MDHB Responses to OIAs received April to June 2021

Under 18s in seclusion (OIA Y21-377)
Intersex children surgery within first year of life (OIA Y21-393)
PSMA PET-CT (OIA Y21-422)
Eligibility criteria required to access a funded PSMA scan (OIA Y21-426)
Locums (OIA Y21-465)
Rest Home complaints (OIA Y21-464)
HealthCert audit 2020 (OIA Y21-504)
Staffing and Supplies (OIA Y21-389)
Maternity review (OIA Y21-381)
Mental health cases 2015-2020 (OIA Y21-390)
Referrals to waiting list for joint replacements (OIA Y21-421)
Interhospital flight transfers (OIA Y21-433)
COVID-19 vaccination rollout (OIA Y21-432)
Dog bite injuries (OIA Y21-452)
Waiting lists for orthopaedic assessment appointments (OIA Y21-460)
Misoprostol and miscarriages (OIA Y21-462)
Transmasculine chest surgery (OIA Y21-463)
Pathology Services (Y21-503)
HPV-Gardasil vaccine (OIA Y21-509)
Drug and Alcohol Testing (OIA Y21-512)
HPV Vaccination (OIA Y21-566)
Clinicians trained in long acting reversible contraception (OIA Y21-568)
Gift registers (OIA Y21-571)
Maternity review (OIA Y21-572)
Referrals rejected due to MoH waiting time targets (OIA Y21-562)
ICU costs to non NZ eligible (OIA Y21-600)
Challenge to Coroners Findings (OIA Y21-651)
SMO Annual leave (OIA Y21-725)
Wait list for psychiatric services (OIA Y21-727)
Psychometric Testing (OIA Y21-656)
Effects of aeromedical transfer of patients caused by Wellington Airport runway closures (OIA Y21-729)
Abortion counselling (OIA Y21-752)
Referrals for joint replacements (OIA Y21-726)
Liquor Licensing Information (OIA Y21-730)
Missed COVID-19 vaccination appointments (OIA Y21-850)
Ward 21 deaths last 3 months (OIA Y21-932)

Gender dysphoria (OIA Y21-903)
Neurologists (OIA Y21-933)
Colonoscopy data (Y21-910)

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

14 March 2021

[redacted]
[redacted]

Dear [redacted]

We are in receipt of your Official Information request dated 1 April 2021, regarding seclusion for patients aged under 18 in Mental Health Services.

You advised that you would like the information as stated below:

1. Number of seclusion incidents each year since 2018 until 1 April 2021 for patients aged under 12.

   I understand that you can request all of the information pertaining to this query through the Ministry of Health, not-withstanding, MidCentral District Health Board (MDHB) has recorded no instances where this has been required for patients within our service.

2. Number of seclusion incidents each year since 2018 until 1 April 2021 for patients aged between 13-18.

   MidCentral District Health Board (MDHB) has recorded no instances where this has been required for patients within our service.

3. How long were patients in section over that period and in what conditions? Please provide a breakdown of average, minimum and maximum seclusion duration for each year (2018,2019,2020 and to April 1 2021) for patients aged under 12, and for patients aged 13-18.

   No response required.

4. Number of patients put in seclusion each year since 2018 with their age, or age range if possible and how many times they were placed in seclusion.

   No response required.

You have the right to seek an investigation and review by the Ombudsman of this information. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive
Mental Health & Addiction Services

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

12 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act (OIA) request – Y21-0393 Intersex children surgery within first year of life

Thank you for your request for information dated 26 February 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

"I was hoping to grab some information around how many intersex children have had genital surgery within their first year of life?"

"Could I please have this from 2016 to 2021, broken down into the number each year and the overall number for the past five years. Could I also request whether or not the surgery was medically necessary or whether it was cosmetic, the gender of child as recorded on their birth certificate and the total cost per year of the surgeries"

MDHB does not perform this type of surgery on children under two years of age.

"Could I also request how many referrals have been made to other DHBs for intersex babies in their first year of life looking for the surgery in other DHB regions. Could I please have this from 2016 to 2021, broken down into the number each year and the overall number for the past five years."

MDHB has not referred any baby in their first year of life to another DHB for this type of surgery in the time frame specified.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

12 April 2021

Email:

Dear

Official Information Act (OIA) request – OIA Y21-0422

Thank you for your request for information dated April 12. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following question:

1. **Whether PSMA (Prostate Specific Membrane Antigen) PET-CTs are funded by the DHB or only available privately?**

   Our DHB does not have a PET-CT scanner so funds the scans using an external provider.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Mātai Matengau
Cancer Treatment, Screening and Support

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

14 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Email:

Dear

Official Information Act (OIA) request – OIA Y21-426

Thank you for your request for information dated 12 April 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following question:

The eligibility criteria required for men with prostate cancer to access a funded PSMA scan?

As Chair of the MDHB Positron Emission Tomography (PET) Variance Committee, I can confirm that the MDHB PET Variance Committee has specific criteria for agreeing to fund a prostate specific membrane antigen (PSMA) scan for patients with prostate cancer.

These criteria were developed in consultation with the MDHB Urology multidisciplinary meeting (MDM) team members and align with the criteria developed by the Northern Region for prostate cancer patients.

The current criteria are:

- High risk prostate cancers in the untreated patient who is fit for radical treatment. High risk prostate cancers are defined as 2 of 3 criteria: stage T3a-T4, Gleason score 8-10, PSA > 20.
- Biochemical, hormone sensitive, prostate cancer relapse (PSA ≥ 0.5 post prostatectomy or PSA > 2.0 post radical radiation therapy) in patient fit for radical treatment that may be suitable for stereotactic radiation therapy.
- Indeterminate or discordant conventional imaging findings suggestive of metastatic prostate cancer in a patient that was being considered for radical treatment.

Patients who do not meet these criteria are considered by the PET Variance Committee on a case by case basis.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Dr Claire Hardie
Clinical Executive
Te Uru Mātai Matengau
Cancer Treatment, Screening and Support

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

5 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Via email:

Dear

I refer to your Official Information Act request received by email on 6 April 2021 with regard to staffing and supplies and respond as follows. Please note that the information supplied in Questions 1 – 4 provides data from 1 January 2020.

1. *Since the start of 2020 how many people have been made redundant at MidCentral DHB?*

   11

2. *How many fixed term contracts been terminated?*

   83

3. *How many people have been employed as permanent staff?*

   405

4. *How many fixed term contracts have been initiated?*

   238

5. *How are your supplies of smart infusions, infusion sets, medications, and IV fluids?*

   To ensure DHBs have access to infusion pumps and other consumables, the Ministry of Health has put in place a system not dissimilar to the centralised PPE national supply.

   The Ministry is able to leverage its ability to secure global allocations across trade and supply arrangements, with recognition of current global supply and logistics constraints

6. *Are any of your supplies at critical levels? If so, what, and when will they be restocked?*

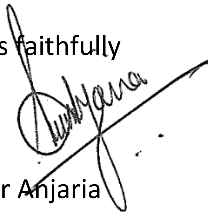
   The Ministry, together with Medsafe, PHARMAC, district health boards, suppliers, clinicians and technicians, has moved quickly to centralise the supply management of IV consumables, infusion pumps and syringe drivers generally, to ensure services can be maintained nationally and alternative solutions identified and supported.

7. *Are you able to replenish your above-mentioned supplies easily?*

Generally, MDHB manages our own sourcing of "business as usual" devices and consumables. However, when the supply chain is disrupted, we alert the Ministry of Health. The Ministry of Health determines where the supply chain has been disrupted and can intervene, or if the supply is of national concern to maintaining critical health care services, the Ministry centralises the management and purchasing of items in constrained supply.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully



Keyur Anjaria
General Manager
People & Culture

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

26 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

OIA request – Rest Homes
Our Ref: A08-39

Our response in reference to your official information request dated 22 April 2021 for copies of residential care complaints received by MidCentral DHB since 1 Januar, 2020 and any associated investigations and findings.

MidCentral DHB received 18 complaints for 12 of the 36 facilities which operate in our district for the period requested, these are summarised below.

We have not provided copies of the complaint documents to protect the privacy of the residents involved and their families (Section 9 (2)(a) of the Official Information Act 1982). You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

Midcentral DHB does not have any reports, documents, memoranda, correspondence, legal advice or emails, internally or and externally regarding how aged care facilities/rest homes and their residents fared during COVID-19 related restrictions (such as lockdowns but also ongoing visitor restrictions), including any concern about the impact on residents, or staffing levels.

Summary of outcomes

MidCentral DHB complaints received 2020 pertaining to ARC facilities				
Date received	**From**	**Summary of complaint**	**Outcome and Findings**	**Date closed out**
15/01/2020	Family Member	Concerns of safety of residents and management not taking this seriously	Investigation undertaken by the organisation with DHB involvement. Concerns partially substantiated and actions for	27/01/2020

			improvement recommended. These have been implemented.	
30/01/2020	Family Member	Care and welfare concerns	Investigation undertaken by the organisation with DHB involvement. Concerns un-substantiated	20/07/2020 (delayed due to COVID-19)
11/02/2020	Family Member	Concerns for safety of mother and other residents	Investigation undertaker organisation with DHB involvement. Concerns partially substantiated and actions for improvement recommended. These have been implemented.	17/03/2020
27/1/2020	Family member	Issues related to the care at the facility	Investigation undertaken by the DHB. Concerns partially substantiated and actions for improvement recommended. These have been implemented	28/4/2020
18/04/2020	Health and Disability Commission	Infection precautions control processes and welfare and safety of residents	Investigation undertaken by the organisation with DHB involvement. Concerns un-substantiated.	20/07/2020 by MDHB 31/8/2020 by HDC
8/6/2020	Family Member	Issue related to the care at the facility	Investigation undertaken by the DHB. Concerns unsubstantiated. No recommendations.	20/7/2020
8/6/2020	Family Member	Issues related to care at the facility	Investigation undertaken by the DHB. Concerns partially substantiated and actions for improvements recommended. These have been implemented.	13/7/2020
24/6/2020	Former Facility Staff Member	Issues around care of residents, facility condition and maintenance, communication with staff.	Investigation undertaken by the facility with DHB involvement. Concerns partially substantiated and actions for improvements recommended. Some recommendations have been completed and plans in place to complete others.	4/8/2020

31/7/2020	Via Health Cert from resident at a facility	Issues around breach of Code of Rights in relation to the function of the home and management structure	Investigation undertaken by the DHB. Concerns unsubstantiated. However, there were recommendations. These have been implemented.	18/8/2020
3/8/2020	Family Member	Issues around care at the facility and communication	Investigation undertaken by the facility with DHB involvement. Concerns partially substantiated. There were recommendations and these have been implemented.	27/8/2020
5/8/2020	Health and Disability Commission (HDC)	Issues around infection control in Level 2 in ARC	Investigation undertaken by facility with DHB involvement. Concerns unsubstantiated. There were recommendations and these have been implemented. HDC choose to implement their own full investigation in Oct 2020 – awaiting outcome	18/8/2020 By MDHB
7/9/2020	St Johns ambulance	Vulnerable Persons Report - Issues around lack of intervention on acute medical issue	Investigation undertaken by the facility with DHB involvement. Concerns partially substantiated. Recommendations were made and were followed up on.	21/9/2020
7/9/2020	Older Adult Mental Health (OAMH) MDHB	Issue around clinical issues in relation to Care	Investigation by facility with DHB involvement. Concerns partially substantiated. There were recommendations and these have been implemented.	27/10/2020
5/9/2020	Needs Assessment Service Coordination (NASC)	Issues around clinical care at the facility	Investigation by DHB. Concerns unsubstantiated. No recommendations.	23/10/2020
19/12/2020	Via Health Cert from a Family Member	Issue around the care at the facility in relation to Dementia care.	Investigation by DHB. Concerns partially substantiated. There were recommendations and these have been implemented.	29/1/21
9/1/2021	Family	Alleged	Investigation by the	21/1/2021

	Member	assault to resident by another resident	facility with DHB involvement. Concerns unsubstantiated. There were some recommendations, and these have been implemented.	
28/1/2021	Family Member	Issues around communication with the Enacted Enduring Power of Attorney (EPOA) by the facility	Investigation by the DHB. Concerns partially substantiated. There were some recommendations, and these have been implemented.	18/2/2021
1/2/2021	Family Member	Issues around care at End of Life at the facility	Investigation by the DHB. Concerns partially substantiated. There were some recommendations, and these are in progress currently.	17/3/2021

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Andrew Nwosu
Operations Executive
Healthy Ageing and Rehabilitation

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

28 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Via email:

Dear

I refer to your Official Information Act request received by email on 20 April 2021 with regard to further information in relation to locum services and respond as follows:

1): How are locums at MidCentral recruited? Are they mostly from New Zealand or overseas as well?

The majority of short-term locums are sourced from within New Zealand via recruitment agencies.

2): Why has the spend on locums dropped from $1.99 million in 2015/16 to $939,269 in 2019/20?

Locums are used to cover vacancies while MDHB recruits permanent medical officers. Costs will fluctuate from year to year depending on the number of vacancies the DHB holds which are being covered by a locum.

3): It's still a not insignificant amount. Why is this spending necessary?

To ensure that the delivery of services to our community is not impacted, employing locum medical officers is necessary while MDHB recruits to vacancies. For medical officers, the time to hire from a resignation to an appointee commencing is at least 6 months. For some hard to recruit positions it can be significantly longer. Engaging a locum allows service delivery to continue while recruitment is underway.

4): What is the average time a locum spends at the DHB?

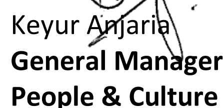
Depending on the time needed to recruit, a locum can come for one week (to fill a roster gap) or up to a year.

5): What sort of senior positions, if any, have been filled by locums?

In recent times most of the locum spend has been to vacant psychiatrist vacancies.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully



Keyur Anjaria
General Manager
People & Culture

29 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act Request Y21-0504

Thank you for your email of the 28 April 2021, to Kathryn Cook, Chief Executive, in which you request a copy of the HealthCert Audit report from October 2020 as well as the corrective actions received at that audit.

Please find attached, the HealthCert audit report which contains the 10 corrective actions that were received by MidCentral District Health Board.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Judith Catherwood
General Manager
Quality & Innovation
MidCentral District Health Board, PO Box 2056, Palmerston North

HealthCERT Service Provider Audit Report (version 6.2)

Introduction

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

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

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

Audit Report

Legal entity name:	MidCentral District Health Board
Certificate name:	MidCentral District Health Board

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit			
Premises audited:	Te Papaioea Birthing Centre; Horowhenua Health Centre; Palmerston North Hospital			
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services			
Dates of audit:	**Start date:**	6 October 2020	**End date:**	9 October 2020

Proposed changes to current services (if any):
None

Total beds occupied across all premises included in the audit on the first day of the audit:	363

Audit Team

Lead Auditor	Joanna Harper	Hours on site	32	Hours off site	16
Other Auditors	Elaine Elbe, Christine Dean, Karen Davis, Chris McLelland, Christine Davies	Total hours on site	120	Total hours off site	56
Technical Experts	Mikaela Shannan, Katrina Burns, Michel Manning, Claire West, Kirsty Mitchell	Total hours on site	56	Total hours off site	0
Consumer Auditors	Belinda Walker	Total hours on site	8	Total hours off site	6
Peer Reviewer	Cathy Cummings			Hours	8

Sample Totals

Total audit hours on site	216	Total audit hours off site	86	Total audit hours	302

Number of residents/patients interviewed	32	Number of staff interviewed	138	Number of managers interviewed	69
Number of residents'/patients' records reviewed	78	Number of staff records reviewed	41	Total number of managers (headcount)	235
Number of medication records reviewed	109	Total number of staff (headcount)	2521	Number of relatives interviewed	17
Number of residents'/patients' records reviewed using tracer methodology	8			Number of GPs interviewed (Residential Disability providers only)	0

Declaration

I, Robyn Byers, General Manager of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Thursday, 3 December 2020

Executive Summary of Audit

General Overview

MidCentral District Health Board (MDHB) provides services to around 190,000 residents living in the region. Hospital services are provided from the 350-bed facility at Palmerston North, the Te Papaeioa eight bed birthing centre and the 24-bed facility at Horowhenua. Services include medical, surgical, maternity, children's and women's health and mental health and addiction services. These services are supported by a range of diagnostic, support and community-based services.

This four-day certification audit, against the Health and Disability Services Standards, included a review of management, quality and risk management systems, staffing requirements, infection prevention and control, and review of clinical records and other documentation. Interviews with patients and their families and staff across a range of roles and departments were completed and observations made. Auditors visited both hospital sites.

This audit identified the following areas for improvement: performance appraisals for staff; staffing numbers and skill mix in some areas; patient identification details on clinical records; the placement of patients and patient flow; assessment and evaluation of care; management of medicines; maintenance of equipment; facilities that are not always suitable for their purpose; and documentation in the clinical record when enablers are being used.

Outcome 1.1: Consumer Rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) was visible around all areas of the district health board (DHB) in both English and te reo Māori. Patients and families/whānau reported an awareness of the Code and that their rights were upheld. All patients spoke positively about their care, treatment, and communication with staff. Staff were observed respecting patients' rights, including their privacy.

The organisation has a strong commitment to providing services that meet the cultural needs of its catchment area.

Innovative approaches to delivering care and examples of evidence-based practice were evident throughout the services. Promotion of patient safety and a safe environment was noted across services.

Communication with patients and families was reported to be open and honest and examples of open disclosure were evident where required. Interpreter services are readily available and widely used.

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent.

Staff, patients and whānau were informed about the complaints process and information about how to make a complaint was available. Complaints are managed through an electronic system with the consumer experience team acknowledging and managing each complaint.

Outcome 1.2: Organisational Management

The current board of directors has now been in place for around one year and members interviewed were clear about priorities and risks. The chief executive officer (CEO) is experienced in the role and is supported by an organisational leadership team (OLT) using an integrated model of health delivery. At the service provider level, the six clinical service streams (clusters) are supported by three clinical professional executive directors. Several strategic plans support an annual planning process. Locality and cluster wellbeing plans support positive community and clinical engagement and an inter-sectoral approach. A strong focus on equity for Māori with an increased focus on

Treaty responsibilities was evident along with good partnerships with the six iwi groups in the region. Reporting to the board on equity outcome actions has been strengthened. There are well-established clinical and consumer councils and increasing consumer involvement at strategic and operational levels.

The quality and risk management system is well established both at the organisation-wide level and clinical level. The clinical governance framework is being reviewed to ensure it meets current needs. Several quality and risk roles support quality activities within the clusters. There has been a focus on developing health intelligence to better identify areas for improvement, monitor progress in achieving strategic goals and provide effective reporting. Improvement activity was evident at all levels of the organisation, from large projects across the continuum of care, to small ward-based initiatives. Risks are well managed and reported to the finance risk and audit committee and the board.

Adverse events are managed through an electronic management system, with improvement plans developed. A serious adverse events governance group (SAEGG) supports a thorough review process and follow-through of recommendations.

Family and consumer advisory services are well established across the mental health and addiction services.

Human resource systems are based on current accepted good practice. Comprehensive orientation programmes are in place for new staff in all disciplines at both organisational and service level. Staff are well supported with training opportunities for mandatory and ongoing training.

A range of mechanisms are used to ensure that the right number of staff are available to meet the changing needs of patients across the services. The organisation is progressing with the implementation of the Care Capacity Demand Management (CCDM) programme, which is positively impacting on matching patient requirements to nursing staffing. The developments in the Integrated Operations Centre (IOC) are ongoing with improved responsiveness to patient flow and placement of staff where most needed.

Patient records are integrated and easily accessible. Patient information was held securely and not visible to those without the authority to have access.

Outcome 1.3: Continuum of Service Delivery

Patients access services based on need, guided by policy. Waiting times are managed and monitored. Risks are identified for patients through screening tools. Pre-admission assessment processes are used where appropriate. Entry is only declined if the referral criteria are not met, in which case the referrer and patients are informed of the reasons why and alternatives available.

Eight patients' 'journeys' were reviewed as part of the audit process and involved the emergency department, surgical, medical and maternity wards, children's and older persons' health ward, mental health units, department of coronary and intensive care and the operating theatre suite. Auditors and technical expert assessors worked collaboratively with staff reviewing the relevant documentation and interviewing medical, nursing and allied health team members, patients and families/whānau. Additional sampling was undertaken throughout the audit.

A qualified and skilled multidisciplinary team provides services to patients and there were good examples of teamwork throughout clinical areas. Shift handovers were efficiently managed and included a bedside handover.

Assessments were undertaken in a timely manner with results reviewed, discussed and actioned as appropriate. This was supported by patients and family members interviewed. Admission assessment tools utilised were based on best practice. Various care plans and pathways were evident throughout the hospital. Most areas were using the 'early warning score' (EWS, PEWS and MEWS) to prompt triggers when a patient's condition deteriorates, and this tool was well completed. Evaluation was undertaken of patients' progress on a regular basis and included progress towards discharge.

Activities meet the requirements of the individual patients and these were particular to the various specialty settings.

Overall, the audit identified a strong focus on meeting patients' needs and good teamwork between the multidisciplinary team members.

Policies and procedures provide guidance for staff on medicines management. The national medicine chart was in use.

At the time of the audit, food services were transitioning to a new provider. Both Palmerston North and Horowhenua hospital services have been verified as complying with a documented food safety programme/plan. Special dietary needs are accommodated. Patients interviewed were satisfied with the food provided.

Outcome 1.4: Safe and Appropriate Environment

Planning has commenced for a major infrastructure upgrade over the next few years including a new mental health unit.

All MidCentral DHB facilities have a current building warrant of fitness and meet regulatory requirements. Proactive and reactive maintenance occurs. Biomedical testing has fallen behind schedule with planning underway to address this. Electrical checks of equipment are undertaken and are traceable through electronic systems and maintenance requests. Waste is managed under contract in conjunction with cleaning, and the processes are well defined in policies and procedures and effectively implemented.

There are adequate numbers of bathrooms and toilets, communal areas and bed spaces that are suited to the needs of the different patient groups. The patients' personal spaces are adequate for staff movement and equipment use in areas visited. Most wards have adequate communal areas for recreation and receiving visitors. All areas of the hospital have adequate natural light and the whole environment was warm and comfortable.

Emergency management planning is well established with staff trained in current evacuation and emergency responsiveness. There has been detailed planning to manage and respond to the Covid-19 pandemic. Trial fire evacuations are completed six-monthly. Back-up power supplies and emergency water was available across all three sites. There are processes and equipment checked and available for dealing with medical emergencies. Staff are trained in emergency responses relevant to their area of work.

Outcome 2: Restraint Minimisation and Safe Practice

Current policies and procedures guide practice for safe restraint and enabler use. Restraint interventions are overseen by the restraint team and restraint approval group (RAG). Staff understood the difference between a restraint and an enabler.

Episodes of restraint reviewed during the audit indicated that restraint was used as a last resort, had been appropriately approved and only applied when required. Any potential restraint events are responded to by trained individuals, including trained security officers. There has been a reduction in incidents and restraint events through use of the managing actual or potential aggression (MAPA) approach and the focus on de-escalation and providing alternative approaches. Mental health staff and security staff are trained in 'Safe Practice Effective Communication' (SPEC).

Restraint events are recorded via the incident reporting system and assessment and evaluation documentation was fully completed. The mental health unit has the zero-seclusion project well underway with no seclusion events for the month prior to the audit.

Outcome 3: Infection Prevention and Control

MDHB has an infection prevention and control programme for 2020-2021. The infection prevention and control committee includes a consumer representative and reports go to the chairperson of the clinical board. The infection prevention and control programme is facilitated by a team comprising a nurse manager, an administrator, a clinical nurse specialist and a registered nurse. They are supported by the infectious disease physician and microbiologist, and clinical pharmacists. All the infection prevention and control team members participate in relevant ongoing education.

Policies and procedures are available electronically to guide staff practice. Orientation and ongoing education are also provided to DHB staff, community health providers, and patients / family members.

Surveillance for infections is occurring. The surveillance programme is appropriate to the service setting and includes significant organisms, surgical site infections following 'clean' procedures, invasive device related infections, blood stream infections and outbreaks. The surveillance results are communicated appropriately. Regular monitoring of compliance with prophylactic and therapeutic antimicrobial use is occurring.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	0	7	1	1	0
Criteria	0	131	0	8	1	1	0

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

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		employment practice and meet the requirements of legislation.				
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Appraisal updates are progressing well, with consistent progress towards meet the organisation's benchmark. However, work needs to continue to ensure this is achieved in a timely manner.	Continue to progress annual performance appraisal completion.	180
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low			
HDS(C)S.2008	Criterion 1.2.8.1	There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	CCDM and variance reporting indicates heavy workloads in most clinical areas, including consistently working over the resourced bed numbers. The bureau is often unable to meet nursing staffing requests.	Complete the CCDM reviews in a timely manner and ensure permanent staffing is in line with FTE requirements.	180
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.1	Information is entered into the consumer information management system in an accurate and timely manner,	PA Low	There were several areas across the clinical areas visited where there were no patient identification labels on pages in the clinical record.	All pages in the clinical record have patient identification details.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		appropriate to the service type and setting.				
HDS(C)S.2008	Standard 1.3.1: Entry To Services	Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	PA Low			
HDS(C)S.2008	Criterion 1.3.1.4	Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.	PA Low	Patients' entry into the various speciality service areas when their need for services has been identified is not consistently being undertaken in a timely, appropriate and respectful manner. For example, patients are waiting in the emergency department (ED) for extended hours for a ward bed. On the day of audit, two patients had been in the ED corridor for over six hours and many patients had been in the department for over ten hours. Eleven patients under the care of the medical team were placed in the orthopaedic ward area. Patients are staying longer than ideal in the intensive care unit due to a lack of bed availability in the ward.	Entry to the various services be undertaken in a timely manner and processes related to the management of outlier patients be documented and clearly communicated.	180
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		gathered and recorded in a timely manner.				
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	Assessments are not always being completed and it was not always evident that these assessments serve to form the basis of the service delivery plans.	The needs, outcomes and/or goals of patients are identified through the assessment process and documented to serve as the basis for service delivery planning.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Evaluations are being inconsistently undertaken and the responses are not being documented to enable progression towards the desired outcome. For example, fluid balances are consistently not fully completed and early warning scores that should trigger a response were not always actioned.	Ensure evaluations are undertaken, indicating the degree of achievement or response to the interventions, and that these are clearly and consistently documented	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review,	PA High	Medication management systems are in place to ensure the safe and appropriate prescribing, dispensing, administration, storage and disposal	Medicine management complies with legislation, protocols and guidelines.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		of medications mostly complied with legislation, protocols and guidelines; however, practice did not always comply with the systems as described. These shortfalls are long standing and have seen minimal improvement over the years.		
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Biomedical equipment performance monitoring checks across the organisation have fallen behind schedule.	Implement and maintain a robust system to ensure biomedical testing is carried out according to the schedule.	180
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Moderate	Aspects of the physical environment within MidCentral DHB pose some risk of harm or are not appropriate to the needs of patients or staff. This includes recent alterations to ventilation systems and negative pressure rooms, and storage and waste management, including layout of some dirty utility rooms.	Review current systems for utility rooms, storage and waste management and make improvements to maximise the safety of patients and include any learnings in planning for new buildings or upgrades in clinical service areas. Review the status of negative pressure rooms and ventilation system changes in association with the IPC team to ensure they are functioning effectively.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(RMSP)S.2008	Standard 2.1.1: Restraint minimisation	Services demonstrate that the use of restraint is actively minimised.	PA Low			
HDS(RMSP)S.2008	Criterion 2.1.1.4	The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	There was little documentation noted in the clinical record (with the exception of Horowhenua Health Centre and Star 2) that bedrails had been requested by the patient, that an assessment regarding their safety had been made and that this had been reviewed as appropriate.	The use of enablers is documented as defined within the MDHB enabler policy.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

Consumers receive services in accordance with consumer rights legislation.

Attainment and Risk: FA

Evidence:

Staff interviewed across the services, including medical, nursing and allied health, understood their responsibilities in relation to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Examples included respecting privacy, identifying and supporting individual cultural and spiritual needs, communication related to informed consent, management of complaints and support from advocacy services. Staff receive training in relation to the Code as part of the orientation programme and specific training relevant to their clinical area as and when required. Staff are guided by relevant policies. Patients and families/whānau interviewed felt respected by staff and that their rights were adhered to.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Consumers are informed of their rights.

Attainment and Risk: FA

Evidence:

Staff provide opportunities to inform patients and their families/whānau of their rights. This occurs at the most appropriate time, based around clinical needs. Within the maternity service, the lead maternity carers (LMC) midwives understood the need to discuss the Code at first point of contact with the women and family/whānau. In the paediatric area and neonatal area, parents reported being given information related to the Code on admission. Patients having an arranged admission have this explained as part of the pre-admission process. Staff indicate on the admission assessment documentation that information on the Code has been provided. Information on the Code was widely displayed in all wards and clinical areas with brochures available, including information on accessing advocacy services. Evidence was sighted of compendiums by the bedside containing information on the Code, advocacy services, spiritual and culture services available; however, other areas reported having removed these compendiums due to Covid 19. Staff interviewed knew how to access the Code in languages other than English, with copies in te reo Māori and a range of Pacifika languages also displayed. In the paediatric area copies of the Code were also sighted in Somali. Patients and families/whānau were aware of the Code and felt able to seek further information as needed. They felt well informed; involved in decision-making and that their privacy and individual needs were met.

The consumer auditor interviewed patients and their family /whānau within the mental health services who reported being well informed of their rights and that these had been respected. Information about advocacy and the nationwide health and disability advocacy service was readily available within the service.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Patients interviewed reported being treated with respect and that their privacy and dignity had been maintained. Patients, families/whānau and staff provided examples of ways to address privacy in an environment where this can be a challenge, for example, offering and providing alternative private rooms for discussions such as whānau rooms, visual screening, and careful attention to displaying of private information. Women at Te Papaioea primary birthing unit have one single room throughout labour, birth and the postnatal stay, whereas in the hospital maternity ward some rooms are required to be shared in the post-natal period; however, women reported that privacy was maintained when discussions were held between staff and themselves. In the medical and surgical wards in the four and five bedded rooms, patients reported challenges maintaining privacy; however, staff made attempts to converse privately and curtains were used.

MidCentral District Health Board welcome the carers of patients into the ward areas and have introduced Mahi Tahi Better Together programme. Carers are invited to become a kaimanaaki partner in care. Evidence of Kaimanaaki were seen throughout the hospital supporting patients. Te Whare Rapuora (accommodation) is made available for patient's family/whānau. The Pae Ora Team are also available to support patients as required and their involvement was noted in sampled records.

As part of the admission process, staff seek information from patients and their families/whānau, where appropriate, in relation to their individual cultural, religious and social needs and provide support to address these. This is documented in the assessment and planning document and was sighted in most of the records reviewed. Patients interviewed reported being asked if they had any cultural or spiritual needs that had to be met. Staff discussed the need to be cognisant of the various cultural needs of their patients, particularly as they had a growing number of refugees in the area. The hospital provides cultural support through the Pae Ora Paiaka Whaiora Māori Health team and evidence of their involvement with patients was sighted throughout areas visited. Spiritual needs are supported through the pastoral and spiritual care team; posters advertising this service were sighted throughout the hospital. A quiet space is provided on site in the form of the hospital chapel at Palmerston North hospital for patients and families.

Patients and families/whānau felt involved in decision-making and that their wishes were respected. Independence is encouraged by staff and supported through use of allied health team members, for example, occupational therapists, physiotherapists, social workers. In the assessment, treatment and rehabilitation service (AT&R) examples of supporting independence were evident. In maternity areas, women are encouraged to be independent, but staff are available to support and assist as needed.

Family violence screening is part of the assessment process. Staff have been trained in the process and documentation reviewed demonstrates that this was completed where required. Policies and procedures support and guide staff in this process, along with support roles such as the family violence coordinator and social workers. Midwives are all trained in family violence screening as part of their annual practising certificate requirements. Evidence of screening was sighted in records reviewed in the paediatric and neonatal units. Staff interviewed in the medical area could detail their responsibilities if they were concerned about a patient's safety. Social workers are involved where applicable. An example of follow up about disclosure comments was sighted with community-based supports for a patient arranged before discharge. At Horowhenua, evidence of family violence screening was evident. A record was also sighted where screening was not completed, as an intimate partner had been present; however, the midwife caring for the women was aware that this needed to be completed. (Refer also criterion 1.3.4.2)

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Reducing inequities in health outcomes and engagement with the health system is a focus for MidCentral DHB. The DHB's equity strategy includes equity of access, experience and outcomes. The focus is on reducing health inequities for the population that identify as Māori and those who are socio-economically disadvantaged. The district MidCentral serves has a high proportion of Māori (21%). MidCentral DHB have a memorandum (MOU) of understanding with Manawhenua Hauora, a consortium of the six iwi within the district who work with the DHB to achieve its aims.

A Māori health unit provides support for patients and their whānau and staff through health advisors, the Pae Ora Team, and can provide accommodation at Te Whare Rapuora. Māori patients are identified as part of the assessment process and examples of support being offered based on their individual needs included providing access to the Māori health advisors on admission. The documentation of cultural assessment, values and beliefs was evident. Māori patients and their whānau interviewed expressed satisfaction in relation to their cultural needs being respected, including family involvement.

Staff receive training in the Treaty of Waitangi and application of this within their work environment as part of the orientation process and on an ongoing basis. Staff were familiar with how to access services available to support Māori patients and their families.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

MidCentral DHB has a pacific health promotion advisor who works with the region's Pacifika population to enable the DHB to better meet their needs. The Pacifika population is 3% of the MidCentral DHB total population. There were no patients interviewed who identified as Pacifika.

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

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:
(a) Developing effective relationships with Pacific people to support active participation across all levels;
(b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
(c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
(d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.
This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Patients have their cultural, spiritual, and ethnic values and beliefs identified through the assessment process on admission and an ongoing basis. Documentation reviewed supported this, as did interviews with patients who stated being asked about their needs. Further work in the mental health unit to document the conversations they are having with consumers re cultural needs is encouraged, especially documentation of hapu and iwi. Staff provided examples of meeting specific individual needs of patients and families/whānau for example specific dietary needs. In the Star One unit a patient who identified as Muslim had expressed his needs to staff, who were in the process of implementing these. His mattress was on the floor as this was his usual practice and a prayer mat was being brought into the hospital.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

A Code of Conduct describes staff behaviours that are not acceptable and actions that will be taken should these occur. All staff sign the Code of Conduct on employment. Police vetting is undertaken for all staff prior to employment. Policies and procedures guide staff, should they observe any signs of discrimination, coercion, harassment or exploitation. Staff interviewed had not observed any such practices. Patients and families/whānau reported feeling safe and had not observed any examples of discrimination or exploitation.

In the maternity service professional boundaries were understood by the registered midwives and nurses interviewed. Staff within the mental health service are actively working on a programme called 'Let's Get Real', which is values and attitude training, and looks at prejudicial attitudes and behaviours. There were posters around the walls in the tearoom describing the sort of behaviours expected and ways to talk with patients to decrease barriers.

Staff respect a patient's right to refuse treatment, working with the patient to provide care and treatment that best meets their needs. Patients reported feeling empowered to make decisions about their care and treatment.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Consumers receive services of an appropriate standard.

Attainment and Risk: FA

Evidence:

Examples of good practice were observed and discussed throughout the course of the audit. Staff in each area provided examples of changes to practice and service developments based on evidence-based practice. Examples included: the Emergency Department (ED) transfer of care handover sheet - 'know the plan, share the plan and review the risk; the OPAL project with the purpose of pulling patients from ED and providing rapid rehabilitation and discharge; the shared goals of care planning work currently being undertaken. The health recovery bed system in place to allow patients to have six weeks to heal or mobilise in a rest home before being assessed for rehabilitation allows patients to optimise their potential. In maternity, the newly renovated Mama Aroha Sands room for those couples experiencing grief and loss is a great asset to the service. Improvement in the reduction of Caesarean birth rates by 25% has occurred due to the improving birth outcomes work using the Robson ten group classification system. The community/home care service interface with the inpatient ward and staff enabled an ease of access for children with chronic conditions when things were not going well in the community. Multidisciplinary team meetings in paediatrics included community/home care services and Oranga Tamariki. The neonatal unit uses an electronic application 'Babble app', which is given to all parents to allow them to understand what the unit provides. It also allows them to make a diary with pictures of their baby/ babies. Parents interviewed were very complimentary about the app. Throughout the hospital quality improvement boards were visible, displaying areas of quality including results from monthly 'i-auditor' audit results.

Policies and procedures are referenced to best practice and are updated when current accepted best practice changes.

Staff (both clinical and non-clinical) are supported to develop skills and expertise through attending national and international conferences, belonging to professional and peer review groups and being involved in quality improvement activities using current accepted best practice tools and techniques. Staff felt well supported in relation to professional development opportunities and access to evidence-based resources such as the library, professional journals.

