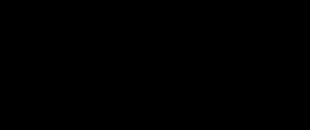
Waitematā District Health Board
Best Care for Everyone

Specialist Mental Health and Addiction Services
Level 3, 44 Taharoto Road
Private Bag 93-503, Takapuna
Auckland 0622
Telephone: (09) 487-1500
Freephone: 0800 80 9342
Facsimile: (09) 487-1333
Visit: www.waitematadhb.govt.nz

18 June 2019



Dear

Re: Official Information Act request – Operation of He Puna Waiora

Thank you for your Official Information Act request received by Waitematā District Health Board (DHB) on 31 May 2019, seeking a range of information about the operation of He Puna Waiora mental health inpatient unit.

Waitematā DHB acknowledges that you requested the information to be provided under urgency. We are unable to provide all of the information requested under urgency as the collection and collation of some parts will take longer. The outstanding information will be provided within 20 working days of receipt of your original request, as per the Official Information Act, in a second response.

Waitematā DHB also notes your comment that *"In seeking this information, I am wanting to establish whether there have been any recent issues in the operation or safety of this unit or the quality-of-care offered at this unit. So I am seeking any material that directly speaks to this query from approximately the last 12 months".*

We acknowledge that public discussion about self-harm and suicide can be useful. However, we respectfully ask that all information made available in any responses regarding suicide or suspected suicide is treated with sensitivity to the impact that public discussion about suicide can have, particularly any impact on individuals contemplating suicide.

Guidelines for responsible media management of suicide reporting are published on the Mental Health Foundation website and can be found here: https://www.mentalhealth.org.nz/home/our-work/category/39/suicide-media-response-service?gclid=EAIaIQobChMIk_Tls4OP1wIVQiRoCh3D6g-2EAAYASAAEgIlL_D_BwE.

Before responding to your specific questions, it may be useful to provide some context about our services to assist your understanding. Waitemata DHB serves a population of more than 630,000 people. Our Specialist Mental Health and Addiction Services (SMH&AS) are the largest of this kind in the country, by volume of service-users seen. The speciality comprises Adult Mental Health Services, Child Youth and Family Mental Health Services, Takanga a Fohe (Pacific mental health and addictions), Whitiki Maurea (Kāupapa Māori mental health and addictions), the Regional Forensic Psychiatry Service (covering Northland and greater Auckland regions) and Community Alcohol and Drug Services (CADS). All of our addictions services cover the Auckland region. Mental Health

Services for Older Adults sits within Waitemata DHB's Speciality Medicine and Health of Older People Division.

We have endeavoured to answer all of your questions below.

1a. What are the staff-to-patient ratios in the unit?

The minimum staff-to-patient ratio at He Puna Waiora is five patients to one Registered Nurse (RN) in the main ward and three patients to one RN in the High Care Area, during both the morning and afternoon shifts. This ratio is reduced (ie, more staff are present) to address increased acuity and need in the patient group. On night shift, there are four RNs over the four wards of the unit (a ratio of about nine patients to one RN). Fewer staff are rostered on the night shift as most patients will be sleeping overnight and not as many staff are required to be available. There are also five Health Care Assistants (HCAs) on the night shift: two on the main unit and three within the High Care Area. During morning and afternoon shifts, there are four HCAs on shift: two in the main unit and two within the High Care Area. At any time, the number of staff on a shift can be increased to address increased acuity and need in the patient group. This decision is made by the shift coordinator in consultation with the clinical charge nurse or the on-call coordinator (outside of hours).

1b. Please also provide details of experience and staff mix in terms of those ratios and the risk levels of the patients. What are the recommended ratios?

To be answered in our second OIA response.

2. In the past 12 months, how many times has the unit been understaffed or under optimum staffing levels? Please provide details. These details should include but not be limited to any reports, memos or emails relating to these matters.

To be answered in our second OIA response.

3. What is the average length of a shift at He Puna Waiora?

For full-time staff, shifts run from 0700 to 1605hrs, 1500 to 2335hrs and 2300 to 0735hrs. For part-time staff, shifts run from 0700 to 1500hrs, 1500 to 2300hrs and 2300 to 0700.

4. How many times in the past 12 months have patients in He Puna Waiora had access to items they should not have had; for example patients in suicide prevention gowns still having access to towels or sheets or patients on observation and at risk, who still have access to prohibited items? Please provide details, including but not limited to any reports, memos or emails relating to these matters. Please provide details of action taken following any such events.

To be answered in our second OIA response.

5. In terms of patient checks please provide details of any instances where patient checks have not been carried out at the appropriate time or to an acceptable level. In particular please provide specific details relating to night time checks. How often are checks audited?

To be answered in our second OIA response.

6. What patients get one-to-one observation and what is HPW's policy around this?

Please see Therapeutic Engagement Observation policy - Adult MHS (Appendix One).

7. What is the wait time for people discharged from inpatient care at He Puna Waiora to access a clinical psychologist via the community mental health team? Please provide details of wait times over the past 12 months.

We do not record the length of time a person waits to see a psychologist. We only record the fact that a person has been referred for psychological intervention. We record such referrals in each person's individual clinical notes. To answer this question would require substantial collation and research as we would have to review more than 600 individuals' clinical records. Therefore, we are refusing your request under s18(f) of the Official Information Act 1982. If you are dissatisfied with this decision, you are entitled to make a complaint to the Office of the Ombudsman, whose details are available via www.ombudsman.parliament.nz.

We note that we have considered whether we could provide the information if we extended the time for responding to your request or charged to provide the information but have decided that this would not assist as the work required to collate this information from HCC (the electronic patient record system used by SMH&AS) would need to be done by a mental health professional used to working with HCC who would ordinarily be providing frontline mental health services. There is a national shortage of mental health professionals, which means that we would not be able to backfill the frontline position so that the information could be collated. This would compromise SMH&AS' ability to provide services to patients.

8. How many complaints has He Puna Waiora received in the last 12 months and what are the nature of those complaints?

Of the 666 admissions to He Puna Waiora in the last 12 months, 11 complaints were received. The categories of complaint have been recorded as clinical care, communication, sensitivity to culture, communication about discharge, discrimination, informed consent, attitude/manner of staff, information about care processes, environmental hygiene, food, patient's sense of safety and an alleged theft.

9. In the case of the two recent deaths, what specific steps did you take to ensure patient safety after the first death? This should include but not be limited to details of increased staffing and patient checks.

After the first death, a risk assessment of all patients in the unit was completed. Those considered most-vulnerable were identified and a plan was made to manage the risk for each individual service-user, which was documented in their personal clinical record.

10. Did you inform family of all other patients of the death and if so over what time frame?

All of the patients on the ward were provided with the information that another patient had died but the details of the death were not discussed. Families are not routinely informed in the case of serious adverse events occurring on hospital wards.

11. In the case of the two recent deaths, what frequency of checks were the patients on and what type of checks. In a recent interview, Dr Cleary said they were on a monitoring regime rather than continuous observation. Were these checks done to the required level? What is that level? And if not, why not?

Both patients were under hourly therapeutic observations whereby they are located and engaged with at least hourly. In both cases, the therapeutic observations were completed to the assigned level and each patient had been seen by staff well within that time frame.

12. At the time of the patient deaths, was the unit fully staffed, with staff of an appropriate experience level?

On both occasions, the unit was fully staffed with an appropriate level and mix of staff skill and experience.

