



## Hawke's Bay Health Consumer Council Meeting

**Date:** Thursday, 10 August 2017

**Meeting:** 4.00 pm to 6.00 pm

**Venue:** Te Waiora Meeting Room, District Health Board Corporate Office,  
Cnr Omaha Road & McLeod Street, Hastings

### **Council Members:**

Graeme Norton (Chair)  
Rosemary Marriott  
Heather Robertson  
Terry Kingston  
Tessa Robin  
Leona Karauria  
Sami McIntosh  
Deborah Grace  
Dr Diane Mara

Jenny Peters  
Olive Tanielu  
Jim Henry  
Malcolm Dixon  
Rachel Ritchie  
Sarah Hansen  
Dallas Adams  
Kylarni Tamaiva-Eria

### **Apologies:**

### **In attendance:**

Kate Coley, Executive Director People & Quality (EDP&Q)  
Ken Foote, Company Secretary (Co Sec)  
Tracy Fricker, Council Administrator / EA to EDP&Q  
Jeanette Rendle, Consumer Engagement Manager  
Debs Higgins, Clinical Council Representative  
Linda Dubbeldam, Health Hawke's Bay Representative

## HB Health Consumer Council Agenda

**PUBLIC**

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4.00
2.	Apologies	
3.	Interests Register	
4.	4.1 Minutes of Previous Meeting (Combined with Clinical Council) 4.2 Minutes of Previous Meeting (Consumer Council)	
5.	Matters Arising - Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Report (verbal)	
8.	Consumer Engagement Manager's Report (verbal)	
9.	Youth Consumer Council Report (verbal)	
	<b>Section 2 – For Discussion</b>	
10.	Information Services Plan / Consumer Issues (verbal) – Anne Speden	4.20
11.	Quality Annual Plan - Annual Review 2016/17 Year – Kate Coley	4.40
12.	A Disability Strategy for HBDHB – Consumer Council to lead? – Graeme Norton & Jeanette Rendle	4.50
13.	Consumer Council Annual Plan 2016-17 - Review	5.10
14.	Ka Aronui Ki Te Kounga / Focussed on Quality (draft) – Kate Coley / Jeanette Rendle	5.40
15.	Te Ara Whakapiri HB - Last Days of Life – Leigh White	5.45
	<b>Section 3 – For Information only</b>	
16.	Te Ara Whakawaiaora - Mental Health and AOD (National and local indicators)	-
17.	Annual Maori Plan Q4 Apr-June 17 (Dashboard)	-
	<b>Section 4 – General Business</b>	
18.	Topics of Interest - Member Issues / Updates	6.00
19.	Karakia Whakamutunga (Closing)	

**NEXT MEETING: Thursday 14 September 2017 at 4.00 pm**



**Interest Register****Hawke's Bay Health Consumer Council**

Aug-17

<b>Name Consumer Council Member</b>	<b>Interest eg Organisation / Close Family Member</b>	<b>Nature of Interest eg Role / Relationship</b>	<b>Core Business Key Activity of Interest</b>	<b>Conflict of Interest Yes / No</b>	<b>If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to</b>
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	Group is sponsored by HBDHB  Could be a perceived conflict, however will not take part in any discussions relating to any contract matters if these arise.
	NZ Sustainable Business Council	Deputy Chair	Sustainable Development	No	
	HB Diabetes Leadership Team	Chair	Leadership group working to improve outcomes for people in HB with diabetes	No	
	Advancing life cycle management thinking across NZ	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
	U Turn Trust	Trustee	Relationship and and may be contractual from time to time	Yes	
	Integrated Pharmacist Services in the Community (National Committee)	Steering Group Member	Health and wellbeing	No	
Rosemary Marriott	YMCA of Hawke's Bay	President	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.			No	
	Age Concern Hawke's Bay	Board Member		No	
	Positive Aging Trust	Committee Member		No	
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	If contracted for service, there could be a perceived conflict of interest.  Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	

HB Health Consumer Council 10 August 2017 - Interests Register

<b>Name Consumer Council Member</b>	<b>Interest eg Organisation / Close Family Member</b>	<b>Nature of Interest eg Role / Relationship</b>	<b>Core Business Key Activity of Interest</b>	<b>Conflict of Interest Yes / No</b>	<b>If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to</b>
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon	Hastings District Councillor Sport Hawke's Bay Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Board of Trustees Allocation Committee Hastings District Council Rep	Non paid role	No No No No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara	TBA				

**MINUTES OF THE COMBINED MEETING OF THE  
HAWKE'S BAY CLINICAL COUNCIL AND HAWKE'S BAY CONSUMER COUNCIL  
HELD IN THE "TAKARANGI" CONFERENCE ROOM, TE TAIWHENUA O HERETAUNGA,  
821 ORCHARD ROAD, HASTINGS  
ON WEDNESDAY, 12 JULY 2017 AT 3.00 PM**

**PUBLIC**

**Present:**

***Clinical Council:***

Chris McKenna (Co-Chair)  
Dr Mark Peterson (Co-Chair)  
Dr Tae Richardson  
Dr John Gommans  
David Warrington  
Dr Andy Phillips  
Lee-Ora Lusi  
Debs Higgins  
Jules Arthur  
Dr Nicholas Jones  
Maurice King

***Consumer Council:***

Graeme Norton (Chair)  
Rosemary Marriott  
Heather Robertson  
Terry Kingston  
Tessa Robin  
Sami McIntosh  
Deborah Grace  
Olive Tanielu  
Jim Henry  
Malcolm Dixon  
Sarah Hansen  
Dallas Adams  
Kylarni Tamaiva-Eria

**In Attendance:**

Ken Foote, Company Secretary (Co. Sec)  
Tracee Te Huia, Acting Chief Executive Officer (Acting CEO)  
Kerri Nuku, Maori Relationship Board Representative  
Linda Dubbeldam, Health Hawke's Bay representative  
Tracy Fricker, Council Administrator and EA to EDP&Q  
Jill Garrett, Strategic Services Manager – Primary and Carina Burgess,  
Head of Planning (*Clinical Services Plan item only*)

**Apologies:**

Dr Russell Wills, Dr Robin Whyman, Dr David Rodgers, Dr Kiri Bird, Anne McLeod, Leona Karauira, Dr Dianne Mara, Jenny Peters and Rachel Ritchie

**SECTION 1: JOINT DISCUSSION WITH HAWKE'S BAY CONSUMER COUNCIL**

**1. WELCOME AND INTRODUCTIONS**

Graeme Norton (Chair of Consumer Council) welcomed everyone to the combined meeting of the Clinical and Consumer Councils. Tracee Te Huia, Acting CEO provided a Karakia.

Chris McKenna (Co-Chair of Clinical Council) welcomed the new member of the Clinical Council, Maurice King, Community Pharmacist who has been appointed Council while Billy Allen, Chief Pharmacist is seconded to the Health Quality & Safety Commission for six months.

Graeme Norton also acknowledged the two new members recently appointed to the Consumer Council, Deborah Grace who is in attendance today and Dr Diane Mara who starts next month.

## **2. CLINICAL SERVICES PLAN**

Graeme Norton introduced David Moore and Tom Love from Sapere Research Group who were here to facilitate discussion on the Clinical Services Plan.

Graeme Norton introduced the topic he, Tae Richardson and Andy Phillips had prepared a short pre-reading paper as a warm-up for discussion on the topic.

Roundtable discussion took place, the feedback from which was captured by Sapere Research Group who will present back at future Clinical and Consumer Council meetings.

The Chair thanked everyone for their contributions.

## **3. SURGICAL EXPANSION PROJECT – CLINICAL AND CONSUMER ENGAGEMENT**

Chris McKenna (Co-Chair) welcomed Rika Hentschel, Surgical Director and her team which included John Rose, Clinical Director, Anna Harland, Perioperative Unit Manager and Ben Duffus, Improvement Advisor to the meeting to present on the project.

### **Key points:**

- Phase 1 – indicative business case approved by the Board in March 2017
- Phase 2 – workstreams for production planning capacity planning; delivery planning; capital works and detailed business case. Steering Group and Clinical Advisory Group established as well as stakeholder and user groups used for co-design, process reviews, model of care changes and floor space layout.

