of an accident.

I am uncertain a patient with a significant intellectual disability is able to agree to this form of restraint. At the time of inspection there was no evidence of welfare guardianship in place to support this decision making on behalf of the patient.

Recommendation 3 response:

Two robust systems are in place. These are the South Island Safety1st for reporting an event and Healthlinks the clinical information system which records the hours of an event. Both are necessary for appropriate checking. Monitoring is undertaken by Informatics staff. Safety 1st and Healthlinks are not connected therefore human error can occur.

Protective measures

Complaints process

The complaints process was not readily available to consumers in the Unit. The complaints process, including complaint forms, was attached to the wall behind a table and chairs and partly obscured by curtains. Given the intellectual and physical challenges often faced by consumers within the Unit the current complaint process was not easily accessible.

There had been one complaint in the previous six months. The complaint received was not responded to within DHB timeframes⁶ however, the response included an apology for the delay in reply. The consumer's complaint was individualised and addressed in detail. Inspectors had no concerns with the quality of the response.

Rights and advocacy information, including induction information, was kept in the staff office and was inaccessible to consumers and their family/whānau. There was no advocacy service available in the Unit; the position had been vacant for 18 months.



Figure 3: Location of complaint box



Figure 4: Advocacy information (staff office)

⁶ The DHB Complaints Management Process states complaints will be investigated within 20 working days from the date of acknowledgement.

Records

There were six consumers in the Unit over the inspection period (one consumer was on overnight leave during this period). Inspectors checked all of their files.

Five consumers were being detained and treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Two were informal, and therefore not required under legislation to remain on the Unit or accept treatment.

All files contained the necessary paperwork to detain and treat the consumers in the Unit who were under the Mental Health (Compulsory Assessment and Treatment) Act 1992. However, the two informal consumers did not have consent to treatment documentation on file.

Recommendations – Protective measures

I recommend that:

4. The DHB's complaints process should be visible in the Unit and more accessible for consumers, taking in to consideration the specific needs of the population group.
5. Informal consumers have consent to treatment documentation on file.
6. Advocacy services should be available to consumers and their family/whānau.

PSAID comments

Accepted recommendations 4, 5 and 6.

Recommendation 4 response:

Forms are accessible now.

Material conditions

Accommodation

The Unit, set in the grounds of the Hillmorton Hospital was generally clean and tidy however, no longer fit for purpose. Built in the 1970s, the Unit lacked space to de-escalate consumers and therefore incompatible with modern treatment practice.

The Unit was dated and tired and did not promote optimal opportunities for wellness due to its environmental constraints. Long, narrow corridors hindered good line of sight from the nurse's station, and staff felt that the physical environment was not conducive to recovery.

The Unit had lost a portion of its floor space to the neighbouring Assessment, Treatment and Rehabilitation (AT&R) Unit. This was to provide a separate annex area for a high and complex needs patient.⁷ The reduction of floor space was felt by staff to have had a negative impact on an environment already restricted in space. There were inadequate areas for individual consumers to have space and time to themselves other than their bedrooms.

Although basic, bedrooms were clean and had sufficient storage space for personal items. Bedroom doors could be locked; alarms alerted staff when consumers exited their room during the night.

Although there were adequate bathroom facilities for the number of consumers, shower rooms were small and mechanical aids such as hoists difficult to manoeuvre.

There were several lounges and a shared dining room/kitchen with the AT&R Unit.

Consumers had access to laundry facilities on the Unit.



Figure 5: Typical bedroom



Figure 6: Main lounge

Food

Consumers had a daily choice of meals which were transported from the main hospital kitchen. Food was of a satisfactory standard. It was apparent to the Inspectors that individual consumer's tastes and dietary requirements were considered and accommodated for with evidence of individualised meal plans, including preferences, within files. The dietician had

⁷ AT&R Unit refer to consumers as patients.

been involved in the development of individual meal plans (Dietary Prescriptions) for consumers.

Inspectors noted the water fountain was not easily accessible for people with mobility issues and there were no cups available within easy reach.

Breakfast was scheduled for 8.00am, lunch at 12.00pm and dinner was served at 5.30pm.

Recommendations – Material conditions

I recommend that:

7. The building is upgraded as a matter of urgency.
8. Consumers need to be able to easily access drinking water.

PSAID comments

Accepted recommendation 7 and neither accepted or rejected recommendation 8.

Recommendation 7 response:

Access to funding for significant building upgrades/rebuilds is governed by national capital processes. Canterbury DHB acknowledges that these buildings are substandard and intends to develop a facilities case for the Hillmorton campus within the next 12 months.

Recommendation 8 response:

There is access to cold water. Consumers are regularly offered hot drinks and are provided with hot drinks when they request one. Boiling water is not freely available due to the potential risk to consumers and staff.

NPM further response:

A water fountain without cups was considered problematic by my Inspectors for those patients with mobility issues.

Activities and programmes

Outdoor exercise/leisure activities

The opportunity for outdoor exercise was limited due to the regular practice of locking the courtyard doors and entrance door. The internal courtyard was locked at the commencement of the inspection due to a reported rodent infestation, however it was unlocked on the second day of inspection and then locked again on subsequent days.

The courtyard itself was stark, poorly maintained, had limited furniture and limited shade for protection from the sun. Inspectors were of the view that the courtyard was not promoted or facilitated for consumer use and was therefore rarely used. However, consumers were able to walk around the hospital grounds as their leave status and staffing allowed.



Figure 7: External garden



Figure 8: Internal courtyard

Leisure activities appeared to be restricted to completing jigsaw puzzles and watching television in the communal lounge area. The extended absence of the Occupational Therapist (OT) appeared to be impacting on opportunities for consumers to access purposeful activities and programmes.

The occupational therapy room was large with a kitchen, laundry, computers and various materials available for creative activities.

A neighbouring unit had a gym that consumers were reportedly welcome to use however, it was not clear to Inspectors how often the gym was utilised by consumers from the Unit.

Despite not having an OT during the course of the inspection period it was pleasing to observe an interactive art programme taking place which was organised by nursing staff. Consumers appeared to be enjoying the opportunity to participate.

Programmes

There were limited programmes available to consumers due to the vacant psychologist position; which had been vacant for over 12 months.

Cultural/spiritual support

The specialist Māori mental health service: Te Korowai Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health service for Māori. Ngā Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori consumers. Their role was specific to providing cultural assessments that sat alongside the clinical assessment and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work.⁸

The Pukenga Atawhai is employed one and a half days a week within the Intellectually Disabled Persons Health Service (IDPH). Part of the role is to engage with people who identify as Māori who are admitted to the Unit. Inspectors reviewed a number of admission checklists and noted one consumer had not been referred by the Unit to the Pukenga Atawhai.

Inspectors were pleased to hear that the Pukenga Atawhai felt the role was respected and valued by clinical teams within the service.

There was a part-time chaplain (three days a week) available at Hillmorton Hospital. The chaplain did not have a set timetable for visiting the Unit. Staff report the chaplain would visit the Unit if requested. The contact information for the chaplain was kept in the staff office and inaccessible to consumers. Chaplaincy services were not well developed in the Unit.

⁸ A holistic health model developed by Professor Mason Durie encapsulating a Māori view of health and wellness.

Recommendations – Activities and programmes

I recommend that:

9. Consumers can freely and regularly access fresh air.
10. Opportunities for consumers to participate in activities and programmes are improved.
11. Referral process to the Pukenga Atawhai is adhered to.

PSAID comments

Accepted recommendations 9, 10, and 11.

Communications

Access to visitors/external communication

Visiting times on the Unit were 10am to 8pm however, these times appeared to be flexible. There was no requirement to book visits in advance.

Inspectors were concerned that consumers were unable to access the phone independently of staff as the telephone was based in the staff office.

Consumers could send and receive mail daily.

Recommendations - Communications

I recommend that:

12. All consumers should be able to freely access the telephone.

PSAID comments

Accepted recommendation 12.

Recommendation 12 response:

Consumers currently have access to a mobile phone. Options to have a phone accessible to all is challenging in the current environment due to the need for a private area.

NPM further response:

The mobile phone is accessible through staff only. I support changes to the environment to facilitate improved independence and privacy for patients when using the telephone.

Health care

The Consultant Psychiatrist had a comprehensive knowledge of the consumers' primary health care needs. MDT meetings were well attended and referrals for further investigations were actioned. A house surgeon saw new admissions for a physical examination and an on call house surgeon could review consumers for acute physical health issues.

A General Practitioner (GP) was employed one day per week providing cover to five units on the hospital campus including PSAID. Consumers could ask to be seen by the GP by notifying the Unit staff. The GP would see consumers predominantly for longer-term health issues and health promotion.

The hospital had a dentist onsite who reviewed consumers in the Unit. Any required treatment was carried out in the dental department.

Recommendations – Health care

- I have no recommendations to make.

Staff

Personnel

A theme of the inspection was the positive feedback received from staff in relation to the leadership on the Unit, accessibility and approachability of senior staff, and the in-depth knowledge senior staff had of consumers in the Unit which in turn promoted continuity and consistency of care.

Sick leave within the Unit was high. In the 2017/2018 financial year, of the 22.67 full time equivalent (FTE) staff employed, there was 152.39 hours per FTE of sick leave equating to over 3.8 weeks per staff member. An increase in 1.5 weeks from the previous financial year.⁹

Staff turnover within the Unit was trending upward from 12 percent in the 2015/2016 financial year, 31 percent in 2016/2017 to 36 percent in the 2017/2018 financial year.

Inspectors were concerned the high level of sick leave taken by staff and the upward trend of staff turnover had the potential to negatively impact on consumer's care and treatment.

⁹ The 2015/2016 financial year recorded 112.19 hours per FTE of sick leave per year or 2.8 weeks.

Unit staff advised they were, on occasion, re-deployed to other units within the hospital at short notice. This practice was observed by Inspectors during the visit when a supernumerary manager was required to take a consumer caseload to cover the staffing shortfall.

The Unit routinely accepted sleepovers¹⁰ reportedly with little notice. Staff spoken with describe this as unsettling for both consumers and staff.

Recommendations – Staff

I recommend that:

13. The reasons for staff resignations should be analysed, and where necessary, appropriate remedial action be implemented.