External expertise is sought when required, with examples noted of referring patients to specialist services and individuals, where required.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Patients reported that communication was open and effective and commented that they felt well informed and any questions were answered.

The MDHB adverse events policy details expectations for 'open communication' and when this should occur. This aligns with current accepted practice. There is also an open disclosure policy describing a more detailed process as to how disclosure should occur. A number of incidents and complaints documented on the electronic database were reviewed, including the review of serious and 'Always Report and Review' events. The event synopsis form includes open disclosure and these indicated there has been communication with the affected patient and/or their next of kin. The quality improvement and assurance manager discussed a recent project that reviewed the ongoing communication with patients/families during the event review process and upon completion of the review. Areas were identified for improvement and actions to address shortfalls are in the process of being implemented and embedded into practice. Cultural support, where appropriate, is available and examples of this were discussed. Staff interviewed understood the principles of open disclosure and there were examples of family members confirming being informed of an event related to their relative.

Officially trained interpreters are available through several external services, including for sign language interpreters. A policy and a procedure described requirements and processes for access. Staff knew how to access interpreters when required and described other support offered for patients.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Patients, and where appropriate, their families, reported being provided with the information they need to make informed choices. Staff (including medical and nursing staff) were knowledgeable about the organisation's policies and processes relating to informed consent, including consent for children, consent for those with diminished capacity, consent in emergencies and consent for Section 25 and Section 29 medicines. Patients' records reviewed showed evidence of relevant information being provided to facilitate informed consent, including information related to adverse effects, and completion of relevant consent documents. Consents were sighted for surgical procedures, peripherally inserted central catheters (PICC) insertions, blood and blood products administration and computerised tomography (CT) scans where contrast was going to be administered. The consents were well completed by the person performing the procedure. Patients interviewed were satisfied with the information provided. Examples were sighted where consent was refused including for physiotherapy treatment. The physiotherapist documented the discussion with the patient about the risks of not having the treatment and the benefits and respected the patient's refusal. Parents in the paediatric wards felt well informed and felt well informed to make decisions in relation to consent. None of the patients spoken to had been involved in an incident requiring open communication.

Specific consent practices reviewed in maternity services demonstrated that the necessary consents were obtained such as " Anti D" administration, epidurals, caesarean sections and metabolic screening and Guthrie test for the baby were all sighted. Palmerston North is a baby friendly hospital and complies with the requirements for this, such as, consent for giving of baby formula and use of nipple shields. ā

In the mental health service examples of good practice related to consent were reviewed and discussed with staff and consumers related to the Mental Health (Compulsory Assessment and Treatment) Act 1993. Consumers reported feeling well informed. A range of written information was readily available to consumers and families/ whānau to support sharing of information.

In line with national developments, the organisation has recently updated processes in relation to advance directives, including 'resuscitation' directives. MidCentral DHB are piloting the Health Quality Safety Commission's 'Shared Goals of Care' which is the third part of the deteriorating patient improvement work. Evidence of these documents were sighted throughout the

hospital with a high completion rate sighted. The discussion that is held with the patients/families/whānau related to the shared goals of care document does however need to be documented consistently in the clinical records. In the medical areas, discussions with patients and family/ whānau were very well documented in clinical records reviewed, including where the decision to change during the inpatient stay was identified. Staff were well aware of these decisions. Improvements have been made to the availability of information to patients, relevant training and support to staff. MidCentral DHB have also developed a tool kit for staff, iwi and community partners in relation to Personal Protection and Property Rights Act 1988 (PPPR), Enduring Powers of Attorney (EPOA) and enactments, welfare guardian and property manager administrator applications and personal order protections. Staff were familiar with these concepts and knew where to access the information. The document includes how to assist with decisions for those who are vulnerable. A social worker interviewed confirmed that this was a valuable tool and has improved understanding of the legal requirements, including in aged residential care. No advance directives are used in maternity services as all women and babies are for resuscitation.

Documented processes related to storage, return or disposal of body parts, tissues and bodily substances meet the requirements of Right 7 (10) of the Code and staff were familiar with requirements. At the time of audit, the maternity service was in the process of changing the management of returning the placenta / whenua to the women and her whānau.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Information about the Nationwide Health and Disability Advocacy Services was displayed throughout the areas visited in the form of posters and pamphlets. Patients understood their right to access independent advocacy services and felt able to have family and other support as desired. Staff discussed examples of accessing independent advocates to support patients. Women in the maternity services were aware of their right to have a support person of their choice during all stages of service delivery. Partners can stay at Te Papaioea for the duration of the woman's stay. In older persons' health service, Star 2, patients interviewed stated that their family were made to feel welcome and supported as required. No barriers to visiting were identified. One patient's husband visited daily and was able to bring in the patient's dog.

Evidence was sighted of an increasing number of examples involving the national advocacy service in the raising and resolution of complaints. Staff involved in the complaints process provided examples of using advocacy services and other supports (eg, Pae Ora Paiaka Whaiora Maori Health Team)) to support patients and families/whānau when resolving an issue or making a complaint. All complainants are formally informed of their right to access advocacy services and how to do this as part of the complaint management process.

Consumers in the mental health service provided examples of accessing advocates and support people to assist in decision-making. Staff interviewed spoke of the use of Te Whare Rapuora for the support of support persons.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Staff are aware of the importance for patients to maintain links with family and visitors of their choice. This was particularly evident in the maternity service were women and their partners spoke of being able to be together during the hospital stay and visiting hours being flexible. Parents in the children's ward felt welcomed and involved in their child's care and treatment. Relatives interviewed in other services reported being able to access their relative when they wished. For patients whose families do not live nearby there is access to accommodation.

A policy on visiting guides staff, aiming to balance the need for access to visitors with the need for privacy and rest.

Staff discussed examples of accessing community groups and supports for patients such as palliative care services and district nursing services. Clinical records reviewed and patients interviewed spoke of referral to these services. Families of patients in the mental health services interviewed were aware of the Support Families service and had been offered referral to this service. Community support services contact numbers are displayed in the patient phone room.

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

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Complaints policy guides practice in relation to complaints management. A complaints process documents each step, with data available to identify resolution rates, analysis, recommendations, and actions taken. A 'Tell us what you think' brochure is widely available throughout the organisation. It is in hard copy freepost format and offers a variety of ways in which patients can give feedback. The form outlines the process including acknowledgement as outlined in the Code. Additional assistance through the Health and Disability Advocacy Service or the Health and Disability Commissioner (HDC), including contact numbers is provided.

The consumer experience team is responsible for complaints and records all types of feedback in the Riskman system. This electronic database enables tracking of progress, response times and uploading of additional documents. Six feedback examples reviewed confirmed this process is consistently followed. The feedback workload is shared, with one person taking the lead on more complex cases. The team is proactive in dealing with queries, as these are seen as an opportunity to be responsive and avoid escalation to a formal complaint. Complaints are categorised according to the primary issues. Increasingly, complaints are co-managed with the local HDC advocate.

Data reviewed indicates a drop-off of complaints during Covid-19 lockdowns. On average, from June to August 2020, complaints took 12 days to resolve. Close monitoring ensures complaints are resolved at the earliest opportunity. Where time extensions are required (e.g., awaiting investigation reports from clinicians), these are logged, and alerts ensure these are followed up and extensions recorded. The letters sent to complainants provide clear information about contacting the advocate or HDC. Up to 5% of complaints may be reopened in situations where the complainant is not satisfied with the response.

Open HDC complaints are tracked according to response dates, with four responses being due in the two weeks following the audit. At the time of audit, 22 complaints were open pending a decision, awaiting feedback or for MDHB to provide further information. Weekly progress is provided to the executive team.

Learnings from complaints are presented in the form of consumer stories. Three times a year, a consumer story is presented to the Health and Disability Advisory Committee (a subcommittee of the Board). It is presented in a workshop format with input from the consumer/whānau and staff involved.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Outcome 1.2: Organisational Management

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

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

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

Attainment and Risk: FA

Evidence:

A range of strategy and planning documents were reviewed and discussed with the organisational leadership team (OLT) and six members of the board. The strategy document is in the process of being reviewed and updated. Four strategic imperatives and four values have been defined. The two key areas of strategic emphasis are equity for Māori and digital developments. Values are well embedded with a high level of visibility around the organisation and within documents reviewed. The use of locality health and wellbeing plans is a strength of the organisation covering regional/local areas (eg, Ōtaki, Horowhenua) and services/clusters (eg, acute and elective services, mental health and addictions). These plans were informed by the community with active representation from each iwi. The Ka Ao, Ka Awatea 2017-2022 Māori Health Strategic Framework brings together the integrated approach/actions of the Primary Health Organisation (PHO) and the DHB. The Ministry of Health prescribed annual planning process is driven by national government priorities and local priorities. The Statement of Intent covers a one to four-year period, the Operational Business Plan covers a one to three-year period and the cluster plans cover a one-year period. A planning and alignment tool reviewed provides a diagrammatic explanation of the various plans and how they fit together to support the implementation of the DHB's strategic direction.

Manawhenua Hauora, MDHB's Iwi Partnership Board, established in 2001, is a formal part of the governance structure. The Hauora provides coordinated leadership for Māori residing in the district and is made up of representatives from the six iwi groups. The strong focus on equity was evident at all levels within the organisation and has included an in-depth focus on projects, plans and monitoring. Examples of an improved equity approach were noted for breast and bowel screening programmes, for example.

There are two committees reporting directly to the board; the clinical council and the consumer council. A strong and increasing consumer input in the organisation was evident through representation on a wide range of groups (eg, the infection prevention and control committee, credentialing committee and restraint advisory group). The clinical governance structure was undergoing a 'refresh' at the time of audit.

Monitoring of the plans occurs as required to the ministry and governance groups. A Performance Improvement Plan supports the monitoring of progress against plans with the key deliverables falling under four categories: the Improving Value Programme; Quality and Reducing Variation; Workforce and Culture; and Savings Plan. The monthly results are tracked and monitored by the OLT. The Covid-19 response has impacted on the delivery of planned care with a variety of strategies to progress outstanding elements. A range of reporting dashboards were reviewed and indicated sound linkages to plans. A Māori Health Equity Dashboard was developed in June 2020 and approved by the DHB Board and Manawhenua Hauora in July 2020, as described by the general manager (GM) Pae Ora Paiaka Whaiora Hauora Māori Health. The are 76 equity outcome actions being reported to the board. In addition, specific area dashboards have been developed (eg, selected child and youth health indicators).

The current CEO has been in the role since May 2015 and is supported by an experienced OLT. She is well-qualified and experienced in the role, and staff and the board expressed confidence in her leadership.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Several organisational charts were reviewed. The organisation leadership team (OLT) is made up of three executive directors covering nursing and midwifery, allied health and medical officers, the chief digital officer and five general managers (GMs) who are seen as 'enablers' (strategy, planning and performance, finance and corporate, people and culture, quality and innovation and Pae Ora Paiaka Whaiora Māori health). Six 'clusters' cover clinical services, including primary public and community health care, each with an operation's executive and a clinical executive working in partnership. The OLT also has representation from the GM of Enable New Zealand and a strong link with the CEO of THINK Hauora (PHO). Within each cluster, structures vary to meet the unique needs of the service. An integrated approach was evident. There have been recent changes to support the Māori equity developments with the establishment of a Māori Alliance Leadership Team (MALT) with each cluster establishing a Cluster Alliance Group (CAG) as a formal structure to engage and integrate all parts of the health and disability system.

The integrated operations centre has been a focus for improvement over the past year and provides a 'real time' view of hospital utilisation and supports efficient and effective delivery of patient care. There is always a senior manager on call. When any member of the executive management team is absent there is a designated person to perform the role. The OLT have a 'buddy' system and a partnership approach to support succession planning, leadership development and to provide support. The OLT members reported that the relatively flat structure and clinical and management partnership model supported an effective response during the Covid-19 period.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Quality and risk management systems are well embedded at MDHB with commitment to effective clinical governance and patient experience and safety from the board, clinical leaders, OLT and the CEO. This has been demonstrated with the increase in an integrated systems improvement approach and consumer engagement. Members of the board and OLT are involved with regular 'walk arounds' talking with staff and consumers about their experiences. Board members interviewed reported this was of value.

There is a planned approach to quality and patient safety based around national and local imperatives with four goals defined. Six domains of quality are defined. The most current quality plan is awaiting sign off by the Health and Disability Advisory Committee (HDAC). Each cluster also has a quality plan and a sample reviewed showed these were linked with the relevant locality plans and aligned with strategic goals.

The quality and innovation enabler includes a GM, quality improvement and assurance manager, a medical advisor quality & improvement and a consumer experience manager. Several quality advisor/facilitator roles support staff within the clusters with quality improvement activities (eg, incident reviews, quality training, quality improvement projects and audit activities). Other roles within the directorate include (but are not limited to) the family violence intervention coordinator, spiritual care and chaplains, the clinical library, the Riskman administrator and document control coordinator. Senior professional leads also work closely with members of the quality and innovation team.

The clinical governance system includes a clinical board (CB) with 11 groups currently reporting to the board and a further three either under review or on hold. Formal reporting is occurring to the board from each group on a regular basis. The review/refresh of the clinical governance structure has involved clinicians and is due for finalisation the week following the audit which will better align with ongoing developments across the organisation. The CB acts as they key group to integrate quality improvement activities with members of the quality and innovation team on all sub-groups/committees along with representation from each cluster. Each cluster also has a clinical governance structure focused on quality and patient safety.

A range of quality and patient safety improvement work was discussed at all levels of the organisation. This included hospital wide projects (eg, Shared Goals of Care project, Mahi Tahi partners in care work, rationalising acute demand projects), and unit/cluster specific projects including the project to reduce unnecessary peripheral intravenous cannulation in the emergency department and the project to reduce rates of Caesarean sections in the maternity service. The organisation continues to be committed to the Health Quality Safety Commission (HQSC) key projects and measures. Staff are engaged with quality improvement activities through audit activity, incident and complaint review involvement, policy development/review and morbidity and mortality reviews and project work. Education for staff is provided on quality improvement methodology and tools and techniques, audit and quality and safety markers, supported by members of the quality and innovation team.

An internal audit programme is agreed with the board finance risk and audit committee (FRAC) each year and monitored through this committee. The programme is administered through 'CentralTAS'. In addition, 'iAuditor' is used inhouse to measure compliance against a range of clinical indicators in accordance with the internal auditing plan. There has been little change in the content of these audits since they were originally set up and it is recognised that a review would be of value. Results of audits are reviewed by the RN and circulated to the charge nurse for follow-up. Examples of these were sighted. Other quality information is gathered from Health Round Table data and from mortality and morbidity (M&M) reviews. The chief medical officer (CMO) discussed a range of improvements already made in this area and planned for the future.

Several examples of effective corrective action planning were reviewed and discussed, including for events, external reviews, complaints, audit activity and through meeting minute actions. Responsibilities and timeframes were noted.

Quality improvement, risk and patient safety data is gathered and reported at all levels within the organisation, including to the board, as sighted in a sample of board minutes reviewed. A team of analysts support organisation-wide reporting and analysis of data for individuals, teams, clusters, professional groups and project work both on a planned and ad hoc basis. Balanced scored cards are widely used with dashboard developments being supported by Qlik for the executive team and in development for the clinical board and finance areas. The Care Capacity Demand Management (CCDM) programme supports patient flow, nursing and midwifery resourcing and covers a range of patient quality and safety indicators.

The organisation's controlled documents are accessed through the intranet. A number of developments over the past 18 months have resulted in very few of the around 2500 policies being overdue for review (seven percent at the time of audit, many of which were either awaiting final approval or under active review). A policy governance group has agreed on a framework and principles and is working to simplify, reduce the numbers of policies and improve access. The use of Lippincott over the past year is resulting in fewer nursing internal documents and improved currency and inclusion of best practice. A national and regional approach was apparent. Reporting on overdue policies is transparent with good support from the leadership team to support timely reviews. Documents are approved, distributed and archived appropriately. Staff are informed of any changes.

Management of risk is well established using the electronic tool Riskman. The risk register, risk reports and minutes to the FRAC and board were reviewed and discussed with the principal risk and resilience officer. Interviews with board members and the OLT indicated an awareness of current key risks and satisfaction with mitigation plans and risk levels. There are around 220 'live' risks on the register – both enterprise and local. Risks are analysed using a standardised 'bow tie' process, rated according to severity, with mitigation plans developed and reviewed regularly based on severity. During the Covid-19 response some reviews of risks were not conducted. These areas have recently been fully reviewed. Risks around Covid- 19 have been raised with plans in place for readiness. A sample of new risks were reviewed (eg, fatigue, as part of the wide suite of workplace safety recorded risk) and demonstrated an appropriate process. The links between the incident management system and the risk management system were evident with trends leading to risk identification and linked to events/incidents reporting (eg, falls with fractures).

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

The Riskman incident module is used to report events/incidents related to patients, staff, visitors and contractors at MDHB. This is supported by policy and a guide for staff. The serious adverse events governance group (SAEGG) is effective in ensuring a thorough process around event reviews for events rated as having a severity score (SAC) of one or two and on occasions three, and all 'Always Report and Review' events. The group reviews the quality of the review process and the follow-through of corrective actions/recommendations to ensure completion. The clinician who is the lead for the review process presents to the SAEGG. Cultural oversight is provided on this group to support a culturally responsive approach which has resulted in a resolution system to better connect and engage with whānau. There is also a consumer on the group. Improvements have been noted in several clinical areas around reporting of events; this has been particularly notable in maternity services. A new process has been developed to support a more effective and timely review process. This allows for a 72-hour period to complete an initial exploratory review to progress the process and review safety. The quality improvement and assurance managers reported that, on occasions, audits are completed to check the effectiveness of recommendations. Summary data is reported to the SAEGG, the HDAC and the board, as evidenced in meeting minutes reviewed.

A sample of events reviewed and discussed, including for all SAC ratings, showed fully completed documentation and the development of appropriate recommendations and close off of these. Staff in ward/unit areas interviewed were familiar with the reporting requirements and documentation in this area also showed complete reporting and follow-up as needed.

Staff and managers interviewed detailed the type of events that require external notification and the designated manager that is responsible for making these notifications. This included serious harm events, SAC one and two and 'Always Report and Review' events to the Health Quality and Safety Commissioner, unexpected patient deaths to the Coroner, and radiation events to the Ministry of Health Office of Radiation Safety. External notifications had occurred for the applicable incident/adverse events sampled. The timeframes for reporting to the HQSC are generally within the required timeframes, and where this was not the case, there was an appropriate explanation.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Consumer involvement at all levels across mental health and addiction services was evident. In 2017/2018 MDHB moved to a cluster arrangement and the consumer advisor role became the consumer project lead moving from a 0.6 FTE to a 1.0 FTE. There is also a part time addictions consumer advisor based within the alcohol and drug team. The consumer project lead (CPL) sits on the leadership team and now reports to the planning and integration lead.

All policies and procedures are reviewed by the CPL, with some policies reviewed by the service user advisory group (SUAG) where appropriate. The CPL is also involved in assisting the social worker in developing housing/accommodation options for clients with complex needs and emergency accommodation. The consumer advisor and CPL participate when asked on interview panels for staff at all levels. The SUAG meets monthly and representatives on the group report back on behalf of client peer groups.

Posters are up throughout mental health services displaying the addictions and consumer advisor roles. Consumer advisors will support clients to make a complaint, if required. Consumer feedback is now via the Marama real-time feedback tool.

The CPL leads the Te Pou ‘Values & Attitude’ training workshops, recovery sessions in the Safe Practice Effective Communication (SPEC) training and is also involved in several advisory groups (eg, the ‘Rainbow Forum’, Restraint Advisory Group).

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

The service assists with training and support for consumers and service providers to maximise consumer participation in the service. This shall include:
(a) Education and/or training for service providers whose colleagues are consumers working in the services;
(b) Supervision; debriefing and peer support.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:
(a) Employing consumers where practicable;
(b) The service assisting with education, training, and support for consumers to maximise their participation in the service;
(c) Training for service providers in working with consumers as advisors;
(d) Advisors liaising with consumer groups or networks.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

A Family/Whānau Advisor (Whānau Ora Kaitautoko) is employed by MidCentral DHB (Mental Health and Addiction Services). The role is varied with key elements focused on increasing family/whānau involvement across most levels of service provision via Pae Ora Paiaka Whaiora Māori Health team. The Whānau Ora Kaitautoko co-facilitates weekly inpatient meetings (with the consumer advisor). They also support MHAS service users' family and whānau to provide feedback through two forums each year. There is a booklet available for families/whānau titled Family & Whānau Information When In Crisis Booklet (Oct 2020). Family and whānau have been included in co-design projects and initiatives. Whānau Ora Kaitautoko are also available for staff and community organisations to provide advice and support. Family/Whānau representation has occurred on interview panels for specific roles. They have also participated in the Supporting Parents Healthy Children programme.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Family/whānau who participate in an advisory capacity have clear terms of reference. This shall include, but is not limited to:
(a) Advice sought from the family/whānau advisory groups when developing a terms of reference;
(b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality and conflicts of interest.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:
(a) Employing family/whānau where practicable;
(b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;
(c) Training for service providers in working with families/whānau as advisors;
(d) Advisors liaising with family/whānau groups or networks.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA Low

Evidence:

There is a well organised human resources department and a suite of relevant human resources policies and procedures. The medical administration unit supports the recruitment of senior medical officers (SMO) and resident medical officers (RMO) with a dedicated recruitment resource. MDHB is working to implement an e-recruitment system, with a vendor currently being sought. Records are held in hard copy, with a plan to move to digital records in the foreseeable future.

Recruitment:

Recruitment is coordinated by the human resources department. The recruitment process is defined including an implemented vetting process. Decisions about appointments are devolved to the lowest level but monitored by the HR department. Qualification records and referees are checked, with referee reports and interview notes remaining on the individual's personnel file in a sealed envelope. A sample of hard copy personnel files showed that these were well organised and contain the appropriate information. These included confidentiality and employment agreements, job descriptions and records of appraisals. Staff have job descriptions which are updated as appropriate during the appraisal process.

Several positions are reported as challenging to recruit into, including psychologists, psychiatrists, allied health professionals, midwives, sonographers, clinical physiologists, and anaesthetic technicians. Strategic planning in relation to this is in place and some progress has been made (e.g., recruitment of radiologists). A nursing and midwifery workforce plan 2020 to 2025 has also been developed. Recent 2020 success has been achieved with medical officer recruitment, where a third of recruits identify as Māori.

Orientation:

New staff receive a comprehensive orientation at a 'New Staff' day in the first four weeks of their employment. Formalised orientation to the unit/service area occurs within the first three months of commencement. There has been a change in the new staff programme, with a greater focus on understanding the culture and values of the organisation, communication, and an opportunity to meet other staff. Most recent figures indicate an 89% completion rate. Mandatory learning has largely moved to the e-learning platform and covers topics such as the Code of Rights, electrical safety, fire evacuation, health and safety, incident reporting, infection control and security via Ko Awatea. Completion is recorded electronically. Other learning is completed over the year based on a training matrix for various disciplines. Open learning is available on an ongoing basis through Ko Awatea. Good rates of completion of training requirements are recorded and overseen by line managers.

Registered nurses interviewed advised they had received a comprehensive orientation including provision of workbooks (sighted). The clinical educators support the completion of service level orientation, including timelines for new staff. New nursing staff are allocated a preceptor, with nursing staff appraised within three months of commencement. New entry to practice (NetP) staff also undertake a structured programme.

Ongoing Education:

Upcoming education opportunities are displayed for staff in service areas. Training has occurred recently related to Covid-19 and use of personal protective equipment (PPE). There are a range of study days offered. Each service is responsible for managing the mandatory training for their area. These records can be accessed to show compliance with this requirement. Staff interviewed confirmed regular ongoing education was offered relevant to their role.

The professional development recognition programme (PDRP) is well established. Approximately 50% of nursing staff are undertaking proficient and expert portfolios which are moving to e-portfolios. Appraisal completion has improved but does not yet meet the organisation's benchmark. Systems are fully implemented to manage currency of annual practising certificates (APCs) for all disciplines.

Records of education attendance are maintained in a spreadsheet of attendance which shows the percentage of staff that had completed each of the training sessions (including refreshers) within the required period of time. Some staff were overdue CORE advanced training; however, this has been delayed due to Covid-19.

There are examples of responsive education plans, such as that developed to address the larger number of higher acuity medical patients admitted to Ward 25 (OPAL). Staff are required to complete designated training before being rostered to work in CCU. They have this noted on the roster.

Of note, is training that has been undertaken by the Māori health directorate. A comprehensive training programme has been undertaken with the board on 'Te Tiriti o Waitangi implications for health governance' and an increasing focus on Māori equity in health services. Organisational cultural training (Māori cultural responsiveness in practice) is available to all staff. This service has a contract with Massey University to provide te reo Māori and Tikanga to the organisational leadership team (OLT) from September to November 2020.

Medical credentialing:

Robust processes were evident in relation to medical credentialing which covers pre-employment processes, yearly requirements, five yearly individual requirements and departmental/service requirements. Systems cover both permanent and locum doctors and any 'honorary' staff. A minimum of two referee checks are completed prior to appointment which are discussed with the clinical lead in each service. There is an initial credentialing process followed by a re-credentialing after six months. All appointments are approved through the credentialing committee including a process around accepting doctors already credentialed in other DHBs. A checklist is used to identify completion of all requirements. An annual checklist is completed re APCs, declarations regarding health and any complaints/investigations in process and was underway for the current year. A five yearly re-credentialing for individual doctors is also in place. This was not fully up to date at the time of audit, but all doctors who were not current were being followed up and in the process of updating requirements. A review of departmental credentialing is underway following the recent appointment of the new chief medical officer (CMO). Any new procedures and equipment requests also go through the credentialing committee. Credentialing for electroconvulsive therapy (ECT) was not able to be verified on site.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA Low

Evidence:

Appraisal completion has improved since the previous audit, with significant effort to address overdue completions. Currently appraisal completion is 66% but remains below the organisation's benchmark of 75%.

Finding:

Appraisal updates are progressing well, with consistent progress towards meet the organisation's benchmark. However, work needs to continue to ensure this is achieved in a timely manner.

Corrective Action:

Continue to progress annual performance appraisal completion.

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

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

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

Attainment and Risk: PA Low

Evidence:

Interview with the CMO indicated that recruitment to psychiatry remains challenging and it is difficult to fill the complement with permanent roles. This has resulted in a high use of locums (currently two are providing cover), with efforts to contract them for a year. Other areas experiencing difficulties are interventional cardiologists and radiologists although there are strategies to manage current shortfalls. For example, a roster of medical support to mental health services inpatient wards has been put in place and appointments made to radiology. RMO skill mix and FTE levels take into account MECA compliance, College requirements and roster capacity (especially after-hours rosters) as well as relief capacity to cover absent RMOs. SMO full-time equivalents (FTEs) are determined following job and service sizing.

Since the previous audit, additional pharmacy FTE has been recruited. Turnover across the DHB remains at a low level as indicated in the work force reports to the board. Overall vacancy for all professional groups being monitored equals approximately 129 FTE. Targeted recruitment is being undertaken such as for the surgical procedural interventional recovery expansion (SPIRE). The two-year implementation of this sustainability plan for workforce and productivity improvement is underway.

The integrated operations centre (IOC) actively monitors the nursing vacancies and staffing levels. Planning meetings are held each day to ensure there is cover for all service areas and provides 24 hours a day, seven days a week (24/7) facility support, bed management and patient flow across clusters. There is electronic visibility of patient placement in most service areas.

The care capacity demand management (CCDM) programme is established and undertaken in association with union partners. It provides a set of tools and processes that assist in matching capacity of care to patient demand, as well as a systematic approach to nursing staffing requirements and budgets. Recalculation of FTE requirements is underway (10 have been completed and a further 10 in progress) some of which are calculations being run for a second time. Variance response management (VRM) is actively used to mix skills and care delivery including escalation pathways. Reports for Trendcare, VRM and CCDM were sighted, together with procedures for safe staffing and variance response management and for managing nursing staff

shortages and therapy staff. The Local Data Council reviews results of bed utilisation, shifts below target, care hours variance and variance response. Data reviewed on the days of audit identified that the hospital is working at capacity, and in some areas over capacity, with variances in orange and red occurring. Miya boards display patient numbers and location. For example, the charge nurse of medical assessment and planning unit (MAPU) stated she constantly looks at data to see how patient flow can be facilitated and patients accepted from emergency department (ED).

Overall pressure within the hospital has also resulted in a significant number of outlying patients (e.g., 14 medical patients located outside the medical wards) (Refer to CAR 1.3.1.4). The patients remain under the care of the allocated medical team. A resident medical officer (RMO interviewed reported being stressed with the workload. The clinical lead - medicine advised there was not usually additional resource to cover increased medical patient numbers that are being cared for in other wards/departments. MAPU is consistently working overcapacity.

The internal bureau currently has a core pool of 6-7 FTE staff available. Some of these staff are deployed to ward areas on short-term contracts, reducing flexibility for deployment elsewhere. It is reported that issues around time to recruit can be a factor, however any staff who are suitable for employment are generally recruited to the bureau. Capability has been improved with a nurse educator allocated for this area, which has seen achievement of all mandatory training requirements. Currently part time staff are asked to work extra hours/shifts in ward areas, but if unable to cover, bureau are contacted. If bureau staff are unable to fill shifts, then the ward discusses what care will be prioritised and VRM is activated. The charge nurse in MAPU is allocated one 'office/paper day' a week but often ends up working clinically. She reported that approximately 70% of requests for bureau staff for MAPU cannot be filled. Variance response data for MAPU for August 2020 showed only four days in which overall staffing was in 'green'.

There is a duty manager covering 24 hours a day providing both management and clinical oversight. The associate charge nurse of ward 28/CCU advised the ACNM and one other staff member are sent to attend Medical emergency Teams (MET)calls weekdays and the duty manager is also alerted when a call occurs. Afterhours the duty manager and one other person attend MET calls. They report a 500% increase in calls with the implementation of the early warning score (EWS) system, and no corresponding increase in staffing.

A 'specialling' project action plan has been developed to address the high number of patients at risk of harm to themselves or others who require one-on-one care. All five inpatient services regularly require access to health care assistants and hospital aids to assist with 'specialling'. The aim is to achieve a sustainable clinical and operational model across all inpatient services. Priorities for action have been established according to work streams. Work has been delayed due to the impact of Covid-19 but is due for completion by the end of the year.

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

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

Attainment and Risk: PA Low

Evidence:

Work is progressing well with the care capacity demand management (CCDM) programme. Trendcare is being utilised with variance reports increasingly being used to support decisions around nursing staffing resources. The integrated operations centre (IOC) developments are also supporting improved allocations and reallocation of nursing staff on a shift by shift basis.

During the audit, the hospital was working at near capacity and this is now common. Several areas are working at over and above their resourced bed numbers with no extra staff allocation, with staff provided from the bureau or other areas to meet the increased demand. For example, MAPU is resourced for 13 beds and has been operating with 15 beds since December 2019. Staff in the area reported there had been no increase in staffing. Variance reports in several areas are showing variances in the orange and red areas. Subsequent information provided, indicated there had been an increase in staffing of 2.45 FTE following FTE calculations which factored in the increased patient care required with the increased beds.

There are several vacancies that are impacting on the ability to staff areas (eg, psychiatrists in the mental health area, midwives for the maternity service, older persons' health and in the bureau). The impacts of Covid-19 have had some effect on recruitment. Vacancies are said to be filled through use of the bureau staff, but data shows that this is not always possible. Staff are redeployed within clusters wherever possible.

Staff in most areas visited talked of feeling 'stretched' with the persistent heavy workloads. Family and patients interviewed in medical areas noted that call bells were not always answered in a timely manner.

Finding:

CCDM and variance reporting indicates heavy workloads in most clinical areas, including consistently working over the resourced bed numbers. The bureau is often unable to meet nursing staffing requests.

Corrective Action:

Complete the CCDM reviews in a timely manner and ensure permanent staffing is in line with FTE requirements.

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

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

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

Attainment and Risk: PA Low

Evidence:

Interviews were held with the clinical records department manager and a sample of clinical managers during the course of the audit. Areas where records are stored were reviewed both in central departments and in the ward areas. Clinical records were also viewed throughout the audit process.

Patients' paper based clinical records are stored in a designated area under the national health index (NHI) number. The maternity service uses 'Badgernet' and this also allows access to patients' files from other facilities at early stages of planned transfer. Access to all paper-based records was secure and there are fire protection systems in place. There is a 'Webpas' tracking system. Mental health services hold a hard copy clinical file and use the same electronic systems as the hospital (Webpas and clinical portal). These records are stored separately and also securely.

Records can be requested for access and these are provided in a timely manner. The organisation is working toward an electronic record system with phase 1 (selecting vendor) under way and a committee established to support the process. There is authorised only access to files, with a privacy officer managing any external access requests. Records held in clinical areas were kept secure.

In general, entries in records were legible and met good practice requirements. However, there were several areas visited where patient identification details were not on every page of the record.

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

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

Attainment and Risk: PA Low

Evidence:

Records reviewed across all clinical areas visited during the audit, including Horowhenua Health Centre, showed that entries were timely and appropriate to the service area. With the exception of maternity services, who use the electronic system Badgernet, records are paper based. Entries were written in ink, legible and met good practice requirements, including date and time of entry. The name and designation of staff were noted, in most cases (refer 1.3.12 for exceptions on medication charts). Allied staff and some others use stickers or stamps to detail their role. Not all assessment and care planning forms were completed as required. This is noted in standards 1.3.4 and 1.3.5.

In several areas visited there were multiple pages in patients' records that had no patient identification labels. These were primarily in the A-D planner in the medical service areas which is a booklet format document. Labels were also missing on several pages in the mental health service, including Star 1. The manager of clinical records noted that at times when staff receive records, labels are noted as missing from pages and this is rectified at the time; however, there is no ability to check all pages in the record at this point in the process.

Finding:

There were several areas across the clinical areas visited where there were no patient identification labels on pages in the clinical record.

Corrective Action:

All pages in the clinical record have patient identification details.

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

Attainment and Risk: PA Low

Evidence:

Patients access services either as an arranged admission or acute admission based on their needs. Relevant criteria, procedures and protocols were sighted, including for some children who have direct admission to the children's ward and some patients who have direct admission to the mental health unit. The co-location of the community team and the child health outpatient clinic beside the inpatient ward allows for identification of children who may require acute or arranged admission. The community team, who are part of the multidisciplinary (MDT) weekly meetings, can also facilitate this. Acute paediatric admissions can be via ED where the child has an 'open letter', which allows direct access to the ward. The neonatal unit have entry criteria, which is known to all clinicians, internal and external. An infant, who had multiple previous admissions, was followed using tracer methodology. The homecare staff had arranged admission, with the patient and parents well known by the ward staff. On admission, a plan of care was already in place to be activated. In older persons' health services admissions, either acute or arranged, are approved via the older persons' health consultants or registrars. Women are booked into Palmerston North maternity service even if they are booked into Te Papaioea birthing centre and/or Horowhenua hospital. This process is in case women need to be transferred from primary to secondary care either in labour or postnatally for continuing care or due to the baby requiring a higher level of care. There are a number of clinical pathways in use for patients when they present to ED. These pathways include stroke, chest pain, adult sepsis and fractured neck of femur.

Acute admissions occur through the emergency department based around a standardised triage category and process. Waiting times, based on triage scores, are monitored. The DHB monitors the national target of less than six hours in the ED and this shows 73.5 % of patients met this target in the last quarter, which is well below the national target of 90%. During the audit, patients were observed in the ED for many hours over the six-hour target. Medical patients are admitted under a medical consultant via the medical admitting unit. This unit provides care for patients who are expected to stay in hospital less than 24 hours, or while awaiting an inpatient bed. During the audit, medical patients were seen throughout all the inpatient wards as 'outliers'. A patient who lived in a rural area was interviewed and reported living in the Whanganui District Health Board zone, but had asked the ambulance service to take them to the Palmerston North Hospital instead as they had an appointment with the oncology service the next day. If they had been in Whanganui hospital, they would not have been able to attend this appointment. This was facilitated and the patient attended their oncology and radiotherapy appointments whilst an inpatient. A delay in treatment was avoided.

The process around a First Specialist Assessment (FSA) is defined, monitored, and reported on. National referral guidelines are used. The process around arranged surgical admissions is documented and includes a pre-admission assessment process.

Staff in the mental health service discussed the single point of entry process. Patients are able to self-refer, be referred by other service providers or transfer from other services. Staff interviewed discussed how they take admissions via the police and community teams.