### **Questions / Feedback:**

- Outsourced work to Royston, does that mean patients will not return to the hospital? Correct, these patients are screened and potentially do not need intensive care, short stays (1-2 days) and day cases.
- A lot of great work is going on with the partnership with Royston and our tertiary providers, day surgery rates, model of care work, outpatient procedures, changes to the model of care and changing practice by doing things outside of theatre which were previously done in theatre.
- How will this re-organisation impact on waiting lists? We are looking at our 4 month waiting time for first specialist assessment and to see if we can do better, we hope the changes being made will enhance this process as well. The changes will increase our capacity and we are also anticipating an increase in demand. It is hard to predict a waiting time for an individual because the increase in demand is developing as the population ages.

The Co-Chair thanked the team for their presentation and congratulated them on the work done so far.

#### 4. COMMUNITY PHARMACY SERVICES AGREEMENT

The Co-Chair welcomed Di Vicary, Portfolio Manager to the meeting. Di provided an update on the community pharmacy services agreement contract which has been extended for 12 months to give certainty to the sector as a new contract is developed in readiness for 1 July 2018. The new contract will align with the other two national contracts for Aged Related Residential Care and Primary Health Organisation and will be consistent in delivering the key objectives of the New Zealand Health Strategy and the Pharmacy Action Plan. The contract extension includes additional funding for smoking cessation; workforce development and long term conditions for mental health.

It was acknowledged that the contract negotiations had been challenging but that they are trying to make the national contract be flexible regionally to reduce barriers and free up access for consumers. It is our opportunity to have a say on how this additional funding is spent in Hawke's Bay.

Please provide feedback on the draft terms of reference for Pharmacy Services in the Community Development Group to [di.vicary@hbdhb.govt.nz](mailto:di.vicary@hbdhb.govt.nz).

#### 5. 2017/8 BUDGET

The Co-Chair welcomed Ashton Kirk, Acting Finance Manager to the meeting. Ashton provided a presentation on the HBDHB budget for the 2017/18 financial year, pre and post receipt of the funding envelope from the MoH on 26 May 2017.

A breakdown summary was provided, and explanation given on scenarios regarding five options presented to the Board. At the Board Meeting on 28 June, option 5 was approved, being budget for \$0.5 million surplus, \$3.0 million contingency offset by a "risk reserve" of \$0.6 million, and \$0.3 million rising to \$1.0 million investment. Also to maintain a universal savings target of 2.0%, writing off the bulk (77.6%) of "unidentified savings" accumulated in budget lines. The Board also requested a change to the word surplus to "new investment" or "capital investment fund".

The plan has been submitted to the MoH and we are waiting approval.

The Co-Chair thanked Ashton Kirk for the presentation.

The Co-Chair thanked the Consumer Council members for attending the joint meeting and brought the meeting to a close. The Clinical and Consumer Councils re-convened for their separate meetings.

The combined meeting closed at 5.40 pm.

Confirmed:

Chair

Date:





**MINUTES OF THE HAWKE'S BAY CONSUMER COUNCIL  
HELD IN THE "TAKARANGI" CONFERENCE ROOM, TE TAIWHENUA O HERETAUNGA,  
821 ORCHARD ROAD, HASTINGS  
ON WEDNESDAY, 12 JULY 2017 AT 5.40 PM**

**PUBLIC**

**Present:** Graeme Norton (Chair)  
Rosemary Marriott  
Heather Robertson  
Terry Kingston  
Tessa Robin  
Olive Tanielu  
James Henry  
Sarah Hansen  
Malcolm Dixon  
Sami McIntosh  
Deborah Grace  
Dallas Adams  
Kylarni Tamaiva-Eria

**In Attendance:** Ken Foote, Company Secretary (Com. Sec)  
Linda Dubbeldam, Health Hawke's Bay Representative

**Apologies:** Jenny Peters, Dr Diane Mara, Leona Karauria and Rachel Ritchie

**SECTION 2: ROUTINE**

Following the combined meeting with the Hawke's Bay Clinical Council the Consumer Council members re-convened separately and held a short meeting to discuss routine business items.

**6. APOLOGIES**

Apologies received as noted above.

**7. INTERESTS REGISTER**

No new interests or changes to the register were noted.

**8. MINUTES OF PREVIOUS MEETING**

The minutes of the Hawke's Bay Health Consumer Council meeting held on 15 June 2017 were confirmed as a correct record of the meeting.

Moved and carried.

**9. MATTERS ARISING – REVIEW ACTIONS**

**Item 1: Presentation by Anne Speden, Chief Information Officer (CIO)**

An invitation to present at the August meeting has been accepted by the CIO.

**Item 2: Topics of Interest / Member Issues / Updates**

The MoH disability recommendations letter was included in the June meeting papers but was not discussed due to time constraints. Carry forward for future discussion

**Item 3: Consumer Engagement Strategy**

The latest version of the document was sent to Consumer Council members. *Item can be closed.*

**Item 4: Funding Opportunities for the Youth Council**

Contact details not yet forwarded. To be followed up.

**Item 5: Consumer Council Annual Plan**

This item is to be discussed at the August meeting. The Chair encouraged all members to review the plan before the next meeting, to particularly consider what has changed, what could be taken out, what should be added in, and what the priorities should be.

**Item 6: Patient Experience Project**

Actioned. *Item can be closed.*

**10. WORK PLAN**

The Chair advised the work plan is included in the meeting papers for information.

**11. TOPICS OF INTEREST MEMBER ISSUES / UPDATES**

- Consumer Councils Nationally – the Chair updated the meeting on work he is doing in supporting the development of Consumer Council equivalents in other DHBs. Many are choosing to model themselves on Hawke's Bay. The current situation is:
  - 9 Councils are functioning
  - 8 have been approved and are currently being formed
  - 2 are still in discussion phase
  - 1 appears to have no current action but an intent has been identified
- Concern was expressed and noted around the way some student nurses had not been able to access some staff facilities within the hospital. The Chair advised that this issue had been raised at MRB earlier in the day, with senior DHB leaders expressing surprise and extreme disappointment that this had occurred. Assurances were provided that this will be addressed immediately.

**12. KARAKIA WHAKAMUTUNGA (CLOSING)**

The Chair thanked everyone for their attendance and input.

The meeting closed at 5.55 pm.

Confirmed: \_\_\_\_\_  
Chair

Date: \_\_\_\_\_

## HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising  
Reviews of Actions

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Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	11/05/17	CIO Anne Speden to be invited to attend June meeting to discuss <b>IS Plan</b> and listen to top issues for consumers.	Chair	June	Agenda item August
2	11/05/17	<b>Topics of Interest - Member Issues / Updates</b> <ul style="list-style-type: none"> <li>Ministry of Health Letter on Disability re: recommendations from investigation in 2008/09 to be sent out to Consumer Council Members. To be discussed at next meeting</li> </ul>	Chair / CEO	June	Not considered in June
	15/06/17	<ul style="list-style-type: none"> <li>Kate Coley will review the recommendations with EMT and come back to Council with further detail. Timing to be advised</li> </ul>	Kate Coley	TBC	TBC
3	15/06/17	<b>Funding Opportunities for the Youth Council</b> <ul style="list-style-type: none"> <li>Malcolm Dixon offered to provide contact details to Kylarni and Adam to seek support within the Hastings District Council's Social Development Group.</li> </ul>	Malcolm Dixon		To be followed up
4	15/06/17	<b>Consumer Council Annual Plan</b> <ul style="list-style-type: none"> <li>Discussion points raised to be worked through and on issue will be provided in A3.</li> </ul>			Agenda item August
5	12/07/17	<b>Topics of Interest - Member Issues / Updates</b> <ul style="list-style-type: none"> <li>Concern raised re: student nurses not able to access some staff facilities in hospital</li> </ul>	Chair	TBC	TBC





