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

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Foreword

Tēnā koutou katoa

The *2025 Specialist Opioid Substitution Treatment (OST) Service Audit and Review Tool* (the Tool) updates the *Specialist Opioid Substitution Treatment (OST) Audit and Review Tool 2014*.

The Tool is specifically aimed at auditing the practice of OST as reflected in the Ministry of Health publication: *Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment 2025* which aligns with the Misuse of Drugs Act 1975 section 24A.

The Tool reflects significant themes and important developments that align with the Guidelines, including:

- an emphasis on human rights, in particular informed consent processes and the least restrictive practice
- a closer focus on the tāngata whai ora pathway of care
- the establishing peer support and lived experience workforce
- supporting tāngata whai ora in residential settings, such as ageing related care and residential programmes
- a stronger emphasis on actively supporting treatment for OST provision within Correctional facilities

Over the years, audit exercises have focused primarily on what services say they are providing. This has been primarily evidenced through a review of policies, and interviews with staff and tāngata whai ora.

Going forward, the focus is on determining whether services meet the Guidelines by showing partnership with tāngata whai ora in treatment and care pathways (using a trace audit), tailored risk management, and the use of least restrictive approaches. I am confident this revised tool will assist in a deeper, quality-focused exploration of how well services are meeting people's needs.

We acknowledge and thank those who have contributed to the revision of the Tool, in particular, Jenny Wolf and Carina Walters and to members of the National Association of Opioid Substitution Treatment Providers (NAOTP), who provided advice throughout the revision process.

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

We hope that this in turn will boost confidence in OST service provision among tāngata whai ora, whānau, service providers, funders, the broader health sector and the general public.

Noho ora mai

Dr John Crawshaw
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 compliance with legislative requirements and that 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:

- Medicines Act 1981
- Misuse of Drugs 1975 Act Section 24A
- Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment 2025 (Ministry of Health 2025) (referred to in this document as the *OST Guidelines*)
- Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)

The primary focus of audit processes is to remain consistent with the guidelines laid out in these 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 necessary details of what is required when planning the audit questions and focus points. Some discretion is required on the part of the lead auditor on a range of audit aspects, such as to determine who should be asked certain questions covered within the Tool, and which questions might need to be added or not required. The lead auditor and audit team may need to design some flexible approaches based on having read the service documentation and other factors that may change in the lead-up to the site visit.

Supporting the Philosophy of OST

The *OST Guidelines* place tāngata whai ora at the centre of their experience of OST. The following legislation guides health services to be tāngata whai ora centred: Bill of Rights Act 1990, the Human Rights Act 1993, and the Code of Health and Disability Services Consumers' Rights 1996 (the Code).

OST services will evidence tāngata whai ora have been actively involved in decision making about their treatment and care and are to receive their medication within the least restrictive way. Services will demonstrate how takeaway regimes have taken into consideration tāngata whai ora stability and circumstances.

Tāngata whai ora and their whānau will experience mana enhancing care by the service.

Harm reduction approaches will be evident throughout the service's documented philosophy and in practice.

Tāngata whai ora file reviews will include the above using a 'trace audit' approach, to determine where practice is reflected in the Guidelines.

What the Audit Tool includes

The audit team and audit process

This section is more prescriptive than previous audit tools and is to ensure consistency across audit teams and approaches. It also provides increased guidance for the role of each of the auditors and for services to know what is expected in preparing and supporting an audit.

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*.

For ease of reference, the audit report template is divided into sections that correspond directly with the sections in the *OST Guidelines*.

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 acceptance 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. Tāngata whai ora records review tool
8. Prescription audit tool
9. Manager, team leader, lead clinician, staff interview tool
10. Tāngata whai ora interview tool

11. Whānau / whānau / support person interview tool
12. Pharmacists, authorised prescribers,[1] Medicines Control, and other key interfaces/links interview tool.
13. MDT observation

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
- Tāngata whai ora 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
- Observation O

[1] 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, pharmacists and other designated health professional prescribers.

The audit team and audit process

Composition of an audit team

The audit team should comprise three auditors, one of whom has an in-depth understanding of best practices in OST, one who has in-depth understanding of quality systems and administration and staff management and a consumer auditor who ideally has experience in receiving OST. The team must also have a clear understanding of the requirements set out in the *OST Guidelines*, Misuse of Drugs Act 1975 Section 24A and the other key references.

There are three teams of auditors who work with a three-yearly cycle of auditing, on behalf of the Ministry.

Audit teams primarily comprise representatives from OST services. The OST service supports staff to be part of audit teams. This encourages peer review across services with the formal mandate of following a recommended audit process.

Audit instigator and lead auditor responsibilities

Audit instigator

The audit of an OST service is generally instigated by the Ministry of Health with support from Health New Zealand (Health NZ) every three years or when a Health NZ locality, as part of its service planning and funding responsibilities, initiates an audit. An external formal audit is recommended, with the aim being to use the Tool to achieve an objective, fact-based critique of the service.

The audit instigator engages an external audit team and advises the service of the audit in writing, requesting that the service manager return an Opioid Substitution Treatment Audit Request Acceptance form (refer Appendix). The audit instigator also provides the OST service with the lead auditor profile and a copy of the full audit and review tool.

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

Lead auditor

Each audit team is co-ordinated by a lead auditor who is contracted by Health NZ on behalf of the Ministry. The lead auditor takes overall responsibility for the audit, the audit team composition, including budget holding for the audit team travel, accommodation and other expenses. Sometimes an additional 'shadow auditor' might accompany the team as a means to training for a specific auditor role to contribute to future audits. Health NZ makes provision for costs associated with this and liaises with the lead auditor.

The lead auditor is to ensure all aspects of the audit process are completed as comprehensively as possible. Lead auditors may bring varied approaches to how they lead an audit team and how they manage processes and may exercise their own discretion in how they get the job done.

The lead auditor initiates contact with the service a few months prior to formal correspondence to the service from the audit instigator (refer Table 1)

At the time of contracting to lead an audit, the lead auditor is to declare any potential conflict of interest at the outset to the Ministry of Health. All members of the team must sign a confidentiality document at the outset of the audit, held by the lead auditor. The lead auditor leads the process shown in Table 1: The external audit process. 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.

At audit the lead auditor looks at quality documentation systems and administrative documentation, building security, GP / prescriber authorities, and interviews staff (except prescribers) and reception staff, and looks at a complaints and incidents process with the consumer auditor.

During and after the audit, the lead auditor is responsible for the various times when the audit team require briefing and debriefing. One significant briefing preparation is the evening prior to the audit site visit, when the team focus on documentation received from the service and are advised of any pre-audit interviews such as with Ara Poutama (Corrections) or OST staff who will be on Leave at the time of audit.

Should a risk related query arise during the audit when the *OST Guidelines* don't seem to have specific guidance, the lead auditor will make every attempt to seek clarity from the Ministry during the audit visit and/or confer with either of the other lead auditor/s. It is recommended this is addressed while onsite. To do so after the audit visit means other onsite evidence or narrative cannot be as readily accessed.

Best practice auditor

Best practice auditors have a strong clinical background within OST, eg, lead clinicians, team leaders, senior experienced clinical staff. Their focus is to review the service's local policies and procedures where they relate to medical and clinical treatment and ensure MODA requirements are met.

Ideally best practice auditors focus on policy and procedure documentation that is clinically focused, views the medical clinic room, ensures a medications safe is in place, interviews clinical staff and key medical associated services (eg, pain clinic) and community pharmacies and shared care in primary care and other prescribers.

Best practice auditors will declare any potential or real conflict of interest with a service to be audited as the lead auditor invites them to be part of an audit team.

Consumer auditor

Consumer auditors ideally have direct experience of receiving OST. They look for the following: that tāngata whai ora and whānau have access to information, resources and engagement opportunities; the physical environment is safe and accessible; the culture of the service encourages and supports tāngata whai ora and whānau engagement; there are systems to ensure broad tāngata whai ora and whānau representation and feedback, and there is evidence that the service responds to the feedback; people employed into advisory and peer support roles are well supported by the OST service; services support the people using their service to have a voice and participate in service planning, implementation, monitoring and evaluation of service delivery (refer Nga Paerewa 2.1.8).

Ideally the consumer auditor views all policies and procedures that are relevant to how the tāngata whai ora experiences the service, as well as tāngata whai ora information such as fact sheets, booklets, information available in waiting rooms and interview rooms; interviews tāngata whai ora and whānau and views a complaint and incident process with or without the lead auditor.

Consumer auditors will declare any potential or real conflict of interest with a service to be audited when the lead auditor invites them to be part of an audit team.

Shadow auditor

Best practice and consumer auditors may not have capacity to be part of a number of audit teams throughout the year. Some auditors will have a direct conflict of interest as they may be employed by the service that is being audited. Some lead auditors may also signal cessation of being contracted to lead audits. Therefore, from time-to-time shadow auditors are brought on to familiarise with the experience of conducting an audit. A shadow auditor could be a lead auditor, best practice auditor or consumer auditor. The lead auditor prepares the shadow auditor of what to expect, anticipates times to briefs and debrief the shadow auditor throughout the course of preparations to post audit report completion.

Key steps in preparing for the audit

Documentation and pre-site visit interviews

The lead auditor requests an initial service context (overview) document that provides an outline of the service, staffing and locations to assist with the planning of an audit site visit. Notably this includes information of where satellite clinics are located and their days of operation as well as the day and times of the MDT. The service would ideally have four weeks' notice after the initial setting-up conversation with the lead auditor to compile the service context document.

The lead auditor also requests the service to provide either by electronic transfer or hard copies all documentation and basic information as requested within the 'Document Review' form. Forms A–C in Part B of this Tool can be used for this set-up process. Documentation is to be received at least four weeks prior to the audit visit. Once the lead auditor receives the service information and documentation, they forward it to the audit team for their assessment, or request the service also sends the documentation to each of the auditors – either in hard copy or electronically.

At least three weeks prior to the audit visit, the lead auditor will have compiled any tāngata whai ora and whānau survey information to send to the consumer auditor, to be received within 2 weeks of the audit visit.

The lead auditor may initiate some pre audit visit interviews with external parties such as the closest prison. The lead auditor will make every effort to engage with Medsafe (Medicines Control) in advance of the audit visit and indicate within the audit report if engagement with Medicines Control was not achieved. The primary purpose of making contact is to find out if there have been / are currently prescribing practices of concern in the area to be audited.

Arranging the on-site visit

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

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

- tāngata whai ora, including those from the waiting list, general practice and interim-prescribing programme (if the service is providing this). Tāngata whai ora also includes preparations for interviewing a tāngata whai ora and whānau (if appropriate) for the trace audit exercise
- whānau
- the service manager / team leader
- the lead clinician and medical officers

- planner/funder/commissioner. Interviewing this role highlights the importance of adequately resourcing OST
- incidents/complaints co-ordinators
- staff members representing each discipline and staff group employed on the team, including consumer advisor, peer and lived experience staff, primary health care liaison, pharmacy liaison, prison liaison, administration/reception staff
- staff members who support OST clients where they reside in another service, eg psychologists, social workers, cultural staff
- Health NZ senior management and clinical director / non-government organisation Board chairperson or most senior manager (note one OST service is operated by an NGO), commissioner (if possible)
- community pharmacists and authorised prescribers (including prison medical staff). Determining whom is to be interviewed is discussed between the lead auditor and the service, as there may be a city-based prescriber and community pharmacy representative interviewed as well as a prescriber and community pharmacy near a satellite clinic. Caution also applies that the service does not suggest favourite prescribers and pharmacies. Note those interviewed are not to be the same who are interviewed in previous or subsequent three-yearly audits. The lead auditor will ensure those to be interviewed will receive the interview questions in advance
- referrers and other key links, eg, local prison, needle exchange, peer support service (if external to Health NZ)

Note: the lead auditor will provide a form of payment to acknowledge tāngata whai ora and whānau for their time (in the form of vouchers) and payment on invoice is offered to GPs and community pharmacists interviewed, for their time. There may also be a voucher gifted as a 'prize' draw for completed surveys.