PSAID comments

Accepted recommendation 13.

Acknowledgement

I appreciate the full co-operation extended by the Charge Nurse Manager and staff to my Inspectors and Advisor during their visit to the Unit. I also acknowledge the work involved in collating the information requested.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

¹⁰ Sleepovers involve consumers having to move to other units to sleep; returning to their ward in the morning.

Appendix 1. List of people who spoke with the inspectors

Table 2: List of people who spoke with Inspectors

Senior Managers	Unit staff	Others
General Manager (MHS)	Consumers	Customer Services - Complaints
Quality Improvement Manager	Registered Nurses	Chaplain
Pou Whirinaki	Enrolled Nurses	Quality and Patient Safety Team
Director Area Mental Health Services	Health Care Assistants	Learning and Development
Director of Nursing	Housekeeper	Consumer Advisor
Director of Allied Health	Occupational Therapist	Family Advisor
People and Capability Advisor	Family/Whānau	NZNO local delegate
Clinical Director – Intellectually Disabled Health Persons Health Service	Psychiatrist	NZNO Regional Officer
Nursing Director - Forensic and IDPHS	Ngā Pukenga Atawhai	
Clinical Director – Canterbury Regional Forensic Service)	Union Representative	
	General Practitioner	
	District Inspector	
	Social worker	
	Care Managers	

Appendix 2. Overview of OPCAT – Health and Disability places of detention

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT. Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

- (d) a hospital*
- (e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - a. for improving the conditions of detention applying to detainees;
 - b. for improving the treatment of detainees;
 - c. for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector’s (COTA). This is to ensure that there is a clear distinction between the Ombudsmen’s preventive monitoring function under OPCAT and the Ombudsmen’s investigation function under the Ombudsmen.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

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 **Ombudsman**

Fairness for all

.....
OPCAT Report

**Report on an unannounced inspection to
Te Whare Hohou Roko (Extended Care
Secure Unit)
(Hillmorton Hospital)
Under the Crimes of Torture Act 1989**

.....
30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the general conditions and treatment of clients in New Zealand secure hospitals.

On the 25 and 26 July 2018, two Senior Inspectors and a Specialist Advisor (to whom I had given authority to carry out this visit on my behalf) visited Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit), which is located in Hillmorton Hospital grounds.

Summary of findings

- There was no evidence that any clients had been subject to torture, or other cruel, inhuman or degrading treatment or punishment.
- Paperwork was up to date and well maintained.
- Files contained the necessary authorisations to detain and treat the clients in the Unit.
- Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns.
- Inspectors observed good client/staff relationships with respectful and meaningful interactions taking place.
- Clients had their own bedroom which they could lock, if they chose to and had access to clean bedding.
- Clients could access the external garden/courtyard throughout the day.
- The Unit was clean, tidy and reasonably well maintained.
- There was a selection of programmes/activities on offer to clients.
- Clients were invited to attend weekly resident's meetings to discuss Unit issues.
- Clients received a copy of their multi-disciplinary team (MDT) minutes.
- Clients were afforded privacy when using the telephone.
- Clients had ready access to refreshments.

The issues that need addressing were as follows:

- There was insufficient hot water for showers due to a faulty hot water system.
- There was no separation between male and female accommodation.

Recommendations

I recommend that:

1. The hot water system in the Unit is repaired or replaced to ensure it operates efficiently.
2. Accommodation and facilities are provided for female clients that ensure their need for privacy and safety are met.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

What was working well

All recommendations from my 2016 inspection report had been implemented to a high standard.

The Unit worked collaboratively with clients and their family and whānau. The Unit utilised a whānau travel fund to support families travelling significant distances to visit clients; this assisted maintenance of important family connections.

The Responsible Clinician (psychiatrist) was based in the Unit which facilitated effective and timely communication with staff and clients. The Responsible Clinician also accompanied clients on ground leave. Inspectors supported the move from a primarily medicalised model to more person-centred and holistic approach to client care.

There was evidence of good working relationships with community organisations and the Probation Service.

The Unit employed interpreter services when required and provided English language courses.

The Unit was proactive in supporting healthy food options, whilst allowing clients the autonomy to make their own decisions.

All clients had some form of Unit leave.

There was evidence of ongoing cultural input and responsivity. Nga Pukenga Atawhai supported some clients through the admission process and throughout their recovery (which involved transitioning to less restrictive units).

A part-time General Practitioner (GP) was based in the Unit to address client's physical health needs.

Feedback meeting

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection and provided an early opportunity for the Acting Charge Nurse Manager (CNM) to offer any corrections or clarifications. Prior to this meeting, the

Manager OPCAT provided high-level feedback of Inspectors' initial findings for the four units inspected at Hillmorton Hospital (Mental Health Services) to the General Manager, Director of Nursing and the Quality Manager.

Consultation

A draft copy of this report was forwarded to Te Whare Hohou Roko (Extended Care Secure Unit) for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

Facility Facts

Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit)

The Unit is one of three Regional Forensic Psychiatric Service Mental Health Inpatient Units on the Hillmorton Hospital grounds. The Unit assesses and treats people that have either acted violently in the context of mental disorder or who may be at risk of doing so. It also caters for prisoners that require inpatient treatment.

The Unit provides specialist ongoing treatment for clients who have a diagnosed severe and enduring mental illness. The Unit's Service Provision Framework provides for rehabilitation opportunities depending on clinical, legal and individual assessment for clients to develop skills that promote positive life change.

Te Whare Hohou Roko is a locked unit. The average length of stay is three to four years.

District Health Board (DHB)

Canterbury

Operating capacity

Nine

Clinical Nurse Manager (CNM)

Kathryn Woodall

Director Area Mental Health Services (DAMHS)

Dr Erik Monasterio

Last inspections

Unannounced inspection – April 2016

Unannounced inspection – August 2012

Announced visit – May 2008

The Inspection

The inspection of Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit) took place on 25 and 26 July 2018 and was conducted by two Senior Inspectors and a Specialist Advisor (the Team).

Inspection methodology

At the commencement of the visit the Team met with the Acting Clinical Nurse Manager before being shown around the Unit. During the inspection, there were nine clients in the Unit comprising seven males and two females.

Inspectors were provided with the following information during the visit:

- a list of clients and the legislative authority under which they were being detained (at the time of the visit);
- details on the use of seclusion and restraint for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in the use of restraint and reasons why some staff training was not up to date;
- the number and a sample of complaints for the previous six months and the complaints policy;
- information for clients on admission;
- the activities programme; and
- staff retention and sickness for the past three years.

Inspection focus

The following areas were examined on this inspection to determine whether there had been any torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on clients.¹

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

Seclusion

Restraints

Electro-convulsive therapy (ECT)

¹ Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, available at www.apt.ch.

Clients' views on treatment

Protective measures

Complaints process

Records

Material conditions

Accommodation

Food

Activities

Outdoor exercise

Leisure activities

Communications

Access to visitors

Access to the telephone

Health care

Primary health care services / medication

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to a number of managers, staff and six clients. Family and whānau were also spoken with.²

Inspectors also reviewed records, were provided additional documents upon request, and observed the facilities and conditions.

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any clients had been subject to torture, and other cruel, inhuman or degrading treatment or punishment.

² For a full list of people spoken with by the Inspectors and Specialist Advisor see Appendix 1.

Seclusion

Seclusion facilities

The Unit did not have a seclusion facility. If a client required seclusion they would be moved to a seclusion room in Te Whare Manaaki (which was located in the building next to the Unit).

There was no record of any client being placed in seclusion in the previous 12 months.

Restraints

There were no reported incidents of restraint for the previous 12 months.

From the information provided, it appeared that the majority of staff in the Unit were up to date with their Safe Practice and Effective Communications (SPEC) training. Three staff had been unable to attend the training due to sickness, however they were scheduled to undertake training in September 2018.

Electro-convulsive therapy (ECT)

There were no clients undergoing a course of ECT treatment in the Unit at the time of the inspection.

Clients' views on treatment

Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns. Inspectors observed good client/staff relationships with respectful interactions taking place.

Clients reported that they were treated with respect and their privacy was maintained. Clients had their own bedroom, which they could lock if they chose to. Staff were observed knocking prior to entering bedrooms.

Clients could access the external garden/courtyard during the day. There were no complaints to Inspectors about the food, access to clean bedding, laundry facilities, the telephone or access to family or friends. Clients were positive about the programmes and leisure activities available to them, which included daily walks, art sessions, education and horticulture. Some clients attended the Alcohol and Other Drugs (AOD) and Emotions Programmes.

Unit community meetings were scheduled to occur twice a week. These meetings were minuted. Planned Unit activities as well as cooking rosters were discussed. Meetings covered a range of issues from new arrivals, food quality and activities, as well as discussion of current affairs.

Clients had access to both the Consumer Advisor and Family Advisor. The Unit was pro-active in maintaining and strengthening family and whānau contact.

Recommendations – Treatment

I have no recommendations to make.

Protective measures

Complaints process

A copy of the DHB complaints process was provided to Inspectors. Details of the complaints process were readily available in the Unit and contact details for District Inspectors were displayed in an area easily accessible to clients. The Health and Disability Commission's advisory posters were visible throughout the Unit.

There were ten recorded complaints made by four clients in the Unit for the six months preceding the visit. A sample of these complaints were reviewed; they were dealt with in a timely and satisfactory manner.

Records

There were nine clients in the Unit on the day of the visit. Inspectors reviewed all client's files.

Three clients were being detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and six under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Section 76 Mental Health Act reviews (Certificate of Clinical Review of Conditions of Patient Subject to Compulsory Treatment Order) were in date.

All files contained the necessary documentation authorising the detention [and treatment] of the clients in the Unit.

Client's family and whānau contacts and associated levels of disclosure were comprehensive and clearly documented on file and signed by both the client and staff.

The Inspectors attended multi-disciplinary team (MDT) meetings and case conferences and considered them to be comprehensive, well-attended and well-documented. An effective multi-disciplinary approach with client involvement was apparent.

Recommendations – Protective measures

I have no recommendations to make.

