NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

24 August 2011

Mr Anthony Hill
Health & Disability Commissioner
PO Box 1791
AUCKLAND

Dear Mr Hill,

Re : Case

One of the recommendations you made in your report on this case was that "ADHB contract an independent reviewer to critically appraise the appropriateness of the changes made to the services as a result of the recommendations arising from the 2007/2008 reviews, in particular :

- Discharge protocol
- Interface between the adult acute inpatient unit and the CMHS regarding discharge planning
- Interface between mental health and addiction services
- Inpatient management model
- Observation procedures
- Criteria for triggering complex case review
- Training for senior medical and nursing staff regarding diagnosis assessment and management of clients with co-morbid substance use disorders, and
- Adult acute inpatient leadership."

I have undertaken this review for ADHB and at the request of ADHB I am providing the following report directly to you. The Terms of Reference for my review were as outlined in your recommendation above.

Background

I undertook an external review in July 2007 of the ADHB Mental Health Services in relation to the management of the patient referred to as in your report on this case. The recommendations I made then are amongst those to which you refer, so it was thought that I would be an appropriate reviewer to evaluate changes made since then. I am currently employed as Chief Medical Advisor, and was previously the Clinical Director of Mental Health Services, at Northland District Health Board.

Written information available to me has included :

- Your report in relation to case C09HDC01156.
- My July 2007 external review report.
- The following documents provided by ADHB -

HEALTH ADVISORY SERVICE Phone: (09) 430 4100 - Fax: (09) 430 4110 - Maunu Road, PO Box 742, Whangarei, New Zealand

1. Mental Health Service Improvement Group Terms of Reference and examples of minutes
2. Mental Health Service Improvement Plan Projects/Workstreams update : July 2011
3. Recommendations update : July 2011
4. Mental Health Service Improvement Plan Review/Update : July 2011
5. Adult Service Continuum Service Improvement Action Plan 2010-11
6. TWT/CMHS Core Clinical Systems and Transition Pathway 2009
7. Decision Document : TWT Care Coordinator and Social Work roles : July 2011
8. TWT Nursing checklist, discharge : in use May 2011
9. TWT admission/discharge checklist for Care Coordinators : in use May 2011
10. TWT admission/discharge checklist in use in 2009
11. Mental Health Policy : Increase Observation
12. Mental Health Policy : Service Users of Concern/High Risk (currently under review)
13. Mental health Policy : Observations – Physical – Te Whetu Tawera
14. Scoping document for MH wide High and Complex Needs meeting
15. ADHB HSG Organisation Charts
16. Explanation of Te Whetu Tawera clinical/management leadership model
17. TWT Quality meeting minutes
18. TWT Clinical Governance meeting minutes
19. Collaborative Review meeting

In addition, I conducted face-to-face interviews at ADHB on 18 August 2011 with the following groups of staff :

1. ADHB Mental Health Service leaders
2. Te Whetu Tawera Consultant Psychiatrists
3. Te Whetu Tawera Leadership Group
4. Te Whetu Tawera Charge Nurses
5. Te Whetu Tawera Nurse Educators
6. Te Whetu Tawera nurses

7. Community/Liaison Service Consultant Psychiatrists

I also spoke on the telephone with , on 22 August 2011. All staff appeared to speak openly and willingly and to offer thoughtful opinions. Those spoken with included a mix of staff who had been working in the service since 2007 or earlier and more recent recruits. There were no significant inconsistencies in the information provided to me by the different staff groups.

Findings

A. General Observations

There has been a striking change for the better in the treatment culture and practices at ADHB in the four years since my previous review. Standards of care are much clearer and higher, there is much greater acceptance by staff of the responsibility they have to meet the needs of the people they treat, and there is ongoing evaluation of the service provided.

B. Discharge Protocol

Transition planning has been undertaken and the concept of a continuum of care has been embedded, leading to development of a transition pathway and discharge checklists. Discharge planning for individual patients starts on admission. Patients are no longer ever discharged to homelessness, which is a major change. Substantial effort is put into obtaining suitable accommodation to meet the needs of individuals, and to ensuring that patients are well enough to be looked after in the community before discharge, even if this delays discharge substantially. As a consequence, and as evidence for this, the unit now has a relatively long average length of stay but this is offset by a low readmission rate and the greatest drop in HONOS score over the course of inpatient admissions by comparison with other mental health services around New Zealand, indicating that both the inpatient care and subsequent community placement are particularly successful.

