

Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool

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Foreword

Tēnā koutou katoa

The 2014 *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool* (the Tool) updates the *Specialist Opioid Substitution Treatment (OST) Audit and Review Tool 2011*. It complements the work completed over the last five years, which focused on ensuring the provision of the best possible service to clients and their families and whānau.

The Tool is specifically aimed at auditing the practice of OST as reflected in the Ministry of Health publications: *New Zealand Practice Guidelines for Opioid Substitution Treatment 2014* and *National Guidelines: Interim methadone prescribing (2007)*.

The Tool reflects significant themes and important developments that align with these documents, including:

- a strong emphasis on actively supporting clients to plan their own wellness and recovery
- a focus on recovery-orientated treatment and psychosocial support
- peer support
- transitioning clients in a timely manner to primary health care services
- providing continuity of care and treatment to OST clients entering prison.

We acknowledge and thank those who have contributed to the revision of the Tool, in particular, Jenny Wolf and Raine Berry and to members of the National Association of Opioid Substitution Treatment Providers (NAOTP), who provided advice throughout the revision process. Also, we acknowledge the Southern District Health Board's Dunedin-based OST service for volunteering to trial the Tool at their service and also Eileen Varley, Danie Ralph and Marc Beecroft for providing their time to be part of the audit team to test the Tool.

It is important for OST services to be reviewed and audited regularly to maintain a quality client centred service. Revision of the Tool has been vital in supporting that process, ensuring that OST audits continue to follow current best practice.

Our intention is for the Tool to help services provide OST that meets best practice guidelines and improve practices that require further development. We hope that this in turn will boost confidence in OST service provision among clients, families, service providers, funders, the broader health sector and the general public.

Noho ora mai

John Crawshaw
Director of Mental Health & Chief Advisor
Office of the Director of Mental Health

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Introduction

Aims

The *Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool* (the Tool) sets out the audit requirements to determine whether practices within specialist opioid substitution treatment (OST) services are consistent with current best practice in OST and to clarify service providers' responsibilities in providing OST.

The indicators against which services are audited are primarily drawn from the following key documents:

- New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (Ministry of Health 2014) (referred to in this document as the *OST Guidelines*)¹
- National Guidelines: Interim methadone prescribing (Ministry of Health 2007).²

The primary focus of audit processes is to remain consistent with the guidelines laid out in these two key documents. Services must clearly outline and clinically justify the rationale for any practice that varies from these key documents.

The Tool is designed primarily to support an external audit / review process undertaken by an expert team. The Tool does not provide all the micro-detail of what is required when planning the audit questions and focus points. Some discretion is required on the part of the lead auditor to determine who should be asked certain questions covered within the Tool; which questions might not be required, based on having seen the evidence within documentation, and whether multiple sources are needed in order to resolve certain questions, eg, observation, policy documentation and interviews.

What the Tool includes

Part A: Audit Report Template

This template enables the audit team to provide a structured report on service performance against each section of the *OST Guidelines* (Ministry of Health 2014).

For ease of reference, the audit report template is divided into sections that correspond directly with the sections in the *OST Guidelines*, even down to including indicators drawn from the corresponding section in the *OST Guidelines*. Any sections of the *OST Guidelines* that do not need to be audited are referenced as 'no audit requirements'. Where necessary, to ensure the Tool is comprehensive and up to date, additional indicators have been drawn from feedback provided by the National Association of Opioid Substitution Treatment Providers (NAOTP).

¹ Ministry of Health. 2007. *National Guidelines: Interim methadone prescribing*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/national-guidelines-interim-methadone-prescribing (accessed 18 September 2014).

² Ministry of Health. 2014. *New Zealand Practice Guidelines for Opioid Substitution Treatment 2014*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014 (accessed 18 September 2014).

Part B: Audit set-up and data-gathering tools

These are a series of tools provided to help the audit instigator set up the audit and the audit team gathers information for the report. Auditors may wish to tailor these tools to their specific audit context.

These set-up and data-gathering tools include:

1. Opioid substitution treatment audit request form
2. Documentation request form
3. Service context information request form
4. Documentation review tool
5. Observation of facility tool
6. Incident reports review tool
7. Client records review tool
8. Prescription audit tool
9. Manager, team leader, lead clinician, staff interview tool
10. Client interview tool
11. Family / whānau / support person interview tool
12. Pharmacists, authorised prescribers,³ Medicines Control, and other key interfaces/links interview tool.

Data sources

Audit data may be drawn from the following, which should also be referenced as evidence in the report template, using the abbreviations as below:

- | | |
|-----------------------------------|-----|
| • Documentation | D |
| • Client records | CR |
| • Incident reports | IR |
| • Service reports | SR |
| • Staff interview | STI |
| • Manager / team leader interview | MI |
| • Lead clinician interview | LCI |
| • Consumer interview | CI |
| • Māori focused interview | MaI |
| • Key stakeholder interview | KSI |
| • Visual inspection | VI |

³ Authorised prescribers include any health professional authorised to prescribe OST medication by either the specialist service lead clinician or a specialist service medical officer who has the authority under section 24(2)(b) Misuse of Drugs Act (MoDA). Authorised prescribers might include specialist service medical officers, general practitioners, prison medical officers, nurse practitioners and other designated health professional prescribers.

The audit team and audit process

Composition of an audit team

The audit team should comprise at least two auditors, (one of whom has an in-depth understanding of best practices in OST) and a consumer auditor who has experience in receiving OST. The team must also have a clear understanding of the requirements set out in the *OST Guidelines* and the other key references.

Audit instigator and lead auditor responsibilities

Audit instigator

The audit of an OST service is generally instigated by the Ministry of Health or a district health board (as part of its service planning and funding responsibilities). An external formal audit is recommended (rather than an ‘internal’ audit, which can be subjective) with the aim being to use the Tool to achieve an objective, fact-based critique of the service.

Lead auditor

A lead auditor takes responsibility for the audit team. All members of the team must sign a confidentiality document at the outset of the audit. The lead auditor leads the process shown in Figure 1: The external audit process (page 9).

Key steps in the audit process are:

1. Notifying the service and providing information

The audit instigator engages an external audit team and advises the service of the audit in writing, requesting that the service manager return an audit acceptance form. The audit instigator also provides the OST service with an auditor profile and a copy of the full audit and review tool.

Ideally, preparation for the audit visit would begin 5–6 weeks before the actual visit to allow sufficient time for all the parties involved, such as authorised prescribers, to make themselves available for the audit.

2. Requesting documentation

The lead auditor requests three copies of all documentation and basic information from the service. Forms A–C in Part B of this Tool can be used for this set-up process.

We recommend that the lead auditor contact the most senior manager of the service to be audited (for example the CEO of a DHB) to alert them to the audit.

The service should be made aware from the outset that the lead auditor will immediately notify the Ministry of any risk that is identified as being ‘critical’, and the service will also be informed.

3. Forward information and documentation to the audit team

Once the lead auditor receives the service information and documentation, they forward it to the audit team for their assessment.

Audit team responsibilities

Setting up the audit and arranging the on-site visit

The lead auditor liaises with the service manager to set up the audit and arrange the on-site audit visit.

Requesting coordination of interview schedule

The lead auditor provides the service manager with a list of people to be interviewed and asks them to arrange the interview schedule. The number and range of stakeholders interviewed will depend on the individual service context. Generally, interview lists include:

- clients, including those from the waiting list, general practice and interim-prescribing programme (if the service is providing this) (note: the lead auditor might consider some form of payment to acknowledge clients for their time)
- family/whānau members
- the service manager / team leader
- the lead clinician
- incidents/complaints co-ordinators
- staff members representing each discipline and staff group employed on the team, including consumer advisor, primary health care liaison, pharmacy liaison, administration/reception staff
- the DHB senior management / non-government organisation Board chairperson, planner and funder
- community pharmacists and authorised prescribers (including prison medical staff) (note: the lead auditor might consider some form of payment to acknowledge authorised prescribers for their time)
- referrers and other key links, eg, local prison.

Some of the questions within the Tool may require reframing to be relevant to the particular interviewees.

Reviewing documentation

The audit team reviews the documentation before conducting the audit. The findings of the documentation review will inform the focus of the other steps in the audit, including interviews, review of client records and inspection of facilities.