## HB HEALTH CONSUMER COUNCIL WORKPLAN 2017-2018

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Meetings	Papers and Topics	Lead(s)
<b>6 Sept</b> <b>9am-3pm</b>	<b>HB Health Sector Leadership Forum, East Pier, Napier</b>	
<b>14 Sept</b>	Social Inclusion Metabolic (Bariatric) Surgery - in the context of a Healthy Weight Strategy for Adults Position on Reducing Alcohol Related Harm Implementing the Consumer Engagement Strategy Quality Accounts (Final) Quality Dashboard Concept paper Quality Annual Plan 2017/18 Consumer Experience Feedback Quarterly Report Waioha Primary Birthing Unit - Benefits Realisation <b>Monitoring (info only)</b> Te Ara Whakawaiaora - Healthy Weight (national indicator) Te Ara Whakawaiaora - Culturally Competent Workforce (local indicator)	Tracee TeHuia/Carina Burgess Tracee TeHuia/Jill Garrett  Tracee TeHuia / Rachel Eyre Kate Coley/Jeanette Rendle Kate Coley/Jeanette Rendle Kate Coley Kate Coley Kate Coley/Jeanette Rendle Chris McKenna / Jules Arthur
<b>12 Oct</b>	Bowel Screening Collaborative Pathways Update Establishing Health and Social Care Localities in HB	Tracee TeHuia Leigh White Tracee TeHuia
<b>9 Nov</b> <i>With Clinical Council TBC</i>	Recognising Consumer Participation - Policy Amendment Best Start Healthy Eating & Activity Plan update People Strategy (2016-2021) – update Tobacco Annual Update against plan <b>Monitoring (info only)</b> Te Ara Whakawaiaora - Smoking (national indicator) Annual Maori Plan Q1 July-Sept 17 – Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard	Kate Coley/Jeanette Tracee TeHuia / Shari Tidswell Kate Coley Tracee TeHuia / Johanna Wilson
<b>7 Dec</b>	Consumer Experience Feedback Results Qtly	Kate Coley /Jeanette
<b>15 Feb 18</b>	Quality Annual Plan 2017/18 – 6 month review People Strategy Clinical Services Plan Collaborative Pathways Annual Maori Plan Q2 Dashboard <b>Monitoring</b> Te Ara Whakawaiaora / Access 0-4 / 45-65 year (local indicator) Annual Maori Plan Q2 Oct-Dec 17 – Dashboard Pasifika Health Plan Q2 Oct-Dec 17 – Dashboard	Kate Coley Kate Coley Tracee TeHuia / Carina Leigh White Tracee TeHuia / Patrick  Mark Peterson Tracee TeHuia Tracee TeHuia





## CHAIR'S REPORT

Verbal







## **CONSUMER ENGAGEMENT MANAGER'S REPORT**

Verbal





## YOUTH CONSUMER COUNCIL REPORT

Verbal





## **INFORMATION SERVICES PLAN / CONSUMER ISSUES**

**Anne Speden, Chief Information Officer**

Verbal



 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Quality Annual Plan – Review 2016–2017</b>
	For the attention of: <b>Clinical Council, Consumer Council &amp; Finance Risk and Audit Committee</b>
Document Owner & Author:	Kate Coley – Executive Director of People & Quality
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Information

**RECOMMENDATION**

**That Clinical Council, Consumer Council & the Finance Risk and Audit Committee:**

1. Note the contents of the report

**PURPOSE**

The purpose of this paper is to provide the Clinical & Consumer Councils and FRAC with a full review of the Quality Improvement & Patient Safety Annual Plan 2016/17.

**EXECUTIVE SUMMARY**

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. The annual plan for 2016/17 was aligned to a number of foundational documents as follows:

- Hawke's Bay "Working in Partnership for Quality Framework"
- National programmes & safety markers (Health Quality & Safety Commission)
- Regional priorities (RSP through the Central regions Safety & Quality Alliance)
- Transform & Sustain
- HQSC "Governing for Quality" February 2016 publication

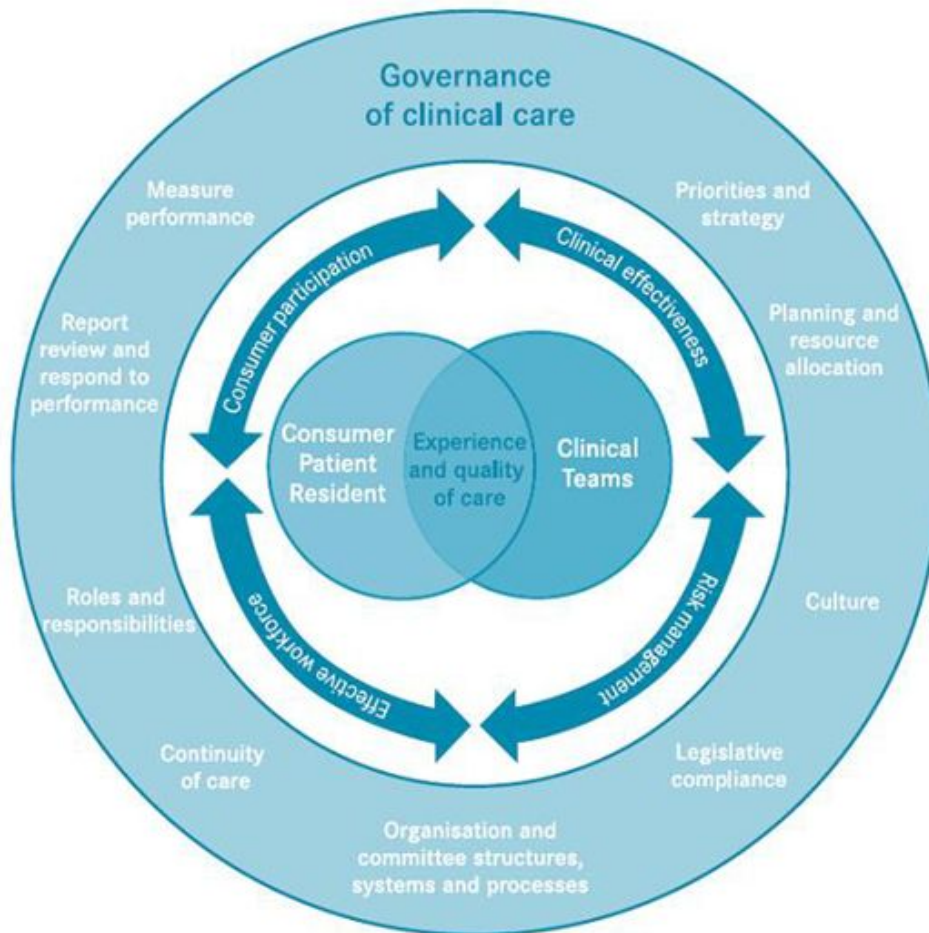
In addition to this the DHB aligned the annual plan to the recognised definition of clinical governance and framework.

Clinical Governance is defined as

*"the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community"*

An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement.

The below framework aligns to both the domains of quality and safety and provides the key principles on which good clinical governance is based.



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The key challenge as an organisation and the wider sector is to continue to maintain and embed the quality framework so as to ensure that patient safety and quality of clinical care is part of everyone's business and is embedded in our culture.

Appendix 1 details the progress against agreed objectives for 2016 – 17 in relation to embedding a clinical governance framework.

## SUMMARY OF ACHIEVEMENTS

The following highlights the key achievements and activities that have been implemented in the past 12 months:

- Significant improvement in directorates and services engagement with consumers in co-design projects. The Consumer Engagement manager has provided support and advice for projects, improvement initiatives and developed capability around ensuring that the consumer's voice is heard.

<sup>1</sup> Victorian Clinical Governance Policy Framework, 2009



- Improvement advisors becoming embedded with Directorate leadership teams and providing a high level of support and expertise in key programmes of work including Faster Cancer Treatment, FLOW, Surgical Expansion.
- Achievement of all HQSC Safety markers and maintaining number one position in Hand Hygiene for the last three quarters of 2016/17.
- Investment made to increase the skills and capability of teams in relation to improvement methodology, patient safety, privacy matters and consumer engagement.
- Establishment and endorsement of a new clinical governance committee structure and advisory groups providing assurance to Clinical Council and Board on matters relating to patient safety and clinical quality.
- Positive feedback from MoH and HQSC on our fourth Quality Accounts publication.
- Development of Relationship Centred Practice development programme supporting clinicians to improve their face to face engagement with consumers across the central region.
- Development of the Consumer Engagement Strategy with the implementation falling into the refreshed Transform & Sustain programme of work.
- Full RFP process undertaken to identify a provider for the new cross sector integrated risk management system.
- Better relationships built at a local level with the PHO, Primary Care and other contracted providers through interactions with experts from the People & Quality directorate.