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

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

Attainment and Risk: PA Low

Evidence:

The medical wards have been running at over full occupancy now with medical patient outliers being placed in surgical wards. On the first day of audit, there were many adult medical patients as outliers. Thirteen were in the orthopaedic ward and three were in a surgical ward. Attempts are made to have the less complex patients as outliers; however, there is no

organisation policy or guidelines that provide a framework for this process.   A report was reported to have been written discussing outcomes of outlier patients; however, this was not sighted. The medical team responsible for their care visits all medical patients daily, Monday to Friday. A process is in place to notify the medical staff where all medical patients are located.

Since January 2020, there have been twenty patients discharged home directly from the intensive care unit, as beds were unavailable earlier in the wards. It was reported that for some patients it is appropriate to discharge direct from the unit; however, numbers are increasing for those where it was inappropriate for them to remain in an intensive care environment.

Another patient was transferred in from Capital and Coast District Health Board the evening before the audit, to the coronary care unit, as there were no other medical beds available. The patient was discharged home the next day.

On the day final day of audit, the ED was visited. The unit had been in amber and red for the most part of the week. Several patients were sighted in the corridors and awaiting a hospital inpatient bed.   Others were waiting to be seen by a consultant and a decision made as to whether to be admitted or not. Some patients had been in the department well over twenty hours. On discussion with staff, they stated this was becoming a regular pattern.

Cancellation of angiogram procedures was reported as becoming more frequent. Data was not provided to confirm this. The patient followed using tracer methodology was booked on the 1st October, for first available appointment on the 5th. The patient was then cancelled due to an emergency and rebooked for the 8th October. It was not clear if there was a process around capturing this data and analysing trends.

Finding:

Patients' entry into the various speciality service areas when their need for services has been identified is not consistently being undertaken in a timely, appropriate and respectful manner. For example, patients are waiting in the emergency department (ED) for extended hours for a ward bed. On the day of audit, two patients had been in the ED corridor for over six hours and many patients had been in the department for over ten hours. Eleven patients under the care of the medical team were placed in the orthopaedic ward area. Patients are staying longer than ideal in the intensive care unit due to a lack of bed availability in the ward.

Corrective Action:

Entry to the various services be undertaken in a timely manner and processes related to the management of outlier patients be documented and clearly communicated.

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Entry is only declined if the referral criteria are not met, in which case the referrer is informed of the reasons why and any alternatives available. Reasons are discussed with patients and their family/ whānau, where appropriate. Where any arranged surgical admission is cancelled either due to the person being unwell, inadequate preparation or due to acute work demands, this is discussed with the patients and another date is arranged. Data related to the cancellation of surgeries was sighted and demonstrated that theatre cancellations are for a variety of reasons, with the average number of surgeries cancelled being 193 cases a month. The top five reasons being: acute substitution (650), patient unfit for surgery (266), insufficient operation time (239), patient cancelled (232) and surgery no longer required (189).

In maternity services, women are not declined entry to service. In primary birthing suites, they are only able to admit non high risk women/ babies as per section 88. If women are high risk, they are required to attend secondary care services. If women and or babies require higher level of care than can be offered at Palmerston North Hospital, they would be transferred to another tertiary level District Health Board hospital.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

The eight patients reviewed using tracer methodology were selected in collaboration with staff in the clinical areas based around criteria defined by the Ministry. Tracer journeys covered surgical, medical, mental health, paediatric, maternity, older persons' health and emergency departments and wards. Auditors and technical expert assessors worked collaboratively reviewing the relevant documentation and interviewing medical, nursing and allied health team members, the patients, and where possible, their family / Whānau member/s. This information, plus supplementary sampling forms the basis of the comments within the continuum of care standards below.

Multidisciplinary teams (MDTs) provide services to the patients, all of whom are qualified and skilled for their roles. Health care assistants support nursing staff with adequate supervision and guidance provided. Health Care assistants are utilised throughout services as care companions for those patients who require one on one observation. A registered nurse (RN) supervises nursing students working in the ward areas; entries were sighted in the progress notes by the student nurses and countersigned by the RNs. Student nurses interviewed confirmed being well supported by the designated preceptors. Medical and nursing staff reported that there is access to on call junior and senior medical staff 24 hours a day, seven days a week. Nursing staff access after-hours duty managers to support problem solving and decision-making. Timely access to allied health services was evident in the records reviewed and there is access to a dedicated allied health staff such as physiotherapists, social workers, occupational therapists and pharmacists. Examples of patients accessing specialist services as and when appropriate were noted. In the primary maternity service there is no medical staff input. Lead maternity carer's access agreement allows them access to primary and secondary care facilities.

MDT meetings occur on at least a weekly basis and staff reported an integrated approach to care with good communication between team members. MDT meetings were observed in a surgical and orthopaedic ward and input by all nursing and allied health staff was seen to occur. Each morning there is a handover meeting involving the medical teams. Weekdays each consultant and their teams attend along with the charge nurses of the medical wards. New admissions are allocated to the most appropriate clinical team based on clinical need and speciality. Twice a week allied health staff attend this meeting also and discuss discharge planning and any other referrals required to enable the patient to be prepared for discharge. Medical staff interviewed confirmed instructions are carried out in a timely manner and concerns re the changing condition of patients are communicated promptly. A medical staff weekend plan from the previous weekend was sighted in patient records reviewed. Requests for medical staff on subsequent shifts to review patients and undertake or follow up laboratory/ investigation results occurred in sampled records.

In the coronary care unit (CCU), there is a traffic light system in use to identify which patients may be transferred to the ward if a CCU bed is required for a new admission. Staff reported that this was discussed in a proactive manner so that there is a clear plan for the next shift.

Nursing staff's shift handovers observed demonstrated a thorough sharing of information between staff and identification of patients requiring increased vigilance or follow up of results. This is supported by summary documentation and handover at the bedside in some cases, with involvement of the patient. Transfer between wards, departments and hospitals follows a standardised transfer of care process supported by a communication tool ('ISBAR'). Documentation reviewed, staff interviewed and observations demonstrates this is effective.

Tracer patients' records and additional records reviewed show that assessments and subsequent plans and interventions are thorough and timely. Diagnostic tests are completed in a timely manner in the emergency department, and elsewhere, with results reviewed, discussed and actioned as appropriate. Where needed, changes to the plan are promptly initiated with evidence of ongoing re-evaluation. The early warning score (EWS) is in use, completed as required, and where action is required, this is sought.

Involvement of the patient and family was evident in records reviewed. Patients interviewed expressed satisfaction with the care and treatment provided.

Patients interviewed in mental health services knew their mental health and medical diagnoses. They reported that staff were accessible to discuss any queries they had about their condition. The person's family / whānau whose service delivery was reviewed in detail conveyed that the information provided contributed to a better understanding and acceptance of their family member's condition. The mental health service works to reduce the impact and distress of ongoing mental illness.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA Low

Evidence:

Completion of assessments is occurring at the first point of contact, at the time of admission and on an ongoing basis depending on the needs of the patients. Thorough assessments were documented for all members of the MDT either using the admission assessment tools or included in the progress notes section of the clinical record. Assessment tools are available for each service specific to their needs, in both electronic and paper-based formats. A range of generic assessment tools, based on good practice, were in use across the clinical areas visited, these included falls risk, pressure area risk, family violence screening tools, smoking assessments, and nutritional assessments. Specific nursing assessments have been completed and updated on a shift-by-shift basis. A review of each patient's ability to complete activities of daily living and identify any social/cultural needs is also included. Staff interviewed from across the MDT identified the approaches used to ensure referral and assessment by specialists and disciplines outside of the normal ward/service team.

Patients' records sampled demonstrated the assessments have been completed in a timely manner with occasional exception. Patients and family members reported their involvement in the assessment process and felt this process was thorough and timely. In the medical areas, the assessment process was comprehensive for both nursing and medical assessments. Allied health and medical staff document their assessment at each consultation. Many of the nursing notes include an assessment component recorded, based on body systems and functions. The Admission to Discharge Planner was completed well in all records reviewed in the medical areas. At Horowhenua Star 4 the nursing assessments are completed in Trendcare and serve as the basis for care planning. The medical assessment is ongoing and documented. Allied health document in the notes and use a relevant coloured sticker to identify their documentation according to their discipline.

The assessment findings and the needs and goals of the patient are used to develop a planned approach to care. This was reflected in the documentation reviewed.

In the mental health service, comprehensive assessments were in place for all patients reviewed. Physical assessments occurred as required, this included on admission and physical observations for patients in seclusion. Metabolic screening and monitoring are also undertaken along with smoke free assessments. Patients are offered nicotine replacement therapy by

trained staff who are adept at also helping patients to develop distraction techniques. There is a good relationship with cultural advisors. Cultural assessments have been completed where appropriate.

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

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

Attainment and Risk: PA Low

Evidence:

Within the maternity area, there was no evidence of care goals sighted in records reviewed and not all required interventions were documented in full. Women in the 'Te Papaioea' primary birthing suite stated that family violence screening had not occurred when opportunities existed.

In the paediatric ward, the care plan is pre-populated with potential problems. Only one of four care plans sighted had individual goals documented. The care plan has an area to document individualised activities; however, this was not completed in all four plans reviewed.

In the older person's health service, assessments are undertaken; however, they were not seen to inform the care plan nor updated as new assessments were completed. An example of this was seen in a record where a gentleman only spoke a small amount of English but was fluent in Chinese. This was not documented anywhere in the care plan or Trendcare. In Star 1, family violence screening was not completed.

In the surgical areas, not all assessments were seen to be undertaken, in particular, risk assessments for falls and pressure areas. Those assessments that were seen to be completed did not inform the care plan. Of eleven records reviewed, only three had all necessary assessments completed and only two of these were fully documented in the care plan reflecting the care required.

Finding:

Assessments are not always being completed and it was not always evident that these assessments serve to form the basis of the service delivery plans.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Various treatment and care planning tools are in use across the services. These include clinical pathways and the 'A-D Planner'. Paediatrics have developed their own care plan, which is based on child specific assessments. Care plans are an evidence-based model and framework that clarifies what best practice, holistic, culturally responsive, person and whānau centred fundamental care should look and feel like. Plans are individualised, based on the initial and ongoing assessments and were mostly up to date (Refer criterion 1.3.4.2). Ward 26 has been piloting a new care plan, which was proving favourable with staff. The plan has an element of variance reporting to it and the area to document the narrative of the progress notes is on the reverse side of the care plans. Those sighted were completed daily and the care needs as detailed aligned with the patients' needs.

All health professionals involved in the care of the patient make entries in the progress notes, in relation to ongoing assessments, progress and updating of the plan. Medical and allied health staff document their interaction with the patient after each interaction. Multidisciplinary (MDT) reviews and planning meetings, either daily in some cases or weekly in others support this. In the surgical wards, the outcome of the MDT meeting was documented in the progress notes. Documentation of meetings reviewed provided evidence of a thorough and focused process. The shift handover at the bedside, in use in some areas, allows for the patient, and in some cases their families/ whānau, to be involved in the process and contribute to a patient focused approach. This was confirmed by tracer patients and families interviewed.

There was an example in the older persons' health service of a patient having had two swallow assessments and the diet plan updated accordingly in the progress notes by the speech language therapist; however, this change in diet was not transferred to the care plan or Trendcare. This was not found to be a systemic problem.

Staff discussed examples of where disciplines and services have worked together to ensure an integrated approach to care planning. This included involvement of the district nursing services, the specialist pain service and the Māori health team. The 'whiteboards' in the ward offices are also used as a quick reference to track and plan progress, including referrals, the expected date of discharge and specific risks. MDT meetings in mental health ward 21 were held daily and a weekly MDT meeting included the community team. This process contributed to a negotiated treatment plan that all service providers and the consumer committed to. The early warning signs and a relapse prevention plan were included in the risk management plan. The consumer knew the triggers, early warning signs and how to manage those in order to prevent relapses. Other consumer records and interviews showed that the established treatment planning processes were consistently applied.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Interventions required to meet the patients' needs are based on the initial assessment and ongoing re-assessment and are documented as part of the care planning process. Clinical records reviewed showed examples of interventions carried out as planned and prescribed such as daily weighs, glucose monitoring, special diets, use of pressure relieving devices and falls prevention strategies. Members of the MDT discuss progress for each patient, and the best interventions to respond to any changing needs. The medical patient followed using tracer methodology, who had recently suffered a stroke, had his care plan altered every week following the MDT meeting, depending on his progress. Family meetings are also held to keep the family/whānau up to date with progress. Decisions around the most appropriate interventions are based on results of diagnostic tests, recordings and other relevant clinical information. Specialist input is sought as was evident in files reviewed and from discussion with patients and families.

Evidence was sighted of a patient developing a wound and who was referred to and seen by the tissue viability nurse promptly. Detailed wound assessments were documented. The pain team were observed visiting another patient and making repeated adjustments of analgesia based on the patients underlying health condition and pain levels. Discussion occurred with another DHB cardiothoracic team related to a patient's presentation and guidance received for the management of the patient.

Interventions are provided using the least restrictive method within mental health services and these include moving a patient from seclusion to the open ward as soon as possible. Staff communicated positively with patients and included them in decision making related to planning and interventions. The MDT, including community-based services where necessary, are responsive to the changing needs of the patient. Patients and families reported being kept well informed about their illness, medications, treatment plan and support available to them in the community.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Activities meet the requirements of the individual patients; these are particular to the various specialty settings. Allied health staff are part of the MDT and examples of referrals to physiotherapists and occupational therapists were seen. Patients in medical and surgical services are supported with activities to promote rehabilitation and timely discharge. In the Assessment, Treatment and Rehabilitation (AT&R) service the allied health team play a key role in preparing patients for transition to more independent living through activities such as re-assessing ability to perform activities of daily living and home visits to assess for suitability of home environment.

Patients in the medical ward reported that their activities were all based around getting better and were observed reading, listening to the radio and working with staff to become as independent with their activities of daily living as is safe in preparation for going home. Following the principles of Mahi Tahi, the families are encouraged to be involved and provide support.

Patients and relatives interviewed in the paediatric service were positive about the access to a dedicated play area, the availability of age appropriate toys and activities. Staff and family/whānau discussed how they use the activities as distraction therapy during procedures.

In maternity services activities are based around developing parenting skills and confidence. Parenting education was provided at every opportunity such as baby bathing, settling baby, safe sleep programme encouraged, baby positioning and pepi pod use. Parents learn about baby clothing, napkin changing, making up infant formula if required and sterilising methodologies are demonstrated.

In the mental health area, there was sufficient space for the clients to move around freely. A music/ play station room was also on site. There are two rooms for interviews/ therapy rooms which can also be used for family/ whānau rooms if required when not in use. A room with a telephone is also provided to allow the consumers to make and receive private telephone calls.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA Low

Evidence:

Care and treatment were evaluated on an ongoing basis in all services visited. Records reviewed had evidence of evaluation occurring by those health professionals involved in the patients' care. This was documented either as part of the care plan or in the progress notes on a shift-by-shift basis. The frequency of evaluation and reassessment of patients is based on the acuity and progress of the patient. This varies between continual monitoring in the intensive and coronary care units, the high dependency unit, Post anaesthetic care unit (PACU) and emergency department (ED), to daily review of patients in the AT&R unit and as required in the mental health unit.

Access to specialist advice and support is available 24 hours a day, seven days a week to support ward staff with timely evaluation, this includes services such as the pain service and the ICU team. Tools to evaluate progress included laboratory and radiology services, the early warning score (EWS), regular observations and recording of vital signs, fluid balance charts, re-assessments using standardised assessment tools, and monitoring of wound healing. Related documentation was inconsistently completed across several services. This finding was also evidenced in MDHB own audit results. Fluid balance charts were totalled each day in the sampled records in the coronary care unit and Ward 28. Prescribed daily weighs were seen documented consistently on the medicine chart.

Neurological observations were seen to be undertaken following unwitnessed falls and for stroke patients. The DHB has changed the assessment of intravenous sites (IV) and now moved to phlebitis score. Staff were seen to be documenting these assessments and subsequent evaluations in the patient records. Sedation scores were also observed to undertaken when indicated. Paediatric areas and neonatal unit had appropriate child specific assessment tools, which are used continuously to assess the progress of the child. Tools from Starship hospital were in use. In the maternity services, evaluations were seen to be occurring at each point of contact with the mother and baby. Staff were well informed about the use of modified early warning score (MEWS) records and the escalation processes if needed. Lead maternity carer midwives are contacted if any changes observed with the women or the babies.

Where progress was not as expected there were examples of timely changes made. Staff reported that the use of the communication tool 'ISBAR' supported a thorough and objective way to pass on evaluation information. Detailed evaluations were documented by medical staff and allied health staff in records reviewed. The results of investigations are detailed in progress

notes. Summaries of electrocardiograms (ECG) had been documented on the ECG recording or a summary written in the progress notes. Where applicable telemetry monitoring reports were clearly documented.

In Ward 21, the effectiveness of service delivery was assessed at the regular MDT meetings. The standardised approach used provided a way of tracking the patients' treatment progress and identifying those interventions that were successful and those that were not. Changes to treatment plans were seen to be implemented based on progress. Patients interviewed were well informed about their treatment plans and their progress. Recovery plans usually started in the community were updated as needed. Relapse prevention plans were also sighted.

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

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

Attainment and Risk: PA Low

Evidence:

Within the surgical wards, of the twelve records reviewed, ten patients had a fluid balance chart commenced but none of the patients had a completed chart and only one had a chart totalled. This finding was supported by the ward audits that were regularly undertaken. This included two patients who had problems related to renal function. Early warning scores were also sighted to be inconsistently totalled and did not appear to always follow the guidelines as to when they should be increased according to the patient status. The PCA chart used within the ward also required recordings to be taken and a EWS score to be calculated; however, there was no guide as to the scorings that should have been captured. (PCA chart 2015 V 4). One of the patients followed using tracer methodology complained about being in constant pain; there was no evidence in the clinical record of their pain ever being evaluated following analgesia being administered to assess their response.

In the older persons' heath service, EWS charts were reviewed. One patient was constantly triggering a response due to their low blood pressure; however, a response was never escalated to the medical staff and there was no request for a modification made. Another patient had a score requiring an increase in observations; this was not done and was left to be repeated until the next day. Fluid balance charts sighted were not consistently totalled.

In mental health services the 24 hour care plan was to be evaluated every 24hours and the plan signed as verification that the current care had been evaluated each shift. This was inconsistently completed. In records reviewed, three out of eight files had no signatures on care plan.

In medical areas fluid balance charts were poorly completed and totalled, this included patients who were at risk of dehydration or it was clinically indicated. Five out of six records reviewed had incomplete fluid balance charts.

In Ward 23, vital signs are not being assessed as frequently as required by the EWS. One example included a patient post chemotherapy was febrile. A full set of vital signs was not undertaken for 13 hours. Two recordings of temperature recordings were noted in the interim.

Finding:

Evaluations are being inconsistently undertaken and the responses are not being documented to enable progression towards the desired outcome. For example, fluid balances are consistently not fully completed and early warning scores that should trigger a response were not always actioned.

Corrective Action:

Ensure evaluations are undertaken, indicating the degree of achievement or response to the interventions, and that these are clearly and consistently documented

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Medical and nursing staff interviewed discussed examples of referrals to other health services and how these were facilitated. This was supported in clinical records reviewed. Staff from other services are included in MDT reviews and can visit the patient to provide an assessment, advice and support when indicated such as the pain service or associated community teams. Ongoing referrals were seen to be made following the regular MDT meetings throughout the hospital. Evidence was sighted of referrals made to the diabetic team and palliative care team. Staff interviewed were able to explain the process of referral to internal or external services.

As needed women and /or baby are transferred from one service to another. The primary maternity services have a new ambulance transfer protocol, which was developed in partnership with maternity and ambulance services. The feedback has been positive on the new process.

Patients interviewed as part of the tracer methodology process felt involved in decisions about their care and discussed examples of where referrals had been made with their involvement. In the mental health services, families are asked if they would like to be referred to the Supporting Families services. Referrals to palliative care services are discussed with the patient and their families. Where patients are being discharged to an aged care facility, the social worker works with the family to discuss options and facilitate an appropriate assessment and referral process. Women in the maternity service spoke of services available to them in the community and that they have been provided with information, pamphlets, and in some cases referrals.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Discharge is a planned process, in collaboration with the patients and their families/ whānau. For those with a planned admission, discharge arrangements are discussed as part of the pre-assessment process and any particular needs catered for. For acute admissions, an estimated date of discharge is documented as soon as possible and any barriers to discharge are identified, documented and a discharge plan developed. For patients with more complex needs, the MDT works together to progress the discharge. Patients interviewed expressed satisfaction with the process and those who were about to be discharged felt well prepared. Examples of referrals and interventions to support a safe discharge were noted in clinical records reviewed, including an occupational therapy home assessment, and referral to district nursing services. For patients in the orthopaedic areas who are unable to reach their rehabilitation potential due to the requirement of their surgery, such as non- weight bearing for six weeks, there is the opportunity to go to a rest home for this period. At the end of this stay, they are assessed by a nurse as to the suitability for them to return to the hospital for rehabilitation.

The ISBAR tool is used for transferring women from one service to another in the maternity areas. Discharge planning occurs for both women and their babies when going home to the community. A discharge checklist is documented and checked off by the ward staff prior to discharge. Any follow up or ongoing support is arranged as necessary. A discharge summary was seen to be completed from both secondary and primary care services at the time of discharge.

In the medical areas, transfers were well documented; this included from ED to medical assessment and planning unit (MAPU) and then MAPU to a ward. The information was individualised and accurate including isolation precautions where required, unique patient risks were documented and the ongoing plan of care. Transfer forms are completed and faxed to the receiving ward in advance to assist the areas to prepare for the patient. Discharge planning commences on admission and is detailed in the narrative of progress notes, and in the discharge component of the A to D Planner, on the 'Miya board' in the ward office and the estimated date of discharge is noted on the patient whiteboard at the bedside. Patients and family/ whānau were mostly kept well informed of the plans.

Transfers from ED to the surgical wards were also of a high standard. Important and relevant information was given in the PACU area when transferring the patients to the ward following surgery. There are good communication mechanisms set up throughout the theatre environment to ensure that all relevant information is passed on to the appropriate people.

Plans reviewed in the mental health services were comprehensive with evidence of consumer and family involvement and paced with consideration of the patient's vulnerability to relapse. The risks involved in the inpatient to community transition for the patients were documented. Discussion with the patient and the family/ whānau member on how to mitigate those risks were confirmed during interviews with the patient reviewed using tracer methodology. Other patients interviewed confirmed that they and their families/whānau were involved in planning for discharge.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

MidCentral DHB provides a regional electroconvulsive therapy (ECT) service for patients for outpatients and patients in ward 21 and STAR 1. The mental health consult liaison nurse who has oversight of the process was interviewed. The mental health consult liaison nurse carries out education of the ward staff to ensure good processes are followed.

They provided a range of documentation which showed the processes meet the requirements of legislation and current Ministry guidelines. An average of eight to twelve patients receive ECT annually.

Patients are assessed for a course of ECT by a psychiatrist and seen by an anaesthetist and RN prior to each session. ECT is carried out in the theatre suite with recovery occurring in the post anaesthetic care unit. Documentation of ongoing assessment during the session and post session including the patient's recovery was sighted in two patients' files reviewed.

A comprehensive consent process is undertaken, and the mental health consult liaison nurse spoke of ensuring patients are aware they can refuse treatment at any stage of the process. This includes the risks and side effects associated with ECT. Some acute patients, under the Mental Health Act, have ECT without giving written consent.

Reporting occurs on each patient to the Ministry and copies of that information were sighted.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

The consumer shall be fully informed.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA High

Evidence:

The DHB wide Medicines and Therapeutic committee meets monthly. Minutes reviewed and members interviewed demonstrated involvement in emerging issues, projects, audit results, review and monitoring of errors and changes to practice. The aim is to promote safe, rational and cost-effective use of medicines at MDHB and to provide leadership in all matters relating to medicines management. The group is comprised of various medical officers, the chief pharmacist, an infectious disease physician, Executive Director of Nursing and Midwifery, a quality representative and a charge nurse or educator. Members of the committee interviewed discussed the frustrations of not having as much impact on practice as they would like and seeing very little improvement in prescribing and medication errors.

The national medication chart is in use and completed inconsistently throughout most areas of the hospitals visited. Prescribing practices do not always meet the standard required in particular the prescribing of pro re nata (PRN) medicines, cessation of discontinued medication, block dating the prescribing of medications and general legibility of prescribing.

Medication policies and procedures are in place and meet legislative requirements, with the exception of weekly controlled drug checks and quantity stock account checks. Administration practices observed and supporting documentation reviewed demonstrated noncompliance with many aspects of the medication policies.

Medicines are mostly stored in dedicated medicines areas, which were not always clean but mostly well organised with stock controlled by the pharmacy. Any specific medicines required for a patient are ordered from the pharmacy and delivered to the ward areas at regular intervals throughout the day. Patients own medication is placed in a green bag on admission and stored in the medication rooms. The tab is then placed in the patient record to prompt return on discharge. Practice varied around the hospital as to the returning of these drugs on discharge. A registered nurse was observed going through a discharge medication list with a patient prior to discharge and was explaining the changes that had been made. Some areas in the hospital have electronic medicine dispensers and staff interviewed reported that they liked this process and felt that they had improved medication safety.

A focus across the organisation on medicines reconciliation has led to an increase in reconciliation completed since the last audit. There are up-to-date internal policy and procedures for reconciliation. Prioritisation of reconciliation occurs due to available resource with a screening tool used to identify patients with risk factors. The form for medication reconciliation on

admission has been revised to easily record medication and clinical history. Recently there has been an increase of support provided to surgical services and this was evident in the charts reviewed. Pharmacy input was noticeable, a discussion was heard between junior medical staff, and a pharmacist who was advising them on better prescribing practice. It was evident that pharmacists are preventing many errors by being present on the wards and picking up early omissions in prescribing and incorrect prescribing. The hospital pharmacy remains under resourced according to the framework set out by the pharmacist's professional body.

There is a system to monitor and record the use of Section 25 and 29 medicines.

A patient in ward 29 was observed self-administering her inhaler medication. The medicine was kept at the patient's bedside, and staff checked with her regularly to see if she had administered any. The patient reported that she was responsible for ensuring that it was safely stored and was extremely happy and capable to manage her own medications whilst in hospital. No other evidence of self-medication was sighted on the days of audit.

In the paediatric area, where required, the paediatric calculation had been documented. There was evidence of pharmacy input for children being discharged on medication and education for parents.

In the mental health unit, the pharmacist attends the daily MDT meeting, evidence of their input was sighted in all medication charts reviewed. Consumers are assessed prior to being given inhalers to self-administer, under supervision of staff and kept in pharmacy. Daily checking of Controlled Drugs sighted in all CD registers checked. Medication rooms had temperature monitoring occurring as did drug fridges. Patients interviewed were familiar with their medications, possible side effects, and treatment plan. They felt involved in related decision-making. A continuum of care approach, involving the community health teams and services, is evident including consultation when changes to the treatment plan are being considered.

In Horowhenua, a well-organised medication room and imprest system was sighted. The controlled drug register was well managed with Quantity Stock Accounts completed at the bottom of the page.

The medication tracer was undertaken looking at the system. A tour of the pharmacy and a review of the policy and procedures mostly confirmed that the system was in place to maintain a safe medication management system. Pharmacy staff discussed the ongoing issues around the prescribing in medication charts. Much time is spent chasing up house officers prior to be able to dispense the prescribed medicines. The process for the transportation of medicines from pharmacy to the various wards is efficient and meets legislative requirements. There is analysis occurring of medication errors and changes implemented following the analysis. In the ward areas, there was a general feeling that medication safety was not a high priority. The issue appears to be multi-faceted but generally, there appeared to be a general casualness as to how medications are managed by clinicians. As the process was followed throughout ward areas and practices of concern were highlighted, there was a general acceptance that this could not be helped and was acceptable practice in a busy hospital. Some nursing staff interviewed could not see that drawn up opioids left in the safe for days was a risk, and took no responsibility for their colleagues practice. Registered nurses interviewed were not up to date with medication policies and procedures and were not concerned about the poor prescribing practices that were evident. Missing a dose of antibiotics that was prescribed was not seen to be relevant to a nurse caring for a patient when highlighted to her, and there was certainly no intention of raising an incident form. The antibiotic was given following this discussion; however, it was three hours after the prescribed time.

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

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

Attainment and Risk: PA High

Evidence:

Controlled Drugs:

The DHB's policy does not comply with legislation (there is confusion between the legislation and what the controlled drug registers direct to occur), MidCentral are currently exploring the correct procedure in regard to daily/weekly checks and the six month quantity stock account (QSA). These are currently only being signed off by one person.

One of the pharmacists did not complete the QSA correctly.

There was a lack of understanding and knowledge amongst nursing staff interviewed related to the Misuse of Drugs Act 1975 and its regulations 1977. They were not well informed of their responsibilities for the safekeeping and correct procedures for documentation in controlled drug registers.

The Emergency Department (ED) are not recording to whom the controlled drug scripts are being given. This is also occurring in the paediatric area where they are not recording when receiving the scripts from pharmacy or when given out to medical staff. These are for use in the children's clinic.

Patients own controlled drugs are being left in the drug safe for quite some time and are not included in any regular checks. This was sighted throughout the hospital

In the surgical area, two out of the three wards had drawn up unused opioids in a kidney dish in the safe. These were noted to have been there for many days. There is a process for discarding of unused opioids; however, this is not always being followed.

On review of the medications errors in the last year, many of these involved controlled drugs. Many were able to be rectified with further investigation; however, it demonstrated a general lack of regard for the management of controlled drugs.

Nursing staff were unsure of the process for returning controlled drugs to the pharmacy that had expired, or for discharged patients who had bought in their own controlled drugs, which had been left in the controlled drug safe on discharge. Whilst undertaking the medication systems tracer, in five different areas, patients' own controlled drugs were found remaining in the drug safe despite the patient's discharge. In four of the areas these controlled drugs had not be included in a weekly drug check.

Prescribing

Prescribing of medications was not of a high standard; multiple issues were identified through the audit process, examples being:

Illegibility of prescriptions

Incorrect prescribing of a pro re nata (PRN) medications such as lack of maximum dosages and indications for use; this was sighted in all areas of the hospital in nearly all charts reviewed.

There were downward arrows on the prescriptions indicating all prescribed medications on the same date as the first medication charted; this was also sighted in all areas of the hospital, in nearly all charts.

Date and signatures were rarely signed on the discontinuation of medicines

In paediatrics two examples were sighted where re-charted/changed medications had been written over the initial prescription.

Allergies were not always documented on the medication charts but were reported in the clinical record. Others were seen to be documented on the front cover of the medication chart but not followed through on the inside.

Signing of medications given via standing orders had not occurred in three out of three applicable medication charts reviewed in both the medical area and older persons' health.

Verbal orders sighted (three) were signed by two registered nurses but these were not signed by the prescriber of the verbal order; the orders were over 48 hours old.

At Horowhenua seven medication charts were reviewed and examples of were sighted of poor prescribing included: PRN medication (two) did not include maximum dose in 24 hours; one example of oxycodone not double signed; three examples where changes of medication were not initialled or dated by the prescriber – where these should have been recharted; bracketed dates. A patient transferred from Palmerston North had been given a prescription on discharge from that unit. This had been filled by the patient enroute to Horowhenua. Staff at Horowhenua were unaware of this and there was no record to indicate the patient was self-medicating and therefore no assessment of risks had been undertaken.

Storage

All areas reported that the medication rooms were centrally monitored; this was not the case. Only the central pharmacy has its ambient temperature monitored.

In the intensive care unit / high dependency area the medications are stored in an open cupboard; they are not secure. The chief pharmacist has spoken with the area about this, but no changes have made.

Medications were sighted being kept in the refrigerators; some of these were restricted medications and costly medications when the patients had been discharged. Insulin was sighted in refrigerators after the 30 days since it had been opened.

In older persons' health Star 4 there is a practice in the ward of the registered nurses placing medications in a pottle and entering the administration time on the chart. The pottle and chart remain in the medication room until administered later.

In the primary birthing unit, the medication cupboard is situated in a locked room, but the cupboard is not secured. The process for women to self-administer their own medications was not clear and women kept their medications on the lockers.

Practice/Culture

House officers spoken with reported they had had little education on how to prescribe at MDHB and that the time given at the orientation on this process was insufficient. Three house officers out of six spoken with had only worked in the South Island and were used to an electronic system and found the prescribing at MDHB difficult especially as they reported being busy.

Nurses interviewed did not display a high level of knowledge in relation to correct medication management and were accepting of examples of poor prescribing, being more focussed on providing care to their patients.

Pharmacy reported poor prescribing as a big issue for them and that they spend much time tracking down house officers to re-prescribe medication prior to the pharmacy being able to dispense. Medicine and therapeutic committee members spoken with expressed concern related to medication management; however, had been unable to have much influence on change of practices.

Finding:

Medication management systems are in place to ensure the safe and appropriate prescribing, dispensing, administration, storage and disposal of medications mostly complied with legislation, protocols and guidelines; however, practice did not always comply with the systems as described. These shortfalls are long standing and have seen minimal improvement over the years.

Corrective Action:

Medicine management complies with legislation, protocols and guidelines.

Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

At the time of audit, the food service was transitioning to a new provider (30 November 2020). The current manager, a dietitian and a member of the kitchen staff were interviewed. Both Palmerston North and Horowhenua hospital services have been verified as complying with a documented food safety programme/plan. Areas that required attention following the audit have been addressed. The kitchen was visited, and the required processes and facilities were evident.

A comprehensive range of diets/menus are provided with diets ordered via Trendcare (the patient management system). Diets comply with food and nutrition guidelines. A flow chart in relation to assessing cultural needs in relation to food is used. A malnutrition screening tool is also in use (MUST) which is incorporated into the risk assessment tool. Special diets can be catered for with referrals made to the dietitian service as and when needed; this normally follows an initial nursing assessment. Food service assistants (FSAs) support patients with food choices on the ward.

Patients interviewed were happy with the food, including parents of children. One parent who stays with a child is provided with a meal and a volunteer group provides snacks in the parents' room. In the neonatal service a good feeding regime prescribed by medical staff was in use.

The 'red tray' initiative supports staff to monitor those patients with specific food and fluid intake needs. This was noted to be well utilised in the clinical areas.

In the Te Papaioea Birthing Unit women can access breakfast in a kitchen dining area in their own time between 7am and 10am. Food is transported to the facility from the main hospital site. Any special dietary requests are obtained as part of the admission process and can be accommodated. Additional food is available over the 24-hour period.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

Attainment and Risk: FA

Evidence:

Waste management practice follows the principles of the safe management of waste in accordance with NZS 4303:2002. A waste management guideline policy includes definitions, transport of waste, health and safety, categories of waste, segregation and disposal, containerisation, and spill kits. All waste is placed in the dirty utility room. Waste is currently managed, together with cleaning and food services, by Spotless under contract. These contracts have been re-tendered and a new provider is pending.

There are effective systems in place to manage hazardous substances including designated trained HZNO handlers at both sites. Material safety data sheets are available where hazardous substances are stored. There is a hazardous substances register. Chemicals used on site use a smart dose system to prevent over application. Spill kits are available around the site.

Personal protective equipment and clothing is available to staff when handling waste or hazardous substances, including in the Te Papaioea Birthing Unit. Staff in various disciplines are observed to be using personal protective equipment as required and gloves, aprons, and goggles are available where required in the workplace. This is available in ward areas as well as waste collection points at the site.

There are well established processes in place including for staff training through the Spotless programme and site-relevant operating information. Regular monitoring records are reported to the DHB. Orderlies who work full-time are offered training in the national certificate for orderlies which includes a specific unit standard for handling medical waste including cytotoxic material, as part of the site induction process.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: PA Moderate

Evidence:

All regulatory requirements for the facilities are in place. This includes the building warrants of fitness which are well-managed and current. Medical gases, theatre and general air quality have all been monitored and records were available supporting their compliance.

Parts of the hospital have been upgraded as part of planned maintenance. For example, the paediatric unit had recently had a repaint and new, age appropriate, decals being put up which had made it bright and welcoming for children. A stock-take of isolation rooms was also taken and some retrofitting of HEPA filters undertaken in preparation for the expected surge of patients with Covid-19.

The condition of DHB facilities is captured in an asset management database and, overall, the current condition of facilities reflects the age and functionality of old healthcare buildings and the added pressure of high demand for beds. Strategic planning for the future development of the site has commenced. Some areas of the physical environment within MidCentral DHB require careful management to ensure the risk of harm is minimised and the environment is appropriate to the needs of patients. This is an area for improvement. Some reconfiguration is already underway with relocation of the STAR 2 and the renal wards,

Electrical testing and calibration of biomedical and other equipment is lagging significantly behind schedule. A remedial programme is planned for the next three months and, from February 2021, biomedical testing will be managed in house. Body and cardiac protected areas are tested according to requirements.

