MDHB Responses to OIAs received July to September 2022

Resignations and Terminations (OIA Y22-544)
Pregnancy and perinatal data (OIA Y22-545)
Ward 21 patient information (OIA Y22-546)
Spiritual Care Policy (OIA Y22-557)
Essure devices (OIA Y22-578)
Staff on Individual Employment Agreements (OIA Y22-583)
Patient meal budget (OIA Y22-778)
Holidays act Contractors (OIA Y22-507)
ICU Reviews (OIA HNZ00004538)
Number of beds PNH (OIA Y22-840)
Acute Mental Health Unit (Y22-843)

27 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Via email: [redacted]

Dear [redacted]

I refer to your Official Information Act request received by email on 4 July 2022 with regard to your request for information relating to resignations and terminations due to non-compliance of the COVID Vaccination mandate for Te Pae Hauora o Ruahine o Tararua | MidCentral (formerly MidCentral DHB) and respond as follows:

1. *Total number of Registered and Enrolled Nurses who have left the MidCentral District Health Board (MCDHB) since 1st October 2021.*

   158.

2. *Total number of Health Care Assistants who have left the MidCentral District Health Board (MCDHB) since 1st October 2021.*

   29.

3. *Total number of Registered and Enrolled Nurses, working for the MCDHB whose employment contract was terminated under the Covid - 19 Public Health Response Vaccinations Amendment Order 2021(No 3)*

   9.

4. *The current number of Registered Nurse and Enrolled Nurse Job vacancies at MCDHB.*

   59.5 fte as at 30 June 2022.

Please note that this response, or an edited version of it, may be published on the Te Pae Hauora o Ruahine o Tararua | MidCentral website ten working days after your receipt of this letter.

Yours sincerely

Keyur Anjaria
General Manager
People and Culture
Te Pae Hauora o Ruahine o Tararua | MidCentral

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North,
4440
Phone: +64 06 350 9196

Te Whatu Ora
Health New Zealand

14 July 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) request – OIA – Y22-545

Thank you for your request for information dated 4 July 2022. Your request is acknowledged and has been passed onto me for a response.

You have requested Te Pae Hauora o Rauhine o Tararua | MidCentral provide you with information regarding pregnancy and perinatal data for the first six months of 2022.

1 – The number of miscarriages recorded per year

PN Hospital	Jan	Feb	Mar	Apr	May	Jun	Total
Spontaneous Abortion diagnosis	9	11	11	10	5	12	**58**

2 – The number of ectopic pregnancies per year

Discharges PN Hospital	Jan	Feb	Mar	Apr	May	Jun	Total
Ectopic Pregnancy diagnosis	2	1	2	1	3	3	**12**

3 – The number of molar pregnancies per year

Discharges PN Hospital	May
Molar Pregnancy diagnosis	**1**

4 – The number of live births per year

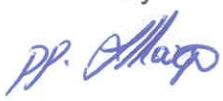
MDHB Wide	Jan	Feb	Mar	Apr	May	Jun	Total
Livebirth	163	145	183	156	165	151	**963**

5 – Number of perinatal deaths and neonatal deaths per year

MDHB Wide	Jan	Feb	Mar	Apr	May	Jun	Total
Antepartum Stillbirth	1	1	2	1	1	1	7
Infant Death	1					1	2
Intrapartum Stillbirth	1	1					2
Neonatal Death					1	1	2
Total	**3**	**2**	**2**	**1**	**2**	**1**	**13**

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

Te Whatu Ora
Health New Zealand

18 July 2022

[redacted]

Tēnā koe [redacted]

OIA request
Our Reference: Y22-546

We are in receipt of your Official Information request dated 4 July 2022 requesting a copy of the latest information that is provided to patients admitted to Ward 21, Palmerston North Hospital.

Attached is the pack of information that is given to patients and whānau upon admission to Ward 21.

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.

Ngā mihi

Scott Ambridge
Operations Executive
Te Uru Rauhī - Mental Health & Addictions Services
Te Pae Hauora o Ruahine o Tararua | MidCentral

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Ward 21

A comprehensive guide from admission to discharge

For

Patients, Family / Whānau and support people.

Index

Welcome to Ward 21

An admission to hospital can be disruptive, and this can be especially so when it involves an acute mental health problem. It is not unusual to be feeling confused, disorientated or anxious. With that in mind, we have put together this information to assist to provide you with information and a guide to what you can expect here on Ward 21 for you and your family / Whānau.

What is Ward 21?

We offer two separate areas of care – the Acute Ward and the High Needs Unit (HNU).

Staff

You can expect all staff to introduce them self to you by name. All hospital staff wear identification badges which should be clearly displayed. Later in this guide we will explain the staff's role in your care.

Multi-Disciplinary Team (MDT)

All clinical staff who is involved in your care work as a Multi Disciplinary team. The people included in your care can include:

- Psychiatrists
- Registrars
- Registered Nurses, Associate Charge Nurses and / or the Charge Nurse
- Registered Social Workers
- Psychologists *(access off site)*
- Occupational Therapists
- Key Worker
- Consumer Advisors
- Family/Whānau Advisor (Whānau Ora Kaitautoko)
- Health Care Assistants (HCA's)
- and office administration staff.

Care Team

CLOSE CIRCUIT TV ON WARD 21 –

The ward has a close circuit TV (CCTV) system that assists Clinicians in offering enhanced levels of care and security to patients, staff and visitors.

For safety and security of patients, staff and visitors, cameras are placed in communal areas, corridors and exit points.
No CCTV camera is placed in areas where the privacy and dignity of patients may be compromised. This includes toilet and bathroom / shower, bedrooms, or similar.

Cameras are not hidden from view and appropriate steps are being taken by signage and displaying posters, to inform the public of the presence of the system. This signage includes an image or picture of a camera as additional information.

Monitors are located in the Ward 21 entrance, dining area, corridor to female wing and externally in the main courtyard and will only be accessible to MDHB security personnel, clinical and support staff working in Ward 21, as well as Mental Health & Addiction Service (MHAS) clinical and management leadership staff.

The Privacy Commissioner - the term CCTV means camera surveillance systems that capture images of individuals or information relating to individuals to include:

- Tracking and monitoring individuals and groups
- Capturing information that could be used to investigate a crime
- Surveillance as a means of deterring crime.

MidCentral District Health operates its CCTV under these guidelines with a focus of the Privacy Act principles.

HELP US KEEP EVERYONE SAFE

MidCentral District Health Board; Mental Health and Addiction Ward 21 are guided by a policy that allows for search and seizure of banned or illegal property. A personal / property search will be undertaken on admission. Searches can also occur at other times, including before and after leave.

BANNED:

- Illegal drugs and drug paraphernalia
- Weapons and firearms
- Alcohol and legal highs
- Photographing and audio/video recording
- Any item that causes harm to self or others
- Offensive materials or images, including pornography

RESTRICTED:

- Sharp items – scissors / razors / glass / aerosols
- Lighters / matches
- Cameras / internet capable equipment / cell phones / chargers
- Potentially toxic or flammable substances
- Jewellery and valuables e.g. more than $40.00 cash

Restricted items are not permitted at the start of any admission. Later people may be allowed to have some restricted items, if the Doctor gives permission.

Prescribed and over the counter medication or natural remedies should be reported to staff.

Visitors are advised that a condition of entry **may** be a property search and that visiting access to the Ward can **be denied** in extreme cases.

Mental Health and Addiction Services reserve the right to request Police assistance, including Drug Detection Dogs at any time.

ZERO DRUG TOLERANCE

Ward 21 has implemented a Zero drug tolerance policy. This includes the use of cannabis, sniffing of glue and consumption of hand sanitizer or legal high substances such as herbal stimulant forms.

All patients will be drug tested on admission to Ward 21. Thereafter all patients will be required to provide random urine samples to nursing staff for drug testing when asked. All patients admitted to the ward will have a thorough inspection through all their belongings on admission to the ward to search for drugs. All drugs found within the ward will be immediately confiscated and either given to the Police or destroyed.
Should medical or nursing staff suspect that a patient is using illegal drugs within the ward this will be addressed and robustly managed. If any patient is suspected of using drugs, then patients will be drug tested by nursing staff to confirm any illegal substance use.

If a patient tests positive for drug use, then they will then be reviewed by their Consultant Psychiatrist at the earliest opportunity. Patients who are found to be using illicit drugs on the ward will be assessed with regard their suitability for discharge and will be immediately discharged from the ward where appropriate.
Where discharge is not deemed appropriate, but the patient is found to be using illegal drugs when they are a patient on the ward the following restrictions will be immediately implemented:

(1) Any patient found to be using drugs whilst a patient on Ward 21, will have no unescorted time out of the ward authorized by the treating team. This includes no day or overnight leave. These restrictions will remain in place for the entire duration of the patients stay within Ward 21. The use of drugs on the ward may be reported to the Police for further action.

(2) Any patient found to have visitors bringing drugs into the ward or arranging/facilitating drugs being delivered to the ward – will have all visiting privileges immediately removed. This means that the patient will not be allowed any visitors for the duration of their stay in Ward 21. Any visitor known to be bringing or facilitating drugs into Ward 21 will be reported to the Police for further action. Visitors may be asked to be searched by nursing staff whilst they are visiting the ward. Any visitor suspected of bringing drugs onto the ward will be asked to leave immediately by nursing staff with security assistance where required.

(3) Any patient who returns back to the ward following unescorted time out of the Ward (such as time limited shop leave or day/overnight pass) and whom staff suspect of having used or purchased illicit drugs whilst they were out of the ward, will be immediately drug tested by nursing staff. Should this test prove positive then the patient will immediately have the above restrictions put in place.

(4) Any patient suspected or found to be using their mobile phone within the unit to arrange for drugs to be brought to the ward –will immediately have their mobile phone use prohibited by their Responsible Consultant. As such, patients will be required to hand in their mobile phone for safekeeping with staff. Mobiles phones will not be returned for patient use until such times as the Responsible Consultant agrees.

(5) If staff suspects that any patient is using the ward phone to order drugs to the ward – then patients will have all unsupervised telephone call privileges removed. As such, all patient phone calls will then be supervised and monitored by nursing staff to ensure that drugs are not being ordered for delivery to the ward.

Nursing staff may conduct random, searches of the ward area for drugs. All patients being treated under the Mental Health Act 1992. must comply with staff requests to search both them and their belongings. If informal patients are unwilling to comply with this request, then they will be noncompliant with treatment. Here, patients will be assessed with a view to being immediately discharged from the ward. If discharge is unsafe, due to patient safety concerns then the treating team will consider the use of the Mental Health Act 1992. so that each treatment continues, and the measures associated with supporting the ward to remain drug free can be enforced.

Any drugs found either on a patient or within patient's possessions will be reported on our hospital incident reporting system which is reviewed by our hospital management. It will also be noted within a patient's medical file and this information may be considered with regards any future, subsequent admissions to the ward.

Should you have any questions relating to the above, please discuss these with nursing staff who will try to help answer any questions you may have.

Please discuss any concerns with nursing staff. Thank you for your support.

WARD 21 is SMOKE FREE and Vape friendly

To promote healthy lifestyles, and to reduce effects of secondhand smoking.

To comply with MidCentral District Health Board service wide Smoke free policy. We are however permitted to vape in the internal courtyard by the dining area.

ALL visitors to Ward 21 please respect our Smoke Free policy

Ward 21 requests that you do not bring tobacco related products into the Acute Inpatient building and grounds.

- **A range of free nicotine replacement products including nicotine gum, lozenges and patches.**
- **Staff support to manage their nicotine dependence whilst in Ward 21.**
- **Staff support for those people interested in quitting smoking longer term.**
- **Education sessions about the many benefits of quitting smoking including the relationship between smoking and medication.**

On **discharge** from Ward 21, people can be provided with **Quit Card Prescriptions** for subsidised nicotine replacement including gum, lozenges and patches.

For More Information *Ask a Ward 21 Staff Member or Contact the Quitline Ph 0800 778 778*

Te Ohu Auahi Mutunga (06) 350 9119

smokefree AOTEAROA NEW ZEALAND 2025

ADMISSION

It is not unusual to be feeling confused, overwhelmed or anxious during admission. This is a common experience related to any hospital admission, and Ward 21 staff is skilled in providing support and will assist you, to settle in.

What to expect on admission
When you arrive at Ward 21, staff will:

- Introduce them self by giving their name
- Explain to you what is going to happen during your admission
- Explain who will provide your treatment and give you their names
- Show you your bedroom and show you around the Ward
- Include your Family / Whānau and support people wherever possible
- Aim to answer any questions you might have
- We can provide on request a Translation Service to patients.

This is a telephone service; please see your Nurse or administration staff to request this.

You may want to review this information again when you feel more settled. All staff understands this and will answer your questions or explain information throughout your stay at your request.

INFORMAL PATIENTS – WHAT THIS MEANS

An informal patient is receiving treatment of their own free will (voluntarily). You have the right to be informed about your assessment and treatment and to give your consent to any assessment and treatment plan. Your Psychiatrist, Nurse and care team will discuss these with you. Treatment can only be undertaken with your informed consent. You are entitled to seek further advice (including a second opinion) if you wish. You may have to pay for independent medical advice however if you wish to seek a second opinion.

As an informal patient, you may or may not wish to have your Family /Whānau and support people involved in discussions about treatment plans. Please make your wishes known and these will be respected.

A copy of "Your Rights under the Health and Disability Act" is on page 34

PATIENTS BEING TREATED UNDER THE MENTAL HEALTH ACT 1992.

Different conditions apply and you should discuss these with your care team. You will come under the care of your Responsible Clinician (RC), the Psychiatrist, overseeing your care. You may not leave the Ward without permission and your care team may make decisions on your behalf regarding your treatment. Treatment Plans will be discussed with you wherever possible. Your care team will seek your collaboration and consent. You are subject to Compulsory Assessment and Treatment Orders that restrict your right to refuse certain treatments. You can be fully treated without your consent for the first 30 days of your admission.

You have the right to consult the District Inspector regarding your status under the Mental Health Act 1992. You can discuss this with your Nurse or another staff member at any time.

Your Responsible Clinician can release you from compulsory status under the Mental Health Act 1992 at any time during the process of assessment and treatment. Please refer to the section on the Mental Health Act on pages 30 and 31 for a comprehensive easy to understand guide. Alternatively ask your Nurse or Social Worker to get someone to speak to you about this.

TREATMENT AND CARE AIMS

Ward 21 provides services for patients who are experiencing severe mental distress and who are too unwell to be cared for at home.

The aim of treatment on Ward 21 is on recovery and for you returning to ordinary life as soon as possible. Community support is available if required.

Ward 21 aims to provide the best possible clinical care in a respectful, supportive, safe and caring environment.

See page 37 for your own 'patient owned' care plan to fill in when you feel ready prior to discharge.

Nursing Team

On admission, and throughout your stay, you will be assigned to a Registered Nurse (RN). Your Nurse will change on each shift. Shift times are as follows:

Morning Shift:	***7.00am – 3.30pm***
Afternoon Shift:	***2.30pm – 11.00pm***
Night Shift:	***10.30pm – 7.30am***

On arrival at Ward 21, your allocated Registered Nurse will go through the admission process with you.

Nurses will work with you to carry out a nursing assessment, to identify specific mental, physical, spiritual /cultural and social health needs.
Your inpatient assessment and Community Integrated Treatment Plan (ITP) are used to formulate a Care Plan.

We will work alongside you to manage your safety needs, monitor your progress in treatment and provide you with information about your treatment and medication to help you.

We will attend medical reviews and support you with your concerns/questions when you see your Doctor. Talk with your Nurse if you have any unanswered questions.

We work as part of a Multi Disciplinary Team (MDT). Other team members involved in your care will be the community mental health & addiction staff (Key Worker), Registered Social Worker, Consumer and /or Family / Whānau advisor (Whanau Ora Kaitautoko), Psychologist, Psychiatrist and Occupational Therapist.

You can expect to spend time with your Nurse to discuss your thoughts and feelings and to ask questions.
Your Nurse will provide education about your medication. Written information will be given to you.

Any questions about your prescribed medication can be answered by your Nurse.
You will have your blood pressure, temperature, pulse, respirations done daily.

Your Nurse link is you with members of the inpatient team and the wider Mental Health team. Verbally and written notes will be put into your file to provide information about your progress to others team members.

Ward nursing staff consists of:

Registered Nurses (RN), Charge Nurse (CN) & Associate Charge Nurses (ACN) & Clinical Nurse Specialist (CNS).

Charge Nurse (CN):
Is responsible for the overall management of Ward 21.

Charge Nurse - Monica Barnes

Associate Charge Nurse (ACN):
The ACN reports to the CN and is responsible for the day to day running of the ward. They oversee the intake of admission through to discharge, and they facilitation of Multi Disciplinary team meetings.

Associate Charge Nurses: Carolyn Firmin, Susan Constable, Bernie Gormanly, Casey Kempthorne, Siobhan Hennessy

Clinical Nurse Specialist: Nicky Redwood

Registered Nurses (RN's):
The RN's role includes administration of medication, patient education and supporting patients to understand their diagnosis. Assisting patients to develop strategies to minimise the impact of their illness on their quality of life. RN's also provide care coordination and monitoring of client symptoms and risks. All staff is trained in de-escalation and Safe Practise Effective Communications (SPEC) if an event occurs. Along with documentation, therapeutic use of the sensory modulation room and the handing over of information are also important factors as part of being a Registered Nurse.

Ward Doctor who assists your Responsible Clinician (RC)

Within 24 hours of arrival, you will see a Doctor. Your Doctor will provide an assessment which will includes:

- ✓ organise a time for routine blood tests
- ✓ may also include a blood screen for drugs/medication.

This requires your consent if you are an informal patient. If you are admitted, subject to the Mental Health Act 1992.

When you are admitted to Ward 21, you will be allocated a Psychiatrist who works with a Registrar & trainee Intern.

The Primary Doctor is a Psychiatrist. They specialise in the diagnosis and treatment of mental illness. If you are under the Mental Health Act 1992, then your Primary Doctor is known as your Responsible Clinician (RC).

Doctors on Ward 21:

Will thoroughly assess, accurately diagnose and effectively treat your mental illness. Doctors will holistically coordinate the care of patient by involving relevant Multi Disciplinary teams (MDTs) to address mental, physical, spiritual/cultural and social needs.

Your Doctor will help to educate you, your Family/Whānau and support people about mental illness and associated issues such as medications.

What we provide

Regular assessments of mental state through interviewing and discussion with patient, staff, Family/Whānau and support people. This may involve assessments by the Responsible Clinician for patient under the Mental Health Act 1992.

- Treatment of mental illness with medications. We may also refer you for other treatments such as Psychology
- Physical examinations. Investigations of physical state including blood tests, urine tests, heart recordings (ECG), brain scans (CT, MRI) etc
- Treatment of physical state where appropriate.

While ward Doctors aim to address physical concerns, **they do not replace the role of your GP**. Your GP will be required to continue following you in the community. Physical assessments may require the Ward Doctor to liaise with your GP. A consent form is signed on admission. Note if you do not have a GP a referral can be made for you.

For education about mental disorders, treatment and medications, this is usually done through discussion with you and written information is given by your Nurse.

Coordination of care through Multi Disciplinary team meetings and referral to appropriate services for on-going assessment and/or treatment.

If you wish to speak with your doctor, then let your Nurse know. Your Nurse will be able to contact your doctor on your behalf and arrange a suitable time.

You will often see your Ward Doctor on Ward 21 during the day. Please feel free to approach them to let them know you wish to speak with them, and a suitable time will be negotiated with you.

Working hours for Doctors

Daytime 8.30am - 5.00pm

Nighttime /On-call 5.00pm – 8.30am

What you can expect from the Doctors

On Admission:

- Assessment by interview
- Physical examination by the Ward Doctor soon after admission
- Request for routine blood tests, urine tests and other medical investigations may be requested such as heart recordings and brain scan.

During admission:

- Regular reviews by Primary Doctor (at least 1 time per week) and Ward Doctor. This is to make further assessments and evaluate progress with treatment. Your Doctor reads Nurses notes and attends handover meeting to keep up to date on your progress daily.
- Education by Doctors about mental disorders, medications, treatments etc.

This is a good opportunity for patients to ask questions. See page 42 for questions you can ask at the Dr. Review meeting.

Discharge Planning:

- Your Doctors will discuss your plans for the time after you are discharged from hospital. They will coordinate follow-up in the community which is usually by an allocated KeyWorker.
- Your Family / Whānau will be involved as much as possible.
- A copy of your discharge summary will be sent to your GP.
- A copy of your discharge plan with your approval can be given to your Family / Whānau
- You will be given a copy of your Treatment Plan on discharge.

See 43 for discharge meeting questions you may wish to ask. These forms are also available in the dining area.

YOU CAN HELP Patients can help ensure they receive better care by:

- Reporting symptoms or experiences they are having, no matter how trivial they seem
- Reporting medical conditions and allergies they may have
- Reporting all medications, they are taking, including over the counter or herbal medications.

Feel free to ask your Doctor questions at any stage of your admission and throughout your stay.

No question is too silly! If in doubt, ask!

CONSUMER ADVISOR

The Mental Health and Addiction Service employ a 'Consumer Project Lead' & a 'Consumer Advisor' to provide support and information to inpatients.

Through education and the interpretation of information they will give you guidance to encourage patients and Family/ Whānau on how best to participation in services and your care.

The role is to advisor patients in determining their needs and to provide a co-ordinated role between Ward 21 staff and the community services teams.

FAMILY / WHĀNAU ADVISOR
(Whānau Ora Kaitautoko)

The Mental Health and Addiction Service employ a Family/Whānau Advisor (Whānau Ora Kaitautoko) to provide support and advice to inpatients and their Family / Whānau.

Through education, the interpretation of information and guidance to enhance and encourage service users and Whānau participation in the services.

The role is to assist whānau in determining their needs and to provide a Co-ordinated role between Family / Whānau, mental health, addictions and community services.

We also work very closely with Manawatu Supporting Families.
Offices are located throughout the Manawatu.

Palmerston North / Feilding– Phone 06 355 8561 main office
Offices located in Dannevirke / Pahiatua

The Consumer Advisors and Whānau Ora Kaitautoko also support MDHB with looking over Policies from a service user and Family / Whānau perspective, sit in on Job interviews for suitability to work with service users, host community feedback sessions on MidCentral DHB services, working with National Organisations to ensure MidCentral DHB is up to date with what is going on around New Zealand.

"ADVOCACY IS DIFFERENT TO ADVISORY"

Call 0800 555 050 Advocacy for Health & Disability.

Advocacy is done through an external independent agency.

REGISTERED SOCIAL WORKERS

What is SocialWork and what do they do for you?

Social Work is about working with people, and their Family/Whānau, and the problems they have within their social environment. Each patient is allocated a Social Worker depending on where you live.

When people are admitted to hospital, there are often social and interpersonal problems in addition to their mental ill-health, which continue to impact on them, and on their mental health.

Your Social Worker during your admission will assist you with any problems and challenges you may be having with your social wellbeing – such as social, support, financial matters, work / study, housing, Family / Whānau issues, benefits, employers or need for additional supports, etc.

Your Social Worker is trained to work with you and your Family/Whānau or support people or with others on your behalfto achieve the best possible outcomes. In this way, the Social Worker is focused on working in partnership with you in your recovery for your return home or to a community situation, supporting your discharge from hospital.

The Social Worker on Ward 21 are a registered health professional *(belonging to a group called Allied Health which includes Social Workers, Psychologist and Occupational Therapy staff)* they too are a member of the Multi Disciplinary team providing treatment services to you.

How can a Social Worker help me?

A Social Worker can help with financial, work and accommodation matters:

- Helping with Work and Income benefit applications, banks, ACC, and budget advice
- Liaising with employers and linking people in with supported employment services. (Whaioro Trust)

A Social Worker can helpwith housing and accommodation problems:

- We can assist with addressing problems with landlords
- Assistance with finding affordable accommodation. Liaising with Housing NZ, Plamerston North City Council & WINZ, Rental Agencies and private landlords
- Completing Support Needs Assessments for community supports or supported accommodation.

A Social Worker can helpyou with o additional information such as:

- Information, support and advocacy regarding your Rights
- Support with childcare family issues
- Help with developing personal social support systems
- Provide some short-term counseling or assistance with access to counseling services
- Assistance with access to legal services, and information regarding legal aid and legal matters
- Assistance with other agencies - such as Oranga Tamariki, Community Probation, NZ Police, MSD, Work & Income and other welfare and advocacy agencies
- Assistance with information regarding the Mental Health (Compulsory Assessment and Treatment) Act 1992, and other key legislation.

Howdo I get a Social Worker to help me?

The Social Worker works with the treating team and is available to all patients and their Family/Whānau while on the Ward 21. The Social Workers are based on Ward 21, Monday to Friday 8.30am – 5.00pm.

A Social Worker is trained in working with you and your Family/Whānau and support people:

- We can arrange Family/Whānau meetings with the treatment team
- Providing information about MidCentral DHB Mental Health & Addiction Services
- Providing information and education about your mental health condition
- Assisting with access to community support for you and your Family/Whānau or support people such as a referral to Manawatu Supporting Families
- WE work with you and your Family/Whānau by attending to acute problems or challenges that may exist now while on the Ward
- Family/Whānau support evenings can be arranged with the social worker and the Family/Whānau Advisor as needed
- We are also able to answer any Privacy questions you need answering.

YOU & YOUR BENEFIT

When you commenced receiving a Work and Income (WINZ) benefit, you agreed to inform Work and Income of any changes in your circumstances.

Being admitted to Ward 21 Palmerston North Public Hospital is a change in your circumstances and Work and Income need to be made aware of this.

You can do this directly by contacting the Work and Income Call Centre by phoning 0800 559 009 or the Ward 21 Social Worker can assist you.

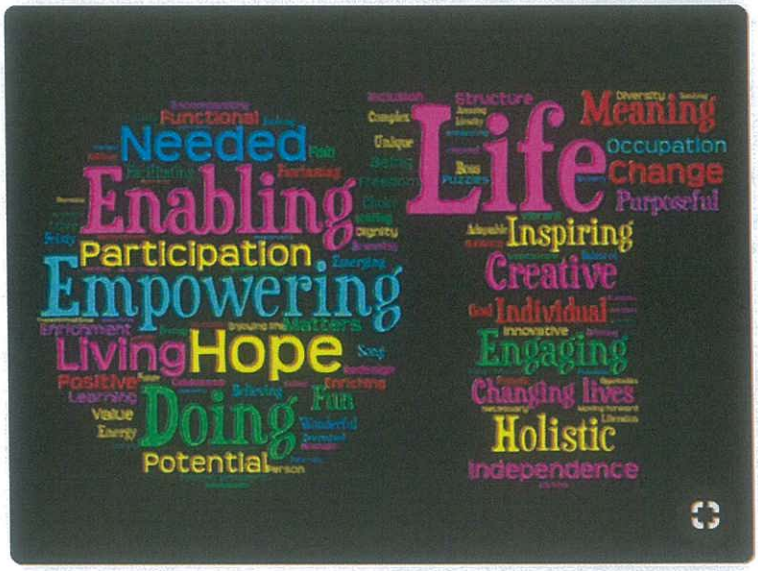
Be aware - If you are in hospital for more than 13 weeks (100 days), your benefit will be reassessed and paid at the hospital rate of benefit. It is important that Work and Income are aware of your date of admission so that this can occur.

BENEFIT ASSISTANCE

Your Ward 21 Social Workers can also liaise with the Work and Income Hospital Liaison Case Manager to assist with the following:

If you are receiving a Job Seeker Benefit, you may now be eligible instead the Supported Living Benefit. If you have no income, or you are employed, but are losing earnings due to illness the Work the Ward 21 Social Worker can assist you with an application for a Supported Living Benefit.

OCCUPATIONAL THERAPY /WHAKAORA NGANGAHOU - WARD 21



WHO ARE WE?

Registered Occupational Therapist 'Gemma' and Occupational Therapy Assistant Kate. We also have a supported role with the Health Care Assistant (HCA) 'Kelly' who has experience in diversional therapy. Come along and meet our team.

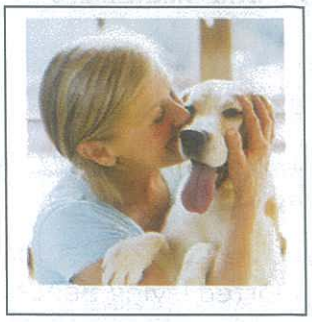
WHAT DO WE DO?

Occupational Therapy is part of the Multi Disciplinary team at Ward 21 and we offer individual and group interventions to support your recovery and transition to home During your stay in Ward 21 you will be seen by an Occupational Therapist and/or Assistant. You will be encouraged to attend aspects of the therapeutic day programme or someone may work with you individually.

"Doing": is about getting up, getting dressed and getting involved is prescribed to promote recovery.

WHAT DO WE OFFER?

Some of the regular activities may include:



- Morning walk
- Going to the gym
- Swimming in the heated pool on site
- Yoga
- Cooking sessions
- Creative workshops (arts & crafts)
- Harakeke (flax weaving)
- Karakia Rangimarie
- Pet Therapy
- Managing distress through knowing your senses: Sensory Modulation
- Social activities
- Focus groups on nutrition, sleep and hygiene etc.

The programme we offer will be displayed outside the Occupational Therapy lounge in the main dining area or on the white board beside the staff station.
Being involved in a tailored activity programme can help improve your mood and lessen anxiety and agitation: It will improve your well –being!

WE CAN HELP WITH:

- Structuring your day
- Improving your physical health
- Understanding your senses and how they impact on your ability to regulate your emotions and do the things you want to do
- Increasing or maintaining your concentration, problem solving, social skills and daily living skills
- Developing your interests and community connections
- Supporting your transition to home
- Assess what you can do and what supports you might need when you go home.

SELF- CARE **PRODUCTIVITY** **LEISURE / SOCIALISATION**

HOW CAN YOU ACCESS US?