Satellite clinic visit

Services often operate clinics in other areas to ensure easier access for tāngata whai ora who live some distance away.

When setting up for a satellite clinic visit, this is usually the same location where the best practice auditor will interview a primary shared care prescriber and a community pharmacy.

Auditors look at a range of variables that the city-based OST service ordinarily has in place that a satellite may not have, eg, medical equipment, access to other health specialists and services.

OST staff are also ideally interviewed at the clinic to provide more geographical and localised themes facing tāngata whai ora to the auditors, eg, pharmacy hours on weekends.

Often an OST clinic will be shared with other health clinics in the same facility. Auditors look for relevant and informative signage, health and OST related information, waiting rooms (eg, a range of clients from various clinics converge in a small area), medical room, and sharps containers.

The most relevant manager and reception staff of the satellite clinic facility are also interviewed regarding safety of tāngata whai ora and staff, and how any co-located communications occur between the OST service and the satellite site.

Reviewing documentation

The audit team reviews the documentation before conducting the audit site visit. The documentation provides the audit team with the start of a picture of the OST service. The findings of the documentation review will inform the focus of the other steps in the audit, including for example focused interview questions based on potential gaps in policies, additional focus areas when reviewing tāngata whai ora records and inspection of facilities.

On-Site Audit

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

- instigating an initial introduction (opening) meeting with the service to establish the purpose of the audit, methods to be used, respond to any questions about the audit process and a reminder they are invited to attend the summation (closing) meeting. The service may choose to welcome the audit team in a formal or informal way
- conducting interviews and discussions with staff, tāngata whai ora and whānau members, the manager, team leader, lead clinician, medical officers and, as available, the senior manager and the clinical director (note: tāngata whai ora and whānau members interviewed should be informed of the context of the audit, the intended recipients and the fact that their comments will remain anonymous. If it is not appropriate to seek signed consent form at the time of setting up or conducting a phone interview, the tāngata whai ora or whānau may provide verbal consent.) Tāngata whai ora feedback could also be obtained by developing a questionnaire for them to complete and anonymously leave in a marked box in agreed parts of the service and/or community pharmacies. Another feedback option is an online survey for tāngata whai ora and one for whānau which is arranged by the lead auditor. Ideally whānau members may be nominated for interview by the tāngata whai ora at the end of the survey document
- reviewing documentation and records, including staff records, policies and protocols, incident reports, complaints documentation, samples of tāngata whai ora records and treatment/individual plans. Note: in preparing for the site visit, the lead auditor should check if any tāngata whai ora 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 tāngata whai ora file that they review, refer ‘Obtaining information from tāngata whai ora and accessing tāngata whai ora records’
- touring the service and making observations, and observing an MDT

Tāngata whai ora and whānau interviews

Tāngata whai ora will have an option at the end of online or hard copy surveys to nominate themselves to be interviewed by the consumer auditor. Also, posters will provide an option for tāngata whai ora to volunteer themselves to be interviewed.

Should there be a small number of tāngata whai ora to be interviewed, the lead auditor may request the service to identify and invite some tāngata whai ora to be interviewed based on a selection of criteria provided by the lead auditor, eg, rural, Māori, pregnant, changed from methadone to buprenorphine or vice versa, or transferred from another area. The lead auditor may liaise with the service to set up these interviews and seek the necessary consent.

Whānau will have an option at the end of online or hard copy surveys to nominate themselves to be interviewed by the consumer auditor. Also, posters will provide an option for whānau to volunteer themselves to be interviewed. Should there be a small number of tāngata whai ora to be interviewed, the lead auditor may request the service to identify and invite some whānau to be interviewed based on a selection of criteria, eg, rural, Māori, etc. The lead auditor may liaise with the service to set up these interviews and seek the necessary consent.

Consent to be interviewed

Consent to be interviewed includes advising the tāngata whai ora or whānau of the purpose of the audit (adherence to the OST Guidelines) and approach of the audit (triangulation), and that feedback is anonymised and described as themes to the service within a report.

Consent can be in either written or verbal form. If verbal the person who invites the tāngata whai ora or whānau to be interviewed, the service representative provides the above outline and notifies / emails the lead auditor that verbal consent has been provided.

Obtaining information from tāngata whai ora and accessing tāngata whai ora records

The Health Information Privacy Code 1994 allows tāngata whai ora records to be used for clinical and quality audits. Users must make every effort to maintain the privacy of tāngata whai ora. Tāngata whai ora 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 tāngata whai ora 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 tāngata whai ora 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 tāngata whai ora at the next contact.

Reviewing tāngata whai ora File – Tracer Audit

Historically, viewing tāngata whai ora files has proved challenging for a number of reasons, eg, file information is contained within multiple online systems and also in hard copy; a knowledgeable service representative needs to use their time to navigate through the file for auditors to source relevant aspects. This is time consuming and ineffective to gain a picture of how the service meets the requirements of the OST Guidelines.

A tracer audit method will be used to comprehensively review a tāngata whai ora file.

A tracer audit *'...involves surveyors ... retrospectively analysing the sequential steps of either a consumer's clinical care processes via a review of patient progress notes, or a type of healthcare product (eg, blood sample, clinical equipment) (Siewert 2017). Tracer methods, including patient journey surveys, are used internationally to identify discrepancies between the expected and actual levels of quality and safety within a health service organisation (Azami-Aghdash and Mohammadi 2013).'*[2]

The purpose of a tracer audit is to thoroughly review one file of a tāngata whai ora journey through the service, from acceptance and engagement, recovery focused goals, treatment planning, risk management and reviews that demonstrate informed consent, individualised and partnered tāngata whai ora focused arrangements. The specific tāngata whai ora is also interviewed. Note all best efforts are made to do interview the tāngata whai ora, however circumstances on the day may mean they are unable to be interviewed. An interview cannot take place retrospectively after the audit.

Ideally a file to be reviewed by tracer audit is of no longer or less than four years. The reasons for a four-year old file is to a) avoid the challenge of sourcing multiple older archived files, b) that a four-year connection with OST means any practice changes based on the findings of the most recent audit might be reflected in the file, and c) that the tāngata whai ora might have reasonable recall regarding the service's initial engagement.

Tāngata whai ora may find it difficult recalling service experience when they first started on OST especially if that was 25 years ago, for example. Guidelines and practice have also changed since then.

Ideally the lead and best practice auditors are involved in the tracer audit process. It is optional for the consumer auditor to be part of this process, however, this would be the exception rather than the norm. Consumer auditors' preference (based on best use of their time) is to hear from tāngata whai ora rather than read about them.

The practical steps to set up for a tracer audit are discussed between the lead auditor and the service and will include:

- Six weeks prior to audit visit, lead auditor sending the service a list of tāngata whai ora file themes.

[2] Australian Commission on Safety and Quality in Healthcare. 2017. *Patient Journey and Tracer Methodologies Literature Review*. URL: **https://www.safetyandquality.gov.au/sites/default/files/migrated/Patient-Journey-and-Tracer-Methodologies-Literature-review.pdf** (accessed 10 April 2026).

- Five weeks prior to audit visit, service identifies three files commensurate with the themes – one of which should be Māori. The service provides brief anonymous summary overview of each of the three tāngata whai ora and their OST journey to lead auditor.
- Within two working days, the lead auditor selects two of the three.
- Service seeks (on standby) the corresponding tāngata whai ora and whānau* to be available by phone at time of audit visit. This could be separate calls to the tāngata whai ora and whānau – or together if that is the preference of the tāngata whai ora. The service informs the tāngata whai ora and whānau: about the nature of the audit; that no more than four auditors view their file and that the auditors have all signed confidentiality agreements; the anonymity of the tāngata whai ora is prioritised; only themes are written into the report; there is an option to view the draft section of the report that is relevant to the file review (with two working days to reply); that vouchers will be provided to the tāngata whai ora and whānau for their time; that the tāngata whai ora and whānau are one of two selected and that the service will get back to them at least two weeks prior to the audit date to confirm or cancel. Verbal consent is sought by the service and noted to the lead auditor.
- The above steps may determine that only one of the two tāngata whai ora will be available during the audit visit time (an interview is not to occur after the audit visit).
- Three weeks prior to audit visit the lead auditor selects one of the two options of tāngata whai ora to be interviewed.
- The service confirms with the tāngata whai ora and whānau.
- The file review is to occur **before** the call with the tāngata whai ora to ensure only one contact is needed with the tāngata whai ora. Should they state anything that needs checking against the file, the file can be revisited.
- The tāngata whai ora is provided opportunity to view the draft relevant section of the audit report by the lead auditor and through the service if they had agreed to this.
- It is optional the consumer auditor is involved in the file review as they may know the tāngata whai ora and opt to self-exclude from this. The lead auditor will advise the consumer auditor three weeks prior to the audit visit.

The phone call interview with the tāngata whai ora and whānau is facilitated by the lead or best practice auditor.

If there was opportunity to do a thorough tracer audit file review remotely (via screen sharing) between a service representative and at least one auditor, this is also appropriate. However, some logistics (hard copy information) may preclude this option.

It is the service responsibility to ensure the appropriate internal permission and that of the tāngata whai ora is given for the auditors to view tāngata whai ora information. Auditors sign a privacy form provided by the lead auditor.

*Ideally a whānau member is also interviewed wherever possible.

Observing a Multidisciplinary Team Meeting (MDT)

The practice of auditing incorporates a triangulation approach – reading, interviewing and observing.

One way to determine how the service demonstrates individualised approaches and relevant aspects of the *OST Guidelines* for tāngata whai ora is to observe an MDT during the site visit.

Note site visits are to be arranged around a naturally occurring MDT schedule.

A template for observing an MDT is within Part B – Set-up and data-gathering tools.

Note auditors are a silent observer presence with no disruption to the natural flow of the MDT process.

Audit team meetings and closing meetings with the service

It is good practice for the lead auditor 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, for example. Often this occurs over lunch periods.

As a matter of courtesy, it is recommended the lead auditor arrange a mini pre-summary meeting with the service's relevant senior management to ensure a "no surprises" approach, particularly if there are risks highlighted. If this is the case, the lead auditor will highlight the relevant risk matrix finding and negotiate a plan for the service to address the risk within the specified time period as stated on the risk matrix.

The lead auditor will arrange an audit summary (closing) 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 advise 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 'there was no designated consistent fire warden in place'. 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

At the end of the audit visit, the audit team should hand over all written feedback to the lead auditor (to insert into the report) or by other arrangement, eg, the auditors insert their own notes into the audit report. The audit team retains all service documentation as reference points during the report drafting process, until the final report is lodged.

The lead auditor prepares a draft report with recommendations for further action (if appropriate) within 20 working days and sends it to the best practice and consumer auditors for their review within the following 10 working days. The lead auditor then

sends the draft report to the service for review and comment (to be returned to the lead auditor within 10 working days). The service may comment on the factual accuracy of the report, for example the spelling of names, role titles. The lead auditor then makes any final amendments and submits the final audit report to the Ministry of Health and sends copies to the service. The reporting process is to occur within 50 working days.

After the Ministry receives the final audit report the service can note within the comments section of the report what intended actions are to occur. The Ministry will initiate discussions with the service regarding plans for any corrective actions.