Planned and remedial maintenance occurs. The Building and Engineering Information Management System (BEIMS) system is used to manage equipment maintenance and provides an overview of a range of automated functions such as temperature monitoring and water quality. BEIMS performance KPIs are reported monthly. On call staff monitor facilities out of hours. There is some ageing equipment requiring replacement, such as fluoroscopy equipment in the radiology department, and other examples in which necessary equipment has been away for servicing for an extended period (e.g., ceiling hoists from Horowhenua and Palmerston North sites have not been available for some months, in spite of the demand for management of bariatric patients).

Ongoing issues with storage, particularly of large equipment, has led to clutter which, in some cases, is left in corridors. The neonatal unit is small and has required a review of the limited storage available. There is limited external space for patient use at the Palmerston North site, however some modifications are being made for STAR 2 patients to access a secure external area as part of the recent relocation. Overall, there is insufficient storage, with items/equipment stored in the corridor in ward 26, 28, MAPU and oncology. In ward 23 (oncology/renal) a four-bed room has been made into an interim renal dialysis unit. There are chairs placed blocking one of the exits from the room.

The Mental Health Unit (Ward 21) has an outside area which is well used by patients but lacks shade on hot days. In Horowhenua, there are accessible external areas from the ward lounge. External space is limited in Palmerston North where ward areas are not located on the ground floor.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

Records of biomedical testing indicate that checks are 54% compliant with the required testing regime.

Examples of noncompliance identified included but was not limited to:

- Infusion and syringe pumps in wards 26, 28, CCU, MAPU
- Pulse oximeters (two)and a sphygmomanometer in mental health

A transition plan is in place to manage updating the equipment checks via an external contract through to Feb 2021 when the management of biomedical equipment will be brought in house. In some wards, the charge nurses are keeping lists of equipment which require or are overdue testing.

Finding:

Biomedical equipment performance monitoring checks across the organisation have fallen behind schedule.

Corrective Action:

Implement and maintain a robust system to ensure biomedical testing is carried out according to the schedule.

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Adequacy of storage for equipment and other large items in corridors does not enable efficient workflows in several areas of the Palmerston North site.

In the paediatric ward, the dirty utility room is small and it is difficult to maintain clean and dirty designated areas. Full waste bags including biomedical waste were built up and detergent was stored on the floor.

The mental health areas, including STAR 1, are not conducive to a therapeutic environment in terms of their layout. The acute mental health area is divided into a high dependency unit (HDU) and an open ward. Both areas are not conducive to a therapeutic environment and this has been recognised with funding being approved for a new unit. The nursing station is a raised area, with a closed gate to prevent patients' access. This means staff look down on patients who come to the area for assistance or to talk to staff. Planning for the rebuild has begun and is likely to take two years to complete. New furnishings have been bought for the HDU to try to improve the environment. There are a number of areas that require painting, particularly the inside of the HDU room doors which have graffiti. This is a constant challenge. Privacy for mental health court attendees (except those in HDU) has improved since the previous audit; however, has not been fully addressed due to physical constraints of the area. A room is available for sensory modulation. It is over-crowded with equipment and needs modification to meet the needs of the clients.

Urgent changes were made to ventilation systems in theatre, ward 24 and ICU/HDU in response to the Covid-19 pandemic. There is variation in understanding of staff and managers of what result the ventilation changes are able to provide, with some reporting it gives negative pressure and other staff/managers noting it gives increased air flow. The top of these ventilation units in some rooms in ward 24 were visibly dusty. The ventilation systems are in each room in ward 24 (single rooms and multi bedrooms), however not in bathroom areas. Temporary walls were installed in some areas and in ICU/HDU some ceiling mounted air-inlets were observed to be covered. The ventilation units are not turned on in ward 24 and theatre but were in use in ICU/HDU. Staff and managers interviewed in MAPU, ICU/HDU, and ward 24 and the infection prevention and control team did not have a clear plan of what interventions/steps were required to be implemented in the event of Covid-19 re-emergence.

A patient was in a negative pressure room in airborne isolation in OPAL ward. The pressure gauge on the outside of the room did not show negative pressure is occurring. The charge nurse escalated this to building/maintenance services for review during the audit. It was unclear if there was an issue with the gauge reading accurately or if negative pressure was not occurring. The doors to the room, and anteroom were shut, and staff advised the doors had not been opened recently. The gauge remained at neutral pressure when rechecked by the auditor after approximately 30 minutes.

The seven members of the infection prevention and control committee interviewed advised they are not consulted in a timely manner about building design and renovation projects or when the model of care is planned on being changed. When consulted it is often nearer the end of a project and recommended changes are not always able to be incorporated into the final design. An example is of a negative pressure isolation room not able to be included in the new renal unit design, due to the building ‘footprint’ despite IP&CC recommendation. The IP&C team advised they were consulted about changes to STAR 1 well after changes were made to the building footprint. However, this is not a systemic issue but does provide an opportunity to involve the IPCC team in the early stage of planning. The suitability of building changes and arrangements put in place for Covid-19 requires review.

The Te Papaioea Birthing Unit has 11 spacious rooms that are used for labour, birthing and post-natal stays. One smaller unit, without a bath, is used for post-natal stays only. The environment is comfortable and fit for purpose.

Finding:

Aspects of the physical environment within MidCentral DHB pose some risk of harm or are not appropriate to the needs of patients or staff. This includes recent alterations to ventilation systems and negative pressure rooms, and storage and waste management, including layout of some dirty utility rooms.

Corrective Action:

Review current systems for utility rooms, storage and waste management and make improvements to maximise the safety of patients and include any learnings in planning for new buildings or upgrades in clinical service areas.

Review the status of negative pressure rooms and ventilation system changes in association with the IPC team to ensure they are functioning effectively.

Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Clinical areas have adequate toilet and bathing facilities which are readily accessible. Patients can maintain their privacy and report no concerns. Hot water is available in all bathrooms and bedrooms and the temperature is monitored. Alcohol-based hand gels are widely available to support hand hygiene and visitors are seen to be using this along with staff, including at entry to ward areas. Each clinical area undertakes environmental audits and follow up actions are reported, and improvements requested via the BEIMS maintenance system. Some of the wards have recently had refurbishments to the bathroom areas, and those sighted at audit at both sites are in generally good repair. Ongoing maintenance occurs when required. Shared bathrooms are spacious and enable the use of equipment and the presence of support persons.

ICU/HDU has two negative pressure isolation rooms with ante rooms and is resourced for six patients. There is one patient bathroom in this area. This limitation is becoming a challenge, with the increase of ambulatory patients in the unit as a consequence of delayed transfer to the ward.

Eleven of the 12 rooms in the Te Papaioea Birthing Unit have their own ensuite bathrooms within the room. A large bath with an overhead shower and a toilet and hand basin can be screened off to provide privacy. The baths are large for women to labour and/or birth in. Rails are around two sides of the bath and steps are available for entering and exiting the bath. Visitor and staff bathrooms with a shower and area to change babies and younger children are also available.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

There is adequate space around all beds so that patients can move freely, including with mobility aids, except in MAPU. Some single rooms are available, but most rooms are four bedded in the surgical and medical wards. Where possible, men and women are placed in same gender rooms. A procedure guides management if this is not possible.

The mental health unit has ensuites for eight of the 28 rooms. All NHU rooms have ensuites. Paediatrics had adequate toilets and showers with some single ensuites, and others shared between two rooms. There were visitors and staff toilets available.

Overall, the ward areas reflect the age and design of the buildings and some ward areas are challenging for staff to work in. MAPU is cramped, with beds close together and with limited space for family and equipment. There are no appropriate facilities for isolation available in MAPU and future plans do not include these. Currently, patients are cared for in a multi bed room with a sign on the curtain. If a single room is required, the patient is sent from ED to a ward. These areas have inadequate space for storage of equipment and clinical consumables, limited bathrooms and none of the bedspaces are set up for bariatric patients in the draft plans sighted.

STAR 1 has rooms of a good size and two have ensuites of a reasonable size to allow ease of movement of a patient with mobility aids and staff supervising.

In Horowhenua, there are ‘parking spaces’ available for larger items such as hoists which need charging. There was also an example of a bariatric bed hired during an inpatient stay. There was still adequate space to manoeuvre beds and equipment in the space. Placement of patients in four-bedroom units considers their needs and any equipment required.

In Te Papaioea Birthing Unit there is plenty of space in each room to meet the needs of women and their whānau and for staff to safely provide care.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

All wards have communal areas and places where patients can receive visitors. The medical and surgical wards have less space available and this is managed within the constraints of patient numbers and space. Most wards have dining spaces and a TV area, including mental health, paediatric ward, and the STAR wards.

The maternity wards, including the primary birthing units at Palmerston North and Horowhenua, have space for whānau. There is a dedicated play space in the children’s ward.

The paediatric unit has a well-stocked playroom with toys for different age groups. These are available for staff and parents to use, as there is no play therapist. There is a family room for parents to use during the day, and snacks are provided by a volunteer organisation. One parent is encouraged to stay with each child and a fold down bed is provided.

Visiting hours are 10am – 8pm; however, there were visiting restrictions imposed during levels 3 & 4 of the Covid-19 lockdown which are now relaxed.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

At the time of audit, the cleaning is provided under a contract with an external provider. The organisation is working through a change process to a new provider. Laundry services are provided by Allied Laundry Services with the laundry facility on site at Palmerston North. The manager of the laundry service and the manager of the current cleaning service were interviewed.

The cleaning contractor has a regime of regular cleaning audits using a specialist audit tool. These reports were sighted and identified there is a high level of compliance with cleaning requirements. Cleaning staff are trained during orientation and ongoing with around 60% having achieved a level 4 NZQA qualification and the rest of the team are working towards this qualification. The cleaning manual was sighted and provides comprehensive information. This has been developed with input from the infection prevention and control (IPC) coordinator. The supervisor reported effective links with the IPC coordinator. The team worked with the IPC coordinator during the Covid-19 response and extra training was provided to all cleaning staff (sighted). This included safe and effective use of PPE.

The cleaning trollies sighted were well equipped and orderly and safely stored. Material safety data sheets for chemicals used are available. With a few exceptions noted, appropriate cleaning practices were observed throughout the clinical areas visited.

Adequate supplies of clean linen are delivered to the services on a regular basis. Clinical areas have an agreed stock which can be adjusted if required. There are additional supplies available for use in emergency or due to increased patient numbers and need. Linen was generally stored safely, with some exceptions noted of overloaded trollies that were not covered. The soiled linen is removed from the service areas in a timely manner; however, examples of overcrowding in sluice room areas was noted (refer 1.4.2).

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

MDHB has an evacuation plan in place for each of its buildings in accordance with the approved fire evacuation plan. Spotless conduct ongoing evacuation training sessions as part of fire evacuation training. A small number (six) are overdue, but a scheduled trial is planned for October 15, 2020 at the Palmerston North site. At Horowhenua, recent fire evacuations have been undertaken in association with local volunteer Fire Brigade exercises. Security and fire safety sessions are part of new staff induction. An emergency warning intercom system (EWIS) assists communication with all inpatient areas in the main block in the event of emergencies.

Security is contracted to Spotless and is part of the integrated facilities management and hotel services arrangement between MidCentral and Whanganui DHB. There is 24-hours, seven days per week coverage in the Emergency Department and across the facility by the security team. Incidents are recorded in the security database and Riskman, with reporting visible to management. Security cameras are positioned to monitor the external doors into the wards.

Alternative energy and utility sources are available at both sites and were inspected as part of the audit. Boilers are well maintained. Additional capacity for diesel storage has been added at the Palmerston North site, providing a supply for at least two weeks at full capacity. Medical gas storage is in accordance with regulation and manifolds checked in August 2020. Water temperatures are monitored, and tempering valves control the water temperatures throughout the buildings.

At Horowhenua, a gas and diesel boiler provide a five-day backup for heating of the facility. The service is on a priority list for ‘top up’ in the event of ongoing supply failures. Two 25,000 Litre tanks provide a water supply for up to nine days.

Results of air quality testing are recorded, and any follow-up action completed. Records are well maintained.

The emergency management policy provides a framework for business continuity management at the MidCentral DHB. It uses the CIMS, coordinated incident management system, and describes the role of the emergency operations centre (EOC) and the IMT (incident management team.) An emergency operation centre is located on site and has been activated on a number of occasions since the previous audit.

Emergency trolleys are regularly checked. More recently, yellow infection control trolleys have been commissioned in key parts of both hospitals in response to Covid 19. Training records reviewed indicate that staff are meeting mandatory training requirements and, where appropriate, emergency training included in the orientation programme. These records demonstrate that most staff have attended their mandatory two-yearly training which includes emergency systems. Emergency response procedures flipcharts are in place in work areas.

In Te Papaioea Birthing Unit staff have been provided with training to meet obstetric emergencies. The necessary equipment is available and is checked daily. 'Grab bags' are available (eg, for post-partum haemorrhage). A neopuff/resuscitaire is available for baby resuscitation and is placed outside a room if a woman is in labour, for easy access. Full assistance is provided by core midwifery staff should an emergency arise and can assist with any transfer. Obstetrician support is always available. Security systems ensure mothers, babies and staff are safe and includes access from the lower ground by lift to the first floor. An afterhours button is available to summon staff. Swipe card access for all staff throughout the building is required. Contractors and visitors sign in on arrival to the centre.

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

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

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

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

Attainment and Risk: FA

Evidence:

All patient rooms have natural light, heating, and ventilation. Regular checks and maintenance are carried out to ensure heating and ventilation are optimal. Patients report the temperature is comfortable in ward areas. In the mental health unit, the whānau room is small, dark, and windowless.

The heating, ventilation and air conditioning systems are regularly maintained.

In Te Papaioea Birthing Unit all rooms have external windows and adequate light. Heat pumps are in all individual women's rooms. Other areas are controlled centrally and were at a comfortable temperature.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

Attainment and Risk: PA Low

Evidence:

Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. These have been recently updated with a clear focus on the minimisation of restraint. The restraint approval group (RAG), has wide representation, including a consumer representative and a person who provides a 'bi-cultural lens' to support culturally appropriate processes. This group oversees developments and practice with an increase in the frequency of meetings from quarterly to monthly. Minutes reviewed demonstrated good attendance and several improvements over the past year focused on reducing restraint.

Restraint was used as a last resort when all alternatives had been explored. This was evident on review of the RAG minutes, in clinical files and the Riskman system and from interviews with staff. Staff and members of the RAG discussed an increased array of tools available to staff to provide alternatives (eg, sensory modulation, quiet area spaces available, kete kit/distraction boxes, increased use of whānau, use of one to one observation/'safety companion' and improved access to education). There is increased support available from the Māori health team who support the mental health service using weekly waiata and supporting individual patients and families/whānau. In Star 1 a room is available for sensory modulation; however, it is overcrowded with equipment and needs modification to meet the needs of the patients (refer CAR 1.4.2.4)

Staff spoken to were aware of the difference between restraints and enablers.

Bedrails were in use in most areas visited around the hospitals. With a few exceptions (Horowhenua and Star 2), there was little or no documentation sighted to indicate that the rails were being used voluntarily and that this was safe.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: PA Low

Evidence:

Bedrails were being used in many areas around the hospital wards visited. Staff were aware of the difference between a restraint and an enabler. While there was no indication that bedrails were compromising patient safety, there was little documentation noted in the clinical record (with the exception of Horowhenua Health Centre and Star 2) that these had been requested

by the patient, that an assessment regarding their safety had been made and that this had been reviewed as appropriate. The enabler policy states that this should be documented in the care plan and progress notes.

Audit results of enabler practice also supported this finding, which was as low as 10 percent compliance in one area visited. Several patients interviewed indicated they had requested the bed rails be raised for safety, security and to attach a call bell to.

Finding:

There was little documentation noted in the clinical record (with the exception of Horowhenua Health Centre and Star 2) that bedrails had been requested by the patient, that an assessment regarding their safety had been made and that this had been reviewed as appropriate.

Corrective Action:

The use of enablers is documented as defined within the MDHB enabler policy.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

Attainment and Risk: FA

Evidence:

The RAG provides oversight of the restraint minimisation and safe practice (RMSP) policies and procedures, training, restraint definitions and types, and monitors use of restraint. The use of physical restraints is no longer permitted at MDHB. The focus is on reduction and avoidance of restraint. The paediatric service has a policy which includes 'secure safe positioning of children for procedures'; this was discussed by the paediatric representative on the RAG.

Any staff member who uses restraint must be trained and this includes security staff who have attended the SPEC (Safe Practice Effective Communication) programme. There are three levels of training offered; level 1 'CALM' an online programme offered through 'Ko Awatea'; level 2 'Essential Skills' which is a one day programme for all RNs; and level 3 which is the SPEC programme for those within the mental health service and security staff. The level 2 programme has recently been modified with the new programme recommencing in November. There were some delays in training of this programme during the Covid-19 restrictions.

The restraint coordinator role has been replaced by a 'restraint team' of three people with responsibilities defined within the policy. These meet the requirements of the standard. The clinical board review and approve the RAG reports to ensure compliance with RMSP standards. The yearly report to the clinical board from the RAG was sighted and shows a robust analysis of data and trends, which indicates a reduction in the total use of restraints across the organisation (June 2019 to June 2020).

All restraint episodes are recorded on Riskman and events reviewed showed the forms used for this process were consistently completed.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

Attainment and Risk: FA

Evidence:

The Restraint Minimisation and Safe Practice policy and associated documents sets out the guidelines for safe restraint practice, expected documentation guidelines, and the evaluation procedure. Documentation reviewed in the Riskman electronic database (nine examples from a variety of settings including ED, ICU, Star 1, Star 2, MAPU and operating theatre) showed that a comprehensive assessment of the patient was undertaken. In ward 21 (mental health services) evidence was sighted of completion of assessments to ensure restraint was minimised. This may be completed prior to admission for patients who were being admitted via the police, as sighted in examples reviewed.

Patients have access to advocacy services and cultural advisors as confirmed by the representative on the RAG from the Māori health team. Examples of this were provided.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

Attainment and Risk: FA

Evidence:

All episodes of restraint are required to be reported via the electronic incident management system Riskman, as verified by staff and managers interviewed. This functions as the restraint register and enables key staff to review details of the reported events. Restraint is only used by trained staff as a last resort and for the shortest and safest duration. Sixteen restraint related events were reviewed: ten in mental health services (Wards 21 and Star 1), and six in non-mental health service areas. In several examples reviewed in the non-mental health services security staff were part of the team working as directed by the person in charge of managing the event. In one case reviewed in ICU, 'mittens' were used to prevent a patient removing tubes; however, this type of equipment is no longer considered appropriate in the DHB, as stated in the updated policy. Through review of this episode by the RAG team members, the team are working with the department to educate staff and find other approaches to safely manage care in these situations.

Episodes reviewed in ward 21 showed restraint was applied for the least amount of time required, for example, one minute and five minutes to give medication. Some episodes were longer usually to move the patient towards seclusion. One mental health patient who had surgery was being cared for following surgery in ICU supported by a healthcare assistant and RN from the mental health service. There were multiple episodes of restraint recorded for this patient and each episode was completed to meet the requirements of the standard. There was evidence of the associate charge nurse making comments on any documentation where deficits were identified. In Star 1 four events were reviewed and all areas were completed to meet the requirements of the standard.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

Attainment and Risk: FA

Evidence:

All episodes of restraint are reviewed by the charge nurse of the area and then reviewed by one of the restraint team, involving additional staff where applicable. The review includes whether staff acted appropriately to manage the reported events, whether the least restrictive options were used, if the patient and whānau were involved in the review, if cultural needs were met and future action required and taken to prevent recurrence of the use of restraint. Risks are identified. Any required changes to the patient's plan of care is noted. Assessing the impact on the patient is also included. All episodes reviewed showed evaluations have been completed according to requirements of the standard. In the mental health service, the associate director of nursing (ADON) has carried out an audit of the evaluation of restraint and there are plans to use this audit process in all areas of the hospital.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

Attainment and Risk: FA

Evidence:

The RAG committee meet monthly and this includes a review of all reported restraint and seclusion events. Audit of restraint events is in development with this already occurring in ward 21 and the plan to audit quarterly in all areas. The tool to be used is in development. A restraint dashboard report with commentary is prepared quarterly for the RAG meeting to monitor trends. Education, audit activity, documentation, policy and procedure changes and trends are all discussed at the RAG, as noted in minutes reviewed and from discussion with members of the RAG. A yearly report to the clinical board (July 2020) showed an overall reduction in restraint use, the top 5 locations where restraint is used, and detailed use for those areas where restraint use is more common (eg, ward 21, Star 1 and the emergency department).

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Outcome 2.3: Seclusion

Consumers receive services in the least restrictive manner.

Standard 2.3.1: Safe Seclusion Use (HDS(RMSP)S.2008:2.3.1)

Services demonstrate that all use of seclusion is for safety reasons only.

Attainment and Risk: FA

Evidence:

There are comprehensive policies which cover the use of seclusion, in line with current legislation. Currently, the High Dependence Unit (HDU) has two seclusion rooms which have been approved by the Director of Area Mental Health Services (the certificates were sighted). The unit is planning to reduce to one room in the near future and no seclusion rooms are planned for the new unit. This is in line with their zero-seclusion plan. There is a zero seclusion 2020 action group, which includes a Māori representative and is linked to the national programme. Monitoring includes individual seclusion episodes and overall seclusion rates. Reports go to the RAG, clinical governance group and the Health Quality and Safety Commission. The rate of seclusion is trending down with no seclusion used for 30 days being reported in September/October.

Seclusion documentation includes a description of the event and the reason for seclusion, including interventions used prior to seclusion and if restraint was used. The details include input from the initiating clinicians, including consultation with the consultant. Ten-minute observations are documented as well as ongoing assessment which includes medical assessment every eight hours. There is an area for seclusion feedback and evaluation which includes a description of seclusion debriefing with the patient and suggestions for next time. Two files (including tracer 7) of patients who had an episode of seclusion were reviewed and demonstrated documentation was consistently completed.

Criterion 2.3.1.1 (HDS(RMSP)S.2008:2.3.1.1)

The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.1.2 (HDS(RMSP)S.2008:2.3.1.2)

Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.1.3 (HDS(RMSP)S.2008:2.3.1.3)

There exists a legal basis for each episode of seclusion.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.1.4 (HDS(RMSP)S.2008:2.3.1.4)

Any factors that may require caution must be assessed for each episode.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.1.5 (HDS(RMSP)S.2008:2.3.1.5)

The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 2.3.2: Approved Seclusion Rooms (HDS(RMSP)S.2008:2.3.2)

Seclusion only occurs in an approved and designated seclusion room.

Attainment and Risk: FA

Evidence:

The two seclusion rooms were visited. On the days of audit, they were being used by patients who were not in seclusion but in need of intensive monitoring (See CAR 1.4.2.4). The room doors were open and patients were able to exit into the high dependence area and outside area.

The rooms had natural lighting, were warm and ventilation systems were in place. Call bells are in place in case the patient requires assistance. The observation windows were high up on the doors and blinds in the window allow a degree of privacy. The furnishings and fittings were appropriate for safety, with ensuite toilet and shower facilities. Ten-minute observations allowed staff to be alert to the needs of the patients in seclusion.

Criterion 2.3.2.1 (HDS(RMSP)S.2008:2.3.2.1)

The seclusion room provides adequate lighting, room temperature, and ventilation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.2.2 (HDS(RMSP)S.2008:2.3.2.2)

The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.2.3 (HDS(RMSP)S.2008:2.3.2.3)

The seclusion room provides a means for the consumer to effectively call for attention.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 2.3.2.4 (HDS(RMSP)S.2008:2.3.2.4)

The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

Attainment and Risk: FA

Evidence:

There is a documented overarching infection prevention and control (IP&C) programme for the period 2020 to 2021. The IP&C programme has been developed by the infection prevention and control team and endorsed by the infection prevention and control committee (IP&CC). Reporting lines for the infection prevention and control team are defined. The clinical nurse specialist (CNS) IP&C, administrator, and the registered nurse (RN) IP&C report to the nurse manager infection prevention and control, who in turn reports to the executive director of nursing and midwifery.

The infection prevention and control committee meet every second month and reports to the chair of the clinical board. Terms of reference for the committee have been recently reviewed and updated and await review and approval / amendment by the clinical board. The committee reports twice a year to the clinical board via a written report. This includes projects undertaken, risk issues, the challenges around aging infrastructure, outbreak management and future planning. There is ongoing review of progress towards achieving the IPC team and IP&CC goals. Urgent issues are escalated to management. Committee representation includes a consumer representative. The consumer representative, and six other members of the committee were interviewed. Three IP&CC meeting minutes and the most recent six-monthly report to the clinical board were reviewed.

The nurse manager IP&C provides a monthly report to the IP&CC. This includes hand hygiene compliance data, surveillance results (including surgical site infections, hospital acquired blood stream infections, occupational health investigations, follow up and vaccination data, number of reported blood and body fluid exposures, projects, and follow-up of actions/updates required from previous reports.

There is a staff vaccination programme which is facilitated by the infection prevention and control team. The staff health programme includes pre-employment screening, contract tracing, blood and body fluid exposure follow-up and vaccinations. Vaccinations offered include influenza, hepatitis B, boostrix, and mumps, measles and rubella (MMR). External vaccinators were utilised to help with the staff influenza vaccination programme in 2020. There was an improvement with 61% of staff vaccinated.

A member of the IP&C team monitors patients admitted with multi-drug resistant organisms (MDROs), follow-up any patients who are in isolation as reported on the shift Trendcare reports, and electronic whiteboard records, and the admission data from the patient management system (PMS). A daily visit to each ward is conducted to follow up with staff. The IP&C team maintain an accumulative data base of all patients with infection control related alerts. This includes patient demographic data, details of the alert, and the results of previous laboratory or other investigations that have been deemed significant.

There was an outbreak of Methicillin Resistant Staphylococcus Aureus (MRSA) infection in May and June 2020 in the neonatal unit (NNU). A total of 11 positive results were received from the infants, parents and staff screened. The investigation, actions taken, and the ongoing monitoring plan was sighted.

Significant work has been undertaken by the DHB in relation to Covid-19 pandemic. This includes (but is not limited to) staff training (refer to 3.4), obtaining engineering/ventilation engineering advice and retro-fitting ventilation ducts and temporary walls to ICU/HDU, the operating theatre and ward 24, restricting /monitoring hospital access (depending on the alert level in place), social distancing, and symptom screening. Staff and some managers in these units are unsure what effect the changes made to ventilation, and some of the temporary walls have been removed. Staff and some managers were unsure what environmental changes would need to be done if Covid -19 remerges in the community. Some of the ventilation ducts above bed spaces were visibly dusty. The seven members of the infection prevention and control committee advised they are not always consulted on renovation, refurbishment and site

development planning in a timely manner, and examples discussed. The new ED/MAPU pods (30 beds), in the final stages of design have insufficient handwashing facilities, no designated isolation areas, insufficient equipment and clinical consumable storage and bed spaces that are not adequately sized for patients requiring bariatric supports. The dirty utility rooms in several wards were cluttered with full rubbish bins and laundry bags. These issues are raised as an area for improvement in criterion 1.4.2.4.

Infection prevention and control tracer - The systems related to the identification, communication and implementation of transmission-based isolation precautions was reviewed via the tracer methodology process. Interviews were conducted with the nurse manager and CNS IP&C, the infectious disease physician, the antimicrobial stewardship pharmacist, clinical pharmacists, the consumer representative and a quality improvement representative. Additional interviews took place with clinical nurse managers, a ward based clinical pharmacist, and ward nursing, medical and cleaning staff. In addition, patient records and patient placement was reviewed. A daily report is printed weekdays by the IP&C CNS's detailing which patients are reported to be in isolation and the information is followed up at ward/unit level. A review of the current data along with a visit to the medical admissions and planning unit (MAPU), ward 24, ward 25 (OPAL), ward 28, ward 29, and the intensive care/high dependency unit (ICU/HDU) occurred. Infection prevention and control practices were also reviewed in ward 26 and ward 28/coronary care unit (CCU), during the two medical patient tracers', and by all other auditors including at Horowhenua Health.

Single rooms are used where able for the care of patients in isolation, and when not available patients are placed in multi-bed rooms with signs attached to the bed space curtain, or the personal protective equipment (PPE) stand that is placed just outside the applicable curtain space. The PPE stands and PPE trolleys have been recently purchased by the DHB. Appropriate supplies of personal protective equipment (PPE) were available in all areas. The correct signage identifying the isolation precautions required was present on all applicable patient bedroom doors or bedspace curtains.

Negative pressure isolation rooms are present in the emergency department and intensive care unit with one each. Wards 26, 27,29 and OPAL have two negative pressure isolation rooms each. There are two negative pressure rooms in the neonate unit (without an anteroom) and two at Horowhenua Health. There was one room dedicated for isolation, with positive pressure and an anteroom in the children's ward.

A cleaner was interviewed and could detail how isolation rooms are required to be cleaned and this aligned with DHB policy sighted.

Eleven of the patients in isolation in the wards visited had their files reviewed and the isolation precautions in use were observed. This is in addition to the information sighted by the other auditors. The patients were in isolation with a confirmed multi-drug resistant organism (MDRO) that required isolation, a suspected respiratory pathogen, or gastroenteritis symptoms. Communication from the laboratory to the ward staff was very timely when the results confirmed a patient had significant result. In the event patients are admitted via emergency department or transferred between wards and departments, including to the operating theatre, the patient transfer documents sighted identified if isolation precautions are required to be implemented. This was correctly completed in all applicable patients' files sighted. The patients care plans and progress notes also reflected this information and when the decision was made to remove the patient for isolation where applicable. Where patients are in isolation, the shift handover records included communication on the isolation precautions required.

Written information for patients is available on the MDROs and isolation precautions. Three patients in isolation and a family member were interviewed. The patients interviewed advised they were informed and given information on why they were in isolation. The patients advised staff wore the required personal protective equipment (PPE) during cares and were always using hand gel. Staff with appropriate PPE were sighted entering and exiting the rooms of patients in isolation during audit.

The gauge outside the negative pressure room of a patient requiring airborne precautions did not reflect negative pressure was in place despite the doors being appropriately shut for at least 30 minutes when rechecked. Staff were unaware if this was a gauge fault /issue or whether the ventilation was not functioning appropriately. This was escalated to the engineers. This is included in the area for improvement raised in 1.4.2.4.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

Attainment and Risk: FA

Evidence:

The infection prevention and control programme is facilitated by the three members of the infection prevention and control (IP&C) team. This comprises the nurse manager IP&C and the CNS IP&C (who both work full time), and the RN IP&C who works 0.9 FTE. The service administrator works 0.9 FTE. They are supported by the medical officer of health, a microbiologist from the contracted laboratory and the infectious diseases (ID) physician who has been working on a one year contract at MDHB before being recently appointed to a permanent infectious diseases role. The ID physician has 0.2 FTE allocated to infection prevention and control/infectious diseases. They joined discussions remotely. The IP&C team also provide occupational health services, pre-employment health screening, staff vaccination, staff blood and body fluid exposure follow-up, and contact tracing.

The IP&C team work weekdays. Afterhours the duty manager provides advice and support as required. The IPC team can be contacted afterhours by the duty manager if there is a significant issue that requires more specialist input.

The infection prevention and control nursing team have been in their roles for between four months (RN) and 25 years (CNS). The nurse manager has worked in IP&C since 2003.

In addition, there are up to 15 ward/department based infection prevention and control representatives. The IC representatives help champion infection prevention and control at ward/department level. There are documented responsibilities for the representative who can attend two study days a year for update information as an alternative to regular meetings.

There are currently 34 staff working in MCDHB that are trained gold hand hygiene auditors.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

Attainment and Risk: FA

Evidence:

Infection prevention and control policies and procedures are available for staff electronically on the intranet. These align with current accepted practice and legislative requirements. Some policies have been developed by the MDHB IP&C team. Others are adopted from Lippincott where these have been reviewed and determined to be appropriate to the MDHB services.

All policies required to meet the standards are available. The IPC team are responsible for reviewing, consulting, and updating policies. The draft policies are then discussed with the infection prevention and control committee, and agreement or amendments discussed. The final draft is forwarded to the clinical board for review and sign off if there are significant changes proposed in the documents. Otherwise, the chief medical officer is responsible for reviewing and approving the policies on behalf of the clinical board. A spreadsheet is used to monitor all documents, their next review dates, the consultation process and feedback, and to track the progress of each document during the review and sign off process. There are five documents currently overdue for review. Three of these documents are under review. The other two polices cannot be updated until new DHB contractual requirements have been implemented.

All staff and managers interviewed on this topic confirmed they were able to readily access infection prevention and control policies online when required and the process was demonstrated. The managers advised the IP&C team would be contacted for advice if there was any clarification required about the content of policies.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

Attainment and Risk: FA

Evidence:

The IP&C team participate in relevant ongoing education. This include attending national infection prevention and control conferences, attending national quality forum days, attending regional meetings with other IP&C practitioners, and attending planned education sessions by product suppliers/manufacturers. Records of attendance records were sighted.

The IP&C team participate in the DHB orientation programme and provide ward / department and community in-services and speak at other applicable study days. Education is also provided by the infectious disease physician on topics including appropriate antimicrobial use. Details of all education provided, and attendance records are maintained. There have been at least 40 education sessions offered to staff by the IP&C team between March 2019 and September 2020, with between three and 100 staff attending each session. This is in addition to the ongoing education which has recently focused on hand hygiene, respiratory etiquette, and 'donning and doffing' personal protective equipment (PPE) as part of Covid 19 pandemic management programme. The clinical educators have assisted the IP&C team with this education. All applicable staff have been required to attend this training.

A patient experience video has been recently created telling the story of a patient who developed a significant intravenous device infection. This video is being used to educate staff on infection prevention and control principles and doing the right thing.

Staff confirmed that they are provided with infection prevention and control information during orientation. Fit testing of N95 masks is being undertaken by an external provider. Online hand hygiene training is completed by staff.

Two study days are provided each year for the ward/department-based infection prevention and control representatives. These were last held on 28 November 2019 and 30 May 2019. The May 2020 programme was deferred due to Covid-19 requirements.

Patient education has occurred primarily around MDRO's and isolation precautions. There are brochures that are used to help communicate this information to applicable patients. In addition, education is provided on Covid-19 precautions, cough etiquette and hand hygiene as applicable. Patients interviewed on this topic confirmed they were provided with relevant information by staff, and some information is on the DHB website.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

The surveillance undertaken is detailed in the infection control programme. This includes (but is not limited to) monitoring healthcare associated blood stream infections, the number of staff occupational exposures to blood and body fluids, and central line bacteraemia and intravenous device infections. If the bacteraemia is thought to be intravenous device associated, the infection prevention and control team and infectious disease physician review. The intravenous resource nurse also undertakes a clinical practice review of each event and communicates findings/learnings with the consultant and team caring for the patient. Total joint replacement surgical site infection (SSI) surveillance is undertaken as per the Health Quality and Safety Commission programme and benchmarked with other DHB hospitals. The DHB obtains data related to all outsourced applicable surgeries. A review of the last 5 years SSI data has been recently reported to the IP&CC. The overall reported infection rates are low. Surveillance of lower segment caesarean section (LSCS), and other 'clean' surgical procedures SSI is also occurring, and includes patients readmitted within 30 days of a clean surgical procedure. Each reported infection is investigated. Surveillance results are reported monthly in the nurse manager infection prevention and control report, and SSI data is reported quarterly. There were 11 HAI bacteraemia infections reported in 2019 related to intravenous devices. The IP&C team are implementing a 'know your IV line' project.

Surveillance results and SSI data up to March 2020, along with three nurse managers IC monthly reports up to and including August 2020 were sighted and reviewed. Variances in trends are identified and investigated and the surveillance results are communicated to the infection prevention and control team, applicable medical staff and managers and to the clinical board.

Hand hygiene products are readily available throughout MDHB health facilities. The DHB is participating in the national hand hygiene audit programme. With six weeks to go in data collection for the current quarter, 76.1% compliance was reported for the just over 1100 moments audited in 16 departments/units. Staff in the emergency department had the lowest compliance (33% for 45 moments) and staff in the neonatal unit the highest compliance (100% for 21 moments). Staff in nine wards/departments have a hand hygiene compliance rate above the target of 80%. The results are communicated to managers and staff.

The IP&C team advised they are provided with prompt notification from the laboratory of significant results. The IP&C team have access to electronic patient management systems to review patient records and diagnostic results.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Standard 3.6: Antimicrobial usage (HDS(IPC)S.2008:3.6)

Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.

Attainment and Risk: FA

Evidence:

The DHB has antimicrobial resistance and antimicrobial stewardship as a component within the annual plan, with antimicrobial resistance the focus for 2020.