13. How many staff vacancies are there currently at HPW?

He Puna Waiora has a complement of 109 clinical staff. At the time of the patient deaths, there were four staff vacancies at He Puna Waiora, made up of two RN vacancies and two HCA vacancies. All positions had been recruited to, and although the new staff had not yet started, the rosters were fully covered through the use of experienced casual staff to backfill the vacancies.

14. Please provide details of any briefings, memos instructions to staff after the first death and any material/warnings sent to patient representatives after the first death and the second death.

To be answered in our second OIA response.

15. Please provide copies of any reviews or incident reports completed after the deaths.

To be answered in our second OIA response.

16. Please provide details of daily activities, talk therapy and Occupational therapy that are available to patients, including the number of hours budgeted for each patient for these activities or similar for each day.

These ward activities are not delivered on the basis of number of hours budgeted for each patient. A structured programme of daily activities is provided by the multidisciplinary team. Groups are run by the occupational therapists, peer support workers, psychologists, pharmacist, social workers, RNs, cultural advisor and drug and alcohol clinicians. Service-users with identified needs will also have individual assessment or intervention sessions with psychologists, social workers and/or occupational therapists. In addition, nursing staff aim to spend at least one hour face-to-face with their allocated service-users on each shift. A copy of the He Puna Waiora programmes can be found in Appendix Two.

17. What are the daily nursing objectives and practices of staff?

To be answered in our second OIA response.

18. What patient information is required to be transferred to staff at shift changes or handover and who is required to be present? How is the information transferred?

Please see the Nursing Handover Process – Adult Acute Inpatient Units in Appendix Three.

19. What is HPW protocol for informing parents or guardians if their loved one has apparently committed suicide? Is it acceptable to relay this information to a parent by phone rather than in person?

As per Waitematā DHB's Bereavement Care Policy and staff information sheet Breaking Bad News over the Telephone (see Appendices Four and Five), it is acceptable that family/whānau are informed of a loved one's death over the telephone. This is particularly important in the case of a sudden or unexpected death to provide the family the opportunity to see their loved one prior to the Coroner taking over. This is because where there is a Coroner's case or post-mortem, there is usually a delay prior to the release of the deceased to their family/whānau. In addition, where a patient is under compulsory treatment, such as being assessed and/or treated under the Mental Health Act, there is a requirement to notify the family/whānau as soon as possible.

I trust this information will satisfy your request. Waitemata DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Susanna Galea-Singer
Director
Specialist Mental Health & Addictions Services

Waitemata District Health Board
Best Care for Everyone

Therapeutic Engagement Observation – Adult MHS

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1. Overview

Waitemata District Health Board (WDHB) recognises the importance of reducing the risk of harm to people using inpatient services by promoting the well-being and safety of vulnerable people.

WDHB also recognises the importance of ensuring that all clinical staff working in the inpatient units are trained in the skills and competencies required to provide effective therapeutic engagement observations.

Purpose

To provide direction on the standards expected of clinical staff for the observation and engagement of Service Users and to provide direction for making decisions about Therapeutic Engagement Observation levels, including reviews, carrying out Therapeutic Engagement Observations Therapeutic Engagement Observations and correct completion of documentation.
All inpatient Service Users will be assessed and reviewed for the level of Therapeutic Engagement Observation by the responsible clinical staff.

Scope

This policy applies to all staff involved in Therapeutic Engagement Observation and monitoring of Service Users in an inpatient setting.

Therapeutic Engagement Observation practices and documentation are subject to regular audit.

2. Definition

Therapeutic Engagement Observation	A minimally restrictive intervention of varying intensity in which a clinical member of the healthcare team observes and maintains contact with a Service User to protect the Service User's safety and the safety of others. Observation is not passive nor does it predominantly include watching a Service User from a distance. Undertaking Therapeutic Engagement Observations Therapeutic Engagement Observations requires staff to be person-centered and engage therapeutically with the Service User. It provides an opportunity to develop rapport and contribute to ongoing assessment and recovery.

Therapeutic Engagement Observation – Adult MHS

3. Observation Types and Indicators

Type	Definition	Indicator
Routine Therapeutic Engagement Observation - Main Ward	Every Service User will be located and engaged with at least hourly during their stay on an Adult Inpatient Unit (IPU).	A required continuous (24 hour) ward activity
Routine Therapeutic Engagement Observation - Intensive Care Unit (ICU)/High Care Area (HCA)	Every Service User will be located and engaged with at least every 15 minutes while in ICU/HCA.	A required continuous (24 hour) ward activity
Time-specific Therapeutic Engagement Observation (Every 15 minutes – also known as 15/60s)	The Service User is located and engaged with at intervals of the nominated time. These are usually at a frequency of every 15 minutes or less.	Not all Service Users will require individual time-specific Therapeutic Engagement Observations. Therapeutic Engagement Observation levels must be based on regular clinical assessment of individual Service User needs. 15/60 may be indicated when : • active risk of leaving the unit without authorisation • transitioning from ICU/HCA to main ward. • active risk of harm to self • requiring high levels of physical care and/or assistance
Special Therapeutic Engagement Observation	The Service User is subject to continuous engagement and observation by an assigned staff member	Indications for this level of Therapeutic Engagement Observation include: • acutely psychotic with impaired judgement • acutely suicidal with impaired judgement • imminent risk of harm to self • acute medical conditions • delirium or dementia • active risk to others • imminent risk of leaving the unit without authorisation
Constant Therapeutic Engagement Observation	Service User must be within arm's reach of an assigned staff member at all times.	Indications for this level of Therapeutic Engagement Observation include: • having the intent and plan to commit suicide • being a high and imminent risk to others • actively harming self

4. Initiating, changing and discontinuing time-specific, special and constant observations

4.1 Initiating and discontinuing therapeutic observations

Type	Decision to initiate	Decision to discontinue
Time-specific therapeutic engagement observations (i.e. Every 15 minutes)	Registered Nurse (RN) in consultation with Clinical Charge Nurse (CCN) or Shift Coordinator (SC). The responsible medical team must be informed of the decision as soon as practicable. **Note: All admissions** will receive a minimum of 15 minute Therapeutic Engagement Observations Therapeutic Engagement Observations for the **first 24 hours,** until they are reviewed by their treating team.	• RN in consultation with CCN or SC and responsible medical staff (or out of hours on-call medical staff) • Prior to discontinuation/reduction of Therapeutic Engagement Observations, a risk assessment considering dynamic risk factors, access to means of harm and likelihood, frequency, seriousness, imminence and motivation must be undertaken • Where the Service User is subject to the provisions of the Mental Health Act, the Responsible Clinician or delegate will be involved in any decisions to reduce or discontinue levels of Therapeutic Engagement Observation • The rationale for changing Therapeutic Engagement Observation levels, including evidence of risk evaluation and any activities to reduce risk must be documented in the clinical file
Special and Constant Therapeutic Engagement Observations	Registered Nurse (RN) in consultation with Clinical Charge Nurse (CCN) or Shift Coordinator (SC). The responsible medical team must be informed of the decision as soon as practicable. A copy of the Special/Constant Nursing Operations - Service User information sheet will be provided to the Service User	• RN in consultation with CCN or SC and responsible medical staff (or out of hours on-call medical staff) • Prior to considering discontinuation of special or constant Therapeutic Engagement Observations, a risk assessment considering dynamic risk factors, access to means of harm and likelihood, frequency, seriousness, imminence and motivation must be undertaken • The rationale for changing Therapeutic Engagement Observation levels, including evidence of risk evaluation and any activities to reduce risk must be documented in the clinical file

4.2 Re-assessment of observation levels

Re-assessment of a Service User's level of Therapeutic Engagement Observation during their inpatient admission must be undertaken where any relevant change in the individual's presentation or circumstances is noted. These changes may include:

- Sudden alteration in usual behavior
- Re-grading of legal status under the Mental Health Act
- Specific evidence of intentions to harm themselves or others
- Changes in life circumstances (separation, loss, employment)

Changes in the level of Therapeutic Engagement Observation must be accompanied by a clear rationale which is documented in the Service User's clinical file.