Please speak to your Nurse or just come and visit us in the Occupational Therapy space and we can make a time to see you individually to plan.

We would love to see you!

AFTER HOURS:

There is a trolley in the Ward main office with activities provided (e.g. games, puzzles, art & craft).
Often the nursing staff will facilitate weekend activities.
Please ask if you would like the Ping Pong table brought out.

OCCUPATIONAL THERAPISTS ASK: "WHAT MATTERS TO YOU?"

We look forward to seeing you and working alongside you.
All the above will go towards helping assist with your treatment plan.

TREATMENT PLAN

Your Treatment Plan may include the following:

- Assessment and treatment along with
- Therapeutic activities – individual and groups
- Information about mental illness and medications
- Information on Community Mental Health and Addiction Teams for follow-up and care after your discharge
- Information and links to other mental health services in the community (see list page 39 & 40.
- Identification of triggers which may indicate a relapse so you can easily get help early.

You will be involved in helping create your own Treatment Plan, as fully as possible. You will also have everyday opportunities to talk with your allocated Nurse about your treatment and progress. This is a great opportunity to raise any questions or concerns you may have.

LEAVE FROM WARD 21

If you are an informal patient, you can go on leave from the Ward and you can discuss this with your allocated Nurse. You will be given a leave card; this is to ensure your safety in an emergency, or in case of a fire on the Ward, so that everyone's whereabouts can be accounted for.

If you are being treated under the Mental Health Act 1992 and wish to leave the Ward, your Responsible Clinician will have to agree with this. If this is agreed to, you will be given a leave form informing you of the conditions of leave. **If you do not have an agreement, please do not leave the Ward.** If you are given unaccompanied leave, you can go out on your own. If you are given accompanied leave, this means you can go with staff if available, Family / Whānau or friends. **NO ALCOHOL OR ILLISIT DRUGS ARE TO BE CONSUMERED / TAKEN WHILE ON LEAVE.**

If you do not return from leave at the agreed time staff will contact your Family / Whānau, friends or support persons to establish you are safe and well. If there is significant concern for your wellbeing, they will contact the Police for assistance to return you to the Ward. A leave card looks like this.


LEAVE CARD

WARD 21
ACUTE MENTAL HEALTH
INPATIENT UNIT

Telephone: (06) 350 8160 (24 hours)
027 350 8160

Palmerston North Hospital, Gate 2,
Heretaunga Street, Palmerston North

DISCHARGE

Discharge starts on admission.

Before you are discharged from Ward 21, you can expect to attend a review and or a discharge planning meeting. This is an opportunity for you to say what you would like to put in place to help support you when you leave Ward 21. This is also an opportunity to review your progress and ensure coordination of what support you may need when you are discharged from hospital to help sustain your recovery. You can authorise an advocate or support person to attend these meetings with you, either on your behalf or to accompany you.

Treatment and discharge planning will include the following:

- ✓ Information on any prescribed medication
- ✓ Your current community contacts and supports
- ✓ Referral to a Community Mental Health Team or other mental health support team or service
- ✓ Contact details of peer support agencies or other community groups/supports
- ✓ Referral to other agencies regarding housing, income, employment etc, if required.

Your Family / Whānau and other significant support persons are welcome to support you through each step, from admission through to discharge, and will be included with your consent.

SUPPORT WHEN YOU ARE PLANNING FOR YOUR DISCHARGE

On discharge from Ward 21 you will be required to have a Key Worker who will visit you within 7 days of discharge from the hospital. The Community Mental Health key worker will assist in the community when you leave Ward 21. Any referrals will be made where possible prior to your discharge and you we try to facilitate for you to meet with your allocated Key Worker before you are discharged from Ward 21.

UNPLANNED DISCHARGE

If you are an informal patient and wish to discharge yourself from the Ward, please inform staff. You are required to sign the Self-Discharge form prior to leaving the Ward. If you do not do so you will be registered as a missing person with the Police.

If you are being treated under the Mental Health Act 1992. you are restricted from discharging yourself without the agreement of your Responsible Clinician. If you leave without permission, you will then be considered "AWOL" Absent without Leave" and the Police and your Family / Whānau will be contacted to determine your whereabouts and return you to the Ward.

DAY TO DAY LIVING ON WARD 21

Your bedroom

You will have a private room. Visitors or other patients are **NOT** permitted in your room. Staff will knock and wait to be invited into your room.

Meals and drinks

Meals are served (approximately) at the following times:

Breakfast:	***8.20am***
Lunch:	***12.30pm***
Dinner:	***5.20pm***
Supper:	***8.00pm***

All meals are served in the dining area. Each day, at dinner time, you will be given a menu to choose from for the following day. Please advise your Nurse if you have any special dietary requirements as they will need to amend this on the internal meal ordering system.

Tea, coffee, milk, sugar and Milo are available in the dining room. A water cooler is in the dining area next to the fish tank.

You have the choice of four meal sizes: small / medium / large and extra large.

Bathing facilities

There are shower and toilet facilities on the Ward and there are also a baths, showers and toilets in the High Needs Unit (HNU). Toilets are shared and are cleaned daily. However, please report any hygiene issues to staff. There are toilets down each wing and one opposite reception for patient and visitors to use.

Clean linen can be requested from nursing staff.

Communal rooms and facilities

There are rooms available for general and daily activities - dining area, TV / video room and chill-out space located next to the dining area. In the male and female wings, they have a small television lounge. All televisions are turned off at 11pm to allow for a quiet environment. Please ensure that the volume is always at a reasonable level. There is an Xbox and DVD player in the chill out space.

Family / Whānau Room

There is a Family / Whānau Room situated off the main corridor as you come into Ward 21 on the left-hand side. This is designed as a room especially for Family / Whānau to spend time together away from the ward environment.

Courtyard

There is a courtyard that exits from the dining area. The courtyard is used by all patients and their visitors to the ward. Vaping is permitted in this area only.

Garden of Tranquillity

There is a lovely garden called 'Garden of Tranquillity' for walking around and this is adjacent to Ward 21's entrance. Ask your Nurse if you can take time out and smell the roses, it is beautiful.

Closed Door Policy

Our doors are locked to keep you and other patients safe. If you are a voluntary patient, doors will be opened upon request between 8.00am and 8.00pm.

Cell phones

Cellphones are permitted on Ward 21. However, they remain the responsibility of the owner/user. Ward 21 does not accept any responsibility should your phone be damaged or go missing. You cannot hold on to your cell phone charger, all phones are charged in reception for safety.

PXT or photo-capable cellphones are permitted. **However, patients / visitors on Ward 21 have no right to invade anyone else's privacy by taking pictures of them. Staff may ask to check phones, and you may be asked to show them any pictures you may have taken and be asked to delete them.**
If you do not co-operate you cell phone will be put away.

Cell phones in the High Needs Unit (HNU)

Cellphones are **NOT** permitted in the High Needs Unit (HNU). Cellphones can be placed in safe keeping or given to your relatives or support person/s.

Calls in HNU *will be at the discretion of the Nursing staff. Where appropriate phone calls to Family / Whānau members will be facilitated by nursing staff working in partnership with families.*

Telephone Ward 21 area

We appreciate that staying in contact with loved ones is important. There is a phone booth by the dining area for patients use and the number is:

(06) 350-8160 you can give this number to your Family / Whānau to call you.

To make a call dial one (1) for an outside line. Local calls are FREE. Please be considerate to others when on the phone if someone is waiting.

Calls to mobile phones and out of area require staff support to put calls through.
A telephone book is available on request just ask staff.

Calls after 10.30pm need to be at the discretion of the nursing staff. Where appropriate phone calls to Family / Whānau members will be facilitated by nursing staff working in partnership with families.

Mail

Mail can be sent to you while on the ward. You can also leave any outgoing mail at reception which is posted daily.

Postal address is:

Ward 21
Palmerston North Hospital
Private Bag 11036
PALMERSTON NORTH 4412

Email/Internet access

Wifi available on Ward 21 & internet access on a computer is through the 'Top Cafe'. A patient computer has been donated and is in Occupational Therapy lounge for patients to use to access banking, helpful websites, Work & Income applications and clear your personal emails. Please be conscious there is only one computer so time may be limited for access to other patients if required.

Laundry

The laundry is available for all patients. There is a washing machine and dryer as well as an iron and ironing board. Washing powder is provided by the Ward. The door to the laundry is locked; please access a Nurse or Health Care Assistant to open this - or you can arrange a time with your allocated Nurse which best suits you to do your own washing. The door is locked to maintain safety of property and for hygiene reasons.

Personal property and clothing

When you are admitted to Ward 21, your property may be recorded on a property sheet with you present. Your property will be stored in a locked property room if required. It is not a good idea to bring items of great value with you. The ward is not responsible for valuable items and/or personal property that may be damaged and/or go missing during your inpatient stay. It is recommended that items of value and/or personal sentiment be kept at home or given to staff for safe keeping and returned on discharge. There is a locked drawer that can be used in reception area if needed.

Money and valuables

Money over $20 and valuables can be stored in a drop safe at reception. However, this service is only available from 8.00am – 5.00pm Mon-Fri if you need access. There is a form to sign at reception for money / valuables that are deposited in the drop safe. Please talk to your allocated Nurse for assistance as money / valuables are not able to be accessed after hours.
You can ask your nurse to put small items of value away for you if you don't want to leave them in your room.

Televisions / stereos / portable gaming consoles / iPods / laptops

This is on a case-by-case basis as to whether you can use these on the Ward. The Ward is not responsible for any losses you may incur. You will need to lodge a claim with your insurance company should your property be lost or stolen. It is your responsibility to keep the volume at a minimum level. This is to respect other patients who maybe resting.

Items to bring with you

Like any hospital admission you will need to bring your day clothes, underwear, footwear, nightclothes and toiletries with you. For safety reasons, sharp objects such as tweezers, nail clippers, razors etc. will be stored with nursing staff.

It is advisable to wear shoes or slippers around the Ward, as the floors can be slippery. It is not safe for patients to walk around in just their socks.

Sensory Modulation

Sensory modulation techniques help to promote self-care, well-being, resilience and recovery. This is a specially designed quiet space, with sensory tools that explore the senses to help reduce distress, alert or calm you. The sensory room is available under the supervision of a trained staff member. Ask the Occupational Therapy team or your Nurse if you would like to use this room.

Spiritual, Religious observances and Chaplaincy's

Visits from persons of your own faith are welcomed and the Family / Whānau Room are a great place for a private visit. There is a Chapel located not far from Ward 21, for times of private reflection. Please ask staff for directions.
If you require a visit from one of the hospital Chaplains or to attend Sunday service at the hospital Chapel, please talk with your allocated Nurse who can arrange this on your behalf.

Discrimination

We do not accept discrimination against any person. We support and respect diversity.

MEDICATION

All medication on Ward 21 is stored in a locked drug room and dispensed by a Registered Nurse. On admission, you should give any medication you are carrying to your allocated Nurse. This includes dietary supplements or homeopathic / natural medicines.
All your medication will be stored for you until your discharge from the Ward.

Local dairy / vendors / Newspapers

- There is a local dairy across the road from Ward 21 in Heretaunga Street. EFTPOS is available. Reminder DO NOT buy items for other patients as they may not have the money to repay you.
- On Monday-Friday, the Evening Standard is available free for you to reading the dining area or your room.
- The snack vendor visits around morning teatime on the ward. You will need to pay cash for your purchases as they do not offer eft-pos.

Visiting hours

Please refer to the information for Family / Whānau and friends.

YOUR FEEDBACK

Ward 21 welcomes feedback. This ensures a service improvement. There are different ways for you to be able to do this:

"Tell Us What You Think" forms

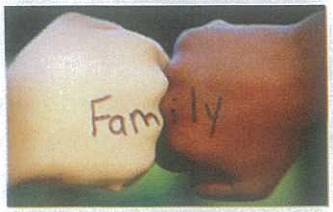
- You will find this form located by the front door to Ward 21 along with a post box for feedback to be placed. Once in (assistance is available from staff if you need it), they are sent to our Customer Relations Coordinators who process them and ensure that they get sent to the right department for a response. They can be contacted on (06) 350-8980.
- The Consumer Advisors and Family / Whānau Advisor (Whānau Ora Kaitautoko) are available to sit and talk through compliments or complaints you may wish to put forward. See dining notice board for numbers.
- The Consumer Advisors and Family / Whānau Advisor (Whānau Ora Kaitautoko) also offer a discharge interview for your feedback on your Ward experience.
- On Ward 21, there is also a weekly Patient, Family / Whānau and Natural Supports meeting facilitated by the Consumer Advisors and Family / Whānau Advisor (Whānau Ora Kaitautoko). This is a forum for patients and their support people to bring issues up regarding our service delivery or improvements. By making us aware of what we do well or not doing so well, you can help us to continually improve the service we provide.

- We also offer on discharge feedback via Marama Real-time Feedback in a paper base form or on an ipad. Be sure to give us your suggestions for improvement.

HONOS

You may hear us talk about your HONOS score? HONOS is a Health of the Nation Outcome Scales (**HoNOS**) is a clinician rated outcome measure.

'If you are unsure of anything covered in this section please ask your Nurse'.



Having a Family / Whānau member or friend in hospital can be a worrying and stressful time. We aim to provide the best possible clinical care in a respectful, supportive, safe and caring environment.

Visiting

Most patients find regular visits important and they can help recovery significantly. Visits can also assist patients maintain relationships with their Family / Whānau members during their hospital stay. We welcome your visits.

There are areas for visitors which will assist with privacy. The Family / Whānau Room in the main entrance corridor and the Garden of Tranquillity are two places where you can have private visits.

Same as the main hospital – 2.00pm – **8.00pm.**
This enables all patients to attend treatments, appointments or other activities.

Visiting outside these hours will need to be arranged prior to your visit with our Associate Charge Nurse (ACN) in charge of that shift.
Please phone (06) 350-8160.

Visiting hours for the High Needs Unit

Please phone to arrange a visit on (06) 350-8160. Visiting in this area needs to be pre-arranged.

Children Visiting

Visiting children **must be accompanied by a responsible adult** to ensure their safety and wellbeing. No children are to be left alone or left to wander around by themselves.

It is recommended that children visit only in the Family / Whānau Room.

Please note: NO CHILDREN ARE ALLOWED TO VISIT IN THE HIGH NEEDS UNIT

GENERAL GUIDELINES FOR VISITING

Your cooperation with these guidelines will help ensure quality time in your visits.

- Please respect the privacy and dignity of other people at the Ward who, like your own Family / Whānau member, friend may be feeling vulnerable or distressed.
- Do not visit if you are intoxicated or affected by drugs. If this seems to be the case, you will be refused entry / asked to leave.
- If you bring anything in for your Family / Whānau member, friend, please check with their allocated Nurse to ensure it is safe for them to have - or is safe for others on the Ward.
- Alcohol and drugs must not be brought to the Ward. Their use by patients can cause harm and/or have serious consequences.

- Please do not enter any of the bedroom areas.
- If you have any questions, please do not hesitate to ask a staff member.

If you require support during your Family / Whānau member's admission, the Ward Social Worker will be happy to talk with you and help with any information / education that might assist you.

There is also a Family/ Whānau Advisor (Whānau Ora Kaitautoko) who can offer you support during your family / Whānau member's admission. Phone 06 350 9155

Your support is of great value currently.

THE MENTAL HEALTH ACT 1992. and YOUR RIGHTS

- The Mental Health (Compulsory Assessment and Treatment) Act 1992, often shortened to the Mental Health Act 1992 is an important law for people who experience mental illness. This Act sets out the circumstance under which people can be compulsorily assessed and treated. It also sets out the process that must be followed when a person is thought to be mentally disordered. If you have any questions, please ask about this process.

- There are many people involved in administering the provision of the Mental Health Act 1992.

- Everyone who is receiving Compulsory Assessment and Treatment under the Mental Health Act 1992. is referred to as a patient.

ROLES OF PEOPLE INVOLVED IN THE MENTAL HEALTH ACT AND WHAT THEY DO:

Director of Area Mental Health Services (DAMHS)

The Director of Area Mental Health Services (DAMHS) is formally appointed by the Ministry of Health but is a MidCentral DHB Mental Health Services employee. (Either a Psychiatrist or a Registered Nurse).

The DAMHS oversees the Mental Health Act's use across the MidCentral DHB area and makes sure patients' rights are protected.

The DAMHS has responsibility regarding Responsible Clinician's and Duly Authorised Officers they receive written monthly reports from the District Inspector regarding everyone who is in hospital under the MH Act 1992.

Responsible Clinician (RC)

Every patient being treated under the Mental Health Act 1992. is assigned a Responsible Clinician who oversees their treatment. Responsible Clinician's are usually Psychiatrists but may also be other senior mental health professionals such as Psychologists.

Duly Authorised Officers (DAO)

Duly Authorised Officers (DAOs) are the frontline operators of the Mental Health Act 1992. They are experienced mental health professionals (usually Registered Nurses, and or Social Workers) who you are most likely to have first contact with. They are appointed by the Director of Area Mental Health Services.

Duly Authorised Officers provide information and advice on a wide range of mental health concerns. They facilitate the process of the Mental Health Act 1992, often involving compulsory assessment and compulsory admission to Ward 21. All staff in the Acute Care Team (Crisis Team) are Duly Authorised Officers. Several staff members on Ward 21 are also Duly Authorised Officers.

District Inspector (DI)

The District Inspector is a Lawyer appointed by the Ministry of Health but is independent of Ward 21 MidCentral DHB.

The District Inspector acts as a watchdog and advocates for persons who are being assessed and treated as compulsory patients under the Mental Health Act 1992. The District Inspector meets with patients to talk about their rights, to explain the process of compulsory assessments and treatment, and to ensure that patients have access to a Lawyer and a Judge, if necessary.
The District Inspector can also investigate complaints by patients or other people about breaches of Patient Rights. District Inspector's services are free to patients under the Mental Health Act 1992, and their Family / Whānau.

The District Inspector can be contacted directly by yourself or you can get someone else, such as the Consumer and /or Family/Whānau Advisor (Whānau Ora Kaitautoko), your Registered Nurse, Social Worker, DAO, or a Family / Whānau member to do this for you.
Phone **0800 118 393.**

Patient's Lawyers

Every patient under the Mental Health Act 1992 is entitled to consult a lawyer about his or her Rights. This is provided free of charge under Legal Aid. The lawyer will assist the patient at the Court hearing before the Judge. As a patient, you can call a lawyer yourself or the District Inspector can help with this; ask your Social Worker for the Mental Health Lawyer list and phone numbers or look online.

Mental Health Act Court hearings

On Ward 21, patients attend Court on Ward 21 in the Courtroom which is by the main entrance doors. Community patients and patients also attend Court on the Ward. Court is usually held every second Thursday on the Ward.

Police

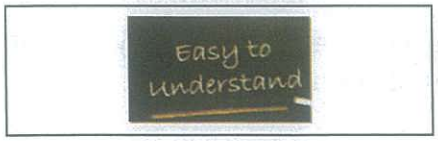
The Police may have been involved in assisting to bring you to Ward 21. Under the Mental Health Act 1992, the Police may be called to assist Duly Authorised Officers or a Doctor/GP to assess or transport a person for assessment and / or treatment.

Police can apprehend a person appearing mentally disordered in a public place and will arrange for assessment. Police are only ever involved in this process if there are concerns about safety.

IMPORTANT NOTE

A person can only have compulsory assessment or treatment if they meet the statutory definition of mental disorder. This requires the person to have "an abnormal state of mind to such a degree that the person is a serious danger to themselves or other people, or unable to care for themselves".

If you would like advice on the Mental Health Act 1992 , please do not hesitate to ask your allocated Nurse to arrange for a Duly Authorised Officer, Director of Area Mental Health Services or District Inspector to talk to you at any stage of the process should your Whānau member be subject to compulsory assessment / treatment under the Mental Health Act 1992.



MENTAL HEALTH ACT 1992 EASY REFERENCE

Section 8 Application for assessment.
By anyone who is over 18 and has seen the proposed client within the last three days.
Must be accompanied by a Medical Practitioners Certificate.

Section 8B Certificate. Supporting an application for assessment.
Must be examined by a Registered Nurse or Dr. and reasonable grounds for believing that the person is suffering from a mental disorder.

Section 9 Notice to attend an assessment.
Date, time, place and with whom.
Given by a duly authorised officer.
Dr. must not be the same Dr who issued 8B.

Section 10 Certificate of preliminary assessment by a Psychiatrist.
If the client is found to be mentally disordered a copy of the certificate must go to the:

- The client.
- Any welfare guardian of the client.
- The applicant for the assessment.
- The client's principle caregiver.
- The client's GP.

Section 11 Notice to undergo a 5-day assessment period.
Can be either inpatient or outpatient.

Section 12 Certificate of further 5-day assessment by a Psychiatrist.
Same provisions as apply to section 10.
A letter of reason for continuance to go to the Director of Area Mental Health (DAMHS) from the Psychiatrist.

Section 13 Further assessment and treatment for 14 days.
Second period of assessment and treatment.
Same provisions as apply to section 11.

Section 14 Certificate of final assessment.
Can be adjourned 2 times to a maximum total of 6 weeks in 12 months.
If the client is to remain under the act an application for compulsory treatment order is to be made.

Section 16 Review of a consumer's condition by a Judge (2nd opinion required).

Section 29 **OUT-PATIENT** community order (6 months).
No power to detain the client for the purpose of treatment.

Made by a Judge.

Section 29 (3) (A) Responsible Clinician can direct a consumer to be treated as an inpatient for up to 14 days.
Cannot be any more than twice in a six-month period.

Section 29 (3) (B) Responsible Clinician directs patient / service user / consumer subject to a community treatment order (CTO) to be assessed. CTO ceases and reassessed under section 13 & 14 of the act.
*It is possible for a patient / service user / consumer subject to a CTO to have an informal admission for a short period.

Section 30 **IN-PATIENT** order (6 months). Made by a judge.

Section 76 Clinical reviews if still mentally disordered extension of 6 months.
Clinical review at 3 months and again at 6 months.

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DISTRICT INSPECTOR FOR HELP AND SUPPORT
WHEN ON THE MENTAL H ACT

0800 118 393
Michelle Woods

This is a free service to people on the Mental Health Act 1992.

Your Rights & Responsibilities

when receiving health and disability services from MidCentral Health

MidCentral Health

1 Respect

You should be treated with respect, including respect for your personal privacy, including your cultural, religious, social and ethnic needs, values and beliefs.

2 Fair Treatment

You should be free from discrimination and services should be delivered without coercion, harassment or any form of exploitation.

3 Dignity & Independence

Services should be provided in a way that respects your dignity and independence.

4 Proper Standards

You have the right to be treated with care and skill, and to receive services that reflect your needs. All those involved in your care should work together for you.

5 Communication

You have the right to be listened to and information should be given in a form, language and manner which you can understand. When reasonably practicable, an interpreter should be available.

6 Information

You should always be given an explanation of your condition and your options – including the expected risks, side effects, benefits, costs and an estimate of when you will receive a service. You can also ask any questions to help you get all the information you need.

7 It's Your Decision

Anything to do with your health is up to you – you can say no or change your mind at any time. In circumstances where services have to be delivered without your consent, they should be in your best interest.

8 Support

You may have a support person or people of your choice with you, as long as it is safe and other consumers' rights are not unreasonably affected.

9 Teaching & Research

All of these rights apply when you are being asked about or taking part in teaching or research.

10 Complaints

It is OK to complain – your complaints help improve our service. It must be easy for you to make a complaint, and it should not have an adverse effect on the way you are treated.

Mental Health and Wellbeing Apps

Apps hold amazing potential as mental health and wellbeing tools. You can carry them everywhere, engage with them in real time as you're experiencing distress, and interact with them in a completely different way to other self-help tools. But it is important to remember that apps don't replace professional help or your Doctor's advice, and there is no current accreditation system for apps that are designed. It's important to note an app will only be effective if you use it, and you are probably more likely to use something you enjoy using so if you don't like the look of the app, don't like the language it uses, or don't like the things it asks you to do, it's probably best finding another one.

CALM

Calm was branded as Apple's "App of the Year" in 2017. The app is designed to reduce anxiety, improve sleep, and help you to feel happier. Calm focuses on the four key areas of meditation, breathing, sleep, and relaxation, with the aim of bringing joy, clarity, and peace to your daily life. The app delivers meditations that can help you to distress, as well as breathing programs, music, and sounds from nature to relax your mind and body and promote better sleep. Calm is the perfect app if you are new to meditation, but it also offers programs for more advanced users. Meditation sessions are available in lengths of 3–25 minutes, to fit in with your schedule. *Free

SAM

One of 2018's Best Anxiety Apps. SAM is a friendly app that offers a range of self-help methods for people who are serious about learning to manage their anxiety. SAM has been developed by a university team of psychologists, computer scientists and student users. Established methods of self-help have been combined with high standards of usability to provide an engaging, flexible, and practical resource. *Free

CALM HARM

Calm Harm provides tasks that help you resist or manage the urge to self harm. You can add your own tasks too and it's completely private and password protected. The four categories of tasks target the main reasons for why people self harm. Distract helps to combat the urge by learning self control; Comfort helps to care rather than harm; Express gets those feelings out in a different way and Release provides safe alternatives to self injury. Calm Harm is an award-winning app developed for stem4 by Dr Krause, Consultant Clinical Psychologist using ideas from evidence-based therapy called DBT. The focus is to help learn to identify and manage your 'emotional mind' with positive impact. The app enables you to track your progress. Please note that the app is an aid in treatment but does not replace it. *Free

BEYONDNOW

If you or someone close to you is experiencing suicidal thoughts or feelings, having a safety plan can help you get through the tough moments. Your safety plan starts with things you can do by yourself, such as thinking about your reasons to live and distracting

yourself with enjoyable activities. It then moves on to coping strategies and people you can contact for support – your friends, family and health professionals. Convenient and confidential, Beyond Now puts your safety plan in your pocket so you can access and edit it at any time. You can also email a copy to trusted friends, family or your health professional to help them support you. *Free


PACIFICA

Apple's Best of 2017, Stress, anxiety, and depression can get in the way of you living your life. Pacifica gives you psychologist-designed tools to address them based on Cognitive Behavioral Therapy, mindfulness meditation, relaxation, and mood/health tracking. Stress, anxiety, and depression are caused by an ongoing cycle of negative thoughts. Thoughts cause physical feelings and emotions which cause actions. Pacifica helps break this cycle using tools that target each of its components. Day-by-day, you'll learn to manage stress, anxiety and depression at your own pace. We're not about quick-fixes or false promises. We are about real progress, a day at a time. *Free


CHECK-IN

The Check-in is for anyone who wants to check in with a friend but is concerned about saying the wrong thing or making the situation worse. The app takes you through four steps, getting you to think about where you might check in, what you might say and how might you support your friend. There is also a section showing you things to consider, such as what if my friend denies there is a problem or what if I say something silly. *Free


HEADSPACE

Headspace is the simple way to reframe stress. Sleep trouble? Meditation creates the ideal conditions for a good night's rest. Relax with guided meditations and mindfulness techniques that bring calm, wellness and balance to your life in just a few minutes a day. *Free

PTSD COACH

PTSD Coach was designed for those who have, or may have, posttraumatic stress disorder (PTSD). This app provides you with education about PTSD, information about professional care, a self-assessment for PTSD, opportunities to find support, and tools that can help you manage the stresses of daily life with PTSD. Tools range from relaxation skills and positive self-talk to anger management and other common self-help strategies.


WHAT'S UP

What's Up? is a fantastic free app utilising some of the best CBT (Cognitive Behavioural Therapy) and ACT (Acceptance Commitment Therapy) methods to help you cope with Depression, Anxiety, Anger, Stress and more! With a beautiful, modern design, simple heading and easy-to-follow methods, you can get to what helps you the most in seconds! *Free

Full Apps booklet located in the dining area.

My Care Plan

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

24/7 SERVICE MENTAL HEALTH & ADDICTIONS
Acute Care Team
TEL: 0800 653 357

COMMUNITY MENTAL HEALTH AND ADDICTION SERVICES

Recovery Plan
(Client owned document)

Name:
DOB:
NHI:

Address:

Phone:
Mobile:
Email:

Who do I want to share my plan with?

If you have any concerns or queries, please contact Mental Health and Addiction Services
Monday to Friday - 8.00am – 4.30pm

Palmerston North Phone 06 356 9169 or 0800 653 357

NEED TO TALK?
1737
free call or text any time

Levin:
Dannevirke:
Pahiatua:
Weekends and after hours
Mental Health Line 0800 653 357 – Acute Care Team

Team	Name	Phone	Support people	Phone
Key Worker				
GP				
Consultant				
Community Support Worker				

What are my priorities (Goals)
Agreed actions
Who else will be involved (NGO, Family/Whanau)
Things I can do to stay well
Things that may make me unwell
My early warning signs

When things are breaking down (crisis plan)

SUPPORT I may need help with

What kind of support do I need? Place phone numbers and names in here

Someone to	tick	who
Look after the children		
Help with finances & budgeting, pay bills		
Gardening, mow lawns etc.		
Help with housework cooking etc.		
Support me at Appointments		
Help me make decisions about my treatment and medication		
Help with transport		
Help me find out about using a computer		
Help me to see when I am becoming unwell		
Be with me		
Socialise and have fun – celebrate		
Offer cultural supports and links to my culture		
Talk to me about what's happening - listen		
Provide residential care or home-based support		
Discuss things with me and give advice		
Support me when I need in-patient or protective care		
Know I can ring anytime, if I am distressed		
Pray with me, Karakia, spiritual guidance		
Offer counseling		
Support me to rest and taken time out		
Provide information, resources		

Support services for people, Families /Whānau and friends of people affected by mental distress & addictions in the MidCentral Region.