Guidelines are available for prescribers on appropriate therapeutic and prophylactic antimicrobial use for adult patients. The document is readily available to the prescribers electronically and is updated as required. The service is starting to obtain some data related to the usage of this 'app' to help inform future development/education. This is in the early days of being reviewed. Paediatric antimicrobial guidelines from Starship Hospital are used for paediatric services.

There is a 'private messenger group' which the includes the infectious diseases physician, antimicrobial stewardship pharmacist, and microbiologist. This forum is used to discuss, seek feedback or alert on current antimicrobial related issues. The infectious disease physician and pharmacist interviewed advised the 'app-based guidelines' can be readily updated as required. The guidelines for surgery prophylaxis antimicrobial guidelines are currently under review.

Prescribers are encouraged to use appropriate antimicrobials. Guidance is also provided for switching intravenous doses to oral doses with a 'IV to oral antibiotics switch' campaign currently underway, to prompt prescribers to review if intravenous antibiotics and intravenous lines are still required by the patient after two days. The clinical pharmacists are wearing bright T-shirts with the 'Switch IV to orals' message. There are also posters with this messaging displayed throughout the hospital.

Monitoring compliance with prophylaxis antimicrobial use is occurring as a component of the surgical site infection surveillance programme. Monitoring of compliance with therapeutic antimicrobial use is also occurring. This is facilitated by the clinical pharmacists who undertake medicine chart reviews. If there are concerns about appropriateness of antimicrobials prescribed, the dose or duration of treatment, this is discussed with the clinical team caring for the patients, and prescribers are referred to the DHB antimicrobial guidelines. Discussions occur with the infectious disease physician if required. A junior medical officer interviewed confirmed that antimicrobial prescribing guidelines are readily available, and additional advice readily obtained if required.

Electronic medicine dispensing machines are used for issuing medications for administration in the operating theatre, medical assessment and planning unit (MAPU) and emergency department patients. The antimicrobial stewardship pharmacist reported regularly reviewing the antimicrobial usage data and reports and following up on any variances.

There is an antimicrobial stewardship committee (comprising the ID physician, antimicrobial stewardship pharmacist, microbiologist and IP&C CN), who review a range of antimicrobial use information.

Antimicrobial susceptibility patterns are updated annually, and the summary for 2019 is available on the DHB website.

Criterion 3.6.1 (HDS(IPC)S.2008:3.6.1)

The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

Criterion 3.6.4 (HDS(IPC)S.2008:3.6.4)

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

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

05 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act (OIA) request – OIA Y21-0381

Thank you for your request for information dated 06 April 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with the Maternity Report written by Emma Farmer. Please find this attached.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

MidCentral DHB – External Director of Midwifery Site Visit (March 2021) Report

I orea te tuatara ka patu ki waho
A problem is solved by continuing to find solutions

Background

In January 2021 the leadership team at MidCentral DHB requested a site visit to understand the local stressors caused by a chronic shortage of midwives and make recommendations to assist the service going forwards.

The Terms of reference requested the following:

- Provide expert midwifery advice and opinion
- Review and support the midwifery leadership team especially the Acting Associate DoM
- Review and assess workforce issues and offer support and advice
- Review the growing demand for LMCs to hand over in secondary care and help identify solutions
- Advise regarding a culture where services focus on mothers, babies and whānau
- Advise on strategies to ensure sustainability of maternity workforce
- Review quality and patient safety systems within the maternity service.

The visit encompassed the following meetings (either in person or via zoom), and correspondence via email:

- Paula Spargo - Previous Midwifery Director
- Megan Grieve – Acting Associate Director of Midwifery
- Celina Eves – Executive Director of Nursing and Midwifery
- Sarah Fenwick – Operations Executive Te Uru Pā Harakeke (Healthy Women, Children and Youth)
- Jeff Brown – Clinical Executive Te Uru Pā Harakeke (Healthy Women, Children and Youth)
- Per Kempe – Medical Lead Obstetrics and Gynaecology
- Alison Eddy – CEO New Zealand College of Midwives
- Caroline Conroy – MERAS Co-Leader
- Holly Westcott – MERAS staff rep
- Jen Green – Charge Midwife
- Obstetric SMOs x4
- Associate Charge Midwives x3
- Core Midwives, Community Midwives, Lactation Consultants and Nurses x 2 sessions (approx. 15 per session)
- LMC midwives x 2 sessions (approx. 15 per session)
- Senior midwives who have resigned including Cheryl Benn (5 Midwives)
- Amanda Douglas (NZCOM Regional Chair)
- Māori Midwives (4 Midwives) both in person and later via email
- Lactation consultants via email

- Midwifery Students x2 via email

In addition, I read the following documents provided:

- Correspondence between NZCOM and MidCentral DHB
- Correspondence between MERAS and MidCentral DHB
- Women's Health Unit Staff Survey
- Maternity Work Programme 17/18
- Nursing and Midwifery Practice Council Terms of Reference
- Nursing and Midwifery Shared Governance Model ppt.
- Hospital Advisory Committee Update March 2016.

Acknowledgement

Firstly, I would like to thank the very many individuals and teams that made the time to meet me personally or via zoom or to later email me their thoughts. It is their openness and willingness to provide feedback that made this report possible. I would also like to acknowledge the leadership team who hold a genuine concern around the current situation and a willingness to create a safe maternity service for mothers, babies and their whānau.

Key findings and recommendations

I have grouped my recommendations in to six sections:

1. Creating immediate clinical safety
2. Creating a safe environment for core staff
3. Creating a safe environment for LMC Midwives
4. Creating a robust and strengthened community and outpatient service
5. Creating a safe environment that is respectful of Māori and reduces inequity
6. Proposed leadership structure.

1. Creating immediate clinical safety

Maternity units are an acute clinical area (much the same as ED); women are admitted directly from the community and need triage, assessment and immediate care. The course of labour is also unpredictable and maternity units must be able to respond to significant life-threatening emergencies with little or no warning.

To safely manage this complex environment, it is essential that there are highly skilled, experienced and professional midwives on each shift. This role (currently called ACM) must be enabled to operate as such on all shifts and cannot be replaced by the Charge Midwife who may need to leave the unit to attend to other matters. The ACM is critical to a safe culture by supporting staff, students, new graduates and LMCs.

The maternity ward is now nearly 100 percent staffed by registered nurses. Nurses can have a role in the provision of maternity care for example in the post-operative care of mothers giving birth by

caesarean section. However, the growth in the number of nurses has created a significant skill mix issue and at times nurses may be working outside their scope and outside the limits of their skills, knowledge and experience. This leaves the service vulnerable to significant adverse event, for example a secondary postpartum haemorrhage or a neonatal collapse would put the woman or neonate at significant risk. I note that newborns returning to the ward following caesarean section birth may not be receiving the two hours continuous observation that is required in the Ministry of Health guidelines.

In order to manage the risk on the maternity floor, it is essential that a suitably trained senior midwife work on the Maternity Ward at all times to support the nursing staff and provide expert care in the event of an emergency. This senior role cannot be filled by an experienced nurse, for the reasons outlined above.

2. Creating a safe environment for DHB employed staff

Staffing

Creating a stable roster is critical to the healthy safe functioning of the maternity unit. At present midwives are expressing frustration at their work environment. A number of examples were provided by core staff around the expectation that they work without breaks and beyond the end of their shifts. Whilst this can sometimes occur due to pressure of work this should not become the norm or the expectation. Having staff working many and long shifts places the organization at risk of breaching the Employment Relations Act 2000 and the Health and Safety at Work Act 2015[1].

Actions to ameliorate this include:

1. Give a strong message that staff are enabled to take breaks and finish their shifts on time.
2. Pay T1.5 or T2 if staff are expected to work without breaks or beyond their rostered shift
3. Implement a retention allowance for any midwife working 0.7FTE or above for a 6-month period. This has been shown to be cost neutral due to a reduction in overtime.
4. Ensure CCDM variance reporting and response mechanism is functioning well and there is organizational visibility of the pressures and a commitment to provide support.
5. Consider stopping postnatal admissions to Te Papaioea (I appreciate this was requested by women and midwives), but it creates confusion at the primary unit about its core function which is primary birth. Restrict postnatal stays at Te Papaioea to those women who gave birth there, then the staffing complement can reduce to one midwife and one HCA, freeing up a staff member for the maternity ward.
6. Stop cross rostering between Te Papaioea and the hospital as this increases work place stress and reduces the opportunity for staff to build skills, confidence and increase proficiency in their chosen area of expertise.

[1] https://www.sitesafe.org.nz/globalassets/guides-and-resources/best-practice-guides/fatigue-guidance-crsf.pdf

Acuity

Workload is a significant area of concern. The work regularly exceeds the resources; this places an exceptional burden on the staff and causes tensions with LMCs. The service has attempted to manage this workload by adding to the Registered Nurse workforce, however while helpful this adds to the burden experienced by midwives who by default take clinical responsibility for the care of mothers and babies.

Actions to ameliorate this include:

1. Ensuring a robust CCDM system that accurately records acuity
2. Increase HCA support to 2 HCAs per shift
3. Increase lactation consultant support to 12 hours per day 7 days per week
4. Increase ward clerk support to 7am -9pm 7 days a week
5. Create a clinical supplies coordinator role - This role ensures that clinical supplies are ordered and available in the correct quantities. They also manage any facility maintenance and repairs, and repairs of equipment. This role removes a lot of low-level time-consuming work from the Midwife Manager and creates a more efficient work environment. This position quickly becomes essential and often pays for itself in reducing waste.

Creating an effective workforce pipeline

Attrition is a common feature of maternity staffing as midwives can elect to be employed or self-employed and staff will circle through different roles in their career. Having a robust midwifery pipeline will enable the service to manage attrition as it occurs.

The current undergraduate programme does not appear to be working effectively and insufficient numbers of students are entering the programme to provide graduates in the numbers needed. In addition, student midwives are reporting an unfriendly work environment with staff unwilling to provide teaching or clinical supervision. This approach to the next generation of midwives is disappointing and self-defeating.

Actions to ameliorate this include:

1. Students must be treated as a Taonga, appoint a clinical coach to assist them to orientate and awhi them into the workplace.
2. AUT have indicated a willingness to set up a satellite programme but they are not resourced to provide a clinical educator this year. In order to move quickly to establish the local programme appoint a clinical educator 0.8fte for 12 months until AUT is able to supply.
3. Offer an open day to target local women for a career in midwifery; Tairawhiti DHB has had considerable success with this approach.
4. All NZ Schools of midwifery have access to MoH funding to support Māori and Pacific undergraduates, explore with AUT or Otago Polytechnic how this will support local wāhine Māori women to become midwives.

5. AUT are currently exploring a programme for registered nurses seeking to gain midwifery registration. There is already significant recognition for prior learning so this should be explored further to enable current nurses employed in the service to transition to midwifery.

3. Creating a safe environment for LMC Midwives

LMC midwives make up over 50% of the midwifery workforce, so an environment that is judgmental and disrespectful is alienating, counterproductive and unsafe. Research shows that environments that have highly functioning clinical relationships are far safer for mothers and babies[2]. LMCs gave many examples of disrespectful and judgmental behaviors. Identifying and publicly calling out LMCs for not providing epidural care is an example of alienating the workforce. If LMCs choose to spend as little time as possible in the Maternity Unit the question has to be asked why and what can be done to make it a more supportive and collegial place where midwives feel safe to work.

Actions to ameliorate this include:

- Rebuilding relationships of trust
- Regular forums where LMC can air their concerns and be heard
- Meet their needs where this is feasible – small wins are appreciated
- Avoid encroaching on their area of expertise, i.e. do not try to control what occurs outside of the hospital setting, LMCs are experts in community care.
- Respect that LMCs are responsible for their practice and are not accountable to the DHB provider arm they are accountable to the woman, her whānau and the Midwifery Council for their practice.
- Offer updates, education, workshops and seminars to enable the midwives and doctors to come together in a safe environment to learn together from each other. An example of this is the PROMPT training but this must be led by a midwife with expert relationship skills.
- Treat practitioners as individuals not as a uniform group. Midwives, like GPs, pharmacists or any other community health professional have significant responsibilities outside of the hospital and they have different priorities. It is not reasonable to expect a uniform response.

4. Creating a robust and strengthened community and outpatient service

The effective functioning of community services has a direct impact on effective functioning of inpatient services. Making sure that work is managed effectively requires good leadership and management attention. Placing the focus on inpatient services because they appear the most acute misses and opportunity to manage this workload before it arrives on the ward.

---

[2] Liberati EG, Tarrant C, Willars J*, et al* Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation *BMJ Quality & Safety* Published Online First: 25 September 2020. doi: 10.1136/bmjqs-2020-010988

Actions to ameliorate this include:

1. Create a specialist SGA clinic. This means that women who are on the SGA pathway are seen at booked appointments in clinic and are not sent for "scan review" in the acute assessment area. This would also reduce waiting time for women. Several adverse events in New Zealand are associated with women abandoning acute appointments as their wait times are excessive.
2. Improve the quality of obstetric consultation and plans of care to LMCs. Currently there is a lack of medical and midwifery oversight in the antenatal clinic that means many women are being recalled unnecessarily.

Obstetric clinics and community midwives

Overall, there is a sense that the obstetric clinics lack oversight, this results in women returning for multiple obstetric appointments when they could be referred back to the care of the LMC with a detailed plan of care and a re-refer instruction. There are some technical issues with communicating plans of care that need managerial oversight.

The community midwifery service is also probably not well aligned with the work, as women are being separated from their LMC to be offered "unit" care, and those women under the community midwives lack continuity. This means that the women with the most complex pregnancies often have the most fragmented care. A significant piece of work is needed here to realign the outpatient work to make it more fit for purpose. This is likely to have positive flow on benefits for the workload in the wards also.

Te Papaioea and Kōhungahunga

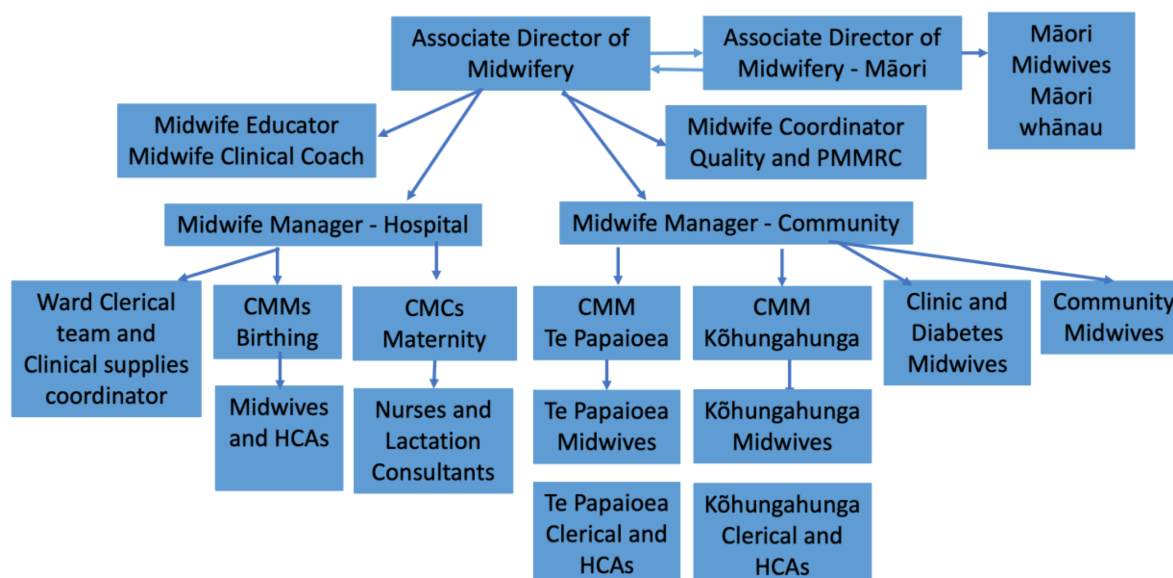
Primary birthing is in the domain of midwives and should not be encroached upon by obstetrics. Evidence shows that primary birthing units can deliver safe and effective care to well mothers and babies and thrive in environments where midwives are enabled to take ownership of their service. Operating Te Papaioea as an extension of a secondary maternity unit makes it unsafe and unlikely to deliver clinical benefits. It is my strong recommendation that the unit be enabled to operate as it was intended with a midwifery led model of care. By not using the unit as an overflow for postpartum women (and I appreciate this was requested by midwives and the community) the unit can focus on its core business that is primary birthing. This would enable the staffing model to reduce to one midwife and one HCA and release another staff member for the wards.

5. Creating a safe environment that is respectful of Māori and reduces inequity

Māori midwives took pains to feedback both in person and via email about their experiences of racism in the maternity services. This kōrero was difficult to hear and the mamae evident. Some factors associated with this are leadership inexperience of working in a bi-cultural environment where Māori are partners in decision making. Māori midwives spoke of having their views

discounted and their clinical and cultural practice questioned. Creating a senior leadership role for Māori would assist in bridging this divide and help the service to move forward in this respect.

6. Proposed leadership structure



The leadership structure aims to achieve three things:

1. Create a structure that ensures that staff receive good support and can have their issues and concerns addressed in a timely way. Much of the concern expressed from staff is that their ideas do not get progressed and they do not get feedback about why. This is most likely to be due to the pressure of work experienced by the current leaders.

2. Creating a strong management structure for community services as has a positive impact on both community and also inpatient services. The Midwife Manager – community has a responsibility for relationships with LMCs and this removes the tension built up by the workload demands in the hospital. The Midwife Manager – Community also attends to relationships with primary care providers and manages the vulnerable families workstream, in co-ordination with the Associate Director of Midwifery - Māori

3. Creates a structure that supports Te Tiriti in creating a partnership leadership model

Caveat

This document provides a simple summary of my findings and recommendations from a very short visit. I acknowledge that in this short time I may not have been able to assimilate all the intricacies of service provision or of the wider DHB expectations and support structures. I am more than happy to provide on-going advice to the leadership at MDHB if needed.

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

4 May 2021

Dear

We are in receipt of your Official Information Request submitted on 6 April 2021.

You advised that you would like the following information on the performance and services of the MidCentral District Health Board (MDBH) for their provision of mental health services.

1. For all Mental Health Services including Child and Adolescent Mental Health; Adult Mental Health, Emergency, Acute, Crisis Response and Elderly; you would like the following:

   a. Number of new entries/cases per month, by age group (five year bands if possible*), 2015 – 2020 calendar year.

      Please see attached report: New Cases by Month.

   b. Number of cases open at month end, by age group (five year bands), 2015 – 2020 calendar year

      Please see attached report: Number of Open Cases.

   c. Number of people exiting per month, by age group (five year bands if possible*), 2015 – 2020 calendar year

      Please see attached report: Discharges By Month.

2. For the DHB:

   a. Number of hospitalisations for mental health per year, emergency and non-emergency, by age group (five year bands), 2015 – 2020 calendar year.

      MidCentral DHB admissions are relevant only to the Acute Ward (Ward 21) and Elderly Adult Mental Health (Star 1), both of which are captured in the data provided for question 1a.

b. Number of people waitlisted to see a psychologist per year, by age group (five year bands), 2015 – 2020 calendar year.

   MDHB does not have a waiting list for patients referred for mental health services. Referrals for services of patients over the age of 18 years can be made by GP, health professional, guidance councillor or self-referral. The referral will be assessed and allocated to one of the Mental Health Service teams as appropriate.

   Patients under the age of 18 can be referred by GP, health professional or guidance councillor, however they will only be referred to Child Adolescent and Family Services.

   A client assessed as requiring the services of the Mental Health and Addiction Service will be assigned a psychologist and/or support worker upon acceptance to the relevant service.

c. Number of people seeing a psychologist, per year, by age group (five year bands), 2015 – 2020 calendar year.

   MidCentral DHB is unable to provide information based on caseload by profession by year.

d. Number of psychologists employed by the DHB at year end (split by part time, full time, contracted) by year, 2015 – 2020 calendar year.

   The table below identifies the number of psychologists employed by MDHB over the period requested. Unfortunately are unable to provide information regarding contracted personnel over this period.

Year	Total	Full time	Part time
2015	20	12	8
2016	18	11	7
2017	19	12	7
2018	21	14	7
2019	18	11	7
2020	19	12	7

I trust the information provided satisfies your request. If you are dissatisfied with the information provided you have the right to seek a review through an investigation and review by the Ombudsman.

Information about how to initiate this is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8358

Please note that this response, or an edited version of the same, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive
Mental Health & Addiction Services

Encl: *New Cases By Month*
Number of Open Cases
Discharges By Month

DISCHARGES BY MONTH

Inpatient

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	0	0	1	3	0	1	5	0	0	0	1	1	6	0	0	0	4	3	0	1	2	1	0	0	1
16-20	7	1	10	3	6	10	8	7	6	10	13	7	10	4	3	10	17	8	12	9	10	6	8	10	7
21-25	4	4	8	6	8	4	7	8	7	4	10	3	7	5	9	7	5	4	3	10	7	5	0	6	5
26-30	4	1	4	2	6	4	3	4	6	7	3	7	9	8	9	7	6	9	5	10	11	6	6	10	3
31-35	2	0	4	4	3	1	6	4	4	5	1	3	7	3	3	6	3	6	1	5	7	4	5	4	9
36-40	1	7	6	1	2	3	0	5	4	2	3	1	3	3	6	3	1	5	2	2	8	2	6	6	3
41-45	4	6	0	0	8	5	8	4	6	3	5	6	8	8	4	10	7	10	8	7	7	6	4	2	2
46-50	1	3	5	9	4	3	10	6	5	7	5	2	3	5	3	6	1	2	6	4	6	6	5	7	5
51-55	1	4	4	4	5	5	5	0	3	0	4	1	5	7	3	5	5	5	8	4	4	6	5	4	5
56-60	0	2	3	2	2	0	4	0	3	4	4	1	1	4	3	3	2	0	4	3	1	3	4	3	5
61-65	0	1	0	4	4	6	2	1	2	1	0	1	2	0	0	4	1	3	2	2	3	2	3	0	3
66-70	1	1	0	2	1	0	2	4	3	6	1	3	0	1	4	1	1	0	2	1	0	1	1	1	3
71-75	0	0	0	0	1	0	1	1	3	2	0	0	1	0	2	0	3	0	0	1	0	0	0	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**25**	**30**	**45**	**40**	**50**	**42**	**61**	**44**	**52**	**51**	**50**	**36**	**62**	**48**	**50**	**62**	**56**	**55**	**53**	**59**	**66**	**48**	**47**	**53**	**51**

Community

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
1-5	0	2	3	4	5	4	6	6	2	7	10	7	5	6	15	7	11	7	7	11	7	5	12	7	8
6-10	3	5	16	14	17	9	25	15	11	23	36	28	20	20	31	22	32	27	29	34	39	26	30	51	35
11-15	11	19	41	26	30	35	44	39	42	51	60	62	41	55	51	50	54	56	43	58	53	57	86	75	54
16-20	30	43	54	38	61	56	79	77	76	82	92	80	75	79	75	77	106	96	78	94	81	79	113	101	101
21-25	36	38	58	43	60	60	59	72	66	49	76	59	70	75	57	58	67	55	62	74	67	66	72	81	76
26-30	18	19	38	33	39	46	43	46	53	49	48	66	82	50	45	52	70	51	64	65	65	71	73	65	38
31-35	8	15	35	20	33	30	25	31	35	39	40	45	41	49	46	35	39	45	38	52	53	36	61	67	39
36-40	13	19	27	25	24	28	32	31	33	38	23	29	34	29	38	31	31	29	23	36	46	33	48	37	33
41-45	17	20	25	28	36	29	35	32	29	39	32	41	33	41	44	34	35	37	33	46	35	36	39	37	40
46-50	6	18	20	25	18	15	30	22	31	23	24	34	27	25	35	34	19	19	23	33	29	36	40	39	26
51-55	13	18	17	25	21	20	12	20	24	27	22	18	31	29	22	18	26	20	20	31	25	18	37	24	25
56-60	6	8	14	16	18	10	14	11	17	14	18	11	23	25	14	16	20	17	10	18	15	23	25	19	18
61-65	2	2	11	6	13	9	13	9	7	6	13	8	12	9	4	8	10	6	7	14	15	17	9	14	22
66-70	2	1	2	4	5	2	3	6	7	10	7	11	3	7	6	7	2	2	8	9	13	10	13	12	10
71-75	0	0	1	0	0	2	3	4	2	0	1	1	3	4	3	1	3	3	4	6	9	15	6	15	8
76-80	2	0	0	0	1	2	0	1	0	0	0	1	2	0	1	0	0	2	3	7	5	11	6	14	4
81-85	1	1	0	0	0	1	2	0	0	0	0	1	1	0	1	2	0	0	2	10	5	20	6	8	5
86-90	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	5	4	11	6	6	9
91-95	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	2	4	4	0	2	0
96-101	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**168**	**228**	**362**	**307**	**381**	**358**	**425**	**422**	**436**	**457**	**502**	**502**	**503**	**503**	**489**	**452**	**525**	**472**	**457**	**605**	**570**	**574**	**682**	**674**	**551**

Inpatient

	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	0	0	0	0	2	0	0	2	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0
16-20	6	8	4	10	6	9	3	10	8	8	10	13	7	9	8	3	10	11	13	7	10	10	11	14	9
21-25	7	5	3	7	8	10	12	12	8	9	6	6	7	6	6	9	6	6	9	7	10	18	11	14	17
26-30	5	8	4	6	9	5	10	10	10	7	5	6	3	8	6	9	5	10	8	4	4	4	10	7	7
31-35	3	6	5	7	5	7	6	5	10	6	4	6	6	7	7	5	3	8	6	5	6	11	8	6	9
36-40	4	4	0	7	6	7	2	2	8	6	6	6	3	4	6	7	2	5	4	11	8	6	7	8	6
41-45	2	5	2	8	7	3	10	7	5	7	8	8	3	1	4	4	4	6	4	7	9	6	6	4	5
46-50	9	6	4	1	3	5	6	4	3	2	10	7	7	5	4	7	4	7	3	5	5	13	4	6	4
51-55	4	4	2	7	4	6	4	3	3	3	11	8	9	8	2	5	4	6	3	1	6	0	7	7	3
56-60	5	3	3	1	1	1	3	5	0	4	4	5	6	0	6	1	1	4	5	1	1	0	4	4	0
61-65	3	1	0	1	0	1	2	4	3	5	3	7	5	4	1	6	4	5	10	6	5	2	1	2	0
66-70	0	1	0	1	2	1	2	2	1	2	1	0	0	3	1	0	0	0	0	0	0	5	0	1	1
71-75	1	0	0	0	0	1	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	1	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
TOTAL	**49**	**51**	**27**	**56**	**53**	**56**	**60**	**66**	**60**	**59**	**68**	**72**	**57**	**55**	**52**	**58**	**44**	**69**	**66**	**54**	**64**	**76**	**70**	**73**	**61**

Community

	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
1-5	3	6	8	12	10	7	6	5	3	7	7	5	4	2	6	9	7	0	7	4	6	8	5	9	5
6-10	25	47	30	51	42	43	29	39	33	46	42	35	22	34	21	45	27	29	37	30	32	24	26	17	18
11-15	52	63	43	69	55	60	61	52	65	53	62	55	36	51	54	52	69	43	76	64	41	57	44	52	55
16-20	84	72	65	113	127	99	112	112	122	134	81	103	88	84	102	108	113	107	109	102	90	103	109	94	96
21-25	59	69	52	82	71	105	107	91	109	91	80	83	89	103	97	97	80	87	108	93	91	96	80	76	90
26-30	46	84	58	65	85	90	119	83	91	63	66	59	61	76	88	77	72	78	75	88	78	87	61	54	63
31-35	38	50	41	69	58	69	66	61	72	51	46	46	54	55	55	69	42	50	70	43	57	59	54	53	69
36-40	28	31	32	31	40	55	59	42	59	57	40	31	38	32	46	42	39	46	36	51	43	56	38	52	32
41-45	25	44	34	47	53	57	71	51	45	64	51	44	36	45	44	56	36	39	37	46	46	50	38	36	28
46-50	30	47	26	25	40	53	44	37	52	41	53	36	32	34	45	55	34	56	42	36	50	43	40	23	18
51-55	31	23	20	22	32	43	42	30	47	43	29	35	35	42	35	35	28	27	30	24	35	37	37	27	35
56-60	15	29	16	27	29	26	31	20	32	32	23	31	25	31	27	23	15	29	22	31	27	21	24	11	25
61-65	15	14	11	20	11	23	36	14	21	35	16	24	25	25	35	23	19	33	30	23	16	15	21	19	9
66-70	6	5	9	11	18	16	20	19	17	20	12	10	12	16	7	13	18	15	13	16	12	16	16	9	13
71-75	13	7	5	11	12	17	13	4	4	11	7	13	10	18	12	10	14	17	11	15	16	3	12	9	11
76-80	8	13	4	8	15	7	13	8	3	5	2	8	11	13	5	16	13	9	9	15	18	9	13	15	6
81-85	10	10	3	8	19	6	9	3	4	2	2	3	9	12	13	15	6	6	7	8	15	7	13	10	8
86-90	10	10	4	9	12	3	12	2	2	13	5	4	3	7	7	13	9	9	9	4	6	6	5	14	4
91-95	1	2	2	1	5	3	7	3	2	0	5	0	1	6	1	5	2	1	0	0	2	2	1	4	3
96-101	0	0	0	0	1	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**499**	**626**	**463**	**681**	**735**	**782**	**857**	**676**	**784**	**769**	**629**	**625**	**591**	**687**	**700**	**763**	**643**	**681**	**728**	**693**	**681**	**699**	**637**	**584**	**588**

Inpatient

	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
6-10	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
11-15	1	1	2	0	0	1	1	0	0	0	0	1	0	0	0	2	1	2	0	0	0	1	**50**
16-20	10	8	12	9	8	9	14	4	11	14	8	6	8	6	6	5	9	3	7	5	9	1	**591**
21-25	8	15	19	5	8	11	17	11	8	10	13	12	14	6	7	3	12	5	7	8	5	18	**587**
26-30	11	12	18	12	8	14	8	9	11	11	11	8	7	1	8	9	4	6	6	11	4	6	**515**
31-35	6	7	6	6	9	6	6	5	7	4	9	4	8	8	5	1	2	5	7	3	6	3	**380**
36-40	11	6	8	8	7	4	9	7	7	4	6	5	3	1	1	3	2	5	1	3	7	0	**328**
41-45	5	3	4	4	7	7	4	4	5	4	5	6	7	0	5	5	6	5	2	3	7	2	**373**
46-50	2	1	3	3	4	3	9	7	3	11	11	6	2	1	1	3	1	2	3	3	2	5	**339**
51-55	2	8	5	4	4	6	8	3	7	6	3	5	5	1	3	4	2	1	2	3	1	3	**308**
56-60	2	5	4	3	0	4	1	7	6	3	1	2	4	7	3	2	2	4	1	1	4	3	**198**
61-65	4	1	2	1	1	0	2	6	3	4	1	2	3	4	2	2	1	3	4	1	2	1	**178**
66-70	0	1	0	0	2	0	0	2	3	1	0	0	2	0	1	0	2	0	0	1	1	1	**81**
71-75	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	**25**
76-80	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
81-85	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
TOTAL	**62**	**68**	**84**	**55**	**60**	**66**	**79**	**65**	**71**	**73**	**68**	**57**	**63**	**35**	**42**	**39**	**44**	**42**	**41**	**42**	**48**	**44**	**3960**

Community

	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
1-5	5	2	9	7	6	5	8	7	5	4	6	6	2	1	2	5	8	6	8	3	6	4	**430**
6-10	25	16	28	35	43	35	33	38	35	24	34	21	33	14	17	34	24	45	38	32	36	46	**2108**
11-15	43	48	75	51	72	94	65	64	75	67	72	55	62	39	62	68	71	104	81	84	79	98	**4106**
16-20	101	103	115	111	130	115	122	123	105	94	97	113	109	96	110	114	129	92	93	100	96	105	**6825**
21-25	114	101	91	91	88	107	102	95	112	90	107	88	106	81	83	104	116	93	112	117	92	128	**5960**
26-30	78	62	101	117	83	105	81	100	103	102	88	84	89	47	86	97	95	73	67	95	68	80	**5057**
31-35	61	65	70	82	75	63	68	65	85	64	68	65	75	77	59	67	84	60	74	66	60	53	**3860**
36-40	40	51	44	58	55	42	53	40	47	59	48	46	65	45	37	44	45	47	38	38	42	38	**2848**
41-45	42	36	43	36	45	41	47	26	50	37	37	35	53	30	29	39	46	34	36	28	36	41	**2823**
46-50	29	30	32	50	47	44	33	32	30	50	34	33	42	29	36	36	35	33	30	27	38	47	**2440**
51-55	33	38	31	44	40	38	52	47	44	48	39	39	47	33	37	37	39	40	26	34	34	26	**2233**
56-60	25	27	21	18	37	23	20	30	34	26	21	20	25	32	30	27	34	27	34	33	30	36	**1632**
61-65	18	26	23	23	34	25	23	21	24	24	16	18	27	16	18	21	27	20	15	23	21	15	**1257**
66-70	17	13	13	16	20	15	18	18	23	20	20	17	20	13	18	19	14	21	28	16	18	14	**892**
71-75	12	13	13	5	20	15	9	8	10	9	15	8	15	14	14	11	25	25	20	14	11	13	**668**
76-80	6	10	16	8	6	8	14	8	11	9	9	4	9	4	9	9	16	15	18	14	10	11	**532**
81-85	6	5	9	7	9	11	5	8	10	2	13	7	7	6	8	8	9	13	12	6	5	10	**450**
86-90	6	8	6	6	6	4	7	5	5	1	6	2	10	7	6	10	10	7	8	7	3	8	**364**
91-95	0	3	1	5	3	1	1	3	1	0	4	2	1	2	3	2	2	2	7	5	4	4	**129**
96-101	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	**6**
TOTAL	**661**	**657**	**741**	**770**	**819**	**791**	**761**	**738**	**809**	**730**	**734**	**664**	**797**	**586**	**664**	**752**	**830**	**757**	**745**	**742**	**689**	**777**	**44620**

NEW CASES BY MONTH

Inpatient

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	0	0	1	3	0	2	4	0	0	0	1	1	6	0	0	0	4	3	0	1	2	1	0	0	1	0	0	0
16-20	8	3	9	4	9	10	6	5	7	12	13	5	8	3	5	10	18	10	10	7	10	7	8	9	9	7	5	6
21-25	6	5	11	4	7	2	10	6	8	4	9	5	5	6	8	6	6	5	3	10	8	3	3	3	5	8	4	4
26-30	4	1	4	3	6	5	0	8	4	8	3	6	13	6	6	6	10	5	9	9	10	9	6	6	4	6	7	5
31-35	2	3	2	4	3	3	5	3	4	6	1	3	6	4	2	6	3	5	2	4	8	5	5	6	5	5	4	6
36-40	4	5	5	1	1	2	2	4	4	2	4	1	3	5	3	2	4	2	2	4	6	3	9	6	1	3	4	3
41-45	7	2	0	1	8	7	5	5	5	5	5	7	5	7	8	13	4	10	10	4	6	7	3	1	2	3	4	4
46-50	2	5	4	9	3	5	8	6	8	7	4	1	3	2	6	3	3	1	7	6	4	6	6	8	5	6	6	3
51-55	4	4	4	3	7	4	2	1	2	2	2	2	9	4	3	6	5	5	7	6	3	4	8	2	4	4	4	3
56-60	1	2	2	2	1	0	6	1	3	3	4	1	2	3	3	3	1	1	5	1	3	3	4	3	3	5	4	1
61-65	1	1	1	5	4	3	4	1	1	0	3	0	0	0	3	2	1	3	2	3	2	3	1	0	3	4	0	0
66-70	3	0	1	1	1	1	3	3	3	6	2	0	1	3	3	1	1	0	0	1	0	2	1	3	1	0	0	1
71-75	0	0	0	0	1	1	1	1	3	2	1	0	0	1	1	1	1	0	1	0	0	0	0	0	0	1	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**42**	**31**	**44**	**40**	**51**	**45**	**56**	**44**	**52**	**57**	**52**	**32**	**61**	**44**	**52**	**59**	**61**	**50**	**58**	**56**	**62**	**53**	**54**	**47**	**43**	**52**	**42**	**36**