Decisions to **increase a Service User's Therapeutic Engagement Observation level** should be made as far as possible via MDT discussion, based on ongoing assessment of the Service User's needs. Decision making should include the Service User wherever possible.
RNs in consultation with the CCN/SC or Responsible Clinician have the authority to implement an increase in the level of Therapeutic Engagement Observation in the first instance. All decisions must be reviewed by the responsible MDT at the earliest opportunity.

Therapeutic Engagement Observation – Adult MHS

Therapeutic Engagement Observation levels can be reduced following MDT review or by the RN in consultation with the CCN or SC and out of hours on-call medical staff for time-specific observations, except where the Service User is subject to the provisions of the Mental Health Act, when the Responsible Clinician or delegate will be involved in any decisions to reduce Therapeutic Engagement Observation levels.
Where special or constant Therapeutic Engagement Observation levels are to be reduced, this decision is made by the RN in consultation with CCN or SC and responsible medical staff (or out of hours on-call medical staff)

MDT Review of Therapeutic Engagement Observation levels will occur at each clinical review or more frequently if indicated. This clinical discussion should include:

- The senior nurse on shift
- The Registered Nurse working with the Service User
- The Health Care Assistant working with the Service User
- A member of the medical team working with the Service User
- Other members of the multi-disciplinary team
- The views of Service User
- The views of their identified carer (where appropriate)

Whenever there is a change to Therapeutic Engagement Observation levels this will be documented in the Service User's clinical file with clear rationale for the decision. The treating team, Service User and their identified carer will be informed as soon as practicable.

4.3 Advance planning to reduce Therapeutic Engagement Observation levels

If Therapeutic Engagement Observation levels are not immediately reduced following MDT review, the MDT or Responsible Clinician will agree and document in the clinical file any changes in risk and mental health presentation needing to be demonstrated before levels of Therapeutic Engagement Observation will be reduced. These criteria will be agreed and documented in advance. A consultation between the RN the CCN/SC and medical staff must still take place prior to any reduction in the level of Therapeutic Engagement Observation taking place.

5. Allocation

Therapeutic Engagement Observation is a core part of the therapeutic role of the ward team and must be conducted safely and consistently. The nurse in charge is responsible for allocating appropriate staff members to carry out Therapeutic Engagement Observations throughout the shift and ensuring that they are aware of their allocated duties.

Out of hours, staffing resources may need to be adjusted in consultation with the on-call manager if there is a need for additional Special or Continuous Therapeutic Engagement Observations.

6. Handovers

The RN going off shift must hand over to the RN coming on shift all information in relation to Service Users subject to any levels of non-routine Therapeutic Engagement Observation. Handovers should include:

- a summary of the last 24 hours
- Service User's treatment plan, including progress, any interventions, and current assessment of needs
- current risk – including any vulnerability, suicide/self-harm, violence and aggression, potential or recent substance misuse
- medication
- mental state examination updates
- any physical healthcare needs

- any social care information, including any that has the potential to be distressing news for the Service User, in relation to family, accommodation, contentious treatment changes , and other matters.

Prior to taking over the Service User's care the staff member will:

- Familiarise themselves with the Service User's care plan, background and recent clinical notes
- Consider potential individual triggers for an increase in risk
- Consider potential individualised methods for reducing risk (e.g. by utilizing the Service User's strengths, resources, and values)

If Service Users are under Special or Constant Therapeutic Engagement Observations the staff member taking over the Therapeutic Engagement Observations activity must sign the Therapeutic Engagement Observation Recording Form to indicate they have accepted responsibility and are aware of why the Service User is currently under this level of Therapeutic Engagement Observation.

7. Record Keeping

- Each shift the responsible RN will document a full summary of the Service User's presentation that shift, including mental state and risk assessment with care plan update. Where indicated the staff member providing the Therapeutic Engagement Observations will also document in the clinical file.
- Staff allocated to carry out Therapeutic Engagement Observation activities will record this on the approved Therapeutic Engagement Observation Recording Form and sign the form (if using a paper version) at the time of completing the Therapeutic Engagement Observation. Entries should never be recorded retrospectively.
- Where using paper forms, entries must be legible, signed using an identifiable signature, with dates and times recorded as required. It is the responsibility of the member of staff allocated to carry out the Therapeutic Engagement Observation to keep the record up to date and complete before handing to the next allocated staff member. The Therapeutic Engagement Observation record must be maintained without any omissions
- At the end of each shift it is the responsibility of the CCN or SC to check the forms have been completed correctly and that they are filed in the correct place

8. Length of time staff may be allocated to Therapeutic Engagement Observations activities

When the clinical area is optimally staffed the time frames for clinical staff providing Therapeutic Engagement Observations are:

- Special Therapeutic Engagement Observations:
  - no longer than two consecutive hours without a break
- Constant Therapeutic Engagement Observations:
  - no longer than one consecutive hour at a time without a break, unless escorting a service user off-site
- At the end of each Therapeutic Engagement Observation period, staff should have at least one hour of non-Therapeutic Engagement Observation activity.