Audit tasks

On-site visit

The on-site visit includes (not necessarily in this order):

- instigating an initial introduction meeting with the interviewees to establish the purpose of the audit and methods to be used and to set the day's schedule
- conducting interviews and discussions with staff, clients and family members, the manager, team leader, lead clinician and, as available, the senior manager or the Board chair (note: clients and family members should be informed of the context of the audit, the intended recipients and the fact that their comments will remain anonymous. They should also be asked to sign a consent form. Client feedback could also be obtained by developing a questionnaire for them to complete and return by post in a reply-paid, self-addressed envelope or an online survey format to the lead auditor)
- reviewing documentation and records, including staff records, policies and protocols, incident reports, complaints documentation, samples of client records and treatment/individual plans (notes: in preparing for the site visit, the lead auditor should check if any client files are held electronically, especially at the GP surgery, as this may require access to a computer during the audit. Also, they must note their audit in any client file that they review, see 'Obtaining information from clients and accessing client records' below)
- touring the service and making observations.

Auditor review meetings

It is good practice to schedule periodic audit team mini-meetings throughout the audit to provide team support, check for gaps during the audit and discuss any emerging risks, etc.

Also, as a matter of courtesy, we recommend that the lead auditor arrange a mini pre-summary meeting with the service's relevant senior management to ensure there are no surprises for the service.

The lead auditor should arrange an audit summary meeting with the service manager, lead clinician and other staff to provide general feedback on what is working well as well as areas for further development or improvement, to clarify any outstanding issues and respond to any queries that have arisen during the audit. Also, at this meeting they will finalise the draft report timeframe.

Note: Some identified themes/issues may not relate directly to the *OST Guidelines* or this audit tool. They may come under either a category of risk or other guidelines/legislation, for example 'no spillage kits'. The audit team should use their discretion to decide how to deal with such themes/issues. They can be noted as part of the audit general report and/or considered as a risk.

Reporting

The audit team prepares a draft report with recommendations for further action (if appropriate) within 10 working days and sends it to the service for review and their comment (to be returned to the audit team within five working days). The lead auditor then submits the final audit report to the Ministry of Health and sends copies to the DHB and the service.

The report should accurately reflect the findings from the audit process and summary meeting.

Once the final report has been sent to the relevant parties, the lead auditor ensures all documentation held by the audit team (including electronic completed forms) is destroyed/deleted.

Measures of attainment

The following levels of attainment apply to each indicator in the Audit Report Template:

- FA – Fully attained: The service clearly demonstrates that the criterion has been implemented.
- PA – Partly attained: The service can demonstrate evidence of appropriate provision of services as defined in the guidelines without the required supporting documentation or there is a documented process, system or structure without demonstrated implementation.
- UA – Unattained: The service is unable to demonstrate appropriate processes, systems or structures to meet the required outcome of the criterion and implementation has not occurred.
- N/A – Not applicable.

The Audit Report Template includes a summary for each section that shows the level of attainment and suggested actions required to meet the fully attained level.

Risk

A risk column is included in each set of tools. Risk can be categorised as:

- negligible (not applicable)
- low
- moderate
- high
- critical.

When the audit result for any criterion is partially attained (PA) or unattained (UA) the Risk Management Matrix should be used. Refer to Appendix 1 (Risk Assessment Matrix, page 61).

The 'risk' should be assessed in the first instance in relation to the possible impact on consumers or service providers, based on the consequence and likelihood of harm occurring as a result of the criterion not being fully implemented.

To use the Risk Management Matrix:

1. consider the consequences on consumers/support persons/staff safety of the criterion being only Partially Attained or Unattained – ranging from extreme/actual harm to no significant risk of harm occurring
2. consider the likelihood of this adverse event occurring as a result of the criterion being only Partially Attained or Unattained – ranging from the occurrence being almost certain to rare
3. plot your findings on the Risk Management Matrix in order to identify the level of risk – ranging from Critical to Negligible

4. prioritise risks in relation to severity (for example Critical to Negligible)
5. take appropriate action to eliminate or minimise risk within the timeframe indicated by the 'Action Required' column.

Likelihood of an event occurring

The likelihood describes the probability of an event occurring. For example the statistical probability of an event occurring is indicated as follows:

- Almost certain 91–100%
- Likely 61–90%
- Moderate 41–60%
- Unlikely 11–40%
- Rare 0–10%

Action required

Specific timeframes for corrective actions to be completed by the service are specified in the risk management matrix, according to the level of risk identified. The lead auditor should request corrective actions within these timeframes, but is expected to use discretion on a case-by-case basis at audit. The lead auditor must be able to justify setting a timeframe outside of those specified, if requested by the service.

If the audit team identifies a risk as being 'critical', the lead auditor will immediately notify the Ministry of Health and inform the service. This possibility should be flagged with the service when they initially agree to an audit.

If a risk is identified that does not fall within the scope of the audit tool, the risk still has to be noted and raised with the service. If the risk is not critical, the lead auditor should bring it to the attention of the service before and at the summation meeting and note it within the final audit report with an allocated risk rating.

Audit templates

Audit templates have been developed that are linked to this document. They are available on the Ministry of Health website.

Service manager/team leader responsibilities

Notifying clients and staff

The service manager must notify clients and staff of the upcoming audit in writing. Clients must be informed that the auditors will carry out interviews and that they may be invited to participate in the interview process. They must also be reassured of the confidentiality of the interviews and the auditors' independence.

Confirming acceptance and providing documentation

The service manager must forward the required documentation to the lead auditor within two working weeks, preferably electronically. They will need to supply sufficient copies of any hard-copy documentation for each auditor.

Coordinating the interview schedule and setting up the on-site audit

The service manager arranges coordination of the interview schedule as requested by the lead auditor and sets up the requirements for the on-site audit. Sometimes the auditors may need transport, where the schedule requires them to visit and interview a range of external people. The service might help arrange transport in such cases.

Coordinating feedback on the draft audit report

The service manager coordinates service personnel to review and provide feedback on the draft audit report.

Managing the implementation of the audit recommendations

It is the responsibility of the service manager / team leader and lead clinician to review and where appropriate implement the auditors' recommendations and to inform the Ministry/DHB instigator of the action plan resulting from the audit.

Table 1: The external audit process

Set up 6 weeks	Audit Instigator (Ministry of Health) <ul style="list-style-type: none"> • Agree service to be audited • Engages Audit Team • Advises service of audit and requests acceptance form • Provides service with auditor profile and audit tool 	
	Lead Auditor <ul style="list-style-type: none"> • Takes responsibility for the audit team • Contacts the most senior manager to alert them of the audit • Request documentation and information from the service • Forwards documentation etc to the audit team • Provides the service with interview requests and assists the service manager with the coordination of the interview schedule • Arranges site visits with the service manager • Arranges and carries out any pre-service telephone interviews, eg, Medicines Control and Corrections 	
	Audit Team <ul style="list-style-type: none"> • Reviews documentation provided by the service 	
	Service Manager <ul style="list-style-type: none"> • Provides the acceptance form to the audit instigator • Provides documentation and information to the lead auditor • Confirms dates for on-site audit visit • Notifies clients and staff • Coordinates interview schedule in partnership with the lead auditor • Prepares for on-site visit 	
On-site 2 days	Audit Team <ul style="list-style-type: none"> • Conducts interviews • Inspects facilities • Reviews clients' records and incident reports • Attends audit review meetings and feeds back to lead auditor 	
	Lead Auditor <ul style="list-style-type: none"> • Facilitates opening and closing meetings with the service • Prepares draft report and provides to service manager 	
Reporting 8 weeks	Audit Team <ul style="list-style-type: none"> • Prepare formal feedback for the Lead Auditor 	within 5 working days post the service visit
	Lead Auditor <ul style="list-style-type: none"> • Prepares draft findings for Service Manager (after first seeking input from the Audit Team – as above) 	within 20 working days post the service visit
	Service Manager <ul style="list-style-type: none"> • Return findings to Lead Auditor with comments on factual accuracy 	within 10 working days from receipt of draft from the Lead Auditor
	Lead Auditor <ul style="list-style-type: none"> • Provides final report of the Audit Instigator (MoH) 	within 10 working days from receipt from the Service Manager

Obtaining information from clients and accessing client records

The Health Information Privacy Code 1994 allows client records to be used for clinical and quality audits. Users must make every effort to maintain the client's privacy. Client records are not taken from the site and are only used for auditing purposes.