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

During the course of an audit, potential risk/s may become apparent. Any emerging risk is to be initially discussed amongst the audit team and investigated as a priority, to determine whether it is an actual or a potential risk. The audit team determines the level of risk, likelihood and consequences of it occurring.

In the rare situation of the Guidelines' silence on a particular potential risk scenario, the lead auditor might confer with other lead auditors for advice or the Director of Mental Health for a determination.

A risk column is included in the audit report. Risk can be categorised as:

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

When the audit result for any criterion is unattained (UA) the Risk Management Matrix should be used as guidance. In some instances, a partially attained (PA) finding might also carry some risk. Refer to Appendix 1 (Risk Assessment Matrix).

The risk should be assessed in the first instance in relation to the possible impact on tāngata whai ora 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 tāngata whai ora/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. findings are checked against 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 however it is expected discretion applies 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.

Wherever possible in the pre-summation meeting, the lead auditor discusses with the service the steps required to remedy the corrective action if the finding is of significant risk. The lead auditor writes this up immediately with the service or sends an email as close as possible after the site visit outlining the steps and timeframes. The lead auditor emails the Ministry and the service. Sometimes the Ministry requests the lead auditor remain involved to determine if the risk has been satisfactorily resolved. At some stage the lead auditor may need to assert they are no longer part of the risk remediation follow-up process and requests the Ministry continues the process with the service.

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 tāngata whai ora and staff

The service manager must notify tāngata whai ora and staff of the upcoming audit in writing. For tāngata whai ora this could be in the form of a poster at relevant clinics and pharmacies that the lead auditor has provided. Tāngata whai ora 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 from the service and the Ministry.

Confirming acceptance and providing documentation

The service manager must forward the required documentation to the lead auditor within a specified timeframe, either in hard copy or electronically. If hard copy, 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. This also includes promoting access to online and hard copy surveys for tāngata whai ora and whānau and promoting the audit visit via placing posters around the service provided by the lead auditor.

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.

In some instances, OST service staff may have leave pre-planned and will not be present at the audit. It is at the discretion of the lead auditor that staff be interviewed prior to the audit visit. Under no circumstances should unexpectedly absent staff during the audit visit be interviewed after the audit. This could potentially raise new information that was not discovered during the audit visit, resulting in retrospective actions for the audit team.

At the pre-summation meeting with senior management, if risk/s require immediate action, it may be advisable the audit team follows through with the service of the actions taken. Should this be the case, the lead auditor will confer with the Ministry immediately after the audit visit. Examples of immediate corrective actions for the service could be to put in place an action to eliminate or mitigate the risk, draft or amend a policy that the audit team assures the Ministry has been completed.

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/Health NZ instigator of the action plan resulting from the audit.

Table 1: The external audit process

Set up **6 months**	**Audit Instigator (Ministry of Health and Health NZ)** • Agree service to be audited • Engages Audit Team • Three months prior to audit, Ministry of Health formally advises service of audit • Provides service with auditor profile and audit tool
	Lead Auditor • 6 months prior to audit, informally advises the OST service to be audited • Accesses previous audit report for the OST service, from Health NZ or the Ministry of Health • Takes responsibility for the audit team including confidentiality agreements • Contacts the most senior manager to alert them of the audit • Request documentation and information from the service • Forwards documentation to the audit team (or the service does this) • Provides the service with interview requests and assists the service manager with the coordination of the interview schedule and describes the tracer audit file review process and MDT observation • Co-ordinates with service support, tāngata whai ora and whānau hard copy and online surveys • Sends a poster to the service for waiting rooms to advise of the audit including tāngata whai ora and whānau online and hard copy surveys • Arranges site visits with the service manager • Arranges and carries out any pre-service telephone interviews, eg, Medsafe and Corrections, service staff who may be away at the time of the audit
	Audit Team • Reviews documentation provided by the service
	Service Manager • Provides the acceptance form to the audit instigator • Provides documentation and information to the lead auditor • Confirms dates for on-site audit visit • Notifies tāngata whai ora and staff • Circulates tāngata whai ora and whānau hard copy surveys and promotes online survey options • Coordinates interview schedule in partnership with the lead auditor • Prepares for on-site visit, eg, meeting room space, access to tāngata whai ora file, drivers and vehicles
On-site **2 days**	**Audit Team** • Conducts interviews • Inspects facilities • Reviews tāngata whai ora records, complaints and incident reports • Attends periodic audit team review meetings and feeds back to lead auditor
	Lead Auditor • Facilitates opening and closing meetings with the service • Prepares draft report and provides to service manager

Reporting up to 50 days	**Lead Auditor** • Prepares draft audit report • Seeks review and input from the audit team • Sends draft to the Service Manager and Service Manager responds	 within 20 working days within 10 working days within 10 working days
	Service Manager • Return findings to Lead Auditor with comments on factual accuracy	within 10 working days from receipt of draft from the Lead Auditor
	Lead Auditor • Provides final report to the Audit Instigator (MoH)	within 10 working days from receipt from the Service Manager

Checklist for lead auditor in setting up, conducting an audit and reporting

Time before Audit	Task	Responsibility	In Progress/ completed
Within 6 months Within 6 months	Identify audit team Set up meeting with service leads and agree date for audit Send service the service context document and documentation request form	Lead auditor Lead Auditor	
At least 3 months	Arrange travel and accommodation for audit team	Lead auditor	
Between 2-3 months	• Needle Exchange - arrange 1-1 visit by Consumer Auditor and that the Consumer Auditor interviews Needle Exchange tāngata whai ora • Email poster about the audit and when the Consumer Auditor will be present for informal interviews • Interview Medsafe in advance of the audit visit. If this cannot occur, a rationale is noted within the audit report. • Interview Prison Health	Lead auditor Lead auditor	
At least 2 months At least 1 month	Overview documents required pre audit visit: • Completed service context received • Completed documentation request received	Lead Auditor & service lead	
At least 2 months	Ensure posters are placed in service areas for tāngata whai ora awareness and information about audit	Lead auditor sends posters and service lead puts in place	
At least 2 months	Discuss tāngata whai ora survey options and process Discuss tracer audit process steps as a 'heads up'	Lead auditor send survey info and service lead puts in place	
At least 2.5 months	Establish whom is the 'go-to' person at the service to assist with the schedule	Lead Auditor and service lead / representative	
At least 3 weeks	Ensure consumer auditor receives tāngata whai ora survey information	Lead auditor	

Time before Audit	Task	Responsibility	In Progress/ completed
At least 2 weeks	Ensure a range of options for tāngata whai ora files to be reviewed and the tāngata whai ora and whānau to be interviewed are on standby	Lead auditor and service representative	
Post Audit			
Within 20 working days post audit	Send a draft of report within 20 working days of the audit visit to the audit team for review	Lead auditor Note to do this within less than 20 days to allow time to turn around changes from audit team review and get the draft to the service	
Within 30 working days post audit	Auditors comment within 10 days	Auditors	
Within 40 working days post audit	Make any changes to the report and send to service within 10 days	Lead auditor	
Within 50 working days post audit	Service to respond with any factual inaccuracies within 10 working days Make necessary adjustments and send to Ministry, Health NZ and cc the service	Lead auditor	

Part A: Audit report template

Audit report executive summary

<Name of service>

Audit report date:

Executive summary

Audit report

Report date:

Service context

Service provider:	

Premises name	**Street address**	**Suburb**	**City**

Number of funded OST places	**Number of tāngata whai ora at date of audit**	**Number and percentage of tāngata whai ora 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 tāngata whai ora interviewed		No. of whānau interviewed	
		No. of authorised prescribers/ staff prescribers interviewed	
No. of staff/management interviewed		No. of pharmacists interviewed	

1 Opioid substitution treatment

Indicators	Data source/Evidence	Attainment	Risk
1.1 Objectives of OST			
The service delivery reflects the principles of recovery and harm reduction.			
To improve the physical and psychological health and wellbeing of tāngata whai ora.			
Access to recovery support systems and networks.			
1.2 Roles of specialist OST services			
Overview documentation about the role of the service and practice demonstrate the provision of specialist interventions to minimise the harms associated with continued opioid and other substance use.			
1.3 Recovery-orientated OST			
The service delivery reflects the principles of recovery and wellbeing orientated treatment. • tāngata whai ora are involved in their own treatment and recovery plans • The assessment and planning processes help individuals consider their current and potential future 'recovery capital' • tāngata whai ora with lived experience inform service delivery	Count as three indicators with comment on each and determine average attainment finding		
Health information that is pertinent to OST should be displayed, such as posters and/or brochures of tāngata whai ora rights under the Code and information about OST, addiction, recovery, and hepatitis C. These materials should be current, displayed, and available to take away.			
1.4 Evidence to reducing barriers that impact on access to shared care in primary care.			
1.5 Whānau involvement in care All tāngata whai ora should be invited to engage whānau in treatment, and this invitation should be revisited periodically.			

Section attainment summary

Indicators (out of 10):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

2 Entry into opioid substitution treatment

Indicators	Data source/Evidence	Attainment	Risk
2.1 Access without undue delay			
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.			
2.2 A welcoming service			
Locations of OST services should be accessible via public transport where possible, and access should be easy to navigate, with relevant clear signage directing tāngata whai ora to the appropriate service entrance. The waiting room should be welcoming, suitably ventilated, and adequately furnished. If the reception is shared with other health services, sufficient space should be made for tāngata whai ora. Sharps containers should be visibly located within the bathroom or other areas	Count as 1 indicator with comment on each and determine average attainment finding		
2.3 Tāngata whai ora care pathway			
A documented care pathway identifies key steps from OST pre-entry and post exit.			
2.4 Rights of Tāngata whai ora			
Services must supply tāngata whai ora with information about: • their rights under the Code of Health and Disability Services Consumers' Rights • consumer advisor, and health and disability advocacy contacts • limits of confidentiality under the Health Information Privacy Code 1994 (such as situations under which the specialist service may need to break confidentiality) • the range of treatment options and psychosocial interventions available • the complaints procedure • Complaint processes must be transparent, visible, easy to access and be sensitive to tāngata whai ora and whānau and respect their values and beliefs	Count as 1 indicator with comment on each and determine average attainment finding		

Indicators	Data source/Evidence	Attainment	Risk
2.5 Comprehensive Assessment			
Risk-taking behaviours are documented in the assessment, eg, injecting practices, blood-borne virus transmission, driving, unsafe sexual practices. The comprehensive assessment should be regularly reviewed and all versions (particularly the original) readily available to the treatment team. Reviews should occur at least yearly or whenever there is a substantial change in the person's condition.	Count as 3 separate indicators		
2.6 Treatment and Recovery Planning			
Assessments must be accompanied by individualised treatment and recovery plans. These plans reflect the biopsychosocial aspects and goals of tāngata whai ora, including the assessed problems, strengths, treatment priorities, and recovery and wellbeing goals. Treatment and recovery plans need to be reviewed and updated at regular intervals.	Count as 1 indicator		
2.11 OST for rangatahi under 16			
The admission of rangatahi under 16 years old is supported by an opinion from an addiction medicine specialist and/or a child and youth psychiatrist.			
2.12 Informed consent and treatment information			
Consent for OST is signed by the tāngata whai ora.			
Before consenting to treatment, tāngata whai ora are informed of and provided with written information on: • 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 • limits of confidentiality under the Health Information Privacy Code 1994 • the availability of consumer advocacy and peer support services.	Count as 8 indicators		

Indicators	Data source/Evidence	Attainment	Risk
Informed consent is reviewed and updated on a regular basis, including when changing OST medication and reflected throughout treatment, ie, there is evidence that tāngata whai ora have been fully informed of any changes in service delivery and any proposed changes to their treatment plans.			
2.13 Choice of OST medication			
Tāngata whai ora are provided with information on the OST medications available and their choice is guided by their preference and goals.			
2.13.1 Long-acting injectable buprenorphine OST services should have policies and procedures in place for the use of LAIB if it is prescribed.			