ACROSS TE KOTAHITANGA O TE WAIRUA Social work, foster care services, counselling, post natal depression, bereaved by suicide, and parenting programmes.
Ph: 06 356 7486
www.across.org.nz

BEST CARE WHAKAPAI HAUORA
Social service and disability service provider arm of Tanenuiarangi Manawatu Inc, the mandated Iwi authority for Rangitaane o Manawatu.
Ph: 06 353 6385
www.whakapaihauora.maori.nz

CENTRAL PHO (Levin, Otaki, Feilding, Palmerston North & Dannevirke)
Primary Solutions – information, find a GP, support and coordinating access to early intervention.
Ph: 06 354 9107
www.centralpho.org.nz

DALCAM / ST DOMINICS (Feilding)
Level 3 & 4 Residential Supported Care for short- or long-term clients.
Local Crisis Respite. (Feilding)
Ph: 06 324 0557

HIGHBURY WHANAU CENTRE
Social Services and Alternative Education Programme. Youth and Community Development.
Ph: 06 358 0504

MANA O TE TANGATA TRUST (Levin & Palmerston North)
Peer Support and Advocacy for people with mental distress and addictions. Wellness workshops and support groups. Information on mental health and addictions.
We deliver Mental Health and Addiction services for Rangatahi, Adults and their Whanau.
Ph: 06 358 5444
www.manaotetangata.org.nz

MANAWATU SUPPORTING FAMILIES (Levin, Palmerston North & Dannevirke)
Support for families and people affected by Mental Illness and Addictions.
Ph: 06 355 8561
www.manawatusf.org.nz

MASH TRUST
Residential Supported Accommodation, Mental Health and Addiction Services, Support in the Community Services (SCS), Child & Youth Crisis Respite, LUCK Drop-in Centre, Planned Respite, Alcohol and Other Drug Treatment Services.
Ph: 06 355 7200
www.mashtrust.org.nz

NEEDLE EXCHANGE—DRUGS PROJECT
Needle Exchange Programme referral and advice to minimise harm for PWID (*people who inject drugs*).
Ph: 06 353 5063 www.drugsproject.co.nz

RANGITANE O TAMAKI NUI A RUA (Dannevirke)
For people who experience a Mental Health diagnosis or Drug/Alcohol issues. Living within Tamaki nui a Rua. (Dannevirke)
Ph: 06 374 6860 www.rangitane.co.nz

RAUKAWA WHANAU ORA INC (Levin, Otaki & Feilding))
Adult Mental Health, Alcohol & Other Drugs, Child, Adolescent & Family, Community Support, Day Activities.
Ph: 0800 742 6666
www.ruakawa.info

WHAIORO TRUST (Palmerston North & Levin)
Providing Tangata Whaiora with the tools and opportunities to strengthen themselves to participate and engage in everyday life. One-on-one advice, advocacy and support as well as job search workshops as part of the "Mahi Tu Ora" programme.
Ph: 06 354 0670
www.whaiororo.org.nz

YOSS—YOUTH ONE STOP SHOP (Palmerston North & Levin)
FREE counselling, health services, alcohol and drug support, advice, Family / Whānau work for young people aged 10 – 24 years of age who live in Palmerston North.
Ph: 06 355 5909
www.yoss.org.nz

DAY ACTIVITY CENTRES – LOOKING FOR SOMETHING TO DO? –
Don't forget the Library

LEVIN / OTAKI	Mana o Te Tangata Trust, Raukawa Whanau Ora
PALMERSTON NORTH	LUCK Venue, Manawatu Supporting Families, AGAPE, Mana o te Tangata Trust
FEILDING	Raukawa Whanau Ora
DANNEVIRKE	Rangitane o Tamaki Nui a Rua *We provide a Pickup Service on Tuesday and Wednesday from Woodville, Pahiatua and Eketahuna for the Day* Activity Centre

Patients Person Check list – Dr. Review meeting

This checklist is to assist you to keep a record of what is being said in your doctor review.
People present in the review:

_____

_____

Questions I might want to ask	*Answer given*
Diagnosis: What is my diagnosis? Information you can supply me on this?	
Treatment: Do I have a treatment plan? What are the options?	
Medication: What am I currently taking? How long does the medication take to work? What are the side effects? How long will I have to take this medication for? Information written I can read about the medication I am taking?	
Mental Health Act: Am I an informal patient? Am I under the MH Act?	If so what Act:
Information about me; Who needs to know and who I am happy for you to share with? Family / whānau, caregiver / GP / workplace – please let us know.	
Other information I might like to know: Nurse / Social Worker / Occupational Therapy / Psychology / alcohol & drug service	

Goal I want to achieve from this admission?

People involved in my recovery journey:

My Dr., Key Worker, Community agencies

_____

When will I be discharged? _____

Who will make the arrangements?

Other questions I may have:

Patient / Family / Whānau
Discharge meeting

This checklist is to assist you to keep a record of what is being said in relating to your discharge.

People present and assisting me with my discharge:

_____

_____

Questions I might want to ask	*Answer given*
Diagnosis: Is my diagnosis confirmed? My understanding of it? What does this mean for me?	
Mental Health Act: Am I under the MH Act? Yes / no Do I need to appear at the ward court? If so when? Who can I task to about the MH Act 1992?	
Medication: What is the medication name? When do I take it? Supply given? Dosage & times to take. Information / instructions? Medication options discussed	
Discharge Plan: What are you planning? Do I have a copy of the discharge summary to take with me? Who else will receive a copy? Can copies go to please list.	
Follow up care – Mental Health Team: Allocated Key Worker? Which Mental Health Team? Next Psychiatrists appointment? Information on service team and contact phone number? **When is my next appointment? Day, date & time?**	

Who can I call in Crisis? Who can my Family / Whānau contact?	0800 653 357 or 1737
Follow up care: Doctor General Practitioner What if I don't have a GP? Other health care support / follow up?	
Community & recovery supports Local support agencies Support groups? Iwi / Kaupapa Māori? Information on what services can offer me?	
Assistance I may need: Returning to work or study, Medical certificate, Benefit & accommodation sorted out Food in my cupboard & power on?	

Before leaving the ward

- ☐ Does the ward have my correct contact details?
  Home Address, Phone, Mobile number, Email, Correct Family / whānau contact details?
- ☐ Have I got all my personal property?
- ☐ Have I got all the information I require?
- ☐ Magnet for my fridge 0800 number?
- ☐ Discharge summary to take home with me.
- ☐ Have I given feedback on my inpatient stay?

MY NOTES:

HELPLINES AND ONLINE THERAPY

- Need to talk? Free call or text **1737** anytime.
- **Lifeline** – 0800 543 354 for counselling and support.
- **Skylight** – 0800 299 100 for support through trauma, loss and grief.
- **Samaritans** – 0800 726 666.
- **Manline** – 027 358 1212 text for call back.
- **Youthline** – 0800 376 633, free text 234 or email talk@youthline.co.nz. For young people, and their parents, whānau and friends.
- **Kidsline** – 0800 54 37 54 for young people up to 18 years of age.
- **www.thelowdown.co.nz**
- **www.depression.org.nz**

NEED TO TALK?

1737

free call or text any time

Te Uru Rauhī
Mental Health & Addiction Services
MidCentral District Health Board

January 2021 C: 2966

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

Help and support in tough times

Mental Health & Addictions

We care, you matter

He rā ki tua
Better times are coming

Are you experiencing mixed emotions, loss, trauma or grief?

WHAT TO EXPECT?

Getting through a tough time is different for everyone – even the length of grieving will differ from person to person. There'll be good days and bad days, but gradually things will change and get easier.
Pouri me te pouri.

You don't have to do this alone, you can reach out to others.

Some common trauma and grief reactions and thoughts you may have are:

scared

frightened confused

shocked numb relieved

exhausted abandoned disbelieving

depressed worried lonely guilty

irritable vulnerable devastated tense

bewildered stunned tearful hurt

panicky angry suicidal alone

confused frozen empty

overwhelmed nothing

out of control

SOME THINGS YOU CAN DO THAT MIGHT HELP

- Take time out, **Wa-waho**. Try giving yourself a break by doing something you enjoy, even if you don't feel like it at the time. Be patient with yourself.
- Stay connected with friends, family/whānau. Being with others will help reduce feelings of loneliness associated with grief. Talk to someone you trust. **Timata i te korero.**
- Look after your health – eat well, do some gentle exercise, try to get enough sleep and avoid drugs and alcohol. Keep up daily routine.
- Take one day at a time – only do what is essential, avoid making major decisions until you can think more clearly.
- Ask for help if you need it. Accept support from others if it will reduce some stress. **Pātai ki te awhina ina hiahiatia ana e koe.**
- You may prefer getting help from someone of your own culture – look for this among your friends and family/whānau or online.
- Take notice, keep learning about what is happening for you and why. **Ako mo te pouri.**
- Contact your GP if you are unwell or struggling with anxiety, depression or sleep problems.

We know this is a difficult time and you have lots of questions. Check out www.healthpoint.co.nz to help plan to get through.

LOCAL SUPPORT

Best Care Whakapai Hauora
(06) 353 6385
Support/tautoko hoa

Mana o Te Tangata Trust (06) 358 5444
Peer support/tautoko hoa

Manawatu Supporting Families
(06) 355 8561
Family/whānau and natural supports

Pae Ora Paiaka Whaiora/Maori Health Directorate (06) 350 8210
Support/tautoko

Pastoral Care (06) 350 8690
MidCentral DHB

Rangitane o Tamaki Nui A Rua
(06) 374 6860
Peer support/tautoko hoa

Raukawa Whānau Ora (06) 368 8678
Peer support/tautoko hoa

THINK Haoura (06) 354 9107
Brief intervention therapy/tohutohu

YOSS (06) 355 5906
Counselling/tohutohu

24 HOURS SERVICE

MidCentral District Health Board

MENTAL HEALTH & ADDICTIONS

Acute **C**are **T**eam

If you already use our service, please contact your key worker in the first instance during office hours.

Specialist assessment and treatment for people of all ages experiencing a psychiatric crisis.

TEL: 0800 653 357

WHAT HAPPENS NOW?

We will send acknowledgment of your feedback within five working days.
If you have not heard from us, feel free to contact our Consumer Experience Team on (06) 350 8980.

If your feedback is a concern or complaint, we will investigate and let you know the outcome.

NEED MORE HELP?

If you are unsatisfied with the outcome, or wish to use an independent advocate, you can contact the following services:

Health & Disability Advocacy
P (06) 353 7236 or 0800 55 50 50
E advocacy@hdc.org.nz

Health & Disability Commissioner
P (04) 494 7900 or 0800 11 22 33
E hdc@hdc.org.nz
PO Box 11934
Wellington 6142

PRIVACY ACT 1993

If you are providing feedback on behalf of another person, we may need to get his/her permission to provide you with a response.

Information you share will be treated in confidence within MidCentral District Health Board.

MDHB-7172 Ver. 3 9 May 2019 731671 C:1261

Please tape closed here when sending back via post

Consumer Experience Co-ordinator
MidCentral Health
Private Bag 11036
Manawatu Mail Centre
Palmerston North 4442

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

FreePost Authority Number 118079

Free

Tell us
what you think

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

HELP US, HELP YOU

Providing quality health care services is what we do – and we want to hear your feedback to find out what we are doing right and what we can improve. To give feedback you can:

TALK TO US

You can give feedback to the person providing your care, or ask to speak to the person in charge

EMAIL US

Get in contact with our Consumer Experience Team by sending us an email

customer@midcentraldhb.govt.nz

GIVE US A CALL

Talk to our friendly Consumer Experience Team

(06) 350 8980

GO ONLINE

Fill out our online feedback form

www.midcentraldhb.govt.nz

WRITE TO US

Write us a letter or send us this form

Consumer Experience
PO Box 2056
Palmerston North 4440

TELL US THE DETAILS

☐ Compliment ☐ Concern ☐ Query ☐ Suggestion

Please feel free to add extra pages if you need to.

Name: .....

Address: .....

Phone: ..... **Date of visit:** ..... ☐ *No response required*

Email: ..... **I am:** ☐ *Patient* ☐ *Family* ☐ *Visitor*

Name of ward/department/service: .....

Location of service *(eg Palmerston North Hospital)*: .....

You can give this form to a staff member, drop it in one of the boxes at hospital exits or post it to us externally - postage is free.

Ko ngā tika me ngā kawenga

ina whai wāhi mai koe ki ngā ratonga hauora, me ngā ratonga hauā a MidCentral Health

Ka whākina atu e MidCentral Health āna kōrero mōu ki ētahi atu tāngata, ki ētahi atu whakahaere hauora, kaituku ratonga hauā, kaitautoko ohaoha rānei, e tutuki tonu ai te tiaki i tō hauora.

Tērā pea, ka whākina ngā kōrero ki tētahi tangata whakapā māu tonu e tautuhi, me i kore koe i tohu mai kia kaua e whākina.

I ētahi wā ka herea a MidCentral Health ki te tuku i ngā kōrero mōu i raro i ngā whakaritenga ture, i ngā tikanga matatika rānei.

Ehara i te mea e here ana koe ki te whāki mai i ngā kōrero mōu ki a MidCentral Health. Otirā, ki te kore e whākina mai, akene pea ka whakararua ngā ratonga haumanu ka tukuna ki a koe.

Mēnā ka tau te whakaaro ki a koe, kua whati o tika matapuku, kaua e tawhitawhi ki te kōrero mai ki ngā kaimahi kua whakaaturia i te pānui nei, me whakapā rānei ki te Kaikōmihana Matapuku, Pouaka Poutāpeta 466, Tāmaki-makau-rau 1, 1140.

E whakarāpopotohia ana i tēnei pānui ngā take e tiakina ana i raro i Te Ture Ratonga Hauora me te Hauā mō ngā Tika Kiritaki.

Kei roto tonu i te ture ngā whakaritenga me ngā tika. Me tono mai ki te Āpiha Kiritaki, ina hiahitia ana ngā kōrero mō te ture.

He Tauāki Matapuku mō ngā tāngata katoa ka whai wāhi mai ki ngā ratonga hauora a MidCentral Health

E rārangi ake nei ngā tika e pā ana ki ngā kōrero katoa mōu, e purihia ana e MidCentral Health. E ū ana mātou ki te kaupapa here, kia noho matatapu ngā kōrero mōu.

Ka whakamahia ngā kōrero mōu, mō ngā take e whai ake nei:

- Hei arotake, hei tuku i ngā ratonga hauora ki a koe
- Hei whakangungu i ngā kaimahi hauora ngaio
- Mō ngā rangahau hauora i runga i te here ka kore e whākina atu tō tuakiri
- Mō te mahi whakahaere i a MidCentral Health
- Mō ngā take e pā tōtika ana ki ngā kōrero i runga nei, hei ārai atu rānei i ngā whakararu hauora ka pā kino atu ki a koe, ki tētahi atu tangata, ki te hauora me te haumaru o te iwi whānui rānei.

Ko tā mātou e whai nei, kia kohia katoatia ngā kōrero mōu, mai i a koe anō, ōtirā, ka rapua pea he kōrero mai i tō whānau, i ōu whanaunga, i ōu hoa, mai i tētahi atu tangata rānei e mōhio ana ki a koe, mēnā ka kore e taea e koe te tuku kōrero mai.

Ka āhei tonu koe ki te tirotiro i ngā kōrero mōu. I ētahi wā, e whakaae ana mātou kia whakatikahia e koe ēnei kōrero e puritia ana e MidCentral Health, me i kore i tukuna matapuku mai e tētahi atu tangata, ki te kore rānei e aukatia ana i raro i te ture.

HE TAUĀKI KAWENGA

Koia nei ngā kawenga mō ngā tāngata katoa ka whai wāhi mai ki ngā ratonga hauora a MidCentral Health

Nā te mea e whiwhi ana koe ki ngā ratonga a MidCentral Health, e tika ana māu ēnei take e kawe:

- Kia tiakina paitia e koe ngā taputapu ka tukuna ki a koe i runga anō i ngā whakaritenga, me te whakahoki wawe mai i aua taputapu i te wā ka kore noa he take ki a koe.
- Ki te whai i te ture 'auahi kore' MidCentral Health.
- Kia kaua e kai i te waipiro, i te tarutaru, i te rongoā rānei, hāunga ngā rongoā kua whakaaetia e te tākuta e tiaki ana i a koe, e tētahi atu kaimahi rānei e whai mana ana i raro i a MidCentral Health.
- Kia wawe te whakamōhio mai ki ngā kaimahi mēnā ka kore koe e hiahia ki ngā ratonga a MidCentral Health kia whakarite mēnā ka kore koe e hiahia ngaio me ngā taumata matatika.
- Mēnā ka tonoa e MidCentral Health, kia noho mai tētahi atu tangata i te wā e tirotiro ana te tākuta i a koe, i roto rānei i ngā whakawhitiwhiti kōrero. Kia hāngai anō tēnei whakaritenga ki ngā taumata ngaio me ngā taumata matatika.
- Kia utua ō nama katoa i te rā e tika ana, mō ngā ratonga e tika ana kia utua, kua whakaaetia e koe me utu i raro i te Tauāki Tika Tangata. Ki te kore e tau tētahi whakaaetanga, me utu tonu koe tētahi utu e hāngai ana ki ngā ratonga i tukuna ki a koe. Ki te kore e utua e koe, ka whiriwhiria e MidCentral Health (i raro i ngā tikanga o te Tauāki Matapuku) tētahi huarahi e ea ai ō nama.

Mēnā e toro mai ana koe ki tētahi whare o MidCentral, ka tau ēnei kawenga ki a koe:

- Ki te whai i ngā herenga katoa a te tangata whiwhi ratonga, e hāngai ana.
- Ki te whai i ngā tohutohu a ngā kaimahi mēnā ka tau te mate whawhati tata.
- Ki te whai i ngā pānui me ngā tohutohu katoa e whakaaturia ana i roto i ngā whare.

MidCentral Health

Te Ratonga Kiritaki

customer@midcentralhb.govt.nz
www.midcentralhb.govt.nz

February 2017 MDHB-5771 Ver.2 C: 1596 731669

HE TAUĀKĪ TIKA TANGATA

1 TE TIKA TUATAH

- Kia pūmau tonu tō mana, kia manaakitia tō kiri matatapu.
- Kia whakaaronuitia ō āhuatanga motuhake i roto i ngā ratonga katoa, arā, ō tikanga ahurea, ō tikanga hāhi, ō āhuatanga noho, ō tikanga ā-iwi, ō uara, me tō whakapono.

2 TE TIKA TUARUA

- Kia kaua koe e aukatia, e whakahāweatia rānei, i runga i te āhua o tō pakeke, tō ira tangata, tō iwi, tō whakapono, tō hoa rangatira, tō whānau, tō hōkakatanga, tō hauātanga rānei.
- Kia kaua koe a āia, e whakatīwhetatia, e apohia rānei i roto i ngā ratonga ka tukuna ki a koe.

3 TE TIKA TUATORU

- Kia pūmau tonu tō mana tangata me tō rangatiratanga i roto i ngā ratonga ka tukuna ki a koe.

4 TE TIKA TUAWHA

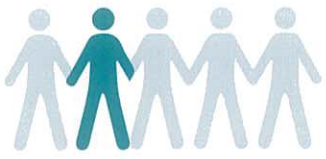
- Kia eke ngā ratonga ka tukuna ki a koe i ngā taumata e tika ana.
- Kia eke anō ngā ratonga i ngā taumata o te ture, o te matatika, o te ngaiotanga, me ērā atu taumata e hāngai ana.
- Kia hāngai ngā ratonga ki ō mate.
- Kia whakaitia te tūpono whara i roto i te tuku ratonga ki a koe.
- Kia mahi ngātahi ai ngā kaituku ratonga, kia kounga anō ai te manaaki i a koe.

5 TE TIKA TUARIMA

- Kia tukuna ngā kōrero ki a koe, i roto i te reo me te āhua e tika ana mōu.
- Kia rangona anō āu ake kōrero.
- Kia tīkina atu he kaiwhakamāori kōrero, mēnā e tika ana māu, ā, e taea ana.
- Kia māhorahora, kia tōtika, kia whaihua anō hoki ngā whakawhitinga kōrero.

E hāngai ana ēnei tika i ngā wā katoa?

Akene pea i ētahi wā, e kore e taea ēnei tika katoa e te kaituku ratonga. Otirā, me ngana tonu i roto i te horopaki o te wā.



6 TE TIKA TUAONO

- I ngā wā katoa, kia tukuna ki a koe ngā kōrero nei:
  - ngā whakamārama mō te āhua o tō mate
  - ngā kōwhiringa e wātea ana ki a koe, arā, ko ngā painga, ngā hua, ngā whakararu, me ngā utu ka tau ki a koe
  - ngā whakatau tata mō āhea tukuna ai te ratonga ki a koe
  - te whai wāhitanga atu ki ngā kaupapa whakaako, rangahau rānei
  - ngā whakakitenga o ngā whakamātautau me ngā tūhuratanga
  - ngā kōrero katoa hei āwhina i a koe ki te whakatau i te huarahi e hiahia ana koe.
- Kia pono anō ngā whakautu ki ō pātai atoa e pā ana ki ngā ratonga. Arā, ko ngā pātai mō:
  - te tangata, te rōpū rānei e tuku ratonga ana ki a koe, me ā rātou tohu mātauranga
  - ngā taunaki a te kaituku ratonga
  - te huarahi e whiwhi ai koe i ngā whakaaro o tētahi atu kaituku ratonga
  - ngā whakakitenga o ngā kaupapa rangahau i whai wāhi ai koe.
- E taea ana e koe te tono kia tuhia he whakarāpopototanga o ngā kōrero katoa.

7 TE TIKA TUAWHITU

- Kia whakatauria, kia whakaaetia rā anō e koe tō kōwhiringa, ā, kia mārama hoki koe ki tō kōwhiringa, kātahi ka tukuna he ratonga ki a koe.
- Ki te kore e kitea e te kaituku ratonga he take e whakaatu ana e kore e taea e koe, ka tau tonu ki a koe te āheinga kōwhiri, me te mana whakaae.
- Ki te tau tētahi āhuatanga me haere tonu te ratonga, ahakoa kāore e taea e koe te whakaae, me haere i runga i te whakaaro nui ki tō hauora. Kia hāngai tonu te ratonga ki ō hiahia, arā, ka whiriwhiria i te taha o tō whānau, me ō hoa tata.
- I runga i te āhua o te ture noa, e taea ana e koe te whakatau kōwhiri i mua rawa o te wā ka tukuna te ratonga ki a koe.
- Kia tuhia tō whakaaetanga ki te pepa, ina uru atu koe ki tētahi rangahau, ki tētahi rautaki e tūhuratia ana, ki te rehu tokitoki, ki tētahi rautaki rānei tērā pea ka puta he āhuatanga kino.
- E taea ana e koe te huri tuarā ki tētahi ratonga, me te whakakore anō i tō whakaaetanga.
- E wātea ana koe ki te whakawhiti atu ki tētahi anō kaituku ratonga mēnā e taea ana.
- Kei a koe ngā whakatau e pā ana ki ngā wāhanga me ngā putanga katoa o tō tinana.

8 TE TIKA TUAWARU

- Kia noho mai tētahi kaitautoko i tō taha, he tangata rānei māu e whiriwhiri, mēnā he haumaru, ā, ka kore e pāngia ngā tika o tētahi atu.

9 TE TIKA TUAIWA

- E hāngai ana ēnei tika katoa, mēnā e whiriwhirihia ana kia uru atu koe, e uru ana rānei ki tētahi kaupapa whakaako, kaupapa rangahau rānei.

Ki te whakaahu koe ki ngā otinga i puta i te whakawākanga o tō amuamu, ki te hiahia rānei koe ki te kōrero ki tētahi whakahaere kē atu, me whakapā atu ki tētahi Kaitaunaki mō te Kōmihana Hauora me te Hauā, ko te nama waea utukore – 0800 11 22 33. Me tuku rānei tō amuamu ki te Kaikōmihana mō te Hauora me te Hauā, Pouaka Poutāpeta 1791, Te Whanganui-a-Tara, 6144.

10 TE TIKA TUANGAHURU

- Wātea ana koe ki te tuku mai i ō amuamu, me te whai anō i te āhua tuku e pai ana ki a koe.
- Kia whakamōhiotia koe, e ahu pēhea ana tō amuamu, he aha hoki ngā putanga.
- Kia whakamōhiotia koe, e wātea ana tētahi kaitaunaki, te Kaikōmihana rānei mō te Hauora me te Hauā hei āwhina i a koe ki te tuku amuamu mai.
- Kia kaua e pāngia kinotia koe, ina tuku amuamu mai.
- E āhei ana koe ki te tuku mai i ō kōrero, i ō amuamu, i ō whakaaro rānei mō ngā āhuatanga katoa o ngā ratonga. Ka taea te whakawhiti kōrero mai ki ngā kaimahi o MidCentral Health e tiaki ana i a koe, te whakapā rānei (ā-tuhi, ā-waha) ki te Āpiha Kiritaki e pātata ana ki a koe:

Papaioea: **Customer Relations**
MidCentral Health
Private Bag 11036
Palmerston North 4442
Waea: (06) 350 8980

Acute Mental Health

Inpatient Unit (Ward 21) Phone: 06 350 8160

My important phone numbers:

Name:	Number:
_____	_____
_____	_____
_____	_____

[redacted]

From: OIA <OIA@midcentraldhb.govt.nz>
Sent: Tuesday, 26 July 2022 12:29 PM
To: [redacted]
Subject: Official Information act reply
Attachments: Pastoral-Spiritual Care Team -Procedure-.doc

Dear [redacted]
In reply to your OIA request of 22 July 2022 please find enclosed a copy of the MidCentral Health document, Pastoral-Spiritual Care Team -Procedure-.

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 email.
Regards
Zelda

Zelda Rogers
Quality & Innovations Coordinator
Te Pae Hauora o Ruahine o Tararua | MidCentral
waea pūkoro: 06 3508915 | **īmēra:** Zelda.Rogers@midcentraldhb.govt.nz
PO Box 11036 | Palmerston North 4442

Te Whatu Ora
Health New Zealand

Te Whatu Ora – Health New Zealand
TeWhatuOra.govt.nz

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PROCEDURE

PASTORAL/SPIRITUAL CARE TEAM	
Applicable to: **MidCentral District Health Board**	Issued by: **Pastoral/Spiritual Care Team**
	Contact: **Spiritual Care Coordinator**

1. POLICY STATEMENT

MidCentral District Health Board (MDHB) commits to the implementation of holistic care through the MDHB Transforming Spiritual Care Strategy. The Spiritual and Compassionate Care Implementation Group (SCCIG) oversees the implementation of the Strategy by monitoring the Spiritual and Compassionate Care Standards, embbeded through the work of the Pastoral/Spiritual Care Team (PSCT).

2. PURPOSE

The purpose of this procedure is to provide spiritual care definitions, outline MDHB staff responsibilities for pastoral/spiritual care and how to make referrals to the PSCT.

3. SCOPE

The PSCT is available to all MDHB staff, patients/residents, family/whanau at the Palmerston North Hospital campus, and Horowhenua Health Centre.

4. ROLES & RESPONSIBILITIES

4.1 MidCentral DHB Staff will:

- provide front line spiritual care under a specialist/generalist model.
- use screening tools to identify need.
- contact the PSCT when requested or if there is an identified need.
- ensure the identified need is entered in the clinical record.

Staff processes are also outlined in the Spiritual Care Standards and the Pastoral/Spiritual Care @ Palmerston North Hopsital Practical Help for Staff booklet.

4.2 PSCT Members will:

- provide ongoing staff education to embed pastoral/spiritual care into practise.
- respond to referrals within one business day.
- assess Pastoral/Spiritual needs using agreed screening tools and respond appropriately.
- document their care in the clinical record.
- refer to wider spiritual care professionals on request from patient and whanau.
- liase with the healthcare team by attending family/whanau meetings and MDT's.

5. ACCESS

Palmerston North Hospital Campus

- The PSCT is available in person from Monday to Friday 8 am to 5pm
- Phone ext 8690
- Fax completed Allied/Specialist Referral forms to 8122
- Email to chaplains@midcentraldhb.govt.nz
- After hours calls for emergencies only, may be made through the Hospital switchboard
- Chapel is open 24/7
- Requests to use the chapel for gatherings and sitting with deceased persons ***must*** come through the PSCT team, ext 8690.

Horowhenua Health Centre

- A PSCT member visits each week
- Referrals to the PSCT as above
- There is a spiritual room available for services and private use.

6. DEFINITIONS

PSCT Members
Have education, background and formation in one of the world's varied faith or philosophical traditions along with further education in people related disciplines like counselling or pastoral care. *Practical Help for Staff*

Chapel
A sacred space, universally available, set apart for private or group ritual -reflection, meditation, prayer or worship.

Spiritual Care
Clincial Definition: Spiritual care is the provision of assessment, counselling, support and ritual in matters of a person's belief, traditions, values and practices enabling the person to access their own spiritual resources. *Spiritual Health Australia Capability Framework, 2020*

Non-Clinical Definition: Spiritual care can help you feel more connected with yourself, other people or to something beyond. It is about the beliefs, traditions, values and practices that are important to you. Spiritual care supports what gives meaning and purpose to your life. *Spiritual Health Australia Capability Framework, 2020*

7. RELATED MDHB DOCUMENTS

- MDHB Transforming Spiritual Care Strategy
- MDHB Spiritual and Compassionate Care Standards
- Pastoral/Spiritual Care @ Palmerston North Hospital Practical Help for Staff

8. KEYWORDS

Pastoral/Spiritual care,screening, referral.

Te Whatu Ora
Health New Zealand

28 July 2022

[redacted]

Dear [redacted]

Official Information Act (OIA) request – OIA – Y22-578

Thank you for your request for information dated 25 July 2022. Your request is acknowledged and has been passed onto me for a response.

You have requested Te Pae Hauora o Rauhine o Tararua | MidCentral provide you with information regarding essure devices data for the period of 2010 to July 1, 2022.