The service is required to take reasonable steps to ensure that all clients are aware that an audit of the service is going to take place and, specifically, are aware of:

- the fact that information is being collected
- the purpose(s) for which the information is being collected
- the intended recipients of the information
- the contact details of the auditors
- the possibility of individual client files being randomly selected by the auditors and the purpose behind this.

A note is placed in each audited file when it is audited. The relevant staff member will then provide information about the audit to the client at the next contact.

Part A: Audit report template

Audit report executive summary

<Name of service>

Audit report date:

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

Report date:

Service context

Service provider:	
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Premises name	Street address	Suburb	City

Number of funded OST places	Number of clients at date of audit	Number and percentage of clients in shared care	
		<Number>	<Percentage>%

Current waiting time	Number of community pharmacies	Number of GPs authorised

Staffing roles	Qualifications	Number and % of staff with no professional registration	
		<Number>	<Percentage>%

Audit team

Audit team	Name	Qualification
Lead auditor		
Clinical expert		
Consumer auditor		
Other		

Data collected

No. of clients interviewed		No. of whānau interviewed	
No. and % of clients records reviewed	<Number> <Percentage>%	No. of authorised prescribers/ staff interviewed	
No. of staff/management interviewed		No. of pharmacists interviewed	

1 Opioid substitution treatment

Indicators	Evidence	Attainment	Risk
1.1 Objectives of OST			
The service delivery reflects the principles of the Treaty of Waitangi.			
The service delivery reflects the principles of recovery and harm reduction.			
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.			
The overarching treatment objectives are consistent with the objectives set out in section 1.1 of the <i>OST Guidelines</i> .			
1.2 Roles of specialist OST services	No audit requirements		
1.3 Recovery-orientated OST			
The service delivery reflects the principles of recovery and wellbeing orientated treatment.			
Recovery is visible to the clients, eg: <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 the service employs peer-support workers and consumer advocates. 			

Section attainment summary

Indicators (out of 6):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Clients accepted for OST meet diagnostic criteria for opioid dependence and indicators of how such criteria are met are clear in the assessment.			
Risk-taking behaviours are documented in the assessment, eg, injecting practices, blood-borne virus transmission, driving.			
The client's strengths and recovery capital are identified in the assessment.			
2.2 The treatment plan			
Comprehensive assessments include an individualised treatment plan that is reviewed and updated at regular intervals.			
Treatment plans are developed in collaboration with the client and are self-directed and recovery focused.			
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.			
2.3 Other treatment options for opioid dependence			
Alternative treatment options have been discussed and documented.			
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.			
2.5 Contraindications for OST	No audit requirements		
2.6 Priority admissions			
A transparent system is in place to determine priority access based on the risks of delaying treatment.			
2.7 OST for clients under 18			
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.			
2.8 Informed consent and treatment information			
Consent for OST is signed by the client.			

Indicators	Evidence	Attainment	Risk
<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>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.</p>			
2.9 Choice of OST medication			
<p>Clients are provided with information on the OST medications available and their choice is guided by their preference and goals.</p>			

Section attainment summary

Indicators (out of 15):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Clients are informed about how long they will wait for OST and are offered interim methadone or buprenorphine and psychosocial support.			
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> .			
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.			
3.3 Ongoing OST			
Appointments with the key worker occur no less than three monthly.			
The client is seen by the authorised prescriber, preferably with the key worker, at least once every six months.			
Transfer to a primary health care provider is in place or being pursued.			
Therapeutic doses are generally in the range of 60–120 mg methadone or 12–24 mg buprenorphine.			
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.			
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.			
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.			
3.6 Reviewing progress			
Reviews occur at least once every six months and involve the client, the authorised prescriber and the key worker.			
Key worker monitoring sessions include review of progress in relation to the treatment plan and an updated assessment of risk.			
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> .			
Written procedures are available for clients on how to request a treatment review.			

Indicators	Evidence	Attainment	Risk
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.			
3.8 Psychosocial interventions			
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).			
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.			
Family-inclusive practices are central to the service delivery.			
The interventions provided are evidence based, recovery orientated and tailored to individual needs and have defined goals.			
Self-help techniques for emotional distress, including sensory modulation, are promoted.			
The service has links with other supports, including peer support, employment and housing agencies.			
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.			
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.			
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.			
The client has a discharge plan and after-care plan, <i>OST Guidelines</i> section 3.9.1.			
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.			
Decisions regarding involuntarily cessation of OST are supported by an independent addiction medical specialist, or equivalent, <i>OST Guidelines</i> section 3.9.2.			
Clients subject to involuntary withdrawal are: <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. <i>OST Guidelines</i> section 3.9.2.			
The client has a discharge plan, including how they might re-engage in OST, <i>OST Guidelines</i> section 3.9.2.			

Section attainment summary

Indicators (out of 30):

Fully attained ☐

Partially attained ☐

Unattained ☐

Not applicable ☐

Summary of recommended actions

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.			
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.			
Identified risks are effectively managed and documented.			
4.3 Methadone and cardiac safety			
Clients are screened for the risk of QTc interval prolongation at entry to, and during, OST as appropriate.			
4.4 Drug interactions	No audit requirements		

Section attainment summary

Indicators (out of 4):

Fully attained ☐

Partially attained ☐

Unattained ☐

Not applicable ☐

Summary of recommended actions

5 Managing dose-related issues

Indicators	Evidence	Attainment	Risk
5.1 Takeaway doses			
The service policy and practices are relevant to takeaway doses of OST medication, support safety and recovery goals and are consistent with requirements, including: <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. 			
Safety requirements concerning takeaway doses are specified in writing and provided to clients and pharmacists.			
5.2 Notice of prescription changes			
Clients are given information on how to request changes to prescriptions.			
5.3 Replacement doses			
Replacement of lost or stolen doses occurs at the direction of the prescriber only in exceptional circumstances that are verified.			
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.			
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.			
5.8 Withholding an OST medication dose			
The rationale for withholding or cancelling OST doses is outlined in the client's file.			

Section attainment summary

Indicators (out of 7):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Clients who are known to use other substances problematically do not receive takeaway doses, and their OST medication consumption is closely observed.			
Clients are advised about potential interactions between OST medication and other substance (including alcohol).			
Smoking cessation is promoted and offered by both specialist services and GP prescribers.			
6.2 Managing side effects			
Clients are provided with information on potential side effects and management of side effects.			
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.			
6.4 Managing challenging behaviour	No audit requirements		
6.5 Co-existing medical and mental health problems			
The service routinely assesses for co-existing medical and mental health problems.			
Frameworks are in place for identifying and treating (or facilitating treatment) of coexisting mental health and/or medical problems.			
The service has appropriate systems in place for identifying and supporting clients to manage health issues associated with blood-borne viruses.			
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.			
The service encourages good dental hygiene and facilitates access to dental treatment as needed.			
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.			
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.			
The service liaises appropriately with medical and surgical services to ensure continuity of OST for clients who are hospitalised.			
OST is managed appropriately, in consultation with pain management services, for clients presenting with chronic non-malignant pain problems.			

Indicators	Evidence	Attainment	Risk
6.7 Management of pregnant and breastfeeding women			
Pregnant women have priority access to OST.			
The service implements clear protocols for managing pregnant women.			
Women of childbearing age are given information about the safety of methadone and buprenorphine in pregnancy.			

Section attainment summary

Indicators (out of 18):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
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.			
Admission to the new service is not conditional on discontinuation or withdrawal of any other (prescribed or illicit) substances.			
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.			
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.			
Reviews take place at least annually and involve appropriate prison medical and specialist service staff. All out-of-area reviews are conducted by TeleMed.			
7.3 Transferring from overseas	No audit requirements		

Section attainment summary

Indicators (out of 6):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
The service proactively supports the transfer of clients to their authorised GP as soon as possible after dose stabilisation.			
The specialist service complies with the responsibilities outlined in the <i>OST Guidelines</i> section 8.1.			
8.2 Requirements of GPs in shared care with a specialist service			
Authorised GPs are working within a broader primary health care team.			
Authorised GPs have undertaken training relevant to managing clients receiving OST.			
A formal agreement is in place regarding providing advice and consultation.			
Clients are provided with access to psychosocial support.			

Section attainment summary

Indicators (out of 7):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

9 OST and the pharmacy

Indicators	Evidence	Attainment	Risk
9.1 Responsibilities of the pharmacist			
The service provides training and support to community pharmacies and communicates with them regularly.			
The service provides pharmacies with accurate information as to which GPs are authorised to prescribe OST.			
The pharmacist notifies the prescriber when a client: <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. 			
Pharmacists inform specialist services when they receive OST prescriptions for unknown prescribers.			
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.			
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.			
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).			
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.			
The service notifies the pharmacist when a client has transferred to a new pharmacy.			
The service has systems/policies for documenting and responding to errors in a community pharmacy.			