Material conditions

Accommodation

Set in the grounds of Hillmorton Hospital, the Unit, both inside and out, was clean and tidy and had an open, spacious feel to it. However, aspects of the Unit's infrastructure such as heating and the hot water system were reportedly not operating at optimal level. Both staff and clients reported that the hot water system was not functioning effectively, resulting in a lack of available hot water for showers for clients.

There were nine bedrooms (all with en-suite facilities). Rooms were of a reasonable size with adequate storage and natural light. Bedrooms could be locked from the inside and had curtains for privacy. The Unit did not use Night Safety Orders.³

There was no separate accommodation area for female clients, which presented challenges for both clients and staff. Although female clients were in rooms in close proximity to one another, this provision did not adequately address issues around safety and privacy.

Clients had access to clean bedding on request and laundry facilities at their disposal.



Figure 1: Typical bedroom



Figure 2: En-suite bathroom

There were several quiet areas and three TV lounges which consisted of a general lounge and separate female and male lounges. All were well-maintained.

³ Night Safety Orders - the practice of locking the service users' bedroom door overnight for security/safety reasons.

Food

Meals were prepared in the main hospital and brought to the Unit in a trolley. Clients had a choice of meals from a daily menu. The quantity and quality of the food during the visit was satisfactory. Clients with whom we spoke did not raise concerns about the meals.

Breakfast took place from 8.00 to 8.30am, lunch at 12pm and the evening meal from 5pm. Supper was also provided. Clients had access to refreshments at all times. All meals were served in the dining area.

The Acting Charge Nurse Manager reported that the Unit hosts BBQ and take away evenings on a regular basis.

Recommendations – Material conditions

I recommend that:

I recommend that:

1. The hot water system in the Unit is repaired or replaced to ensure it operates efficiently.
2. Accommodation and facilities are provided for female clients that ensure their need for privacy and safety are met.

Te Whare Hohou Roko comments:

Accepted all recommendations.

1. Accepted. A business case for several repairs to the building, including the hot water system has been put forward for consideration. Water temperature is regularly checked and is within an acceptable range.

2. Accepted. The Forensic Service agrees that this is a significant shortcoming. All consumers have individual bedrooms with ensuites and are able to lock the bedroom door from the inside. There is a female only lounge. When female consumer numbers are sufficiently high a wing is designated female only.

Activities

Outdoor exercise

Clients had open access throughout the day to a spacious, well-maintained garden with adequate seating and shade.



Figure 3: Garden



Figure 4: Courtyard

Leisure activities/programmes

A full-time Occupational Therapist provided a wide range of programmes and leisure activities, either individually or in groups, to those clients well enough to access them, including community outings and an emotions group.

Clients could access education classes off the Unit.

Clients had access to a selection of gym equipment (in the Unit) and a large sports hall (shared across the Hillmorton site).

A well-presented sensory modulation / comfort facility was available and clients regularly accessed this area.

A moderate sized activities room also doubled as a drop in centre/meeting room where clients could meet and discuss issues with staff or meet with other clients and undertake art and craft activities.

A pool table was also available to clients in the Unit.

Inspectors had no concerns with clients' access to programmes and leisure activities.

Recommendations – Activities

I have no recommendations to make.

Communications

Access to visitors/external communication

Clients could receive visitors if they choose. Visits took place in one of two private rooms leading off the main foyer. There was flexibility around visiting times depending on the visitors' personal circumstances. Visitor rooms were clean and tidy.

There was practical proactive support in place for families in terms of funding for facilitating travel to the Unit. The Unit's Social Worker ensured that family connections were maintained. Strong family collaboration in client care was encouraged and evident.

A telephone was available for clients in the Unit. A cordless phone was available, which would receive incoming calls only, so clients could have telephone conversations in private.

Clients had access to computers in the Unit; a policy had been developed to support client's computer use.

Inspectors had no concerns with clients' access to family and friends, and acknowledge the pro-active approach to maintaining family and whānau contact with the Unit.

Recommendations – Communications

I have no recommendations to make.

Health care

A GP worked one day a week in the Unit and was familiar with the client's physical health needs. There was evidence that clients received regular health reviews, and health promotion education. Inspectors had no concerns in relation to the provision of healthcare to clients.

Recommendations—Health care

I have no recommendations to make.

Acknowledgement

I appreciate the full co-operation extended by the Acting Charge Nurse Manager and staff to my Inspectors and Advisor during their visit to the Unit. I also acknowledge the work involved in collating the information requested.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 1: List of people who spoke with Inspectors

Management and other service providers	Unit and other
Acting Charge Nurse Manager and Charge Nurse Manager	Clients
Quality Improvement Manager	Clinical Nurse Specialist
Pou Whirinaki	Registered Nurses
DAHMs	Enrolled Nurses
Director of Nursing	Health Care Assistants
Director of Allied Health	Housekeeper
People and Capability Advisor	Occupational Therapist
Clinical Director – Intellectually Disabled Persons Health Service	Family/whānau
Nursing Director - Forensics and Intellectually Disabled Persons Health Service	Psychiatrist
Clinical Director – Canterbury Regional Forensic Services	Pukenga Atawhai
Customer Services Coordinator– Complaints	NZ Nursing Organisation, local delegate
Chaplin	NZ Nursing Organisation Regional Officer
Quality and Patient Safety Team	Visiting General Practitioner
Learning and Development	Email contact with District Inspectors
Coordinating Consumer Advisor	Coordinating Family Advisor

Appendix 2. Overview of OPCAT – Health and Disability places of detention

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

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- (d) a hospital*
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Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - a. for improving the conditions of detention applying to detainees;
 - b. for improving the treatment of detainees;
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Under COTA, NPMs are entitled to:

3. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
4. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
5. interview any person, without witnesses, either personally or through an interpreter; and
6. choose the places they want to visit and the persons they want to interview.

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 **Ombudsman**

Fairness for all

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OPCAT Report

Report on an unannounced inspection
to the Assessment, Treatment and
Rehabilitation (AT&R) Unit
(Hillmorton Hospital)
Under the Crimes of Torture Act 1989

.....
30 October 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of patients in New Zealand secure hospitals.

From 23 to 27 July 2018, two Inspectors (to whom I have authorised to carry out visits on my behalf) visited the Assessment, Treatment and Rehabilitation (AT&R) Unit (the Unit) which is located in Hillmorton Hospital grounds.

Summary of findings

- There was no evidence that any patients had been subject to torture, or other cruel, inhuman degrading treatment or punishment.
- Staff were committed to providing quality care in what was often, difficult circumstances.
- The Unit had implemented initiatives to reduce seclusion and restraint events, and a positive approach to de-escalate was evident.
- Files contained the necessary paperwork to detain and treat the patients in the Unit.
- Multi-Disciplinary Team (MDT) meetings were holistic and well led.
- Patients had their own bedroom and access to showers daily.
- Cultural engagement with patients was active and visible.
- Patient's physical health was monitored throughout their admission.

Issues that need addressing were as follows:

- The location of the seclusion room and de-escalation area was problematic, and compromised seclusion practice.
- Seclusion data was inaccurate.
- The complaints process was not easily accessible in the Unit.
- Patient advocacy services were unavailable in the Unit.
- Patients were not routinely given a copy of their care plans.
- The Unit was no longer fit for purpose, and general maintenance was poor.
- The Unit was unable to provide gender specific accommodation areas.
- Patients were unable to freely access fresh air daily.
- Patients were unable to access programmes due to a number of key staff vacancies.

- Access to the telephone was only available through staff facilitation.
- Staff were not sufficiently trained in working with high and complex needs.
- Not all staff had the necessary knowledge and skills to deal with the patient group.

I recommend that:

1. Seclusion practice, including access to the seclusion room, should be reviewed.
2. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.
3. The complaints process needs to be made available in all areas of the Unit.
4. Advocacy services needs to be made available to patients as a matter of urgency.
5. Patients should receive an up-to-date copy of their care plan in a format they can understand.
6. The building is upgraded as a matter of urgency.
7. Accommodation and facilities are provided for female patients that ensure their needs for privacy and safety are met.
8. Patients can freely access fresh air daily.
9. Opportunities for patients to participate in programmes are increased.
10. Patients should be able to freely access the telephone.
11. Staff training to increase knowledge and skills for working with patients with high and complex needs to be enhanced.

Suggestions for improvements

- Clean linen should be made available to consumers without the requirement to request it from staff.
- Carpeting in the hallway should be replaced, and minor maintenance issues addressed.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

What was working well

Patient/staff relationships were positive with respective interactions taking place.

The Unit took a proactive approach to reducing seclusion and restraint.

Cultural engagement with the Pukenga Atawahi was working well and showed a strong working relationship between the two services.

Discharge planning was well established.

Feedback meetings

A feedback meeting took place before the conclusion of the inspection. The Inspectors outlined the initial findings of the inspection to the Acting Charge Nurse Manager (CNM) and sought any corrections or clarifications. Prior to this meeting, the Manager OPCAT provided high-level feedback of Inspectors' initial findings for the four units inspected at Hillmorton Hospital to the General Manager (Mental Health Service), Director of Nursing and the Quality Manager.

Consultation

A draft copy of this report was forwarded to the Assessment, Treatment and Rehabilitation (AT&R) Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

Facility Facts

Assessment, Treatment and Rehabilitation Unit (the Unit)

The Unit, located in the grounds of Hillmorton Hospital, provides comprehensive behavioural assessments and treatment for adults with an intellectual disability, and significant challenging behaviour.

Patients who are involved in the criminal justice system or remanded by the Courts under the Intellectual Disability (Compulsory Care and Rehabilitation (IDCC&R)) Act are admitted to the Unit via the Forensic Coordination Service (Intellectual Disability) (FCS (ID)).

Individuals can also be admitted under the Mental Health (Compulsory Assessment and Treatment) Act.

The Unit was divided into two areas:

- the main Unit; and
- the Annex.

The Annex, a sectioned off area of the Unit, was introduced to assist in managing an assaultive patient.

Region

South Island

District Health Board (DHB)

Canterbury

Operating capacity

10 (although capped at seven for safety reasons). The Unit was not accepting any new admissions at the time of the inspection due to the complexity and makeup of the patient group.