1 – Since 2010, to July 1, 2022, how many Essure devices have been removed by the DHB

Zero

2 – Since 2010, to July 1, 2022, how many Essure devices have been removed as a result of adverse reactions and/or side effects

Zero

3 – Please include a breakdown for the reason for removal if recorded/known.

Zero

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

Te Whatu Ora
Health New Zealand

10 August 2022

[redacted]

[redacted]

Dear [redacted]

I refer to your Official Information Act request regarding parental leave and those on IEAs at Te Pae Hauora o Ruahine o Tararua | MidCentral and respond as follows:

1. What percentage of DHB staff (currently on payroll) work under an individual employment agreement?

   0.07 per cent.

2. Have any staff on an IEA contract (current or previous) received 14 weeks of parental leave top-up payments in-line with the various collective agreements?

   One since 1 July 2021.

Please note that this response, or an edited version of it, may be published on the Te Pae Hauora o Ruahine o Tararua | MidCentral website ten working days after your receipt of this letter.

Yours sincerely

Keyur Anjaria
General Manager
People and Culture
Te Pae Hauora o Ruahine o Tararua | MidCentral

2 September 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-778

Dear [redacted]

In response to your Official Information Act 1982 requesting:

The dollar amount allocated for inpatient meals/food at Palmerston North Hospital. This could be a daily, or per meal budget. We advise as follows:

Health New Zealand Te Pae Hauora o Ruahine o Tararua | MidCentral (previously MidCentral District Health Board) has a per meal budget of $11.30 at Palmerston North Hospital.

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 website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North, 4440
06 350 8061

13 July 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-0507

Dear [redacted]

In response to your Official Information Act 1982 requesting:

"*In each of the financial years ended June 30 2018, 2019, 2020 and 2021 please state how much external contractors, including Ernst & Young (EY New Zealand), were paid by your DHB to undertake work arising out of the application of the Holidays Act. Also how much has been paid to date (and estimated) for work undertaken in the current financial ending 2022? Separate these payments to each financial year, and, within those years, to each external contractor. When is it expected that this work related to the Holidays Act will be completed?*" we advise for MidCentral as follows:

The costs for individual contractors and consultants, including Ernst & Young, used in the Holidays Act project are provided in the table below. Engagement of contractors and consultants commenced in the 2019/20 financial year. Prior to this, work relied on internal resource alone.

	2019/20	2020/21	2021/22	Total
[redacted] Name withheld*		22,622	(128)	22,494
Ascender HCM New Zealand Ltd	2,730	840		3,570
Beyond Recruitment		236,504	34,901	271,405
Ernst & Young		1,111,000		1,111,000
[redacted] Name withheld*		33,400	132,400	165,800
[redacted] Name withheld*		4,588	8,618	13,206
[redacted] Name withheld*		18,841		18,841
People & Co Limited		39,258	27,275	66,533
PN Personnel Ltd	31,215	260,664	245	292,123
Qual It Solutions Limited		206,401	49,764	256,165
[redacted] Name withheld*		9,120		9,120
Wayne Mason Consulting (Auckland)		13,440	176,790	190,230
Total	**33,945**	**1,956,678**	**429,866**	**2,420,488**

*Names withheld under Section 9 (2) (a) of the Official Information Act 1982

When is it expected that this work related to the Holidays Act will be completed?

It is anticipated that this work will be completed by March 2023.

Te Whatu Ora
Health New Zealand

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 website ten working days after your receipt of this response.

Yours sincerely,

Neil Wanden
General Manager, Finance & Corporate Services

Te Whatu Ora
Health New Zealand

26 October 2022

[redacted]

Official Information Act (OIA) Request – HNZ00004538

Your OIA request of 4 October 2022 to Te Pae Hauora o Ruahine o Tararua | MidCentral is acknowledged. The information you have requested follows.

- **Can I please request copies of external service reviews undertaken into the Palmerston North Hospital Intensive Care Unit since 2010? I understand some were done in 2012 and 2019, but unsure if there have been others.**

  Please find attached the 2012 and 2019 Service Credentialing reports for the Intensive Care Unit (ICU). These reports are **not** external service reviews.

  Service Credentialing is a regular scheduled process for all hospitals and their services. Service Credentialing includes consideration of the range of competencies in a unit, department or service and the resources available to it.

  Credentialing of each service is undertaken by the Credentialing Committee which generally includes an external senior medical officer (External Credentialer) and recommendations are made, as appropriate, for improvements that would maintain or improve the ability of medical practitioners to undertake their individually credentialled role.

  Departments or Services undergo Service Credentialing every five years unless special circumstances require earlier credentialing. Credentialing considers;

  - The clinical work the Department or Service is funded to provide
  - Clinical leadership
  - The adequacy of the facilities
  - The composition and skill level of the clinical team, including other health professionals
  - Practitioner workload
  - Introduction of new procedures and technologies
  - Service outcome data, including patient satisfaction and performance to contract and delivery of services to Māori
  - Associated clinical activities such as teaching and research
  - Clinical quality assurance processes
  - Peer review processes and systems
  - Consideration of individual medical credentialing summary information

  The ICU Service Credentialing reports contain the opinions (some quoted) of the External Credentialers, not the Committee as a whole, which help to form the agreed recommendations in the reports.

I have also attached a 2012 internal ICU report which was a prospective audit on ICU activity to support the current ICU model into the future with the Coronary Care Unit/Medical HDU (High Dependency Unit) remaining located on the fourth floor. Ideally in the future hospital rebuild, they would be located on the same floor but with separation between the two units.

Additionally, I have attached the 2017 report to the then MidCentral District Health Board Clinical Council regarding progress on the recommendations from the 2012 Service Credentialing report, all of which were completed.

The recommendations from the 2019 Service Credentialing report and their current status are as follows;

1. It is imperative that improvements be made to the existing ICU facilities given that any significant rebuild is a number of years away. The facilities do not meet required standards to deliver the level of care that the people of MidCentral District are entitled to.

   The ICU capacity at Palmerston North will be augmented by an adjacent High Dependency Unit to provide additional acute care beds. That project is being scoped with the intention to have the new beds open before next winter (2023).

2. Further review of the Senior Medical Officer (SMO) call schedule and relief provision is essential for workforce safety. Specifically, ICU SMOs should have a rostered Monday 'off' following their weekends on call.

   A review of the SMO call schedule and developing the Long Term Plan for Senior Staff have also been completed and implemented.

3. Developing a long term plan for senior staff that cover night and weekend call to maintain exposure to routine daytime work, specifically morning rounds and patient planning, is viewed as essential. Recruiting a new Intensive Care Specialist in conjunction with service lines outside of Anaesthetics should be explored.

   A review of the SMO call schedule and developing the Long Term Plan for Senior Staff have also been completed and implemented.

4. With respect to stocking and tracking of medications and supplies, the Emergency Department and Operating Theatres have both successfully implemented e-cupboards and temperature monitored refrigerators without patient care disruptions.

   A programme is underway to upgrade the stocking and tracking of medications in line with the system used in Emergency Department and Operating Theatres, with the roll out of a digital system in the coming months.

5. Exploration of a shared nursing pool so that skill maintenance, education and research can be expanded, with the long term aim of achieving the minimum standard of 50% of Nurses in ICU holding postgraduate qualifications in critical care.

   Training and education pathways to support Registrars and Nurses to further their careers and qualifications in critical care has been implemented. This work will be ongoing and continue to grow.

6. Thought needs to be given to how the ICU can grow and develop its own Registrars (vocational trainees in Intensive Care) in addition to providing opportunities to trainees from other services and providing experience to prospective anaesthesia trainees.

   Training and education pathways to support Registrars and Nurses to further their careers and qualifications in critical care has been implemented. This work will be ongoing and continue to grow.

7. Establish formal documentation and analysis of, reasons for admission of patients to ICU, of deteriorating patients who may have benefited from earlier ICU input, and details of handover of patients when they are discharged from ICU.

   A formal documentation process has been implemented in the ICU.

Please note that this response, or an edited version of this response, may be published on the MidCentral website 10 working days after your receipt of this response.

Yours sincerely

Lyn Horgan
Operations Executive
Te Uro Arotau – Acute & Elective Specialist Services
Te Pae Hauora o Ruahine o Tararua | MidCentral

SERVICE CREDENTIALING

INTENSIVE CARE UNIT

MIDCENTRAL HEALTH

Date of Credentialing Visit **Wednesday 18th July** 2012

AIM

To Credential MidCentral Health's Intensive Care Unit as per MidCentral Health's Medical Credentialing–Service Review Policy and Procedure.

Service Credentialing Committee Membership

Name	Position Held
[redacted]	General Surgeon Member MidCentral Health Credentialing Committee
	Head of Hawkes Bay ICU President College of Intensive Care Medicine External Credentialer
	Clinical Director Anaesthesia and Intensive Care
	Medical Head Intensive Care Unit
	Manager Quality and Clinical Risk Member MidCentral Health Credentialing Committee
	Community Representative MidCentral Health Credentialing Committee

Interviewees

[redacted]	Clinical Director Mental Health
	Dietician
	Clinical Director Internal Medicine
	Consultant Anaesthetist - Anaesthetics and ICU
	Medical Head General Surgery
	Charge Nurse ICU
	Orthopaedic Surgeon
	Consultant Anaesthetist - Anaesthetics and ICU
	Clinical Director Child Health
	Nurse Educator
	Clinical Director Emergency Department
	Consultant Anaesthetist - Anaesthetics and ICU
	Consultant Anaesthetist - Anaesthetics and ICU
	Consultant Anaesthetist - Anaesthetics and ICU
	Operation Director
	Consultant Intensivist
	Consultant Anaesthetist - Anaesthetics and ICU Deputy Head Intensive Care
	SHO Intensive Care
	Service Manager and Nursing Director Intensive Care

Documentation Received

List of documents received by the Service Credentialing Committee including any written submissions from interviewees or others.

Service Credentialing Template completed by [redacted] Medical Head ICU
Written submission by [redacted] Medical Head Women's Health
Written notes from [redacted] Consultant Anaesthetist
Written submission from [redacted] ex Medical Head ICU and copies of letters to [redacted] Sept 2010, [redacted] Dec 2004 and article from Manawatu Standard Sept 2005
Project Paper on Provision of High Dependency Care within the Intensive Care Environment
Capex Requests
ICU Admission Referral Audit Project
Written submission from [redacted] Chief Pharmacist
Written submission from [redacted] Medical Head Urology
Written submission from [redacted] Consultant Radiologist
May 2012 Financial Summary ICU

INTRODUCTION/CONTEXT

The Intensive Care Unit occupies approximately one half of one side of the top (5th) floor of the tower block. First occupied in the late seventies, there are six physical bed spaces in the main area and two "back rooms". Although resourcing for six beds has occurred at one stage in the past (at then current recommended levels), for a number of years now only four beds have been resourced permanently, with some flexing upwards at times of emergency need.

Historically Palmerston North was one of the first hospitals in this country to provide a general intensive care service, well before the current unit was built. From this position of leadership, Intensive Care Service reviews in 2005 and 2007 have reported the MidCentral service lags well behind national benchmarks for beds per head of population and space per bed, though reporting favourably on the quality of care delivered.

Intensive care has evolved over years from a service provided by a few passionate individuals, through a period where most of the specialists involved have been anaesthetists; to the situation where in bigger or tertiary units most, or all, SMOs are intensive care specialists belonging, in Australasia, to the College of Intensive Care Medicine (CICM). MidCentral has relatively recently recruited its first vocationally registered ICM Specialist since the departure of [redacted] in 1999.

The College publishes recommendations and minimum standards for differing levels of ICU and for training purposes. MidCentral is generally recognised as a level II unit, though not meeting all recommendations (eg. number of staffed beds; majority of specialists be members of CICM). The unit is accredited by the College of Intensive Care Medicine for basic training, but not for registrars in advanced training.

It is generally recognised that there are a number of ill patients who fall short of requiring intensive care, but who require levels of care difficult or impossible to deliver in a general ward. These "high dependency" patients are in most hospitals managed either in a dedicated High Dependency Unit (HDU), or within a mixed ICU/ HDU. MidCentral briefly tried to establish a surgical HDU in Wd 29, but this was unsuccessful, principally due to inadequate physical facilities, an inability to retain trained nursing staff, and poor provision of medical cover. The provision of care to this group of patients has long been a source of anxiety to staff and management at MidCentral and has been discussed and debated in many forums, and by more than one working party. Currently patients are managed in an ad hoc fashion; some, mainly medical patients nursed in CCU, some kept longer than desirable in Post Anaesthesia Care Unit (PACU), some on general wards and some in ICU since a relaxation of admission criteria

over the last few years. With only four staffed beds obviously only very limited numbers can be managed in ICU.

Another multidisciplinary working party in 2011 recommended that as a partial , interim solution to the provision of high dependency care at MCH, ICU should be staffed to manage six patients (at a 1:1 nursing level for four patients and 1:2 for two patients), with some ability to flex to seven patients. With Management insisting that "new" beds were not created, this would have required transfer of some nursing resource from Coronary Care, and some new money budgeted. This budget increase was approved by SMT, but ICU medical staff, concerned that this proposal merely reallocated resources and would disadvantage CCU, elected to defer the increase in staffed bed numbers in ICU. An audit of all referrals for ICU and HDU care was agreed and is currently underway. Reports at three and six months are scheduled.

COMMENTS

Comments on each of the key considerations for Credentialing –

The clinical work the unit is funded to provide.
There are two overwhelming difficulties in considering the adequacy of the unit's resources. Firstly, there is no clear idea of what service, currently, it is expected to provide, and secondly, there appears to be limited agreement among staff working within the unit as to what service it should seek to provide in the future. Even regarding the unit strictly as an intensive care unit, it seems that the four beds currently resourced (≈2.5/100,000) falls below the national norm of ≈ 4.2/100,000 and well below the number at the nearest comparable DHB, Hawkes Bay, with ≈5/100,000. The Ministry of Health has in the past identified six beds per 100,000 as a target for the country. The unit averaged 326 admissions per year from 2005-2011. With laudable improvements in unit practices and some relaxation of admission criteria to manage a number of high dependency patients over the last year, admissions increased to 363 patients, about 250 of whom were ventilated. Depending on whether Trendcare or bed occupancy at midnight is used to calculate occupancy, figures are 77% or 86%. Bed utilisation figures calculate out at an average of three, or 3.4 if Trendcare is used. There is obviously a fluctuating and unpredictable demand however and for approximately 25-30 days per year the unit has to "flex up" and accommodate five patients. Only occasionally do patients have to be transferred to another ICU.

Because of the need to have beds available for emergencies, the unit has had a policy of not admitting an elective patient to the fourth bed. Surgical staff report that this has meant on numerous occasions patients scheduled to undergo major, complex surgery for life threatening conditions have had to their surgery cancelled at short notice. A practice of having a "standby" list has developed whenever a patient needing ICU care post-operatively is scheduled, in order not to waste operating time. Cancellations have been less frequent over the last year.

Surgical, ED, Anaesthetic and PACU staff do not feel that the unit is capable of taking all HDU type patients, or in fact that staff are always willing to provide this care even when beds are available. Similarly, Medical consultants feel that access to ICU and or HDU, although better than previously, is still a problem. The Emergency Department CD indicated that access to ICU is better than previously, but that help was inconsistent, and dependent on whom the on-call consultant was.

The unit admits and keeps Paediatric patients who are anticipated to have short term requirements for intensive care, and also looks after those patients who are awaiting transfer to the Starship ICU. Child Health indicate that the level of support is appropriate for their needs.

Mental Health are happy with the level of support, but indicate there can be a difficulty with discharge of patients, as there is no medical nursing capability within Mental Health.

The adequacy of the facilities.

The ICU is now outdated. Clearly, with six physical beds in the main area and two small side rooms it could not accommodate the number of HDU beds necessary for a comprehensive service. The space per bed is much smaller than CICM recommends for new units, and with six beds occupied, working space is severely compromised.

The location of the Unit on the fifth floor, remote from ED, Radiology and Theatres is a significant impediment. It seems likely that the current seismic survey will find that the Unit is non compliant with the code and this will precipitate relocation/rebuilding earlier than might have been the case otherwise.

The unit has insufficient desk space, insufficient storage space, and inadequate areas for family meetings.

Equipment is generally seen as being adequate.

The composition and skill level of the clinical team, including other health professionals.

The Unit has, until recently been staffed medically by Consultant Anaesthetists with an interest in Intensive Care, and Senior House Officers who are usually aspiring anaesthetic trainees. A Specialist Intensivist and fellow of CICM has been appointed this year, and this is seen as a very positive move by everyone, with changes in unit practices and more consistency in the care plans for patients. There is a lower average ventilation time, and unit throughput has increased significantly. More teaching is able to be done.

With the Intensivist filling seven of the fifteen weekly five hour shifts, this has however meant less exposure to ICU work for the Anaesthetic Consultants. Three of the Anaesthetists on the weeknight call roster have no exposure to ICU work during the normal working week. (Pre-dating, and unchanged by the appointment of [redacted].) With the current size of the unit and the disconnect between daytime staffing and on call needs, there is no enthusiasm to attempt to recruit a further Intensive Care Medicine specialist, even though the trend in bigger units is very much towards staffing by specialists.

The SHOs are usually seeking selection into vocational training in Anaesthesia or Intensive Care Medicine and are appointed for twelve months. They usually start as very inexperienced doctors, have extensive input over some months from senior staff and generally learn quickly. Six month appointments, although sometimes made to accommodate the needs of aspiring trainees in other specialties, do mean that the "pay-back" time for the effort of training them is less.

The nursing staff are seen as highly skilled and motivated, with most having some post-graduate qualification in the area of critical care. Some senior staff have been lost over the last year and turnover was higher than usual, with FTE gaps at times. Very few applicants are New Zealand trained. It was stressed that Intensive Care is a highly integrated multidisciplinary pursuit, with close interaction between medical and nursing professions, and some staff feel that traditional reporting lines are inappropriate.

The Unit is fortunate to have very effective service and support from Pharmacy and Dietetics, though pharmacy support is ad hoc, and Pharmacy do not have the resource to attend daily rounds as they would like.

Radiology have not had any regular review sessions, though would be able to do this now that radiology staffing has improved.

Practitioner workload

Currently, in addition to the Intensive Care Medicine specialist, nine anaesthetists have part time duties in intensive care. Six share in the day time running of the unit, and the weekend call roster. Two SMOs are rostered on for a five hour morning shift, and one for a five hour afternoon shift. Three further SMOs are part of a one in nine weeknight roster, but these anaesthetists have no exposure to the daily routine of the unit. The SMO FTE allocation to the ICU has been quoted at 2.28, but the mixed responsibilities of the Anaesthetic Consultants makes it difficult to corroborate this, and it is probably only important if a change to the staffing model was ever contemplated. By the calculation of the writer, the ICM specialist has 35 hours of unit clinical time, and 8 hours non clinical, the six daytime Anaesthetic consultants 30-35 hours of clinical time and 8 hours non clinical, and the on call recompense probably accounts for about 41 hours per week. This totals 132 hours, or 3.3 FTE.

Four SHOs provide 5.04 FTE of cover and the workload is thought to be satisfactory. The Unit is not recognised for advanced training by CICM. Nursing is led by a Charge Nurse who has to double as "runner', or clinical resource nurse, when short. The default expectation for ICU is for a nurse-to-patient ratio of one, which for four "ICU" beds would mean five nurses per shift with a runner. This would equate to a required budget of 24.24 FTE. Current budgeting is for 21.96 FTE. Based on Trendcare estimations of utilisation this amount of nursing resource is not only able to staff the actual needs of the unit, but also allows nursing resource to be deployed outside the unit during quiet times to the extent of ≈.1.3 FTE. It is apparent that there is significant discord about the level of nursing resource and the extent to which spare resource on quiet days should be re-deployed or alternatively given "unanticipated leave" or have the time dedicated to training. There are also issues related to annual leave, support for educational activities and flexible rostering.

There has been talk of an ICU nurse run follow-up service, and nurse led outreach type service, but no proposals tabled.

The Nurse Educator role was cut from .8 FTE to .5 FTE relatively recently, and it is felt this is insufficient to both support mandatory maintenance training and to up-skill new appointees, especially new graduates. Most education is done one on one and there is little opportunity for group education activities.

Leadership
The Unit falls within the Clinical Directorship of Anaesthesia and ICU, with a separate Medical Head for the Unit. This role was filled with distinction by [redacted] for many years until early 2011 when he resigned due to his frustration at lack of progress with facility redevelopment. [redacted] has filled the position since then to general acclaim. It is anticipated that [redacted] (the ICM Specialist) will move in to the role of Medical Head later this year but this does not seem to have been formalised yet.
Management
The ICU lies within the province of the Service Manager of Theatre, Ambulatory Care, Women's Health and Gastroenterology. There is widespread dissatisfaction with this structure, with views expressed that as Anaesthesia does not have a Service Manager (the role incorporated within the Clinical Directors responsibility), the ICU does not need a Service Manager either. Friction between unit medical and nursing staff, and management is obvious. Staff feel that management are unsupportive of redevelopment, expansion, nursing needs and timely discharge of unit patients to wards. Management feel there is a lack of insight from the unit about the needs of the hospital as a whole, an unwillingness to look for or accept HDU type patients, and a general lack of respect for the role of management. There is a feeling that ICU tend to silo themselves from the rest of the organisation. There are no regular (or irregular) meetings between the Medical Head and the Service Manager. The Service Manager also has the role of Nursing Director.
Introduction of new procedures and technologies.
No formal policy exists, but this will now be addressed by the new hospital wide policy.
Service outcome data, including patient satisfaction and performance to contract.
No formal data was presented, but there seems to be high regard for the care given to ICU patients admitted. Dissatisfaction from within the hospital primarily relates to capacity, and admission and discharge criteria.
Associated clinical activities such as teaching and research.
There is a formal introductory course for SHOs with protected teaching time for approximately the first eight weeks. There after the SHOs attend protected formal FANZCA Part 1 teaching every Wednesday afternoon, Those SHOs not interested in Part 1 teaching are encouraged to attend the FANZA Part 2 (clinical) teaching on Wednesday mornings. There is also informal teaching done frequently, especially since [redacted] has been appointed. A journal club for combined Anaesthetics/ICU is held every two months. Much of the research

in the combined group has been related to Malignant Hyperthermia, led by [redacted] an international authority. The CPX facility recently obtained is thought to represent a research opportunity.
Clinical quality assurance processes.
The SMOs in the unit hold a quarterly meeting where case histories and morbidity /mortality data are presented. There is also a monthly anaesthetic morbidity and mortality meeting, and individual audit topics are also presented, some of which may be related to ICU. Quality indicators, e.g. Infections, Falls, Incidents, Medication errors, Central line infections, Complaints, Infection control and Health and safety are monitored.
Peer review processes and systems.
The quarterly review meeting appears to be the main opportunity for ICU peer review. Due to the constraints of overnight call personnel not working in the unit the next day, no formal face to face SMO morning handover occurs.

KEY ISSUES / POINTS

- The Intensive Care Unit delivers a high standard of care for patients admitted, with a recent decrease in ventilation time and tracheostomy rate.

- A limited HDU type service is provided, mainly for surgical patients. There has been a significant increase in such admissions over the last year.

- Admission guidelines for those requiring true Intensive Care exist but there is inconsistent application of these guidelines.

- There is no clear consensus on whether the ICU and its staff should provide an HDU service.

- The wider hospital regards the Intensive Care Unit as its name suggests, rather than a combined ICU/HDU, though realises less stringent admission criteria over the last one to two years means that some HDU type patients will be admitted. All potential HDU patients are certainly not referred for admission currently, and it seems unlikely that the current audit of admission requests will provide accurate data on need. There remains scepticism in some quarters that the current audit will provide accurate data or serve a useful purpose.

- Provision of High Dependency Care at MCH remains fragmented and inadequate. The inability to address this in any way reflects poorly on senior clinical advisers and management.

- The Unit is poorly situated, too small per bed by modern standards, lacking in space for family meetings, and lacking office space, desk space and computer access. Relocation or expansion of space has been examined on many occasions and clearly will not happen in the current economic environment until such time as a major hospital redevelopment.

- Regardless of whether high dependency patients are admitted or not, four resourced beds for our population is below national benchmarking and contributes to cancellation of major elective surgery, with serious consequences.

- The relationship between management and Unit leaders is strained.

- The relationship between the nursing director and staff is strained. A feeling exists that medical and nursing staff have a closer relationship than in other areas and that traditional reporting lines should not prevail.

- There is disagreement about how spare nursing resource should be utilised, with at least some feeling that, contrary to other areas, spare resource should not be redeployed, but be protected for leave or education purposes.

- Dissatisfaction about discharge criteria exists both with ICU staff, and users. ICU staff feel that with ICU being a precious resource, when a patient no longer "needs" ICU they should be accepted back in to a ward, even if the ward is under pressure, and that this should take precedence over any elective admission. At least some other clinical staff tend to think more of the hospital as a whole, and that if ICU have a bed and the patient will be "better" cared for in the unit than in an under pressure ward, it is unwise to transfer. In addition some staff question the cancellation of an elective admission when there is a spare bed in the unit.

- Handover from night to day staff is less than optimal.

- Having senior staff cover night call when they no longer have exposure to routine daytime work is not ideal, and the longer this occurs the less satisfactory it is likely to become.

RECOMMENDATIONS

- That a meeting of stakeholders (Medical Head ICU, Future Medical Head ICU, Charge Nurse ICU, Service Manager ICU, Clinical Director Anaesthesia and ICU, Clinical Director Internal Medicine, and Clinical Director Surgery at least) be convened to further discuss and agree on current admission and discharge policy.

- That a similar small group of stakeholders under the chairmanship of the Chief Medical Officer receive and consider the first three month figures from the current audit. This group should then again consider how high dependency care can be improved. If expansion of resourced beds within ICU is still considered the best interim, partial solution, then the case for this to occur without such a loss of resource from CCU must be compellingly put to SMT.

- That the Medical Head ICU, Charge Nurse ICU and Service Manager/ Nursing Director ICU meet regularly.

- That if the seismic survey identifies a need to relocate ICU within an identified time frame, a group be convened to agree on the longer term delivery of intensive care and high dependency care at MCH, and assist in facility design.

- That definite proposals for the nurse run follow–up service and outreach service be presented.

- That ICU staff decide whether to pursue approval for advanced training with CICM. If so, a list of probable necessary changes needs to be compiled. Implementation should then be considered by the Medical Head, Clinical Director Anaesthesia and ICU, Service Manager, and Operations Director Hospital Services.

SERVICE TEMPLATE (attached)

As completed by the Medical Head.

MidCentral Health	**Unit/Service: Intensive Care Unit**
(1) Description of Unit/Service	**Describe the Unit/Service in narrative form using the headings listed**
1.1 Clinical role within MidCentral Health and within the New Zealand health system. List core and sub-specialty services.	A level II unit providing care to those patients too unwell to be cared for on general wards, as well as the post-operative care to those having major operations. Funding is currently for 4 ICU beds, though physical space would allow up to 7 patients, although this is all at less than recommended work space.
1.2 Role of clinical sub-units (if any).	No clinical sub-units. The medical cover is a combination of Intensive Care specialist and Anaesthetic specialists
1.3 "Catchment" population and boundaries for 1°, 2°, 3° and 4° services.	Servicing the MidCentral population of approximately 180,000, as well as secondary urology and to Wairarapa and Whanganui, acute dialysis services to Whanganui, and tertiary services for Regional Cancer Treatment Service
1.4 Contracted services and volumes (if relevant) and relation of these to clinical need.	No contracted volumes, though elective surgical work sometimes has to work with available ICU capacity

1.5	Teaching, training and research roles.	Teaching and training of SHO's whose primary path is likely to be Anaesthesia, some to combined Anaesthesia and Intensive Care training. In the past, 6 month posts have been provided to trainees in Emergency Medicine and Surgery. These were withdrawn more than 2 years ago, however revision of the ED post has been mooted. With the appointment of an Intensive Care specialist, the department will be pursuing College of Intensive Care Medicine training accreditation. ICU SHO and registrar teaching has been established this year with protected time once a week. No specific research roles currently, in the past contributions have been made to externally run research projects
1.6	Senior and junior medical staff establishments. (Number of individuals and total FTE for House Officer (PGY1+2), SHO, Registrar, MOSS and Specialists)	One Specialist Intensivist and 6 Specialist Anaesthetists share the day to day medical input to the ICU. The on-call commitment is shared by 3 further Anaesthetic Specialists. Four SHO's, usually at the start of their Anaesthetic training, make up the junior doctor contingent

MidCentral Health	Unit/Service: Intensive Care
(2) Match of Resource to Workload	**Identify any <u>significant</u> discrepancies between available resources and role/workload. Any deficiency must be substantiated with data and (if available) references to benchmarks. Non-US international comparisons are preferred.**

	Resource	Appropriate	Details of relevant work and discrepancy
2.1	Medical staff establishment.	Yes	
2.2	Senior medical skill mix (include unused clinical skills)	Yes	The appointment of a Specialist Intensivist has been an injection of clinical expertise, leadership and support. Support from Anaesthesia is good.
2.3	Nursing staff (ward, clinic, OR, etc.)	No	There is a need to continue to recruit experienced ICU nurses. The desire to increase patient throughput will only be maintained with this. Currently well led by Charge Nurse [redacted] and supported by senior nurses FTE's employed- 21.18 staff nurse FTE's, 0.5 ICU Educator FTE, 1 Charge Nurse FTE
2.4	Allied Health support	Yes	ICU enjoys close and expert support of physiotherapy, dietetics and pharmacy
2.5	Clerical, technical and other support staff	No	The ICU receptionist readily takes on extra work; I believe her job description could be revised in her favour. A large part of her current work is the inputting of Anaesthetic audit data which would not be necessary if electronic record keeping was established
2.6	Equipment	Yes	Capex list provided, mainly for time-expired equipment. Monitoring equipment is of a good standard. Request for new intubating aid to be purchased.