Therapeutic Engagement Observation – Adult MHS

9. Flowchart

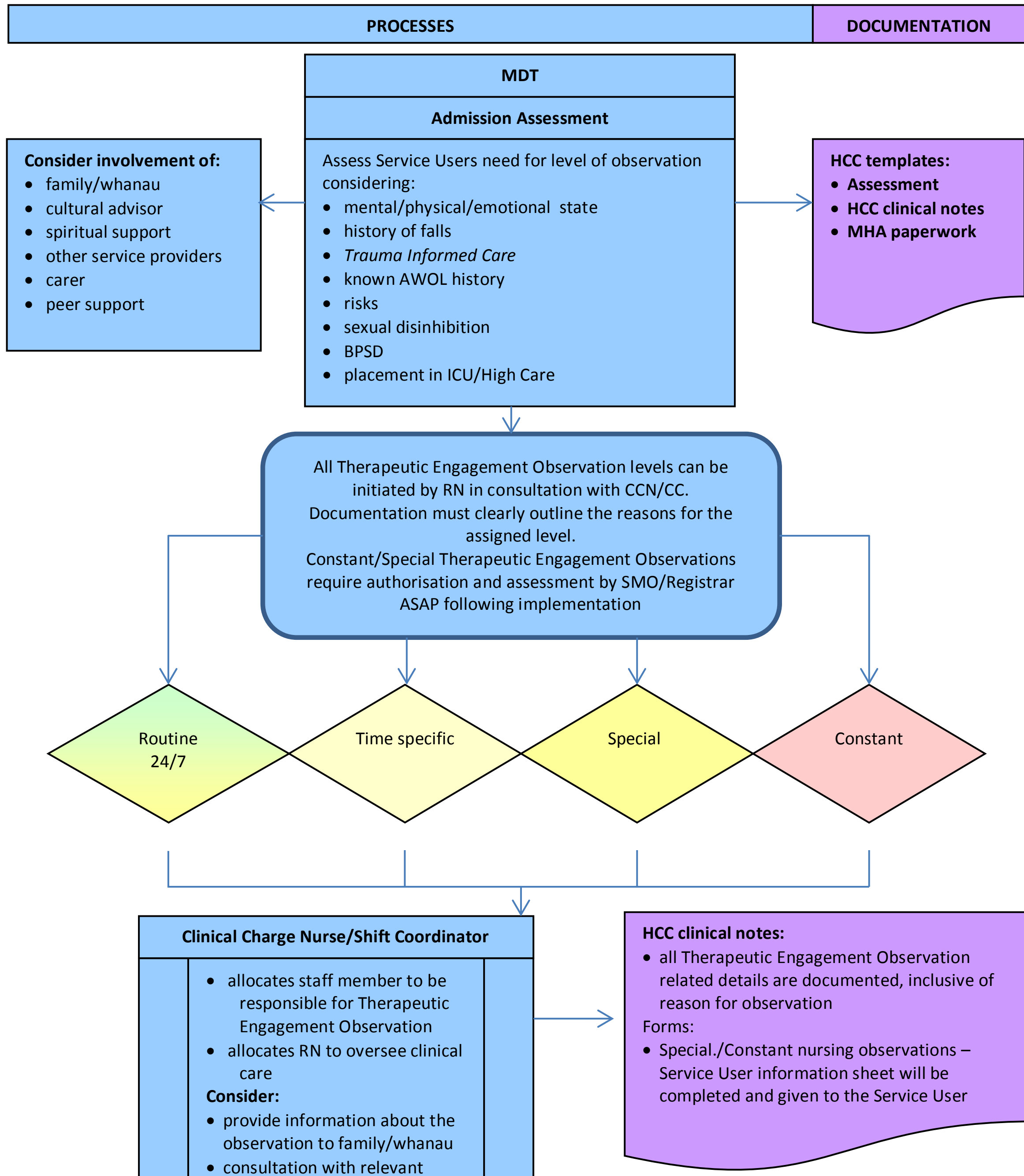
9.1 Assessment

Purpose

The level of Therapeutic Engagement Observation will be indicated by Service Users need

Scope

All clinicians and other service providers involved in the Service User's assessment



Therapeutic Engagement Observation – Adult MHS

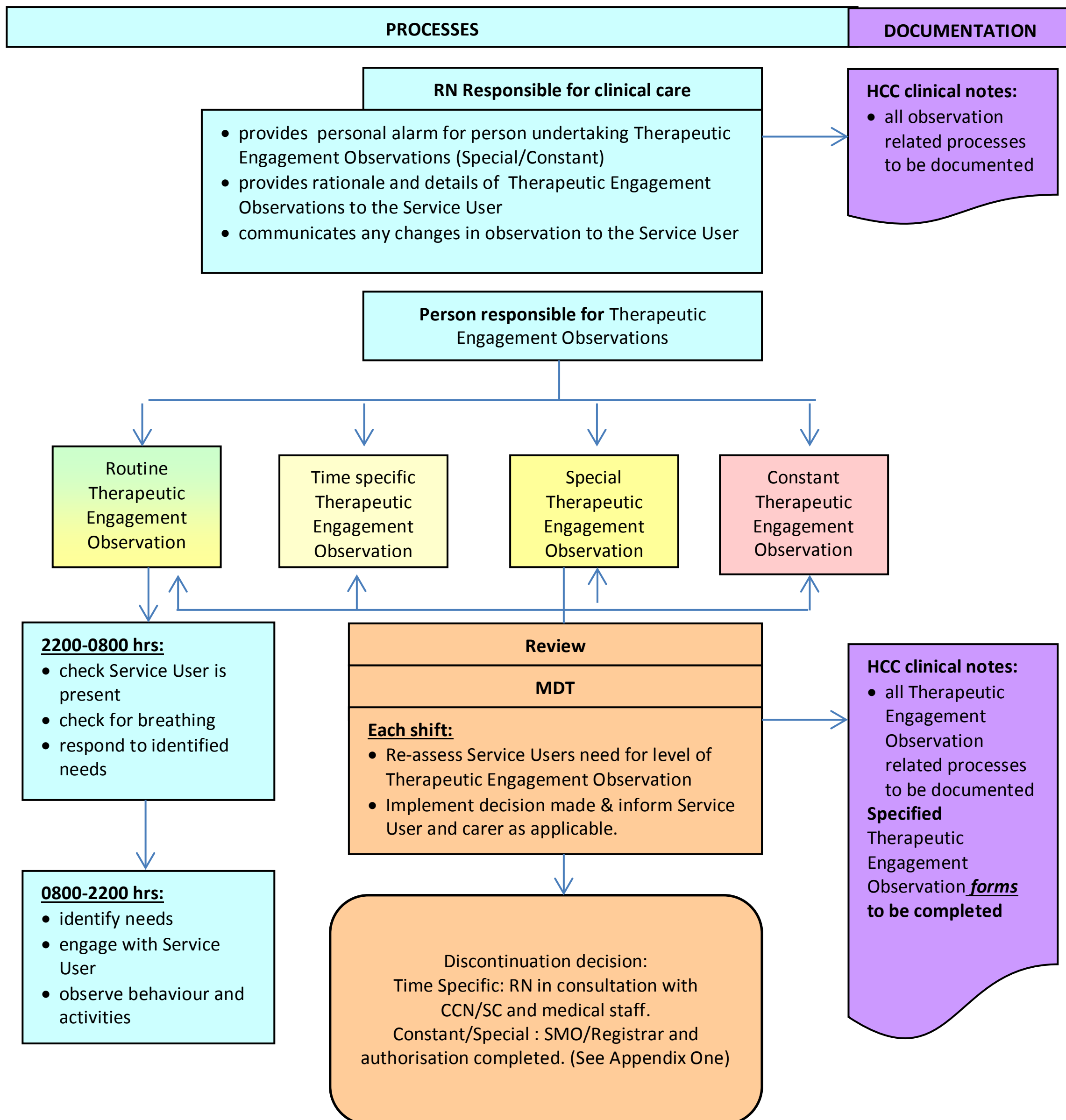
9.2 Therapeutic Engagement Observation Management and Review