Section attainment summary

Indicators (out of 10):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Clients are able to access peer support and consumer advocacy from within or outside the service.			
OST staff demonstrate knowledge, skills and attitudes appropriate to their role.			
10.2 Workforce training and professional development			
Clinical staff members receive appropriate orientation, mentoring and supervision and ongoing in-service education.			
Clinical staff have completed or are enrolled in relevant tertiary addiction education.			
Clinical staff are members of a relevant professional body.			
Lead clinicians and senior staff members are supported to attend specialist sector meetings and networking opportunities with OST providers.			
Staff in leadership/management positions and medical officers are supported to attend at least one NAOTP meeting per year.			
Senior medical staff are supported to attend the majority of NAOTP meetings.			

Section attainment summary

Indicators (out of 9):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

11 Administrative expectations of specialist OST services

Indicators	Evidence	Attainment	Risk
11.1 Record keeping			
Comprehensive records are held for all clients.			
11.2 Reporting requirements			
The service fulfils regular reporting requirements, eg, to PRIMHD and to the Director of Mental Health.			
11.3 Rights of clients receiving OST			
Clients are provided with information about: <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. 			
11.4 The complaints procedure			
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.			
Records of complaints are not kept in clinical files.			
11.5 Safety requirements of specialist services			
The service has safety protocols that address the personal safety of clients and staff, as well as safety in prescribing and dispensing OST doses.			
11.6 Local protocols in specialist services			
Local protocols are consistent and do not conflict with the <i>OST Guidelines</i> or with relevant legislation, codes of practice or accountability requirements.			
11.7 Civil defence emergencies			
Management plans are in place for civil defence emergencies.			

Section attainment summary

Indicators (out of 8):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Master copies of the Misuse of Drugs Act 1975, section 24(2)(b) authorisation forms are contained in the service's authorisation folder.			
The Misuse of Drugs Act 1975, section 24(2)(d) authorisation forms are evident in clients' files.			
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.			
Copies of each GP authority are sent to the dispensing pharmacy and to Medicines Control, the Misuse of Drugs Act 1975.			
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.			
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. 			
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.			

Section attainment summary

Indicators (out of 8):			
Fully attained <input type="checkbox"/>	Partially attained <input type="checkbox"/>	Unattained <input type="checkbox"/>	Not applicable <input type="checkbox"/>

Summary of recommended actions

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.			
Clients receiving interim methadone treatment are retained on a waiting list for the full OST programme.			
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.			
13.3 Induction and prescribing			
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. If the interim medication is buprenorphine, induction guidelines should be followed as outlined in the <i>OST Guidelines</i> .			
13.4 Ongoing support			
The specialist service provides information to the client and their support people regarding available psychosocial support.			
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.			

Section attainment summary

Indicators (out of 6):

Fully attained ☐

Partially attained ☐

Unattained ☐

Not applicable ☐

Summary of recommended actions

14 Risk (if any)

Should any risk/s be identified within the course of the audit, this will be documented and given a risk rating (see Appendix 1: Risk assessment matrix).

Part B: Set-up and data-gathering tools

These specialist OST service audit and review tools – audit templates have been developed out of the audit questions and the forms necessary for initiating an audit process.

Not all interview templates and forms are included as the lead auditor has the discretion to devise questions for people such as senior management, board members, or funders. These questions might focus on the history of OST provision and the context of OST provision within their demographics as appropriate.

Before commencing the audit, the lead auditor should ensure that:

- a formal confidentiality agreement is in place with the audit team
- there are explanation slips to go in any clinical file that is audited
- the client survey/questionnaires and fact sheets have been prepared.

1 Opioid Substitution Treatment Audit Request Acceptance Form

To: <Service Manager>

From: <Audit Instigator>

Return address:

Date:

Please return this form, signed and dated on behalf of your service, to confirm that you have received an audit request and that you agree to the service being audited.

Signed:

Role:

Date:

2 Documentation Request Form

To: <Service Manager>

From: <Lead Auditor>

Date:

Please provide the following documentation for review by the audit team and indicate in the checklist below whether or not the document has been provided.

In this form, *OST Guidelines* refers to the *New Zealand Practice Guidelines for Opioid Substitution Treatment 2014* (Ministry of Health 2014).

Documentation	Yes	No	Comment (if necessary)
Approval to offer OST (under section 24, Misuse of Drugs Act 1975 or other relevant legislation)	<input type="checkbox"/>	<input type="checkbox"/>	
Organisational chart	<input type="checkbox"/>	<input type="checkbox"/>	
Treaty of Waitangi: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Treatment outcomes monitoring policy: and/or most recent report	<input type="checkbox"/>	<input type="checkbox"/>	
OST service plans (eg, quality plan, disaster and emergency plan, strategic plan)	<input type="checkbox"/>	<input type="checkbox"/>	
OST service philosophy, principles, description and objectives	<input type="checkbox"/>	<input type="checkbox"/>	
Consumer involvement in service policy development: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Access to service: policy/protocols <ul style="list-style-type: none"> • OST admission criteria • OST exclusion criteria and management • Assessment • Waiting list management • Interim prescribing 	<input type="checkbox"/>	<input type="checkbox"/>	
OST treatment pathway	<input type="checkbox"/>	<input type="checkbox"/>	
Client information booklet/information sheets	<input type="checkbox"/>	<input type="checkbox"/>	
Informed consent: template	<input type="checkbox"/>	<input type="checkbox"/>	
Comprehensive assessment: template	<input type="checkbox"/>	<input type="checkbox"/>	
Treatment plan: template	<input type="checkbox"/>	<input type="checkbox"/>	
Client rights: information	<input type="checkbox"/>	<input type="checkbox"/>	
Complaints: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Benefits and limitations of OST medications: information	<input type="checkbox"/>	<input type="checkbox"/>	
Consumer advocacy and peer-support services: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Treatment review: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Drug screening: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Case management (key worker) and care coordination: policy	<input type="checkbox"/>	<input type="checkbox"/>	

Documentation	Yes	No	Comment (if necessary)
Prescribing and dispensing OST medications: policy/protocols including: <ul style="list-style-type: none"> takeaway medication change of medication dose procedure change of dispensing procedure dispensing arrangements replacement doses missed doses 	<input type="checkbox"/>	<input type="checkbox"/>	
Accessing psychosocial interventions: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Accessing psychosocial supports, self-help, family and whānau support groups and cultural and spiritual guidance: information	<input type="checkbox"/>	<input type="checkbox"/>	
Management of coexisting mental health and medical problems: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Managing blood-borne virus: policy/information	<input type="checkbox"/>	<input type="checkbox"/>	
Managing the needs of older clients: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Safety and risk management: policy: <ul style="list-style-type: none"> Overdose Substance-impaired driving Drug interactions Safety of staff and clients 	<input type="checkbox"/>	<input type="checkbox"/>	
Managing intoxication and/or suspected diversion: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Pain management: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Managing pregnant and breastfeeding women: policy/protocol	<input type="checkbox"/>	<input type="checkbox"/>	
Managing clients ending OST: policy/protocol	<input type="checkbox"/>	<input type="checkbox"/>	
Interim prescribing: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Community pharmacy interface: policy/protocol <ul style="list-style-type: none"> Informing and consulting pharmacists Training and support for community pharmacists Management of errors in community pharmacy 	<input type="checkbox"/>	<input type="checkbox"/>	
Primary health care interface: policy/protocol <ul style="list-style-type: none"> Authorisation of GPs/other health professionals to prescribe OST medications Transfer of clients to and from primary health care Review of treatment Support for authorised GP prescribers 	<input type="checkbox"/>	<input type="checkbox"/>	
Prison interface: policy/MOU <ul style="list-style-type: none"> Managing clients who are in prison Review of client care Liaison Support for authorised prison medical officers 	<input type="checkbox"/>	<input type="checkbox"/>	
Interface with other OST services: policy <ul style="list-style-type: none"> Transfer of care consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
Wellbeing of children: policy/protocol	<input type="checkbox"/>	<input type="checkbox"/>	
Client records: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Staff training/education: policy	<input type="checkbox"/>	<input type="checkbox"/>	

Documentation	Yes	No	Comment (if necessary)
Clinical supervision: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Performance management: policy	<input type="checkbox"/>	<input type="checkbox"/>	
Position description for each designation	<input type="checkbox"/>	<input type="checkbox"/>	
Two most recent reports to Ministry of Health	<input type="checkbox"/>	<input type="checkbox"/>	
Other (please list)	<input type="checkbox"/>	<input type="checkbox"/>	

3 Service Context Information Request Form

To: <Service Manager>

From: <Lead Auditor>

Return address:

Please provide the following information for the audit team.