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## KEY PRIORITIES FOR 2017-18

The following identifies the key priorities for the 2017-18 annual plan, which will be far more focussed on significant projects and pieces of work rather than the normal business as usual activities.

- Projects and activities relating to the implementation of the health literacy principles
- Full implementation of the clinical governance committee structure and the establishment of an effective communication and reporting framework, ensuring clinical assurance and the sharing of learnings across the sector.
- Development and implementation of the Quality dashboard which will be reported quarterly to Clinical Council and FRAC/Board.
- Implementation of the new Integrated Risk Management System across the DHB and the development of a rollout across the rest of the sector over the next 3-5 years.
- Implementation of a new local patient experience survey and mechanisms for closing the loop with our patients identifying the improvements that we have implemented based on that feedback.
- Utilisation of internal audit to review the self-assessment undertaken in August 2016 aligned to the HQSC "Governing for Quality" publication to ensure that this was objective assessment and provide recommendations for any further improvement.
- Continue to grow the capability of clinical teams across the sector ensuring a sustainable improvement and accountability model going forwards.





## A DISABILITY STRATEGY FOR HBDHB

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### HAWKE'S BAY HEALTH CONSUMER COUNCIL ANNUAL PLAN 2016/17


Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
<b>FUNCTIONS</b>	<ul style="list-style-type: none"> <li>Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: <ul style="list-style-type: none"> <li>Development of health service priorities</li> <li>Strategic direction</li> <li>The reduction of inequities</li> </ul> </li> <li>Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery.</li> <li>Seek to ensure that services are organised around the needs of all consumers</li> </ul>	<ul style="list-style-type: none"> <li>Identify and advise on issues that will improve clinical quality, patient safety and health literacy.</li> <li>Seek to enhance consumer experience and service integration across the sector.</li> <li>Promote equity of access/treatment</li> <li>Seek to ensure that services are responsive to individual and collective consumer needs.</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes bay health system</li> <li>Ensure, coordinate and enable appropriate consumer engagement within the health system <ul style="list-style-type: none"> <li>across Hawke's Bay</li> <li>within the Central region</li> <li>at National level</li> </ul> </li> <li>Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities.</li> <li>Ensure regular communication and networking with the community and relevant consumer groups.</li> <li>Link with special interest groups as required for specific issues and problems solving.</li> </ul>
<b>STRATEGIES</b>	<ul style="list-style-type: none"> <li>Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system.</li> <li>Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations.</li> <li>Review and comment on all relevant reports, papers, initiatives to the Board.</li> </ul>	<ul style="list-style-type: none"> <li>Work with Clinical Council to develop and maintain an environment that promotes and improves: <ul style="list-style-type: none"> <li>Putting patients / consumers at the centre</li> <li>Patient safety</li> <li>Consumer experience</li> <li>Clinical quality</li> <li>Health literacy</li> <li>Equity</li> </ul> </li> <li>Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness.</li> </ul>	<ul style="list-style-type: none"> <li>Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making.</li> <li>Ensure good attendance and robust discussions at monthly Consumer Council meetings</li> <li>Co-ordinate consumer representation on appropriate committees and project teams: <ul style="list-style-type: none"> <li>Within Hawke's Bay</li> <li>At Central Region and National levels</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these</li> <li>• Consumer Council members to be allocated portfolio/areas of responsibility.</li> </ul>	<ul style="list-style-type: none"> <li>• Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'.</li> <li>• Advocate / promote for Intersectoral action on key determinants of health.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage with HQSC programmes around consumer engagement and 'partners in care'.</li> <li>• Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations.</li> <li>• Provide regular updates on both the HBDHB and Health Hawke's Bay websites</li> <li>• Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities</li> </ul>
<b>OBJECTIVES 2016/17</b>	<ul style="list-style-type: none"> <li>• Actively promote and participate in' co-design processes for: <ul style="list-style-type: none"> <li>- Youth</li> <li>- Mental Health</li> <li>- Older Persons</li> </ul> </li> <li>• Participate in the development of Health and Social Care Networks</li> <li>• Provide consumer perspective into Customer focussed Booking</li> </ul>	<ul style="list-style-type: none"> <li>• Promote and assist initiatives that will improve the level of health literacy within the sector and community.</li> <li>• Facilitate and promote the development of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council.</li> <li>• Promote the provision of consumer feedback and 'consumer stories'.</li> <li>• Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure.</li> <li>• Facilitate a focus on disability issues</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay</li> <li>• Establish a connection with Youth within the community</li> <li>• Influence the establishment and then participate in regional and national Consumer Advisory Networks.</li> </ul>

Portfolios and areas of interest	HB Health Consumer Council Members:	
<p><b>AREAS OF INTEREST</b></p> <ul style="list-style-type: none"> <li>- Women's health Sami, Olive, Leona</li> <li>- Child health Sami, Malcolm, Rachel</li> <li>- Youth health Dallas, Kylarni</li> <li>- Older Persons health Jenny, Heather</li> <li>- Chronic conditions Rosemary, Terry, James, Rachel</li> <li>- Mental Health Terry</li> <li>- Alcohol and other drugs Dallas, Kylarni, Rosemary</li> <li>- Sensory and physical disability Sarah, Heather, Tessa</li> <li>- Intellectual and neurological disability Heather, Olive</li> <li>- Rural health Leona, Terry</li> <li>- Māori health Tessa, Leona, James, Sami</li> <li>- Pacific health Olive, Sami, Tessa</li> <li>- Primary health Jenny, Rachel, Rosemary</li> <li>- High deprivation populations Jenny, Leona</li> </ul> <p><b>2016-17 PORTFOLIOS</b></p> <ul style="list-style-type: none"> <li>- Co-Design Youth: Dallas, Kylarni</li> <li>- Co-Design Mental Health: Terry &amp; PAG</li> <li>- Co-Design Older Persons: Jenny, Heather, Rosemary</li> <li>- Health and Social Care Networks: Tessa, Rachel, Jenny, Leona, Terry</li> <li>- Customer Focussed Booking: Tessa, Sarah</li> <li>- Health Literacy: James, Leona, Olive</li> <li>- Person and Whānau Centred Care: Rosemary, Leona</li> <li>- Patient Experience Committee (of Clinical Council): Sami, Terry</li> <li>- Disability: Sarah, Heather, Terry</li> <li>- Consumer Engagement Strategy: ALL</li> </ul>	<p>Graeme Norton (Chair) HASTINGS</p> <p>Jim Henry NAPIER</p> <p>Jenny Peters NAPIER</p> <p>Olive Tanielu HASTINGS</p> <p>Heather Robertson NAPIER</p> <p>Leona Karauria NUHAKA</p> <p>Rosemary Marriott HASTINGS</p> <p>Terry Kingston WAIPAWA</p> <p>Tessa Robin NAPIER</p> <p>Malcolm Dixon HAVELOCK NORTH</p> <p>Rachel Ritchie HAVELOCK NORTH</p> <p>Sarah Hansen HASTINGS</p> <p>Samitioata (Sami) McIntosh HASTINGS</p> <p>Dallas Adams HASTINGS</p> <p>Kylarni Tamaiva-Eria HASTINGS</p>	<p><a href="mailto:graeme.norton@clear.net.nz">graeme.norton@clear.net.nz</a></p> <p><a href="mailto:jimbhenry@hotmail.co.nz">jimbhenry@hotmail.co.nz</a></p> <p><a href="mailto:peters.jenny26@gmail.com">peters.jenny26@gmail.com</a></p> <p><a href="mailto:olivetanielu@rocketmail.com">olivetanielu@rocketmail.com</a></p> <p><a href="mailto:Heather.hb@xtra.co.nz">Heather.hb@xtra.co.nz</a></p> <p><a href="mailto:Info@s-a-s.co.nz">Info@s-a-s.co.nz</a></p> <p><a href="mailto:roseandterry@xtra.co.nz">roseandterry@xtra.co.nz</a></p> <p><a href="mailto:terrykingston@xtra.co.nz">terrykingston@xtra.co.nz</a></p> <p><a href="mailto:tessa.robin@tkh.org.nz">tessa.robin@tkh.org.nz</a></p> <p><a href="mailto:dixonmj24@icloud.com">dixonmj24@icloud.com</a></p> <p><a href="mailto:andyrach@xtra.co.nz">andyrach@xtra.co.nz</a></p> <p><a href="mailto:hansennorsemen@xtra.co.nz">hansennorsemen@xtra.co.nz</a></p> <p><a href="mailto:smkoko@live.com">smkoko@live.com</a></p> <p><a href="mailto:Dallasadams31@gmail.com">Dallasadams31@gmail.com</a></p> <p><a href="mailto:kylarnitamaivaeria@hotmail.com">kylarnitamaivaeria@hotmail.com</a></p>