Acting Charge Nurse Manager

Keith Knight

Director Area Mental Health Services (DAMHS)

Dr Peri Renison

Last inspection

Announced visit – July 2014

Announced inspection - May 2010

Unannounced visit - July 2008

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The Inspection

The inspection of the Unit took place on 23 to 27 July 2018 and was conducted by a Senior Inspector and Inspector (the Team).

Inspection focus

The following areas were examined on this occasion to determine whether there had been any torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on patients.¹

Treatment

Torture, or other cruel, inhuman or degrading treatment or punishment

Seclusion/de-escalation

Sensory modulation

Restraint

Environmental restraint

Protective measures

Complaints process

Records

Material conditions

Accommodation

The Annex

Food

Activities

Outdoor exercise/leisure activities

Programmes/therapeutic activities

Cultural/spiritual support

¹ Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, available at www.apt.ch.

Communications

Access to visitors/external communications

Health care

Primary health care services

Staff

Staffing levels/staff retention

Visit methodology

At the commencement of the visit the Team met with the Acting Charge Nurse Manager, before being shown around the Unit. On the day of the inspection there were four patients in the Unit, all male.

The Acting Charge Nurse Manager provided the following information during the visit:

- a list of patients and the legislative reference under which they were being detained (at the time of the visit);
- information for patients on admission;
- the seclusion and restraint data for the previous six months and the seclusion and restraint policy;
- a list of all staff trained in the use of restraint and reasons for those not up to date;
- locked door policy;
- the number of complaints for the previous six months and the complaints policy;
- copies of patients' care plans and any relevant reviews;
- programmes and activities available in the Unit;
- the visitor policy; and
- staff retention and sickness data for past 3 years.

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to a number of managers, staff and patients.² Family and whanau were also spoken with.

² For a full list of people spoken with by the Inspectors see Appendix 1.

Inspectors also reviewed patient records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

There was limited opportunity for Inspectors to interview all patients as a number had communication challenges.

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any patients had been subject to any torture, or other cruel, inhuman or degrading treatment or punishment.

Seclusion/de-escalation

Seclusion facilities

The seclusion facility, separate from the main unit, had one seclusion room with en-suite toilet and shower facilities and a small de-escalation area. Patients requiring a period in seclusion were moved (often while being restrained) through the administration/staff rest area, which was not appropriate.

Although basic, the seclusion room had natural light, heating and a means of raising the alarm. Fixed windows had blinds for privacy but Inspectors found no evidence to suggest patients in seclusion were able to access fresh air on a daily basis.

There was no clock to orientate patients to time however, a white board showed the day and date. The ceiling was low enough for some patients to access the fire alarm/sprinkler system. Staff mitigated the risk by removing the mattress, which could be used to aid climbing, which was not appropriate.

Staff reported that the en-suite toilet for the seclusion room was often locked, with a cardboard receptacle (for toileting) provided instead. Reasons given were to prevent patients from damaging the en-suite and flooding the seclusion room.

Inspectors observed a patient vomiting on the seclusion room floor due to the bathroom door being locked, and no paper receptacle available for their use. The patient had been complaining of a sore stomach prior to being placed in seclusion. The mattress and pillow had been removed from the room, reportedly due to the patient's history of property damage, and ability to reach the sprinkler system in the ceiling. They were given a 'stitch gown' which was being used as a cover for warmth. The patient was placed on 10 minute observations which was contra' to the DHB's 'Seclusion Policy', which stated:

'Where any of the following conditions exist, constant observation with direct line of sight must be implemented. Where these conditions exist seclusion may only be used with extreme caution. This level of observation may not be negotiated with the consumer.'

....Where the consumer is in need of intensive assessment and/or observation, especially where there is a history suggestive of significant trauma, ingestion of unknown drugs or substances, physical illness or organic diagnosis.'

Toilet arrangements for patients in seclusion requires a balance between safety, dignity and the physical well-being of the person. Best practice is to have an en-suite toilet facility that can be used by patients.

At times, Te Whare Manaaki³ seclusion facility has been used to seclude patients from the Unit due to their volatile behaviour, and poor seclusion facilities in the Unit.



Figure 1: AT&R seclusion room



Figure 2: AT&R de-escalation area

Seclusion incidents and policies

Inspectors were provided with a copy of the DHB's 'Seclusion policy' (28 April 2017), and the 'Water access in seclusion room policy' (8 March 18). Neither policy had a review date.

During and after the inspection, Inspectors were given a number of email and computer-generated seclusion reports. Despite a number of attempts to reconcile the data, Inspectors were unable to determine which data was accurate. Inspectors had no confidence in the way the service recorded and reported seclusion events.⁴

Using the seclusion data provided at the time of the inspection, there were 19⁵ seclusion incidents involving four patients and a total seclusion time of just over 174 hours for the period 1 January to 30 June 2018. This can be broken down as follows:

³ Te Whare Manaaki is a forensic mental health unit situated on the Hillmorton Hospital grounds.

⁴ Seclusion data was out by hours and minutes. Some data had been duplicated.

⁵ One patient accounted for 15 seclusion incidents (79 percent).

Table 1: Seclusion episodes 1 January - 30 June 2018

Month	Events	Patients numbers	Hours	Average hours per event
January	6	2	49.30	8.22
February	3	2	10.91	3.64
March	2	1	28.38	14.19
April	3	1	34.18	11.39
May	5	2	51.40	10.28
June	0	0	00.00	00.00
Total	19	Actual = 4	173.69	-

In my 2014 report, I reported the average monthly seclusion hours in the Unit as 168.78. Using current figures, the monthly average was 7.95 hours – a significant reduction. Staff reported that this was due to the introduction of the ‘Annex’.

Sensory modulation

The Unit did not have a dedicated sensory modulation room⁶ however, sensory modulation was used as part of a number of patients’ daily routine. This approach was clearly outlined in the patients’ weekly planners. Inspectors witnessed the use of sensory modulation with one particular patient on a number of occasions. The service did not monitor the use of sensory modulation, or track its use against seclusion and restraint events.

Restraint

A copy of the DHB’s ‘*Restrain Minimisation and Safe Practice*’ policy was provided (19 June 2018). The policy did not include a review date.

From 1 January to 30 June 2018 there were 88 incidents of restraint involving six patients; a decrease on that reported in my 2014 report - 298 incidents involving 12 patients. Staff attribute the reduction in incidents to the development of the Annex; a closed area of the main unit introduced to assist in managing a highly assaultive patient.

A breakdown of the use of restraints is set out below:

⁶ Sensory modulation is one tool that works well and supports initiatives to reduce seclusion and restraint use.

Table 2: Restraint incidents 1 January to 30 June 2018⁷

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint	Seclusion
Patient 1	29	29	00	00	00
Patient 2	2	00	1	00	1
Patient 3	17	00	3	14	00
Patient 4	2	00	00	1	1
Patient 5	30	00	12	2	16
Patient 6	8	00	1	4	3
Total	88	29	17	21	21

Restraint training for staff

The Safe Practice Effective Communication (SPEC) training programme was launched in November 2016. It was designed with service users' input, and has service users as trainers and members of the programme's governing body. The new initiative aims to provide national consistency and best quality, evidence-based therapeutic interventions for effectively reducing restraint and seclusion⁸.

Copies of training records indicated that five (out of 28) staff were out-of-date with their SPEC training however, all five staff were on work-related ACC.

Environmental restraint

The DHB's Restraint Minimisation and Safe Practice policy states:

'Where a service provider intentionally restricts a patient's/consumers normal access to their environment. For example, where a patient's/consumer's normal access to their environment is intentionally restricted by locking devices on doors.'

The doors between the main unit and the Annex were locked during the day and unlocked again later in the evening. The Annex protocol stated that: *'the dividing doors will be locked on B and D shifts and unlocked on A shift'*. However, this was not captured as environmental restraint in the restraint data provided⁹.

⁷ Inspectors note that restraint data provided by the DHB is incomplete in that the number of seclusion events recorded is fewer than those provided for seclusion episodes in Table 1.

⁸ Ministry of Health. 2017. Office of the Director of Mental Health Annual Report 2016. Wellington: Ministry of Health.

⁹ The patient located in the Annex at the time of the inspection was unable to access the main unit throughout the day (16 hours and 20 minutes). The doors were unlocked between 10.50pm until 6.30am although the patient appeared to be unaware of it.

Recommendations – Treatment

I recommend that:

1. Seclusion practice, including access to the seclusion room should be reviewed.
2. A more robust system for accurately checking/recording seclusion incidents needs to be implemented.

AT&R comments:

Accepted recommendation 1 and no response to recommendation 2.

1. *Accepted 1.*
2. *Two robust systems are in place. These are the South Island Safety1st for reporting an event and Healthlinks the clinical information system which records the hours of an event. Both are necessary for appropriate checking. Monitoring is undertaken by Informatics staff. Safety 1st and Healthlinks are not connected therefore human error can occur.*

Protective measures

Complaints process

Access to the complaints process, including access to a complaint form, was not readily available to patients in the Unit. However, contact details for the District Inspectors were available. Staff advised Inspectors that the complaint box was situated in the Charge Nurse Managers office since being pulled off the wall by a patient.

Health and Disability Rights posters were not displayed in the Unit. Again, staff reported this was due to patients destroying them.

There were two complaints for the reporting period 1 January 2018 to 30 June 2018. Inspectors reviewed the two complaints and subsequent responses. Whilst responses were within the required timeframes, the response content of one complaint did not fully address the content of the complaint.

An information kit (for consumers and family/whanau) was available to both patients and their whanau at reception. The information kit provided information on the Unit as well as patients' rights and available support services. A Unit admission booklet in easy read/pictorial format was also given to the patients.

There was no patient advocacy service in the Unit. The position had been vacant for 18 months.

Records

There were four patients in the Unit on the day of the visit and the Inspectors checked all of their files.

Three patients were being detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and one patient under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

All files contained the necessary paperwork to detain [and treat] the patients in the Unit.

All patients had Welfare Guardians and medical Enduring Power of Attorney.

Care plans and daily file note entries were evident. Care plans were thorough and tailored to the individual patient's needs. Three patients had very clear and informative behavioural management plans; although patients did not routinely receive a copy of their plan. Family/whanau, however, did receive a copy of the plan.

The O'Brien's Principles¹⁰ were the adopted model for guiding care in the Unit.