Service name:	
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Premises name	Street address	Suburb	City

Number of funded OST places	Number of service users at date of audit	Number and percentage of clients in shared care	
		<Number>	<Percentage>%

Current waiting time	Number of community pharmacies	Number of authorised prescribers

Staffing roles	Qualifications	Number and % of staff with no professional registration	
		<Number>	<Percentage>%
		<Number>	<Percentage>%
		<Number>	<Percentage>%
		<Number>	<Percentage>%

4 Documentation Review Tool

Guidance notes

This is an optional tool provided to assist auditors to review documentation. Where appropriate, guidance on what the auditor should be looking for in a document is listed in bullet points. Overall, the audit seeks to confirm that all documentation reflects the current legal requirements, standards and best-practice guidelines.

In this form, *OST Guidelines* refers to the *New Zealand Practice Guidelines for Opioid Substitution Therapy 2014* (Ministry of Health 2014).

OST Guidelines section reference	Documentation	Yes	No	Comment (if necessary)
12.6	Approval to offer OST <ul style="list-style-type: none"> Sight documentation, check current 	<input type="checkbox"/>	<input type="checkbox"/>	
	Organisational chart	<input type="checkbox"/>	<input type="checkbox"/>	
Intro	Treaty of Waitangi policy <ul style="list-style-type: none"> Consistent with standards and <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
	Treatment outcomes monitoring policy and/or most recent report <ul style="list-style-type: none"> Outcomes regularly monitored Suitable outcomes monitoring tool(s) used Reflect national objectives 	<input type="checkbox"/>	<input type="checkbox"/>	
11.7	OST service plans <ul style="list-style-type: none"> Quality plan Civil defence and/or emergency plans Strategic plan 	<input type="checkbox"/>	<input type="checkbox"/>	
1.1–1.3	Service philosophy, principles, objectives and role <ul style="list-style-type: none"> Reflect underpinning principles in <i>OST Guidelines</i> Reflect a recovery-orientated and harm-reduction treatment focus 	<input type="checkbox"/>	<input type="checkbox"/>	
	Consumer involvement in the service (design, delivery, planning, evaluation) <ul style="list-style-type: none"> Consistent with health and disability sector standards All aspects are included in the service's policies 	<input type="checkbox"/>	<input type="checkbox"/>	
2.6 2.1 Appendix 18	<ul style="list-style-type: none"> Access to service Admission criteria and exclusion criteria Assessment Waiting-list management Interim prescribing All comply with law, standards and <i>OST Guidelines</i> ; facilitate client engagement	<input type="checkbox"/>	<input type="checkbox"/>	
2.2	OST treatment pathway <ul style="list-style-type: none"> Clear and comprehensive 	<input type="checkbox"/>	<input type="checkbox"/>	

OST Guidelines section reference	Documentation	Yes	No	Comment (if necessary)
6.2, 4.1, 4.3, 4.4 4.2 2.3, 2.9 3.8 2.4 2.8 11.3 11.4 3.6 3.9 5.1, 5.7 6.5.4 6.5.3 6.3, 6.1.1 5.2	Client information booklet/information sheets on: <ul style="list-style-type: none"> • OST, including potential side effects, drug interactions and overdose and cardiac effects (with methadone) • information on the effects of changes of opioid dose and combining opioid medications with recreational or prescribed drugs and service requirements on driving ability • range of treatment options available • use of psychosocial interventions • service inclusion/exclusion criteria • expected responsibilities/obligations of the client, including active participation in all aspects of their treatment • the client's rights and advocacy • the service's complaints procedure (particularly in relation to individuals seeking a review of their situation) • relevant advocacy contacts • treatment review • planned and involuntary withdrawal processes • travel • dental health • blood-borne viruses • suspected intoxication or 'diverting' their OST medication • requesting changes to prescriptions 	<input type="checkbox"/>	<input type="checkbox"/>	
2.8	Informed consent <ul style="list-style-type: none"> • Consistent with health and disability sector standards and <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
2.1	Comprehensive assessment template <ul style="list-style-type: none"> • Consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
2.2	Treatment plan template <ul style="list-style-type: none"> • Consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
11.3	Client rights policy <ul style="list-style-type: none"> • Consistent with health and disability sector standards • Limits of confidentiality under the Health Information Privacy Code 1994 	<input type="checkbox"/>	<input type="checkbox"/>	
11.4	Complaints policy <ul style="list-style-type: none"> • Consistent with health and disability sector standards 	<input type="checkbox"/>	<input type="checkbox"/>	
2.9	Benefits and limitations of OST <ul style="list-style-type: none"> • Information on available OST medications 	<input type="checkbox"/>	<input type="checkbox"/>	
10.1	Consumer advocacy and peer-support services	<input type="checkbox"/>	<input type="checkbox"/>	
3.6	Treatment review policy <ul style="list-style-type: none"> • Consistent with <i>OST Guidelines</i> • Pathways for clients seeking review of their treatment 	<input type="checkbox"/>	<input type="checkbox"/>	
3.7	Drug screening policy <ul style="list-style-type: none"> • Consistent with <i>OST Guidelines</i>: facilitates client engagement and recovery and ensures safety 	<input type="checkbox"/>	<input type="checkbox"/>	

OST Guidelines section reference	Documentation	Yes	No	Comment (if necessary)
3.1–3.3, 3.6	Case management and care coordination policy <ul style="list-style-type: none"> Consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
5.1 3.3 5.2 9.2 5.3 5.4	Prescribing and dispensing OST medications policy/protocols, including: <ul style="list-style-type: none"> takeaway medication change of medication dose procedure change of dispensing procedure safety/dispensing arrangements medication dose replacement missed medication doses All comply with law, standards and <i>OST Guidelines</i> : facilitates recovery and ensures safety	<input type="checkbox"/>	<input type="checkbox"/>	
3.8	Access to psychosocial interventions policy <ul style="list-style-type: none"> Consistent with <i>OST Guidelines</i> Pathway for accessing if not provided by service 	<input type="checkbox"/>	<input type="checkbox"/>	
3.8	Access to psychosocial supports policy <ul style="list-style-type: none"> Consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
6.5	Treatment of coexisting mental health and medical health problems <ul style="list-style-type: none"> Screening, assessment and management provided 	<input type="checkbox"/>	<input type="checkbox"/>	
6.5.3	Blood-borne viruses <ul style="list-style-type: none"> Consistent with OST objectives Reflects current best practice 	<input type="checkbox"/>	<input type="checkbox"/>	
6.5.5	Older clients <ul style="list-style-type: none"> Plans in place for care of older clients (ie, clients aged 45 years or older) 	<input type="checkbox"/>	<input type="checkbox"/>	
4.1–4.4	Safety and risk management policy <ul style="list-style-type: none"> Overdose management Driving and OST Cardiac safety and methadone Drug interactions Safety of staff and clients 	<input type="checkbox"/>	<input type="checkbox"/>	
6.1, 6.3	Managing intoxication and/or suspected diversion policy <ul style="list-style-type: none"> Consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
6.6	Pain-management policy <ul style="list-style-type: none"> Acute and ongoing pain management Emergency admissions Planned admissions to hospital Reflects links with pain management services 	<input type="checkbox"/>	<input type="checkbox"/>	
6.7	Pregnancy and breastfeeding <ul style="list-style-type: none"> Reflects priority admission Information on buprenorphine 	<input type="checkbox"/>	<input type="checkbox"/>	
3.9	Ending OST <ul style="list-style-type: none"> Consistent with <i>OST Guidelines</i>; reflects relapse prevention, after-care and OST re-entry provisions 	<input type="checkbox"/>	<input type="checkbox"/>	
Appendix 18	Interim prescribing policy <ul style="list-style-type: none"> Includes buprenorphine 	<input type="checkbox"/>	<input type="checkbox"/>	