C. Interface between the adult acute inpatient unit and the CMHS regarding discharge planning

This has improved in several respects. There has been increased transition planning as noted above. Community team staff and inpatient (Te Whetu Tawera) team staff are no longer in open conflict with one another and the relationship is described as respectful and collaborative by staff from both settings. There is now an Assertive Community Outreach Team, and staff from this team are actively involved in liaising with the Te Whetu Tawera (TWT) staff whenever any of their patients are in the unit. Community-based psychiatrists and liaison psychiatrists now phone TWT psychiatrists much more readily than in the past to discuss cases, and find it much easier to get cases accepted for admission to TWT. Diagnostic and treatment approaches of community and TWT staff are much more aligned than they

used to be and community staff no longer find that patients are discharged without notice or that diagnoses and treatments are changed radically without explanation. Prior to discharge, follow-up arrangements are made and confirmed for all cases. Primary nurses in TWT are expected to link with relevant community team staff for an individual patient to ensure continuity of care. Handover documents have been improved. Rates of community follow-up within seven days of discharge are now above average by comparison with other DHBs.

There is scope for further improvement from the perspective of both community and TWT staff. For example, the quality of discharge documentation is variable, so community staff sometimes do not have an accurate and complete record of key information such as discharge medications when a patient returns to their care, although that has improved recently with the expectation of routine completion by medical staff of a medication module in the electronic record prior to discharge; TWT nursing staff find that making contact with some community team members can be very time-consuming, particularly since greater responsibility for this has been devolved to the nurses under the primary nursing model; community staff sometimes find that TWT staff have become so risk averse now that discharge is delayed unnecessarily while arrangements are perfected. However, there now appears to be sufficient trust and respect between community and inpatient teams for ongoing efforts to be made to identify the problems with transfer of care and to continuously improve the processes to address these. Enabling selected staff to undertake rotations between community and inpatient positions for a few weeks at a time might be useful in further developing mutual understanding and respect and generating ideas for improved transfer processes.

D. Interface between mental health and addiction services

There is an improved interface. A "Co-existing Disorders" project is underway and there are regular meetings by mental health clinical leaders with the Clinical Director of the regional addiction service, to engage in joint planning for service improvements. Liaison services are provided by addiction specialists to community mental health clinics.

E. Inpatient management model

This has changed substantially. Teamwork and consistency of practice have become much better established and respected. The recovery model is still an underpinning philosophy but the approach is now much more caring so that staff more actively take steps to ensure patients are safe and the capacity of patients to make decisions is now assessed routinely. Patients who have had experience of the unit over several years have told consumer advisors that they now feel staff listen to them and care about them to a much greater extent. Disrespect for patients is still observed occasionally but is seen now as a minority view which can be overcome by the wider unit culture.

Charge nurses and psychiatrists now undertake a morning handover together. Primary nursing has recently been introduced and primary nurses are expected to link with relevant community team staff for an individual patient to ensure continuity of care. A "Releasing Time to Care" programme has just commenced and will be rolled out through all wards in TWT over coming months. This is being received enthusiastically by staff and would be expected to generate further improvements in clinical standards, teamwork and efficiency.

Clinical record templates have been developed and nursing documentation in particular has become more comprehensive and standardised. Similar development of additional standard templates and quality expectations for documentation by medical staff may be useful. Nursing staff expressed some concern about the time the additional documentation takes,

although they see most of it as valuable - the "Releasing Time to Care" programme might provide an opportunity to review the documentation requirements to ensure that they are adequate and useful but not unnecessarily onerous.

The number of ICU beds has been increased from 8 to 12 and the nursing FTE increased accordingly. There is as a consequence less pressure to transfer patients out of ICU and this can be undertaken with greater planning and prior trials in the other sections of TWT. The entire inpatient unit is now locked and patients undergo careful evaluation before, during and after any leave. More information is provided to family or other caregivers prior to leave and more information is collected from them after leave. All patients are now checked hourly while in TWT (whereas it was previously only three times daily) and their possessions are checked on admission and on return from leave. While patients are on leave at home, they or their caregivers are phoned twice daily.