Purpose

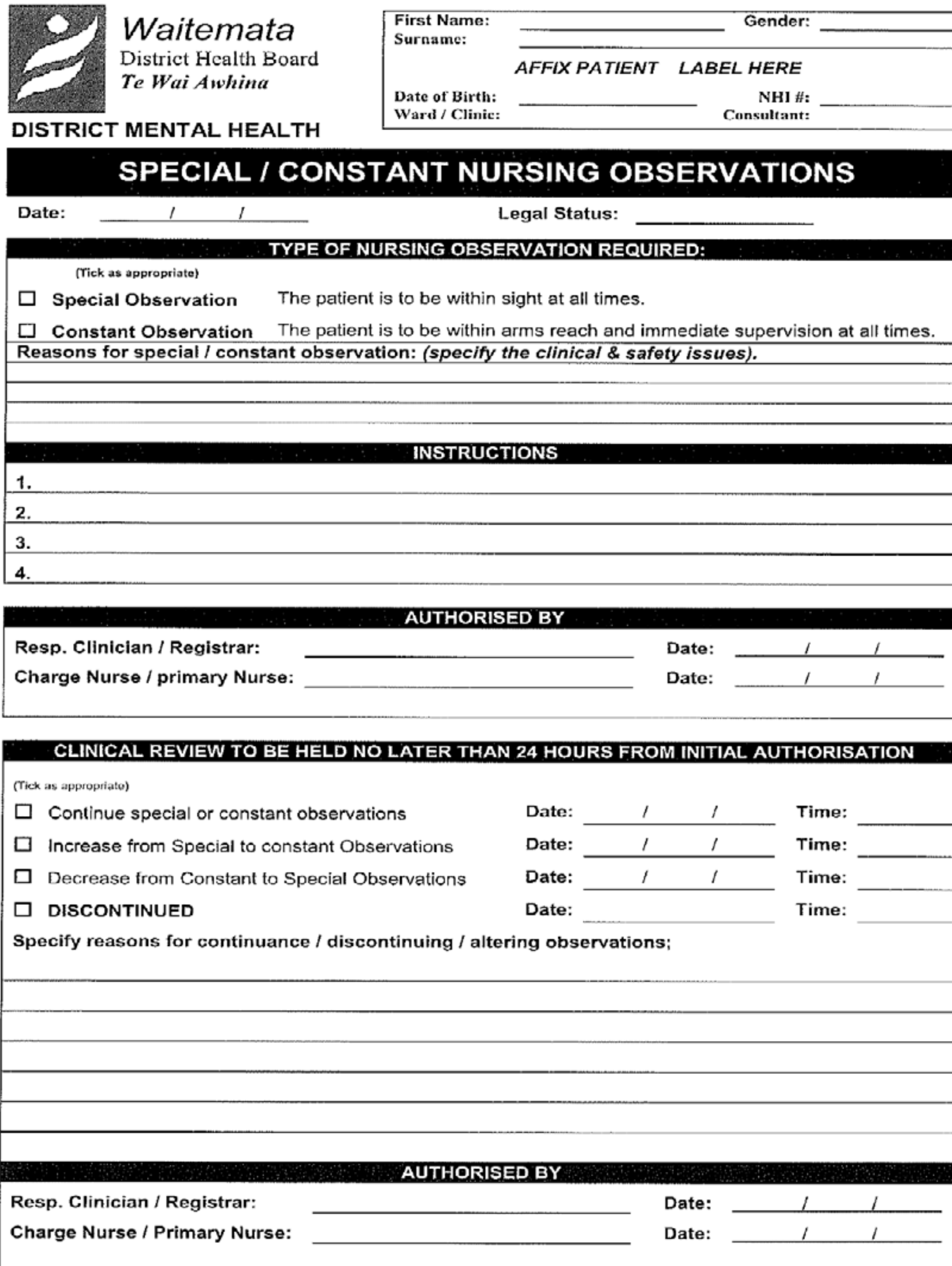
The processes described seek to promote a safe and therapeutic environment for Service Users.

Scope

All clinicians and other service providers involved in Therapeutic Engagement Observations with Service Users



Appendix 1: Special / Constant Nursing Observations Form (example)



Waitemata District Health Board
Te Wai Awhina
DISTRICT MENTAL HEALTH

First Name: ______ Gender: ______
Surname: ______
AFFIX PATIENT LABEL HERE
Date of Birth: ______ NHI #: ______
Ward / Clinic: ______ Consultant: ______

SPECIAL / CONSTANT NURSING OBSERVATIONS

Date: ___ / ___ / ___ Legal Status: ______

TYPE OF NURSING OBSERVATION REQUIRED:

(Tick as appropriate)

☐ **Special Observation** The patient is to be within sight at all times.

☐ **Constant Observation** The patient is to be within arms reach and immediate supervision at all times.

Reasons for special / constant observation: ***(specify the clinical & safety issues).***

INSTRUCTIONS

1.
2.
3.
4.

AUTHORISED BY

Resp. Clinician / Registrar: ______ **Date:** ___ / ___ / ___

Charge Nurse / primary Nurse: ______ **Date:** ___ / ___ / ___

CLINICAL REVIEW TO BE HELD NO LATER THAN 24 HOURS FROM INITIAL AUTHORISATION

(Tick as appropriate)

	Date	Time
☐ Continue special or constant observations	___ / ___ / ___	______
☐ Increase from Special to constant Observations	___ / ___ / ___	______
☐ Decrease from Constant to Special Observations	___ / ___ / ___	______
☐ **DISCONTINUED**	______	______

Specify reasons for continuance / discontinuing / altering observations;

AUTHORISED BY

Resp. Clinician / Registrar: ______ **Date:** ___ / ___ / ___

Charge Nurse / Primary Nurse: ______ **Date:** ___ / ___ / ___

SPECIAL / CONSTANT NURSING OBSERVATIONS

8.4.18

Therapeutic Engagement Observation – Adult MHS

Waitemata
District Health Board
Te Wai Awhina

DISTRICT MENTAL HEALTH

First Name:		Gender:	
Surname:			
AFFIX PATIENT LABEL HERE			
Date of Birth:		NHI #:	
Ward / Clinic:		Consultant:	

SPECIAL / CONSTANT NURSING OBSERVATIONS RECORDING SHEET

Date: ____/____/____

Time	Staff Member's Name & Signature	Comments

SPECIAL / CONSTANT NURSING OBSERVATIONS

8.4.19

Therapeutic Engagement Observation – Adult MHS

Appendix 2: Patient Information Sheet for Special / Constant Nursing Observation

Waitemata District Health Board
Te Wai Awhina

DISTRICT MENTAL HEALTH

PATIENT INFORMATION SHEET FOR SPECIAL / CONSTANT NURSING OBSERVATION

Date: ____/____/____

You have been placed under (tick as appropriate)

TYPE OF OBSERVATION	DEFINITION
☐ Special Observation:	A designated nurse must keep you in sight at all times.
☐ Constant Observation:	A designated nurse must keep within arms distance of you at all times.

At this time, increased nursing care is necessary for you for the following reasons:

____
____
____
____
____
____

Your doctor and primary nurse have applied special observations / constant observations (Delete one). This means;

(tick as appropriate)

☐ You need to be observed closely for your own or others safety.
☐ You can't leave the ward area.
☐ You may be asked to wear pyjamas or a nightdress.
☐ You may have visitors only after discussion with your doctor / nurse.

Other conditions;

1. ____
2. ____
3. ____
4. ____
5. ____

This decision will be reviewed on: ____/____/____

Your Primary Nurse for the AM shift is: ____________________

Your Primary Nurse for the PM shift is: ____________________

Your Primary Nurse for the Night shift is: ____________________

You should approach your shift nurse for any concerns you may have about this treatment.