Section attainment summary

Indicators (out of 21):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

3 Stages of treatment

Indicators	Data source/Evidence	Attainment	Risk
3.1 Induction			
Tāngata whai ora are informed about how long they will wait for OST and are offered interim methadone or buprenorphine and psychosocial support. This question only applies when a service is providing interim prescribing.			
Prescribing and monitoring is consistent with the *OST Guidelines* sections 3.1.1 and 3.1.2, or a clear rationale is documented where practice is not consistent with the *OST Guidelines*.			
3.2 Stabilisation			
Stabilisation is assessed and regularly reviewed on an individual basis in relation to the tāngata whai ora 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.			
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 tāngata whai ora and the multidisciplinary team.			
3.4 and 3.5 Transfer methadone to buprenorphine/transfer buprenorphine to methadone			
There is evidence that transfers are well planned and appropriate information has been provided to the tāngata whai ora on the transfer process.			
3.6 Psychosocial interventions			
Services should provide tāngata whai ora with information about available psychosocial supports, self-help and whānau and whānau support groups as well as cultural and spiritual guidance if appropriate, including a broad range of social and psychological interventions and trauma informed approaches.	Count as 1 indicator and comment on each and average to one attainment		
Psychosocial interventions are delivered by the service or external providers and are one-on-one or in group settings.			

Indicators	Data source/Evidence	Attainment	Risk
All interventions delivered in the context of OST should be evidence based, strengths- and recovery, culturally safe, tailored to individual needs, and have defined goals.			
The service has links with other supports, eg, peer support, employment and housing agencies.			
3.7 Reviewing progress			
Reviews occur at least once every six months and involve the tāngata whai ora, the authorised prescriber and the key worker.			
Sessions with key workers include review of progress in relation to the treatment and recovery plan and an updated assessment of risk.			
Tāngata whai ora are informed in writing about the scheduling of special case reviews and their right to be involved and to have a support person attend, including peer support or health/consumer advocate. Exceptions to this comply with the *OST Guidelines*.			
Written procedures are available for tāngata whai ora on how to request a treatment review.			
3.8 Drug screening			
Services should advise tāngata whai ora of the procedure and rationale for drug screening in writing, either as a specific handout or as part of a general information pack provided at admission.			
A combination of self-reporting, clinical observation and urine screening is utilised for monitoring drug use; policy, protocol and practices are consistent with *OST Guidelines* section 3.8.			
3.9 Completing OST			
Planned withdrawal is tāngata whai ora directed, has a flexible end point and includes relapse prevention (including naloxone), psychosocial, medical and ongoing support, *OST Guidelines* section 3.9.1.			
Tāngata whai ora who are unable to maintain stability after a planned withdrawal from OST are promptly readmitted to OST, *OST Guidelines* section 3.9.1.			
The tāngata whai ora has a discharge plan and after-care plan, *OST Guidelines* section 3.9.1.			
Involuntary cessation OST is considered and decided by the multidisciplinary team only as a last resort, with a second opinion sought externally and only after all efforts have been made to resolve influencing issues, *OST Guidelines* section 3.9.2.			

Indicators	Data source/Evidence	Attainment	Risk
Tāngata whai ora subject to involuntary withdrawal are: • given the reasons for the withdrawal in writing • cautioned about the risks of overdose • 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. *OST Guidelines* section 3.9.2.	Count as 1 indicator and provide comment and average for one attainment		
The tāngata whai ora has a discharge plan, including how they might re-engage in OST, *OST Guidelines* section 3.9.2.			

Section attainment summary

Indicators (out of 21):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

4 Safety issues

Indicators	Data source/Evidence	Attainment	Risk
4.1 Overdose			
Tāngata whai ora and their support people are provided with relevant information on the risks of overdose and actions to take in an emergency.			
Naloxone and accompanying information are made available to tāngata whai ora.			
4.2 Substance-impaired driving			
Before admission, tāngata whai ora 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 prescribed or using other substances that also impair driving or alter the metabolism of the opioid substitution medication as part of the ongoing informed consent processes.			
Identified risks are effectively managed and documented.			
4.3 Methadone and cardiac safety			
Tāngata whai ora are screened for the risk of QTc interval prolongation at entry to, and during, OST as appropriate.			
4.4 Drug interactions			
The clinical relevance of drug interactions is assessed. Where it is not possible to avoid co-prescribing medications, a risk-benefit assessment should be conducted. Decisions to switch medication or adjust doses should be made on an individual basis in discussion with tāngata whai ora and whānau, considering concurrent medical conditions, clinical history, and dosing information.			

Section attainment summary

Indicators (out of 6):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

5 Managing dose-related issues

Indicators	Data source/Evidence	Attainment	Risk
5.1 Takeaway doses			
Decisions by OST services around takeaway doses should reflect the principles of providing least restrictive possible care within the context of the assessed clinical risk, as well as a flexible and individualised approach to care.			
The service policy and practices are relevant to takeaway doses of OST medication, support safety and recovery goals and are consistent with requirements, including: • 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.	Count as 1 indicator and provide comment and average for one attainment		
Safety requirements concerning takeaway doses are specified in writing and provided to tāngata whai ora and pharmacists.			
5.1.3 Services should ensure tāngata whai ora and whānau understand the reasons for the change of takeaways decision, what conditions would need to be met for a return to their previous takeaway regime, and timeframes in which this may occur.			
5.1.4 Dilution of Methadone Any service that elects to dilute methadone doses is expected to have a dilution policy that is clearly explained to tāngata whai ora at time of OST admission. All dispensing pharmacies need to be aware of the policy and the rationale behind it.			
5.2 Notice of prescription changes			
Tāngata whai ora are given information on how to request changes to prescriptions. Services should try to accommodate tāngata whai ora requests while assessing each request on an individual basis.			
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 *OST Guidelines* section 5.4.			

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 file of tāngata whai ora. Efforts to contact tāngata whai ora before they arrive at the pharmacy are documented.			

Section attainment summary

Indicators (out of 9):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

6 Clinical issues and special populations

Indicators	Data source/Evidence	Attainment	Risk
6.1 Managing problematic substance use			
OST providers must therapeutically engage with tāngata whai ora who continue use of alcohol and other substances in ways that increase chances of harm. Responses to ongoing substance use besides opioids should be individualised and complies with *OST Guidelines* section 6.1	Count as 1 indicator and provide comment and average for one attainment		
Tāngata whai ora who are known to use other substances problematically have their takeaway dose arrangements reviewed as part of a treatment review.			
Tāngata whai ora are advised about potential interactions between OST medication and other substances (including alcohol).	Count as 1 indicator and provide comment and average for one attainment		
Services advise tāngata whai ora about interactions between benzodiazepines and OST medication.			
There is regular clinical review where benzodiazepines are co-prescribed.			
Smoking cessation is promoted and offered by both specialist services and GP prescribers.			
6.2 Managing side effects			
Tāngata whai ora are provided with information on potential side effects and management of side effects.			
6.3 Managing intoxicated presentations			
Clear guidance is given to tāngata whai ora and pharmacists regarding the likely outcomes of a tāngata whai ora presenting for doses in an intoxicated state.			
6.4 Managing challenging behaviour			
A negotiated, trauma-informed, and person-centred consultation style can help minimise and support development of a positive therapeutic alliance. Service providers must handle relationships sensitively, avoiding adversarial interactions with tāngata whai ora. Opportunities to maximise tāngata whai ora autonomy in the safe provision of OST should always be sought. Providers should record instances of challenging behaviour in clinical records.			

Indicators	Data source/Evidence	Attainment	Risk
6.5 Co-existing medical and mental health disorders			
Specialist service protocols should have clear frameworks in place to routinely identify and treat (or facilitate treatment for) co-existing mental health disorders and medical problems. Services should provide tāngata whai ora and whānau with information on co-existing problems.			
Specialist services should offer tests for HBV, HCV, and HIV during initial assessment. Regular re-testing should occur (such as annually) if tāngata whai ora continue injecting substances.			
All OST providers should be trained in HIV and hepatitis-related issues and provide information about blood-borne virus transmission, course, and treatment to tāngata whai ora, whānau, and other health and social service providers.			
Service providers are encouraged to collaborate with local gastroenterology services to improve access to HCV and HBV treatment for tāngata whai ora.			
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 tāngata whai ora 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.			
OST providers should have strong relationships with local acute and chronic pain services, and where appropriate, have clear service level agreements or memoranda of understanding, and where appropriate collaboratively review or manage tāngata whai ora with co-existing chronic non-malignant pain problems.			
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.			
OST services need to have pathways and protocols in place for liaising with antenatal and postnatal care teams.			

Indicators	Data source/Evidence	Attainment	Risk
6.8 Ageing tāngata whai ora on OST			
Specialist services and primary health care teams should develop and coordinate plans to support tāngata whai ora aged 50 and over and their whānau and complies with *OST Guidelines* section 6.8			
In the case of tāngata whai ora on OST who enter long-term residential care (like an aged care facility), service providers should liaise with nursing and medical staff at the facility to ensure ongoing OST is appropriate and safe.			
6.9 Working with rangatahi in OST			
There should be careful assessment of the risks and benefits before deciding whether to treat rangatahi with OST. Pharmacotherapy should be prescribed alongside psychosocial interventions based on a comprehensive assessment. A second opinion from an addiction medicine specialist is recommended prior to commencing treatment.			
6.11 Tāngata whai ora in care of Ara Poutama Department of Corrections or other custodial settings			
OST service providers should support Corrections facilities to initiate treatment for OUD within prison, either by providing care directly or by authorising and, where necessary, supervising a prison prescriber to undertake the induction process. Services should accept referrals from Corrections health services for OST continuation or initiation. OST initiation may occur during incarceration or at time of release.			
Services should develop a strong relationship with their local Corrections facilities, supported by a service level agreement where appropriate.			
6.11.1 Services should have policies for managing tāngata whai ora taken into police custody and awaiting court hearings. Services should endeavour to ensure tāngata whai ora receive their OST doses whilst in custody.			
6.11.2 Returnees or deportees Deportees or returnees should be given priority treatment admission.			
6.12 Tāngata whai ora who are hospitalised or in end-of-life care.			
Services may develop relationships with local hospitals and end-of-life care facilities and have service level agreements in place.			

Section attainment summary

Indicators (out of 28):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

7 Managing OST transfers

Indicators	Data source/Evidence	Attainment	Risk
7.1 Transferring between specialist services			
Tāngata whai ora 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.			
Specialist services and primary care providers should fully inform tāngata whai ora intending to transfer to another region about: • possible treatment differences (such as those related to prescribing and takeaway doses) • the need to be reassessed at the new service • dispensing restrictions in the new area • the fact that if they are on GP authority with a primary care provider, they may need to be admitted to a specialist service in the new area for a period of time before being able to transition back to GP authority	Count as 1 indicator and provide comment and average for one attainment		
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 original specialist service for the tāngata whai ora continues to prescribe or authorises the prison medical officer to prescribe for the tāngata whai ora when they are in prison.			
Specialist services in areas where prisons are located are responsible for providing training and liaison with prison medical staff and medical officers, in the same way they provide training to GPs in the community.			
Ideally the specialist service provides psychosocial inventions to prisoners on OST in prisons in their area regardless of the prisoner's service of origin. (Note this is not in the 2025 Guidelines.)			
Reviews take place at least annually Reviews for tāngata whai ora in prison and involve appropriate prison medical and specialist service staff. Reviews occur at least annually and by the most accessible means. All out-of-area reviews are conducted by TeleMed.			