2.7	Access to physical resource (ward beds, OR time, clinics, etc.)	No	The ICU patient capacity is limited by funding for nursing resource, as well as by limitations in physical space. An increased of 20% patient throughput in the last 12 months has been achieved by more 'efficient patient handling'. However timely ward discharges remain an on-going difficulty, with 'parking' of patients on ICU seen as another way of helping with elective admissions. As bed management meetings are not held until mid-morning, this delays patient admission and discharge decisions. Access to the OR can be limited by 'surgeon availability', patient progression the Unit can be delayed by this. But generally the surgical service provides excellent support for the ICU. The provision of an 'HDU' bed in the theatre recovery area, with oversight by the on-call Anaesthetic registrar, while a cheap solution for the company, was considered an adverse risk to patients and staff, and was withdrawn in 2011. This capacity has been taken up by the ICU. Senior communication has been had with surgical and medical lines about the increased availability of HDU capacity on the ICU, so that timely referrals can be made. Admission of course will still be governed by clinical appropriateness and bed/nursing resource. An audit of ICU activity is currently being undertaken to try and assess the resource adequacy for provision of critical care in this hospital. It started at the end of May and is for review at 3 and 6 months.
2.8	Linkages with and support from other services.	Yes	ICU generally enjoys good relationships particularly with General Surgery, the Regional Cancer Treatment Service and Radiology services.
2.9	Resources for teaching, training and research.	Yes	Covered previously under 1.5. The SHO's may also attend the weekly Anaesthetic tutorials, which has achieved outstanding success, within Australasia, in primary exams over the years.

MidCentral Health

Unit/Service: Intensive Care

(3) Quality Assurance Activities

Indicate the level of achievement* of your unit/service in each area of quality assurance activity

	Standard	UNIT/Service RATING*	Details
3.1	Orientation programme(s) meet the needs of senior and junior medical staff		I believe it is adequate
3.2	Appropriate written clinical guidelines and protocols are used		Yes- for Cardiovascular resuscitation/management; feeding; infection screens; daily patient cares/management
3.2.1	Processes are established for the development and regular review of policies, guidelines and protocols		Reviews are undertaken when new clinical information is introduced eg CME gained knowledge or at presentations at regular audit meeting, journal clubs
3.2.2	A policy for the introduction of new or innovative procedures is used		No policy exists, however see template for Quality Improvement Project currently underway
3.3	Senior medical staff participate in the multi-disciplinary quality group		Senior staff are involved in a large variety of multi-disciplinary interactions: weekly senior team meetings
3.4	Regular meetings occur with relevant linked services (e.g. radiology, pathology).		Yes, with surgical services/theatre, dietetics, blood transfusion service
3.5	Departmental clinical case reviews are undertaken		There are quarterly SMO meetings where case histories are reviewed, clinical presentations are made, and morbidity/mortality discussed. Monthly Anaesthetic department meetings are also held where morbidity/mortality,

			critical incidents are discussed
3.6	Individual senior medical staff practice audits are operational		Audit projects of individual/collective practice are presented at these meetings
3.7	Departmental clinical indicators are used	MA	Quality Indicators- Infection, Falls, Incidents, Medication errors, Central line infections, complaints, infection control, health & safety audit Admission/mortality/length of stay/source of admission/transfers- database maintained
3.8	Departmental medical teaching and learning forums are provided	SA	Yes- see before
3.9	Peer review occurs at least annually. ('360 degree' model is preferred)	SA	Yes

MidCentral Health		Unit/Service:
(4) Core Responsibilities		**Describe the responsibilities expected of <u>all</u> senior medical staff of this unit/service, with allowance for varying FTE if appropriate. For core clinical responsibilities indicate minimum qualifications and include outcome or frequency standards only where they are actually measurable. Core quality assurance responsibilities include College CME/MOPS requirements and participation in the current unit/service quality assurance activities (Section 3)**
4.0	Minimum Qualifications/Experience	Fellow of the Australia and New Zealand College of Anaesthetists; vocational registration in Anaesthesia with the Medical Council of New Zealand; Fellow of the College of Intensive Care Medicine
4.1	Clinical Activities	
	Inpatient consultation	On referral by, preferably the consultant of, another service, the consultant will see/examine/decide on the appropriate management of the patient. This may mean admission to the ICU is denied. The patient may be assessed by the ICU SHO, and discussion with the on-call consultant is then expected
	Outpatient clinics (list)	N/A
	Other applicable clinical activities	Trauma and emergency calls to other wards Advice/discussions with colleagues about patients in OT or being considered for OT, on appropriateness, pre-operative optimisation, and post-operative care.
4.2	Quality Assurance	
4.2.1	CME / MOPS	All specialists participate in their relevant college's MOPS programme. Have, to date, achieved required standards
4.2.2	Performance Review	Annual

MidCentral Health	Unit/Service:
(5) Special Responsibilities	**Identify the areas of unit/service clinical practice where special qualifications, skills or experience are required. Specify the minimum requirements for granting privileges in each area, including outcome or frequency standards only where they are actually measurable.**

	Clinical Activity	Minimum Requirements/Standards
	Nil identified	

SERVICE CREDENTIALING
INTENSIVE CARE
MIDCENTRAL HEALTH

Date of Credentialing Visit **Wednesday 27th March 2019**

AIM

To Credential MidCentral Health's Intensive Care Unit as per MidCentral Health's Medical Credentialing–Service Review Policy and Procedure.

Service Credentialing Committee Membership

Name	Position Held
[redacted]	Chief Medical Officer Chair MidCentral Health Credentialing Committee
	Intensivist Hutt Valley DHB Chair NZ National Committee of College of Intensive Care External Credentialer
	Medical Lead Intensive Care Reporting Physician for Service Review
	Emergency Medicine Consultant Member MidCentral Health Credentialing Committee
	Manager Medical Administration Unit Member MidCentral Health Credentialing Committee
	Community Representative MidCentral Health Credentialing Committee

Interviewees

[redacted]	Medical Lead - ICU
	Chief Pharmacist
	Consultant Anaesthetist / Supervisor of Training
	Operations Director
	Service Manager
	Charge Nurse ICU
	ICU – Senior House Officer
	ICU – Nurse Educator
	Consultant Anaesthetist - Anaesthetics and ICU
	Medical Lead - Anaesthetics
	Consultant Urologist
	Consultant Nephrologist / General Physician
	General Surgeon
	Medical Lead - General Surgery
	Consultant Anaesthetist - Anaesthetics and ICU
	Medical Lead - Emergency Medicine
	Medical Lead - Emergency Medicine
	Consultant Paediatrician
	Consultant Anaesthetist - Anaesthetics and ICU
	Acting Medical Lead – General Medicine
	Consultant Anaesthetist - Anaesthetics and ICU
	Consultant Anaesthetist - Anaesthetics and ICU
	Consultant Anaesthetist - Anaesthetics and ICU
	Consultant Anaesthetist - Anaesthetics and ICU

Documentation Received

List of documents received by the Service Credentialing Committee including any written submissions from interviewees or others.

Service Credentialing Template completed by [redacted] Medical Lead ICU
Service Credentialing Report from Anaesthetics

INTRODUCTION/CONTEXT

In 2019 the intensive care department continues to be a desired but finite resource. The Intensive Care Unit occupies approximately one half of one side of the top (5th) floor of the tower block. First occupied in the late seventies, there are six physical bed spaces in the main area and two "back rooms". Resourcing for six beds has occurred since 2012 with one side room available but more often used as for the end of life care.

Historically Palmerston North was one of the first hospitals in this country to provide a general intensive care service, well before the current unit was built. From this position of leadership, Intensive Care Service reviews in 2005 and 2007 have reported the MidCentral service lags well behind national benchmarks for beds per head of population and space per bed, though reporting favourably on the quality of care delivered.

Intensive care has evolved over years from a service provided by a few passionate individuals, through a period where most of the specialists involved have been anaesthetists; to the situation where, in bigger or tertiary units most, or all, SMOs are intensive care specialists belonging, in Australasia, to the College of Intensive Care Medicine (CICM). MidCentral has relatively recently recruited its first vocationally registered ICM Specialist since the departure of [redacted] in 1999.

The College publishes recommendations and minimum standards for differing levels of ICU and for training purposes which will be referenced through this report.
https://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf

MidCentral is generally recognised as a level II unit, though not meeting all recommendations (e.g. number of staffed beds; majority of specialists be members of CICM). The unit is accredited by the College of Intensive Care Medicine for Basic Training and as a Rural Rotation for both early and advanced training. The Australian and New Zealand College of Anaesthetists (ANZCA) have accredited MidCentral for their ICU Module of training. Unfortunately and unilaterally the Australasian College of Emergency Medicine (ACEM) has withdrawn accreditation for ICU training for Emergency Medicine trainees – this was a generic move on that college's part that affected all smaller ICUs in Australia and New Zealand.

It is recognised that there is an ever growing number of ill patients who fall short of requiring intensive care, but who require levels of care difficult or impossible to deliver in a general ward. These "high dependency" patients are in most hospitals managed either in a dedicated High Dependency Unit (HDU), or within a mixed ICU/ HDU. MidCentral briefly tried to establish a surgical HDU in Ward 29, but this was unsuccessful, principally due to inadequate physical facilities, an inability to retain trained nursing staff, and poor provision of medical cover. The provision of care to this group of patients has long been a source of anxiety to staff and management at MidCentral and has been discussed and debated in many forums, and by more than one working party.

There have been considerable efforts to plan for surgical patients needing Intensive Care/HDU services. The Surgical HDU function of ICU has been strengthened since the credentialing in 2012 and together with a higher turn-over of patients through ICU has resulted in a reliable HDU service where cancellation of surgery due to lack of ICU capacity is rare. In 2018 there were a total of 70 elective surgical admissions to ICU with only 3 cancellations. All 3 of these surgeries were performed within a few days of their postponement.

It is noted in the service report that there is significant medical HDU work provided in the Coronary Care Unit (CCU), possibly more HDU work than true CCU work. There have been significant improvements in the interface between the ICU and the CCU with important roles played in 'step-down' arrangements from ICU and 'step-up' to ICU for sick patients in CCU. The concern remains for some however that some patients in the CCU setting lack the Specialist Intensive Care oversight that patients may benefit from.

Since the last service credentialing in 2012 the model has advanced with more patients managed with non-invasive positive pressure ventilation strategies. Fewer ventilated days, fewer days of deep sedation and short length of stays has improved capacity throughput and service delivery for both intensive care patients as well as high dependency care patients with a significant amount of the service delivery for surgical HDU.

COMMENTS

Comments on each of the key considerations for Credentialing –

The clinical work the unit is funded to provide.
The Intensive Care Unit (ICU) operates as defined by the IC-01Minimium Standards for Intensive Care Units, Australia and New Zealand College of

Intensive Care Medicine as a Level II Unit. The ICU is a Mixed Unit admitting Medical, Surgical and Trauma patients and it also delivers care for Paediatric, Neurosurgical, and Cardiothoracic patients until tertiary referral centres can accept care for those patients. It operates as a Closed Unit whereby after consultation with Sub-Specialty teams the ICU Specialist is responsible for all admissions, discharges and management decisions.

MidCentral catchment is around 180,000 with additional regional cancer treatment services for Hawkes Bay, Whanganui and Taranaki, and chemotherapy induction patients from haematology. Urology cover to the Wairarapa and Whanganui can impact capacity as can Chronic Dialysis cover from Whanganui. Bed mix is technically 4 intensive care unit beds but has been expanded to all 6 on rare occasion. Which provided 2.2-3.3/100,000 patients which persist below the 6/100,000 target set by the Ministry of Health.

Changing the model of service provision has allowed for fewer ventilated days, less sedated days and more provision of surgical HDU care. Improving capacity to a peak of 504 patients in 2016 and a 5 year rolling average of 468 patients per year. Again this care and expertise is sought after and regarded as beneficial for the patients, surgeons, and physicians who utilize the ICU/Surgical HDU care.

The interface of the service outside the unit is essential as the ICU team responds to Trauma Calls and consultations on critical patients in the Emergency Department and rapid response or (MET) calls on the floor. The emergency department has sought increased feedback and asked for ICU input and participation in their Critical Incident Meetings and has undergone a steady review of the trauma activation process based on national trauma committee requests. ICU input and formal discussions and feedback have been lacking outside of Francis Group meetings. As well as medical input into feedback on the MET or rapid response call system is lacking. The desire for template intake notes to be available electronically as the discharge summary is from ICU would improve communication for the Medical team. Specific discussion with the accepting service about patients prior to a return to the ward, when a patient is "safe" to leave ICU, remains a concern from the surgical specialities. This remains a theme from the 2012 review of the service.

Surgical, Emergency Department, Anaesthetic, Medical, and PACU staff at times feel there is variation in practice in terms of accepting patients into the ICU with the pattern perhaps based on the individual consultant on call not on the patient or capacity. Some discussion was had around this variation and of

note was that requests for utilization of intensive care services from the Anaesthetic and Surgical departments was more often expectant or planned based on risk and was a discussion held at the consultant to consultant level. From the Medical and Emergency department side, this discussion is more often SHO or Registrar led and had a wide individual variation as to the degree of input from the Consultant Physician.
In the service review provided by the Medical Lead, the ICU-ED interface was a topic for analysis by the Francis Group. Resulting from this work there is now an agreement at leadership level that SMO-to-SMO communication is expected for optimal ED-ICU interface.

The ICU admits and keeps Paediatric patients who are anticipated to have short term requirements for intensive care, and also looks after those patients who are awaiting transfer to the Starship ICU. Child Health indicates that the level of support is appropriate for their needs. Child Health operates a two bed high dependency unit and can deliver non-invasive positive pressure ventilation and high flow oxygen in the Child Health ward. Cover for Paediatric Specialist Intensive Care and Anaesthesia care can be ad hoc and based on goodwill but was not felt to be a risk to patients.

A theme was the desire to have expertise of the ICU medical team in some form of outreach. Nursing outreach after an ICU stay was tried for one period but was not sustained. Mixed views of the effectiveness or lack thereof are held by the consultant anaesthetists and covering intensivist regarding the utility of a rapid response or MET service to avert or recognize a declining patient based on the national EWS system.

There is a desire from several services to have more help and leadership around coordinated transfer services for the critical patient in need of tertiary services. This was quickly recognized by the committee as a regional and national problem but may be somewhat ameliorated once the MidCentral Interventional Cardiology service has been established.

The adequacy of the facilities.

A total rebuild is the best option but not in the reach of this committee to grant.

The External credentialer specifically comments -
Place yourself and family/whanau in this facility at the time of a critical illness then wonder how the patient, family and staff could all be cared for best. The facilities especially those required for isolation (and which are often used for palliative services) are bleak, unwelcoming and poorly lit. The location of the

Unit on the fifth floor, remote from Emergency Department, Radiology, and Theatres is a significant impediment. This unit falls short in almost every area that it could objectively be assessed. Irrespective of its importance within the hospital it is surprising to me (external credentialer) that it has not been shut down on any number of mandatory grounds: health and safety / fire safety / earthquake resilience / infection control. I have appended IC-1 which lists many other ways in which it fails to meet the minimum requirements of an intensive care unit in New Zealand in 2019.
https://www.cicm.org.au/CICM_Media/CICMSite/CICM-Website/Resources/Professional%20Documents/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf *My recommendation is that unless work on the new hospital is to start in the immediate future, a new ICU facility must be built as soon as possible.*

A very specific facility concern relates to the sections of the ICU allocated as areas for family/whanau – there is in fact just one , the "Waiting Room", and it is at best limited and more realistically a depressing and unfriendly space that lacks any real privacy.

The facilities and service processes have not kept pace with other critical care departments at Palmerston North Hospital in relation to stock management principles. ICU lags behind the Emergency and Anaesthesia Departments in e-cupboard utilization and safe stocking of medications and controlled substances. Any and all barriers to modernizing this process to merge with the practice of other higher volume critical care departments should be removed.

The composition and skill level of the clinical team, including other health professionals.

The Unit is staffed medically by one Specialist Intensivist, seven Consultant Anaesthetists with an interest in Intensive Care, and Senior House Officers who are often aspiring anaesthetic trainees.

With the Intensivist filling six of the fifteen weekly five hour sessions, this has however meant less exposure to ICU work for the Anaesthetic Consultants. Two of the Anaesthetists provide 2 sessions each and the remaining all have one session each, however, not all rotate through a morning session - felt to be the most valuable for teaching and development of individual patient plans and

care. The future calls for careful consideration and planning for the aging workforce, which service lines can or will contribute to the Critical Care call roster and daily work.

The current model for fatigue relief does not balance the on call burden and workings hours of 24 hours weeknight call and the 60 hours on call weekend roster. After a single night on call, the consultant has 5 hours of fatigue relief and several schedule annual leave to have a full Monday after the weekend on call or schedule their clinical support time on the Monday afternoon. The current intensivist call roster does not have enough participating members to support a split weekend call roster.

The SHOs are usually seeking selection into vocational training in Anaesthesia and are appointed for twelve months. They usually start as inexperienced doctors, have extensive input over some months from senior staff and generally learn quickly. Six month appointments, although sometimes made to accommodate the needs of aspiring trainees in other specialties, do mean that the "pay-back" time for the effort of training them is less. It is felt that there is opportunity to more actively promote the Unit, at the Basic training level, as a desirable site for vocational training in Intensive Care Medicine. Patient numbers and case mix would be insufficient for higher levels of Advanced Training at this stage.

The Anaesthesia, Intensive Care and Emergency departments have developed a plan to aid all three departments to attract senior Emergency Medicine registrars. Offering 6 month runs in Emergency Department followed by Intensive Care, then Anaesthesia to form a 2 year period of service in the Emergency Department. Access to Anaesthesia training is very limited for trainees who are not aspiring Anaesthetists or already in a training programme. This collaboration should be lauded as beneficial to the hospital as a whole and has been supported by the Operations Executive.

The nursing staff is viewed as highly skilled and motivated, however attrition has become an issue with no nursing staff currently holding postgraduate qualifications in critical care. Palmerston North ICU nurses are inadequately trained for their role according to the "minimum standards" document IC-1(IC-1, it is the minimum standards document for ICUs, adopted as the NZ standard by the Ministry Of Health in 2005):

7.2.8 There should be a minimum of 50% (optimum 75%) of nursing staff with a post registration qualification in intensive care for every shift.

It was stressed that Intensive Care is a highly integrated multidisciplinary pursuit, with close interaction between medical and nursing professions. The senior medical support for nurses is valuable but the formal educational opportunities offered are limited. The variable volume of patients in the ICU is a concern when nurses are 'gifted' to the wards at times of low census in the department but a lack of reciprocity is felt, however no data was provided to support this concern. This gifting is seen to decrease the opportunities for ICU education. Concerns were raised around nursing leadership and a subtle sense that the nursing staff might benefit from a refreshing of the senior nursing team, some of whom have been in position for a long time.

The interviews were positive when specific questions were posed about the approachability, availability and hierarchy of the senior medical staff and specifically no concerns about bullying were raised in this open forum.

The Unit is fortunate to have very effective service and support from Pharmacy and Dietetics. Clinical pharmacist support is based on priority across the entire hospital and is patient risk specific. However Clinical pharmacists available for routine rounds of ICU patient would be recommended for a unit this size.

Other ancillary services were not interviewed but no specific problems have been raised in respect to social work, physical therapies, palliative care or laboratory medicine.

Practitioner workload

Currently, in addition to the Intensive Care Medicine specialist, seven anaesthetists have part-time duties in Intensive Care. Six share in the day time running of the unit, and the weekend call roster. Two SMOs are rostered on for a five-hour morning shift, and one for a five-hour afternoon shift. The SMO FTE allocation to the ICU has been quoted at 2.8-3.2 FTE. Concern was voiced that Anaesthetist time in the ICU is seen as a 'luxury' and anaesthetists are often recalled to ensure operating theatre coverage for elective services.

Five ICU SHOs provide 5.04 FTE of cover and the workload is thought to be satisfactory. The Unit is recognised for Basic and Rural advanced training by CICM.

Nursing is led by a Charge Nurse who has to double as the clinical resource nurse, when short. The default expectation for ICU is for a nurse-to-patient ratio of one, which for four "ICU" beds would mean five nurses per shift with a runner. This would equate to a required budget of 24.3 FTE. Current budgeting is for 24.3 FTE. It is apparent that there is significant discord about the level of

nursing resource and the extent to which spare resource on quiet days should be re-deployed or alternatively given "unanticipated leave" or have the time dedicated to training. There are also issues related to annual leave, support for educational activities and flexible rostering. Most education is done one on one and there is little opportunity for group education activities.

Clinical Leadership

The ICU Medical Lead has been [redacted] (the ICM Specialist) since 2012. His leadership is valued, his outcome goals for patients have shaped the department and have been beneficial from before he took over as Medical Lead. There was widespread praise and loyalty voiced from his immediate medical and nursing colleagues. Specifically there was a sense of shared vision, approachability, respect for his clinical expertise, and an acknowledgement that "everything is better than it used to be". This report wishes to reflect the pride that should be felt by the department for their achievements under [redacted] leadership.

Workforce planning has become a concern. Young Consultant Anaesthetists and new trainees in Anaesthesia have little Intensive Care requirement in their training, meaning that other service lines may need to be explored to cover the call roster in the future (for example Respiratory Physicians, Emergency Medicine physicians). Hiring another intensivist may exacerbate the existing issues with the relative lack of daytime shift/hours available for anaesthetists working in the critical care environment.

Management

The ICU lies within the Acute and Elective Services Cluster.

Staff appear to hold little hope for redevelopment, rebuild or expansion of the existing facilities.

There are persistent concerns around nursing "gifting" or redeployment when patient numbers are low in the ICU, and about timely discharge of unit patients to wards.

Introduction of new procedures and technologies.
The credentialing committee oversees a hospital wide Policy to uniformly address this process.
Service outcome data, including patient satisfaction and performance to contract.
Formal data is included in section 3.7 of the departmental review but is lacking for the past 2 years. Strong trends are demonstrated in decreasing invasive ventilation times, fewer tracheostomies, less blood product cost and increased ICU throughput and of falling mortality. These all support the opinion of the Physicians and Surgeons that the ICU and Surgical HDU provide high quality care they have respect for. Any dissatisfaction from within the hospital primarily relates to capacity, and to perceived variation in individual practice in applying admission and discharge criteria. These matters have been tracked with a one year formal audit which reassuringly did not support these perceptions. Continued interface with all departments that interact with the ICU is required and if possible there should be attendance at the morbidity and mortality meetings of other service providers. Of interest this committee received no feedback from the community or a ny feedback from patients in regard to the service delivery. Future credentialing committee reports should seek out this information.
Associated clinical activities such as teaching and research.
There is formal ICU SHO teaching weekly on Wednesday from 11:00 for 1 hour done by the ICU SMO. There are formal ICU nurse education days several times a year run by the ICU nurse educator with input from the ICU Charge Nurse and the ICU Medical Lead. The unit has no current research activities but does collect and input data into the Australia and New Zealand Intensive Care Society (ANZICS) Database for benchmarking. A unit of Palmerston North's size should have an active research programme. This is likely to take the form of collaboration with other ICUs; Capital and Coast DHB would appear to be the most likely source of this collaboration. This would have downstream benefits for nursing and for registrar and senior house officer training. This could generate funds for furthering the nurse education in the unit. Collaboration between Anaesthesia, Emergency Medicine and ICU to recruit advanced trainees in Emergency Medicine for a pathway of training to include

all three services should be lauded.
Clinical quality assurance processes.
The SMOs in the unit hold a quarterly meeting where case histories and morbidity /mortality data are presented. There is also a monthly anaesthetic morbidity and mortality meeting, and individual audit topics are also presented, some of which may be related to ICU. Quality indicators, e.g. infections, falls, incidents, medication errors, central line infections, complaints, infection control and health and safety are monitored with audit. A more robust accounting of bed utilization would be of benefit and would be of use in addressing any concerns about surgery cancelations due to occupancy concerns.
Peer review processes and systems.
ICU conduct morbidity and mortality meeting on a quarterly basis but no detail was provided as to case nomination. No formal or informal feedback process for outside services appears to exist.

KEY ISSUES / POINTS

1. The Intensive Care Unit delivers a high standard of care for patients admitted, with a continued trend toward decrease in ventilation time, a declining tracheostomy rate and a decline in the mortality rate.

2. A limited surgical HDU type service is provided. The service has seen a 1/3 increase in volume with a sustained increase in HDU service delivery since the last credentialing report.

3. The physical facilities are substandard and are not in keeping with those required to deliver a modern, safe, and effective service to the community served by MidCentral DHB. The external credentialer specifically comments - *"This unit falls short in almost every area that it could objectively be assessed. Irrespective of its importance within the hospital it is surprising to me that it has not been shut down on any number of mandatory grounds: health and safety / fire safety / earthquake resilience / infection control".*

The unit remains unchanged in any major way since the 2012 credentialing report. The following excerpt is taken from the 2012 report -

The ICU is poorly situated, too small per bed by modern standards, lacking in space for family meetings, and lacking office space, desk space, and computer access. Relocation or expansion of space has been examined on many occasions and clearly will not happen in the current economic environment until such time as a major hospital redevelopment.

A very specific concern relates to the area allocated for family/whanau which is entirely substandard and not fit for purpose.

4. The ICU is lagging behind other critical care areas within the hospital with respect to stocking and tracking of medications and supplies. The anaesthesia and emergency departments have both successfully implemented e-cupboards and temperature monitored refrigerators without patient care disruptions. Any and all barriers to modernizing this process to merge with the practice of other higher volume critical care departments should be removed.

5. Regardless of whether high dependency beds are included in our critical care capacity, six resourced ICU beds will not be sufficient for our population in the future. This needs to be factored into any re-build of

the facilities. A 10-12 bed unit will almost certainly be needed in the future.

6. The Surgical-Anaesthesia-ICU relationship has been consolidated through the establishment of a service that flags high-risk surgical patients who would benefit from HDU post-operatively. The CPEX (cardio-pulmonary exercise testing) facility complements the Anaesthesia assessment for these patients and guides the discussion with ICU regarding risk-benefit ratios and degree of invasive escalation post-operatively. Prospective limitations of treatment and end-of-life discussions are therefore better defined through this multi-disciplinary approach.
However, and while not within the ICU's domain, there do appear to be further administrative improvements relating to coordination of the activities of booking clerks in the setting of surgical dates. This may well mean we avoid situations where multiple patients are booked for HDU/ICU on the same date.

7. There is disagreement about how spare nursing resource should be utilised, with at least some feeling that, contrary to other areas, the spare resource should not be redeployed, but be protected for leave or education purposes. A shared pool model whereby nurses are utilized in other high dependency step down or critical care environments to maintain skills and training has been explored previously with little support at that time.

8. *Unchanged from the 2012 summary report* - "Developing a long term plan for senior staff who cover night call to maintain exposure to routine daytime work - specifically morning rounds and patient planning is viewed as essential. Recruiting a new Intensive Care Specialist in conjunction with service lines outside of Anaesthetics should be explored."

9. The services and advice provided by the Intensive Care Team are respected and often seen as invaluable. However the interface can be variable depending on the individual Intensive Care physician. The comprehensive approach of bedside review, the discussion around acute patient needs and developing a plan with the other services involved in the care cannot be emphasised enough. This insight, discussion, and resource for patients who are critically ill are an exceptional part of the service, regardless of the location where the care is ultimately delivered.

10. The Credentialing Committee had an impression of an emerging divide

between the department of Intensive Care and the department of Anaesthetics now that they are two separate departments. This issue needs to be monitored to ensure it does not impact on the services provides by either department.

RECOMMENDATIONS

1. It is imperative that improvements be made to the existing ICU facilities given that any significant rebuild is a number of years away. The facilities do not meet required standards to deliver the level of care that the people of MidCentral District are entitled to.

2. Further review of the SMO call schedule and relief provision is essential for workforce safety. Specifically, ICU SMOs should have a rostered Monday 'off' following their weekends on call.

3. Developing a long-term plan for senior staff that cover night and weekend call to maintain exposure to routine daytime work, specifically morning rounds and patient planning, is viewed as essential. Recruiting a new Intensive Care Specialist in conjunction with service lines outside of Anaesthetics should be explored.

4. With respect to stocking and tracking of medications and supplies, the Emergency Department and Operating Theatres have both successfully implemented e-cupboards and temperature monitored refrigerators without patient care disruptions. Any and all barriers to modernizing this process to mirror the practice of other higher volume critical care departments should be removed.

5. Exploration of a shared nursing pool so that skill maintenance, education and research can be expanded, with the long term aim of achieving the minimum standard of 50% of nurses in ICU holding postgraduate qualifications in critical care.

6. Thought needs to be given to how the ICU can grow and develop its own registrars (vocational trainees in Intensive Care) in addition to providing opportunities to trainees from other services and providing experience to prospective anaesthesia trainees.

7. Establish formal documentation and analysis of, reasons for admission of

patients to ICU, of deteriorating patients who may have benefited from earlier ICU input, and details of handover of patients when they are discharged from ICU.

SERVICE TEMPLATE (attached)

As completed by the Medical Lead.

(1) Description of Unit/Service		Describe the Unit/Service in narrative form using the headings listed
1.1	Clinical role within MidCentral Health and within the New Zealand health system. List core and sub-specialty services.	Our ICU operates as a : 1. Level II Unit: "*...capable of providing a high standard of general intensive care, including complex multi-system life support... mechanical ventilation, renal replacement therapy and invasive cardiovascular monitoring for an indefinite period...*"(IC-01, Minimum Standards for Intensive Care Units, Australia and New Zealand College of Intensive Care Medicine). 2. Mixed Unit - admitting Medical, Surgical, Trauma and Paediatric patients. Our DHB lacks Neurosurgical and Cardiothoracic specialities and as a result these ICU-level patients will be transferred to CCDHB ICU which is our tertiary referral centre. 3. Closed Unit - a model of care promoted by the Australasian College of Intensive Care Medicine in which the ICU Team has the primary role in the delivery of critical care and the ICU Specialists are responsible (after consultation with Sub-specialty Teams) for all admissions, discharges and management decisions.