APPENDIX TWO

He Puna Waiora Ward Programme: 6- 10 May 2019

Monday	Tuesday	Wednesday	Thursday	Friday
09:30 **COFFEE GROUP** Facilitator: OT	09:30 **RELAXATION** Facilitator: OT	09:30 **COFFEE GROUP** Facilitator: OT	09:30 **MINDFULNESS YOGA** Facilitator: OT	09:30 **COFFEE GROUP** Facilitator: S/Worker
11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitators: Psychologists	10:00 **HEALTHY LIFESTYLES** Facilitator: Dietician	10:30 **SKILLS FOR LIVING** Facilitator: OTs Topic: sleep hygiene	10:00 **COMMUNITY MEETING** Facilitator: CNS / OTs 11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitator: Psychologist	10:00 **BARBEQUE PREPARATION** Facilitator: OTs
Lunch	Lunch	Lunch	Lunch	Lunch
1 PM **SENSORY GROUP** Facilitator: OTs	1PM **ART & CRAFT** Facilitator: OTs	2PM **GARDENING GROUP** Facilitator: OTs	1PM **ADDICTIONS GROUP** Facilitator: Mind & Body – Peer support worker 5:30PM **MOVIE NIGHT** Facilitator: Mental Health Assistant	

He Puna Waiora Ward Programme: 13-19 May 2019

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
09:30 **COFFEE GROUP** Facilitator: OT	09:30 **RELAXATION** Facilitator: OT	09:30 **COFFEE GROUP** Facilitator: OT	09:30 **MINDFULNESS YOGA** Facilitator: OT	09:30 **COFFEE GROUP** Facilitator: S/Worker	
10.15 **WELLBEING GROUP** Facilitators: Mind & Body – Peer support workers 11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitators: Psychologists	10:00 **SPCA PET THERAPY** Facilitator: Michelle & Dog	10:30 **SKILLS FOR LIVING** Facilitator: OTs Topic: Values	10:00 **COMMUNITY MEETING** Facilitator: CNS / OTs 11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitator: Psychologist	10:30 **BAKING** Facilitator: OTs	
Lunch	Lunch	Lunch	Lunch	Lunch	
1 PM **SENSORY GROUP** Facilitator: OTs 2 PM **MEDICATION GROUP** Facilitator: Pharmacist	1PM **ART & CRAFT** Facilitator: OTs 2PM **CV & EMPLOYMENT GROUP** Facilitator: Social Worker	1PM **SAFE WARDS POSTER GROUP** Facilitator: Mental Health Assistant 2 – 245PM **HOTAKA HAUORA** Facilitator: Cultural Advisor	1:30PM **ALCOHOL & OTHER DRUG DISCUSSION GROUP** Facilitator :CADS staff member	2PM **CV & EMPLOYMENT GROUP** Facilitator: Social Worker	2PM **COFFEE GROUP** Facilitator: Mental Health Assistant PM **PAMPERING GROUP** Facilitator: Nurse

He Puna Waiora Ward Programme: 20-24 May 2019

Monday	Tuesday	Wednesday	Thursday	Friday
09:30 **COFFEE GROUP**	09:30 **RELAXATION** Facilitator: OT	09:30 **WALKING GROUP** Facilitator: OT	09:30 **MINDFULNESS YOGA** Facilitator: OT	09:30 **COFFEE GROUP** Facilitator: S/Worker
10.15 **WELLBEING GROUP** Facilitators: Mind & Body – Peer support workers 11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitators: Psychologists	10:00 **HEALTHY LIFESTYLES** Facilitator: Dietician	10:30 **SKILLS FOR LIVING** Facilitator: OTs Topic: positive affirmations	10:00 **COMMUNITY MEETING** Facilitator: CNS /OTs 11:15 **ACT GROUP (Acceptance & Commitment Therapy)** Facilitator: Psychologist	10:00 **BARBEQUE PREPARATION** Facilitator: OTs
Lunch	Lunch	Lunch	Lunch	Lunch
1 PM **SENSORY GROUP** Facilitator: OTs 2 PM **MEDICATION GROUP** Facilitator: Pharmacist	1PM **ART & CRAFT** Facilitator: OTs	1PM **SAFE WARDS POSTER GROUP** Facilitator: Mental Health Assistant	130PM **ACTIVITY GROUP** Facilitator: OTs	430PM **PAMPERING GROUP** Facilitator: Mental Health Assistant

Nursing Handover Processes – Adult Acute Inpatient Units

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1. Overview

Definition

Clinical Handover is 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'. *British Medical Association. (2006)*

Purpose

To clearly identify the daily handover processes and provide an effective and efficient exchange of information to all responsible staff in Adult Inpatient Units. (A robust handover process is essential in providing planned continuity of care, patient safety and error avoidance).

Scope

This applies to Clinical Charge Nurses, Shift Coordinators (SC), Registered Nurses and Casual Registered Nurses.

2. Process

Handover will be given by the CCN/SC running the unit during the duty to the oncoming staff.

- The initial session of the handover will provide an overall 'picture' of the unit and will include the Shift Co-ordinators Report (Appendix 1) inclusive of:
  - Admissions & discharges
  - Seclusion/Restraint Events
  - Any incidents
  - Overall bed statues
  - Any other general information needing to be conveyed.

- The nursing handovers take place at 0700hrs, 1500hrs and 2300 hrs.
- All nursing staff are expected to attend handovers on time.
- Registered Nurses will have prepared their handover sheets (Appendix 4) prior to handover times and given these to the CCN/SC
- All staff are expected to actively listen to the information provided during the handover in order to follow up any outstanding issues over the following shifts.

Nursing Handover Processes – Adult Acute Inpatient Units

Handover should be no more than 15 – 20 minutes.

3. Allocation of Service Users

Service users will be allocated by the CCN/SC on the previous shift for the following day i.e. SC on Saturday AM will complete the allocation book for the following Sunday AM.

This allocation will be completed in the allocation book (Appendix 2). The CCN/SC needs to consider the roster for the following day and make every effort to provide consistency for service users and ensure Primary Nurses are allocated to identified clients.

4. Admission Book

All service users admitted must be entered into the admission book (Appendix 3) by the allocated CCN/SC. This book has been designed to ensure the relevant information is handed over to the next shift and MDT.

This process removes the need to print off the Adult Assessment form and this should not be printed.

5. Introduction to Service users

At the commencement of each shift the staff will introduce themselves to the service users allocated to their care and ascertain if there are any immediate concerns which require intervention.