Co-existing alcohol and substance use disorders are not seen as a barrier to inpatient treatment and are addressed as health issues in need of treatment, rather than as behavioural problems to be viewed judgementally. Co-existing physical ill-health is also now actively assessed and treated by all staff with support from a specialist nurse educator and physician. Evening and weekend groups led by occupational therapists have been introduced and are seen as very useful. A sensory modulation room has been developed as an additional treatment modality and training in Dialectical Behaviour Therapy is being undertaken by some staff. Accommodation problems are always resolved prior to discharge, so that patients are never discharged to homelessness. Sexual activity within the unit is no longer tolerated and a vulnerable women's wing has been established. Use of seclusion has been reduced substantially and is now just below the national average. There is no plan at present to reduce it further or to eliminate its use, as is the case in some other mental health units, because it is seen as a useful component of safe management when used appropriately.

Use of medication is still somewhat variable amongst prescribers and there is a belief amongst some staff, both in the community and in TWT, that TWT doctors prescribe lower doses of medication than are required for safe management of acutely ill patients. This appears to contribute to a perception, which I was told was held by a small number of TWT staff and more community staff (but none of those I interviewed), that TWT is a dangerous environment. On the whole, this belief appears unwarranted and when community-based psychiatrists have come to work in TWT, as has occurred recently because of unexpected vacancies, they have been reassured to find that prescribing practices appear sound by comparison with the unit's reputation. Furthermore, seclusion is still being used when required. There was an increase in reported assaults some months ago, which was addressed and subsequently subsided, but there have not been serious staff injuries then or since. However, given the perception and especially the reported variability in practice, there would be value in further training for medical and nursing staff in best practice use of medication for inpatients and in implementation of standard treatment protocols, to increase expertise, reinforce confidence in that expertise and reduce variation.

F. Observation procedures

All patients are now checked hourly throughout their admission. Physical observations (temperature, heart rate, blood pressure, respiratory rate) are now done routinely on admission and at least daily throughout admission. The use of the Early Warning Score to detect and monitor physiologically unstable patients is currently being introduced. These observations have to be recorded, and are audited.

G. Criteria for triggering complex case review

There are now multiple forums in which complex cases are reviewed and various processes for triggering reviews. There is a protocol for Collaborative Review Meetings set up when there are cases or circumstances which involve significant or persistent concerns about safety, liaison between services, resource constraints or major legal, social or ethical issues. There is a clear process for setting up these review meetings, recording findings and making recommendations. The incident reporting and management culture is much more strongly embedded and incident reports are reviewed in staff meetings. Sentinel Incident Review Processes are undertaken when appropriate and Root Cause Analysis (RCA) is undertaken both for cases which meet Ministry of Health criteria for mandatory RCA and for other cases which lend themselves to a systems analysis. Forensic Liaison case review meetings also occur regularly and are attended by members of the Assertive Community Outreach Team and the regional forensic service. Staff from general or forensic services may nominate cases to be reviewed at these meetings.

H. Training for staff regarding diagnosis, assessment and management of clients with co-morbid substance use disorders

There is an ongoing "Co-existing Disorders" project which supports workforce development throughout the service. Dual diagnosis training available from the regional addiction service is now accessed regularly by staff (20 places are available every 4 months) and currently, for example, approximately 65% of the inpatient unit nursing staff have completed this. In addition, Ministry of Health (Matua Raki) training on brief interventions for substance use disorders was undertaken by staff in 2010. The additional training has resulted in improvements in staff skills and attitudes to management of co-morbid substance use disorders – for example, use of an alcohol withdrawal scale when indicated has now become routine, conversations about substance use are initiated with patients by staff and there is a proactive approach to preventing substance use by patients during admissions to Te Whetu Tawera, with regular environmental checks, and limits on access to the unit to keep out drug pedlars. The inpatient unit is now a "smoke-free" environment and this has proven to be a major challenge for all staff as well as patients. This is an ongoing issue but one which has reinforced the staff focus on understanding addiction issues and supporting patients to manage these.