HDU role

During the last credentialing exercise in 2012 the HDU function of our unit was discussed. Since then we conducted meetings with both Surgical and Medical Leaderships and reassured both that ALL patients deemed fit for escalation of therapy above ward level could be referred to ICU. ICU is committed to provide care for all CRITICALLY ILL patients – this care will not be limited to the provision of ICU-level-only invasive support but will also entail intermediate, HDU-level support for both surgical and medical patients.

A special consideration within this context was the interplay between ICU and our hospital's de facto Medical HDU (our misnamed CCU). We committed to ensuring that this space remains purely medical and that no Trauma or Surgical patients will end up in CCU (this was previously a criticism levelled at ICU as, due to limited capacity in ICU many of these patients would end up in CCU). For medical patients only, we recognized the importance of CCU as a potential intermediate level of care, both as a "step-up" to ICU if patients fail to improve; and as a "step-down" from ICU when the transition to ward-level care might be too abrupt. It is important to note however that we see the presence and function of CCU as being complementary to that of our unit in managing unwell medical patients. We also think it is important for our institution to retain this complementary mode in a future re-build of the hospital.

The Surgical HDU function of our unit has also been strengthened since the credentialing in 2012. High-risk surgical patients are flagged during the Anaesthesia Clinic assessment and are discussed with ICU. On the day of surgery ICU is contacted to make sure a post-operative bed is available. This ensures capacity exists before surgery starts and avoids the historical situations where unstable patients had prolonged PACU stays (including overnight). This system has worked very well and together with a higher turn-over of patients through ICU has resulted in a reliable HDU service where cancellation of surgery due to lack of ICU capacity is rare.

Unit Capacity

Physical capacity is 6 beds + 1 side-room (which functions most of the time as end-of-life care room; on rare occasions has been used as isolation room as it is meant to have a negative pressure profile).

There is no rigid delineation for either HDU or ICU capacity. Capacity for each will flex up or down depending on need.

We are currently funded for a 5/5/5 nursing cover (5 nurses per shift for 3x 8 hr shifts). This allows us to look after 6 patients at any time, irrespective of acuity (although in theory our limit would be 4 intubated patients, in reality this would be an exceptionally rare situation).

It should be noted that when the funding increase was discussed in 2014 the initial proposal from management based on past predictions was a 6/6/6 cover. However the ICU Team considered that to be unnecessary and we agreed on a 5/5/5 cover which has worked well.

1.2	Role of clinical sub-units (if any).	N/A
1.3	"Catchment" population and boundaries for 1°, 2°, 3° and 4° services.	MidCentral catchment of around 180.000. Regional Cancer Treatment Service extends our usual catchment to Hawkes Bay patients who have high-risk surgery performed at PNH. Also Haematology patients admitted to PNH for the induction chemotherapy. MidCentral Urology cover to Wairarapa and Whanganui can impact our capacity when these patients are transferred to PNH and are critically unwell. MidCentral Chronic Dialysis cover to Whanganui can also impact our capacity.

1.4	Contracted services and volumes (if relevant) and relation of these to clinical need.	No contracted services. Throughput has increased significantly reaching a peak of 504 in 2016 (431 in 2017; 423 in 2018).

1.5	Teaching, training and research roles.	The unit is accredited by ANZCA (Australia and New Zealand College of Anaesthetists) to provide training for anaesthesia trainees completing their ICU Module of training. The unit is accredited by CICM (College of Intensive Care Medicine) for Basic Training and as Rural Rotation for both early and advanced trainees. Unfortunately in 2018 ACEM (Australasian College of Emergency Medicine), without consultation or review has withdrawn its accreditation of our ICU (and similar sized ICUs in Australia and NZ) for training of ED trainees. This will create a problem both for our unit but especially for our Emergency Department as recruitment of trainees will be hindered. There is a formal ICU SHO teaching schedule with protected teaching time every Wednesday from 11.00 to 12.00. The teaching is done by an ICU SMO. There are formal ICU Nurses Education days several times a year run by the ICU Nurse Educator with input from the ICU Charge Nurse and the ICU Medical Head. No specific research roles. Our unit collects and inputs data into the ANZICS (Australia and New Zealand Intensive Care Society) Database for benchmarking against similar Australasian ICUs.

1.6	Senior and junior medical staff establishments. (Number of individuals and total FTE for House Officer (PGY1+2), SHO, Registrar, MOSS and Specialists)	One Specialist Intensivist (FCICM) and 7 Specialists Anaesthetists (FANZCA) share day-time sessions and on call duties (week-nights and week-ends). The Specialist Intensivist is rostered for 30 clinical hrs a week, 2 SMOs are rostered for 10 clinical hrs per week each and the rest of the SMOs are rostered for 5 hrs per week each. One additional Specialist Anaesthetist contributes to the call roster (week-nights only, with a frequency of on-call of 1:14). This puts the total SMO FTE between 2.8 and 3.2 (depending on how the non-clinical time is worked into it). Five ICU SHOs, in general at pre-vocational training level. They work in 12 hr shifts (08.00-20.00-08.00) with 1 SHO rostered per shift.

			Unit/Service: Intensive Care
(2) Match of Resource to Workload			**Identify any <u>significant</u> discrepancies between available resources and role/workload. Any deficiency must be substantiated with data and (if available) references to benchmarks. Non-US international comparisons are preferred.**
Resource		**Appropriate**	**Details of relevant work and discrepancy**
2.1	Medical staff establishment.	Yes	N/A
2.2	Senior medical skill mix (include unused clinical skills)	Yes	N/A
2.3	Nursing staff (ward, clinic, OR, etc.)	Yes	Nursing FTE 24.3 (currently 1 FTE vacancy). Charge Nurse 1 FTE. ICU Nurse Educator 0.5 FTE. Cover as described above: 5/5/5
2.4	Allied Health support	Yes	ICU enjoys close and expert support of physiotherapy, dietetics and pharmacy
2.5	Clerical, technical and other support staff	Yes	The ICU Receptionist performs valuable work beyond what would be expected from her job description. She fulfils a significant research role by collecting our pen and paper outcome data and inputting it into the electronic ANZICS database.
2.6	Equipment	Yes	7 Bed-space Monitors and 2 Transport Monitors will require replacement

			within the next 18 months. Patient Cooling System (Cooling Machine and blankets) will require replacement within the next 12 months.
2.7	Access to physical resource (ward beds, OR time, clinics, etc.)	Yes	Delayed discharges to ward have remained an issue despite reassurances given by nursing managers that ICU discharges will be prioritized.
2.8	Linkages with and support from other services.	Yes	The Surgical-Anaesthesia-ICU relationship has been consolidated (see HDU section above) through the establishment of a service that flags high-risk surgical patients who would benefit from HDU post-operatively. The CPEX (cardio-pulmonary exercise testing) facility complements the Anaesthesia assessment for these patients and guides the discussion with ICU regarding risk-benefit ratios and degree of invasive escalation post-operatively. Prospective limitations of treatment and end-of-life discussions are therefore better defined through this multi-disciplinary approach. The ICU-ED interface has been discussed at leadership level last year with help from the Francis Group. We have achieved significant agreement with respect to shared expectations – one of the issues ICU SMOs insisted on was SMO to SMO direct communication as a prerequisite for improved management plans.
2.9	Resources for teaching, training and research.	Yes	

			Unit/Service: Intensive Care
(3) Quality Assurance Activities			**Indicate the level of achievement* of your unit/service in each area of quality assurance activity**
	Standard	**UNIT/Service RATING***	**Details**
3.1	Orientation programme(s) meet the needs of senior and junior medical staff		Adequate
3.2	Appropriate written clinical guidelines and protocols are used		Yes
3.2.1	Processes are established for the development and regular review of policies, guidelines and protocols		Yes
3.2.2	A policy for the introduction of new or innovative procedures is used		No Policy
3.3	Senior medical staff participate in the multi-disciplinary quality group		Yes
3.4	Regular meetings occur with relevant linked services (e.g. radiology, pathology).		Yes

3.5	Departmental clinical case reviews are undertaken		Quarterly ICU SMOs Morbidity & Mortality meetings and ICU Business Meeting. Monthly Anaesthesia department Audit and Business Meetings.
3.6	Individual senior medical staff practice audits are operational		Audit projects of individual/collective practice are presented at these meetings
3.7	Departmental clinical indicators are used	MA	Quality Indicators- Infection, Falls, Incidents, Medication errors, Central line infections, complaints, infection control, health & safety audit. Outcome data collected and inserted into the ANZICS CORE Database for benchmarking against other Australasian ICUs. This data shows we are performing very well with a better than average Standardized Mortality Ratio. In 2017 an audit of unit performance was presented to MidCentral Hospital Board in which a comparison was made of the period 2011-2016 with a 10 year period prior to 2011. The audit showed significant improvements across a range of relevant clinical outcomes - see table below:

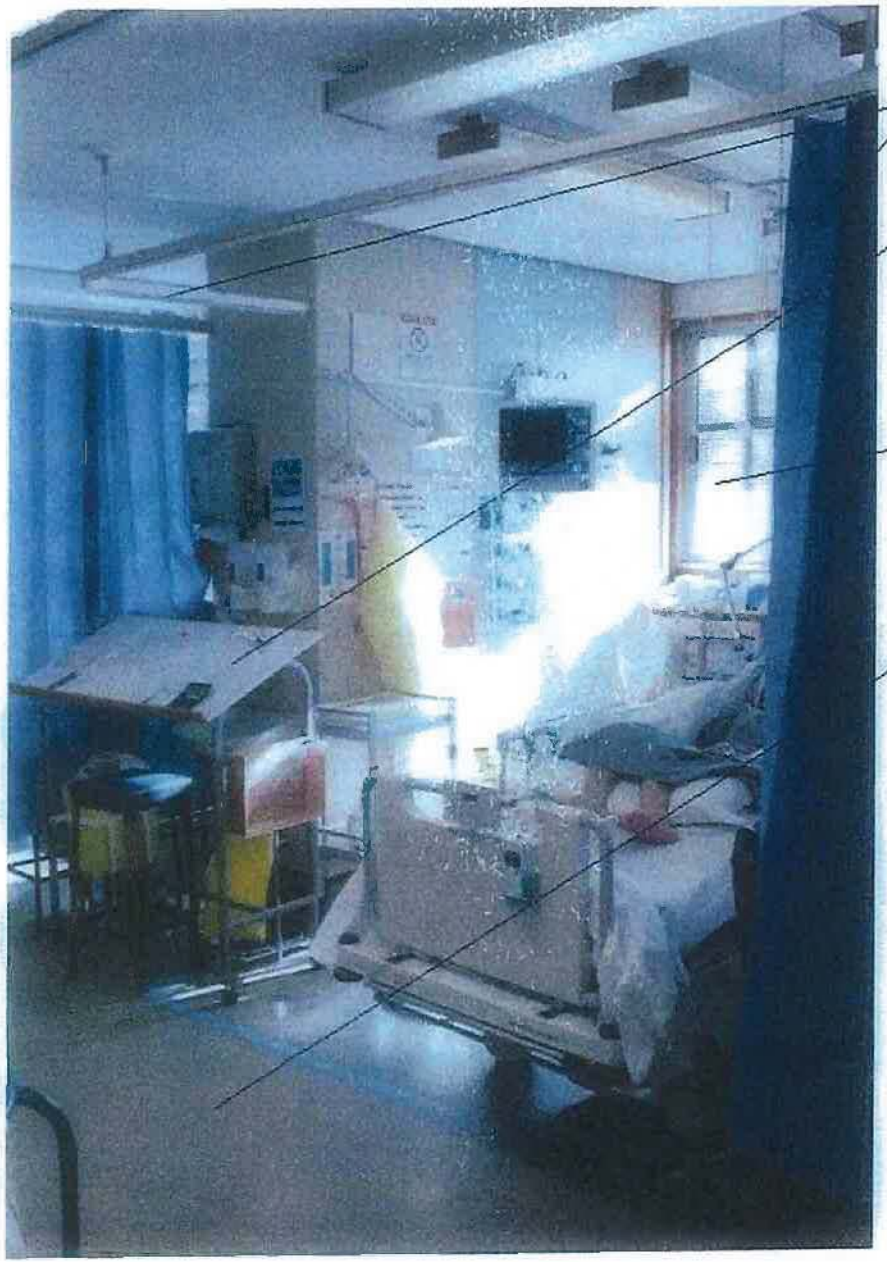
	2002-2011	2011-2016
Time Invasive Ventilation	15.000 hrs/year	5000 hrs/year
Tracheostomies	30-40/year	1-2/year
Blood Products Cost	876.000 $ (2007-2011 period only)	483.000 $

			ICU Throughput 300/year 500/year Mortality 13% 9% The outcomes of interest were chosen to reflect the emphasis on modern, evidence-based critical care principles – for example sedation practices for mechanically ventilated patients were felt to have changed and this impacted ventilation outcomes (time on invasive ventilation, need for tracheostomy); blood transfusion practices were also felt to have changed with a focus on a restrictive transfusion strategy; and ultimately, ICU mortality could have been impacted. Several of these outcomes aligned with the "Choosing Wisely" Campaign championed by the Australian and New Zealand Intensive Care Society.
3.8	Departmental medical teaching and learning forums are provided	SA	Yes- see before
3.9	Peer review occurs at least annually. ('360 degree' model is preferred)	SA	Yes

		Unit/Service:
(4) Core Responsibilities		**Describe the responsibilities expected of all senior medical staff of this unit/service, with allowance for varying FTE if appropriate. For core clinical responsibilities indicate minimum qualifications and include outcome or frequency standards only where they are actually measurable. Core quality assurance responsibilities include College CME/MOPS requirements and participation in the current unit/service quality assurance activities (Section 3)**
4.0	Minimum Qualifications/Experience	Fellow of the Australia and New Zealand College of Anaesthetists; vocational registration in Anaesthesia with the Medical Council of New Zealand; Fellow of the College of Intensive Care Medicine
4.1	Clinical Activities	As above
	Inpatient consultation	Yes
	Outpatient clinics (list)	N/A
	Other applicable clinical activities	N/A
4.2	Quality Assurance	As above
4.2.1	CME / MOPS	All specialists participate in their respective colleges CPD scheme.
4.2.2	Performance Review	Annual

	Unit/Service:
(5) Special Responsibilities	**Identify the areas of unit/service clinical practice where special qualifications, skills or experience are required. Specify the minimum requirements for granting privileges in each area, including outcome or frequency standards only where they are actually measurable.**

Clinical Activity	**Minimum Requirements/Standards**
Adequacy of the physical facilities of the unit	The current space is severely outdated and is well below the standard described by the College of Intensive Care Medicine. One example is the bed space surface area which should be a minimum of 20 square metres (ours are around 13 sq. m). See photos with details below:

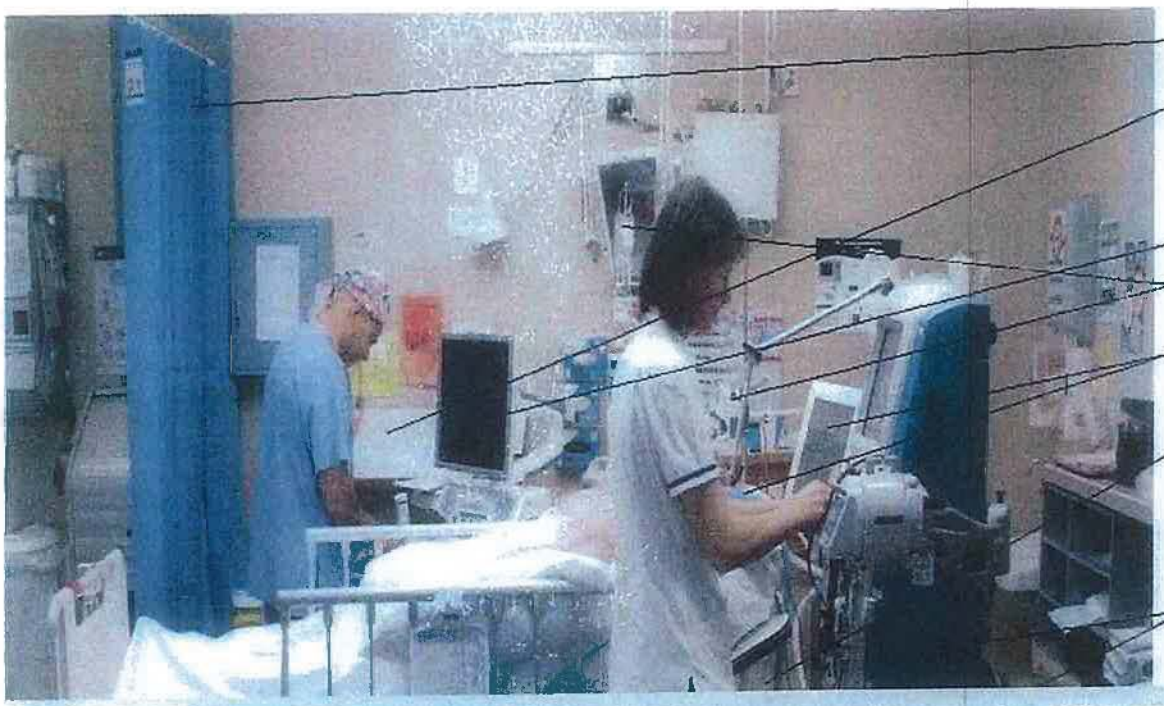


Bedspace divider/curtain again limiting clinical bedspace area

Nurse station and writing desk moved to the side of bedspace due to insuficient surface area. It now blocks the access to the sink interfering with infection control measures.

Windows and natural lighting are part of the ideal setup of an ICU bedspace

Despite the removal of the nurse station from its required position at the end of the bed there is still insufficient floor space and access for movement of staff, beds/patients, equipment past the bedspace.



Bed space divider/curtain - immediately adjacent to end of bed - a clear limitation to the overall space around the bed/clinical work area.

The nurse station with the observation sheet should be at the end of the bed in order to allow the nurse to face the patient and allow continuous monitoring of patient and machines while recording all relevant clinical data - clearly this is not possible in current format due to the limited bedspace area

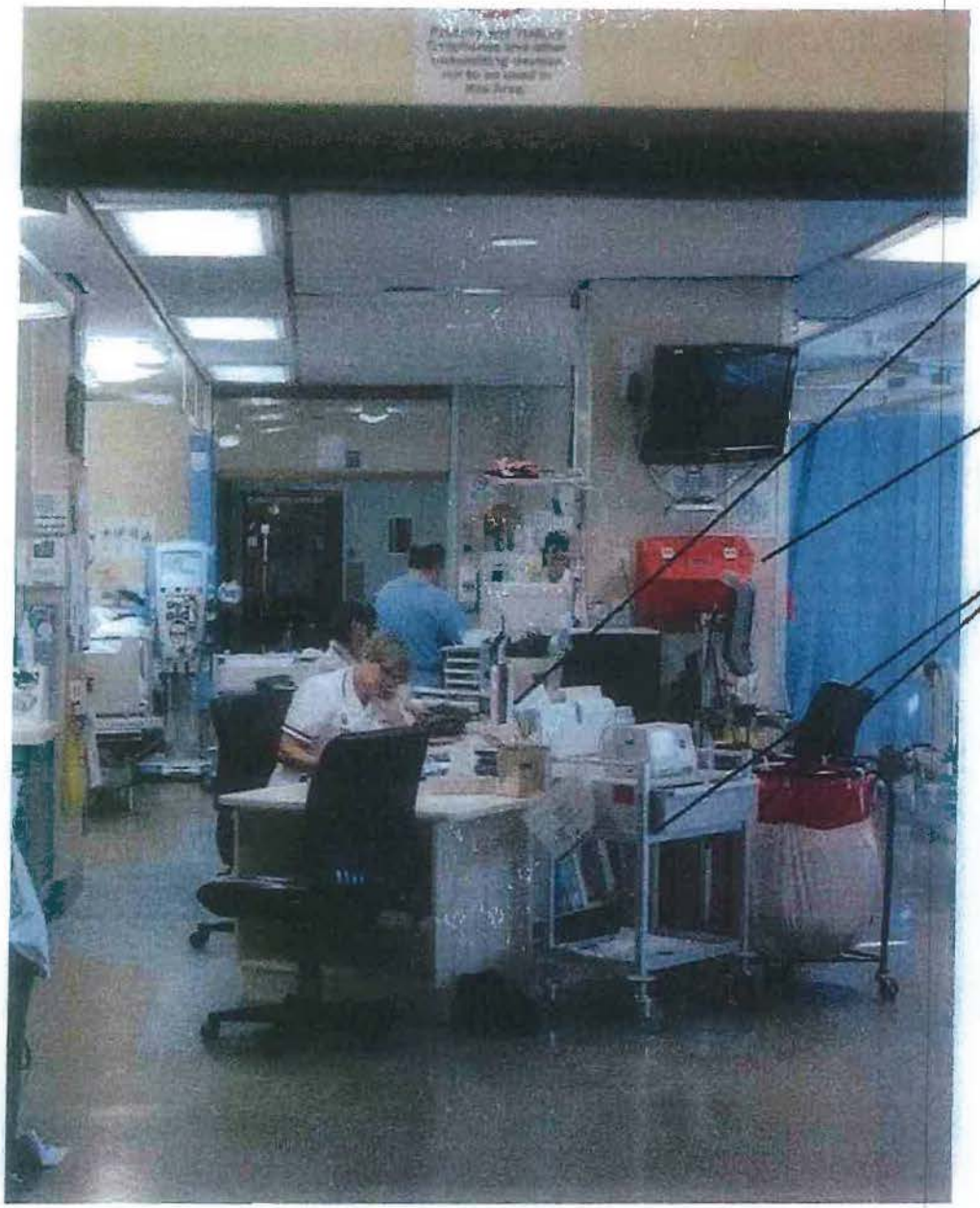
Heart ultrasound machine - difficult access to patient

Multiple infusion pumps on metal poles either attached to head of bed and stand-alone next to bed further crowding the bedspace

Breathing machine with ventilator tubes attached to patient's breathing tube - in a crowded space with many other wires/cables/infusions a disconnection at this level could be fatal

"Bolard" (service outlet) - one of the most important features of the ICU bedspace - it holds the ports for delivery of oxygen, air, suction, power points, light switches, data outlets - in the current design it is the largest impediment to flow and access to patient as it is fixed to the floor. In modern units the service outlet is ceiling mounted and mobile allowing freedom of movement around the bedspace.

Dialysis machine and dialysis troley - fighting for space around the patient - and further crowding the head of the bed which is the vital area for access to patient, both f



Central work station for medical staff - despite its satisfactory position as the "core" of the unit allowing continuous monitoring in all directions of all bedspaces the current size is inadequate - very little writing space and computer space is available.

Large concrete structure obviously interferes with the monitoring function of the central station as it blocks a large part of the view of the clinical spaces.

Appliances and equipment positioned around the station further crowd it and impede the flow/access to bedspaces

FINAL REPORT

ICU ACTIVITY
(May 28th-November 30th 2012)

This report details 6 months of ICU activity for 2012. An interim report has already been presented to management earlier in the year. The current document follows the same format of the previous report. We also thought it was important to re-iterate the arguments outlined in the interim report.

Background

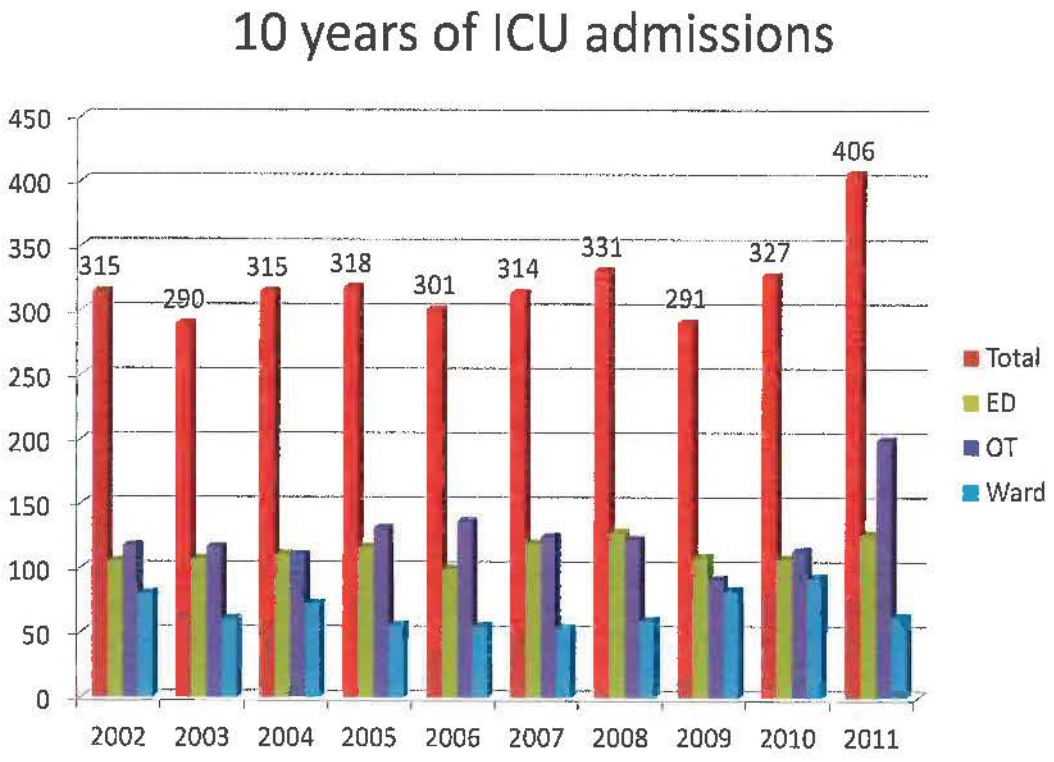
Last year a proposal was put forward to expand the capacity of the Intensive Care Unit to provide a higher proportion of high-dependency care through an increase in ICU nursing FTEs. Management planned to achieve this via redeployment of nursing FTEs from CCU.

The ICU team considered this plan carefully. We expressed the view that CCU was the de-facto medical HDU of the institution and as such already fulfilled an important role delivering intermediate-level care. We contended that taking away FTE resources from this valuable service to increase ICU capacity was counterproductive.

As a result the ICU team chose to defer the management's proposed solution. At the same time we offered an alternative with our commitment to become more efficient within the current framework of the unit. We believed that increasing the efficiency of patient throughput was possible through the following processes:

1. Improvement in the communication between referring SMOs and the ICU SMOs. Historically a perception had developed that ICU was predominantly a surgical/anaesthetic domain, very difficult to be accessed by medical patients. We assured our SMO colleagues, particularly the Internal Medicine Directorate that this was not the current ICU philosophy and we encouraged them to refer to us all patients thought to warrant a higher level of care.
2. Optimizing the existing "Surgical HDU" function of the unit. This function had been established the previous year and had already resulted in a 25% increase in total admissions per year compared to the annual average for the preceding 10 years (see Graph 1). As a consequence of this function surgical patients are no longer cared for in CCU, overnight PACU stay is a rare event and less elective surgery is cancelled. We were confident that further gains were possible through the implementation of a more robust discharge mechanism whereby ward beds are more readily available for patients to be transferred out of ICU once their surgical HDU care is accomplished.
3. Improvement in the consistency of critical care delivery and clinical governance through the appointment, earlier in the year, of a full-time Intensive Care Specialist (Fellow of the College of Intensive Care Medicine).

It was agreed that a review of ICU activity should be undertaken after 6 month to evaluate results.



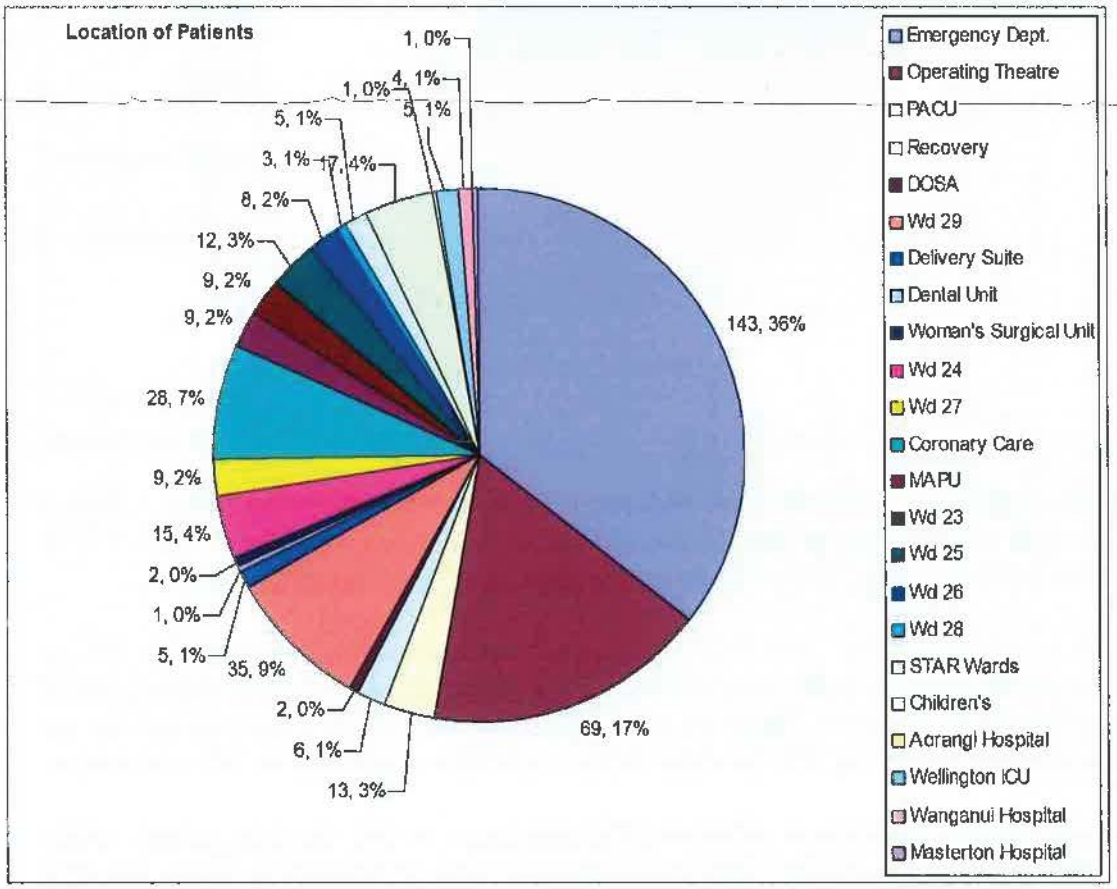
Graph 1.Figures collected from the ICU database. The total number of admissions in 2011 was 406. This represents a 25% increase over the total average of the preceding years. As the graph shows the increase is largely related to admissions from theatre (purple bar).