Indicators	Data source/Evidence	Attainment	Risk
7.3 Transferring from overseas			
Specialist services should admit tāngata whai ora who have been established on OST programmes overseas and move to Aotearoa New Zealand temporarily or permanently as quickly as possible.			

Section attainment summary

Indicators (out of 9):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

8 OST in primary care

Indicators	Data source/Evidence	Attainment	Risk
8.1 Shared care with the primary health care sector			
All tāngata whai ora have a nominated GP.			
The service proactively supports the transfer of tāngata whai ora to their authorised GP as soon as possible after dose stabilisation.			
8.2 Requirements of specialist services in shared care arrangements			
There is a formal and agreed relationship in place between authorised GPs and specialist services that comply with *OST Guidelines* section 8.2 which includes providing advice and consultation.			
8.3 Requirements of prescribers in primary 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 tāngata whai ora receiving OST. At a minimum, this should involve attendance at training provided by the local specialist service. Other staff within the practice, in particular practice nurses, should undertake similar training.			
Tāngata whai ora are provided with access to psychosocial support.			
8.4 Funding for shared care arrangements			
Service leaders should investigate possible opportunities to fund shared care arrangements in their region to improve tāngata whai ora access to primary care prescribers.			

Section attainment summary

Indicators (out of 7):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

9 OST and the pharmacy

Indicators	Data source/Evidence	Attainment	Risk
9.1 Responsibilities of the pharmacist			
At a minimum, staff should complete training available online through the Pharmaceutical Society of New Zealand (PSNZ), training endorsed for OST providers by the Ministry of Health or Health NZ, or training offered by the local specialist service.			
The service provides pharmacies with accurate information as to which GPs are authorised to prescribe OST.			
The pharmacist notifies the prescriber when a tāngata whai ora: • 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 opioid (or other substance) withdrawal symptoms • deteriorates in their physical, emotional or mental state.	Count as 1 indicator and provide comment and average for one attainment		
The pharmacy environment for tāngata whai ora receiving OST medications ensures privacy and respect.			
Local protocols include a service level agreement or memoranda of understanding between the service and community pharmacies (Refer *OST Guidelines* 11.6)			
9.2 The dispensing and administration process			
Pharmacists are consulted as part of the multidisciplinary team, in particular, before making significant changes to a treatment plan for tāngata whai ora that affect dispensing.			
The service is accessible to the community pharmacist, eg, has the contact details of the key worker for each tāngata whai ora, and an afterhours contact number.			
9.3 Managing other aspects of OST provision			
The service communicates clearly with the pharmacist when a new prescription for a tāngata whai ora differs from the previous one (eg, dose change, new takeaway regimen, split dose, early start date).			
Written confirmation (via online e-prescribing messaging or email) is received following any telephoned request for script changes. Hard copy prescriptions are scanned and emailed.			

Indicators	Data source/Evidence	Attainment	Risk
The service notifies the pharmacist when a tāngata whai ora 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 ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

10 The OST workforce and professional development requirements

Indicators	Data source/Evidence	Attainment	Risk
10.1 The OST team			
The OST team ideally includes a range of disciplines and roles including consumer advisors and peer support.			
Tāngata whai ora are able to access peer support and consumer advisor roles from within or outside the service.			
OST staff demonstrate knowledge, skills and attitudes appropriate to their role.			
Lead clinicians and addiction, mana-enhancing care, and recovery-focused and whānau inclusive treatment.			
10.1.7 The consumer, peer support, and lived experience workforce The service staff have their own experience and are open about their own recovery The service employs peer-support workers and consumer advisors where possible Services that employ lived experience workers should ensure supportive workplace environments and infrastructure to promote their growth and development Whānau have access to whānau support	Count as 1 indicator and provide comment and average for one attainment		
10.2 Workforce training and professional development			
Clinical staff members receive appropriate orientation, mentoring and supervision and ongoing in-service education.			
Clinical staff have knowledge of the principles of Te Tiriti o Waitangi and its implications for tāngata whai ora and the provision of equitable OST services.			
Staff receive relevant training in cultural competency and cultural safety Refer *OST Guidelines* section 10.3			
All clinical and medical staff working with tāngata whai ora on OST are expected to have completed training for OST providers endorsed by Ministry of Health or Health NZ.			
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.			

Indicators	Data source/Evidence	Attainment	Risk
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.			
10.3 Cultural support workforce – for tāngata whai ora and the OST service			
Cultural support is available for tāngata whai ora and cultural support and advice is available for staff.			

Section attainment summary

Indicators (out of 15):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

11 Quality systems and administrative expectations of specialist OST services

Indicators	Data source/Evidence	Attainment	Risk
11.1 Documentation Policy and procedure documents should be document controlled and dated and have a review date			
Services include staff input for new policies and procedures or reviews. Tāngata whai ora and whānau are encouraged to provide input to new policies or reviews where relevant and be reimbursed for their time.			
Documents such as forms, templates, and tāngata whai ora information should be dated. Information for tāngata whai ora should be acronym and jargon-free, with medical terms explained, and information easy to understand.			
11.2 Record keeping			
Comprehensive records are held for all tāngata whai ora.			
11.4 The complaints procedure			
Services should inform all tāngata whai ora about the range of mechanisms available for making a complaint (including to the Health and Disability Commissioner) and their right to an independent advocate or support person. This information should be displayed prominently.			
OST services will provide clear reporting of the outcome or findings and remedies to tāngata whai ora as appropriate, in a form they prefer.			
11.5 Safety requirements of specialist services			
The service has a set of safety requirements that addresses the personal safety of tāngata whai ora and staff, as well as safety in prescribing and dispensing doses, including takeaways. Services should discuss safety requirements with tāngata whai ora and whānau as part of initial assessments and whenever relevant.			
11.6 Local protocols in specialist services			
Local protocols are consistent and do not conflict with the *OST Guidelines* or with relevant legislation, codes of practice or accountability requirements.			
11.7 Civil defence emergencies			
Management plans are in place for civil defence emergencies which includes local pharmacies.			

11.8 Service planning and review			
Service planning and regular review includes all staff, Tāngata whai ora and whānau input.			
11.10 Technology systems There is an approved, efficient e-prescribing programme that converses with community pharmacies.			
Telehealth options are to be available for supporting tāngata whai ora out-of-area, for example, those who have transferred to another part of the country and for those in prison.			

Section attainment summary

Indicators (out of 12):

Fully attained ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

Summary of recommended actions

12 Prescribing controlled drugs in addiction treatment (Misuse of Drugs Act 1975, section 24)

Indicators	Data source/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 tāngata whai ora files.			
12.6.3 Prescribers in primary care			
Correct authorisation is given to each prescriber and prison medical officer for named tāngata whai ora, the Misuse of Drugs Act 1975.			
Copies of each prescriber 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: • discuss management problems • request reviews • transfer tāngata whai ora back to services.			
12.7.2 Period of prescriber 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 ☐ Partially attained ☐ Unattained ☐ Not applicable ☐

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 *New Zealand Practice Guidelines for Opioid Substitution Treatment* (Ministry of Health 2025) Appendix 7.

Indicators	Data source/Evidence	Attainment	Risk
13.1 Eligibility			
Interim methadone treatment prescribed by an authorised prescriber is offered to tāngata whai ora when OST is clinically indicated (following comprehensive assessment) and there is a longer than two-week waiting list for OST.			
Tāngata whai ora 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 tāngata whai ora will pay for all GP or alternative prescriber consultations where appropriate. b. The tāngata whai ora 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.	Count as 1 indicator and provide comment and average for one attainment		
13.3 Induction and prescribing			
Induction and prescribing practices for methadone are as set out in the *OST Guidelines* (Ministry of Health 2025). This includes prescribing relevant to missed doses. If the interim medication is buprenorphine, induction guidelines should be followed as outlined in the *OST Guidelines*.			
13.4 Ongoing support			
The specialist service provides information to the tāngata whai ora 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).

15 Summary of Risks and Corrective Actions

Summary of risks (Report author must copy all risks below):

Summary of corrective actions (Report author must copy all corrective actions below):

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 based on their geographical coverage. These questions might focus on the history of OST provision and the context of OST provision within their demographics as appropriate.

During the tāngata whai ora tracer audit process, the auditors will devise appropriate questions for the tāngata whai ora interview, based on their file and relevant parts they could comment on.

Some templates are lengthy, eg, the OST Case Worker/Key Worker interview tool. Only parts of the tool need be used when interviewing staff. Some questions might be repeated for a number of staff to determine common understanding of particular themes.

There are suggested auditor roles to undertake each of the interviews at the beginning of each interview template. This is a guide only. Acronyms will identify Best Practice Auditor (BPA), consumer auditor (CA) and lead auditor (LA).

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

- a formal confidentiality agreement is in place with the audit team
- there is an explanation slip (or an electronic notation provided via the Service staff with authorised access) to go in the clinical file that is audited
- the tāngata whai ora 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:

Due Date:

To be sent (email / or hard copy) to:

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 *Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment 2025* (Ministry of Health 2025).

Note where some policies and procedures below are standardised nationally, please provide evidence of local variation.

Documentation	Yes	No	Comment (if necessary)
Previous audit findings – plans / implementation progress updates	☐	☐	
Organisational chart	☐	☐	Note if this has been requested and provided in the Service Overview documentation there is no need to supply
Treaty of Waitangi / cultural policy	☐	☐	
Service improvement actions following a Coroner's report – narrative and / or implementation plan with progress updates	☐	☐	Note for purposes of confidentiality please do not provide a Coroner's report
OST service plans (eg, quality plan, disaster and emergency plan, strategic plan)	☐	☐	
OST service philosophy, principles, description and objectives (within treatment pathway or service overview documentation that reflect a recovery-orientated and harm reduction treatment focus)	☐	☐	
Tāngata whai ora involvement in service policy development - policy / evidence	☐	☐	
Whānau involvement in service development, service design, delivery, planning, evaluation: policy / evidence	☐	☐	

Documentation	Yes	No	Comment (if necessary)
Tāngata whai ora information / information sheets that relate to your OST service locality on: • range of treatment options available • service inclusion/exclusion criteria • confidentiality • opportunities for involvement in service planning / evaluation • requesting changes to prescriptions	☐	☐	
Access to service - policy/protocols • OST admission criteria • OST exclusion criteria and management • Assessment • Waiting list management • Interim prescribing (if applicable)	☐	☐	
OST treatment pathway	☐	☐	
Client information booklet/information sheets and any example of relevant information tāngata whai ora initially receive about the local OST service	☐	☐	
Informed consent - template	☐	☐	
Comprehensive assessment - template	☐	☐	
Treatment plan and recovery plan - templates	☐	☐	
Client rights - example of client information provided	☐	☐	
Complaints – example of tāngata whai ora information provided	☐	☐	
Benefits and limitations of OST medications – tāngata whai ora information	☐	☐	
Consumer advocacy and peer-support services – tāngata whai ora information	☐	☐	
Treatment review - policy	☐	☐	
Drug screening - policy	☐	☐	
Case management (key worker) and care coordination - policy	☐	☐	
Prescribing and dispensing OST medications: policy/protocols including: • takeaway medication • change of medication dose procedure • change of dispensing procedure • dispensing arrangements • replacement doses • missed doses	☐	☐	