<p><b>Support:</b></p> <p><b>Operational and Minutes</b>  Kate Coley (Executive Director, People and Quality)  Tracy Fricker (Council Secretary and EA to ED People and Quality)  Jeanette Rendle (Consumer Engagement Manager)</p> <p><b>Clinical Council Liaison</b>  Debs Higgins</p> <p><b>Governance</b>  Ken Foote (Company Secretary)  Brenda Crene (Board Administrator and PA to Co-Secretary)</p> <p><b>Communications</b>  Anna Kirk (Communications Manager)</p>	
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	<b>Ka Aronui Ki Te Kounga / Focussed on Quality (draft)</b>
	For the attention of: <b>Māori Relationship Board, Clinical and Consumer Council</b>
Document Owner:	Kate Coley, Executive Director People and Quality
Document Author	Jeanette Rendle, Consumer Engagement Manager
Month:	August 2017
Consideration:	For Endorsement

**RECOMMENDATION****That the Māori Relationship Board, Clinical and Consumer Council:**

- Endorse the new format of the Quality accounts and provide feedback on layout and content.

**OVERVIEW**

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually. Since that time HB health sector has published four sets of accounts detailing our performance against both national and local quality and safety indicators.

The Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver. As they are aimed at our community the aim is to keep them as short as possible, be visual, simple to read and understand, using photo's, images, stories, quotes, and examples to enhance the results and achievements.

The guiding principles are:-

- Accountability and transparency
- Meaningful and relevant whole of system outcomes
- Continuous quality improvement

**FEEDBACK ON HB QUALITY ACCOUNTS 2016**

Last year a working group was established to support the development and review of the Quality accounts publication for our community. It was a huge undertaking and presented multiple challenges. The link to last year's accounts as follows:

<http://www.ourhealthhb.nz/assets/Publications/Our-Quality-Picture-2016-sml2.pdf>

Previously the HQSC has reviewed all Quality Accounts providing annual feedback individually to DHB's and across New Zealand. From 2016, HQSC no longer provide feedback.

In 2016 around 400 publications and accompanying advertising posters were distributed across the community – to GP practises, health centres, public libraries, and community groups. The accounts were advertised in local newspapers and available on ourhealth website. It has been difficult to quantify the level of readership. Feedback from the community was limited.

The feedback from stakeholders and community that we did receive resulted in the recommendation to have a smaller, more concise document this year with increased focus on the quality improvements that have come about from community feedback and consumer engagement. A 'you said, we did' type format. Also, less emphasis on improvements and quality initiatives within services (which perpetuates the idea of working in silos) with increased emphasis on improvements as a result of working together across the sector; in particular more content from Primary care.

**Recommendation:**

The communications team have developed a template based on the recommendations and articles that have been gathered thus far. This is a starting point and provides a flavour for the document. We anticipate profiling another staff member (from PHO) and are waiting on content from Primary care which will include a day in the life of Te Mata Peak practise during the gastro outbreak and will profile Totara and Choices new #whanau work.

I am looking for endorsement to proceed with this new tabloid publication and take any feedback on layout and content that will inform the final draft copy.

The final draft publication will come back to you next month before going to Board for endorsement in September.



# KA ARONUI KI TE KOUNGA

## FOCUSSED ON QUALITY

### OUR QUALITY PICTURE 2017

Kia ora and welcome to the fifth edition of “Our Quality picture”. This is a snapshot of how the health system is working to meet the needs of the Hawke’s Bay community. People should be at the centre of health care and inside we focus on what we have done in the last year in response to feedback from our consumers and community.

We also recognise that providing healthcare is not without risks and sometimes people can be unintentionally harmed while undergoing care. Our aim is to reduce this harm and inside we outline our progress in this area, and how we measure up nationally against patient safety priorities and national health targets.

Kate Coley, Executive Director of People and Quality

# Our Quality Commitment

Our commitment and pledge to you is:

That as individuals, and as a health sector, we continually improve  
the safety and quality of health care for all

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To ensure that we have a blame free culture that embraces  
consumer involvement

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That we put the patient at the centre of everything we do and  
focus on continuous improvement

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That we ensure all of our teams are well supported  
and have the skills to deliver high quality  
and safe patient care, every time.

## Ko ā koutou whakahokinga kōrero Your feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

You can give feedback in a number of ways:

- email us: [feedback@hbdhb.govt.nz](mailto:feedback@hbdhb.govt.nz)

- complete an online feedback form: [www.ourhealthhb.nz](http://www.ourhealthhb.nz)
- Phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

# Ngā whāinga hauora ā-motu

## National health targets

HEALTH TARGET	TARGET	OUR RESULT (04 2015/16)	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not achieved (93%)	↓	Hawke's Bay DHB continues to focus on improving flow through the Emergency Department. Additional staff are being employed to support this.
Improved access to elective surgery	100%	Exceeded (105%)	↑	This year we have continued to focus on Operation Productivity and increasing Hip and Knee surgeries to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved (63%)	N/A	This is a new national health target. The Faster Cancer Treatment team are working with improved processes to identify patients on the cancer pathway and we expect to see improvement in the coming year.
Increased immunisation	95%	Achieved	-	Hawke's Bay DHB remains one of the top performers in this Health Target. All immunisation service providers are working well together.
Better help for smokers to quit (Hospitals)	95%	Exceeded (99%)	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved (81%)	↓	Health Hawke's Bay continues to work with general practices to improve smokefree interventions.
More heart and diabetes checks	90%	Not achieved (88%)	↓	Health Hawke's Bay continue to focus on priority groups who are most at risk of heart disease and diabetes.

### KEY:

- ↑ Improved our performance against the health target.
- ↓ Our performance against the health target has declined
- Our performance against the health target has stayed the same.



## You asked, we did

The following articles are examples of some of the things you told us through your feedback and what we are doing about it.

### Youth Consumer Council

The Hawke's Bay Health sector has its own youth consumer council (YCC). The first of its kind in the country!

The formation of YCC was recommended as part of the youth health strategy that was finalised in July 2016. The development of this involved lots of consultation with health sector staff, community groups and youth in Hawke's Bay.

We learned that youth partnerships, leadership and collaboration across the health system was really important. YCC was initiated in late 2016 to help make this happen!

Aged between 12 and 24, the members of YCC ensure the youth voice is heard. They will also help the health system with ideas and concepts so it can be better connected with young people.

Charged with getting out and about, the council also meets with individuals in the community, other organisations and established youth groups so they can be well informed about what motivates young people to be proactive about their health. By engaging with youth face to face and interacting in different forums YCC were able to confirm their three priorities:

- Teen Suicide Awareness
- Drug and Alcohol culture
- Mental Healthcare Hawke's Bay

Dallas Adams, Chair of YCC and member Kylarni Tamaiva-Eria attend monthly Hawke's Bay Health Consumer Council meetings. Whilst they found it intimidating at first they have now made positive connections and feel confident they have a platform to voice youth opinion and influence decision making in the health system. "They encourage us to have a say and that makes us feel valued" says Dallas.