Audit process
The ICU team developed a prospective audit tool and an electronic database to collect and input data. Every referral made to ICU within the audit period was logged and introduced in the database. The audit tool was designed to capture information relevant to the points mentioned above: number of referrals, number of admissions, reason for referral, type of patient referred, outcome of the referral, reason for declined admission, delay in discharge, reason for the delay in discharge.

Results

Total number of referrals
A total of 402 referrals for various reasons were made to ICU over the 6 months studied.

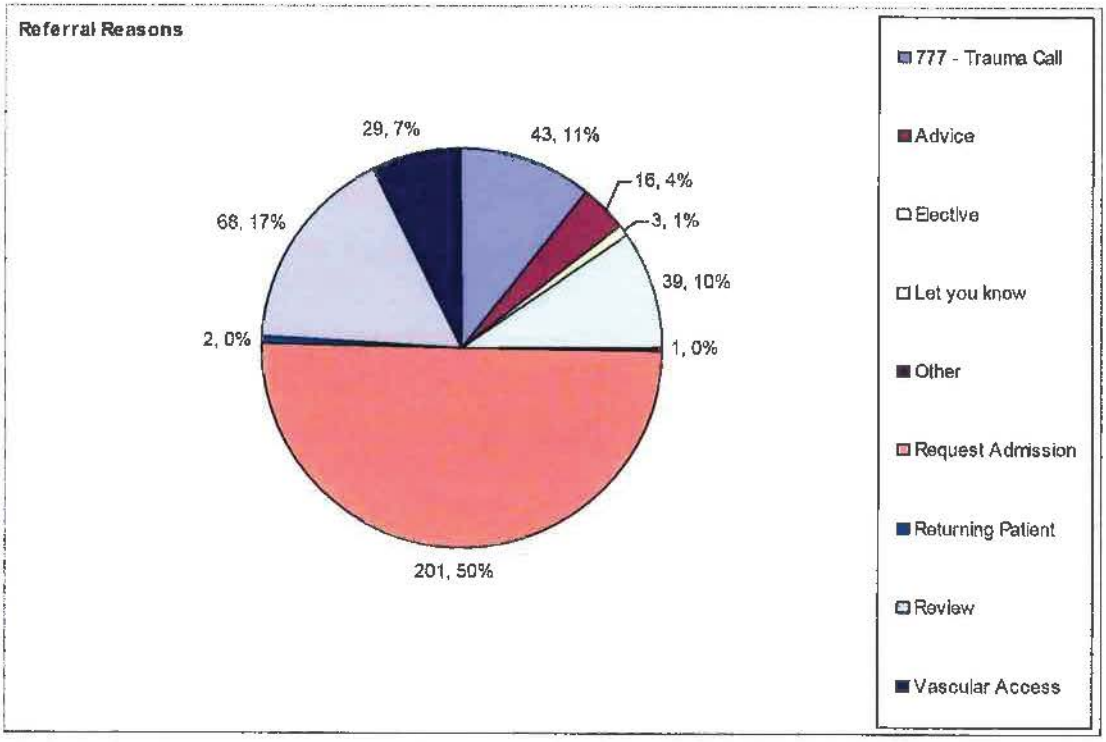
Origin of referrals
- Emergency Department: 143 (36%)
- OT&PACU: 88 (21%)
- Medical Wards: 74 (18%)
- Surgical Wards: 67 (17%)



Most referrals to ICU have originated in the Emergency Department (36%). They represent a mixed group of patients (ED, medical, surgical & paediatric), not simply patients referred by the ED team.
The most frequent source of medical referral was CCU (7% of overall total) whilst amongst the surgical referrals ward 29 was the most frequent (10% of total).

Reasons for referrals

- Admission to the unit: 201 (50%)
- Review of patients: 68 (17%)
- Emergency call-out (777 & trauma calls): 43 (11%)
- Planned admission after elective surgical procedure: 3 (1%)
- "Just to let you know": 39 (10 %)
- Advice: 16 (4%)
- Vascular access: 14 (7%)



The majority of the referrals were requests for admission to the unit (50%). A further 17% were requests for review of patients and 11 % were emergency calls (777 & trauma calls). 1% were planned admissions after complex surgical procedures.

10 % of referrals were "Just to let you know" calls. Teams sometimes wish ICU to know about patients on the ward who have the potential to deteriorate to the point of requiring HDU/ICU care. These are not requests for review but some patients are not infrequently assessed by ICU in order to determine their suitability as ICU candidates.

An appreciable number of referrals (7%) are requests for vascular access, either peripheral or central access. This is an ongoing area of frustration where the ICU SHO or even the ICU Consultant are seen as the first port of call in the delivery of this service, especially when Primary Team resources have not been optimally explored.

Total admissions and admission rate

A total of 233 patients were admitted to ICU during this period. By comparison, over the same period in 2011 a total of 214 patients were admitted. This represents an increase of approximately 9%.

If we only consider the referrals in which the request for admission is either stated directly or implied (request for review, 777 & trauma calls, elective surgical procedure) then the total number of admission requests becomes 315. With a total number of admissions to the unit of 233 this represents a proportion of 74% admissions out of all admission requests. We regard this as a high admission rate.

Declined Admissions

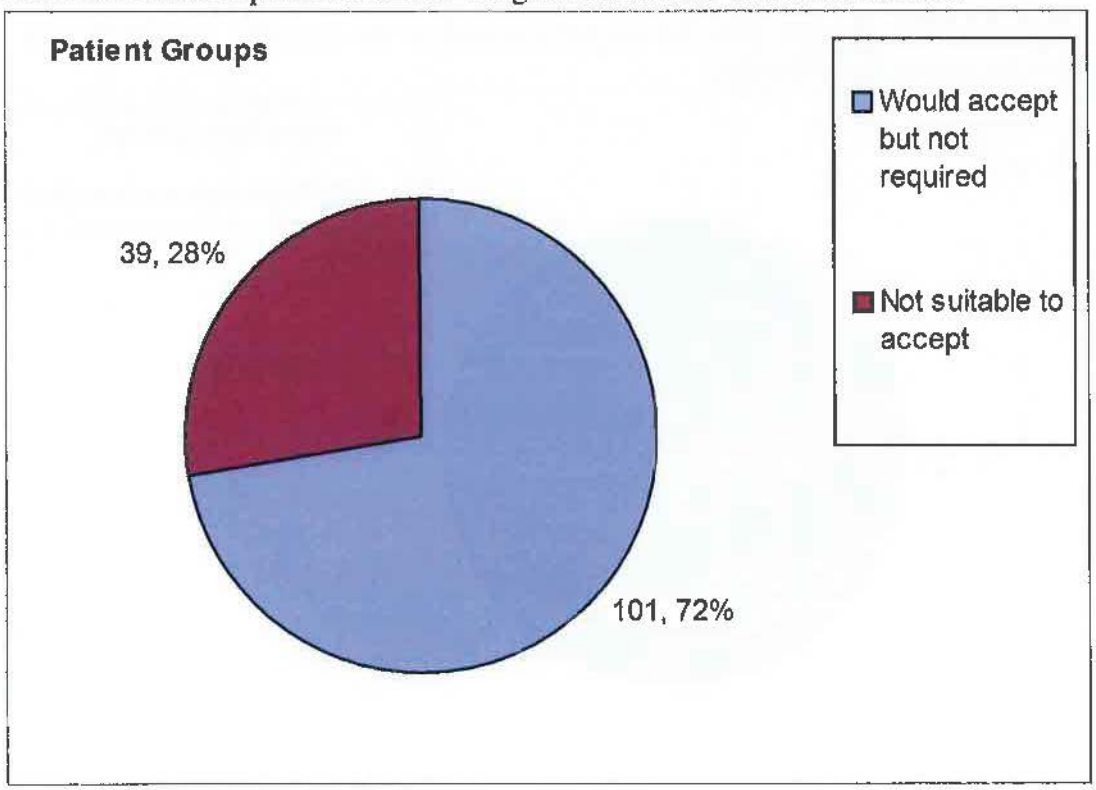
A total of 140 referrals did not result in admission to the unit. This number excludes the requests for IV access but does include "Just to let you know" referrals and requests for advice.

Reasons for declined admissions

We separated the declined admissions into 2 groups:

- **Would accept but not required**: these patients were considered safe to manage outside of ICU. They required no organ support and no further increase in their level of monitoring. Some received advice and/or treatment and some were reviewed again by the ICU team to assess progress.
- **Not suitable to accept**: these were patients with significant co-morbidities and poor functional status for whom escalation of treatment was deemed non-beneficial.

Overall, 28% of declined admissions were for patients for whom escalation of treatment was not thought to be beneficial. This is a large number and indicates that end-of-life discussions and NFR status are either not addressed appropriately on admission to the hospital or deferred altogether until ICU team involvement.

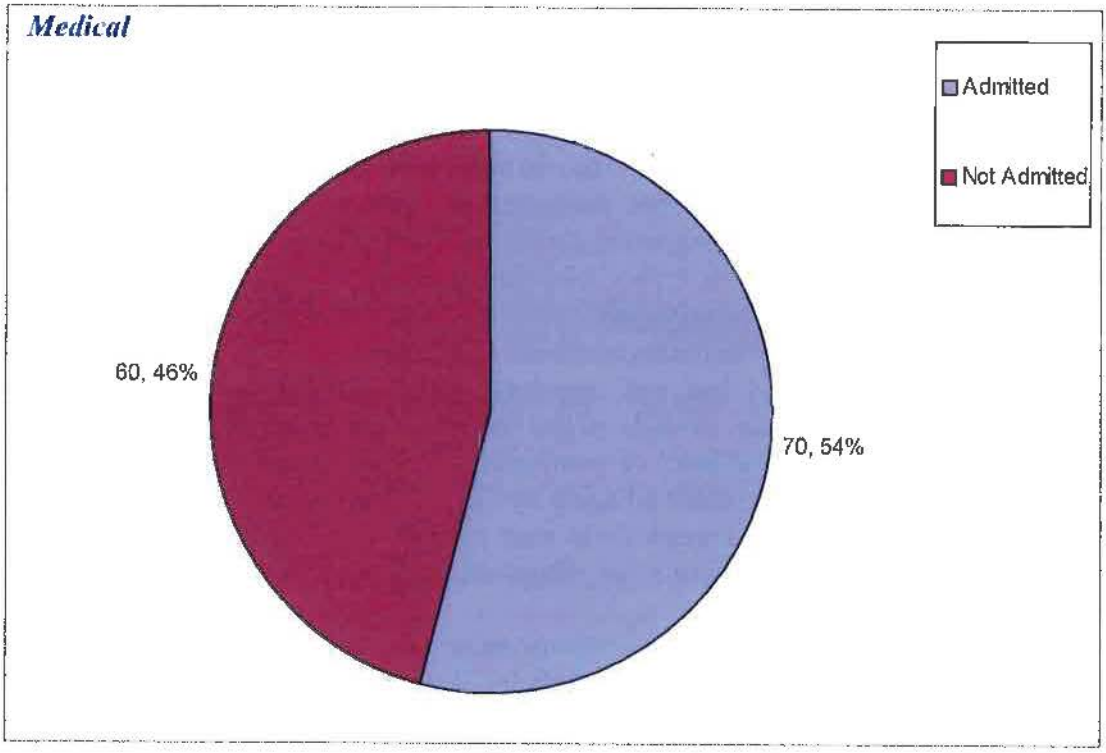


Admissions/Declined admissions – breakdown according to teams

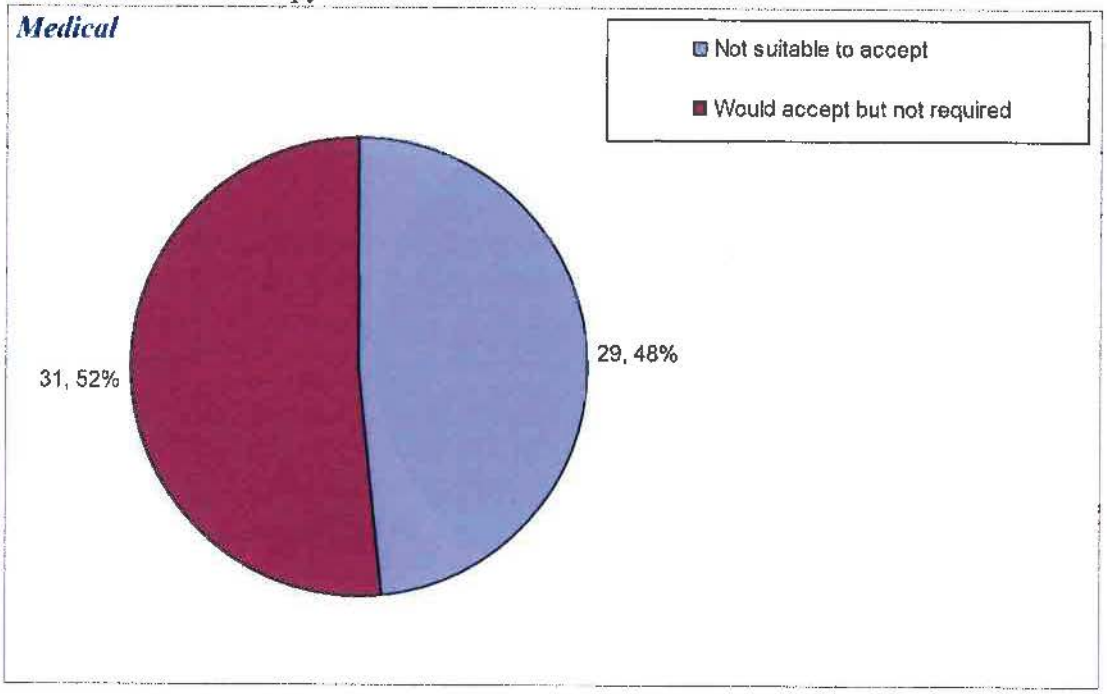
We grouped patients into Medical, Surgical and Paediatric patients. We analyzed for each group the proportion of patients admitted and the reasons for declining admission.

Medical patients

A total of 130 medical patients were referred to the unit. 54% of these were admitted.

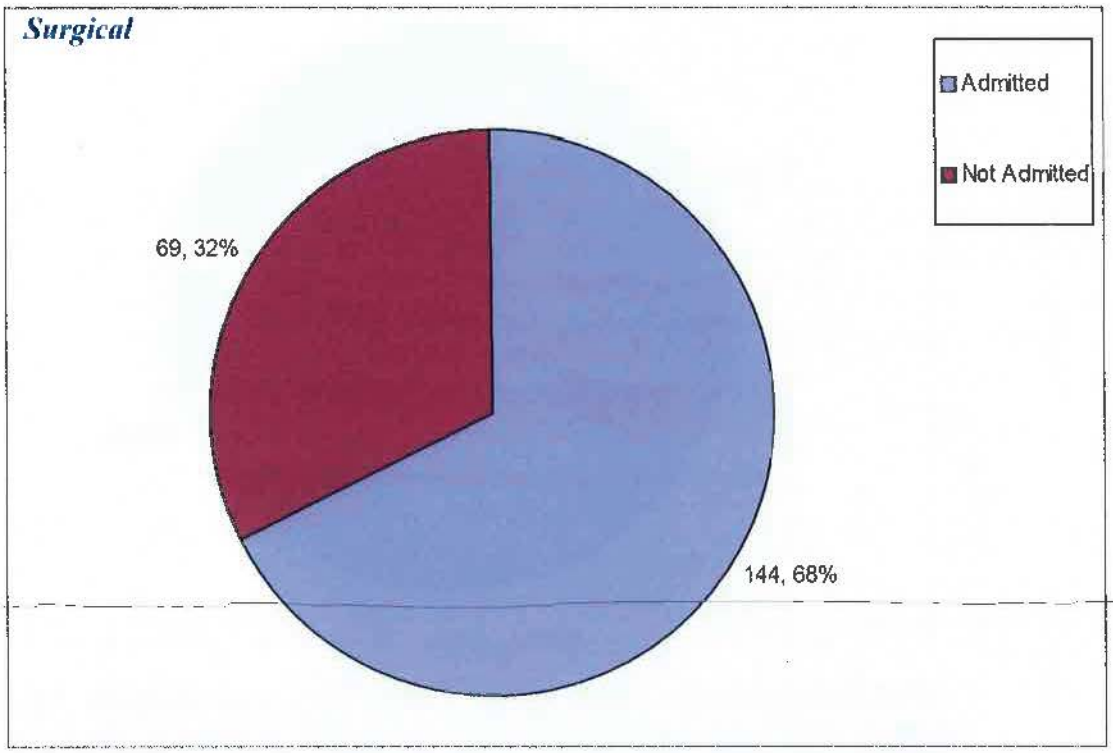


Out of the medical patients who did not get admitted to the unit 48% were found not suitable for escalation of therapy.

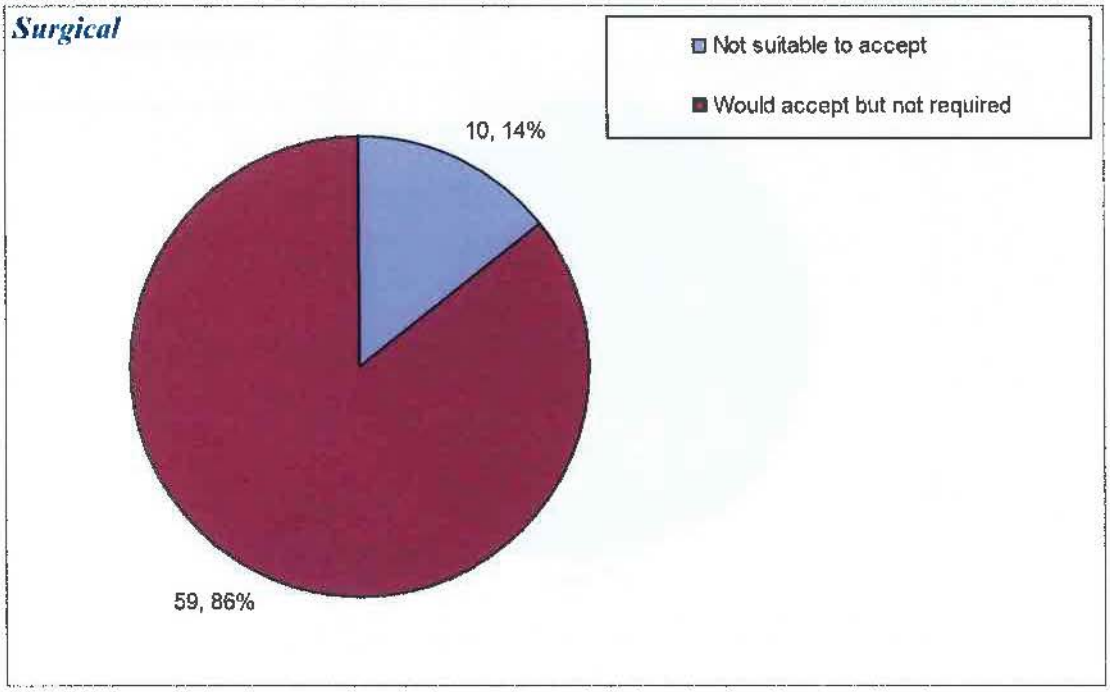


Surgical patients

A total of 213 surgical patients were referred to the unit. They included General Surgical, Urology, Orthopedic, O&G and ENT patients. 68% of them were admitted. This high rate of admission is partly explained by the Surgical HDU function that had been established.

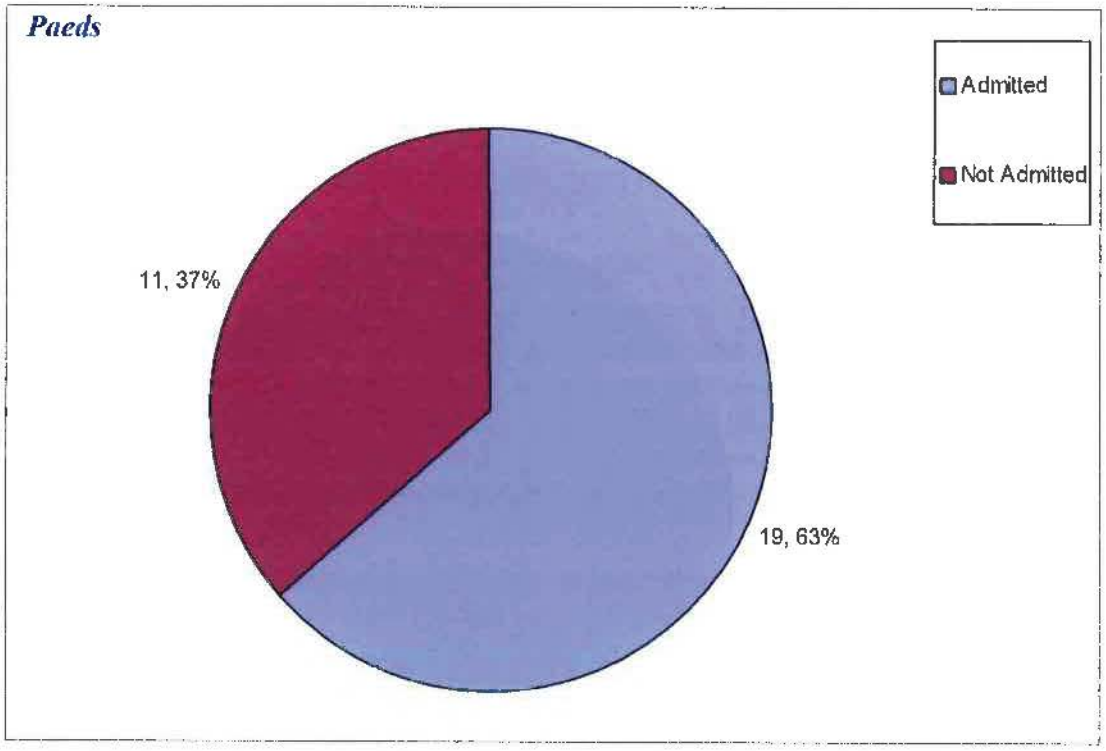


Out of the patients not admitted 14% were found not suitable to accept for ICU admission.

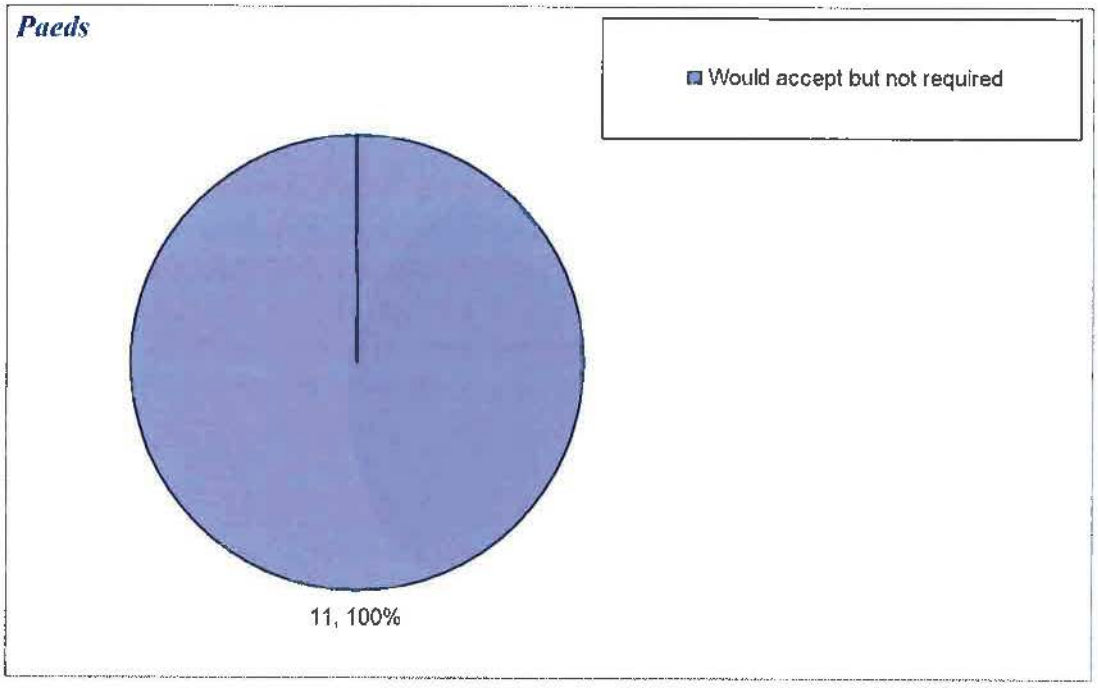


Paediatric patients

These were patients 16 years old or younger.



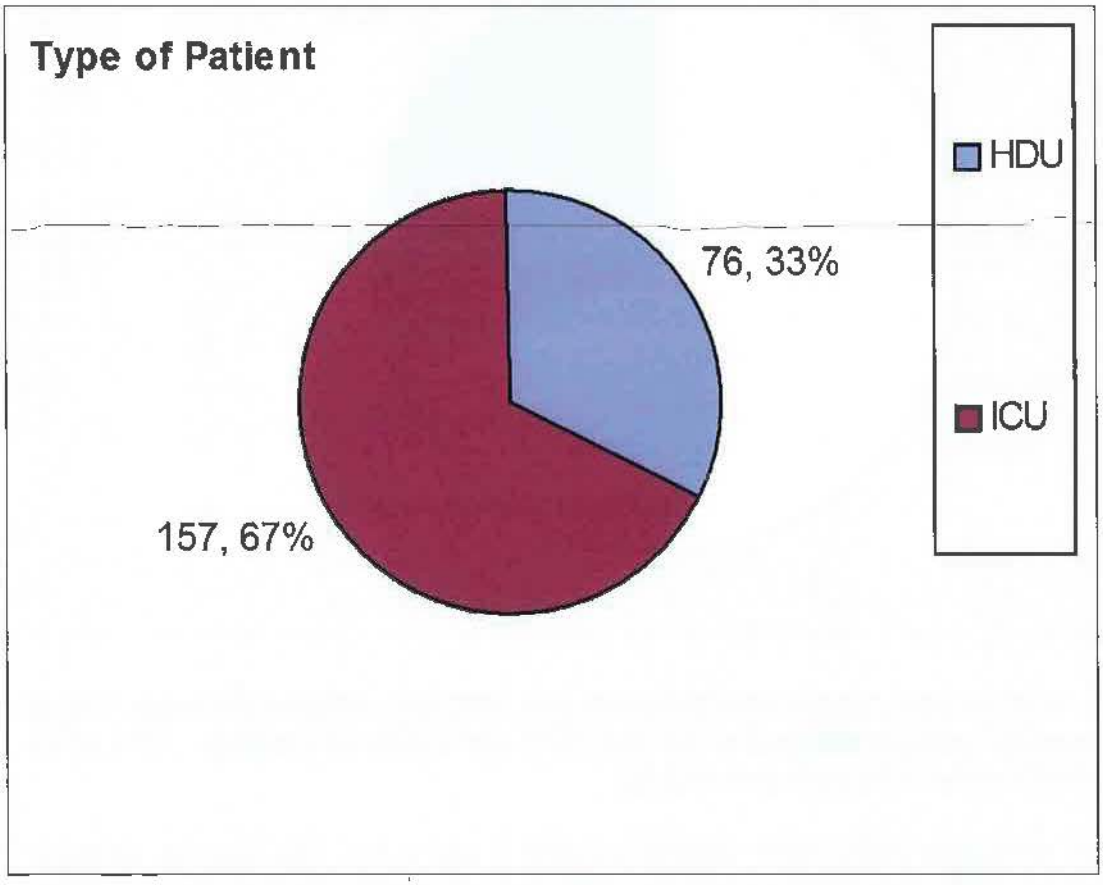
30 paediatric patients were referred to ICU. 63% were admitted. All of the patients that were not admitted were considered appropriate candidates for admission had their clinical situation required it.



Type of patients admitted – level of therapy

67 % of patients admitted to the unit required **"ICU-level" care** – these were patients that required some form of organ support: intubation and ventilation, invasive monitoring, vasoactive support, renal replacement therapy.