Community

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
1-5	6	6	9	8	11	9	2	5	7	10	13	5	5	9	14	3	7	11	5	6	9	7	10	9	4	3	17	7
6-10	12	24	31	21	20	24	14	22	30	41	29	32	16	36	35	29	20	37	22	52	41	31	47	39	19	41	47	32
11-15	30	58	62	43	42	59	54	41	74	51	68	53	39	57	75	51	65	79	52	65	53	48	77	38	43	58	54	52
16-20	60	84	65	52	62	85	83	95	98	82	96	95	67	86	86	104	91	102	75	100	90	94	92	75	104	88	76	85
21-25	72	65	71	61	72	66	65	68	81	62	90	77	70	76	51	59	62	72	56	81	62	69	76	63	72	73	74	75
26-30	34	40	55	40	52	54	46	63	47	55	62	75	81	62	45	62	67	55	75	64	74	58	71	70	43	74	77	53
31-35	28	32	42	23	42	35	43	42	42	40	40	53	38	54	37	34	46	52	40	62	49	48	59	58	44	50	45	35
36-40	33	32	50	29	23	30	40	41	31	37	34	35	39	30	31	31	24	27	28	35	58	32	48	39	41	35	33	39
41-45	36	34	31	33	47	44	33	33	49	43	34	40	45	49	43	33	32	48	36	38	40	36	31	43	35	35	48	25
46-50	22	35	36	27	15	22	31	33	35	31	36	35	30	35	43	27	18	16	24	40	44	36	35	33	39	31	39	25
51-55	31	25	31	24	21	19	19	32	24	36	23	21	41	24	24	26	27	26	30	24	26	28	37	16	20	41	16	17
56-60	14	12	15	26	13	14	19	16	28	16	30	17	23	23	19	16	14	12	16	19	17	30	26	15	17	19	25	19
61-65	5	9	12	9	20	13	14	6	10	5	17	9	10	6	6	10	9	6	17	16	21	13	10	13	24	20	13	12
66-70	4	1	3	7	7	4	3	8	5	12	8	13	4	3	10	5	7	4	25	15	9	11	26	16	6	8	7	11
71-75	1	0	0	0	2	3	3	4	1	1	2	2	4		4	2	2	4	32	12	9	8	14	11	10	8	14	11
76-80	2	0	0	0	1	2	0	1	0	1	0	2	1	0	2	0	0	2	28	18	4	10	16	4	6	13	9	9
81-85	2	0	0	0	0	1	2	0	0	0	0	1	1	0	1	2	0	1	30	12	14	7	10	6	5	9	9	9
86-90	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	24	10	7	7	9	4	8	8	8	4
91-95	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	6	3	4	1	0	4	0	1	4	2
96-101	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
TOTAL	**392**	**457**	**513**	**403**	**450**	**484**	**471**	**511**	**562**	**523**	**582**	**565**	**514**	**553**	**527**	**494**	**491**	**554**	**622**	**672**	**631**	**574**	**694**	**556**	**540**	**615**	**615**	**522**

Inpatient

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
11-15	1	1	0	0	3	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	1	1	2	1	0	1
16-20	9	8	5	5	11	6	12	6	12	7	11	7	5	8	13	13	6	10	10	11	13	9	10	8	13	11	8	9
21-25	11	8	6	11	12	9	9	5	5	9	6	6	11	4	5	11	13	7	14	10	19	15	10	10	19	4	10	13
26-30	5	11	5	10	9	11	4	5	5	6	7	10	5	8	10	4	4	5	6	8	8	5	15	15	15	9	6	17
31-35	9	2	8	5	11	5	6	6	5	8	4	8	7	4	7	5	5	8	8	6	7	8	7	8	5	10	7	5
36-40	5	5	6	2	3	9	6	6	5	5	4	8	3	3	5	4	14	4	7	7	8	7	10	6	9	11	3	4
41-45	8	5	7	8	6	5	7	9	5	3	3	3	7	2	5	6	10	3	6	7	4	5	5	4	5	2	9	8
46-50	1	4	8	4	3	3	3	8	10	6	4	3	9	3	6	4	5	9	9	6	5	3	2	0	5	3	4	3
51-55	7	5	5	5	3	2	9	6	11	5	8	5	3	4	5	2	3	4	1	8	7	2	2	7	5	6	3	7
56-60	2	3	2	3	4	2	4	1	5	5	3	2	1	1	5	5	0	1	2	3	3	1	2	6	3	3	0	3
61-65	1	0	1	3	4	6	4	3	6	6	3	1	8	2	6	10	4	5	2	1	2	2	3	0	2	1	0	0
66-70	2	2	0	2	2	0	3	0	0	0	4	0	0	1	0	0	0	1	3	0	1	1	0	1	0	0	2	0
71-75	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**61**	**54**	**54**	**58**	**71**	**58**	**67**	**55**	**70**	**60**	**57**	**56**	**59**	**41**	**68**	**65**	**64**	**57**	**69**	**68**	**77**	**58**	**67**	**67**	**83**	**63**	**53**	**70**

Community

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
1-5	9	10	3	9	3	3	13	4	1	8	9	4	8	5	4	4	5	5	7	9	5	1	4	5	11	6	6	6
6-10	42	46	39	53	48	29	56	36	22	29	47	32	31	29	24	28	32	22	19	21	10	19	35	34	45	22	34	42
11-15	75	81	49	82	79	48	61	57	36	52	52	49	70	65	47	76	66	47	59	36	45	56	68	58	74	51	63	82
16-20	136	148	95	110	107	125	105	63	107	103	102	88	95	111	114	113	108	104	103	82	83	100	110	110	130	105	114	114
21-25	70	91	96	80	113	103	85	77	97	93	95	77	100	84	80	110	96	81	104	77	93	102	103	90	94	76	87	115
26-30	83	85	69	116	79	79	62	65	69	76	68	71	99	59	82	66	92	66	80	66	65	69	90	78	125	91	73	103
31-35	74	58	62	64	74	52	59	47	56	42	69	44	70	48	53	64	41	55	63	48	65	69	62	75	78	77	64	59
36-40	37	38	60	38	50	57	45	42	43	35	37	45	40	47	43	49	55	36	53	39	44	34	53	45	56	38	42	57
41-45	66	54	66	62	55	56	62	37	37	31	53	25	47	41	49	39	57	38	45	33	39	28	41	31	46	35	49	43
46-50	35	50	50	36	42	46	49	43	39	29	38	39	51	39	59	35	40	53	42	33	23	24	31	36	28	38	49	34
51-55	36	38	37	31	42	34	50	31	36	29	46	34	31	34	33	32	25	39	32	32	31	35	33	44	37	38	40	47
56-60	32	29	31	28	17	35	26	18	42	28	33	23	24	23	32	22	17	21	30	16	14	20	29	25	19	26	34	27
61-65	22	14	18	30	14	23	29	17	37	27	32	25	20	16	30	34	22	15	11	19	17	11	24	26	24	28	33	21
66-70	11	15	20	14	22	15	22	16	12	16	10	11	12	13	8	11	12	12	27	12	10	9	16	13	20	12	25	11
71-75	10	7	9	10	12	13	19	10	12	12	11	11	6	14	22	9	14	8	6	12	6	8	16	10	9	7	18	8
76-80	14	7	5	6	10	4	4	14	7	12	9	9	11	13	8	14	8	12	19	7	8	12	12	8	7	8	6	12
81-85	8	8	2	12	8	6	6	3	4	9	15	12	7	6	4	11	5	13	10	7	6	9	6	6	8	9	9	7
86-90	12	8	7	6	3	13	7	5	3	8	4	13	8	9	6	9	4	4	8	6	10	7	6	1	5	5	5	7
91-95	5	2	4	1	5	2	2	3	2	2	2	2	3	1	1	0	1	4	1	3	3	1	3	5	2	1	1	0
96-101	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**777**	**790**	**722**	**788**	**783**	**745**	**762**	**588**	**662**	**641**	**732**	**614**	**733**	**657**	**699**	**726**	**700**	**635**	**719**	**558**	**577**	**614**	**742**	**700**	**818**	**673**	**752**	**795**

Inpatient

	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
11-15	0	0	0	0	0	1	0	0	1	1	1	2	0	0	0	1	**50**
16-20	11	3	11	16	8	9	4	6	9	8	6	2	5	8	6	3	**594**
21-25	16	8	9	12	14	13	10	4	8	7	11	6	8	7	7	17	**593**
26-30	9	8	12	11	11	8	6	3	6	9	4	6	11	8	5	4	**518**
31-35	5	7	7	2	10	7	4	7	6	0	5	5	5	4	6	2	**381**
36-40	9	6	7	4	6	4	3	1	3	3	3	3	2	4	4	1	**327**
41-45	3	5	2	4	5	5	8	1	5	6	5	5	2	5	3	4	**373**
46-50	9	5	5	13	9	4	2	1	3	3	0	2	3	4	3	4	**340**
51-55	5	5	7	6	5	5	3	2	5	2	2	1	3	2	0	3	**310**
56-60	2	9	3	3	2	2	6	5	2	3	4	4	0	3	2	4	**200**
61-65	4	6	2	3	2	3	3	4	0	4	1	1	5	0	4	1	**180**
66-70	1	2	2	1	0	1	1	0	2	1	0	0	0	2	1	1	**82**
71-75	0	0	0	1	0	0	0	0	0	0	0	2	0	0	0	0	**25**
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
TOTAL	**74**	**64**	**67**	**76**	**72**	**62**	**50**	**34**	**50**	**47**	**42**	**39**	**44**	**47**	**41**	**45**	**3980**

Community

	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
1-5	5	10	4	1	4	4	3	1	4	4	8	1	5	2	9	5	**454**
6-10	19	27	25	26	17	22	30	14	16	41	27	45	27	29	53	16	**2204**
11-15	76	46	60	56	47	78	68	29	72	79	78	114	103	76	117	59	**4383**
16-20	113	100	106	103	98	110	103	91	121	135	116	91	108	97	117	79	**7045**
21-25	115	92	96	90	105	100	104	69	99	102	119	83	114	112	113	114	**6137**
26-30	82	109	81	97	90	86	89	47	95	100	91	79	80	74	76	77	**5233**
31-35	67	79	81	47	72	71	61	78	67	71	87	71	55	72	67	45	**3996**
36-40	57	47	49	52	37	52	58	32	48	49	42	46	36	40	55	34	**2977**
41-45	43	29	36	35	30	44	47	25	41	39	41	45	30	24	40	32	**2920**
46-50	32	32	35	43	31	40	31	30	40	37	33	40	32	33	36	40	**2549**
51-55	60	45	35	37	39	42	42	35	49	42	21	40	22	38	30	30	**2343**
56-60	25	35	20	28	24	16	29	28	39	30	25	32	35	27	34	34	**1712**
61-65	24	20	21	25	17	19	23	18	20	21	21	21	16	28	20	11	**1299**
66-70	14	19	24	21	13	15	18	9	21	20	11	20	24	13	20	14	**925**
71-75	8	15	7	7	13	7	14	10	15	17	23	25	21	9	9	18	**694**
76-80	6	8	8	10	10	4	6	2	5	18	15	12	13	11	12	10	**547**
81-85	8	12	3	5	12	4	6	3	7	11	12	8	10	5	7	6	**457**
86-90	6	4	0	2	4	6	7	7	9	8	9	3	7	7	8	1	**367**
91-95	2	3	2	3	0	6	0	0	1	1	3	6	4	6	2	4	**131**
96-101	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	**6**
TOTAL	**762**	**732**	**693**	**688**	**664**	**726**	**739**	**528**	**769**	**825**	**783**	**782**	**742**	**703**	**825**	**629**	**46379**

NUMBER OF OPEN CASES

Inpatient

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16-20	1	3	2	3	6	6	4	2	3	5	5	3	1	0	2	2	3	5	3	1	1	2	2	1	3	4	1	3
21-25	2	3	6	4	3	1	4	2	3	3	2	4	2	3	2	1	2	3	3	3	4	2	5	2	2	3	2	3
26-30	1	1	1	2	2	3	0	4	2	3	3	2	6	4	1	0	4	0	4	3	2	5	5	1	2	3	2	3
31-35	0	3	1	1	1	3	2	1	1	2	2	2	1	2	1	1	1	0	1	0	1	2	2	4	0	2	0	1
36-40	5	3	2	2	1	0	2	1	1	1	2	2	2	4	1	0	3	0	0	2	0	1	4	4	2	1	1	4
41-45	5	1	1	2	2	4	1	2	1	3	3	4	1	0	4	7	4	4	6	3	2	3	2	1	1	2	1	3
46-50	2	4	3	3	2	4	2	2	5	5	4	3	3	0	3	0	2	1	2	4	2	2	3	4	4	1	1	0
51-55	3	3	3	2	4	3	0	1	0	2	0	1	5	2	2	3	3	3	2	4	3	1	4	2	1	1	1	2
56-60	2	2	1	1	0	0	2	3	3	2	2	2	3	2	2	2	1	2	3	1	3	3	3	3	1	1	2	0
61-65	1	1	2	3	3	0	2	2	1	0	3	2	0	0	3	1	1	1	1	2	1	2	0	0	0	1	0	0
66-70	2	1	2	1	1	2	3	2	2	2	3	0	1	3	2	2	2	2	0	0	0	1	1	3	1	1	0	1
71-75	0	0	0	0	0	1	1	1	1	1	2	2	1	2	1	2	0	0	1	0	0	0	0	0	0	0	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**24**	**25**	**24**	**24**	**25**	**28**	**23**	**23**	**23**	**29**	**31**	**27**	**26**	**22**	**24**	**21**	**26**	**21**	**26**	**23**	**19**	**24**	**31**	**25**	**17**	**20**	**11**	**20**

Community

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
1-5	6	10	16	20	26	31	27	26	31	34	37	35	35	38	37	33	29	33	31	26	28	30	28	30	26	26	37	36
6-10	9	28	43	50	53	68	57	64	83	101	94	98	94	110	114	121	109	119	112	130	132	137	154	142	126	142	142	144
11-15	19	58	79	96	108	132	142	144	176	176	184	175	173	175	199	200	211	234	243	250	250	241	232	195	184	190	181	190
16-20	48	89	100	114	115	144	148	166	188	188	192	207	199	206	217	244	229	235	232	238	247	262	241	215	218	222	226	246
21-25	91	118	131	149	161	167	173	169	184	197	211	229	229	230	224	225	220	237	231	238	233	236	240	222	218	232	237	260
26-30	95	116	133	140	153	161	164	181	175	181	195	204	203	215	215	225	222	226	237	236	245	232	230	235	240	268	261	256
31-35	94	111	118	121	130	135	153	164	171	172	172	180	177	182	173	172	179	186	188	198	194	206	204	195	200	212	207	201
36-40	82	95	118	122	121	123	131	141	139	138	149	155	160	161	154	154	147	145	150	149	161	160	160	162	170	177	179	186
41-45	84	98	104	109	120	135	133	134	154	158	160	159	171	179	178	177	174	185	188	180	185	185	177	183	178	188	192	183
46-50	57	74	90	92	89	96	97	108	112	120	132	133	136	146	154	147	146	143	144	151	166	166	161	155	168	169	161	160
51-55	44	51	65	64	64	63	70	82	82	91	92	95	105	100	102	110	111	117	127	120	121	131	131	123	118	128	121	118
56-60	20	24	25	35	30	34	39	44	55	57	69	75	75	73	78	78	72	67	73	74	76	83	84	80	79	83	79	82
61-65	8	15	16	19	26	30	31	28	31	30	34	35	33	30	32	34	33	33	43	45	51	47	48	47	49	54	53	54
66-70	6	6	7	10	12	14	14	16	14	16	17	19	20	16	20	18	23	25	42	48	44	45	58	62	58	60	62	64
71-75	2	2	1	1	3	4	4	4	3	4	5	6	7	6	7	8	7	8	36	42	42	35	43	39	41	36	43	49
76-80	0	0	0	0	0	0	0	0	0	1	1	2	1	1	2	2	2	2	27	38	37	36	46	36	38	43	39	44
81-85	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	29	31	40	27	31	29	29	28	27	33
86-90	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	22	27	30	26	29	27	26	24	22	22
91-95	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	6	6	3	3	5	5	5	7	7
96-101	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	1	1	1	1
TOTAL	**666**	**895**	**1046**	**1142**	**1211**	**1337**	**1383**	**1472**	**1598**	**1664**	**1744**	**1807**	**1818**	**1868**	**1906**	**1948**	**1914**	**1996**	**2161**	**2228**	**2289**	**2289**	**2301**	**2183**	**2172**	**2288**	**2277**	**2336**

Inpatient

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
16-20	2	4	0	2	3	1	5	1	0	0	2	1	3	1	3	3	2	2	2	2	1	1	1	1	2	4	4	4
21-25	7	7	3	2	2	3	3	2	1	3	3	3	5	3	2	4	10	7	3	2	7	5	7	2	2	1	3	5
26-30	2	4	4	4	3	4	1	1	0	3	2	6	2	5	5	1	1	2	4	2	3	1	5	8	5	2	0	3
31-35	3	0	1	0	6	1	1	3	2	4	1	2	4	5	4	3	3	5	2	0	1	0	1	2	1	5	3	2
36-40	2	1	0	0	1	2	2	2	1	3	3	5	1	2	2	2	5	1	2	2	2	3	2	2	3	6	2	2
41-45	3	1	5	3	2	2	2	3	0	0	2	1	4	2	1	3	6	0	0	1	1	1	1	2	3	1	3	4
46-50	0	1	4	2	1	1	2	0	3	2	1	0	2	1	0	1	1	5	1	3	2	1	1	0	2	2	2	2
51-55	2	3	2	3	3	2	8	3	6	2	2	5	3	3	2	1	3	1	2	3	3	2	2	1	1	3	2	3
56-60	1	3	4	4	3	5	5	2	2	1	4	0	0	0	1	1	0	0	2	1	0	1	1	2	1	1	1	0
61-65	0	0	0	1	1	4	3	3	2	3	2	2	4	2	3	3	1	1	1	1	1	3	2	1	1	1	0	0
66-70	2	2	1	1	1	0	1	0	0	0	1	0	0	1	1	1	1	2	0	0	0	0	0	0	0	0	0	0
71-75	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**25**	**26**	**24**	**22**	**27**	**25**	**33**	**20**	**18**	**21**	**23**	**27**	**28**	**25**	**24**	**23**	**33**	**26**	**19**	**17**	**21**	**18**	**23**	**22**	**21**	**29**	**22**	**26**

Community

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
1-5	33	33	29	32	30	30	36	33	29	33	40	38	37	35	39	36	37	36	35	39	35	31	30	33	35	34	34	35
6-10	135	139	135	159	168	164	174	168	155	162	175	186	172	174	169	160	162	152	147	142	135	136	146	164	181	168	159	166
11-15	196	222	211	232	259	242	250	245	226	242	243	238	256	252	256	256	258	264	266	258	251	252	277	287	286	286	277	265
16-20	269	290	286	284	279	282	253	235	239	254	272	258	245	243	250	254	260	274	274	247	236	240	249	256	271	265	249	248
21-25	248	268	259	232	254	248	242	239	253	257	249	229	232	236	229	231	234	224	232	229	246	258	247	236	239	224	223	231
26-30	274	274	253	250	246	234	233	232	242	257	249	232	254	241	245	236	240	228	221	226	237	243	255	271	295	269	259	257
31-35	206	206	199	197	210	190	198	199	209	197	211	200	201	207	210	204	202	200	204	198	210	210	211	221	229	224	213	209
36-40	192	190	195	174	182	180	168	170	182	179	184	183	181	189	186	199	203	196	193	194	186	188	201	195	207	187	174	189
41-45	202	203	212	203	207	218	216	202	195	190	198	179	170	175	185	187	198	190	185	180	183	183	182	177	180	179	183	185
46-50	170	180	177	169	174	168	176	166	169	166	170	164	160	165	168	161	165	168	167	160	160	166	168	174	170	158	160	150
51-55	132	138	132	121	133	120	127	129	130	124	128	127	123	129	135	137	138	142	137	132	136	136	136	142	148	142	142	151
56-60	87	87	92	89	86	89	83	78	89	92	94	90	91	99	102	102	88	82	91	83	86	81	85	83	81	89	86	90
61-65	56	59	54	48	48	50	44	45	58	60	67	57	54	51	48	52	51	50	46	44	42	44	50	50	51	56	55	51
66-70	64	61	65	59	62	60	62	66	68	72	66	70	69	64	57	55	51	51	62	58	59	55	54	54	61	57	62	58
71-75	48	43	35	32	40	49	57	60	59	61	54	53	49	49	54	52	51	43	46	46	43	40	44	41	37	39	37	30
76-80	50	42	40	33	35	36	35	47	46	47	43	47	42	42	41	46	39	33	43	37	30	36	42	40	31	31	31	35
81-85	33	22	18	21	26	28	32	33	34	34	37	36	28	28	26	30	27	25	28	22	18	19	19	20	19	21	21	17
86-90	25	21	25	19	20	31	25	25	24	29	26	32	27	27	24	24	24	22	24	25	21	24	24	17	16	15	14	17
91-95	11	8	9	3	5	5	7	5	7	8	4	5	3	2	2	2	3	5	4	6	5	3	6	8	9	5	3	2
96-101	1	1	1	1	1	2	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**2432**	**2487**	**2427**	**2358**	**2465**	**2426**	**2419**	**2378**	**2415**	**2465**	**2510**	**2424**	**2394**	**2408**	**2426**	**2424**	**2431**	**2385**	**2405**	**2326**	**2319**	**2345**	**2426**	**2469**	**2546**	**2449**	**2382**	**2386**

Inpatient

	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
6-10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11-15	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
16-20	1	0	0	2	2	5	1	1	4	7	4	3	1	4	1	3
21-25	4	1	2	4	5	6	2	0	1	5	4	5	6	5	7	6
26-30	4	3	4	4	4	4	3	5	3	3	3	3	8	5	6	4
31-35	1	3	3	1	2	5	1	0	1	0	3	3	1	2	2	1
36-40	2	1	1	1	1	0	0	0	2	2	3	1	2	3	0	1
41-45	3	4	1	1	1	0	1	2	2	3	2	2	2	4	0	2
46-50	2	0	2	4	2	0	0	0	2	2	1	1	1	2	3	2
51-55	0	2	2	2	4	4	2	3	5	3	3	3	4	3	2	2
56-60	1	3	0	0	1	1	3	1	0	1	3	3	2	4	2	3
61-65	2	2	1	0	1	2	2	2	0	2	2	0	1	0	2	2
66-70	1	1	0	0	0	1	0	0	1	2	0	0	0	1	1	1
71-75	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
76-80	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
81-85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
86-90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**21**	**20**	**16**	**19**	**23**	**28**	**15**	**14**	**22**	**30**	**28**	**25**	**28**	**33**	**26**	**27**

Community

	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
1-5	32	35	34	31	29	27	28	28	30	29	29	24	21	20	23	24
6-10	152	141	131	133	116	117	114	114	113	120	123	123	112	109	126	96
11-15	276	258	243	232	207	230	236	226	236	247	254	264	286	278	316	277
16-20	239	216	217	226	227	224	218	213	224	245	232	231	246	243	264	238
21-25	244	241	225	225	223	235	233	221	237	235	238	228	230	225	246	232
26-30	258	267	245	240	242	244	244	244	253	256	252	258	271	250	258	255
31-35	208	222	218	201	205	211	197	198	206	210	213	224	205	211	218	210
36-40	193	200	202	195	184	190	183	170	181	186	183	182	180	182	195	191
41-45	181	184	170	168	161	170	164	159	171	171	166	177	171	167	171	162
46-50	149	149	154	147	144	151	140	141	145	146	144	151	153	159	157	150
51-55	159	157	148	137	137	140	135	137	149	154	136	136	132	136	132	136
56-60	95	100	86	88	91	87	91	87	96	99	90	95	96	90	94	92
61-65	52	51	48	49	50	51	47	49	51	51	45	46	47	52	51	47
66-70	54	55	56	57	50	48	46	42	45	46	43	42	38	35	37	37
71-75	29	36	33	31	29	28	27	23	24	30	28	28	29	24	22	27
76-80	27	27	24	25	26	26	23	21	17	26	25	22	17	14	16	15
81-85	20	24	17	20	19	16	15	12	11	14	17	12	10	9	11	7
86-90	16	15	10	11	9	13	10	10	13	11	10	6	5	5	10	3
91-95	3	3	4	7	3	7	6	4	2	1	2	6	3	4	2	2
96-101	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**2387**	**2381**	**2265**	**2223**	**2153**	**2215**	**2157**	**2099**	**2204**	**2277**	**2230**	**2255**	**2252**	**2213**	**2349**	**2201**

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

7 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

E-mail:

Dear

Your OIA request of 9 April 2021 to MidCentral District Health Board (MDHB) in which you have requested information about waiting lists for joint replacements is acknowledged and has been passed on to me for response.

You have requested the following information.

- **In the past 12 months, what proportion of your DHB patients that were referred to a waiting list by a surgeon for a joint replacement were accepted onto the list and got surgery?**

Calendar Year	Not Treated	Treated	Total	Proportion
2020	163	313	476	66%

- **In 2017, what proportion of your DHB patients that were referred to a waiting list by a surgeon for a joint replacement were accepted onto the list and got surgery?**

Calendar Year	Not Treated	Treated	Total	Proportion
2017	66	474	540	88%

- **Is the DHB able to comment on whether there are enough GPs in the region?**

  MidCentral DHB, like most regional DHBs, is subject to a workforce shortage of General Practitioners (GPs).

  Additional GPs are always needed within the district. An estimated six are needed permanently to reduce the reliance on a locum workforce.

  Longer term recruitment and workforce strategies with the primary health organisation and the DHB are in place and continue to be enacted.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

7 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act Request Y21-433

We are in receipt of your Official Information Act Request received 13 April 2021.

You advised that you request information on interhospital transfers on fixed wing and rotary wing. Please see our responses to your questions below.

1. ***How many currently registered flight nurses are employed by the DHB?***

   Response:
   None

2. ***What is the average remuneration of currently registered flight nurses employed by the DHB by qualification and seniority bands?***

   Response:
   Not applicable as above response.

3. ***For each of the last 3 complete financial years, how many flight hours have been charged to the DHB for interhospital transfers by fixed wing aircraft?***

   Response:
   MDHB does not collect this data.

4. ***For each of the last 3 complete financial years, how many flight hours have been charged to the DHB for interhospital transfers by rotary wing aircraft?***

   Response:
   MDHB does not collect this data.

   Received from TAS - Although NASO does have some of the information, some DHBs collected rotary data before the NASO contracts for air ambulance came into effect which is not three complete financial years.

5. ***For each of the last 3 complete financial years, how much has the DHB spent with third parties for interhospital transfers by fixed wing aircraft?***

   Response:

Prior to November 2018, the MDHB records did not distinguish between a fixed or rotary wing flight.

Fixed and Rotary Wing Costs	
2017 - 2018	$311,997.75
2018 – Oct 2018	$852,804.60
Fixed Wing costs	
Nov 2018 – 2019	$2,244,925.73
2019 - 2020	$1,462,918.33

6. ***For each of the last 3 complete financial years, how much has the DHB spent with third parties for interhospital transfers by rotary wing aircraft?***

Response:
Prior to November 2018, the MDHB records did not distinguish between a fixed or rotary wing flight. Unless the cost of the flight personnel is included in the individual flight invoice, MDHB does not collect the data to distinguish personnel costs for fixed and rotary wing flights.

Rotary Wing Costs	
2017 - 2018	See Above
2018 – Oct 2018	See Above
Rotary Wing Costs	
Nov 2018 – 2019	$244,230.24
2019 - 2020	$314,338.66

7. ***For each of the last 3 complete financial years, what is the total number of flights for each destination for interhospital transfers for fixed wing aircraft?***

Response:
Prior to November 2018, the MDHB records did not distinguish between a fixed or rotary wing flight.

Fixed and Rotary Wing Flights from July 2017 to October 2018

Destination	2017 - 2018	2018 – Oct 2018
Auckland	15	7
Burwood	2	2
Christchurch	2	1
Dunedin	2	
Hawkes Bay	4	
Hutt	5	
Middlemore	13	2
Starship	11	3
Taranaki	2	
Waitemata	1	
Waikato	3	3
Wellington	182	64
MidCentral DHB	132	38

Fixed Wing Flights from November 2018 to 2020

Destination	Nov 2018 - 2019	2019 - 2020
Auckland	14	13
Burwood	2	
Christchurch	6	7
Dunedin		1
Hawkes Bay		1
Destination	**Nov 2018 - 2019**	**2019 - 2020**
Hutt	4	2
Nelson		1
Middlemore	8	4
Starship	14	21
Taranaki	2	
Tauranga		1
Waikato	4	2
Wellington	135	143
MidCentral DHB	76	102

8. ***For each of the last 3 complete financial years, what is the total number of flights for each destination for interhospital transfers for rotary wing aircraft?***

Response:
Prior to November 2018, the MDHB records did not distinguish between a fixed or rotary wing flight. (see table above)

Rotary Wing Flights from November 2018

Destination	Nov 2018 - 2019	2019 - 2020
Christchurch		1
Hutt		1
Waikato	1	2
Wellington	31	43

9. ***What metrics does the DHB use to measure service performance of service providers providing interhospital transfer services to the DHB for fixed wing aircraft?***

Response:
MidCentral DHB does not have a metric to measure service performance of the service providers for interhospital transfer services to the DHB for fixed wing aircraft.

10. ***What metrics does the DHB use to measure service performance of service providers providing interhospital transfer services to the DHB for rotary wing aircraft?***

Response:
MidCentral DHB does not have a metric to measure service performance of the service providers for interhospital transfer services to the DHB for rotary wing aircraft.

NASO service specs are posted here on the Ministry of Health website.
https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/national-ambulance-sector-office-naso/emergency-ambulance-services-eas/eas-providers/emergency-ambulance-service-generic-service-agreements

11. What business rules or agreements are in place with other DHBs for cost sharing for interhospital transfers for fixed wing aircraft?

Response:
There is an agreement that costs will be shared between DHBs according to the patient arrangement. This is discussed and agreed at the time of booking with the service provider.

12. What business rules or agreements are in place with other DHBs for cost sharing for interhospital transfers for rotary wing aircraft?

Response received from TAS:

The process is invoice based, where NASO has determined the hourly rate and invoices DHBs for interhospital transfers (IHTs) hours flown. This was first established through a variation to the Crown Funding Agreement.

DHBs are responsible for funding IHTs, however, there are two business rules for when IHTs are funded by either the Ministry or ACC.

- The Ministry will pay for an urgent IHT where a patient is transferred from one medical facility to another within three hours of arriving at the first facility. The exception to this rule is the northern region.
- ACC will pay for an urgent IHT when a patient is transferred from one publicly funded hospital to another within 24 hours of arriving at the first hospital, as long as that first hospital could not be reasonably expected to meet patient needs (eg if a service is usually available at that facility, but at that particular time due to staff absence was not).

For each calendar month, DHBs are sent a list of IHT missions where the patients have been domiciled to that DHB. These missions exclude all missions where the provider indicates the mission is an ACC 24-hour rule IHT.

The DHB reviews the missions sent and advises if they accept the cost of the IHT or whether the cost of the IHT should be elsewhere i.e. Ministry of Health for 3-hour rule missions or another DHB.

Missions that are advised that fall under the 3-hour rule are checked with St John and those that are found to fall outside the rule are resent to DHBs. Additionally, missions that should be sent to another DHB are also sent.
DHBs are invoiced for all accepted missions for each quarter.

13. What advice has the DHB provided to the Simpson Review team relating to patient transfers by aircraft?

Response:
N/A

14. What growth forecasts has the DHB completed or commissioned relating to interhospital transfer demand?

Response:
To date MidCentral DHB has not completed or commissioned a growth forecasting requirement with regards interhospital transfer demand.

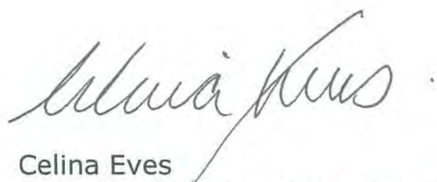
15. ***Who is the DHB currently under contract with to provide interhospital transfer by aircraft, when does the contract expire and what right of renewals exist within the contract?***

Response:
MidCentral DHB has no contracts in place for the provision of fixed wing interhospital transfer. Rotary wing contracting sits with the Ministry of Health.

A partial transfer to the Ministry of Health was requested on 29 April 2021 for information relating to interhospital transfer by rotary aircraft.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours Sincerely



Celina Eves
Executive Director of Nursing & Midwifery

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

05 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act Request: Y21-432
COVID Vaccination Operating Model

The information below is in response to your Official Information Act request dated 13 April 2021.

Under section 12 of the Official Information Act 1982, I request all original communications including responses.

- To the Jan 27 letter from the Ministry of Health around the coronavirus vaccination rollout in your DHB including the confirmatory responses to the request for *" Confirmation of the operating model that your DHB will use to implement the day to day running of your vaccination programme"* and *"Confirmation of detailed service delivery model you will need to implement to deliver vaccinations to border workers and those they live with"*

Please find attached the following:
1. A letter from Kathryn Cook to Dr Ashley Bloomfield dated 28 January 2021 in response to the January 27 letter, which indicated that MidCentral District Health Board were not in the first tranche of fifteen DHB's to deliver the COVID-19 vaccination.
2. The MDHB Service Delivery Model submitted early March 2021.
3. A letter of response, from Sue Gordon Ministry of Health to Kathryn Cook Letter 28 January 2021.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

28 January 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Ministry of Health

By email to: Ashley.Bloomfield@health.govt.nz

Tēnā koe Ashley

Update on COVID-19 Vaccine and Immunisation Programme

Thank you for your letter of 27 January concerning the COVID-19 Vaccine and Immunisation Programme and the proposed roll out in 15 DHBs that have either MIQ facilities, Port facilities or Airports. MidCentral DHB (MDHB) is not included in the 15 DHBs listed.

As you are aware defence personnel from both the Linton Military Camp and Ohakea Airbase work within MIQ facilities. For the New Zealand Defence Force staff, most of their household contacts (people they live with) would reside in the MDHB region.

Your letter refers to our earlier response to your letter of 16 December. In our response to that letter we highlighted this matter. Specifically, we said:

> *It would also be useful to have an understanding on the process by which the Defence Force will be vaccinated (i.e. where and by whom). This has significant implications in the MDHB area given the presence of Linton and Ohakea within our catchment area and noting the role they play in group one priority vaccination under scenario one. See comment under Pillar 4 regarding capturing household contact information.*

We remain unclear as to who will be delivering the vaccine to both the defence force and their household contacts. If this is to be provided to defence personnel at their place of work, the proposed approach to immunise their household contacts is not clear.

This has significant implications for our local planning team should the scenario unfold that we are required to vaccinate defence force staff + / - their household contacts.

We would appreciate clarification on this matter as soon as possible.

We also note that the MDHB acting GM Strategy and Planning (planning and funding), Tracee Te Huia has not yet been engaged in the definition and numbers of the populations referred to in your letter and look forward to this occurring.

Ngā mihi

Kathryn Cook
Chief Executive

MidCentral DHB COVID-19 Vaccination Response to Updated Sequencing and Roll Out Plan March 2021

Summary

There have been several discussions with the Ministry regarding the MidCentral District Health Board's role in delivering the vaccination programme for defined populations. This paper provides a summary of:

- **Sequencing** – the scale and mix of people in groups 1 a, 2 and 3 with the planned timeframes for delivery of the programme
- **Delivery approach** – an outline of the approach proposed for Groups 1, 2 and 3 vaccination delivery
- **Vaccine requirements** – a forecast of the weekly volume of vaccine that would be required for the final two weeks of March 2021

Dry vaccine delivery run yet to be scheduled (planned for end of week of 15/3/2021)

Several meetings have been held regarding the sequencing and deliver of vaccination to tier 1 b, with the initial formal meeting with NZ Defence Force, MoH and MDHB on 9 March. These will be ongoing as required. MDHB is yet to receive a requested confirmatory letter from the MOH regarding MDHB involvement.

Considerable planning is underway, utilising a slightly modified CIMs structure, which is intended to continue for delivery.

Sequencing

The MDHB's sequencing within Tiers 1, 2 and 3 is outlined below.