I. Adult acute inpatient leadership

There has been an almost complete change in leadership personnel and there is general agreement that the new team provides much stronger and more respected leadership. In particular, the new Clinical Director of Te Whetu Tawera is well-respected and viewed as having established much clearer standards and support for high quality care. The nursing leadership is also seen as much more effective and the new role of Nurse Advisor for Te Whetu Tawera has reinforced the need to raise standards of nursing care.

Staff are expected to participate in much more ongoing professional development and more supervision and training is available. Primary nursing has been introduced and staff are seen as accountable for clinical outcomes. Staff competency issues are addressed actively and there are now nurse educators to ensure that individual training needs are recognised and addressed. The higher expectations of staff have led some to leave and have slowed recruitment to vacancies, as a policy of taking only staff who appear to have superior skills and professional attitudes has been pursued. The current level of TWT nursing vacancies (18) has placed pressure on existing staff but is still lower than at a peak (27) in 2010. It is hoped

that the strong emphasis on quality of staff will eventually lead to Te Whetu Tawera being viewed as a prestigious place to work, which should facilitate recruitment.

Several longstanding members of staff commented on the improved communication and working relationships evident now amongst the senior clinical staff at Te Whetu Tawera. Charge nurses and psychiatrists now undertake a morning handover together. There is a trained shift coordinator on each ward. There has been some loss of senior staff and sometimes there has been a higher proportion of junior nursing staff than desirable on some shifts. However, this has been acknowledged and addressed by the Charge Nurses and staff are now rotated around the wards to ensure a spread of skills and seniority in each area.

There are regular staff meetings at which any concerns, including grievances, can be aired. However I was also advised that a small number of nursing staff in particular have been concerned by the pace of change in Te Whetu Tawera and have some mistrust of the management team, and sometimes of some medical staff, fearing that staff safety might be put at risk by the emphasis on patient needs. An example I was given of this mistrust was the readiness of some staff a few months ago to interpret the distribution of a seclusion policy document as implying that the use of seclusion was being banned, when there had been, and remains, no intent to ban it. Similarly, the managers and clinical leaders have struggled to understand the basis for recent union alarms and actions about safety issues in the unit, when an escalation in minor assaults which occurred some months ago appeared to have been effectively addressed and had since resolved. It seems then that there is a degree of mistrust which will require ongoing attention and work on improving communication.

Conclusions

Overall, it appears that there has been a profound change in the culture and clinical standards and practices at ADHB mental health services, and in particular within Te Whetu Tawera and in the relationships between Te Whetu Tawera staff and those from other teams, since the previous reviews in 2007/2008.

The service now is functioning at a high standard and the staff, both at a leadership level and at the "clinical coalface", deserve to be congratulated for achieving such a marked and fundamental change to support improved patient care. This has clearly placed some pressure on staff as individuals and collectively – they are now expected to have greater expertise, to be much more focussed on the needs of the people they treat and their families, and to interact more constructively with other teams. This has required a sustained effort, which is ongoing.

Recommendations

1. The service should be encouraged to continue and build on the excellent progress made over the past three years.
2. Existing forums in the ADHB mental health service should continue to look at ways of improving trust and communication between clinical teams, organisational levels and professional groups.
3. The "Releasing Time to Care" programme should be used as an opportunity to address any concerns about efficiency in practice and documentation by all professional groups.

4. Further training for medical and nursing staff in best practice use of medication for inpatients and in implementation of standard treatment protocols could be valuable. It might be useful for this to be undertaken as a regional or even national initiative, to reinforce best practice everywhere and encourage acceptance.

5. Over recent years the service has experienced considerable scrutiny, at times hostile, from the media, public and various agencies. This is always demoralising for staff, but especially if it persists after they have made substantial efforts to improve services. This has not lessened their commitment to ongoing improvement but may have contributed to the recent recruitment issues and an element of mistrust by some nursing staff. The improvements made to date provide an excellent foundation for ongoing improvement, but it would be helpful for the service to receive some clear and public accolades and endorsement of the steps they have taken to date, to maintain the direction of change.

Yours sincerely,

Dr Gloria Johnson (MBChB, MBA, FRANZCP, FRACMA)
Chief Medical Adviser
Northland District Health Board