6. Night Shift Coordinator Handover

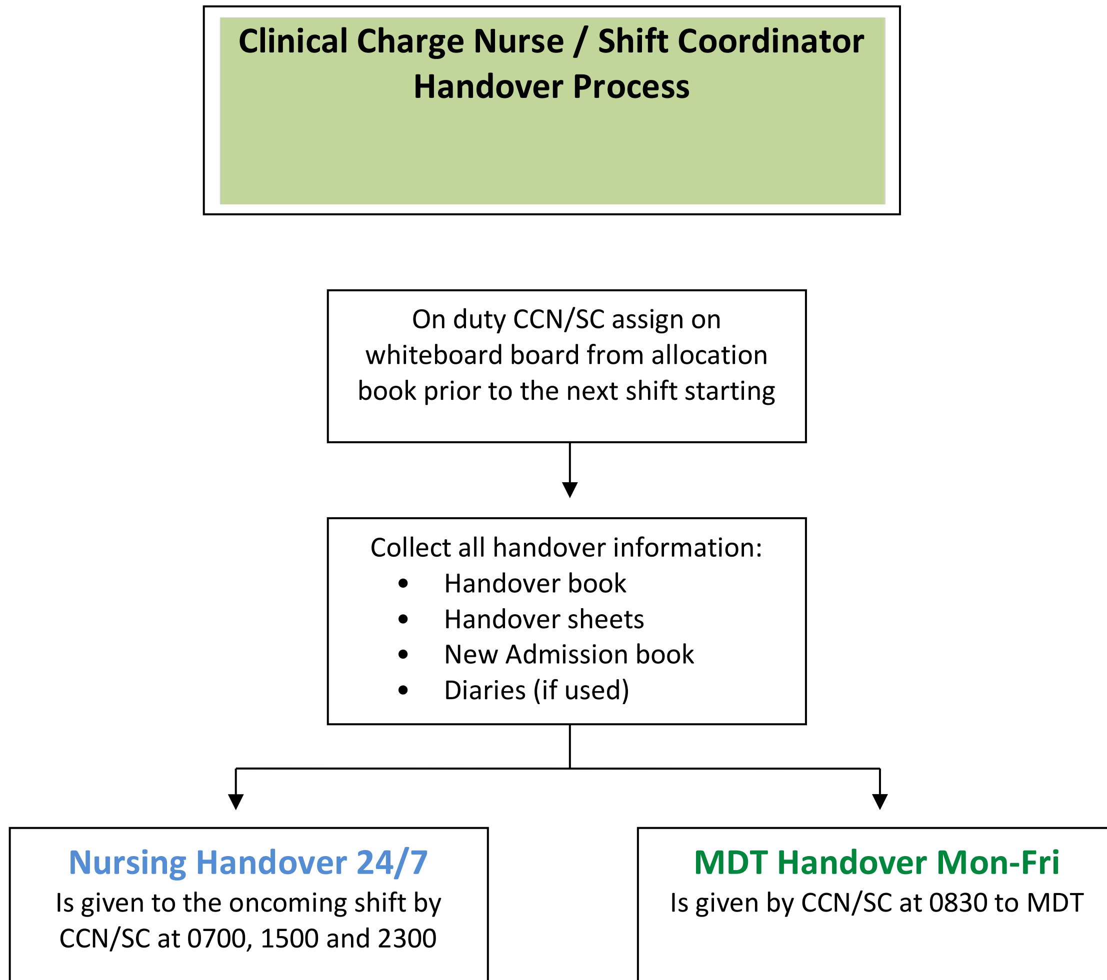
Following the handover from afternoon shift to the night shift staff, the two allocated CCN/SC's, will complete a physical sighting of each service user who is currently in the unit. If there are any concerns these should be discussed and a plan formulated to manage these.

7. Storage of Documents

All documents outlined, inclusive of books and hand over sheets, will be given to admin in each unit and be stored on the unit for 6 months.
At six months all documents will be boxed up and send to Crown for storage. These can be recalled if required at any time.

Nursing Handover Processes – Adult Acute Inpatient Units

Appendix 1: Handover Process Flowchart



Appendix 2: Shift Coordinators Report

TOTAL ADMISSIONS: ( )		**TOTAL ON LEAVE: ( )**	
TOTAL DISCHARGES: ( )		**TOTAL AWOL: ( )**	
BEDS AVAILABLE	**OPEN ( )**	**HCA/ICU ( )**	
NUMBER OF CLIENTS	**MALE ( )**	**FEMALE ( )**	**HCA/ICU ( )**

Nursing Handover Processes – Adult Acute Inpatient Units

INSTRUCTIONS / DUTIES FOR NEXT SHIFT & GENERAL UNIT INFORMATION:

EXPECTED ADMISSIONS OR BEDS HELD ETC:

DAILY WARD REPORT COMPLETED AND TOTALS CORRECT: (please tick) ( )

CO-ORDINATOR'S NAME: ……………………………………………………………………… (please print)

CO-ORDINATOR'S SIGNATURE; ………………………………………………………………

Appendix 3: Allocation Form

ALLOCATION FORM

DATE : **DATE FOR FOLLOWING** AM **SHIFT :**		**DATE :** **DATE FOR FOLLOWING** PM **SHIFT :**	
NURSE	**SERVICE USER**	**NURSE**	**SERVICE USER**

Appendix 4: New Admission Form

<table>
<tr><td colspan="5">NEW ADMISSION FORM</td></tr>
<tr><td colspan="2">DATE</td><td colspan="2">TIME</td><td>TEAM</td><td>TEAM</td></tr>
<tr><td>NAME :</td><td>NHI:</td><td>AGE :</td><td colspan="3">ETHNICITY</td></tr>
<tr><td>ICU/HCA</td><td>OPEN/GENERAL WARD</td><td colspan="4">MHA STATUS</td></tr>
<tr><td colspan="6">Current Address / Accommodation</td></tr>
<tr><td colspan="6">Diagnosis</td></tr>
<tr><td colspan="6">Reason for admission</td></tr>
<tr><td colspan="6">Forensic History</td></tr>
<tr><td colspan="6">Alcohol & Drug</td></tr>
<tr><td colspan="6">Medical</td></tr>
<tr><td colspan="2">S/W Input</td><td colspan="4">Community team</td></tr>
</table>

Appendix 5: Handover Sheets

ACUTE ADULT INPATIENT 24 HOUR HANDOVER SHEET

HCA/ICU

DATE:	
SERVICE USER NAME:	
A	**Mental State:**
	Incidents/Restraints:
	Ward/Environmental Search Completed:
	Tasks for next shift:
P	**Mental State:**
	Incidents/Restraints:
	Ward/Environmental Search Completed:
	Tasks for next shift:
N	**Concerns:**

SERVICE USER NAME:	
A	**Mental State:**
	Incidents/Restraints:
	Ward/Environmental Search Completed:
	Tasks for next shift:
P	**Mental State:**
	Incidents/Restraints:
	Ward/Environmental Search Completed:
	Tasks for next shift:
N	**Concerns:**

ACUTE ADULT INPATIENT 24 HOUR HANDOVER SHEET

GENERAL WARD

DATE	
SERVICE USER NAME:	
A	**Mental State:**
	Incidents/Restraints:
	Tasks for next shift:

P	**Mental State:**	
	Incidents/Restraints:	
	Tasks for next shift:	
		Leave feedback from whanau/friends:
N	**Concerns:**	

SERVICE USER NAME:	
A	**Mental State:**
	Incidents/Restraints:
	Tasks for next shift:

P	**Mental State:**	
	Incidents/Restraints:	
	Tasks for next shift:	
		Leave feedback from whanau/friends:
N	**Concerns:**	

Waitemata District Health Board
Best Care for Everyone

Bereavement Care

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1. Overview

Purpose

This document:

- Outlines the process for the use of bereavement cards within Waitemata District Health Board.
- Describes the required practice for logging the death by ward clerks.
- Describes the required practice for bereavement meetings with next of kin if required.

Scope

- This policy applies to all adult deaths across all Waitemata DHB wards and departments and applies irrespective of whether the deaths are expected, unexpected, sentinel events or Coroners' cases.
- Midwifery and Paediatric Departments: Please refer to your own guidelines and policies with regards to bereavement support.
- **Out of Scope** is provision of on-going bereavement support for family members.

Associated documents

Type	Description
Staff Information Sheets	Breaking Bad News Flowchart Breaking Bad News over the Telephone
Patient Information Sheets	Bereavement Information
Policy	Death of Patient - Inpatient

2. Bereavement Care

Bereavement, whether sudden or expected, can be a bewildering and distressing experience. In the immediacy of bereavement, relatives may experience numbness and disbelief, combined with an overwhelming sense of isolation and vulnerability. When someone dies, those who have been caring can

feel a range of intense feelings, such as sadness, anger, relief, disbelief, numbness or anxiety. People can also start to grieve before someone dies.