Documentation	Yes	No	Comment (if necessary)
Accessing psychosocial interventions - policy	☐	☐	
Accessing psychosocial supports, self-help, family and whānau support groups and cultural and spiritual guidance – tāngata whai ora and whānau information	☐	☐	
Management of coexisting mental health and medical problems - policy	☐	☐	
Managing blood-borne virus - policy/information	☐	☐	
Managing the needs of older clients - policy	☐	☐	
Residential care / Rest home service level agreements as appropriate	☐	☐	
Safety and risk management: policy: • Overdose (including Naloxone policy) • Substance-impaired driving • Drug interactions • Safety of staff and clients	☐	☐	
Managing intoxication and/or suspected diversion - policy	☐	☐	
Pain management – policy / service level agreement with pain service	☐	☐	
Managing pregnant and breastfeeding women: policy/protocol	☐	☐	
Managing clients ending OST-policy/protocol	☐	☐	
Interim prescribing policy (if relevant)	☐	☐	
Community pharmacy interface - policy/protocol • Informing and consulting pharmacists • Training and support for community pharmacists • Management of errors in community pharmacy and links back to OST service	☐	☐	
Primary health care interface: policy/protocol • 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	☐	☐	

Documentation	Yes	No	Comment (if necessary)
Prison interface – local policy/MOU • Managing clients who are in prison • Review of client care • Liaison • Support for authorised prison medical officers / prescribing by OST service	☐	☐	
Police interface service level agreement	☐	☐	
Interface with other OST services - policy • Transfer of care consistent with *OST Guidelines*	☐	☐	
Any other relevant treatment regimes that are not included within the OST Guidelines	☐	☐	
Staff training/education: policy	☐	☐	
Supervision- policy – OST staff (includes peer & consumer workforce)	☐	☐	
Returnees policy / protocol (if relevant)	☐	☐	
Position description for each designation	☐	☐	
Framework / document that describes peer and lived experience workforce contribution / service level agreement with peer support service	☐	☐	
Two most recent reports to Ministry of Health	☐	☐	
Copy of most recent tāngata whai ora newsletter (if relevant)			
Other (please list)	☐	☐	

3 Service Context Information Request Form

To: <Service Manager>

From: <Lead Auditor>

Return address:

Due by:

Please provide the following information for the audit team.

Service name:	

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 shared care authorised prescribers**

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

Please attach an organizational chart which shows how the OST service fits within the organization (this also helps the Lead Auditor determine which senior management needs to be included within the audit site visit).

Service context	Yes	No	Comment (if necessary)
Do you operate any satellite / outreach clinics? If so, where, and what days / times?	☐	☐	
What day of the week and time is your MDT? (Some of the Audit Team will observe this).			
Do you have hard copy / electronic / a mix of both ways of recording client files?	☐	☐	
Do you have an e-prescribing system in place? ie, Medimap?	☐	☐	
Do you provide interim prescribing?	☐	☐	
Do you have a local Needle Exchange you connect with? If so please provide a contact name and contact details.	☐	☐	
Do you employ a Consumer Advisor? If so, contact details please.	☐	☐	
What other consumer functions are also provided within or external to your service that OST consumers may access, eg, peer support. Contact details, please			
Do you employ a Family/whānau Advisor? If so, contact details please.	☐	☐	
What is the closest prison you connect with? Please provide contact name and details.			
Who do you connect within the Health New Zealand – Te Whatu Ora locality regarding Pharmacy incidents / dispensing / medication errors /complaints and incidents? (Contact details please.)			
Who is the Health New Zealand – Te Whatu Ora locality person who oversees the complaints and incidents process? Contact details please.			
Do you provide for smoking cessation?	☐	☐	
Do you have an after-hours service?	☐	☐	
What are the arrangements for Māori support of clients and staff? Contact details of internal Māori service leader.			
What allied health staff do OST clients access eg, social worker / psychologist? Are they based in the Addiction Team / wider Mental Health? Contact details please.			
Is there a local Pain Clinic you work with? If so, where is this situated? Key contact person please.	☐	☐	
Are there any concerns about prescribers in your area? If so, please describe. Is Medicines Control alerted?	☐	☐	

Service context	Yes	No	Comment (if necessary)
Are there any concerns about prescribers in your area? If so, please describe. Is Medicines Control alerted?	☐	☐	

4 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.

Designated auditors are assigned to each of the below for ease of time and specialised focus. (Best Practice Auditor (BPA), Consumer Auditor (CA), Lead Auditor (LA)

	Attainment	Risk	Comments
a. Facility appropriateness and environment			
(CA) Access, entrance, waiting room and interview rooms: • Adequate clear signage directing visitors to the facility • Description of facility including disability accessibility • 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 • Relevant OST and harm reduction tāngata whai ora information visible			

	Attainment	Risk	Comments
(BPA) Clinic area: • 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			
(LA) Safety features of facilities: • 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)			
(BPA) Toilet facilities: • Adequate access, including disability access • If observation is required, staff of the same sex can observe • Infection control information available • Sharps containers are available for public discretionary disposal			
(LA) Security of facilities: • 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 Interview reception staff regarding personal safety, evacuation drills, panic alarms and emergency service responsiveness			
b. Filing systems / privacy of information			
(LA) • 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			

5 Incident Reports Review Tool (LA and or CA)

Service provider:

Unit/team:

Auditor:

Date:

Guidance notes

Seek a description of the Health New Zealand – Te Whatu Ora incident-reporting policy.

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			

	Attainment	Risk	Comments
b. Indicators for incident reports			
Report for months of reviewed			
Evidence of: • 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: – number and type of incidents – location – circumstances, including systems, process and procedures – identification of core issues – outcome of action taken			

6 Complaints Review Tool (LA and/or CA)

Service provider:

Unit/team:

Auditor:

Date:

Guidance notes

Seek a description of the Health New Zealand – Te Whatu Ora complaints procedure policy.

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

- complete and comprehensive records, to enable you to develop an understanding of the circumstances surrounding the complaint
- evidence that appropriate actions and reviews have been completed at the appropriate organisational level and that the tāngata whai ora has received the outcome in a respectful manner and clear and understandable language

	Attainment	Risk	Comments
a. Indicators for complaint documentation			
Initial documentation is consistent with policies and procedures Documentation clear/legible and factual Documentation provides a clear understanding of circumstances surrounding the complaint and evidence of appropriate action instigated and a planned follow-up and any service improvements as a result of the complaint, and evidence that these are in place. Written correspondence and discussions with the complainant are recorded in the complaints system. Feedback to the complainant is respectful and clearly written, describing any actions to be addressed with timeframes.			

7 Multidisciplinary Team Observation Tool (BPA and/or LA)

The audit team may be represented by the lead auditor and best practice auditor (and any shadow lead or best practice auditor.) The auditors are strictly to observe the MDT process and not interact / disrupt the natural flow of the MDT process.

The following tool is a guide to use as a reference point in observing the MDT

Date of MDT:

Team members present:

Apologies:

MDT Chair/facilitator:

Auditors present:

Principles of recovery are demonstrated? Eg, recovery capital, tāngata whai ora goals	
Risks are discussed including co-prescribing of benzodiazepines, concurrent other substance use, mental health, risks related to substance use, physical health risks and any other risks relating to the circumstances of the tāngata whai ora (eg, risk of harm from others or risks related to driving). Risk discussion and planning is tailored for the individual taking consideration of their particular circumstances.	
Takeaways discussion and planning is tailored for the individual taking consideration of their particular circumstances	
Language used to refer to tāngata whai ora is respectful and non-discriminatory	
Relevant aspects of the MDT are commensurate with the OST Guidelines	
Anything else of note	

8 Tracer Audit – Tāngata whai ora Records Review Tool (BPA and/or LA)

Guidance notes

Refer to Introductory section of this document for more context on the tracer audit approach.

The practical steps to set up for a tracer audit are discussed between the lead auditor and the service and will include:

- Six weeks prior to audit visit, lead auditor sending the service a list of tāngata whai ora file themes.
- Five weeks prior to audit visit, service identifies three files commensurate with the themes – one of which must be Māori. The service provides brief anonymous summary overview of each of the 3 tāngata whai ora and their OST journey to lead auditor.
- Within two working days, the lead auditor selects two of the three.
- Service seeks (on standby) the corresponding tāngata whai ora and whānau* to be available by phone at time of audit visit. This could be separate calls to the tāngata whai ora and whānau – or together if that is the preference of the tāngata whai ora. The service informs the tāngata whai ora and whānau: about the nature of the audit; that no more than four auditors view their file and that the auditors have all signed confidentiality agreements; the anonymity of the tāngata whai ora is prioritised; only themes are written into the report; there is an option to view the draft section of the report that is relevant to the file review (with two working days to reply); that vouchers will be provided to the tāngata whai ora and whānau for their time; that the tāngata whai ora and whānau are one of two selected and that the service will get back to them at least two weeks prior to the audit date to confirm or cancel. Verbal consent is sought by the service and noted to the lead auditor.
- The above step may determine that only one of the two tāngata whai ora will be available during the audit visit time (an interview is not to occur after the audit visit).
- Three weeks prior to audit visit the lead auditor selects one of the two options of tāngata whai ora to be interviewed.
- The service confirms with the tāngata whai ora and whānau.
- The file review is to occur **before** the call with the tāngata whai ora to ensure only one contact is needed with the tāngata whai ora. Should they state anything that needs checking against the file, the file can be revisited.
- The tāngata whai ora is provided opportunity to view the draft relevant section of the audit report by the lead auditor and through the service if they had agreed to this.
- It is optional the consumer auditor is involved in the file review.

Interview questions, based on findings or queries found within the file audit are devised by the lead or best practice auditor to verify the tāngata whai ora and whānau experience resonates with what is written in the file. The phone call interview with the tāngata whai ora and whānau is facilitated by the lead or best practice auditor. These can be separate phone calls with whānau involvement as per client choice.

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.

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.

The below template covers a comprehensive overview of all aspects of a tāngata whai ora experience of the OST service. As only one file is thoroughly reviewed, not all of the below are relevant to the particular tāngata whai ora.