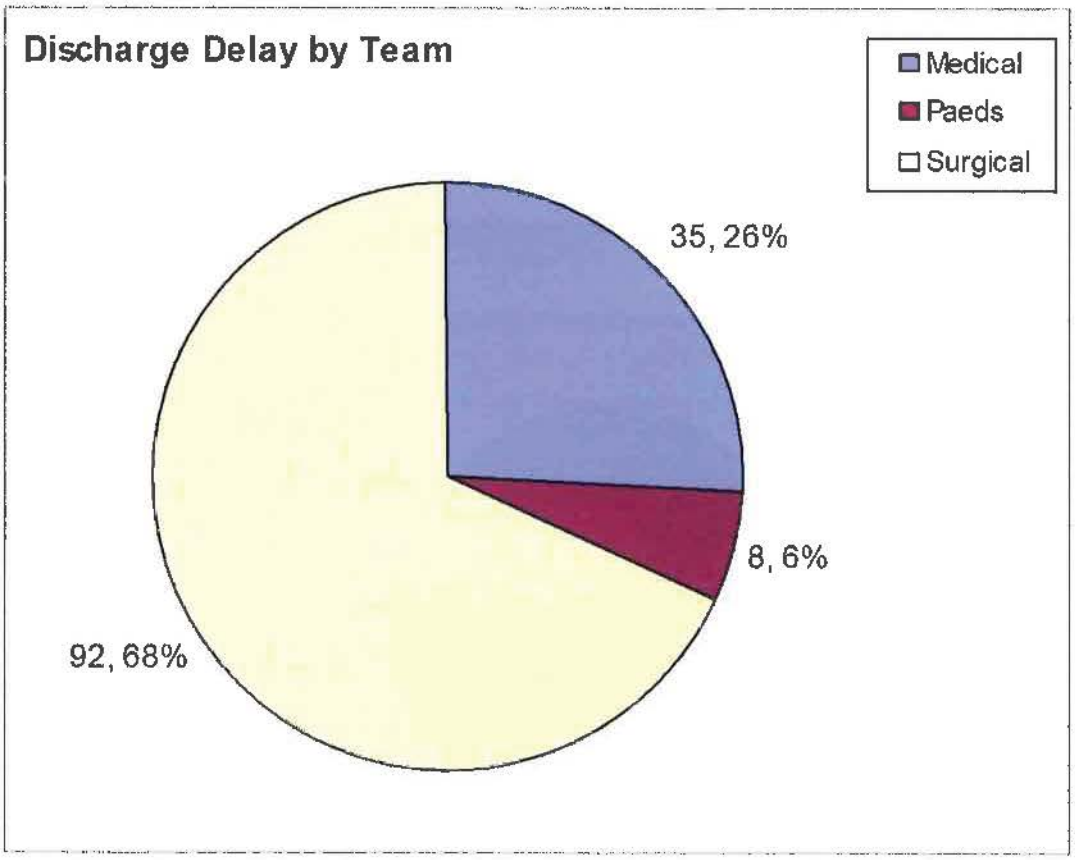
33 % of patients admitted to the unit required **"HDU-level" care** – these were patients that did not require invasive organ support rather were thought to benefit from a higher level of monitoring and medical supervision. This is significant component of HDU/intermediate care delivered by the unit. The majority of these patients were surgical patients (83%) in their immediate post-operative period. Some of these patients were medical patients (9%) admitted for closer monitoring and timely escalation of therapy if required. 8% were paediatric patients.



Discharge delay

After the ICU ward-round, which generally finishes by 0900 hrs, the decision to discharge is conveyed. A discharge was considered to be delayed if it occurred after 1200 hrs on the day of the discharge decision being made. This allowed a further 3 hrs for the discharge to be achieved.

74% of all discharges were delayed. The majority of delays (68%) were associated with surgical patients.



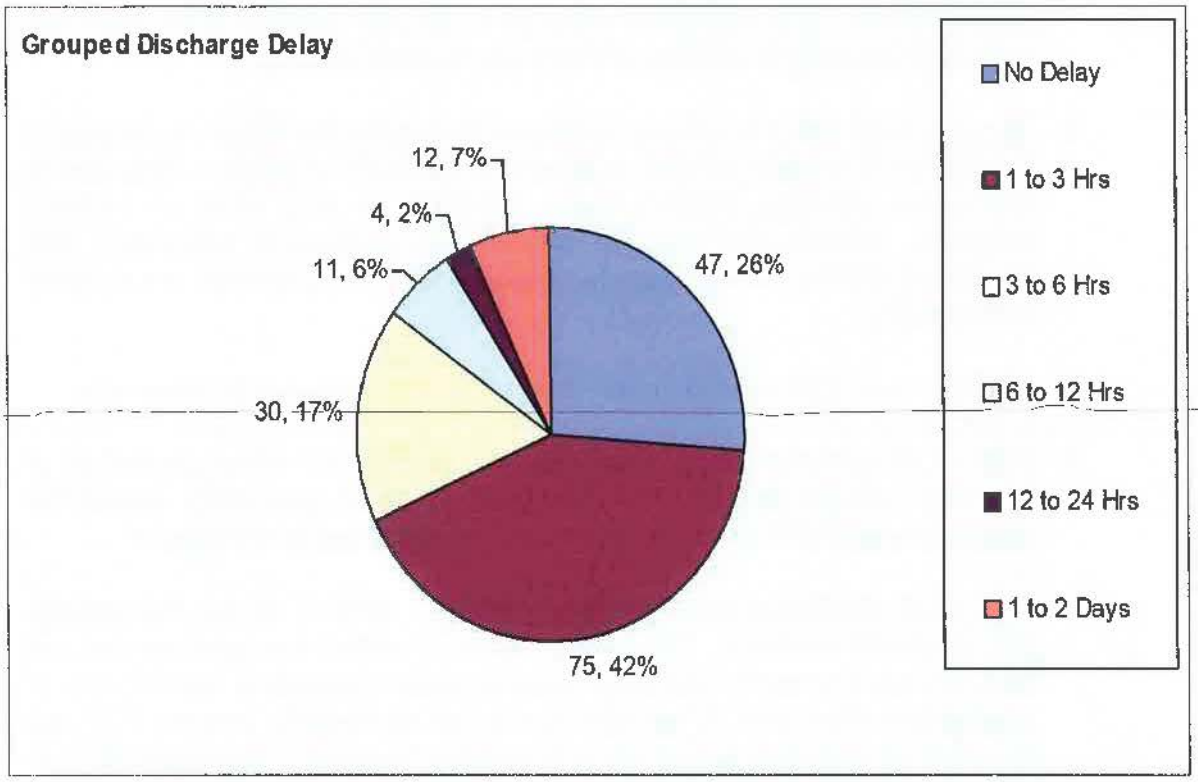
Out of all surgical patients admitted to the unit 64% had a delayed discharge. Out of all medical patients admitted to the unit 50% had a delayed discharge. 42% of all paediatric admissions were also delayed.

Most discharges (42%) were delayed between 1 and 3 hrs. This interval, although relatively brief, does interfere with the daily flow of patients through the unit. If the decision to discharge is made at 0900 hrs and the patient only leaves the unit at 15.00 hrs that particular ICU bed will have been unavailable for an emergency admission or for an elective admission from theatre. It will lead to delay in the initiation of specific ICU therapy for the emergency admission or prolonged PACU stay for the elective admission.

Even more concerning are the discharges that are delayed between 3 and 6 hrs (17%) and between 6 and 12 hrs (6%). Ideally a discharge from ICU should be an elective process occurring during working hours. If the discharge happens at or after 18.00 hrs

this is associated with the increased risk of a patient being received into a ward with less medical supervision and the ability for assessment. If the discharge only happens because an emergency has occurred and an ICU bed is immediately required this creates 2 problems: one for the patient being discharged who needs to be accepted into a ward at short notice; and the second for the in-coming patient whose specific ICU therapy might be delayed.

A significant number of discharges (9%) are delayed between 12 and 48 hrs. This represents an unacceptable block in the overall flow of patients.



Conclusions

1. The total ICU throughput has increased. In 2011 there were a total of 406 admissions which represents a 25 % increase over the average total admissions of the preceding 10 years. This audit has also detected a further increase in admissions of 9% for the period studied this year compared with the same period in 2011. This is a large increase in workload and has been accommodated without any increase in resources.

2. Most of the increase in throughput is related to the establishment of a Surgical HDU function. 33% of patients admitted to the unit required HDU level care only with the majority of these (83%) being surgical patients.

3. The improved efficiency is also explained by a collective desire on the part of the ICU staff to apply modern principles of critical care practice. Specifically this means reducing sedation doses, reducing the time spent on sedative infusions, waking and weaning patients off mechanical ventilation and extubating earlier. The ICU stay is shortened with improvements in morbidity and mortality.

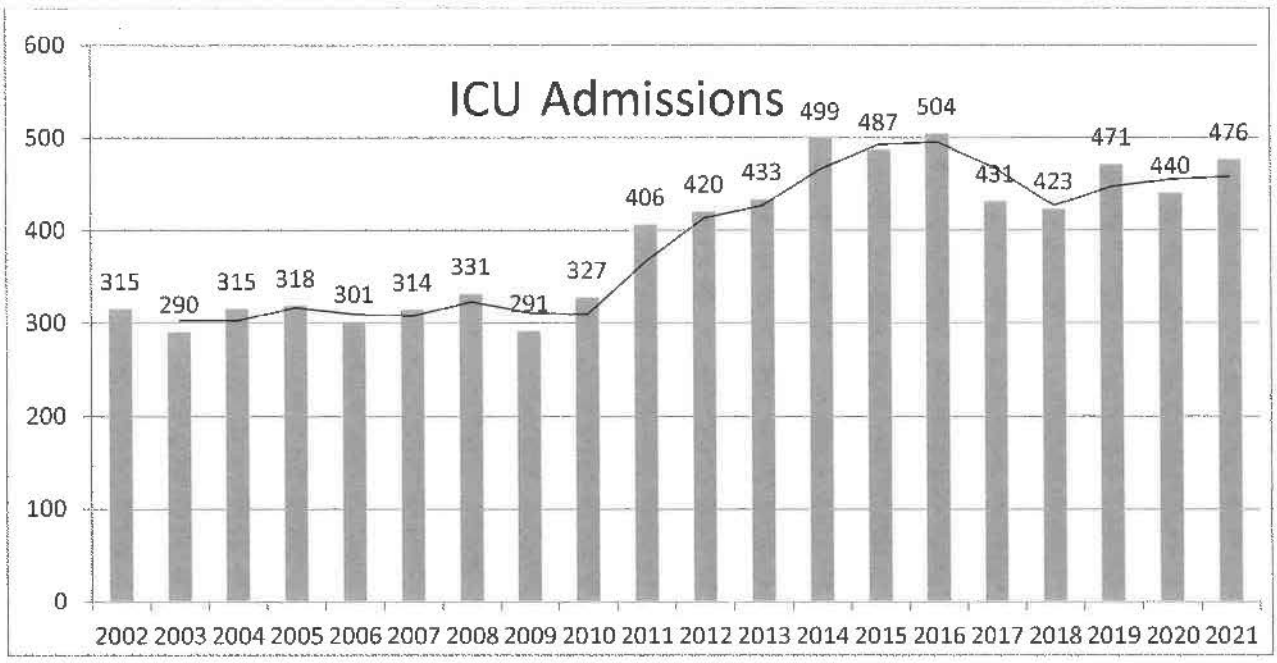
4. The unit has a high admission rate: 74% of all referrals result in admission.

5. 28% of all declined admissions were for patients for whom escalation of treatment was not thought to be beneficial. A better approach to end-of-life discussions and NFR status needs to occur on admission to the hospital.

6. 74% of all discharges from ICU were delayed. 64% of all surgical patients had a delayed discharge. This is one aspect of patient management that can lead, if treated correctly, to further gains in patient throughput and delivery of intermediate-level care. It can lead to a better relationship between ICU and the other services that depend on it. It needs to be stressed though that ICU is only one component of a multi-faceted system. The other components of the system need to change for the improvements to occur. Simply increasing ICU physical capacity will not be enough. Without a more responsive and efficient discharge mechanism even a larger ICU will fill up and become bed-blocked as the wards do not adjust in parallel with the increase in ICU size.

We would like to thank all ICU staff for ensuring that referrals were logged onto the audit forms.
This report was written by [redacted]

We would particularly like to thank [redacted] for creating the electronic database and compiling the information required for writing this report.


ICU Admissions
600
500
400
300
200
100
0
315
290
315
318
301
314
331
291
327
406
420
433
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487
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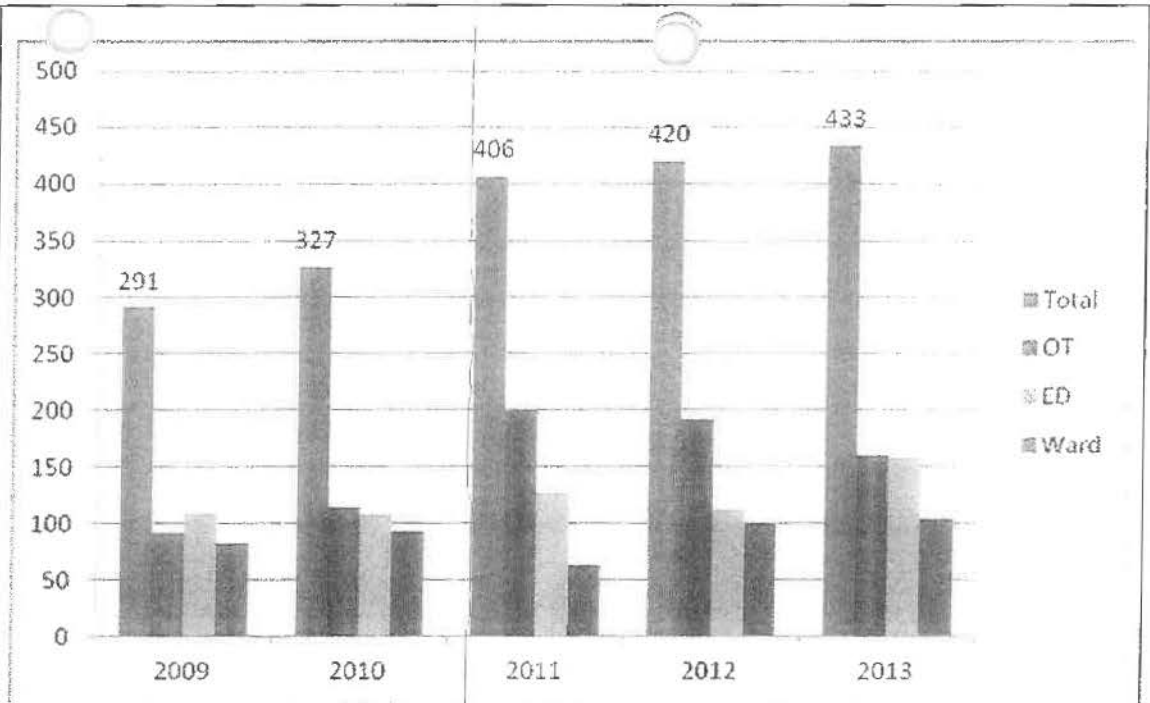
440
476
2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021

Report to the MDT 3 Clinical Council - Progress on Recommendations Following the Medical Credentialing (or Re-credentialing) of the ICU Service Held on 20th November 2017

FILE

Recommendation	Progress	Date for Completion
That a meeting of stakeholders (Medical Head ICU, Future Medical Head ICU, Charge Nurse ICU, Service Manager ICU, Clinical Director Anaesthesia and ICU, Clinical Director Internal Medicine, and Clinical Director Surgery at least) be convened to further discuss and agree on current admission and discharge policy.	This meeting and further discussions took place and an understanding of the role the Intensive Care Unit plays for the organization at large was reached. We reassured both surgical and medical directorates that all patients deemed fit for escalation of therapy to a higher level than the ward environment can provide should be referred to ICU. ICU will be able to provide care for all critically ill patients – this care will not be limited to provision of ICU-level-only invasive support (monitoring, circulatory, respiratory and renal support) but will also entail intermediate level, HDU-level support for both surgical and medical patients. We also clarified the role and the interplay between ICU and the de-facto Medical HDU of the institution (currently still called CCU despite its much larger scope) – we committed to ensuring that this space remains purely medical and, unlike previously, surgical or trauma patients will not be admitted to CCU but will come to ICU. We recognized the importance of CCU as a potential intermediate step both as a "step-up" to ICU of patients initially managed by the medical teams who fail to improve; and as a "step-down" from ICU in situations in which the usual progression to ward-level care can't be completed due to, for example, a high demand for ICU beds. A robust system for identification of high-risk surgical patient that would benefit from HDU care post-operatively was set up. These patients are flagged during the Anaesthesia Clinic review and discussed with ICU. Clear parameters for post-operative care are established including prospective limitations in case of continued physiological deterioration. On the day of surgery ICU is contacted to make sure a post-operative bed is available. This ensures capacity exists before surgery proceeds and avoids situations where unstable patients have prolonged (including overnight) PACU stays. This system has worked very well and together with the faster turnover of patients through ICU has resulted in very few elective surgeries being cancelled due solely to lack of ICU beds.	Completed November 2017 [redacted]
That a similar small group of stakeholders under the chairmanship of the Chief Medical Officer receive and consider the first three month figures from the	Progress on these meetings has previously been presented about 1 year after the recommendation had been put forward. One of the issues raised at the time was the need to acknowledge the limited resource the ICU capacity represents and as a result	

current audit. This group should then again consider how high dependency care can be improved. If expansion of resourced beds within ICU is still considered the best interim, partial solution, then the case for this to occur without such a loss of resource from CCU must be compellingly put to SMT	to prioritize the discharge of patients from ICU in order to mitigate the risk of emergency discharges after-hours (one of the findings of the 12 month ICU audit was the fact that a large proportion of discharges from ICU occurred after-hours). A traffic-light system to be used in conjunction with the HAAG screen was suggested as a means of flagging waiting times and priority for discharges from ICU. This system did not materialize. However, despite the fact that discharges continue to happen in a "delayed" fashion we feel that the situation has improved overall and there is a better appreciation of the need to discharge ICU patients in-hours. The ICU through-put continued to increase (see graphs bellow in the report) and in 2014 new financial resources were put in place to ensure expansion of the nursing FTE. The initial proposal was for 6/6/6 cover (6 nurses for each 8 hr shift). However, ICU medical and nursing staff considered the proposal and decided that an increase to 5/5/5 cover only was sufficient. This nursing structure has continued to the present time with good effect.	Completed November 2017 [redacted]
That the Medical Head ICU, Charge Nurse ICU and Service Manager/ Nursing Director ICU meet regularly.	[redacted] and [redacted] have regular meetings. The Medical Head, Service Manager and Charge Nurse have a formal, monthly meeting as part of the ICU/Anaesthesia Governance structure.	Completed November 2017 [redacted]
That if the seismic survey identifies a need to relocate ICU within an identified time frame, a group be convened to agree on the longer term delivery of intensive care and high dependency care at MCH, and assist in facility design.	Extensive feed-back has been provided during 2 separate reviews (Sapere and Destravis groups). During the development of the Master Plan we have highlighted multiple issues relating to the current make-up of the clinical space of the unit and how these would have to be addressed to achieve a minimum expected standard for a future unit. We have also provided forecasting and a description of the Model of Care to help future planning. Given how strongly we feel about the current model of care and how essential it would be for this model to be protected and retained in any future re-build we included these issues in this report: **MASTER SERVICE PLAN – INTENSIVE CARE UNIT** <u>FORECASTING</u> Based on current trends we expect the number of admissions to the Intensive Care Unit to continue to rise. As shown bellow, the total number of admissions per year has increased steadily for the past 5 years. In 2013 there were approximately 40 % more admissions compared to 5 years ago.	Completed November 2017 [redacted]



5 years of ICU admissions

There are several reasons for this increase in number of admissions. One reason is the establishment in 2010 of a "Surgical HDU" function which resulted in more surgical patients being admitted to the unit post-operatively. At the same time, there has been a steady increase in admissions both from ED and from the ward. Currently 40-45% of patients are admitted from theatre, 30-35% from ED and 25% from the ward. Approximately 65% of patients required "ICU-level" care (invasive monitoring & organ support) and 35% required "HDU-level" care (no invasive organ support but required higher level of monitoring and clinical supervision). The majority (83%) of the "HDU-level" patients were surgical patients.

The current trend is set to continue given the following factors:

1. Population growth
2. Aging population
3. Increased need for medical HDU-level care
4. Regionalisation of cancer and surgical treatment
5. Greater complexity of surgical treatment with increased need for surgical HDU-level care

The current capacity of the unit is 6 clinical beds (plus one side-room). We anticipate the need to increase the capacity to 10-12 beds to meet the increased demand forecasted for the next 20 years.

SERVICE MODEL

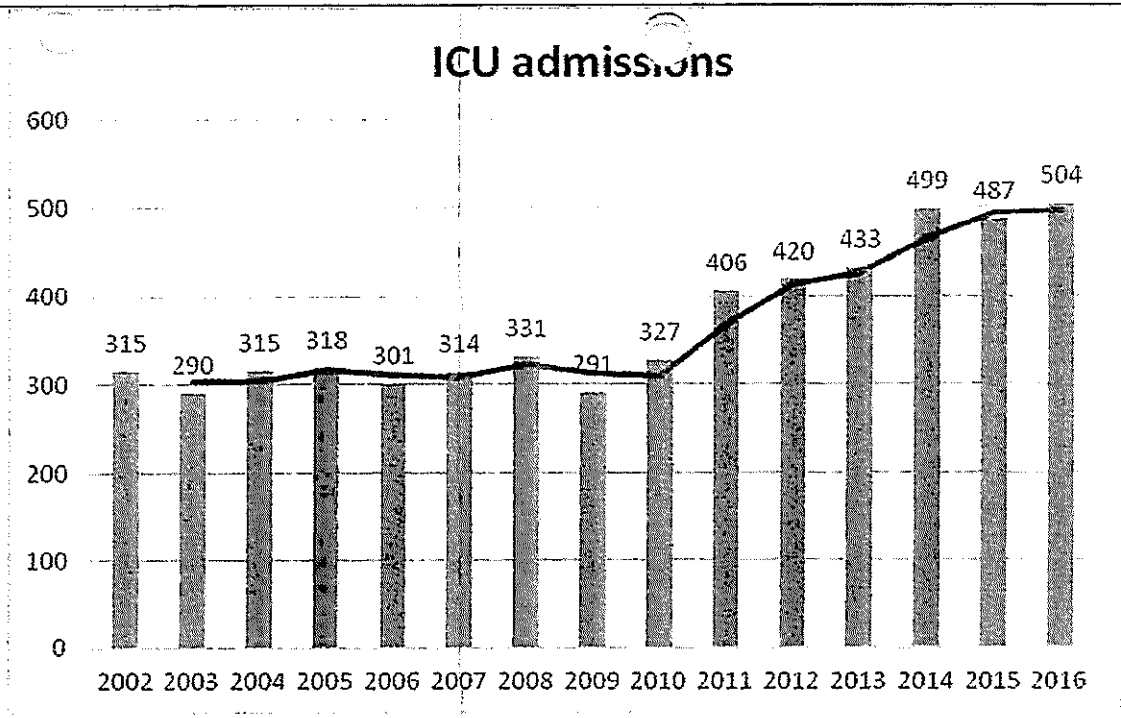
As a clinical model the ICU is a "closed" unit, run by ICU Consultants. The ICU team has the primary role in the delivery of critical care and the ICU Consultant has overall responsibility for the outcome of patients admitted to the unit. This is the model of care proposed and supported by the Australasian College of Intensive Care Medicine.

Currently the Intensive Care Unit is physically separated from the de facto Medical HDU of the institution which is co-located with the CCU on the 4th floor. We would like to emphasise the fact that when we forecasted the increased demand and the need for enlarging the capacity of the ICU for the next 20 years, we have assumed the continued presence and function of a similar service (Medical HDU) running at equivalent capacity as today.

Therefore we would like the current structure to be replicated in a future rebuild. Ideally, the 2 units should be located adjacently on the same floor, but with a clear physical separation between them. This would ensure the continuation of the "closed" model for the Intensive Care Unit while allowing better access to review deteriorating patients in the Medical HDU.

2017 UPDATE

As seen from the last 3 years, the trend indentified in the previous graph continues.



It is therefore crucial for the issues highlighted above during the Sapere review to remain priorities for any future re-development.

VISITS TO OTHER UNITS/NEW FACILITY DESIGN

A number of visits to New Zealand units (Wellington Regional Hospital, Hutt Hospital) and Australian units (The Alfred) were done to assess contemporary facility designs.

A draft proposal for a new unit design was presented during the Sapere review (see attached document).

That definite proposals for the nurse run follow–up service and outreach service be presented.	The possibility of setting up an outreach service was discussed at several stages during the last 5 years. No definite proposals were developed. Overall there was apprehension on the part of the nursing staff to pursue this. Some of the reasons for this included insufficient confidence related to recent recruitment of junior staff . At present we do not feel that this is a pressing issue that requires an immediate solution. If the need arises or interest develops in-house we will revisit the situation.	Completed November 2017 [redacted]

That ICU staff decide whether to pursue approval for advanced training with CICM. If so, a list of probable necessary changes needs to be compiled. Implementation should then be considered by the Medical Head, Clinical Director Anaesthesia and ICU, Service Manager, and Operations Director Hospital Services.	The College of Intensive Care Medicine currently accredits Palmerston North ICU as Basic Training and also as a Rural rotation which can be done as part of the Core Training for CICM Trainees. After reviewing 5 years of ICU admissions characteristics we feel that this classification is appropriate and sufficient. There is no scope for pursuing accreditation for Advanced CICM training at this stage.	Completed November 2017 [redacted]

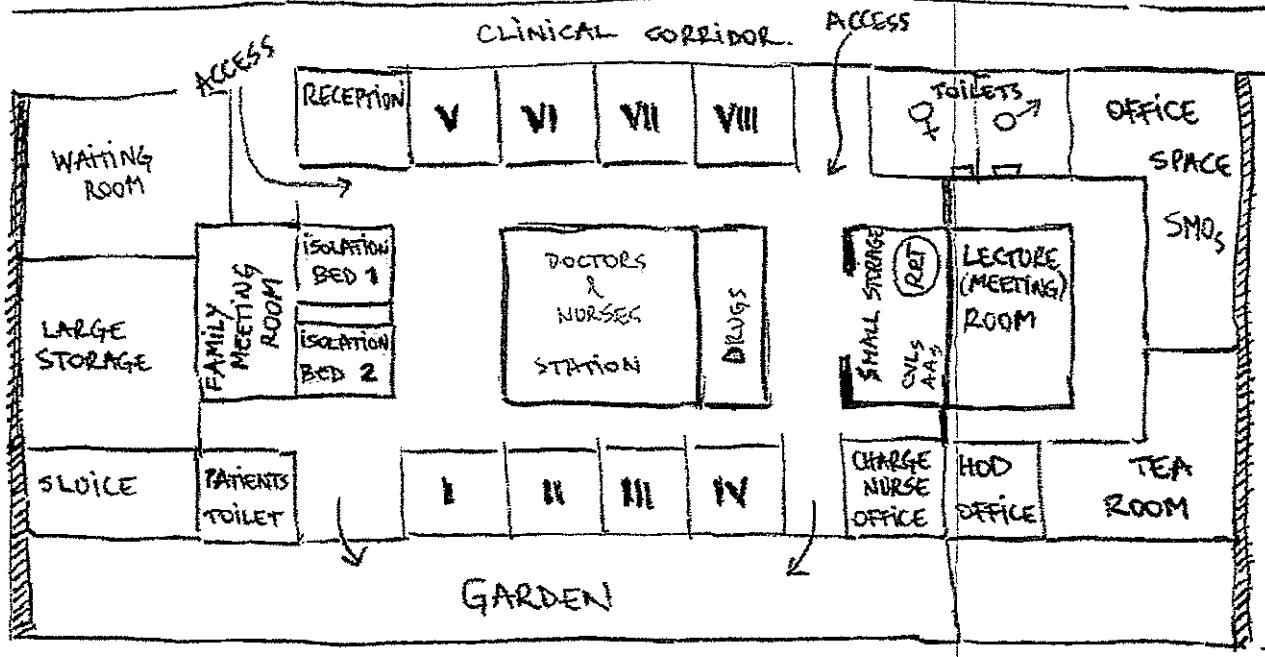
Signed jointly by:

[redacted]

Operations Director

[redacted]

Clinical Director/Medical Head



? MAPU / HDU / CCU

ICU BEDS - 10 (8 REGULAR + 2 ISOLATION)

HDU/CCU SHOULD BE PHYSICALLY SEPARATED FROM ICU
&
SHOULD RETAIN AT LEAST ITS CURRENT BED CAPACITY (6)

DRAFT FUTURE DEVELOPMENT ICU

[redacted]

31 October 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-840 – Number of inpatient beds at Palmerston North Hospital

Dear [redacted]

This response is to your Official Information Act 1982 requesting information on the number of beds at Palmerston North Hospital. The request was then clarified to be the number of *inpatient* beds at Palmerston North Hospital. Health New Zealand Te Pae Hauora o Ruahine o Tararua | MidCentral (previously MidCentral District Health Board) responds as follows:

- The number of inpatient beds at Palmerston North Hospital is 345 which is inclusive of mental health and all specialised areas, eg CCU (cardiac coronary unit) etc.

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 website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North, 4440
06 350 8061

27 October 2022

Te Whatu Ora
Health New Zealand

[redacted]

Ref: OIA Y22-843 – New Mental Health Ward

Dear [redacted]

In response to your Official Information Act 1982 requesting information on the new acute mental health unit, Health New Zealand Te Pae Hauora o Ruahine o Tararua | MidCentral (previously MidCentral District Health Board) responds as follows:

1. *If building has started on the promised mental health ward at Palmerston North Hospital?*

   The construction process has commenced with site clearance work nearing completion and the initial site survey by the construction contractor.

2. *If building has started, when will it be completed by?*

   The full construction programme is still under development.

3. *If building has not begun, what is the reason?*

   Please refer above.

4. *How many beds is it proposed to have?*

   The unit will have 28 beds and 2 low stimulus suites.

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 website ten working days after your receipt of this response.

Yours sincerely

Neil Wanden
General Manager, Finance & Corporate Services

TeWhatuOra.govt.nz
PO Box 2056, Palmerston North, 4440
06 350 8061