#### Did you know

**There are 19,300 15-24 year olds in Hawke's Bay. This is 12% of the total population.**

**Around 2,019 (11%) youth live in rural areas and 15,984 live in urban areas (based on 2013 census)**

YCC member Deveraux Short-Henare has enjoyed learning about the health system and how in his role he can influence changes to better meet the needs of youth. "I accepted the nomination because I honestly believe that youth need to be represented and have a say on what a 'youth' health system looks like and I think this group can enable that to happen". Deveraux and fellow member Tremayne Kotuhi recently represented YCC at Festival for the Future 2017. Hundreds of young innovators and influencers all gathered in Auckland to connect, explore issues, be inspired, and build ideas and skills to create the future. Tremayne came back motivated with new connections and ideas to test in Hawke's Bay.

The council has its own Facebook page, HB Youth Consumer Council, where you can keep up-to-date with what they are up to.



## Improving how we communicate with you

**“He did not tell us what he was going to do. He went ahead without informing us or including us in the decision.”**

It is not uncommon for you to tell us, as health professionals, that we could do better at listening to what you have to say, understanding what is most important to you and including you and your whanau in decisions about your care and treatment.

To support our staff in improving communication with consumers we started a training programme in March 2017 called “relationship centred practice” which has so far been delivered to over one hundred Allied Health Professionals (Physiotherapists, Occupational Therapists, Social Workers etc.). Online learning modules and face to face training workshops were developed with consumer involvement.

The training is a sustainable, skills based training package which is aimed at providing health professionals with practical methods and strategies to enhance their interactions with consumers and their whanau. This includes working in partnership, finding out what is important, what really matters to the consumer in terms of healthcare, and working together to come up with solutions.

This mana enhancing practice clearly puts the consumer and their whanau at the centre of their own healthcare - working in collaboration, building on strengths and being well supported to achieve the goals that are important in the context of their lives. It is focused on improving the connection and quality of interactions with consumers who in turn get greater engagement and thereby health outcomes are improved.

We have plans to roll this out to other health professionals in the hospital and community settings in 2017/18.

**Staff have found this training valuable and it has allowed them to reflect on and improve their practise.**

**“I am much more aware of focusing on what the families want, how important it is to them and changing my approach to empower them more”.**

**“The facilitator delivered the message effectively and simply and made me see how vital whakawhanaungatanga is, with every patient I see”.**

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## Health literacy - making healthcare easy to understand

Health literacy is about making sure healthcare is easy for people to find, understand and use so that they can look after their health and wellness.

To do this HBDHB has committed to changing the way we deliver health care to the people of Hawke's Bay. We have taken the first step by setting some rules around how we provide information such as pamphlets and letters, as well as how our health professionals talk to you about your health and wellness.

The next step is to make sure everyone working in the HBDHB is aware of the importance of making healthcare easy to understand. This involves working alongside our services and health professionals to help them make the changes that are needed to ensure this happens.

Ultimately, we want to make it as easy as possible for people to find the correct information or get to the right healthcare services, so they understand how they are best to take care of themselves.

Achieving this will take time, but people will progressively notice a difference in the way they receive information and healthcare services in Hawke's Bay.

To make this easier, we need the help of our consumers to tell us how we are doing throughout this journey and where we need to make improvements and changes. Feel free to email us at [feedback@hbdhb.govt.nz](mailto:feedback@hbdhb.govt.nz) with your thoughts.

This will go a long way in making sure healthcare is easy to understand to help you be well, get well and stay well.



## National Patient Safety Priorities

The Health Quality and Safety Commissions (HQSC) key role is to publish information including targets about the quality of health care in New Zealand. By having a target we can monitor how we compare with other DHB's which will challenge us to do better. For more information look at the website [www.hqsc.govt.nz](http://www.hqsc.govt.nz).

The four main ways we can monitor how we compare with other DHBs are by:

- reducing the number of injuries from a fall while in hospital or residential care by assessing people and having a plan to look after them
- stopping people from getting an infection while in hospital or during surgery by having good hand hygiene and giving antibiotics before surgery
- preventing people from having more problems because of medication they require
- decreasing problems just from having surgery.

We know we are getting better at this because our results in the January to March 2017 quarter tells us that Hawke's Bay compared to other DHB's are in the top areas for three out of the four areas and we are working hard to improve the fourth area which is the safer surgery marker. The safer surgery marker compares how well surgical staff complete safety checklists and although we know they are doing it – we need to get better at proving it.



Staff and visitors participating in a Tai Chi taster class lead by Sport Hawke's Bay.

Our Falls Campaign across the whole region focused on improving balance and strength, we had a great month working with other providers and we ended up being recognised nationally for our work. This is something everyone can do to help themselves – as we age it's harder to keep our balance and keep strong in our legs. But there are a lot of community programmes to help – staff and visitors tried Tai Chi this year – thanks to Sport HB. Look at their website for a list of programmes [www.sporthb.net.nz](http://www.sporthb.net.nz)

Other national programmes which are coordinated by the HQSC include:

- Recognising Deteriorating Patients - Getting better at identifying when someone is getting sicker while in hospital and having a plan to help them faster;
- Medication Management - Helping people who are in pain and need strong medication to help them, which sometimes means they get constipated – ie. you can't have a 'poo' as often as you would normally, this is a problem so we are doing some things to stop this, for example: making sure if strong medication is needed, medicine to make you poo is also given.
- National Patient Experience Survey (in hospital) – this has been running for three years now and the feedback informs national improvement campaigns for example: medication safety. HBDHB are measured on four main domains – communication, coordination, partnership and physical and emotional needs. (insert table with our scores).





## Let's Talk – Patient Safety Week

Patient Safety is top of mind every day in healthcare. "Let's Talk" was the theme at Hawke's Bay Hospital during Patient Safety Week in November 2016 when we highlighted better communication between patients, whānau and health professionals. We had displays to highlight the Let's Talk campaign making sure we got the attention of staff, patients and visitors to the hospital and our "what matters to you" whiteboards reinforced that whānau/family matters most.

Patient Safety Week is a Health Quality and Safety Commission initiative which we embrace every year. The theme for 2017 will be medication safety. This topic has been chosen because the in-patient experience survey question "Did a member of staff tell you about medication side effects to watch for when you went home?" consistently gets one of the lowest scores from consumers and there are a large number of medication errors in hospitals.



CEO Dr Kevin Snee checks out a display alongside Jane Bailey, Patient Safety Advisor and Jeanette Rendle, Consumer Engagement Manager.

### How to keep yourself safe when in hospital – here are our top tips:

- **Talk** with your doctor and nurse and tell them what you know about your illness or injury.
- **Ask** questions to help you understand your treatment – why you are having it, the choices, what will happen and the risks and benefits.
- **Clean** your hands often to help stop infection, and ask your visitors to clean their hands.
- **Keep** a list of and learn the names of the medicines you are taking, the reasons you are taking them and when and how to take them.
- **Ask** for the results of any tests you have and what happens next.
- **Get** to know your ward and make sure the call bell is always within easy reach.
- **Before** leaving hospital, ask what you and your family/whānau need to do at home.

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## National Patient Safety Priorities In hospital

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's healthcare through the national patient safety campaign 'Open for Better Care'. All of New Zealand's district health boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

✓  
**93%**

**Falls prevention 1:** Older consumers assessed for risk.. Target 90%

✓  
**100%**

**Surgical site infection 1:** Antibiotic administered in the hour before surgery. Target 100%

✓  
**94%**

**Falls prevention 2:** Percentage of older patients assessed as at risk of falling who receive an individualised care plan addressing these risks. Target 90% (an increase of 8% from last year).

✓  
**98%**

**Surgical site infections 2:** Right antibiotic in the right dose. Target 95%

✓  
**89%**

**Hand hygiene:** Percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%.



## Hand Hygiene

Hand hygiene is recognised worldwide as the single most effective way to prevent the spread of infection and improve the quality and safety of patients in our care. The 5 moments for Hand Hygiene is a programme developed by the World Health Organisation (WHO), and implemented across all New Zealand district health boards (DHBs).

HBDHB continues to achieve a high level of compliance with the 5 moments for Hand Hygiene when compared to other NZ DHBs. The quarter ending March 2017, HBDHB achieved a compliance rate of 88.7%, the highest in NZ.

On 5 May, HBDHB celebrated World Hand Hygiene Day. Wall displays across the hospital were created by enthusiastic staff members, an information board was created in the main entrance, and a competition 'guess the hands' was run that created a sense of fun and engagement with staff, patients, and visitors.