Audit number:

Audit date:

Auditor:

Requirement	Attainment	Risk	Comment
National Health Index (NHI) number			
Demographic information			
Whānau / support people involved			
Nominated GP			
Prescriber			
Pharmacy: name, address, telephone number and fax number and email address			
Dispensing arrangements			
Nominated key worker			

Requirement	Attainment	Risk	Comment
Consent forms (informed consent signed for treatment, disclosure of personal information, etc)			
Informed consent is evident for change of treatments			
Comprehensive assessment including unsafe sexual practices			
Diagnosis of opioid dependence			
Date treatment commenced			
Initial treatment plan			
Recovery plan - recovery orientated and appropriateness to client aims; has realistic goals with timeframes, strengths and needs and recovery capital			
Treatment plan and recovery plan are periodically reviewed and evidence that tāngata whai ora has received this in writing			
Initial medication dose within recommended range			
Information provided to client (and support people)			
Medication dose at time of file audit			
Evidence a range of medication options have been discussed and the tāngata whai ora has been provided with choice			
Possible side effects discussed and potential interactions between substances			
Therapeutic doses generally 60-120mg Methadone, 12-24mg buprenorphine Those above notified to Medicines Control. Those above 150mg informed to Director MH			
Current treatment plan			
Current recovery plan			
Evidence that the tāngata whai ora and, where possible, significant others/whānau and as appropriate, other providers involved in the treatment plan			
Expectation of transfer to GP care is explained			

Requirement	Attainment	Risk	Comment
Cultural supports have been offered			
Psychosocial support is assessed and provided			
Evidence of urine drug screening for monitoring drug use			
QTC prolongation evidence			
Blood borne virus testing and treatment / referral			
There is regular clinical review where benzodiazepines are co-prescribed			
Treatment and recovery plans given to tāngata whai ora			
Perceived risk, including criminal behaviour and forensic history			
Information provided to client (and support people) and noted: • OST and You • Client rights • Limits of confidentiality • Relevant local service information • How to make a complaint • Relevant fact sheets • Peer support / consumer advisor and health advocacy contacts • After-hours contact where applicable			
Record of reviews by the prescriber			
Progress notes record ongoing contact with the tāngata whai ora and, where possible, significant others/whānau and other providers (including the GP and pharmacist) and interventions implemented in keeping with the current treatment plan			
Rationale of safety decisions are recorded – eg, cancelling or withholding doses, takeaway dose safety requirements specified in writing and provided to clients and pharmacists			
Tāngata whai ora and whānau understand the reasons for the change to takeaways decision, what conditions would need to be met for a return to their previous takeaway regime, and timeframes in which this may occur			

Requirement	Attainment	Risk	Comment
Record of regular monitoring of progress by the key worker in relation to short- and longer-term treatment plans, recovery plans and updated risk assessments			
Key worker and prescriber reviews at required frequency			
GP authorisation forms, for those in shared care in primary care			
Physical health and mental health is assessed frequently, and relevant health support services are in place			
Ageing related needs are identified and addressed with supports in place			
Concurrent other substance use is addressed			
There is evidence that methadone to buprenorphine transfers are well planned and appropriate information has been provided to the client on the transfer process			
There is evidence that buprenorphine to methadone transfers are well planned and appropriate information has been provided to the tāngata whai ora on the transfer process			
There is evidence that transfer to long acting injectable buprenorphine treatment (when funded) is well planned and appropriate information has been provided to the tāngata whai ora on the transfer process			
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)			
Tāngata whai ora records organised in a clear, consistent and logical manner			
Notes securely stored			
Key information readily accessible			
Staff members involved can be clearly identified			

Summary
Notes – interview questions for tāngata whai ora and whānau –

9 Prescription Audit Tool (BPA)

Use one sheet to record the audit results for each record. Tool can be used for hard copy scrips and e-prescribing.

Audit number:

Audit date:

Auditor:

Requirement	Attainment	Risk	Comment
a. Methadone prescriptions			
• Check for evidence of script pads - If e-prescribing, does the service have spare hard copy script pads in the case of disaster responsiveness (ie, no internet access) • Are handwritten on the approved H572M OR computer printed text (if the service has approval from the Director-General of Health) signed by the prescriber OR generated via an approved electronic prescribing system • Provide for medication supply for a maximum period supply of 84 days • Begin on day when the client consumes their medication dose at a pharmacy under the pharmacist's observation or where this is not possible due to the electronic system being used, prescriptions should be issued in advance of the intended start date for the prescription • Are received by the pharmacist at least one day before the due date to supply • if prescriptions are on H572M, they are endorsed as daily dosing, close control with prescriber initials • Are endorsed with the name of the dispensing pharmacy • if prescriptions are on H572M, they are written with the daily dose in numeric and word form eg, 80 (eighty) mg for methadone . • 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®)			
• 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 or where this is not possible due to the electronic system being used, prescriptions should be issued in advance of the intended start date for the prescription • Are received by the pharmacist at least one day before the due date to supply • Are endorsed with the name of the dispensing pharmacy • If prescriptions are handwritten, they 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 cut tablets into 2 or 4 pieces for observed doses • Include specific instructions for holiday periods			

10 Manager, Team Leader, Lead Clinician, Medical Officer/OST prescriber Interview Tool (BPA, CA, LA)

Guidance notes

The following questions relate to sections of the *Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment* (Ministry of Health 2025) and the sections in the audit report template. They are a guide only.

We recommend that you tailor these questions (based on pre-reading documentation provided by the service) 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.

For purposes of the interview tool, some general roles are provided such as Clinical Director, General Manager, Service Manager, Lead Clinician, OST Co-ordinator/Team Leader, Planner/Funder, Consumer Advisor. The type of role within the OST service and broader organisation and questions may need to be adapted to suit.

The template below is a generic document that covers two interview environments: One large meeting with senior staff present (naming which auditor and whom is asked the question) and 1-1 interviews with Service Management, Lead Clinician and Medical Officer Special Scale. The lead auditor may choose to colour code the template for ease of auditors' reference.

OST service: [Service Name goes here]

Large Meeting with Senior Management:

Clinical Director

General Manager

OST Lead Clinician

Service Manager

OST Co-ordinator/Team Leader

Consumer Advisor

Planner/Funder/Commissioner (if possible)

1-1 interviews with:

Lead Clinician

Service Manager

Medical Officer Special Scale

Auditors:

Date:

Lead Auditor provides a brief overview at the outset for purposes of the Planner/Funder/Commissioner, General Manager and Clinical Director, who may not have attended the opening meeting.

LA to Senior Team – Could you briefly describe any service changes that are currently in place / taking place and where the OST service sits in all of this. Are there further changes for OST?	
LA to the Planner/Funder, Service Manager and Lead Clinician - What is your impression of the breadth of Primary Care options around your geographical area particularly in relation to AOD – eg, sufficient number of GPs, GPs prepared to work with mental health & addiction issues / anything else / sufficient OST places? Are GPs funded for shared care OST visits?	
BPA to Lead Clinician, Service Manager and OST Co-ordinator Could you speak to your perspective of the Addiction service's connection with the hospital services – the interface – any observations about things that are working well, and areas to address?	
CA to Lead Clinician and OST Co-ordinator - What do you believe the strengths to be for the OST service?	
BPA to Lead Clinician and Service Manager - Could you describe the interface between the OST service and the Hospital, for example pain management for clients?	

BPA to Lead Clinician – How does medically managed withdrawal occur? Do you have access to hospital medical beds? Is there a documented agreement in place?	
CA to Service Manager / OST Co-ordinator – Could you describe where the Addiction service is at with consumer and peer roles?	
CA to All What do you believe some of the key challenges (if any) are for the OST service? **The Clinical Director, General Manager and Planner/Funder may choose to depart**	
LA to all – Other than the Medical staff, who else attends NAOTP meetings?	

a. Opioid substitution treatment	
BPA to Lead Clinician 1-1 Where would we see approval is given to each GP and Prison Medical Officer for named clients and that authority is updated at three-monthly intervals, or longer only with approval from a medical officer of health Ensure these are sighted and some are checked for current authorisation dates **BPA to Lead Clinician 1-1.** Where would we see the Service provides authorised GPs with written terms and conditions (protocols) to support OST provision Ensure these are sighted and some are checked for current authorisation dates	
BPA to Lead Clinician 1-1: • The Service co-ordinates regular meetings with GPs and Prison Medical Officers • GP and Prison Medical Officer report forms are received and reviewed three monthly • Can you describe the service working relationship with the Prison medical staff? The auditors understand the prison medical staff prescribe.	

LA to Lead Clinician Section 12.5.3 of the *OST Guidelines states Lead Clinicians are to* promote non-discriminatory practice and implement policies that examine and challenge stigma and discrimination. Can you think of an example where you have actively challenged stigma and discrimination within the hospital and wider health system locally ? Do you have any further comment to make on this section?	
LA to Lead Clinician/OST Co-ordinator (only ask this question when funding for this comes onstream) What comments and insights do you have regarding long-acting injectable buprenorphine?	
b. Entry into opioid substitution treatment	
CA to Lead Clinician and OST Co-ordinator How does the service prioritise access to OST? Do you have any comments to make on the service's exclusion criteria?	
c. Stages of treatment	
LA to all What are the strengths and limitations of the service in terms of safety, quality and consistency in practices overall? **LA to all** Do you have any comments to make about an after-hours service?	
BPA to Lead Clinician 1-1 How does the service ensure consistency in relation to assessing their clients' stability?	

BPA to Lead Clinician 1-1 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 *OST Guidelines*?	
BPA to Lead Clinician 1-1 How would we know 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? **BPA to Lead Clinician** - How does the service support the transfer of care of stabilised clients to their primary health care provider?	
BPA to Lead Clinician 1-1 and BPA to MOSS 1-1 How does the service ensure prescribing and monitoring is consistent with the *OST Guidelines*?	Response from Lead Clinician: Response from MOSS:
BPA to MOSS 1-1 How has the service managed OST medication transfers? Do you have any further comments on this?	

BPA to MOSS 1-1 Planned withdrawal is client directed, has a flexible end point and includes relapse prevention, psychosocial, medical and ongoing support, *OST Guidelines* section 3.9.1	
BPA to Lead Clinician 1-1 Could you please comment on this quote from the OST Guidelines - Clients who are unable to maintain stability after a planned withdrawal from OST are promptly readmitted to OST, *OST Guidelines* section 3.9.1. Can you recall a recent example of this?	
CA to OST Co-ordinator What after-care and/or follow-up does the service provide for clients who are ending treatment?	
BPA to Lead Clinician 1-1 and also BPA to MOSS 1-1 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?	Response from Lead Clinician: Response from MOSS:
d. Safety issues	
BPA to Lead Clinician 1-1 Have there been any issues or concerns in the last 12 months related to: Overdose substance-impaired driving drug interactions QTc interval prolongation?	

If so, how were they managed?	
BPA to Lead Clinician - 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?	
CA to Lead Clinician and OST Co-ordinator – Could you describe how naloxone is promoted and made accessible to tāngata whai ora and whānau.	
BPA to Lead Clinician 1-1 How is the interface with Police? Have you had any tāngata whai ora in the Police cells within the past 6 months?	
BPA to Lead Clinician and OST Co-ordinator How would we know that the OST service regularly checks for concurrent other substance use and can respond to this?	
e. Managing dose-related issues	
BPA to Lead Clinician 1-1 Have there been any issues or concerns in the last 12 months related to: takeaway doses replacing medication doses? Client requests to change doses?	
f. Managing clinical issues	
BPA to Lead Clinician How does the service manage/support clients who are using other substances problematically? Do you have any further comments on sanctions, etc?	
LA to OST Co-ordinator / Lead Clinician Have there been any issues or concerns in the last 12 months related to: clients presenting for medication when intoxicated managing medication side effects managing challenging behaviour? How have these been managed?	

BPA to Lead Clinician What are the strengths and limitations of the service in providing OST for clients: who have co-existing mental health issues who have dental 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?	
BPA to service manager / OST co-ordinator Have all clinical staff been trained in HIV and hepatitis C related issues?	
g. Managing OST transfers	
CA to all Do you have any comments in relation to managing the transfer of clients in and out of the service?	
BPA to Lead Clinician What process is in place for managing clients who are in prison out of area? Do you have any comments about how this is working?	
BPA to Lead Clinician 1-1 How does the service conduct annual reviews for clients in prison?	
h. OST in primary health care	
BPA to Lead Clinician - 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?	

BPA to Lead Clinician How well does the service support authorised prescribers?	
i. OST and the pharmacy	
BPA to OST Co-ordinator How well does the service support community pharmacists?	
BPA to Lead Clinician What systems are in place for ensuring effective communication between pharmacists and the service?	
j. The OST workforce and professional development requirements	
LA to Service Manager 1-1 Can you outline how the service manages staff orientation, supervision, professional development and training and performance management?	
LA to all - Do you have any general comments to make in relation to staffing?	
k. Administrative expectations of specialist OST services	
LA to Service Manager 1-1 Do you have any comments to make in relation to client records?	
BPA to Lead Clinician Have there been any safety issues over the last 12 months, for example, in relation to: staff clients prescribing dispensing?	
CA to OST Co-ordinator Are there telehealth options available for supporting tāngata whai ora out-of-area, for example, those who have transferred to another part of the country and for those in prison?	

