

Capital and Coast District Health Board - Mental Health

Current Status: 12 August 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Capital and Coast District Health Board (CCDHB) Mental Health, Addictions and Intellectual Disability Services (MHAID) are provided at Porirua and in Wellington City. There were 169 of 179 beds occupied on the day of audit. Staff report pressure on beds in some areas as many service areas are specialised. Of significance for this Mental Health Addictions and Intellectual Disability service is a programme to move this service into a three district health board (3DHB) service. The three district health boards involved are Capital and Coast, Hutt Valley and the Wairarapa. This programme commenced in July with the appointment of a 3DHB General Manager for Mental Health Addictions and Intellectual Services.

At the last Certification audit there were seventeen areas for improvement raised. Eight of these remain open and two new areas for improvement have been raised. Areas for improvement include: visual privacy; cultural support; updating policies; completion of patient records; menu variety; departmental credentialling; and incomplete training records. One area is identified as having staff shortages which needs to be addressed. There are some facility issues that require maintenance.

Consumer Rights

Service user privacy is not always fully maintained in some parts of the Forensic Service. The windows in some bedroom doors are insufficiently covered and the chaplain does not have the consent of all affected service users to attend meetings where their clinical information is discussed. These privacy issues continue as areas requiring improvement.

There are processes in place to support effective communication and interpreter services are available. Results of incidents are displayed and service user meetings conducted. Service users and their family, with the service user's permission, attend multidisciplinary meetings. There were previous requirements to ensure that service users were aware of their right to access independent advocacy services and for them to be supported by staff in a non-discriminatory manner. These have now been sufficiently addressed.

There is still no kaumatua for Te Whare o Matairangi and therefore limited Maori mental health welfare education for service users and whanau in that acute service, so this still requires improvement.

Good examples are seen of the implementation of the open disclosure policy.

There are well developed and implemented systems at both DHB and MHAID level for managing complaints. These are monitored to ensure that the practice meets the requirements of the Code. Information about accessing the complaints and advocacy systems is widely displayed.

Organisational Management

The organisation is currently in a change management process due to the region's three district health boards combining in some core areas. There are three Boards, two chief executives (one for CCDHB, and one for Hutt Valley DHB and Wairarapa DHB). The General Manager 3DHB, the Associate Director of Nursing and the Executive Director (Operations) work across the three DHB's. The recently appointed General Manager 3DHB is progressing the implementation phase of the Mental Health Addictions and Intellectual Disability service merge. Additionally two new services are currently being discussed for the CCDHB campus.

A newly appointed acting CCDHB Quality & Risk Manager works with the Quality Consultant in Mental Health Addictions and Intellectual Disability and the CCDHB quality and management teams. The quality and risk structure and reporting is clearly established. Projects are undertaken to improve patient outcomes and to ensure safety, for example, audit tools for metabolic monitoring, ligature audit and medication administration.

Policies and procedures are managed through 'CapitalDoc', an electronic controlled document management system. Improvements are being made to the system for usability. Continuing work has been undertaken to update documents. Document control remains as an area for improvement.

The quality plan expired in July 2014; however this has not been updated due to the changes, a priority diagram has been developed and is to be used for quality planning going forward.

The CCDHB quality managers' report monthly to the strategic clinical governance executive committee. Action plans are developed as a result of the various meetings. Of note is the appointment of a person to focus on continuous improvement and the use of control charts to show acceptable variability and therefore enable increased focus on improvement, when required.

The risk management process and reporting demonstrates risks are defined, assessed, rated, analysed and evaluated, risk treatment is applied and monitoring and review occurs.

Adverse events are reported and managed through a well-developed system used throughout the DHB. The quality consultant provides monthly reports to the clinical governance group and these reports make good use of tools, such as control charts, to illustrate trends and to monitor implementation.

Recruitment and training required improvement in four areas as a result of the certification audit in 2013. Two of these have now been resolved. The previously inconsistent content of personnel files made it difficult to ascertain if the relevant elements were in place. The human resources department has developed an effective internal filing system where information is now readily identified. There is still insufficient information fed back to the human resources department about staff supervision.

Occupancy has been consistently high over the last 12 months. The youth services, as a consequence, at times need to “special” a patient in the adult area. To assist with the bed issue a new position has been created of an Acute Resource Co-ordinator. One ward is experiencing vacancies. Timely planning to fill staff vacancies is an area for improvement.

Individualised files contain information about each consumer. The records are confidential, and only accessed by staff with appropriate authority. Information is recorded across both electronic and hard copy systems with a partially implemented project to establish an electronic record. Some information is difficult to retrieve due to the use of two systems. This is an area for improvement.