There were weekly patient review meetings in the Unit, as well as three monthly MDT review meetings. Inspectors observed a three monthly clinical review and found it to be organised, well led and informative and included cultural representation. Patients did not attend their MDT review. The Unit also conducted weekly incident reviews.

Family/whanau were invited to attend the clinical review meetings, and were routinely contacted after any incidents.

All patients had access to Unit leave.

Recommendations – Protective measures

I recommend that:

3. The complaints process needs to be made available in all areas of the Unit.
4. Advocacy services needs to be made available to patients as a matter of urgency.
5. Patients should receive an up-to-date copy of their care plan in a format they can understand.

¹⁰ John O'Brien's Five Essential Service Accomplishments were aimed at focusing and guiding staff in their work. The accomplishments describe worthy consequences of supported activities. The five accomplishments are choice, competence, relationships, respect and community presence.

AT&R comments:

Accepted recommendations 3, 4 and 5.

3. *Safe alternatives are being investigated to address this recommendation.*
4. *Accepted 4.*
5. *Accepted 5.*

Material conditions

Accommodation

Main unit

Set in the grounds of Hillmorton Hospital, the Unit can accommodate 10 patients, although it seldom has more than six due to the high and complex needs of the individuals being cared for. Two beds were permanently blocked as a result of the Annex development (see Annex section below). At the time of the inspection it was reported to Inspectors that the Unit was closed to any new admission. The temporary suspension of admissions was a directive from the Ministry of Health.¹¹

All patients had their own room with sufficient bathroom facilities within easy access to bedrooms. One room had en-suite facilities which could be used when a female patient was admitted. If there was more than one female, staff advised that this would be problematic as there was no ability to provide gender separation in the Unit. Bedroom doors are locked from the outside and alarms register in the office however, patients can unlock their rooms at night from the inside, if they wish.

Food

Meals were prepared in the main hospital and brought to the Unit in a trolley. Patients had a choice of meals from a daily menu. The quantity and quality of the food during the inspection was satisfactory.

Special dietary requirements were catered for and dieticians had been involved in the development of some patients' diets.

Breakfast took place from 7.30 to 8.00am, lunch at 12pm and the evening meal from 5pm. Times could change as the dining room was shared with PSAID unit.

Morning and afternoon tea was available, as was supper.

¹¹ MHAIDS-Forensic Coordination Service (Intellectual Disability) Quarterly Report to Ministry of Health. Reporting period (01 April 2018-30 June 2018).

There were no concerns with regards to the quality or quantity of meals.

Recommendations – Material conditions

I recommend that:

6. The building is upgraded as a matter of urgency.
7. Accommodation and facilities are provided for female patients that ensure their needs for privacy and safety are met.

AT&R comments:

Accepted recommendations 6 and 7.

Activities and programmes

Outdoor exercise/leisure activities

At times, the dynamics between the patients in the Unit could be volatile therefore, the majority of patients were unable to mix with each other, which added another layer of complexity for staff trying to provide care and activities on a day-to-day basis. In some instances, interventions were based on containment and management rather than rehabilitation.

All patients had leave which allowed for individual planned outdoor activities such as: trips to the hospital café, walks, tennis, van rides, cricket or outings to McDonalds.

There were two outdoor exercise areas; an internal court yard and a grassed area leading from the Occupational Therapy (OT) lounge. Both external areas had secure fencing in place. The internal courtyard was in need of cleaning and maintenance.

Access to both the internal and external courtyards was conducted under the supervision of two staff. Inspectors had concerns that patients were not able to freely access fresh air on a daily basis.



Figure 3: Outside area



Figure 4: Internal courtyard

Programmes/therapeutic activities

A fulltime OT provided a comprehensive weekly timetable of activities, Monday to Friday, such as: pet therapy, individual cooking sessions and sensory modulation. Most activities were 1:1 due to the complexity of the patient group.

Each patient had a sensory profile report and a comprehensive weekly plan which included sensory activities.

The Unit did not have a behavioural specialist or a psychologist, although recruitment was underway for both positions.



Figure 5: OT kitchen



Figure 6: OT lounge

Cultural/spiritual support

The specialist Māori mental health service - Te Korowi Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health services for Māori. Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori patients. Their role was specific to providing cultural assessments that sat alongside the clinical assessment

and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work. Māori Hauora plans were discussed with the patient and their whānau if appropriate.

Pukenga Atawhai attended the Unit to work with patients that identified as Māori. The Unit advised the Pukenga Atawhai when a person identifying as Maori either had been admitted to the Unit or when an existing Maori patient was placed in seclusion.

Pukenga Atawhai were in attendance at a three month clinical review meeting that Inspectors attended. Pukenga Atawhai reported that they felt their cultural input was valued and staff afforded them the professional respect and responsiveness to their cultural interventions with patients.

A limited chaplaincy service was available for patients in the Unit, although finding suitable accommodation to speak in private was often a challenge. Inspectors noted the chaplain in the Unit during the course of the inspection.

Recommendations – Activities and programmes

I recommend that:

8. Patients can freely access fresh air daily.
9. Opportunities for patients to participate in programmes are increased.

AT&R comments:

Accepted recommendations 8 and 9.

8. *Accepted 8.*
9. *Individualised programmes are in place. An increase in staff is required to increase outings.*

Communications

Access to visitors/external communication

Patients could receive visitors if they chose. Visiting hours were from 10.00am to 8.00pm Monday to Sunday and needed to be pre-arranged to ensure adequate resourcing to support the visit. There was some flexibility around visiting times depending on the visitors' personal circumstances. If visitors arrived without prior arrangements staff would complete a risk assessment of the Unit environment to see if it was safe for the visit to proceed.

Visits took place in the main lounge area offering limited privacy. All visitors were provided with a wrist alarm.

The Annex had its own visitor's protocol. Visiting times were structured and time limited. Patient A's family were regular visitors to the Annex and were very receptive to the new environment.

Due to the nature of the Unit, children under 16 years were not permitted.

Although there was no phone located in the Unit, patients could access a cordless phone through staff. Inspectors were advised that calls were supervised by staff and were for approved numbers only. Cell phones are not permitted in the Unit.

One patient had access to web browsing on the Unit computer under staff supervision (the patient was not able to directly access the computer as it was behind Perspex). Staff would access web pages for a period of 30 minutes and then print the web pages for the patient. This was part of the patients' daily routine.

Patients in the Unit could send and receive mail. Restrictions on a patient's mail were placed on their file by the Care Manager.

The Inspectors had no concerns with patients' access to family and friends. The Unit took a pro-active approach to maintaining family/whanau contact.

Recommendation - Communications

I recommend that:

10. Patients should be able to freely access the telephone.

AT&R comments:

Accepted recommendation 10.

10. *Access is facilitated.*

Risk management may result in restriction for some consumers making phone calls. This is managed on a case by case basis.

Health care

Primary health care services

All patients were seen by the house surgeon on admission and could access a house surgeon as required via Unit staff.

A General Practitioner (GP) was employed to cover a number of Units at the hospital. They worked one day a week. Staff would make contact with the GP as needed. Patients could request to see the GP via staff in the Unit.

Records indicated that physical examinations were undertaken, and there was ongoing monitoring of patients physical health.

Inspectors had no concerns in relation to the provision of healthcare to patients.

Recommendations – health care

I have no recommendations to make.

Staff

Personnel

The Unit was operating on a six staff per shift regime during the day and two staff during the evenings. The team was made up of a range of disciplines, with staff from a variety of ethnic backgrounds. Roles included medical staff, nurses and mental health support workers and an occupational therapist.

There were five nurses on ACC due to serious work related injuries. Strategies have been put in place to maintain staffing levels for the Unit through using pool staff and a short-term staff secondment to assist in continuity of care. Staffing shortages, sickness and work related ACC was having an impact on service delivery. Staff reported feeling overwhelmed at times and were often covering double shifts to ensure coverage for staff shortages. Two staff went on sick leave during the inspection following an assault by a patient.

The Unit had seven vacancies at the time of the inspection (four registered nurses, one enrolled nurse, one behavioural specialist and one psychologist). Active recruitment was taking place, however the position had been vacant for a considerable period of time.

At the time of inspection, the staff mix was 86 percent female to 14 percent male, and was making rostering difficult.

Staff retention was stabilising after a difficult period. In 2016/2017 staff retention figures were at 17 percent however, in 2017/2018 staff retention was tracking down at 10 percent. Staff reported to Inspectors that the team were more cohesive since the reduction in assaults. They also reported that the management team was really good on the Unit; they had an open door policy and a holistic approach to both patients and staff.

A number of staff, particularly new staff, commented on the lack of training provided to deal with patients with an intellectual disability and challenging behaviour. Staff reported that they did not have team planning days.

Recommendations – Staff

I recommend that:

11. Staff training to increase knowledge and skills for working with patients with learning disabilities and challenging behaviour needs to be enhanced.

AT&R comments:

11. *Accepted recommendation 11.*

Acknowledgement

I appreciate the full co-operation extended by the Acting Charge Nurse Manager and staff to my Inspectors during their visit to the Unit. I also acknowledge the work involved in collating the information requested.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Management and other service providers	AT & R Unit and other
General Manager	Patients
Quality Improvement Manager	Clinical Nurse Specialist
Pou Whirinaki	Registered Nurses
DAHMs	Enrolled Nurses
Director of Nursing	Health Care Assistants
Director of Allied Health	Housekeeper
People and Capability Advisor	Occupational Therapist
Clinical Director – Intellectually Disabled Persons Health Service	Psychiatrist
Nursing Director - Forensics and Intellectually Disabled Persons Health Service	Family/whānau
Clinical Director – Canterbury Regional Forensic Services	Pukenga Atawhai
Customer Services Coordinator– Complaints	Visiting General Practitioner
Chaplin	NZNO local delegate
Quality and Patient Safety Team	NZNO Regional Officer
Learning and Development	Communication with District Inspectors
Coordinating Consumer Advisor	
Coordinating Family Advisor	

Appendix 2. Overview of OPCAT – Health and Disability places of detention

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT. Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

- (d) *a hospital*
- (e) *a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...*”

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

- (a) to examine the conditions of detention applying to detainees and the treatment of detainees; and
- (b) to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - (i) for improving the conditions of detention applying to detainees;
 - (ii) for improving the treatment of detainees;
 - (iii) for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector’s (COTA). This is to ensure that there is a clear distinction between the Ombudsmen’s preventive monitoring function under OPCAT and the Ombudsmen’s investigation function under the Ombudsmen.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

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 **Ombudsman**

Fairness for all

OPCAT Report

Report on an unannounced inspection
of the
Child Adolescent & Family Unit (CAF),
Princess Margaret Hospital,
under the Crimes of Torture Act 1989

Publication date: 15 April 2019

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions and treatment of patients detained in secure units within New Zealand hospitals.