LA to OST Co-ordinator and Service Manager How would you demonstrate where Tāngata whai ora and whānau are encouraged to provide input to new policies or reviews where relevant and be reimbursed for their time?	
I. Prescribing controlled drugs in addiction treatment	
BPA to Lead Clinician What are the strengths and limitations of the service's system for authorising prescribers?	
BPA to Lead Clinician What is your perspective of where the service is at with e-prescribing (or not)? If you have e-prescribing where would we see a written policy/protocol for this?	
BPA to Clinical Lead 1-1 Have there been any issues regarding the authorisation process?	
LA to all Are you interfacing more with aged care services and facilities? What does this look like?	
LA to all - Is there anything else you believe we should know? Is there anything else you believe we should know? BPA to MOSS	Response from all: Response from MOSS:

11 OST Case Manager / Key Worker and Allied Staff Interview Tool (LA)

Note not all questions are asked of each person interviewed. Depending on theme areas the audit team wish to pursue in further detail, some of the same questions can be asked of multiple staff to ascertain consistency. However, ensure all questions are asked at least once, as they relate to the reporting tool.

There are separate questions at the end of this template for allied health staff who either work within the Ost service or within the wider mental health and addiction service.

Name:

Date:

Role:

FTE equivalent:

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?	
Describe how you work with the client to develop suitable treatment and recovery plans.	
Do you have any comments in relation to managing the transfer of clients in and out of the service? How does the service ensure its clients are fully informed about other treatment options? What is your perspective on client informed treatment and the client's decision-making input?	
How does the service ensure its clients are fully informed about the range of OST medications?	
How does the service manage clients who are suspected of driving while impaired?	

Do you have any comments to make in relation to client records?	
What sort of psychosocial support can be provided for clients? Are there any gaps?	
Please describe an example of working with the Treaty of Waitangi in practice. What cultural safety / cultural awareness training have you attended?	
What things are in place to ensure the safety of staff and clients?	
How would you address a client's challenging behaviour?	
What does the service do regarding dental hygiene?	
What does the service do differently for older people? Have you needed to liaise with an aged care setting with your client? What did that look like?	
Please describe any connection you have had regarding your clients held in custody such as with the Police	
What after-hours support is there for pharmacies and clients?	
Please provide the most recent example of how you ensured a client was aware of Naltrexone. Given your role within OST, what does accessing this medication look like?	
Please provide an example of family inclusive practice	
Please provide an example where you work with tāngata whai ora concurrent other substance use	

What aftercare arrangements are in place post discharge?	
What self-help initiatives are encouraged?	
How do you respond to a person who is intoxicated?	
What supports do you provide GPs / prisons / community pharmacies?	
Please provide an example of how you have promoted and worked with peer support and/or lived experience staff to support your tāngata whai ora.	
What does supervision look like for you?	
When was your last training?	
When were you last refreshed on blood borne viruses, where and how clients can get testing and treatment ?	
When was your last performance appraisal?	
Was there anything you were expecting we might ask you, but we didn't?	

12 Allied Health Interview Tool (LA):

For psychologists / social workers / employment professionals who support OST tāngata whai ora – whether within or external to the OST team.

Name:

Role:

Are you a part of the OST Team? If not, what is your base team?	
What does the referral process look like?	
How do you orientate new OST staff to the type of supports you offer for OST clients?	
What does the waiting list look like to access you?	
Do you have any comments about OST clients access to you, what could be done differently?	
Anything else you would like to let us know about?	

13 Client Interview Tool (CA)

Guidance notes

We recommend that you tailor these questions to suit the particular client 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
Ask all clients: How long have you been receiving OST from this service/your primary health care provider?
If entered since last audit ask about entry process: how long did they wait? Did they feel well informed? Were they given a choice of medication?
What difference does the treatment make in your life? What are the more helpful aspects of OST?
What are the less helpful aspects?
How could the service be improved?
Have you been encouraged to include your family or friends in your treatment?

Does the service encourage you to provide feedback? Have you been invited to take part in service planning or evaluation – things like this? Surveys?
If you wanted to provide feedback – positive or negative – how would you do that? (Does the service have any systems for people to have a voice?)
If you were unhappy with any aspect of treatment, what would you do? Do you know about the complaints process? Do you know how to access the Health and Disability Advocacy service?
Stages of treatment
How helpful are appointments with the OST service medical officer / your key worker / your GP? How often do you see them?
Have you been involved in planning your treatment?
Do you have a recovery plan?
Do you feel well supported by the service in working towards your own goals?
Have you and your key worker/primary health care prescriber done any work around reducing harms associated with your drug use? eg. safe injecting

Has there been any planning towards completing the OST?
Information
Have you received a copy of OST & You? Is it helpful?

Do you feel well informed about: • overdose • substance-impaired driving • managing mental health problems • chronic pain management • drug interactions?	

Have you been given information about or been helped to access other support that is available, for example, counselling, housing support, etc?
Medication management

Would you know what would happen if: • your takeaways were lost or stolen • you missed doses • you turned up at the pharmacy under the influence?	

Managing OST transfers (only if client indicates transfers)
Do you have any comments to make about the process of transferring to another service?
OST in primary care
Do you have any comments to make about shared care in primary care/ primary health care provision of OST?
OST and the pharmacy
How is your experience at your pharmacy?

The workforce
Do you have any comments to make about staff at the service?
Do you have access to a peer-support worker? If so, how have you found that experience?
Does the service provide you with access to a lived experience/consumer advisor/ liaison/ consultant?
Your family / whānau may wish to also have a say about the OST service. Please let them know that there is a specific survey designed for them. ***(The link is to be provided here by the lead auditor.)***

14 Client Interview –

Those who completed the questionnaire / survey and requested to speak with Consumer Auditor (CA)

Thank you for completing the client questionnaire and for providing your contact details to connect with me. Just to emphasise the information you provide is anonymous. Any of your story / comments that might identify you in a documented report back to the service will be removed to keep your anonymity.
What additional things would you like to tell me about, over and above your comments within the questionnaire?

15 Needle Exchange Client Interview Tool (CA)

Please explain the audit process – responses are anonymised – there will be an audit report – feedback will be on general themes.

1. How would you describe your relationship with the OST service?
2. Is there anyone at the service you can talk to re any concerns you might have?
3. If you wanted it, where might you get support for Help B and Hep C testing and treatment?
4. What do you think are the positive things about the service?
5. Any ideas on how they could improve?
6. Is there anything else you think we should know?

16 Family / Whānau / Support Person Interview Tool (CA)

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.

How would you describe your relationship with the OST service?
Depending on previous answer: Do you feel well informed and supported by the service?
Can you describe the impact of the treatment provided by this service on your family/whanau?
Overall from your perspective what would you say are the strengths of the service?
Overall what would you say are the limitations of the service?

Have you, or other members of the family/whanau, ever been invited to participate in service planning, evaluation or any other service initiatives?
If there was something you could change about the service what would it be? Or What do you think they could do differently?

17 Consumer Advisor Interview Tool (CA)

Interviewee and designation

OST service:

Auditor:

Date:

Guidance notes

Note in some instances a response could be noted as "N/A" as the Advisor may not necessarily be involved in a wide range of OST client-related themes.

Opening question (as some Consumer Advisor roles cover a number of service types – not only OST): Could you briefly describe your role and its scope
How are you involved in the service's clinical governance?
How are you involved in reviews of complaints, adverse events, serious incidents etc?
How do clients of this service have input – surveys, focus groups etc?
How do client perspectives get included into things like service design and review, document development and review, recruitment processes etc? Are you involved in staff recruitment, orientation, and training?
Over the past year what are the main themes / concerns for clients? How are these being addressed by the service?

Do you feel the service has a well-resourced and highly valued partnership with consumers and whānau?
How does the service ensure consumers and whanau have access to peer support and consumer advocacy?
What does the service do well and what could be improved?
What does supervision look like for you?
What was the most recent training you attended for your own professional development?
When was your last performance appraisal?
Is there anything else you would like to add?

18 Family/Whānau Advisor / Family Support Worker Interview Tool (CA)

Opening question (note: some whanau advisor roles cover a number of service types – not only OST): Could you briefly describe your role and its scope
How are you involved in the service's clinical governance?
How are you involved in reviews of complaints, adverse events, serious incidents etc?
What, if anything, do you do to support OST whanau?
How do whanau service have input into the service eg. surveys, focus groups etc?
How do whanau perspectives get included into things like service design and review, document development and review, recruitment processes etc? Are you involved in staff recruitment, orientation, and training?
Over the past year what are the main themes / concerns for whanau? How are these being addressed by the service?

How would you describe the relationship between the service and whānau? Is there a well resourced and highly valued partnership with whānau?
What does the service do well and what could be improved?
What does supervision look like for you?
What was the most recent training you attended for your own professional development?
When was your last performance appraisal?
Is there anything else you would like to add?

19 Peer Support interview Tool (CA)

Interviewee:

Auditor:

Could you briefly describe your role and its scope. How long you have been in the role? Are you employed by the OST service or Health New Zealand or an NGO?
How was your orientation into the role?
What did your training look like to become a peer support worker? Have you been supported to access additional training?
What other similar roles do you get to liaise with?
What would a typical day look like for you?
Do you feel the service works well with peer support roles? What could be improved?
What does supervision look like for you?
What was the most recent training you attended for your own professional development?
When was your last performance appraisal? Who was involved in this?
Is there anything else you would like to add?

20 Pharmacist, Authorised Prescribers (excluding GPs) Interview Tool (BPA)

Guidance notes

Pharmacists and authorised prescribers and Medicines Control are key interfaces for OST and should be included in the audit process.

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 Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment 2025 (Ministry of Health 2025).

20.1 Pharmacist, Authorised Prescribers (excluding GPs) Interview Tool (BPA)

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

a. Context	
How many people attend your pharmacy for OST medication?	
Are there days you are closed? If so, how is the impact managed for tāngata whai ora receiving OST?	
How long have you been involved in OST?	
Is the area where clients are administered OST appropriate?	
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 *Aotearoa New Zealand Practice Guidelines for Opioid Substitution Treatment (Ministry of Health 2025)*? How / where do you access these Guidelines?	
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 *OST Guidelines* 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?	

21 Authorised prescribers Primary Care Interview Tool (BPA)

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 *OST Guidelines*? Where/ how do you access the *OST Guidelines*?	
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?	

22 Medicines control (Medsafe) Interview Tool (LA)

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

a. General prescribing practices within the specialist service / other providers / pharmacies	
Have any concerns been raised or identified regarding prescribing?	
Are there any other matters that you wish to raise?	

23 Other key interfaces/links interview tool

eg, Cultural Support Service (LA), Prison (LA), Pain Service (BPA), Peer Support Worker Manager, Needle Exchange Manager (CA)

Interviewee:

Contact details:

Designation:

OST service:

Auditor:

Date:

How would you describe the working relationship with the OST service?
In terms of the interface is there anything that could be improved?
Are there any memorandums of understanding or interface protocols between your service and the OST service? If so what are they and are they adequate? If not, do you think it would be helpful to have a formalised relationship?
What consultation/liaison mechanisms are in place? If you hear things about the service that are concerning what do you do with that information?
Have there been any significant incidents? Eg, instances where shared clients may have been at risk due to gaps in service? Where significant health issues have remained unaddressed? Or similar?
Are there areas or themes that have emerged that require joint development or review?

Appendix 1: Risk assessment matrix

CONSEQUENCE	LIKELIHOOD				
	The likelihood of this occurring is				
Level of risk	**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.