Table 1: Summary Group 1, 2a and 2b, 3 populations, MDHB

	Proposed start date	MidCentral	Notes
MIQ		0	
Port		0	
Subtotal Group 1 Workforce		**0**	
Household contacts (*Contacts received to 15/03/2021)	**Week of March 22**	*82	Expect up to 3, 000
Total Group 1 workforce and household contacts		**82**	
Group 2a (*Plan to be submitted March 22)	***Week of April 13**	2379	Only front-line health workers, no allowance (as yet) for other frontline workforce that may require delivery support. i.e. St. John ambulance.
Group 2b		7407	
Subtotal Group 2		**9786**	
Group 3 (plan in development)		56500	
Total Group 1, 2 3		**66368**	

Further detail on the breakdown of workforce data will provided at Appendix 1 in updated report 22 March. +9

Table 2: Additional MidCentral population estimates

		MidCentral	Notes
Māori 55+		5990	To be vaccinated in 2b
Pacific 55+		860	
Total		**6850**	
Non-Māori/non Pacific 65-74+		14020	
Non-Māori/non Pacific 75+		17690	
Total		**31710**	
Combined total		**38560**	

The timeframes for programme delivery are set out below

2021	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Tier 1 (b)										
Tier 2										
Tier 3										
Tier 4										
Influenza		Influenza*								
MMR**										

*influenza programme 14-28 April for healthcare staff, April/May for general public
** MMR – measles catch-up programme for 15-30 year olds

Delivery approach

MDHB Delivery models and vaccinator team workforce

Tiers 1 & 2	Sites	Tier 1b MIQ + contacts	Tier 2a direct, frontline interaction with patients, personal care, no screening possible					Tier 2b Frontline healthcare workforce working in healthcare service delivery settings interacting with patients / clients							
Groups		MIQ worker families	Covid testing (lab & DTS); vaccinators	Ambulance, Community midwives, WCTO in homes (not Tamariki Ora)	ED Emergency diagnostic, support staff	GPTs, urgent care clinics; Pharmacy	NGOs incl. Whānau Ora (excl. MHA, social support services)	Inpt, outpt DHB services incl, diagnostics, IMT; PH team	Residential care workers including mental health and addictions and disability	Home care support workers including aged care and disability support	Community diagnostics - radiology, laboratories, OIS	All other primary care not included in Tier 2 (a)	Community home-based services	NGO, community-based services incl. iwi-based services, MHA	ARC staff, residents
Setting	**Community Sites**	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT
	Mobile to own site								CRT					CRT	CRT
	Mobile to collective site	CRT		CRT			CRT			CRT	CRT			CRT	
	MDHB site(s)		CRT		IPC+ CRT			IPC+ CRT							
	Own site Locality Specific					Own team+	Own Team+		Own GPT?			Own Team+		Own Team+	Own GPT+
Tiers 3 & 4	**Sites**	**Tier 3* Older people (other ≥65 years; Māori ≥55 years) People with Long term conditions At risk health and social service workers**						**Tier 4 Rest of population not previously vaccinated**							
	Community sites	CRT						CRT							
	Mobile to site	CRT						CRT							
	Own Site	Own team+						Own team+							

Vaccinators:

- **CRT** = Covid Response team (incl. MDHB RN vaccinators, 3rd Year Students; MDHB pharmacists; casual pharmacists; contracted vaccinator teams, PHNs)
- **IPC** = Infection Prevention and Control
- **PHNs** = Public Health Nurses
- **Own Team** (+supported) – GPT; Māori Health Providers

Principles of service delivery models: *Specific vaccine requirements, Te Tiriti responsibilities & access*:

- *accessible* (regions, safe & known sites, parking, transport)
- *affordable* (reduce travel costs, reduce disruption to paid work);
- *available* (hours/days of operation)
- *appropriate* (culturally appropriate sites e.g. churches, marae and team ethnicity mix)
- *appropriate* for the needs of the population e.g. those immobile
- *appropriate* (using known members of the usual carer team when possible)
- *choice* of service delivery model where possible

Service delivery models	
1. Large vaccination site ***A. Community sites*** (Public buildings) • Palmerston North • Feilding • Levin • Dannevirke B. ***Community sites - private***	For vaccination of all tiers with any of the vaccines • Appointments 90% / 10% walk in For vaccination in Tier 3 • E.g. Pacific Churches • Engagement re appropriate protocols, times, days, venues • Involvement of own members in that vaccination team as appropriate or other aligned health professions
2. Mobile team to external site	Tier 2 a/b e.g. ARCs • Scheduled visits x 2 with catch ups x 2; extended time for setup and per vaccination • Shift changeover times if possible • Vaccinating residents and staff at the same time (potential for ARC staff to be vaccinated by own GPT) • Use site in facility • Use own staff for observations when possible (& vaccinating of possible) • Key issues - consent, observation of multiple people in different spaces, and working with a vulnerable population

3. Mobile to collective site	Tier 2 a/b e.g. Iwi health provider
	
	• Work with small NGOs to collectively decide on an appropriate venue that will enable
	    ○ Scheduled visits x 2 with catch ups x 2
	    ○ Use of own staff in roles e.g. vaccinating, observation, support, traffic management if required
	• Consideration of appropriate times, days and protocols

4. MDHB sites • Palmerston North • Levin	For vaccination of MDHB employees and contractors on site (for those in Tier 2a/b) • Clinics seven days per week, covering morning and afternoon shifts • Staff can also choose to be vaccinated at a community site • Staff at other bases will be requested to attend the community site
5. Own site / Own vaccinators+ (investigate potential to supplement workforce)	a. For vaccination of clinical teams that include vaccinators e.g. GPTs vaccinating their own team (in Tiers 2a/b) • Only available for large IFHCs • GPTS could link up (as per green – red protocol for respiratory care) b. For vaccination of enrolled population group e.g. Tier 3 • Use of recall systems • Potential to use models as per flu – with the extended vaccination • Includes linked ARC facility / population groups • Potential to use facilities out of hours • Potential to use booking systems • Potential to use IT c. For vaccination of enrolled and non-enrolled population e.g. tier 4 • As per b.

The proposed models for MDHBs and indicative commencement dates are set out below. For the initial vaccination delivery this will be on site at the Linton Army camp, allowing easy access for close contacts living on site. An additional site is being developed in Palmerston North city so that close contacts residing off base also have easy access.

Week Commencing (2021)	Vaccination Centre Linton Community	Locality Vaccination Centre Palmerston North
Target cohorts		
Week of 15/03/2021	Tier 1b	Tier 1b
Week of 22/03/2021	Tier 1b	Tier 1b
Week of 29/03/2021	Tier 1b	Tier 1b

Our vaccination administration and support base in Palmerston North has been identified and is currently being equipped- expected to be functional by 19 March.

Group	Population being vaccinated	Planned vaccine sites	Timeline	Vaccinators and support staff
1	Tier 1b	As above	March-May	MDHB COVID-19 immunisation response team, including a private vaccination provider (under discussion)
2	Under development			
3	nil			

Vaccine requirements

Vaccine requirements for weeks one and two are to be finalised with Rob Morton, MoH and MDHB COVID-19 Manager Dan Hirst Tuesday 16 March.

Deborah Davies
Vaccination Lead
MidCentral District Health Board

Kelvin Billinghurst
SRO
MidCentral District Health Board

Appendix 1

Breakdown of Tier 2 Populations for Vaccination

Tier 2a (will be developed for plan to be submitted 2 April)

	MidCentral
COVID-19 testing (taking samples and laboratory analysis)	
Administering COVID-19 testing	
Administering COVID-19 vaccinations	
Ambulance services	
Emergency department front line workforces	
Emergency response diagnostics and support staff interacting with patients	
Community midwives and WCTO workers in peoples homes	
General Practice front line workforce including GP's, nurses and receptionists and urgent Care clinics	
Pharmacy front line workforce	
NGOs (including Whānau Ora) providing first response personal health services directly to patients (excluding mental health and addictions, social support services)	
Healthcare providers providing treatment services to people in managed isolation	
Contact tracing personnel required to respond to prevent community transmission	
Tier 2 (a) totals	

Tier 2b

	MidCentral
Inpatient, ambulatory and outpatient publicly funded hospital services including community staff and diagnostics	
All residential care workers including mental health and addictions and	

disability	
Home care support workers including aged care and disability support	
Community diagnostics - radiology, laboratories	
All other primary care not included in Tier 2 (a)	
Community and home-based services	
All NGO and community-based services including iwi-based services and mental health and additions	
Community public health teams	
Outreach immunisation staff	
COVID Incident Management Teams at each DHB	
ARC workers	
ARC residents	
Critical workers	
Māori 55+, Pacifica 55+	
Tier 2 (b) totals	

MINISTRY OF HEALTH
MANATŪ HAUORA

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

19 March 2021

Kathryn Cook
Chief Executive
MidCentral District Health Board

Dear Kath,

Update on COVID-19 Vaccine and Immunisation Programme

Thank you for your letter of 28 January raising the issue of who will be vaccinating the New Zealand Defence Force (NZDF) staff that reside at both the Linton Military Camp and Ohakea Airbase. Please accept my apologies for the delay in coming back to you.

As an update Kath, Joanne Gibbs has now started at the Ministry of Health as the Operations Lead for the continued rollout of the COVID-19 vaccine and will be a key contact point for you going forward. An operations team is also being stood up, so we can fully support the efforts of DHBs as we move through the vaccination of the wider population.

We have also put in place Account Manager and Account Lead functions to support DHBs in their planning and implementation of the vaccine rollout. This is a key point of contact for you and your teams over the coming weeks. For your DHB, Kirsten Curry is your Account Manager. Kirsten can be contacted at Kirsten.Curry@health.govt.nz and is working closely with Deborah Davies your Vaccination Lead on implementation. Your Account Lead is Rachel Mackay, who is on secondment from TAS. Rachel's email address is currently rachel.mackay@tas.health.nz, she will update you with her contact details once she has a Ministry email address. Rachel will be supporting your team with planning, reporting and any higher-level issues. She is a resource for your SRO Kelvin Billinghurst and yourself.

With regard to your NZDF query, the Ministry of Health is engaging nationally with NZDF and working with them on the vaccination of their workforce and household contacts noting the clarifications below.

NZDF will be vaccinating their household contacts who are also NZDF personnel. They are unable to provide health services to non-NZDF (civilian) household contacts due to regulatory requirements.

We have worked on a range of options for vaccinating civilian household contacts with NZDF and your COVID-19 vaccination team. These included a collaborative NZDF / DHB model using NZDF facilities.

Your team's preference is for the DHB to vaccinate civilian household contacts, and they have set up the Linton Community Centre site for this purpose. We understand there are

~80 civilian household contacts who will be vaccinated, which will start on Thursday 26 March.

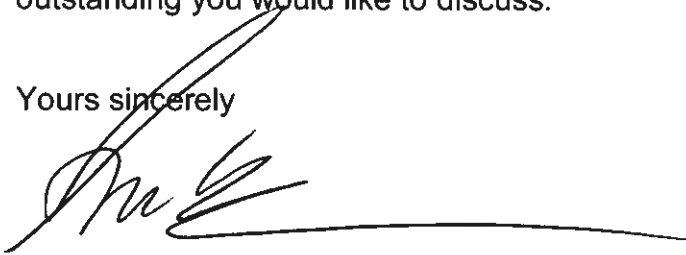
We are working collaboratively with your team, Whanganui DHB and NZDF regarding vaccinating civilian household contacts for Ohakea. The base is in the MidCentral DHB boundary however the housing area falls within the Whanganui DHB boundary.

We appreciate the need to work closely with you and your team on this.

With regard to engagement with your Acting GM Strategy, there is regular weekly engagement occurring through the GMPF working group that is assisting the Ministry with its planning for the vaccination programme rollout. We anticipate that your GM will be engaged through this process. There is also three times a week stand up online meetings occurring with your identified Vaccine Lead to help keep operational leads engaged in the planning process.

Thank you for raising these issues Kath and please get in touch if there is anything outstanding you would like to discuss.

Yours sincerely



Sue Gordon
Deputy Chief-Executive
COVID-19 Health Systems Response

MIDCENTRAL DISTRICT HEALTH BOARD

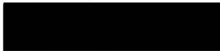
Te Pae Hauora o Ruahine o Tararua

6 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand



E-mail:

Dear

Your OIA request of 17 April 2021 to MidCentral District Health Board (MDHB) in which you have requested information about dog bites is acknowledged and has been passed on to me for response.

The information that you have requested is;

- **How many children aged 0-14 have presented to hospital with a dog related injury in the last year?**

  Twenty five (25) children presented in the 2020 calendar year.

- **How many of those children required a procedure (e.g. sutures) or admission?**

  - One (1) patient did not wait for treatment.
  - Nine (9) patients had a steri strip or glue procedure to close the wound(s) and dressing.
  - Five (5) received wound cleaning and dressing procedures.
  - Three (3) patients received a suture procedure to close the wound(s).
  - Six (6) went to theatre for closure of wound procedures.
  - Note: Five (5) of the above were admitted.

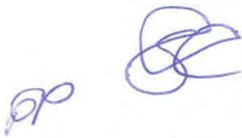
- **What were the ethnic and age demographics of those children?**

Age	Asian	NZ European/ Pakeha	Other European	NZ Maori	Pacific Islander
0-12 months				1	
12-24 months			1	2	
2-3 years		4		1	
3-4 years		1			
4-5 years		2		2	
5-6 years					1
6-7 years		1		1	
8-9 years		1			
9-10 years		1			
10-14 years	1	1		4	
Total	**1**	**11**	**1**	**11**	**1**

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely



Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

17 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Your OIA request of 20 April 2021 to MidCentral District Health Board (MDHB) in which you have requested information regarding waiting lists for assessment appointments is acknowledged and has been passed on to me for response.

You have requested the following information.

- **What is your current waiting list for assessment appointments for all conditions at your Orthopaedics Department in terms of both patient numbers and approximate time in months?**

Current Waiting List	448
0-1 months	77
1-2 months	127
2-3 months	101
3-4 months	50
4-5 months	42
5-6 months	34
6 months	17

- **What is your current waiting list for assessment appointments for hand related conditions including carpel tunnel conditions at your orthopaedics department in terms of both patient numbers and approximate time in months?**

Current Waiting List Hand Related Orthopaedic Conditions	113
0-1 months	20
1-2 months	22
2-3 months	19
3-4 months	15
4-5 months	11
5-6 months	26

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

- **Over the past three months, ending with 31 March 2021, how often has a clinic been held for hand related orthopaedic conditions at Palmerston North Hospital?**

  The Orthopaedic Department at MDHB does not hold separate hand related orthopaedic clinics. Patients with other than carpel tunnel procedures are included in the general orthopaedic clinics run on a daily basis.

  MDHB has however introduced a One Stop Shop concept for the delivery of carpel tunnel referrals. Patients coming to clinic are assessed by the clinician for suitability and proceed straight to the procedure room for their carpel tunnel procedure if surgery is considered the best option.

  Over the last three months, a total of four sessions have been held, all containing 12 patients with a total of 48 patients treated for carpel tunnel.

- **During those three months how many patients with hand related conditions, including carpel tunnel related conditions, were; 1) Assessed, and 2) Resolved?**

Assessed	460
Resolved	317

  These numbers include post discharge ward follow up patients and Fracture Clinic patients for hand related conditions/injuries.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

30 April 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act (OIA) request - Y21-462 Misoprostol & miscarriages

Thank you for your request for information dated 21 April 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

How many people were prescribed Misoprostol (and any equivalent drugs if others are used) following a miscarriage in the 2020 year?

MidCentral District Health Board does not store this type of data.

How many of these people then required D & C surgery?

MidCentral District Health Board does not store this type of data.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

14 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Your OIA request of 21 April 2021 to MidCentral District Health Board (MDHB) in which you have requested information regarding chest reconstruction for trans people, specifically transmasculine people, is acknowledged and has been passed on to me for response.

The information that you have requested is;

- **The average time between acceptance onto the waitlist and first appointment for patients referred to and accepted onto the waitlist for transmasculine chest reconstruction (top surgery)?**

  MDHB does not provide this surgery. The number of referrals for transmasculine chest reconstruction to MDHB is difficult to obtain.

  (a) The number of publicly funded transmasculine chest reconstructions performed in the last year.

  This surgery is not performed at MDHB.

  (b) The number of transmuscular chest reconstructions there is public funding for each year.

  Transmasculine chest reconstruction is not currently funded or performed at MDHB.

  (c) If no publicly funded transmasculine chest reconstruction has been performed in the last year when was the last publicly funded transmasculine chest reconstruction performed?

  Transmasculine chest reconstruction surgery is performed by a Plastic Surgeon. MDHB plastic surgery is provided by Hutt Hospital.

- **How patients are selected from the waitlist for transmasculine chest reconstruction surgery and how often, i.e. if done by lottery how often is the lottery drawn?**

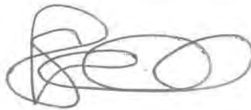
  MDHB does not perform transmasculine chest reconstruction surgery.

- **The number of referrals for transmasculine chest reconstruction in the last year.**
- **Of this number, how many were accepted and how many were declined?**

  Information on the number of referrals for transmasculine chest reconstruction is not something that is easily obtained so we are unable to provide information for these two questions.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely



pp

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

21 May 2021

Ref: Y20-0503

Dear

In response to your Official Information Act 1982 regarding information relating to MidCentral District Health Board's present and previous contracts/tenders for hospital pathology services, we advise for MidCentral DHB as follows:

1) *for each <u>current</u> contract:*

   a) *name of the contract (i.e., types of services being provided)*
   b) *name of the organisation/company contracted to deliver the services,*
   c) *contract start date and expected end (or renewal) date,*
   d) *any options for extending the contract*
   e) *dollar value (per contract)*

1a The contract name is Hospital and Community Laboratory Services.

1b These services are provided by Medlab Central Limited.

1c The contract commenced 1 April 2007.

1c We decline to answer the second part of question 1c regarding the contract expected end (or renewal) date under section 9(2)(b)(ii). Protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information.

1d We decline to answer question 1d regarding the contract expected end (or renewal) date under section 9(2)(j). Enable a Minister of the Crown or any department or organisation holding the information to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).

1e We decline to answer question 1e regarding the dollar value per contract under section 9(2)(b)(ii). Protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information.

Cont'd…,…,…

2) *for each previous contract:*

   a) *name of the contract (i.e., types of services being provided)*
   b) *name of the organisation/company contracted to deliver the services,*
   c) *contract start date and expected end (or renewal) date,*
   d) *dollar value (per contract)*

2a The contract name was Community Laboratory Services.
2b These services were provided by Medlab Central Limited since 2000.
2c The contract commenced in 2000 until 2007.
2d We decline to answer question 2d regarding the dollar value per contract under section 9(2)(b)(ii). Protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information.

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

20 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act Request: Y21-0509
Official Information Act request regarding the HPV Gardasil vaccine

The information below is in response to your Official Information Act request dated 30 April 2021.

Your request was (partially) transferred to MidCentral District Health Board by the Ministry of Health on Friday 30th April 2021. This transfer was made under section 14 of the Official Information Act (1982).

Your request was as follows:

"I'm wanting to lodge an official information request in regard to the HPV Gardasil vaccine. I understand that the Ministry of Health works with schools who are willing to provide a school-based immunisation programme. I'd like to know how many schools, intermediate and secondary schools, are refusing to work with the Ministry of Health on this school-based immunisation programme for the HPV Gardasil vaccine, and could I get a list of the names of these schools who are currently not working alongside the Ministry of Health with this programme."

We do not have any schools who are refusing to work with our Public Health Service on the school-based programme for HPV.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

25 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

I refer to your Official Information Act request received by email on 1 May 2021 with regard to drug and alcohol testing at MidCentral DHB, and respond as follows:

1. *Does the organisation carry out drugs and alcohol testing (among employees or other persons)?*

   In terms of its employees, MidCentral District Health Board (MDHB) has in place an Impaired Employees policy which covers all MDHB employees, students, volunteers, and contractors. In the event an employee, student, volunteer or contractor considered to be impaired by alcohol and/or drugs while at work, MDHB would undertake the appropriate testing in accordance with this policy. Any testing would be undertaken by an independent body. MDHB would not use a general practitioner, or our Alcohol and Drug service for such reporting.

   In terms of "other persons"; urine drug screenings are part of the management of clients at the Alcohol & Other Drug Service.

2. *If drug and alcohol testing does take place at the organisation:*

   a. *Who currently provides the testing service i.e., name of service provider(s)?*

      In terms of our employees, we do not currently have a service provider. This would be identified at the time the testing was required. Given we do not have a named service provider we have not answered the questions below.

      In terms of other persons, MDHB uses Medlab Central, Sobercheck NZ, and Medlab Christchurch.

   b. *For each (named) service provider:*

      i. *What is the nature of the drug & alcohol testing service delivered e.g., saliva, urine, breath and alcohol and synthetic cannabinoids?*

         Medlab Central: urine drug screening.

         Sobercheck NZ for provision of kits only for urine testing for methamphetamine, MDMA, benzodiazepines and cannabis.

         Medlab Christchurch for Ritalin, narcotic specific testing and GCMS (level of amphetamine stimulant use.

      ii. *In what geographic location(s) is the service delivered?*

         MidCentral region.

iii. Is the service provided under contract? If yes:

1. *How many contracts does the provider have with your organisation?*

   Only Medlab Central provide service under contract.

2. *What is the term of that/those contract(s)?*

   The Medlab Central contract expires on 30 June 2021.

3. *What is the dollar value of that/those contract(s)?*

   The specific value of the contract is not identified at this level.

4. *Are there options for renewing that/those contract(s)?*

   The contract is reviewed annually for renewal.

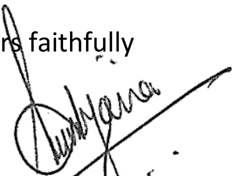
c. What organisation(s)/company(ies) previously conducted drug and alcohol testing for your organisation (repeat all of 'b' for previous service providers)?

In terms it its employees, we do not hold any records of an organisation or company we may have used for drug or alcohol testing in the past years.

In terms of other persons, current contracts have been in place for many years.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully



Keyur Anjaria
General Manager
People & Culture

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

25 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act Request: Y21-0566
Official Information Around School Participation in the HPV Vaccination Programme

The information below is in response to your Official Information Act request dated 07 May 2021.

On Friday 07 May 2021, we received a partial transfer of your request to the Ministry of Health, with respect to the data for the schools within our DHB area. This transfer was made under section 14 of the Official Information Act (1982).

Your request was as follows:

1. *"I wondered if I could request some information regarding the HPV vaccine in schools?*
   We are happy to provide the information that you have requested.

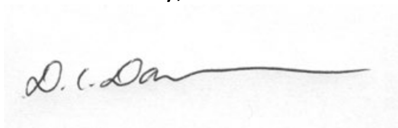
2. *How many schools are part of the HPV immunisation programme in NZ*
   Within the MDHB area there are 73 schools participating in the HPV programme.

3. *How many schools are not part of the HPV immunisation programme in NZ? Which ones?*
   There are no eligible schools in this area that are not participating in the programme.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,



Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

25 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Official Information Act Request: Y21-0568
Clinicians trained under National Contraception Training Service

The information below is in response to your Official Information Act request dated 07 May 2021.

The below response is a compilation of information from our GPTs, IFHCs/ LARC Providers, in response to the amended OIA questions:

"Under the Official Information Act may I please find out how many clinicians have been trained under the National Contraception Training Service, how many are doing the work now and how much training is going on. Family Planning has the contract for the training and reports this back to the Ministry. Broken down by DHB area, can I find out:

1. *How many clinicians are trained through the NCTS in long acting reversible contraception for each region.*
   Five clinicians across MidCentral DHB

2. *How many clinicians are able to deliver LARC training in each region, per year for the last 12 years who have been trained through the NCTS.*
   Five clinicians across MidCentral DHB

3. *How many clinicians are currently doing LARCs for patients in their region per year for the last 12 years who have been trained through the NCTS.*
   Six clinicians across MidCentral DHB

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

21 May 2021

Ref: Y21-0571

Dear

In response to your Official Information Act 1982 regarding the below information:

1. *Gift registers held by the DHB about gifts/contributions/received items given to DHB employees (including medical professionals) for the following years: 2020, 2019, 2018, 2017, 2016*
2. *Records held regarding any flights provided, paid for or subsidised by pharmaceutical or medical equipment companies to employees of the DHB (including medical professionals) in the following years: 2020, 2019, 2018, 2017, 2016*
3. *Any information the DHB holds regarding professional affiliations, board roles or advisory positions held by employees of the DHB (including medical professionals) in connection to pharmaceutical or medical equipment companies. If possible, break these affiliations down by the following years: 2020, 2019, 2018, 2017, 2016.*

we advise for MidCentral DHB as follows:

1. Gift registers held by the DHB about gifts/contributions/received items given to DHB employees (including medical professionals) for the following years: 2020, 2019, 2018, 2017, 2016

Year	Gifts / contributions / received items
2016	• Mountain Buggy • Restaurant voucher • 2 copies of text book – Current Diagnosis and Treatment: Surgery • Bottle of wine • Staff morning tea • Attend after work session for local GPs • Venue paid for a urology regional meeting at Caccia Birch, Palmerston North • Catering • Haemophilia Medical Education weekend – accommodation, catering, dinner • Attendance to the Melanoma Institute of Australia preceptorship – accommodation and meals
2017	• Attend meeting in Auckland – accommodation and meals x 2 people • Sponsorship to cover registration and accommodation to attend meeting

Cont'd…,…,…

2018	• Accommodation to attend 9th Global Summit
2019	• Food and conference room booking – Educational Nurse meeting • Accommodation and meals to attend meeting in Auckland x 3 people
2020	• Accommodation to attend Haemophilia Summit 2020 • 3 jars of Moccona coffee to ward staff • 1Kg bag of liquorice donated to every member of staff whilst working during Level 4 COVID-19 lockdown.

2. Records held regarding any flights provided, paid for or subsidised by pharmaceutical or medical equipment companies to employees of the DHB (including medical professionals) in the following years: 2020, 2019, 2018, 2017, 2016

Year	Flights
2016	• Haemophilia Medical Education weekend • Study Date Multiple Myeloma • Attendance to the Melanoma Institute of Australia preceptorship x 2 people
2017	• Attend meeting in Auckland
2018	• Flights to attend 9th Global Summit • Attend one day meeting in Auckland x 2 people
2019	• Educational Nurse meeting • Flights to attend meeting in Auckland
2020	• Nil

The flights listed above are all flights donated to MDHB. It would require significant time to manually extract the information to know who or which organisation had donated the flights.

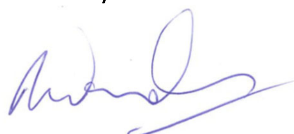
3. Any information the DHB holds regarding professional affiliations, board roles or advisory positions held by employees of the DHB (including medical professionals) in connection to pharmaceutical or medical equipment companies. If possible, break these affiliations down by the following years: 2020, 2019, 2018, 2017, 2016.

Regarding connections to pharmaceutical or medical equipment companies, the DHB does not hold any information other than that recorded on the Register of Interests. A copy of the Register of Interests is attached.

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely



Neil Wanden
General Manager, Finance & Corporate Services

Register of Interests: Summary, 27 April 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists
Hancock, Muriel	4.11.19	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB
		Volunteer, MidCentral DHB Medical Museum
	30.9.20	Sister-in-law is employed as a registered nurse at Whakapai Hauora
Mar, Materoa	16.12.19	Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance
		Chair – EMERGE Aotearoa
		Matanga Mauri Ora MoH Mental Health and Addiction
		Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland
	11.2.20	Member of MDHB Cluster
		Member of local Child & Youth Mortality Review Group (CYMRG)
	5.8.20	Member of MDHB's Māori Alliance Leadership Team (MALT)
Naylor, Karen	6.12.10	Employee – MidCentral DHB
		Member & Workplace Delegate – NZ Nurses Organisation
	9.10.16	Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10	Member – Te Runanga o Raukawa Governance Group
		Chair – Manawhenua Hauora

Register of Interests: Summary, 27 April 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
	13.6.17	Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatu District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatu
	30.8.18	Appointed Member – Massey University Council
	13.4.21	Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha
Waldon, John	22.11.18	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society
	9.2.21	Has a contract with UCOL
Warren, Jenny	6.11.19	Team Leader Bumps to Babies – Barnardos New Zealand Consumer Representatives National Executive Committee – National On Track Network Pregnancy & Parenting Education Contractor – Palmerston North Parents' Centre
	12.2.21	Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society MDHB Rep – THINK Hauora Palliative Care Advisory Panel (MoH advisory body) Director of Palliative Care – Arohanui Hospice Chair of Board – Manawatu Badminton Association
Hartevelt, Tony (FRAC)	14.8.16	Independent Director – Otaki Family Medicine Ltd
	14.8.16	Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company)
	14.8.16	Younger son is news director for Stuff.co.nz – Fairfax Media
	7.10.19	Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
Munro, Gail (HDAC)	23.3.21	Director – Eastern and Central Trust 2020 Governance Strategies Ltd 2007
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil
Amoore, Anne	23.8.04	Nil
Anjaria, Keyur	17.7.17	Wife is a user of the Needs Assessment & Service Co-ordination Service – MDHB

Register of Interests: Summary, 27 April 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Bell, Margaret	28.7.20	Nil
Billinghurst, Kelvin	6.8.20	Fellow of the Royal College of Medical Administration (RACMA) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Bradnock, Barb	26.8.10	Nil
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Caldwell, Vanessa	7.5.18	Nil
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	14.5.18 20.4.20	Owner personal consulting company, UK – Celina Eves Limited (2020 moved into dormancy) Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ) Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Howe, Jonathon	1.8.19	Nil
Matthews, Rory	20.8.20	Managing Partner, FGI (NZ) Ltd trading as Francis Health Trustee/Director Te Hopai Home and Hospital Ltd

Register of Interests: Summary, 27 April 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust & Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Nwosu, Andrew	10.8.18	Director UK health consulting company – AB Therapy Services
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 19	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	19.11.19	Nil
Wanden, Neil	Feb 19	Nil
Williamson, Nicki	Mar 20	Nil
Zaman, Syed	1.5.18	Nil

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

11 May 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Official Information Act (OIA) request – OIA Y21-0572

Thank you for your request for information dated 06 April 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with the Maternity Report written by Emma Farmer.

Please find attached the full report completed by Emma Farmer, Director of Midwifery, Waitemata DHB following her visit to MidCentral DHB in March 2021.

We are grateful for Emma's feedback, support and guidance and we are pleased to note that many of the recommendations we are already working on. Work on other recommendations will be through the Women's Health Quality and Safety Governance Group and dependant on our local resources, models of care and DHB structure and governance.

We would be happy to sit down and discuss this report further if this would be of assistance to you. Please feel free to liaise with our Communications Manager.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible.

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive - Te Uru Pā Harakeke

MidCentral DHB – External Director of Midwifery Site Visit (March 2021) Report

I orea te tuatara ka patu ki waho
A problem is solved by continuing to find solutions

Background

In January 2021 the leadership team at MidCentral DHB requested a site visit to understand the local stressors caused by a chronic shortage of midwives and make recommendations to assist the service going forwards.

The Terms of reference requested the following:

- Provide expert midwifery advice and opinion
- Review and support the midwifery leadership team especially the Acting Associate DoM
- Review and assess workforce issues and offer support and advice
- Review the growing demand for LMCs to hand over in secondary care and help identify solutions
- Advise regarding a culture where services focus on mothers, babies and whānau
- Advise on strategies to ensure sustainability of maternity workforce
- Review quality and patient safety systems within the maternity service.

The visit encompassed the following meetings (either in person or via zoom), and correspondence via email:

- - Previous Midwifery Director
- – Acting Associate Director of Midwifery
- – Executive Director of Nursing and Midwifery
- – Operations Executive Te Uru Pā Harakeke (Healthy Women, Children and Youth)
- – Clinical Executive Te Uru Pā Harakeke (Healthy Women, Children and Youth)
- – Medical Lead Obstetrics and Gynaecology
- – CEO New Zealand College of Midwives
- – MERAS Co-Leader
- – MERAS staff rep
- – Charge Midwife
- Obstetric SMOs x4
- Associate Charge Midwives x3
- Core Midwives, Community Midwives, Lactation Consultants and Nurses x 2 sessions (approx. 15 per session)
- LMC midwives x 2 sessions (approx. 15 per session)
- Senior midwives who have resigned including (5 Midwives)
- (NZCOM Regional Chair)
- Māori Midwives (4 Midwives) both in person and later via email
- Lactation consultants via email

- Midwifery Students x2 via email

In addition, I read the following documents provided:

- Correspondence between NZCOM and MidCentral DHB
- Correspondence between MERAS and MidCentral DHB
- Women's Health Unit Staff Survey
- Maternity Work Programme 17/18
- Nursing and Midwifery Practice Council Terms of Reference
- Nursing and Midwifery Shared Governance Model ppt.
- Hospital Advisory Committee Update March 2016.

Acknowledgement

Firstly, I would like to thank the very many individuals and teams that made the time to meet me personally or via zoom or to later email me their thoughts. It is their openness and willingness to provide feedback that made this report possible. I would also like to acknowledge the leadership team who hold a genuine concern around the current situation and a willingness to create a safe maternity service for mothers, babies and their whānau.

Key findings and recommendations

I have grouped my recommendations in to six sections:

1. Creating immediate clinical safety
2. Creating a safe environment for core staff
3. Creating a safe environment for LMC Midwives
4. Creating a robust and strengthened community and outpatient service
5. Creating a safe environment that is respectful of Māori and reduces inequity
6. Proposed leadership structure.

1. Creating immediate clinical safety

Maternity units are an acute clinical area (much the same as ED); women are admitted directly from the community and need triage, assessment and immediate care. The course of labour is also unpredictable and maternity units must be able to respond to significant life-threatening emergencies with little or no warning.

To safely manage this complex environment, it is essential that there are highly skilled, experienced and professional midwives on each shift. This role (currently called ACM) must be enabled to operate as such on all shifts and cannot be replaced by the Charge Midwife who may need to leave the unit to attend to other matters. The ACM is critical to a safe culture by supporting staff, students, new graduates and LMCs.

The maternity ward is now nearly 100 percent staffed by registered nurses. Nurses can have a role in the provision of maternity care for example in the post-operative care of mothers giving birth by

caesarean section. However, the growth in the number of nurses has created a significant skill mix issue and at times nurses may be working outside their scope and outside the limits of their skills, knowledge and experience. This leaves the service vulnerable to significant adverse event, for example a secondary postpartum haemorrhage or a neonatal collapse would put the woman or neonate at significant risk. I note that newborns returning to the ward following caesarean section birth may not be receiving the two hours continuous observation that is required in the Ministry of Health guidelines.

In order to manage the risk on the maternity floor, it is essential that a suitably trained senior midwife work on the Maternity Ward at all times to support the nursing staff and provide expert care in the event of an emergency. This senior role cannot be filled by an experienced nurse, for the reasons outlined above.

2. Creating a safe environment for DHB employed staff

Staffing

Creating a stable roster is critical to the healthy safe functioning of the maternity unit. At present midwives are expressing frustration at their work environment. A number of examples were provided by core staff around the expectation that they work without breaks and beyond the end of their shifts. Whilst this can sometimes occur due to pressure of work this should not become the norm or the expectation. Having staff working many and long shifts places the organization at risk of breaching the Employment Relations Act 2000 and the Health and Safety at Work Act 2015[1].

Actions to ameliorate this include:

1. Give a strong message that staff are enabled to take breaks and finish their shifts on time.
2. Pay T1.5 or T2 if staff are expected to work without breaks or beyond their rostered shift
3. Implement a retention allowance for any midwife working 0.7FTE or above for a 6-month period. This has been shown to be cost neutral due to a reduction in overtime.
4. Ensure CCDM variance reporting and response mechanism is functioning well and there is organizational visibility of the pressures and a commitment to provide support.
5. Consider stopping postnatal admissions to Te Papaioea (I appreciate this was requested by women and midwives), but it creates confusion at the primary unit about its core function which is primary birth. Restrict postnatal stays at Te Papaioea to those women who gave birth there, then the staffing complement can reduce to one midwife and one HCA, freeing up a staff member for the maternity ward.
6. Stop cross rostering between Te Papaioea and the hospital as this increases work place stress and reduces the opportunity for staff to build skills, confidence and increase proficiency in their chosen area of expertise.

[1] https://www.sitesafe.org.nz/globalassets/guides-and-resources/best-practice-guides/fatigue-guidance-crsf.pdf

Acuity

Workload is a significant area of concern. The work regularly exceeds the resources; this places an exceptional burden on the staff and causes tensions with LMCs. The service has attempted to manage this workload by adding to the Registered Nurse workforce, however while helpful this adds to the burden experienced by midwives who by default take clinical responsibility for the care of mothers and babies.

Actions to ameliorate this include:

1. Ensuring a robust CCDM system that accurately records acuity
2. Increase HCA support to 2 HCAs per shift
3. Increase lactation consultant support to 12 hours per day 7 days per week
4. Increase ward clerk support to 7am -9pm 7 days a week
5. Create a clinical supplies coordinator role - This role ensures that clinical supplies are ordered and available in the correct quantities. They also manage any facility maintenance and repairs, and repairs of equipment. This role removes a lot of low-level time-consuming work from the Midwife Manager and creates a more efficient work environment. This position quickly becomes essential and often pays for itself in reducing waste.

Creating an effective workforce pipeline

Attrition is a common feature of maternity staffing as midwives can elect to be employed or self-employed and staff will circle through different roles in their career. Having a robust midwifery pipeline will enable the service to manage attrition as it occurs.

The current undergraduate programme does not appear to be working effectively and insufficient numbers of students are entering the programme to provide graduates in the numbers needed. In addition, student midwives are reporting an unfriendly work environment with staff unwilling to provide teaching or clinical supervision. This approach to the next generation of midwives is disappointing and self-defeating.