<i>OST Guidelines</i> section reference	Documentation	Yes	No	Comment (if necessary)
9	Community pharmacy interface policy/protocol <ul style="list-style-type: none"> • Informing and consulting pharmacists • Training and support for community pharmacists • Management of dispensing errors 	<input type="checkbox"/>	<input type="checkbox"/>	
12.7 8.1-8.2	Primary health care interface policy/protocol <ul style="list-style-type: none"> • Authorisation of GPs to prescribe OST medications • Transfer of clients to and from primary health care • Review of treatment • Support for authorised GP prescribers 	<input type="checkbox"/>	<input type="checkbox"/>	
7.2 12.7	Prison interface <ul style="list-style-type: none"> • Managing clients who are in prison • Review of client care • Liaison • Support for authorised prison medical officers 	<input type="checkbox"/>	<input type="checkbox"/>	
7.1	Interface with other OST services <ul style="list-style-type: none"> • Transfer of care • Transfer consistent with <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
4.1.1	Safety of children policy/protocol <ul style="list-style-type: none"> • Reflects service responsibility in this area 	<input type="checkbox"/>	<input type="checkbox"/>	
	Client records policy <ul style="list-style-type: none"> • Consistent with law, standards and <i>OST Guidelines</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
10.2	Staff training/education policy	<input type="checkbox"/>	<input type="checkbox"/>	
10.2	Clinical supervision policy	<input type="checkbox"/>	<input type="checkbox"/>	
	Performance management policy	<input type="checkbox"/>	<input type="checkbox"/>	
	Position description for each designation	<input type="checkbox"/>	<input type="checkbox"/>	
	Two most recent six-monthly reports to the Ministry of Health	<input type="checkbox"/>	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	<input type="checkbox"/>	

5 Observation of Facility Tool

OST service provider:

Name of unit/team:

Contact person:

Reviewed by:

Date:

Guidance notes

We recommend observing the facility as part of the manager / team leader / lead clinician interview during the on-site audit visit.

An observation guide is provided below. We recommend that you familiarise yourself with the provisions within the relevant sector standards. You should also record any additional observations relevant to the audit.

	Attainment	Risk	Comments
a. Facility appropriateness and environment			
Description of facility			
Appropriate reception facilities (consider physical attractiveness, welcoming nature, therapeutic environment, adequate number of reception staff and space)			
Appropriate waiting area (consider physical attractiveness, adequate space, relevant reading material, prompt access to welcoming reception staff) Client rights/advocacy information visible			
Clinic area: <ul style="list-style-type: none">• Adequate and appropriate equipment• Adequate space• Drug safe attached to building – appropriate staff access, appropriately secured and locked when not in use• Appropriate key handling• Adequate observation of medication administration			

	Attainment	Risk	Comments
Safety features of facilities: <ul style="list-style-type: none"> • Evacuation procedure in the event of fire or other emergency • Safety mechanisms for staff and clients (eg, alarm buttons in relevant places) • Adequate interviewing facilities (including space, setting, sound proofing) • Safety features balanced with a treatment ethos (ie, promoting client engagement and maintaining a therapeutic relationship) 			
Toilet facilities: <ul style="list-style-type: none"> • Adequate access, including disability access • If observation is required, staff of the same sex can observe • Infection control information available 			
Security of facilities: <ul style="list-style-type: none"> • All external doors have adequate locks • Public areas are clearly marked (distinguished from private areas) • Adequate security lighting • Attended by security personnel after hours and as required 			
b. Filing systems / privacy of information			
<ul style="list-style-type: none"> • Only appropriate staff have access to the filing system • Clinical records are not accessible to the public • Cabinets holding clinical records are able to be appropriately secured • Adequate privacy of client information (eg, computer screens, clinical records) in reception and other public areas 			

6 Incident Reports Review Tool

Service provider:

Unit/team:

Auditor:

Date:

Guidance notes

Seek a description of the service's incident-reporting policy and procedures during management interviews.

During the on-site audit visit, a review of incident reports should include a review of:

- a sample of incident forms, against the following audit objectives
 - complete and comprehensive records, to enable you to develop an understanding of the circumstances surrounding the incident
 - evidence that appropriate actions and reviews have been completed at the appropriate organisational level
- a summary of incident report data.

	Attainment	Risk	Comments
a. Indicators for incident forms			
Initial documentation is consistent with policies and procedures Documentation clear/legible and factual Documentation provides a clear understanding of circumstances surrounding the incident and evidence of appropriate action instigated and a planned follow-up			
b. Indicators for incident reports			
Report for months of reviewed			

	Attainment	Risk	Comments
<p>Evidence of:</p> <ul style="list-style-type: none"> • level of review consistent with the nature of the incidents/events and organisational policy • patterns and trends being reviewed on a regular basis and evidence of a feedback-loop process • monitoring of patterns and trends, including systemic approach to analysis by: <ul style="list-style-type: none"> – number and type of incidents – location – circumstances, including systems, process and procedures – identification of core issues – outcome of action taken 			

7 Client Records Review Tool

Guidance notes

Select a **minimum** sample of 20–25 client record files from all service sites using a randomised method. Systematic sampling uses every nth case (eg, every 10th case). Choose the starting point at random (eg, based on a random number between 1 and 10; use a calculator or computer to ascertain this starting number). It may also be important to specify certain conditions for the sample. For example, to represent Māori appropriately, you can separate the cases into two groups: Māori and non-Māori, and sample from each group at random. If the selection does not include at least one file from each staff member, then add files, using the same randomised process, from the list until you have the appropriate range.

You might also need to consider sampling records of:

- clients who are relatively new to OST
- medium and longer-term clients
- clients who have been discharged from treatment and/or transferred within the past two years
- clients who have been comprehensively assessed and have not been admitted to treatment due to exclusion criteria.

Under the terms of the Health Information Privacy Code 1994, clinical and quality audits are deemed to be a legitimate use of personal health information.

Good practice includes informing the clients of the audit and the purpose for reviewing client records. In addition, in each file reviewed, insert a note advising of the audit. At the next contact with the client concerned, a staff member will provide the client with information on the purpose of the audit.

In addition the audit team should observe the following:

- **No client files are to be taken from the service.**
- No personal health information obtained from a client's record review is to be used for any purpose other than the audit.

(Use one sheet to record the audit results for each record.)

Audit number:

Audit date:

Auditor:

Requirement	Attainment	Risk	Comment
National Health Index (NHI) number			
Demographic information			
Consent forms (informed consent for treatment, disclosure of personal information, etc)			
Comprehensive assessment			
Diagnosis of opioid dependence			
Initial treatment plan: recovery orientated and appropriateness to client aims; has realistic goals with timeframes, strengths and needs			
Initial medication dose within recommended range			
Family/support people involved			
Information provided to client (and support people)			
Nominated GP			
Nominated key worker			
Prescriber			
Date treatment commenced			
Medication dose			
Dispensing arrangements			
Pharmacy: name, address, telephone number and fax number and email address			
Current treatment plan			
Record of reviews by the prescriber			
Record of regular monitoring of progress by the key worker in relation to short- and longer-term treatment plans and updated risk assessments			
Progress notes record ongoing contact with the client and, where possible, significant others/whānau and other providers (including the GP and pharmacist) and interventions implemented in keeping with the current treatment plan			

Requirement	Attainment	Risk	Comment
Evidence that the client and, where possible, significant others/whānau and other providers involved in the treatment plan (including the GP and pharmacist) reviews the treatment progress			
Perceived risk, including criminal behaviour and forensic history			
Summaries of treatment progress			
Key worker and prescriber reviews at required frequency			
GP authorisation forms, for those in GP shared care			
Treatment review forms			
Record of transfers or refusal of transfers and related factors			
Any restriction notices under section 25 of the Misuse of Drugs Act 1975 or section 49 of the Medicines Act 1981 (or other relevant legislation)			
Discharge date; factors involved in any involuntary discharge as appropriate			
Client records organised in a clear, consistent and logical manner			
Notes securely stored			
Key information readily accessible			
Staff members involved can be clearly identified			

Summary

8 Prescription Audit Tool

Use one sheet to record the audit results for each record.