From 26 to 28 November 2018, two Inspectors - whom I have authorised to carry out visits to places of detention under COTA on my behalf – inspected the Child Adolescent and Family Unit, which is located in the grounds of Princess Margaret Hospital.

Summary of findings

My findings are:

- There had been a reduction in the use of seclusion since my predecessor's inspection in 2014.
- Members of the multi-disciplinary team (MDT) worked collaboratively and effectively.
- Interactions between staff and young people were respectful, constructive and appropriate.
- The necessary legal documentation for young people to be detained and treated was on file, where relevant.
- Accommodation was clean and tidy.
- A broad range of therapeutic programmes and education activities were available to young people.
- Young people were able to communicate freely with whānau and friends, either during visits or through the telephone.

The issues that need addressing are:

- The seclusion and de-escalation rooms were unfit for purpose.
- Young peoples' access to the sensory modulation room was limited by inflexible arrangements.
- Information provided to young people on admission does not include details of the complaints process.
- Signed *Consent for use of restraint: Form for parents and guardians* were not completed for the relevant young people in the Unit.
- Some communal areas on the Unit were locked.

- Bedrooms contain potential ligature points.
- Doors to the outdoor areas on both the youth and child wings were locked.
- Evening and weekend leisure activities did not fully meet young peoples' needs or interests for young people.
- Low staff retention.

Recommendations

I recommend that:

1. Young peoples' access to the sensory modulation rooms be improved, starting by monitoring usage to determine if more flexible access arrangements are required.
2. Information about the DHB's complaints process is included in the information booklet given to young people on admission and in the *Information Kit* booklet given to whānau/family.
3. A signed *Consent for use of restraint: Form for parents and guardians* is obtained for all relevant young people in the Unit and kept on file.
4. All young people have unrestricted access to all of the Unit's communal areas.
5. All potential ligature points be removed from bedrooms.
6. Adjust or replace the locks to the toilets in the youth wing to prevent accidental locking.
7. All young people have unrestricted access to the Unit's outdoor areas unless deemed inappropriate for clinical reasons.
8. Evening and weekend leisure activities be reviewed to ensure they meet the needs and interests of the young people.
9. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

Feedback meeting

A feedback meeting took place at the end of the inspection, during which my Inspectors outlined Inspectors' initial observations to the Charge Nurse Manager, Consultant Psychiatrist,

Service Manager, Quality Manager, Nurse Consultant, Clinical Nurse Specialist and Occupational Therapist.

Consultation

A provisional report was forwarded to the Child, Adolescent and Family Inpatient Unit for comment as to fact, finding or omission prior to finalisation and distribution.

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Facility Facts

Child, Adolescent and Family Inpatient Unit

Located in the grounds of Princess Margaret Hospital, Christchurch, the Child, Adolescent and Family Inpatient Unit (the Unit) provides specialist inpatient care for young people with mental health problems up to the age of 18 years old. Services include assessment, treatment and education for individuals and their families.

The Unit has two separate wings, a child wing (for young people up to the age of 12 years old) and a youth wing (for young people between the ages of 12 and 18 years old). However, older individuals may be accommodated in the child wing based on clinical need.

The Unit also provides mental health consultation services to, and liaises with, general practitioners, schools and allied health and social services to the West Coast and South Canterbury regions.

Region

Canterbury

District Health Board

Canterbury District Health Board

Operating capacity

16 beds, plus one seclusion room and one de-escalation room.

Last inspection

Unannounced visit – July 2014

Informal unannounced visit – August 2012

The Inspection

The inspection of the Child, Adolescent and Family Inpatient Unit (the Unit) took place from 26 to 28 November 2018 and was conducted by two Inspectors. On the first day of the inspection, there were 12 young people on the Unit, comprising 11 females and one male. Five young people were on the child wing and seven on the youth wing.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (CNM), before being shown around the Unit.

Inspectors were provided with the following information during the inspection:

- a list of young people in the Unit and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data for the previous six months, and the seclusion and restraint policies;
- a list of all staff trained in the use of restraint and reasons for those not being up to date;
- complaints for the previous six months, a sample of responses and associated timeframes, and a copy of the complaints policy;
- information provided to young people on admission;
- activities programme;
- visits policy;
- staff sickness and retention data for the previous three years;
- staff mandatory training records;
- incident reports relating to medication errors for the previous six months; and
- minutes of consumer group meetings for previous three months.

Inspection focus

The following areas were examined to determine whether there had been torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on patients.¹

¹ My inspection methodology is informed by the Association for the Prevention of Torture's *Practical Guide to Monitoring Places of Detention* (2004) Geneva, available at www.ap.t.ch.

Treatment

- Torture, or cruel, inhuman or degrading treatment or punishment
- Seclusion and de-escalation
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Young peoples' and whānau views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes and education
- Cultural and spiritual support

Communications

- Access to visitors and external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to the Charge Nurse Manager, staff and nine young people.²

Inspectors also reviewed patient records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

Recommendations from previous report

Inspectors followed up on the one recommendation made by my predecessor in 2014, which was:

The lack of heating and the unpleasant odour emanating from the drains in the seclusion room are addressed.

The Unit's adoption, or not, of this prior recommendation is referred to in the relevant section of this report.

Treatment

Torture, or cruel, inhuman or degrading treatment or punishment

There was no evidence that any young people had been subject to torture, or cruel, inhuman or degrading treatment or punishment.

A sensory modulation room was located in both the youth and the child wings. Both were kept locked and could only be accessed with staff supervision. Young people were expected to ask to use the room or staff might suggest to a young person that it would be helpful to them to use the room. During a multi-disciplinary team (MDT) meeting attended by Inspectors, staff discussed the therapeutic benefits of a particular young person using the sensory room.

There was no monitoring of the use of the sensory rooms or their impact on young peoples' mental wellbeing.

Inspectors observed an effective shift handover, during which staff discussed patients' behaviour, risks and care.

Seclusion

Seclusion facilities

The Unit had one seclusion room, with en-suite facilities, located in the youth wing's small high dependency area. The high dependency area also had a small de-escalation room, which had no natural light or bathroom facilities.

² For a list of people spoken with by the Inspectors, see Appendix 1.

I was pleased to note that the following recommendation by my predecessor, resulting from the Unit's 2014 inspection, had been implemented:

The lack of heating and the unpleasant odour emanating from the drains in the seclusion room are addressed.

My Inspectors found the seclusion room to be free of any unpleasant odours and was a satisfactory temperature.

Despite this improvement, I am of the opinion that the seclusion and de-escalation rooms are unfit for purpose. The facilities are dark, oppressive and not conducive to the mental wellbeing of the young people accommodated in them.

During the inspection in 2014, the Unit manager informed Inspectors that the Unit would be moving to a new facility in 2016. I am disappointed that the move has not yet materialised. During the 2018 inspection, the DHB provided my Inspectors with a copy of the plans for the new Unit and they learned that the move may not occur for at least another two years.



Figure 1: Seclusion room – youth wing



Figure 2: De-escalation room – youth wing



Figure 3: Head in the Clouds room – child wing



Figure 4: Headspace room – child wing

Seclusion policies and incidents

The Unit provided Inspectors with a copy of the DHB's *Seclusion Policy* (dated 28 April 2017). The policy document does not indicate a review date.

Data supplied by the Unit showed that, for the period 1 May 2018 to 31 October 2018, there were two episodes of seclusion involving two young people. The total seclusion time for the period was 6.2 hours.

Table 1: Seclusion episodes 1 May - 31 October 2018

Month	Events	Patient numbers	Hours	Average hours
May	0	0	0	0
June	2	2	6.2	3.1
July	0	0	0	0
August	0	0	0	0
September	0	0	0	0
October	0	0	0	0
Total	2	2	6.2	3.1

The data indicates a significant reduction in the use of seclusion since the inspection in 2014. Comparable data for the period 1 January to 30 June 2015 shows 22 episodes of seclusion, totalling 153.5 hours. I am pleased to see this reduction in the use of seclusion.

No young people were in seclusion at the time of the inspection.

Restraints

The Unit provided Inspectors with a copy of the DHB's *Restraint Minimisation and Safe Practice Policy* (dated 19 June 2018). The policy document does not indicate a review date.

Data supplied by the Unit showed that, for the period 1 May 2018 to 31 October 2018, there were 199 incidents of restraint involving 19 young people. Sixty-five per cent (129) of restraint incidents involved one young person.

Table 2: Restraint incidents 1 May - 31 October 2018

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint
Patient 1	1	1	0	0

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint
Patient 2	17	5	2	10
Patient 3	4	2	0	2
Patient 4	3	1	1	1
Patient 5	1	1	0	0
Patient 6	5	1	2	2
Patient 7	6	1	2	3
Patient 8	1	1	0	0
Patient 9	2	2	0	0
Patient 10	1	1	0	0
Patient 11	1	1	0	0
Patient 12	4	3	1	0
Patient 13	10	1	4	5
Patient 14	3	1	0	2
Patient 16	1	0	0	1
Patient 17	1	0	0	1
Patient 18	8	2	0	6
Patient 19	129	5	35	89

This data indicates an increase in the use of restraint since the time of the 2014 inspection. Comparable data for the period 1 January to 30 June 2014 showed 172 incidents of restraint involving 14 young people.

Restraint training for staff

All Unit staff were up-to-date with Safe Practice Effective Communication (SPEC) training, with the exception of three staff for whom refresher training was scheduled for December 2018.