Actions to ameliorate this include:

1. Students must be treated as a Taonga, appoint a clinical coach to assist them to orientate and awhi them into the workplace.
2. AUT have indicated a willingness to set up a satellite programme but they are not resourced to provide a clinical educator this year. In order to move quickly to establish the local programme appoint a clinical educator 0.8fte for 12 months until AUT is able to supply.
3. Offer an open day to target local women for a career in midwifery; Tairawhiti DHB has had considerable success with this approach.
4. All NZ Schools of midwifery have access to MoH funding to support Māori and Pacific undergraduates, explore with AUT or Otago Polytechnic how this will support local wāhine Māori women to become midwives.

5. AUT are currently exploring a programme for registered nurses seeking to gain midwifery registration. There is already significant recognition for prior learning so this should be explored further to enable current nurses employed in the service to transition to midwifery.

3. Creating a safe environment for LMC Midwives

LMC midwives make up over 50% of the midwifery workforce, so an environment that is judgmental and disrespectful is alienating, counterproductive and unsafe. Research shows that environments that have highly functioning clinical relationships are far safer for mothers and babies[2]. LMCs gave many examples of disrespectful and judgmental behaviors. Identifying and publicly calling out LMCs for not providing epidural care is an example of alienating the workforce. If LMCs choose to spend as little time as possible in the Maternity Unit the question has to be asked why and what can be done to make it a more supportive and collegial place where midwives feel safe to work.

Actions to ameliorate this include:

- Rebuilding relationships of trust
- Regular forums where LMC can air their concerns and be heard
- Meet their needs where this is feasible – small wins are appreciated
- Avoid encroaching on their area of expertise, i.e. do not try to control what occurs outside of the hospital setting, LMCs are experts in community care.
- Respect that LMCs are responsible for their practice and are not accountable to the DHB provider arm they are accountable to the woman, her whānau and the Midwifery Council for their practice.
- Offer updates, education, workshops and seminars to enable the midwives and doctors to come together in a safe environment to learn together from each other. An example of this is the PROMPT training but this must be led by a midwife with expert relationship skills.
- Treat practitioners as individuals not as a uniform group. Midwives, like GPs, pharmacists or any other community health professional have significant responsibilities outside of the hospital and they have different priorities. It is not reasonable to expect a uniform response.

4. Creating a robust and strengthened community and outpatient service

The effective functioning of community services has a direct impact on effective functioning of inpatient services. Making sure that work is managed effectively requires good leadership and management attention. Placing the focus on inpatient services because they appear the most acute misses and opportunity to manage this workload before it arrives on the ward.

---

[2] Liberati EG, Tarrant C, Willars J*, et al* Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation *BMJ Quality & Safety* Published Online First: 25 September 2020. doi: 10.1136/bmjqs-2020-010988

Actions to ameliorate this include:

1. Create a specialist SGA clinic. This means that women who are on the SGA pathway are seen at booked appointments in clinic and are not sent for "scan review" in the acute assessment area. This would also reduce waiting time for women. Several adverse events in New Zealand are associated with women abandoning acute appointments as their wait times are excessive.
2. Improve the quality of obstetric consultation and plans of care to LMCs. Currently there is a lack of medical and midwifery oversight in the antenatal clinic that means many women are being recalled unnecessarily.

Obstetric clinics and community midwives

Overall, there is a sense that the obstetric clinics lack oversight, this results in women returning for multiple obstetric appointments when they could be referred back to the care of the LMC with a detailed plan of care and a re-refer instruction. There are some technical issues with communicating plans of care that need managerial oversight.

The community midwifery service is also probably not well aligned with the work, as women are being separated from their LMC to be offered "unit" care, and those women under the community midwives lack continuity. This means that the women with the most complex pregnancies often have the most fragmented care. A significant piece of work is needed here to realign the outpatient work to make it more fit for purpose. This is likely to have positive flow on benefits for the workload in the wards also.

Te Papaioea and Kõhungahunga

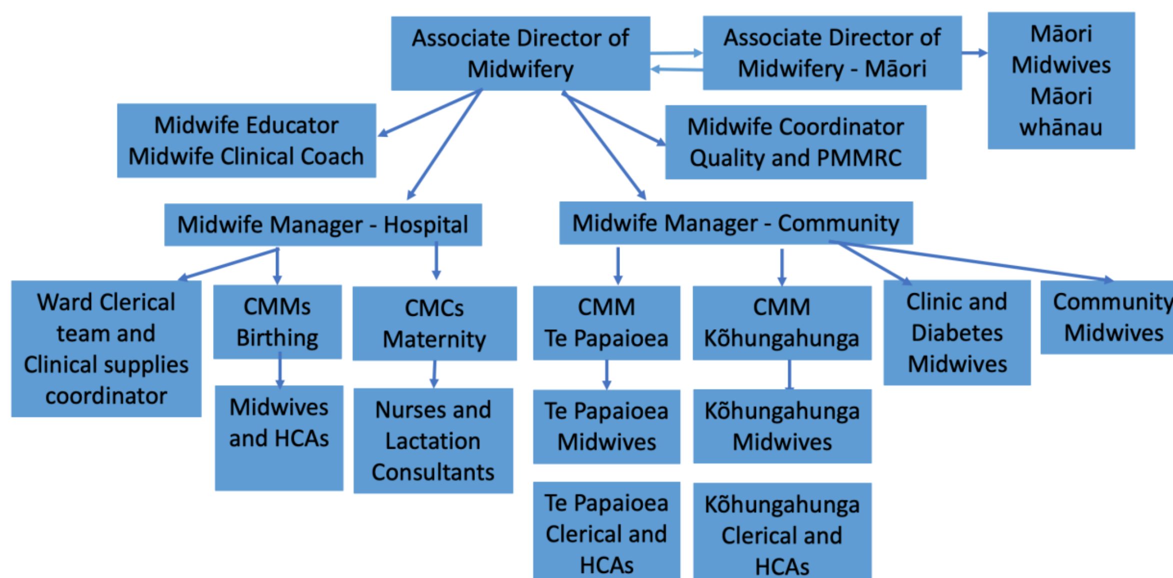
Primary birthing is in the domain of midwives and should not be encroached upon by obstetrics. Evidence shows that primary birthing units can deliver safe and effective care to well mothers and babies and thrive in environments where midwives are enabled to take ownership of their service. Operating Te Papaioea as an extension of a secondary maternity unit makes it unsafe and unlikely to deliver clinical benefits. It is my strong recommendation that the unit be enabled to operate as it was intended with a midwifery led model of care. By not using the unit as an overflow for postpartum women (and I appreciate this was requested by midwives and the community) the unit can focus on its core business that is primary birthing. This would enable the staffing model to reduce to one midwife and one HCA and release another staff member for the wards.

5. Creating a safe environment that is respectful of Māori and reduces inequity

Māori midwives took pains to feedback both in person and via email about their experiences of racism in the maternity services. This kōrero was difficult to hear and the mamae evident. Some factors associated with this are leadership inexperience of working in a bi-cultural environment where Māori are partners in decision making. Māori midwives spoke of having their views

discounted and their clinical and cultural practice questioned. Creating a senior leadership role for Māori would assist in bridging this divide and help the service to move forward in this respect.

6. Proposed leadership structure



The leadership structure aims to achieve three things:

1. Create a structure that ensures that staff receive good support and can have their issues and concerns addressed in a timely way. Much of the concern expressed from staff is that their ideas do not get progressed and they do not get feedback about why. This is most likely to be due to the pressure of work experienced by the current leaders.

2. Creating a strong management structure for community services as has a positive impact on both community and also inpatient services. The Midwife Manager – community has a responsibility for relationships with LMCs and this removes the tension built up by the workload demands in the hospital. The Midwife Manager – Community also attends to relationships with primary care providers and manages the vulnerable families workstream, in co-ordination with the Associate Director of Midwifery - Māori

3. Creates a structure that supports Te Tiriti in creating a partnership leadership model

Caveat

This document provides a simple summary of my findings and recommendations from a very short visit. I acknowledge that in this short time I may not have been able to assimilate all the intricacies of service provision or of the wider DHB expectations and support structures. I am more than happy to provide on-going advice to the leadership at MDHB if needed.

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

28 May 2021

E-mail:

Dear

Your OIA request of 5 May 2021 to MidCentral District Health Board (MDHB) in which you have requested information regarding the number of requested referrals rejected due to Ministry of Health waiting time targets is acknowledged and has been passed on to me for response.

You have requested the following information.

- **The number of referrals from GPs that have not been accepted for an appointment due to the reason of Ministry of Health waiting time targets and insufficient resources to meet that.**
- **Breakdown by department or area and timeframe of the rejected appointment.**

The information you have requested is attached.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Encl

Decline Reason	Department	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Declined due to Capacity	Dental	26	19	35	38	35	33	44	38	28	28	30	
	Diabetes												
	Ear Nose Throat	3							33	40	16	3	
	Endocrinology												
	Gastroenterology					1	1						
	General Medicine							1					
	General Surgery MC				6		13	65	106	71	59	20	1
	Gynaecology	29	52	10							1		
	Maxillo-Facial Surgery						1						
	MC Dermatology	3	12	6	5	1	14	7	13	9	12	8	1
	Neurology	2	5	9	17	6	14	18	14	27	29	27	11
	Ophthalmology						1			3	10	25	13
	Orthopaedics			1	1		1					2	
	Renal Medicine								2				
	Respiratory	1											
	Rheumatology	7	9	3	2	10	2	3	9	3	8	10	
	Urology MC	11	11	5	1	2		7	8	6	1		
Declined Total		**82**	**108**	**69**	**70**	**55**	**80**	**145**	**223**	**187**	**164**	**125**	**26**

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

2 June 2021

Ref: Y21-0600

Dear

In response to your Official Information Act 1982 regarding the below information:

1. *A summary of the costs of hospital intensive care services provided to those not entitled to NZ Free health care.*
2. *The cost summary should include reference to the number of days or hours in intensive care.*
3. *Can this please cover the last 3 years.*

we advise for MidCentral DHB as follows:

1. A summary of the costs of hospital intensive care services provided to those not entitled to NZ Free health care:

During the last three years, we have invoiced four non-resident patients for ICU treatment. The total invoiced was $138,038.54

2. The cost summary should include reference to the number of days or hours in intensive care:

Patient	Time in ICU	Year
Patient One	173 hours and 23 minutes	2020
Patient Two	70 hours and 22 minutes	2019
Patient Three	39 hours and 49 minutes	2018
Patient Four	120 hours and 32 minutes	2019

3. Can this please cover the last 3 years:

Please refer to table above.

Cont'd...,...,...

If you are not satisfied with this response you have the right to raise any concerns regarding our response with the Ombudsman – www.ombudsman.parliament.nz or 0800 802 602.

Please note that this response, or an edited version, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

31 May 2021

Dear

Re: Official Information Act request OIA Y21-651
DHB Challenges to Coronial findings

I refer to your email of 15 May 2021, requesting the following information under the Official Information Act 1982:

- *How many times has your DHB challenged a coroner's findings after an inquest in each of the following years?*
  2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021
- *For cases from 2017 onward:*
  - please give an overview of the case and the name of the patient concerned
  - what points were challenged, and why
  - how much did the DHB spend on its challenge in each of these cases?

MidCentral District Health Board has not challenged any Coroner's findings after an inquest in the years listed.

I trust that this satisfies your interest in this matter.

Please note that this response or an edited version of it may be published on the MidCentral District Health Board website ten working days after your receipt of this response.

Yours sincerely

Dr Kelvin Billinghurst
Chief Medical Officer, Primary Public & Community Health Executive
MBChB, DCH, DipO&G, DTM&H, DPH, MPH(PH) MHA, FRACMA, FCHSM, CHE

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

28 June 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Via email:

Dear

I refer to your Official Information Act request received by email on 28 May 2021 with regard to annual leave taken by Senior Medical Officers at MidCentral DHB, and respond as follows:

1. *The total number of annual leave days taken by (all) Senior Medical Officers (SMOs) in your employ in each of the following months:*

   a. *December 2020*

      480 days

   b. January 2021

      661 days.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully

Keyur Anjaria
General Manager
People & Culture

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

1 June 2021

Dear

We are in receipt of your Official Information request dated 20 April 2021 which has been transferred from the Ministry of Health to the DHB on 31 May 2021.

You advised that you would like the following information as stated below:

1. Can you please provide the number of people on the waiting list for psychiatric services, including eating disorder services, by DHB, as at 20 March 2021?

Our community mental health teams do not have a wait list to be seen for an adult or child referral. In regard to people who may need some assistance for an eating disorder, our child adolescent and family service prioritise these young people.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive

Te Uru Rauhī - Mental Health & Addictions Services
PN Hospital, Private Mail Bag 11036, PALMERSTON NORTH
Phone: + 64 (6) 350 8354

MIDCENTRAL DISTRICT HEALTH BOARD

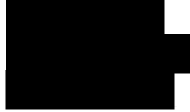
Te Pae Hauora o Ruahine o Tararua

11 June 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand



Via email:

Dear

I refer to your Official Information Act request received by email on 17 May 2021 with regard to psychometric testing at MidCentral DHB, and respond as follows:

1) The details of any psychometric testing undertaken as part of staff recruitment, training, resourcing or outsourcing — including as undertaken by outside recruitment firms.

MDHB undertakes psychometric tests and personality profiling for selective, senior leadership roles. Mostly, these are undertaken for the purpose of development and teamwork. However, in some instances, psychometric testing has been undertaken for recruitment. The DHB has used Winsborough Limited for personality profiling of its executive team, for development purposes. On occasion, the DHB has used Talegent for psychometric assessment undertaken during the recruitment process. About 96 percent of DHB employees are clinical staff and the DHB does not undertake psychometric testing or personality profiling for these roles.

1a) Details including: the types of psychometric test undertaken; copies of the test(s) themselves; statistical distributions of results; information about the staff tested broken down by role, and including designation decisions made upon receipt of the tests; & organisational guidelines and communication pertaining to the analysis of results.

Details of the test and their linkages can be found by contacting the agencies that undertake these tests. Contact details are:

Winsborough Limited – www.winsborough.co.nz and Talegent – www.talegent.co.nz.

These companies own the intellectual property for these tests and would be better placed to respond to questions ask under 1a. All senior executive roles (reporting to the CEO) were profiled prior to commencement of employment. Winsborough Ltd was engaged to undertake these assessments which led to a team profile. Middle management, and some advisory roles, were subject to psychometric assessments conducted via Talegent Ltd.

1b) Names of all and any companies used to provide psychometric testing, including subcontractors used by outsourced recruitment agencies.

As above.

2) All documents and communications pertaining to: decisions made to introduce or modify psychometric testing regimes; initiate use of results in a particular way or change the use of results.

The DHB is guided by the organisations for the interpretation and usage of the test results. Communication to candidates is undertaken by these organisations on behalf of the DHB. The DHB contracts these organisations who take over communication with the candidate (including test results) once approval to engage is provided.

2a) All documents and communications pertaining to financial costs of psychometric testing broken down by year and including names of entities that psychometric testing related transactions occurred within this breakdown.

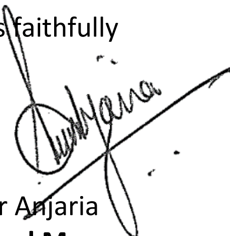
	Winsborough Limited	Talegent Limited
1 July 2016 - 30 June 2017	$3,862.00	0
1 July 2017 – 30 June 2018	$18,212.48	0
1 July 2018 – 30 June 2019	$1,155.00	$2,600.00
1 July 2019 – 30 June 2020	$1,285.00	$1,025.00
1 July 2020 – 31 March 2021	$2,145.00	$250.00
Total	**$26,659.48**	**$3,875.00**

3) Any documentation or communication pertaining to any cost/ benefit analysis taken to: introduce; modify; or make decisions taking into account the results of psychometric testing.

No such analysis was undertaken. Research evidence suggests undertaking these assessments is to better understand candidate personality and work preferences so that the candidate's manager is able to ensure a successful employment engagement.

Please note that this response, or an edited version of it, may be published on the MidCentral DHB website ten working days after your receipt of this letter.

Yours faithfully



Keyur Anjaria
General Manager
People & Culture

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

15 June 2021

E-mail:

Dear

Your OIA request of 1 June 2021 to MidCentral District Health Board (MDHB) in which you have requested information regarding the effects of aeromedical transfer of patients is acknowledged and has been passed on to me for response.

You have requested the following information.

- **Please could you provide all information you may have regarding the effects on aeromedical transfer of patients caused by Wellington Airport's night-time runway closures during 2020-21, particularly;**
  - **The number of patients affected (who could not be transferred, were taken to other airports, or transfer was delayed) and assessment of any harm caused to them.**
  - **Any assessment of the financial cost to MidCentral DHB's aeromedical services caused by Wellington Airport runway closures.**

  We are sorry to advise that MidCentral DHB has had no reason to collect any data relating to the Wellington Airport runway closures. To the best of our knowledge, we are unaware of any impact upon patient transfers due to this information.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

16 June 2021

Dear

Official Information Act (OIA) request – Y21-0752
Pre and post abortion counselling

Thank you for your request for information dated 3 June 2021. Your email has been acknowledged and passed onto me for a response.

You have requested MidCentral District Health Board (MDHB) provide you with information to the following questions:

The number of women who had pre abortion counselling prior to a medical abortion at the Women's clinic, Palmerston North 2020.

111 women received pre abortion counselling in 2020 in total. We do not have any detail regarding how many of these women were having a medical abortion.

The number of women who had pre abortion counselling prior to a surgical abortion at the Women's clinic, Palmerston North 2020.

111 women received pre abortion counselling in 2020 in total. We do not have any detail regarding how many of these women were having a surgical abortion.

The number of women who had post abortion counselling prior to a medical abortion at the Women's clinic, Palmerston North 2020.

41 women received post abortion counselling in 2020 in total. We do not have any detail regarding how many of these women had a medical abortion.

The number of women who had post abortion counselling prior to a surgical abortion at the Women's clinic, Palmerston North 2020.

41 women received post abortion counselling in 2020 in total. We do not have any detail regarding how many of these women had a surgical abortion.

Please note that this response, or an edited version may be published on the MDHB website ten working days after your receipt of this letter. Please let me know if you have any objections to this as soon as possible

I hope this information is what you require.

Yours sincerely

Sarah Fenwick
Operations Executive
Te Uru Pā Harakeke
Healthy Women Children and Youth

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

28 June 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Dear

Your OIA request of 31 May 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information, based on the 2017 and 2020 calendar years.

- **How many people were referred by the GP to the DHB for a joint replacement that year?**

Calendar Year	No.
2017	471
2020	608

- **Of those, how many did not receive a first specialist appointment with a specialist Orthopaedic Surgeon?**

Calendar Year	No.
2017	11
2020	71

- **Of those who had their first appointment with the specialist Orthopaedic Surgeon, how many were then referred/sent back to their GP?**

Calendar Year	No.
2017	4
2020	47

- **Of those patients that were referred by GP for joint replacement surgery, how many went ahead to have surgery by the DHB?**

  General Practitioners refer patients for a First Specialist Assessment. They do not refer directly to the waiting list for surgery.

Calendar Year	No.
2017	184
2020	126

- **Of those who were referred by GP and had a first specialist appointment with an Orthopaedic Surgeon, how many actually had their surgery with the DHB.**

Calendar Year	No.
2017	184
2020	126

- **How many patients were deemed clinically necessary to go on a waiting list for joint replacement that year?**

Calendar Year	No.
2017	180
2020	172

- **How many referrals from the GP and specialist for joint replacements were turned down that year.**

Calendar Year	No.
2017	11
2020	71

- **How many were turned down because of lack of capacity?**

Calendar Year	No.
2017	3
2020	57

- **Can you specify your DHB's criteria for joint surgery?**

  All patients that are seen within the Orthopaedic Department at MidCentral DHB for joint replacement surgery are assessed using the National Clinical Prioritisation Criteria (CPAC) scoring tool.

- **How many points do patients need to get onto the waiting list for joint replacement in your DHB?**

  The threshold for a patient to be allocated certainty of treatment within four months in the Orthopaedic service at MidCentral DHB is 73.

- **How many 'semi urgent' referrals from the GP to DHB for ENT (Ear, Nose, Throat) were actually seen by a specialist?**

Calendar Year	No.
2017	372
2020	1,304

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

24 June 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Tēnā koe

Official Information Act Request: Y21-0730 regarding Liquor Licensing Information

The information below is in response to your Official Information Act request dated 10 May 2021.

Your request was (partially) transferred to MidCentral District Health Board by the Ministry of Health on 31 May 2021. This transfer was made under section 14 of the Official Information Act (1982).

Your request was as follows:

4. What number of following alcohol licence application types for each financial year split by each Public Health Unit were investigated and had a positive outcome?

5. As well as the above, by Public Health Unit, how many of each licence type were:
   a) Applied for in high Māori population areas
   b) Investigated by health regulatory officers in consultation with Māori under public health's obligation to te Tiriti o Waitangi?

6. In relation to the Sale and Supply of Alcohol Act 2012, could you provide me with the following since 2013:
   (a) Each PHU's 'Duty to Collaborate' s295 (b) collaborative plan of intervention and prevention strategies developed with the tri-agencies and other partners to prevent alcohol-related harm.
   (b) If there is no plan, please provide activities per PHU that shows collaboration to reduce and prevent alcohol-related harm under Duty to Collaborate under s295(b).
   (c) Please provide each PHU's successful strategies and interventions under s295 (b)

7. The workforce capacity of alcohol licensing staff per each of the 12 public health units before COVID- 19 (as of December 2020) including vacancies held?

8. The workforce capacity of alcohol licensing staff per each of the 12 public health units as of May 2021 including vacancies held?

The information pertaining to your request is below and incorporates data for the MidCentral (MC) and Whanganui (WG) DHBs.

Question 4:
What number of following licence application types for each financial year split by each Public Health Unit were investigated and had a positive outcome?

PHU	MidCentral Public Health – includes Whanganui					
License Type	2018/19 (July - June)		2019/20 (July - June)		2020/ May 2021	
	Investigated	Positive Outcome	Investigated	Positive Outcome	Investigated	Positive Outcome
New OFF-Licenses	12-MC 8-WG	1-negotiated	8-MC 6-WG		8 MC 6 WG	1-negotiated
Renewal OFF-licenses	33-MC 19-WG		30-MC 10-WG	1-negotiated	29 MC 11 WG	
New ON licenses	28-MC 16-WG	1-withdrawn	25-MC 13-WG	1-negotiated	24 MC 18 WG	
Renewal ON licenses	70-MC 37-WG	2-negotiated 1-Declined 3-negotiated	54-MC 22-WG	1-negotiated 1-negotiated	65 MC 29 WG	1-negotiated
New CLUB licenses	0-MC 1-WG		2-MC 1-WG		0 MC 0 WG	
Renewal CLUB licenses	31-MC 24-WG	2-negotiated 1-negotiated	14-MC 15-WG	1-negotiated 1-negotiated	15 MC 5 WG	1-negotiated
Specials	336-MC 192-WG	1-withdrawn 1-declined	286-MC 162-WG		280-MC 190-WG	1-negotiated
TOTAL	510-MC 297-WG		419-MC 229-WG		421-MC 260-WG	

* Positive outcomes = Declined (DLC), withdrawn by applicant, negotiated outcomes before opposing.

The positive outcomes noted in the above table are the ones we were easily able to access in our database to report on. All NEW applications receive a site visit. Each has an in-depth discussion on the applicants' proposed procedures to meet the requirements under the Sale and Supply of Alcohol Act 2012. Many have negotiations at the time of the visit on the number of duty managers, staff training requirements, provision of low alcohol, their host responsibly policy, etc. The majority of these interactions result in the Medical Officer of Health not opposing the application.

To collate the exact number of these negotiated discussions would take a significant resource to access each application folder, which is not available at this time.

Question 5.
As well as the above, by Public Health Unit, how many of each licence type were:

a) *Applied for in high Māori population areas:*

Our Public Health Service uses a risk assessment tool to prioritise licence applications. The higher the score, the more intensive the investigation. The risk is assessed on a number of factors including deprivation level, license type, proposed hours and host responsibility matters.

While at this point we do not include the proportion of Māori (or of people of other ethnicities) as separate risk factor, it has been agreed that we review our risk assessment tool in light of your request.

b) *Investigated by health regulatory officers in consultation with Māori under public health's obligation to te Tiriti o Waitangi:*

Our current investigation process does not routinely involve consultation with Māori. The sheer number of licences received and the statutory timeframes involved make meaningful engagement problematic. We will be discussing this issue with our colleagues in territorial authorities and Police to see what may be possible (and practicable) in future.

Question 6.
In relation to the Sale and Supply of Alcohol Act 2012, could you provide me with the following since 2013:

a) *Each PHU's 'Duty to Collaborate' s295 (b) collaborative plan of intervention and prevention strategies developed with the tri-agencies and other partners to prevent alcohol-related harm:*

Nil to report

b) *If there is no plan, please provide activities per PHU that shows collaboration to reduce and prevent alcohol-related harm under Duty to Collaborate under s295(b):*

Whanganui District Health Board area:
Reducing alcohol and other drug related harm in New Zealand takes a concerted effort by many sectors of the community working together with a shared vision.
The Whanganui Alcohol & Other Drug Reference Group's agreed vision is 'To reduce alcohol and other drug related harm in the Whanganui community'. Key tasks for the group include:

- Provision of leadership, information and direction to the Safer Whanganui steering group and the Whanganui community on alcohol and other drug related issues;
- Active participation in development of policy that aims to reduce alcohol and other drug related harm;
- Contributing to harm reduction initiatives within the Whanganui community;
- Advocacy to local and central government on relevant community issues;
- Development and implementation of an annual work plan.

Membership aims to reflect the diversity of our community and includes New Zealand Police; Whanganui District Council; Nga Tai o Te Awa; Whanganui Māori Wardens; Te Oranganui Iwi Health Authority; Fire & Emergency New Zealand; Regional Health Network; MDHB Public Health; Whanganui Public Health Service; Community Mental Health & Addictions; Youth Health Trust.

The group has provided input into:
- The Whanganui District Alcohol Control Bylaw 2016 and
- The Whanganui Local Alcohol Policy 2019.

Successful objections have been made with respect to two licence applications.

MidCentral District Health Board:
Within the MDHB area (incorporating Palmerston North City, Manawatu, Horowhenua and Tararua Districts, plus the Otaki Ward of Kapiti District), there are regular meetings of our Alcohol Harm Regulatory Group, which comprises representatives from the statutory agencies, the aims of which are to:
- reduce alcohol-related harm in respect of specific applications;
- address the wider alcohol issues across the rohe.

Members of the group have collaborated around:
- The PNCC Alcohol Control Bylaw;
- Local alcohol policies (several Councils);
- A trial of reduced hours of operation for licensed premises;
- Engagement of street-level safety staff.

Other collaborative activities have included:
- Training and education of alcohol industry staff;
- Liaison meetings with alcohol industry to share information and develop resources eg. to address drink spiking;
- Media campaigns and other initiatives to reduce adult supply to minors;
- Controlled purchase operations aimed at identifying premises who are selling to people under 18 years of age.

c) *Please provide each PHU's successful strategies and interventions under s295 (b)*

Please see above.

Question 7:
The workforce capacity of alcohol licensing staff per each of the 12 public health units before COVID- 19 (as of December 2020) including vacancies held:

Public Health Unit	Regulatory Officers FTE	Regulatory Officers Health Count (no. of people)	Dedicated legal support FTE	Medical Officer of Health FTE	Administrative support FTE
MidCentral Public Health Unit	1.4	3	Nil	0.4	0.5

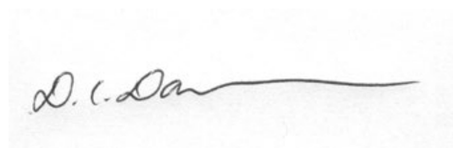
Question 8:
The workforce capacity of alcohol licensing staff per each of the 12 public health units as of May 2021 including vacancies held:

Public Health Unit	Regulatory Officers FTE	Regulatory Officers Health Count (no. of people)	Dedicated legal support FTE	Medical Officer of Health FTE	Administrative support FTE
MidCentral Public Health Unit	1.7	4	Nil	0.4	0.5

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at ww.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,



Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

29 June 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

Email:

Tēnā koe

<u>Official Information Act Request: Y21-0850 regarding missed COVID-19 Vaccination Appointments</u>

The information below is in response to your Official Information Act request dated 10th June 2021. Your request was as follows:

I have been advised by the Minister of COVID-19 Response that data on the number of individuals missing appointments for the COVID-19 vaccine is not held by him or the Ministry but is held by district health boards. Under the OIA I therefore seek:

The number of scheduled COVID-19 vaccination appointments that were missed by people for each month to date in 2021.

From the commencement of the COVID-19 Immunisation Programme earlier this year the MidCentral District Health Board Team has been using a blend of a DHB cloud-based booking system, and General Practice Booking systems. These do not have the functionality to produce a report detailing the number of missed vaccination appointments.

We are in the transition phase to adopt the new national website and phone booking system ("Book My Vaccine") in mid-July. I understand that this system will be able to provide the information that you seek going forward but will not provide the data for past vaccination events.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you are not satisfied with our response to your information request, you have the right to seek a review by way of complaint by the Ombudsman of your decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Yours sincerely,

Deborah Davies
Operations Executive
Te Uru Kiriora, Primary Public and Community Health

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

1 July 2021

Dear

We are in receipt of your Official Information request dated 30 June 2021.

You advised that you would like the following information as stated below:

1. Please confirm if there have been any patients of Ward 21 die on hospital grounds in the last three months?

There have been no patients of Ward 21 die on hospital grounds in the last three months.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

Yours sincerely

Scott Ambridge
Operations Executive

MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

8 July 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

E-mail:

Dear

Your OIA request of 17 June 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information.

- **How many people were referred to the DHB for gender reassignment hormone therapy in each calendar year since 2006 until the present time?**

  Electronic data for the initiation of hormone therapy since 2017 indicates 92 people were referred for gender assignment hormone therapy.

- **What was the breakdown of ages in each of those years (youngest/oldest/median age)?**

  Based on those 92 patients, the youngest was 15 years old and the oldest was 60 years. The median age of this group is 37.5.

- **How many were transitioning male to female and how many female to male in each of those years?**

Male to Female	46
Female to Male	46

- **How many children were referred for puberty blocking drugs in each calendar year since 2006?**

  There are no records prior to 2017. The number seen in Paediatrics for "transgender conversations" are as follows;

2017	4
2018	3
2019	9
2020	13
2021	4 (+4 referred and not yet seen)

- **How many people had psychological treatment for gender dysphoria in each calendar year since 2006?**

  No patients until 2021 have been referred to Mental Health or Psychology primarily for gender dysphoria but often this has been an associated issue. There will not be coding for these patients because they will have been accepted until a Mental Health diagnosis. This year MidCentral District Health Board has set up a referral process with Mental Health.

- **How many people had double mastectomies (top surgery) as treatment for gender dysphoria in each calendar year since 2006?**

  Our electronic records show two mastectomies since 2006 with the coding to indicate ICD-10 coding and sub codes of F64 or F66 – "gender identify issues" or "psychological and behavioural disorders associated with sexual development and orientation".

- **What was the breakdown of ages in each of those years?**

  This information is not available.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

8 July 2021

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

E-mail:

Dear

Your OIA request of 30 June 2021 to MidCentral District Health Board (MDHB) is acknowledged and has been passed on to me for response.

You have requested the following information, which is for the period from 1 July 2020 to 30 June 2021.

- **How many Neurologists do you have on staff (numbers and FTE equivalent)?**

  Currently we have two (2) Neurologists on staff (1.3 FTE) and we have recently advertised an existing Neurologist vacancy of 1.25 FTE.

- **How many Neurologists are Multiple Sclerosis (MS) Specialists on staff (numbers and FTE equivalent)?**

  - One
  - 0.2 FTE

- **How many Neurologists on your staff see patients with MS?**

  - Two

- **How many Neurology Nurses do you have on staff (numbers and FTE equivalent)?**

  - One
  - 1.0 FTE Registered Nurse – Clinic Nurse for Neurology clinics

- **How many MS Nurse Specialists are on staff (numbers and FTE equivalent)?**

  - MidCentral DHB does not have MS Nurse Specialists.

- **What is the current waiting time for a/an;**

  a) First specialist Neurology outpatients' appointment?

  Six patients are currently waiting longer than four months. The waiting time is influenced by an existing Neurologist vacancy which has been recruited to.

b) Follow up specialist Neurology outpatient appointment?

All MS patients are scheduled for annual review with the existing MS Specialist Neurologist. If any patients require urgent or early review, they are referred to the service by their General Practitioner or the MS Field Educator.

c) Outpatient MRI?

The waiting time for MRI is dependent on the information provided by the referrer and/or the priority set by the Radiographer prioritising the referral. Typically, the general waiting time for a non-urgent MRI scan is 6-8 weeks. If the referral is for an urgent scan, the wait time will be immediate or up to four hours, depending on clinic presentation.

d) Outpatient infusion clinic appointment?

Wait times for outpatient infusion appointments are dependent on the type of treatment (medication) and protocol for frequency of infusions for that medication. The referral for the administration of an infusion is sent from the Neurologist/Neurology Department to the outpatient infusion clinic and the patients are booked by that department.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services

Phone (06) 350 8061
Fax (06) 355 0616

Postal Address:
PO Box 2056
Palmerston North Central
Palmerston North 4440
New Zealand

Physical Address:
Gate 2
Heretaunga Street
Palmerston North
New Zealand

19 July 2021

E-mail:

Dear

Official Information Act (OIA) Request

Your OIA request of 24 May 2021 to the Ministry of Health regarding colonoscopy decline data is acknowledged.

As advised in the Ministry of Health's letter of 21 June 2021, it is believes that the information you requested is more closely aligned with the functions of the individual district health boards (DHBs) and MidCentral DHB's data follows.

- **Colonoscopy decline data for the last five years, presented monthly, and as up to date as possible with raw numbers as well as percentages.**

Declined Referrals and Percentages for the Last 5 Years: Colonoscopy

	All Referrals (incl. Declined)	Declined Priority Outcome	Percent
2016			
January	251	0	0.0%
February	283	2	0.7%
March	369	0	0.0%
April	286	1	0.3%
May	377	1	0.3%
June	410	1	0.2%
July	316	1	0.3%
August	352	0	0.0%
September	368	0	0.0%
October	281	2	0.7%
November	350	25	7.1%
December	311	22	7.1%
2017			
January	258	26	10.1%
February	307	22	7.2%
March	389	18	4.6%
April	269	1	0.4%
May	396	9	2.3%
June	286	8	2.8%
July	259	6	2.3%

Operations Executive, Acute & Elective Specialist Services
MidCentral District Health Board, PO Box 2056, Palmerston North 4440
Telephone (06) 356 9169

737092

August	333	1	0.3%
September	330	8	2.4%
October	275	4	1.5%
November	235	5	2.1%
December	142	4	2.8%
2018			
January	114	2	1.8%
February	127	2	1.6%
March	126	1	0.8%
April	127	0	0.0%
May	164	2	1.2%
June	135	3	2.2%
July	144	5	3.5%
August	158	1	0.6%
September	144	3	2.1%
October	196	2	1.0%
November	152	2	1.3%
December	109	1	0.9%
2019			
January	129	2	1.6%
February	131	1	0.8%
March	150	3	2.0%
April	121	1	0.8%
May	167	3	1.8%
June	115	6	5.2%
July	171	4	2.3%
August	164	1	0.6%
September	172	1	0.6%
October	181	3	1.7%
November	161	3	1.9%
December	157	5	3.2%
2020			
January	163	4	2.5%
February	225	7	3.1%
March	174	11	6.3%
April	121	5	4.1%
May	158	8	5.1%
June	174	5	2.9%
July	239	8	3.3%
August	216	12	5.6%
September	301	7	2.3%
October	194	10	5.2%
November	225	5	2.2%
December	214	4	1.9%

2021			
January	168	10	6.0%
February	200	5	2.5%
March	200	7	3.5%
April	184	2	1.1%
May	179	4	2.2%
June	189	4	2.1%
July	76	0	0.0%

- **Provide a definition of "decline" to ensure consistency between DHB data. For example; if a referral from a GP is decline and, later, that person sees a specialist and is successfully accepted for a procedure, is that a decline?**

  When a referral is declined based on the information provided, it is returned to the referrer. They are advice to re-refer the patient if they consider a secondary care assessment is the best option for the patient or if additional clinical information is provided to alter the previous decision.

  If a second referral is received, it is registered into the Patient Management System as a new referral and triaged accordingly. If the patient is to be offered an appointment to be seen, this will not alter the decline decision previously made. They are treated as separate referrals.

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Acute & Elective Specialist Services