It was also a time to celebrate and thank the Hand Hygiene champions within the hospital for their passion and dedication to the programme and ultimately the positive impact it has on patient safety.





## Go Well Travel plan



We know that prior to March 2017 our community were having real trouble finding car parking at Hawke's Bay Hospital – whether coming to an outpatient appointment, or visiting loved ones. In 2016 a lack of car parks was one of our top complaint themes.

**“trying to find parking can take up to 30 minutes. I ended up missing my appointment”.**

**“I had an appointment for my moko at 9am. I couldn't find a park. When I did find one we were 50 minutes late for his appointment...”**

Feedback like this was not unusual. Missing an appointment is inconvenient for our patients, impacts negatively on their overall experience of care and doesn't allow us to best manage our time and resources.

We listened to you. The introduction of paid car parking in March 2017 and the promotion of alternative modes of transport has eased congestion. Patient and visitor parks are now freely available with about 30 spaces available at any given time. It is working well with plenty of positive feedback from people who are grateful to be able to easily find a park and this means a better overall experience, people attending appointments on time and less stress.

**“I have used the car park twice this week for appointments, it was so nice to just be able to drive straight in and park without having to drive around endlessly. I was more than happy to pay the \$1 each time for such an easy stress free arrival”. (Lucy Billings, Facebook).**

Tom Wihapi (pictured below), is our friendly parking officer overseeing the paid parking scheme. Tom averages 15km per day on the job and is only too happy to help visitors and patients with parking queries, lost car keys or machine issues.



**“It has been going very smoothly, people are very understanding of the pay scheme and visitors especially are only too happy to be able to find a car parking space.”**

As well as paid car parking, we have also worked with GoBay to bring you other transport options. Outpatients are making the most of the free bus transport option, with 519 trips to attend their appointments at the hospital or Napier Health in May alone. That's a staggering 122% increase on May last year!

Tom (pictured right) says he enjoys catching the bus to his hospital appointments.

If you have an upcoming outpatient appointment at the hospital or Napier Health, you too can jump on the goBay network for free, together with a support person. Simply show your appointment letter or text reminder to the bus driver and you'll be on your way!



**“It's completely hassle free, it's an easy way of getting across from Napier and I don't need to rely on anyone else.”**

## Adverse events

Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

Adverse events are uncommon but taken seriously. For each event we conduct a formal review which follows the patient's journey through the hospitals systems and processes.

What we learn from these reviews is important and we recognise that each event provides an opportunity to improve the care we provide.

**Adverse events  
2016/17**

Data TBC

### Learning from Adverse Events

Several reviews at HBDHB have led to significant improvements on the front line, examples are:

- The appointment of more senior doctors
- Reducing delays to reach definitive diagnosis
- Education opportunities
- Improvements to the transfer of care – communication information gathering tools have been developed.

**“[we] would like to thank you for investigating [his] death and providing a clear report. My primary intention was to ensure any lessons that could be learnt from this tragedy would possibly prevent others having to experience this and to that end we were heartened to see the changes in DHB operating procedures.**

**...the family was happy to see that our concerns were taken seriously by the depth and openness of the DHB report and the remedial actions that have since been implemented”.**

### Future Focus

The organisation has invested in a new integrated risk management system which is intended to be rolled out at the end of 2017. This new system brings new capabilities and allows the DHB to better monitor and manage its associated risks. We hope to bring the primary care sector on board with the system in 2018.

We value the input of consumers into decision making about our healthcare and improvement activities and as such in 2018 we intend to invite consumers and/or their whanau to be involved in the review process.

## Staff profile

### Wairoa's Rural Nurse Specialist

**Nerys Williams** is relishing the opportunity to make a difference in people's lives by helping them in whatever way she can. Her experiences, she says, have reinforced the importance of her role in keeping people out of hospital and delivering care in the home for rural patients.

Wairoa people are benefitting by having the opportunity to reduce travel to Hastings for procedures that can be provided by Nerys in their own home.

One experience, in particular, has had a positive impact on Nerys and listening to her recount the story of two sons who cared for their terminally ill father is touching.

"It was their Dad's dying wish to return to his papakāinga (original home)," says Nerys, who was determined to try and make that happen. With Nerys' training, the sons were able to inject medication into their Dads muscle over a period of four to five days, being fully responsible for the drug application, and providing constant attention to their Dad in the comfort of their home.

**"The training was robust and this was supported by phone calls and daily visits by me to ensure the sons and wider whānau were supported well," said Nerys.**

"Just as important was coordinating the wider support network including district nurses, occupational therapists and Cranford Hospice and I am proud of how well everyone pulled together to do their respective jobs with very short notice."



# Primary Care

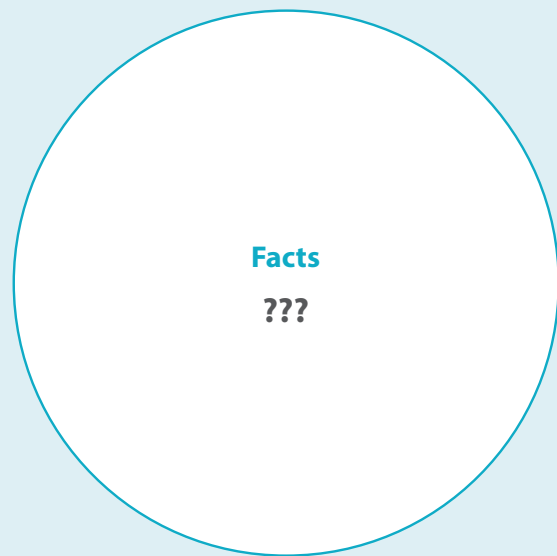
TBC

## Heading

text

## Gastro Outbreak

IText



#whanau

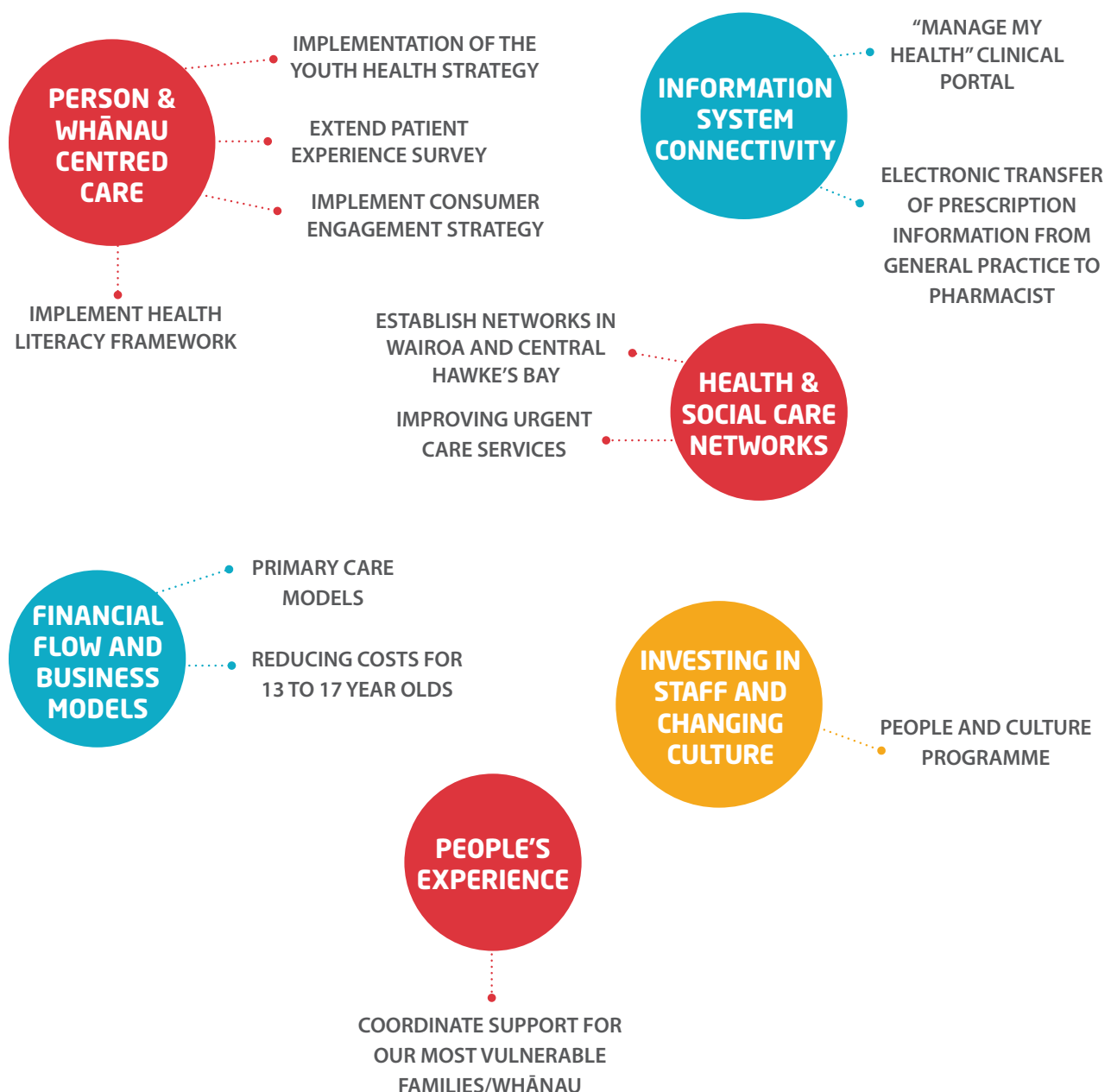
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# TŌ TĀTOU ARONGA MŌ ĀPŌPŌ OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: **All New Zealanders live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.**