However, the SPEC restraint techniques are designed for adults, not young people (some as young as nine or ten years old). In the opinion of the CNM, SPEC is not an appropriate method when restraining young children. My Inspectors were told that the SPEC trainer for the Unit had developed new restraint techniques for the Unit's staff to use that did not involve flexion of the wrist or tension of a young person's skeletal growth plates.

Electro-convulsive therapy

No young people were receiving electro-convulsive therapy (ECT) at the time of the inspection.

Sensory modulation

The DHB provided Inspectors with a copy of its *Sensory Modulation Protocol* (review date July 2021)

A sensory modulation room was located in both the youth and the child wings. Both were kept locked and could only be accessed with staff supervision. Young people were expected to ask to use the room or staff might suggest to a young person that it would be helpful to them to use the room. During an MDT meeting attended by Inspectors, staff discussed the therapeutic benefits of a particular young person using the sensory room.

There was no monitoring of the use of the sensory modulation rooms or their impact on young peoples' mental wellbeing.

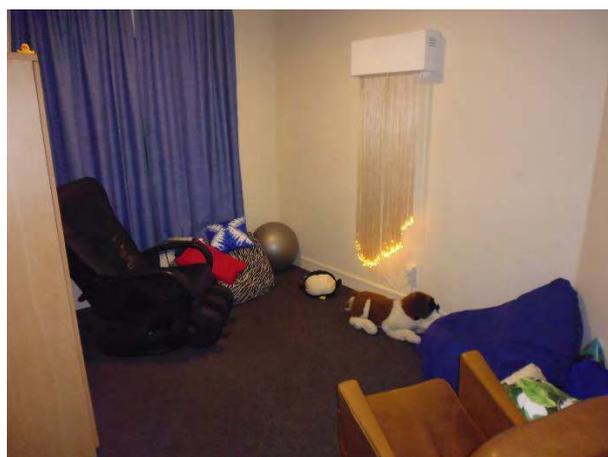


Figure 5: Sensory modulation room – youth wing



Figure 6: Sensory modulation room – child wing

Patients' and whānau views on treatment

Young people told Inspectors that they felt safe on the Unit and staff treated them with kindness. They said that they felt comfortable talking to staff and that the staff were always willing to listen to them.

On discharge, young people and their parents/guardian are invited to complete a satisfaction survey. The information from the survey is collated by the Research Officer six-monthly and a poster-sized infographic of the results is displayed in the Unit. Feedback is also sent to the CNM by email. Inspectors reviewed a random sample of the emails, which included the following comments from young people:

The nurses were very kind

More consistency with nurses, it can be frustrating having to have new people all the time, and makes it difficult to be open with them

Comments from parents included:

The staff are caring and knowledgeable

They listened to..... were very caring and kind.

You guys do a fantastic job with your patients and you have been possibly life saving for..... Thank you.

Lovely nurse on first admission was so kind and understanding.

There was a lack of service at times. No communication. Not knowing what was happening. Some of the nurses were quite disrespectful to daughter and her boyfriend.

The Youth Consumer advisor (YCA) facilitates a weekly consumer group meeting and Inspectors reviewed a selection of minutes from previous meetings. The minutes indicate a broad range of topics discussed, including building maintenance issues, mealtime menus, use of telephones and activities. The YCA sends copies of the minutes to the CNM and Occupational Therapist (OT). However, it is unclear from the minutes what, if any, feedback the young people receive in relation to the issues they raise at the consumer meetings.

Recommendations – treatment

I recommend that:

1. Young peoples' access to the sensory modulation rooms be improved, starting by monitoring usage to determine if more flexible access arrangements are required.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 1

Recommendation 1 response:

We will review how to maximise use of the room, while ensuring safety.

Protective measures

Complaints process

The DHB provided Inspectors with an out-of-date copy of its *Complaints Management Policy* (review date 25 June 2012).

Information about the DHB's complaints process was displayed in the Unit, along with copies of the customer response form, *Suggestions, Compliments and Complaints*. These were located alongside the complaints boxes and easily accessible by the young people.

However, information about the complaints process was not contained in either the information booklet given to young people on admission nor the *Information Kit* for whānau and other support people. I consider that it would be helpful to both the young people and whānau for information about the complaints process to be included in the information booklets.

The Unit had received one complaint in the six months preceding the inspection. However, as the complainant chose not to use the formal complaints process, while the complaint itself was recorded, any response to it was not. It was therefore not possible for my Inspectors to identify the outcome of the complaint, nor establish any timescale within which the complaint was resolved.

Young people told Inspectors that they were familiar with the complaints process, and they would feel comfortable approaching staff if they wished to raise any concerns.

Contact details for District Inspectors were on display in the Unit, as were posters of the Health and Disability Commission's *Code of Rights*.

Records

Of the 12 young people in the Unit at the time of the inspection, one was detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) and the remainder of the young people had voluntary/informal status. Inspectors reviewed the files of all the young people on the Unit.

The file for the young person detained under the MHA contained the necessary paperwork for detention and treatment. The quality of the paperwork in the files for all the young people was of a high standard, with files structured in an ordered manner and all documentation signed and dated as appropriate. Treatment plans for young people were up to date and progress

notes indicated the young peoples' involvement in their treatment management and planning process.

However, my Inspectors noted that one file contained information pertaining to another young person. Staff corrected this error when it was brought to their attention by Inspectors.

None of the files for voluntary young people in the child wing contained consent forms signed by their parent or guardian, in respect of the use of restraint.³

Recommendations – protective measures

I recommend that:

2. Information about the DHB's complaints process is included in the information booklet given to young people on admission and in the *Information Kit* booklet given to whānau/family.
3. A signed *Consent for use of restraint: Form for parents and guardians* is obtained for all relevant young people in the Unit and kept on file.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 2

Accepted recommendation 3

Material conditions

Accommodation and sanitary conditions

The Unit has two wings; the child wing and the youth wing. Both wings are mixed-sex facilities.

My Inspectors noted that the Unit, while clean and relatively tidy, was somewhat tired and dreary in appearance. Staff had endeavoured to improve the ambience of the Unit by the addition of artwork and colourful posters on the walls, but the layout of the building makes any significant improvements difficult. The building contained poor lines of sight and the youth wing, in particular, was dark.

Both wings had combined kitchen/dining/lounge areas and a number of smaller communal areas, which provide quiet space for the young people. However, Inspectors observed the communal areas in the youth wing to be locked on several occasions during the inspection.

³ *Consent for use of restraint: Form for parents and guardians*. This form is for consent to the use of restraint when necessary for a minor aged 12 years and under, who are not under the MHA.

In each wing, each young person had their own bedroom which, although basic, has curtains for privacy and sufficient storage space for personal belongings. Young people were able to enter and exit their bedrooms freely during the day and night. Bedrooms for male and female young people were located together in the same corridor.

I am concerned that a number of the bedrooms in the Unit contained potential ligature points. The Nurse Consultant told my Inspectors that some young people demonstrated suicidal ideation and behaviour and the ligature points in some of the bedrooms will be removed so those rooms could be used for high-risk individuals. In my opinion, it is not possible to predict accurately who might or might not attempt suicide and, therefore, it would be beneficial to remove potential ligature points from all bedrooms.

Young people share bathroom facilities, with those for males and females located close to one another in each wing. I consider that the lack of separate male and female areas for bedrooms and bathrooms has the potential to impact on the privacy and safety of the young people.

Inspectors observed the toilets in the youth wing to be locked on several occasions during the inspection. Staff demonstrated how the lock mechanism can remain locked if the person leaving the toilet does not turn the latch back to the unlock position, resulting in the door remaining locked and the toilet inaccessible to others.

I consider that, despite the best efforts of staff, the structure and layout of the Unit is not conducive to the optimal management of young people or to their mental wellbeing. I am pleased to note that the DHB intends to build a new Unit at Hillmorton Hospital, and my Inspectors have seen plans for the new facility. However, I am concerned that the building of the new Unit is unlikely to start for at least two years.



Figure 7: Bedroom – youth wing



Figure 8: Bedroom – child wing

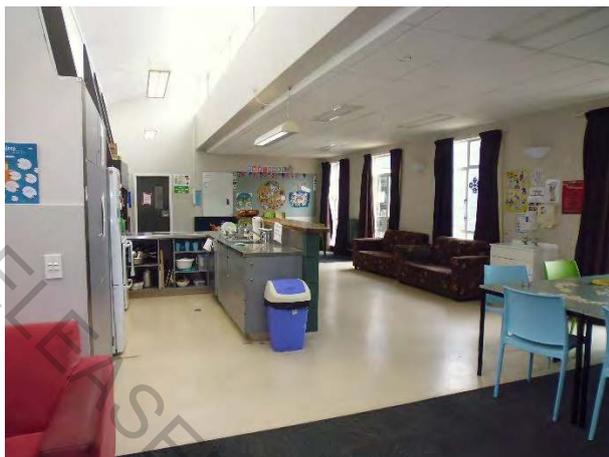


Figure 9: Communal area – child wing



Figure 10: Communal area – youth wing

Food

Assisted by nurses, the young people prepared their own breakfast at 8.00am, comprising cereals, toast and other items such as poached eggs. A similar arrangement existed for lunch at 12.30pm, when young people prepared sandwiches, wraps and salad. The evening meals at 5.30pm (child wing) and 6.00pm (youth wing) were prepared in the hospital kitchen and transported to the unit in a heated trolley. The young people were also able to prepare their own meals at this time – for example, pizza and cauliflower cheese.

Inspectors observed that the quality and quantity of the food over the course of the inspection was satisfactory, and no young people raised with Inspectors any concerns about the food. However, minutes of the weekly consumer meeting showed that young people had requested more healthy options at mealtimes such as more fruit and vegetarian/vegan options.

Recommendations – material conditions

I recommend that:

4. All young people have unrestricted access to all of the Unit's communal areas.
5. All potential ligature points be removed from bedrooms.
6. Adjust or replace the locks to the toilets in the youth wing to prevent accidental locking.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 4

Partially accepted recommendation 5

Recommendation 5 response:

Removal of every ligature point in this facility is impractical. The new facility will ensure there are no ligature points.