Continuum of Service Delivery

The surveillance audit included three inpatient units: Haumietiketike, (Intellectual Disability, 13 beds and two rehabilitation houses); Tane Mahuta (Regional Forensic Rehabilitation - 16 beds inpatient unit and 18 beds in seven adjacent cottages) on the Kenepuru site in Porirua; and Te Whare o Matairangi (TWOM - acute intensive care psychiatric unit, 29 beds) on the Wellington Hospital grounds. TWOM is recently refurbished and is new spacious modern environment.

Three patient journeys were followed through the services: two in the medium secure intellectual disability and regional forensic rehabilitation units; and the remaining tracer in the acute admissions unit (TWOM).

The units all meet relevant statutory and regulatory requirements and provide active and specialist rehabilitation programmes which meet the needs of service users in each programme, within the overall restrictions required under legislation.

All service users have a current treatment plan. Treatment plans sighted are fully documented and reflect recovery principles. Individual goals and related interventions are appropriate to the level of support/treatment required and are regularly monitored. This includes risks, triggers and early warning signs. Interventions in Tane Mahuta reflect a rehabilitation approach. The required screening of physical and mental health needs is also conducted.

There are a number of examples of good practice in Haumietiketike, including access to onsite education and the innovative 'stepping stones' programme. In Te Whare O Matairangi, (TWOM) the tracer has daily psychiatrist contact and review as part of the acute/ psychiatric care clinical programme. TWOM evidences good liaison with families / whanau.

Reviews and evaluations in all services are conducted in an ongoing manner. This includes regular multidisciplinary reviews and the use of outcome measurement tools. Achievement towards goals are reviewed and treatment plans adjusted accordingly.

Transitions and discharges are made in a comprehensive, planned and safe manner. The required referrals and discharge plans are documented. The need for improvement in care planning, identified at the previous audit, is now resolved, although there is further improvement required related to the system of care plan records at service level.

Medication prescribing, dispensing and administration responsibilities are all completed to a good standard and recording is up to date and accurate. It is recommended that the service adopts the national medication chart format.

At the previous audit requirements relating to ECT were unable to be assessed. At this audit, the ECT process is reviewed and demonstrate that there are rigorously implemented systems in place which ensure that this intervention complies with best practice guidelines.

The kitchens have on-going food safety accreditation and the menus are consistent with nutritional guidelines. Various different ways are found to provide menu variation. Nevertheless, the menu cycle remains two weekly, which is too short for the long stay service user population and requires improvement. There is rigorous monitoring of food handling by the contracted provider, however food that is stored on wards is not being as well managed, and this also requires improvement.

Safe and Appropriate Environment

The buildings all comply with regulatory requirements, including having emergency fire procedures in place. Some areas still require improvement. This includes the appropriate and safe storage of equipment by both the service and service users and

the need for refurbishment to replace some peeling paint and damaged surfaces, including shower areas. A previous requirement to improve wheelchair access to showers has been resolved by developing a plan involving improved staff support if the need should arise.

Restraint Minimisation and Safe Practice

Restraint management is well organised and well understood within the MHAID. A new initiative is a high level MHAID group being set up to 'champion' the reduction in the use of seclusion with the intent of its eventual elimination. A previously used seclusion room in Te Whare Ra Uta is no longer used, thus addressing a previous required improvement. Current practice provides a very good example of alternative and more effective ways of managing longstanding challenging behaviour.

Restraint minimisation is overseen by the Restraint Approval Committee which reviews restraint use. Good records are kept and monitored of each event. The registers provide sufficient information to support monitoring and maintenance of an overview of utilisation of restraint. Mandatory staff training supports the reduction of restraint use and the use of alternative strategies and there is an emphasis on de-escalation and diversion through early intervention. There is a sensory room in Te Whare o Matairangi and areas for 'time out' in Haumietiketike as an alternative to restraint. Special observations offer an opportunity for more intensive input which also supports de-escalation. Staff are observed during the audit demonstrating de-escalation skills.

Infection Prevention and Control

Mental Health Addictions and Intellectual Disability Services have an infection control representative who is part of the organisation's infection control team. Responsibility includes monitoring infections through daily reports from the laboratory. Infections in the Mental Health Addictions and Intellectual Disability service are rare. There is currently surveillance for influenza; however, there have been no positive swabs. The patient safety group meet monthly and examples of agenda items discussed are sighted; for example, the July meeting included discussion about hepatitis testing and planning for a procedure to be developed.