Audit number:

Audit date:

Auditor:

Requirement	Attainment	Risk	Comment
a. Methadone prescriptions			
<ul style="list-style-type: none">• Are handwritten on the approved H572M forms, or computer printed text (if the service has approval from the Director-General of Health) signed by the prescriber• Provide for medication supply for a maximum period of 28 days• Begin on day when the client consumes their medication dose at a pharmacy under the pharmacist's observation• Are received by the pharmacist at least one day before the due date to supply• Are endorsed as 'daily dispensing, close control' and initialled by the prescriber• Are endorsed with the name of the dispensing pharmacy• Are written with the daily dose in numeric and word form eg, 80 (eighty) mg• Are written with clear instructions regarding takeaway days and increasing/decreasing dose regimens• Include specific instructions for holiday periods• Where doses are split, there are clear instructions regarding which part of the dose is to be consumed under observation			

Requirement	Attainment	Risk	Comment
b. Buprenorphine prescriptions in combination with Naloxone (Suboxone®)			
<ul style="list-style-type: none"> • Provide for medication supply in a 28-day cycle (ie, 28, 56 or 84 days) • Begin on the day when the client consumes their medication dose at pharmacy under the pharmacist's observation • Are received by the pharmacist at least one day before the due date to supply • Are endorsed with the name of the dispensing pharmacy • Are written with the daily dose in numeric and word form, eg, 16 (sixteen) mg • Are written with clear instructions regarding takeaway days and increasing/decreasing dose regimens • Include instructions to crumble observed doses • Include specific instructions for holiday periods 			

9 Manager, Team Leader, Lead Clinician, Staff Interview Tool

Interviewee and designation:

OST service:

Auditor:

Date:

Guidance notes

The following questions relate to sections of the *New Zealand Practice Guidelines for Opioid Substitution Treatment* (Ministry of Health 2014) and the sections in the audit report template. They are a guide only.

We recommend that you tailor these questions to suit the particular situation and add further questions as needed to verify information from other sources and to probe areas of particular concern or interest.

a. Opioid substitution treatment	
How well does the service reflect the principles of the Treaty of Waitangi? Can you provide some examples?	
How well does the service reflect the principles of recovery and harm reduction? Can you provide some examples?	
How well does the service reflect a partnership approach between the client, the specialist service or the primary health care provider and the client's nominated support people? Can you provide some examples?	
To what extent are the service's treatment objectives consistent with the objectives set out in section 1.1 <i>OST Guidelines</i> ? Do you have any further comment to make on this?	
How well does the service provide recovery-orientated treatment? Can you provide some examples?	
b. Entry into opioid substitution treatment	
Is the service able to commence the comprehensive assessment within two weeks of the client presenting to, or being referred to, the service or any part of the service? Do you have any further comments to make on this process?	
Do all comprehensive assessments include diagnostic criteria and risk-taking behaviours, and do they identify the client's strengths and recovery capital?	
Does the service work with the client to develop suitable treatment plans?	
How does the service ensure its clients are fully informed about other treatment options?	
How does the service prioritise access to OST? Do you have any comments to make on the service's inclusion/exclusion criteria?	
How is consent for treatment gathered?	
How does the service ensure its clients are fully informed about the range of OST medications and funding available?	

c. Stages of treatment	
What processes does the service have to ensure that the client is able to start on OST within two weeks of completing the comprehensive assessment?	
Does the service provide interim methadone or buprenorphine to clients who are unable to be admitted within two weeks?	
What are the strengths and limitations of the service in terms of safety, quality and consistency in practices overall?	
How does the service ensure consistency in relation to assessing their clients' stability?	
What processes does the service have in place to ensure its clients are seen by their key worker and the prescriber within the timeframes outlined in the <i>OST Guidelines</i> ?	
How does the service support the transfer of care of stabilised clients to their primary health care provider?	
How does the service ensure prescribing and monitoring is consistent with the <i>OST Guidelines</i> ?	
How has the service managed OST medication transfers? Do you have any further comments on this?	
How confident is the service that their treatment review practices meet the requirements set out in the <i>OST Guidelines</i> ? (sections 3.3 and 3.6 of the <i>OST Guidelines</i>) Do you have any further comment on this?	
What is the range of the service's psychosocial interventions (social and psychological)? What do you see as the key strengths and gaps? Are any particular groups missing out?	
How many involuntary withdrawals has the service managed in the last 12 months? Do you have any further comments to make about these?	
What after-care does the service provide for clients who are ending treatment?	
Are there any issues or concerns regarding prescribing, dispensing, monitoring and takeaway medication practices? Have there been any incidents related to these in the past 12 months?	
d. Safety issues	
Have there been any issues or concerns in the last 12 months related to: <ul style="list-style-type: none"> • overdose • substance-impaired driving • drug interactions • QTc interval prolongation? If so, how were they managed?	
How does the service manage clients who are suspected of driving while impaired?	
How many clients have had their driver's license revoked due to substance-impaired driving? Do you have any further comments to make on this point?	
e. Managing dose-related issues	
Have there been any issues or concerns in the last 12 months related to: <ul style="list-style-type: none"> • takeaway doses • replacing medication doses? 	

f. Managing clinical issues	
How does the service manage/support clients who are using other substances problematically? Do you have any further comments on sanctions, etc?	
<p>Have there been any issues or concerns in the last 12 months related to:</p> <ul style="list-style-type: none"> • clients presenting for medication when intoxicated • managing medication side effects • managing challenging behaviour? <p>How have these been managed?</p>	
<p>What are the strengths and limitations of the service in providing OST for clients:</p> <ul style="list-style-type: none"> • who have co-existing mental health issues • who have co-existing medical issues, including blood-borne viruses • who are in the older age group (ie, 45 years or older) • who are pregnant or breastfeeding • who have chronic non-malignant or acute pain issues? 	
Have all clinical staff been trained in HIV and hepatitis C related issues?	
g. Managing OST transfers	
Do you have any comments in relation to managing the transfer of clients in and out of the service?	
What process is in place for managing clients who are in prison (locally and out of area)? Do you have any comments about how this is working?	
How does the service conduct annual reviews for clients in prison?	
h. OST in primary health care	
What is the service's system for managing the annual review of clients who are managed in primary health care? Do you have any comments about this?	
How well does the service support authorised prescribers?	
What systems are in place for ensuring effective communication between authorised prescribers and the service?	
i. OST and the pharmacy	
How well does the service support community pharmacists?	
What systems are in place for ensuring effective communication between pharmacists and the service?	
j. The OST workforce and professional development requirements	
Can you outline how the service manages staff orientation, supervision, professional development and training and performance management?	
How does the service manage access to peer-support workers?	
Do you have any comments to make in relation to staffing?	

k. Administrative expectations of specialist OST services	
Do you have any comments to make in relation to client records?	
Please briefly outline any complaints received about the service in the last 12 months?	
Are there any issues regarding resourcing, senior leadership and governance that the service would like to be considered in the audit?	
Have there been any safety issues over the last 12 months, for example, in relation to: <ul style="list-style-type: none"> • staff • clients • prescribing • dispensing? 	
What provisions does the service have in place for dealing with civil defence emergencies?	
l. Prescribing controlled drugs in addiction treatment	
What are the strengths and limitations of the service's system for authorising prescribers?	
Have there been any issues regarding the authorisation process?	
m. Interim prescribing	
How does the service ensure that their practices in interim methadone (or buprenorphine) prescribing are consistent with the national guidelines? Do you have any issues or comments to make on this?	

10 Client Interview Tool

Guidance notes

The following questions relate to sections of the audit report template. They are a guide only.