NPM response:

While I appreciate that it would be difficult to remove ligature points throughout the entire facility, my recommendation relates specifically to the removal of ligature points in all bedrooms. As work is being undertaken to remove ligature points in some bedrooms, I do not consider it impractical to extend this work to include all bedrooms, especially as the new facility will not be built for at least two years.

Accepted recommendation 6

Activities and communications

Outdoor exercise and leisure activities

The Unit provided outdoor areas on both the youth and child wings but Inspectors observed the doors to these areas were locked throughout the inspection. This restricted young peoples' access to the areas and required them to ask a staff member to unlock the doors. Inspectors did not observe any young people in the outdoor areas during the inspection. The one exception to this was the outdoor play area in the child wing, which was used by young people during breaks in their school activities.

A number of leisure activities are available to young people including: MP3 players; Playstation/Xbox; leave from the Unit; cycle rides; walks; brain games, colouring activities; and, craft activities. The youth wing has an activities room, 'The Zone', which contains craft materials and exercise equipment. However, this room was locked during the inspection and Inspectors did not observe any young people using the room.

Young people told inspectors that there was little for them to do in the evenings and at weekends and would welcome a greater range of activities during these periods. During an evening visit to the Unit, my Inspectors observed that all the young people on the youth wing were out on leave with their families. On the child wing, one young person was using the telephone, two young people were playing a board game and the remaining young people were in their bedrooms.



Figure 11: Play area – child wing



Figure 12: The Zone – youth wing

Programmes and education

Young people engaged in a range of therapeutic programmes or education between 9.00am and 3.00pm, Monday to Friday.

Therapeutic programmes included both individual and group sessions designed to meet the clinical needs of each young person. Group sessions focussed on areas such as social skills, relationships, cultural groups, managing stress and regulating emotions. An OT or Clinical Psychologist, supported by a nurse, facilitated most of the groups.

All young people of school age are able to attend the Unit's schoolroom, operated by Southern Health School, which is responsible for providing education to those students who are unable to attend mainstream schools owing to health reasons.

All young people attending the school had an Individual Learning Plan, with subjects based on the national curriculum. Young people are able to sit NCEA examinations and teachers told Inspectors that at the time of the inspection eight young people were scheduled to sit examinations.



Figure 13: Classroom



Figure 14: Occupational Therapy room

Access to visitors and external communication

Visits take place between 3.00pm and 8.00pm, Monday to Friday and at any time during the weekend. Young people meet with their visitors in the communal areas of the Unit or may use the Whānau/family room, which primarily functions as a waiting and information room for whānau.

The Unit provided two parents rooms for those occasions when, for domestic or clinical reasons, it was necessary for a young person's parent(s)/guardian to stay at the Unit.

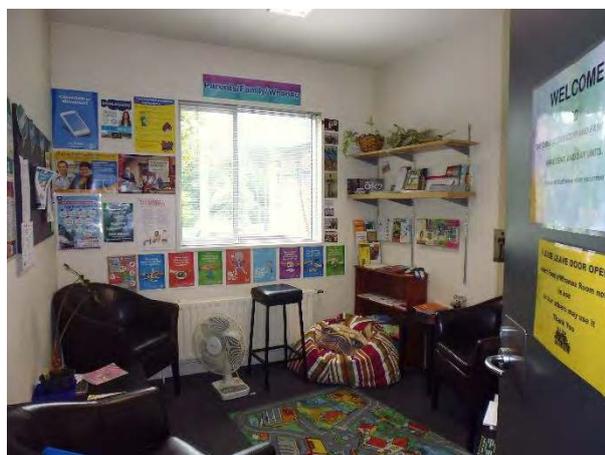


Figure 15: Whānau/family room



Figure 16: Parents room

A telephone for use by the young people was located on each wing. Whilst the telephone on the youth wing provided some degree of privacy, the one on the child wing was located close to the entrance to the wing and so privacy was limited. However, during an evening visit, Inspectors observed staff allow a young person on the wing to use a cordless telephone to make her telephone call in a more private area.

The Unit regulated young peoples' use of their mobile telephones by restricting use between 6.30pm and 8.30pm weekdays and from 10.00am to 12.00pm at weekends. The CNM told Inspectors that the use of mobile telephones was restricted so that it did not interfere with young peoples' programmes and education and to facilitate good sleep hygiene. Young people who spoke with Inspectors expressed mixed opinions on the restrictions on mobile telephone use with some supporting the policy as it gave them time *to do other stuff* and helped them to get to sleep at night.

Cultural and spiritual support

The hospital chaplain visited the youth wing weekly for approximately two hours and engaged with the young people in whatever they were doing at the time. The Chaplain also met with young people individually upon request. Contact details for the hospital chaplains were displayed in the Unit.

At the time of the inspection, the Chaplain did not visit the child wing but he told Inspectors that he planned to discuss with the CNM the possibility of attending the child wing on a weekly basis also.

The Pukenga Atawhai provides cultural support to young people on the Unit and advocates for whānau when requested to do so. A weekly cultural group is co-facilitated by the Pukenga Atawhai and a nurse during which young people can participate in a variety of cultural activities such as tikanga.⁴

Recommendations – activities and communications

I recommend that:

7. All young people have unrestricted access to the Unit's outdoor areas unless deemed inappropriate for clinical reasons.
8. Evening and weekend leisure activities be reviewed to ensure they meet the needs and interests of the young people.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 7

Accepted recommendation 8

⁴ Tikanga: Culture, custom, lore, the customary system of values and practices that have developed over time and are deeply embedded in the social context. Downloaded from the Māori Dictionary <https://maoridictionary.co.nz/search?keywords=tikanga>

Health care

Primary health care services

The Consultant Psychiatrist explained that, on admission, all young people receive a physical examination by the Unit's Medical Officer Special Scale (MOSS) or by the House Surgeon. Routine blood tests are also carried out at this stage. Doctors also explore the young person's use of drugs and alcohol and sexual health issues; appropriate advice and support is provided, as required.

Those young people requiring dental treatment are referred to the community dental service at Hillmorton Hospital or they may use the school dental services.

The Unit's pharmacist works closely with medical staff in designing appropriate medication plans and attends the weekly clinical review meeting. She also facilitates education sessions with nurses to enhance their knowledge of medicines. I am pleased to note the proactive approach of the pharmacist in facilitating weekly sessions with the young people, either in a group or individually, to discuss the medication they are receiving and to answer any questions they may have. I consider this a good example of actively engaging individuals in their treatment.

The temperature in the medicines fridge was recorded daily, and Inspectors observed that temperatures were within the Ministry of Health's guidelines of between 2°C and 8°C.⁵

Data provided to Inspectors by the DHB indicated that in the six months prior to the inspection, the Unit experienced six medication events including failure to administer prescribed medication and the administration of incorrect medication. The Medication Events schedule indicated that no harm or injury was experienced by young people because of the events.

Both the youth and child wings had a designated clinic room for physical examinations and minor medical procedures. The shared emergency trolley, containing oxygen and the defibrillator, was located in the youth wing clinic.

Recommendations – health care

I have no recommendations to make.

⁵ *National Guidelines for Vaccine Storage and Distribution*. Wellington: Ministry of Health, 2012.

Staff

Staffing levels and staff retention

Data provided by the CNM showed the Unit to have a multi-disciplinary staff complement (excluding medical staff) of 40.4 full time equivalent (FTE). The CNM told Inspectors that at the time of the inspection there were three FTE nursing vacancies.

Nursing staff worked to a three-shift roster with a designated staffing level on each shift. The CNM told Inspectors that there was a range of experience among the registered nurses, six of whom had recently completed the New Entry to Specialist Practice (NESP). These nurses required ongoing support from their more experienced colleagues.

Several managers and staff told Inspectors that the turnover among nursing staff was a concern. Data provided by the DHB showed that between 2015/16 and 2017/18 staff turnover increased from 10 per cent to 24 per cent. The CNM told Inspectors that nurses resigned for a variety of reasons, including to undertake further training, new jobs, personal reasons and to go travelling. However, no systematic evaluation of the reasons for the increase in turnover had been undertaken.

All new nurses received an orientation to the Unit, which included the allocation of a 'buddy' or, for new graduates, a preceptor.⁶ New staff who Inspectors spoke with spoke positively about the orientation process and the support they had received from colleagues.

Clinical supervision is available to nurses but the Nurse Consultant told Inspectors that a shortage of supervisors meant that there was a waiting list for supervision.

My Inspectors reviewed the training records of staff, which indicated that the majority of staff had undertaken the core mandatory training or had it scheduled in the new future. Nurses told Inspectors that professional development was encouraged on the Unit by means of post-graduate courses and regular in-house training sessions.

Data provided by the DHB showed that the average staff sickness rate for the Unit for the period 2015/16 to 2017/18 was 3.7 per cent.

Recommendations – staff

I recommend that:

9. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

⁶ Preceptor: An experienced and competent nurse who provides support and learning experiences for a new graduate nurse.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 9

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Acknowledgement

I appreciate the full co-operation extended by the Charge Nurse Manager and staff to the Inspectors during their inspection to the Unit. I also acknowledge the work involved in collating the information requested.



Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Senior Managers	Unit staff	Others
Service Manager	Charge Nurse Manager	Young people
Nurse Consultant	Clinical Nurse Specialist	Research Officer
	Registered nurses	Chaplain
	Enrolled nurses	
	Consultant Psychiatrist	
	Clinical Psychologist	
	Occupational Therapist	
	Pharmacist	
	Social Worker	
	Teacher	
	Youth Consumer Advisor	
	Family/Whānau Advisor	
	Pukenga Atawhai	

Appendix 2. Legislative framework

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – health and disability facilities

Section 16 of COTA defines a “place of detention” as:

“...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

- (d) a hospital*
- (e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...”*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

The *New Zealand Gazette* of 6 June 2018 sets out in further detail the relevant places of detention:

“...in health and disability places of detention including within privately run aged care facilities; ...”

Carrying out the NPM’s functions

Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - a. for improving the conditions of detention applying to detainees;
 - b. for improving the treatment of detainees; and
 - c. for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the designated places they want to visit and the people they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

1. require the production of any information, documents, papers or things that, in the Ombudsmen's opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
2. at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman's NPM function, and read his monitoring reports, online: www.ombudsman.govt.nz under *What we do > Protecting your rights > Monitoring places of detention*.