At the time of death

- Offer support at time of death; this may include social worker, cultural support and/ or chaplain support.
- Relevant members of the interdisciplinary team are advised of the patient's death in a timely fashion.
- Contact the family/whanau, caregiver(s) and other family members (as appropriate) if not present at the time of death. See "Breaking Bad News Flowchart" and "Breaking Bad News over the Telephone" staff information sheets.
- Provide 'Bereavement Information' sheet for families which gives an explanation of the procedure after someone dies.
- Relatives should have the opportunity to view the body.
- In the event of a traumatic death relatives should have time to decide which family member, if any, should identify remains. Officials should prepare relatives for what they might see, and explain any legal reasons why the body cannot be touched. Guidelines for professional practice must be sensitive to the needs and preferences of people bereaved by traumatic death.

See '*Death of an In-patient'* Policy for guidelines on care after death.

3. Process to follow for sending cards

- Bereavement cards should be sent for all deceased patients [from across the DHB] three weeks after the death of a patient.
- This card acknowledges their bereavement, enables the ward/ department to write a personal message and also provides the next of kin with information on how to contact Waitemata DHB if they wish to discuss any questions/ concerns or issues regarding the death of their loved one.
- Bereavement cards can be ordered from the Copy Centre by sending an email request marked 'Bereavement Card'.
- Envelopes can be ordered through oracle (Envelope Plain E12/C6 162mmX114MB500 KRAFT- Item Number P12371)

3.1 Step One: Ward clerk

- When a patient dies, place patient sticker in Bereavement Log (located in the front of wards Admission to Discharge book) with next-of-kin name and address, date of death, date to send the card.
- After 3 weeks put name and address on envelope and place card and envelope on the charge nurse manager's desk and inform them of the need to sign and post the card.

3.2 Step Two: Charge nurse manager or designated staff member

- Sign/ write message on bereavement card and send.
- Tick "sent" box by the relevant patients name in the Bereavement Log when the card has been sent.

3.3 Follow up procedure

The next of kin may wish to discuss any questions/ concerns or issues they have regarding the death of their loved one. The Waitemata DHB customer service representative will contact the ward or department charge nurse to arrange a meeting.

Bereavement Care

4. Meetings

- Ensure the next of kin has the opportunity to bring support people with him/her to any meetings.
- It is recommended that the ward social worker is present at any meetings with deceased's next of kin as issues may be raised that require their expertise. It may also be appropriate for a chaplain to be present.

Post meeting

Charge nurse manager **-** please complete Bereavement Meetings Log, ensuring documentation of the meeting is sent to next of kin, quality and clinical records.

5. Ongoing Bereavement Support

Please note that if family member(s) require on-going bereavement support it is important to refer them to the relevant agencies. Waitemata DHB does not currently provide on-going professional bereavement support services. See *Bereavement Information* on the Last Days of Life CeDSS site.

5.1 Hospice Support

The families of deceased patients who were enrolled with a hospice will receive bereavement support through these agencies. All Waitemata DHB hospices have a free bereavement support service for families/carers of patients enrolled with their service. The hospice team will routinely contact next of kin/main carer within a few days.

If you think that a family member will need urgent bereavement support, please contact the relevant hospice's Family Support Team.

5.2 Deceased patients not enrolled with a hospice

Services include:

- The Grief Centre in Birkenhead which is a not-for-profit charitable organisation that offers a variety of partly subsidised services, including counselling, support groups, information and resources, training, and books for sale to assist those affected by grief and loss.
- Skylight offers a wide range of services to support those facing tough times of change, trauma and grief - whatever the cause, and whatever their age.
- Their own GP.

5.3 For Waitemata DHB staff

Caring for dying patients and their families can be a stressful time for staff involved in their care. Staff may, at times, feel a need for increased support or to debrief following a patient dying.

Services available include:

- Hospital Chaplaincy Team (page on-call chaplain via telephone operator)
- Hospital Specialist Palliative Care Team (Pager 931768, Monday – Friday 0800-1630).
- EAP can also be accessed through staff intranet page.

Bereavement Care

6. Conclusion

Bereavement support at time of death is important and contacting relatives after a few weeks allows them to ask the questions that had been forgotten previously, and to clarify the facts that happened on the day of their bereavement. This may be a useful way of reducing unnecessary guilt, providing a degree of comfort, and allowing an understanding of the situation that gives power back to the relatives to help them in their healing process. Bereaved relatives must not be left with unanswered questions; otherwise there may be a risk that the grieving process may be prolonged.

Please Note:
This bereavement follow up may allow the identification of bereaved relatives who have developed or are at risk of developing a complicated grief reaction. It is important to distinguish this follow-up from a formal bereavement counselling service (a specific intervention dealing with grief reactions), which is provided separately from community provider.

All documents that apply to this policy can be downloaded from the Last Days of Life CeDSS site on the intranet http://staffnet/edss/End_of_life/default.asp

References

1	Te Ara Whakapiri – Principles and guidance in Last Days of Life
2	Parris, R. J., Schlosenberg, J., Stanley, C., Maurice, S. & Clarke, S. F. J. (2007) Emergency department follow-up of bereaved relatives: an audit of one particular service.
3	Hudson et. al., 2012
4	Bereavement Guidelines, Waitemata DHB, 2014.

Bereavement Care

Appendix 1: Bereavement information sheet for families/ whanau

Link: [I] Bereavement Information

Appendix 2. Bereavement Card Log and Bereavement Card Meetings Log

See Last Days of Life CeDSS website: http://staffnet/edss/End_of_life/default.asp

Appendix3. Bereavement Card

Wording on the card:
Our experience has shown us that following the death of a loved one, people often think of questions they wished they had asked but were unable to do so at the time. If you have any questions, we would like to offer you and your family the opportunity to discuss this with the staff involved in the care of your loved one.

If you would like to talk with us, please phone our customer service advisor on (09) 486 8920 ext. 3153 so we can arrange this for you.

We would like to extend our deepest sympathy to you on your loss

Waitemata District Health Board

Best Care for Everyone

Breaking bad news over the telephone

Breaking bad news is difficult. Seek support from senior colleagues about how to communicate with compassion.

- Find a quiet room and mentally prepare yourself to deliver the news, think through what you are going to say before dialing.
- Introduce yourself and confirm the identity of the person answering the phone and their relationship to the patient.
- Explain the purpose of your call. Suggest they may want to sit down.
- Pause before breaking the news gently, using simple language, "I am afraid I have bad news"
- Check if anyone is with them, offer to speak to them and/or offer to telephone another family member or friend. Repeat exactly what you said to the first person to confirm the message.
- Stay on the phone until the relative/friend indicates they are ready to end the conversation. There may be long periods of silence while they process the new information.
- Ensure the relative/ friend has a contact name and direct line number for you/ a colleague, if available. Offer contact phone numbers for the ward social worker, hospital chaplain and/or cultural services.
- Contact the hospital reception/security desk and inform them that family members will be arriving and could they show them to the ward.
- Ensure a member of staff greets the family on arrival at the ward.
- Document and liaise with multidisciplinary team.

References: Hospice friendly hospitals. (2012-2013). Competence and Compassion, end-of-life care map.