We recommend that you tailor these questions to suit the particular situation and add further questions as needed to verify information from other sources and to probe areas of particular concern or interest.

a. Opioid substitution treatment	
About how long have you been receiving OST from this service/your primary health care provider?	
What difference does the treatment make in your life? What are the more helpful aspects of the treatment and what are the less helpful aspects?	
Overall, what would you say are the limitations of the service?	
Have you been encouraged to include your family or friends in your treatment?	
Are you encouraged to provide feedback to the service and to take part in service planning or evaluation or any other service initiatives?	
How can you express dissatisfaction with any aspect of treatment? Do you know about the complaints process? Do you know how to access the Health and Disability Advocacy service?	
b. Entry into opioid substitution treatment	
Thinking back to when your treatment started, how did you find the admission processes? (Prompt the client to consider the waiting time, information, details about GP provision, support provided, collaborative approach.)	
What information have you been given about the range of OST medications available?	
c. Stages of treatment	
How often do you have appointments with the OST service medical officer / your key worker / your GP? How helpful are these appointments for you?	
How satisfied are you with your treatment/recovery plan?	
Do you feel well supported by the service in working towards your own goals?	
Have you been given information about or been helped to access other support that is available, for example, counselling, housing support, etc?	
Has there been any planning towards completing the OST? Have you and your key worker/primary health care prescriber done any work around relapse prevention?	
d. Safety issues	
Have you been provided with information about: <ul style="list-style-type: none"> • overdose • substance-impaired driving • methadone and cardiac safety • drug interactions? How helpful has the information been and has it affected your behaviour in any way?	

e. Managing dose-related issues	
Have you received information about: <ul style="list-style-type: none"> • managing takeaway doses • replacing lost or stolen medication doses • suspected diversion of medication • missed doses • presenting for medication when intoxicated? How helpful was the information?	
f. Management of clinical issues	
Have you received information about: <ul style="list-style-type: none"> • managing problematic alcohol or drug use • side effects of OST medications • health issues related to injecting drug use, for example, hepatitis C • managing mental health problems • chronic pain management • pregnancy and breastfeeding? How helpful was the information?	
g. Managing OST transfers	
Do you have any comments to make about the process of transferring to another service?	
h. OST in primary care	
Do you have any comments to make about primary health care provision of OST? (The auditors should tailor this question to the client's situation regarding GP care.)	
i. OST and the pharmacy	
Do you have any comments to make about your experiences at your pharmacy?	
j. The workforce	
Do you have any comments to make about staff you have dealt with at the service?	
Have you been offered the assistance of a peer-support worker? If so, how have you found that experience?	

11 Family / Whānau / Support Person Interview Tool

Guidance notes

Family and whānau should be interpreted broadly to include whoever the client wishes to involve.

The following questions are a guide only.

We recommend that you tailor these questions to suit the particular situation and add further questions as needed to verify information from other sources and to probe areas of particular concern or interest.

a. Opioid substitution treatment	
Overall, what would you say are the strengths of the service?	
Overall, what would you say are the limitations of the service?	
Have you been encouraged to participate and support your family/whānau member's treatment?	
To what extent do you feel you are working in partnership with your family/whānau member and the service?	
Can you describe the impact of the treatment provided by this service on your family/whānau?	
Have you, or other members of your family/whānau, ever been invited to participate in service planning, evaluation or any other service initiatives?	
Do you have any further feedback about the service and/or the treatment?	

12 Pharmacist, Authorised Prescribers, Medicines Control and Other Key Interfaces Interview Tool

Guidance notes

Pharmacists, authorised prescribers and Medicines Control are key interfaces for OST and should be included in the audit process. Other agencies may include other alcohol and drug services; Child, Youth and Family; and Work and Income.

Key interfaces and links will vary according to the service context. Interviews should focus on accessibility, coordination, continuity and integration of care for clients and their significant others and whānau.

The following questions are a guide only. We recommend that you tailor these questions to suit the particular situation and add further questions as needed to verify information from other sources and to probe areas of particular concern or interest. It is important that all interviews be flexible and reflect the areas emphasised in the *OST Guidelines*.

Authorised prescribers include any health professional authorised to prescribe OST medication by either the specialist service lead clinician or a specialist service medical officer who has the authority under section 24(2)(b) Misuse of Drugs Act (MoDA). Authorised prescribers might include specialist service medical officers, general practitioners, prison medical officers, nurse practitioners and other designated health professional prescribers.

In these forms, *OST Guidelines* refers to the New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 (Ministry of Health 2014).

12.1 Pharmacist interview tool

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

a. Context	
How many people attend your pharmacy for OST medication?	
How long have you been involved in OST?	
b. Support and training	
Can you outline the training you have received specifically in relation to OST?	
How helpful was the training? Do you have any suggestions for improving the training?	
How familiar are you with the New Zealand Practice Guidelines for Opioid Substitution Treatment (Ministry of Health 2014)?	
How would you describe the relationship between your pharmacy and the OST specialist service? What are the key strengths? What are the limitations?	
How would you describe the relationship between your pharmacy and the authorised prescribers involved in providing OST? What are the key strengths? What are the limitations?	
Do you have any concerns around the OST service's support for authorised prescribers providing OST?	
Do authorised prescribers generally follow local and national <i>OST Guidelines</i> with respect to prescribing OST?	
How effective is the system for after-hours support from the OST service?	
c. Practice issues	
How regularly are you consulted about OST for the clients who attend your pharmacy?	
Are the OST service's policies and procedures in relation to medication dispensing and administration clear and workable?	
Do you have any concerns about your role in OST?	
Are there any other matters that you would like to be considered as part of this audit?	

12.2 Authorised prescribers interview tool

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

a. Context	
How many people are you providing OST for?	
How long have you been involved in OST?	
b. Support and training	
Can you outline the training you have received specifically in relation to OST?	
How helpful was the training in preparing you for your role in OST? Do you have any suggestions for improving the training?	
How familiar are you with the <i>OST Guidelines</i> ?	
How would you describe the relationship between your practice and the OST specialist service? What are the key strengths? What are the limitations?	
How would you describe the relationship between your practice and the pharmacies involved in OST? What are the key strengths? What are the limitations?	
How effective is the system for after-hours support from the OST service?	
c. Practice issues	
How well are the policies and procedures working for transferring client care to and from the OST service?	
Is there a satisfactory level of support and timely consultation (for example, regarding client management issues) from the OST service?	
Do you have regular contact with staff from the specialist service? How helpful is this?	
How do you manage the reporting requirements with the OST service?	
Are other staff members of your practice (for example, the receptionist, the practice nurse) involved with the clients and their significant others/whānau?	
Do you involve significant others/whānau of the client?	
How do you ensure that clients have access to psychosocial support and services?	
Are there any other matters that you would like to be considered as part of this audit?	

12.3 Medicines control interview tool

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

a. General prescribing practices within the specialist service / other provider	
Do you have any concerns?	
b. Authorisation of prescribers	
Are there any quality issues related to training/education, supervision or treatment?	
c. Liaising with pharmacists	
Are there any quality issues regarding training/education in relation to treatment?	
d. Meetings with OST services / other prescribers	
What is working well? What could be improved?	
Are there any particular issues / concerns / critical incidents?	
Are there any areas for joint development or review?	
e. Overall delivery of treatment	
What is the quality of treatment / care provided? What are the strengths and limitations of that treatment / care?	
Do you have any particular issues, concerns or critical incidents that you wish to raise?	
Are there any themes or issues about the service provided that require development or review?	
Are there any other matters that you wish to discuss?	

12.4 Other key interfaces/links interview tool

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

What is the quality of your working relationship with the OST service?	
In terms of policies and procedures, protocols/guidelines, etc, what is working well and what could be improved?	
Are the memorandums of understanding with the service and interface protocols adequate?	
What consultation/liaison mechanisms are in place?	
Do you have any comments on the quality of treatment/care provided? <ul style="list-style-type: none">• Are there any gaps?• Have there been any critical incidents?• Are there areas or themes that have emerged that require joint development or review?• Do you have any particular issues/concerns?	

Appendix 1: Risk assessment matrix

CONSEQUENCE	LIKELIHOOD					
	Level of risk	The likelihood of this occurring is				
		almost certain	likely	moderate	unlikely	rare
	The consequence of these criteria not being met would put the client at extreme risk of harm or actual harm is occurring.	Critical	Critical	High	Moderate	Low
	The consequence of these criteria not being met would put the client at significant risk of harm.	Critical	High	Moderate	Low	Negligible
	The consequence of these criteria not being met would put the client at moderate risk of harm.	High	Moderate	Moderate	Low	Negligible
	The consequence of these criteria not being met would put the client at minimal risk of harm.	Moderate	Low	Low	Low	Negligible
	Risk of harm is insignificant even if these criteria are not met.	Low	Low	Negligible	Negligible	Negligible

ACTION REQUIRED				
Critical	High	Moderate	Low	Negligible
This would require immediate corrective action in order to fix the identified issue, including documentation and sign-off by the auditor within 24 hours to ensure the client's safety.	This would require a negotiated plan in order to fix the issue within one month or as agreed between the service and auditor.	This would require a negotiated plan in order to fix the issue within a specific, agreed timeframe, such as six months.	This would require a negotiated plan in order to fix the issue within a specified, agreed timeframe, such as within one year.	This would require no additional action or planning.

Source: Standards Council. 2008. *New Zealand Standard: Health and Disability Services (Core) Standards Auditor Workbook* NZS8134.0:2008. Wellington: Standards New Zealand.