We have reviewed our 5 year strategy Transform and Sustain which aligns to the New Zealand Health Strategy. We will support the elimination of inequity and prepare our health services for more numbers of younger Māori and growing numbers of older people and people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



# I MŌHIO RĀNEI KOE IA RĀ... DID YOU KNOW THAT EVERY DAY...



**3**  
children will  
receive one of their  
vaccinations



**6**  
babies will be  
born



**10**  
fragile babies  
will be cared for  
in the special  
care baby unit



**16**  
people will get  
their free annual  
diabetes check



**22**  
women will have a  
mammogram and a  
further 29 a cervical  
smear test



**35**  
operations will be  
completed in one  
of Hawke's Bay  
Hospital's theatres

## NEW DATA TBC



**200**  
visits/appointments  
will be made to  
support people with  
mental health issues



**209**  
visits will be made by  
district nurses and  
home service nurses



**245**  
children will be seen  
for their free dental  
health check



**1,454**  
people will see  
their family  
doctor



**4,662**  
prescriptions will be  
filled out



**5,680**  
laboratory tests will  
be completed



an orderly can  
walk on average  
of 15km




**85**  
people will be  
admitted to  
Hawke's Bay  
Hospital



**350**  
meals on wheels  
will be delivered



**5,870**  
items of laundry  
will be delivered  
to the hospital

	<b>Te Ara Whakapiri Hawke's Bay</b>
	For the attention of: <b>Māori Relationship Board, Clinical and Consumer Council</b>
Document Owner:	Mark Peterson, CMO Primary Care
Document Author:	Leigh White, LTC Portfolio Manager, Strategic Services
Reviewed by:	Executive Management Team
Month:	August, 2017
Consideration:	For Endorsement

**RECOMMENDATION****That the Māori Relationship Board, Clinical and Consumer Council**

1. Endorse roll out of Last Days of Life Care Plan and Toolkit
2. Support ongoing work

**PURPOSE**

The purpose of this document is for EMT to:

- Endorse roll out of HBDHB localised Care Plan and Toolkit for Last Days of Life into:
  - ✓ All HB ARC Facilities (note: we cannot make this compulsory with national corporates however we will encourage facilities to be in line with local development)
  - ✓ All HB Hospital Wards (staged approach)
  - ✓ Excluding Cranford Inpatient Unit (Care Plan has been analysed with components of Palcare).
- Support further work as we progress with roll out (enclosed action/work plan).

**EXECUTIVE SUMMARY**

An international and national review resulted in the phasing out the Liverpool Care Pathway (LCP), however many service providers providing palliative care report that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools are being used based on the "old" LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke's Bay drafted a localised care plan and toolkit.

In May 2016 HBDHB Executive Management (EMT) and respective Councils were presented with a proposal to review and endorse work as outlined below:

- A proposed proof of concept trial of the HBDHB Last Days of Life Care Plan and toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital.

- An evaluation of the proof of concept to be commissioned and completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools (Full report enclosed). Key findings were:
  - ✓ Overwhelming support from our trial sites and integrated working group that the HBDHB Care Plan and toolkit be adopted locally into all ARC Facilities and Medical Wards of HB Hospital. Note: we cannot insist ARC Facilities but we can encourage and we are supportive to share our local tools to ARC national bodies.
  - ✓ Feedback suggested some minor changes to the care plan and tool kit. These changes are currently being worked on with key members from the integrated working group and publisher. Note: there are no changes to the local medication prescribing tools that have been in place in General Practice for some years.

## RECOMMENDATIONS

- This piece of work has been a truly integrative approach and it cannot go unnoticed of the work of the Integrated Advisory Group (inclusive of GP support), Cranford Hospice, Inpatient Specialist Palliative Care Team and ARC Facilities.
- Committed ongoing support , once endorsed by EMT and respective Councils:
  - ✓ Cranford Hospice will continue to roll out Care Plan and Toolkit to ARC Facilities.
  - ✓ Manager of Specialist Palliative Care Team in-hospital fully supported and has commenced planning to roll out.
  - ✓ LTC Portfolio Manager to seek funding for published tools
  - ✓ Socialise this work through Map of Medicine

## SUCCESS FOR US IN HB

- Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau.
- Staff working with the documents will show high level of confidence in planning and providing care.
- A consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/ whanau experience.

## THIS PIECE OF WORK SUPPORTS TWO SIGNIFICANT DOCUMENTS:

1. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): “Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life”.
2. HBDHB Live well, stay well and die well, Palliative care in HB: actions required: “Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region” with an **outcome** of “100% of ARC facilities and hospital wards implementing the Last Days of Life (Te Ara Whakapiri) supported by Specialist Palliative Care services”.

June 2017: LW

**Action planning for roll out of Te Ara Whakapiri (inclusive of Logic Model)****Brief Summary**

Last days of life care planning is an integral component of care and management of people in their last hours to days of life. It is imperative that all health professionals are competent to provide care.

The impact of delayed last days of life planning can lead to a number of adverse outcomes:

- continued aggressive, unwanted and/or unwarranted life-sustaining measures instigated
- poor experiences for families where distraught family members are called on at a time of grieving to engage in decisions
- potentially avoidable conflicts between families and the health care team, or within the health care team about the best course of treatment and care for the dying person
- care being delivered in acute settings when better outcomes could be delivered in supported community or home environments
- stress for health professionals balancing their obligation to act in the best interests of the dying person, sometimes differing views amongst treating clinicians and families.

**Outcomes:**

- improved decision making
- a positive impact on multi-professional team communication and working
- increased confidence of nurses about when to approach medical colleagues to discuss treatment plans
- people being treated with greater dignity and respect – dying well
- greater clarity around preferences and plans about how these can be met.

**What will show improvements**

Health records will better reflect a holistic approach to care in the last days of life. This includes evidence of communication and consideration of the individual needs of the person and family/whanau.

It is expected that staff working with the document will show high level of confidence in planning and providing care. Having a consistent approach to the delivery and management of care will allow for effective evaluation and subsequent improvement to services provided through evaluation. This will be inclusive of the family/whanau experience.

**The journey thus far**

1. HBDHB Integrated Steering group was formed: Key purpose:
  - develop a Care plan and Toolkit unique for HB but aligns with the Te Ara Whakapiri document
  - note: half way through our HB process a decision was made to develop same nationally
2. Pilot the Care plan and Toolkit (enclosed document). GPs were kept informed of Pilot and progress:
  - ARC Facilities Piloted : Mary Doyle, Brittany, Masonic and Atawhai/Gracelands
  - GP support: Dr M. Peterson, Dr P. Henley, Dr L. Whyte and Dr J. Eames
3. Evaluation of the pilot (enclosed document)

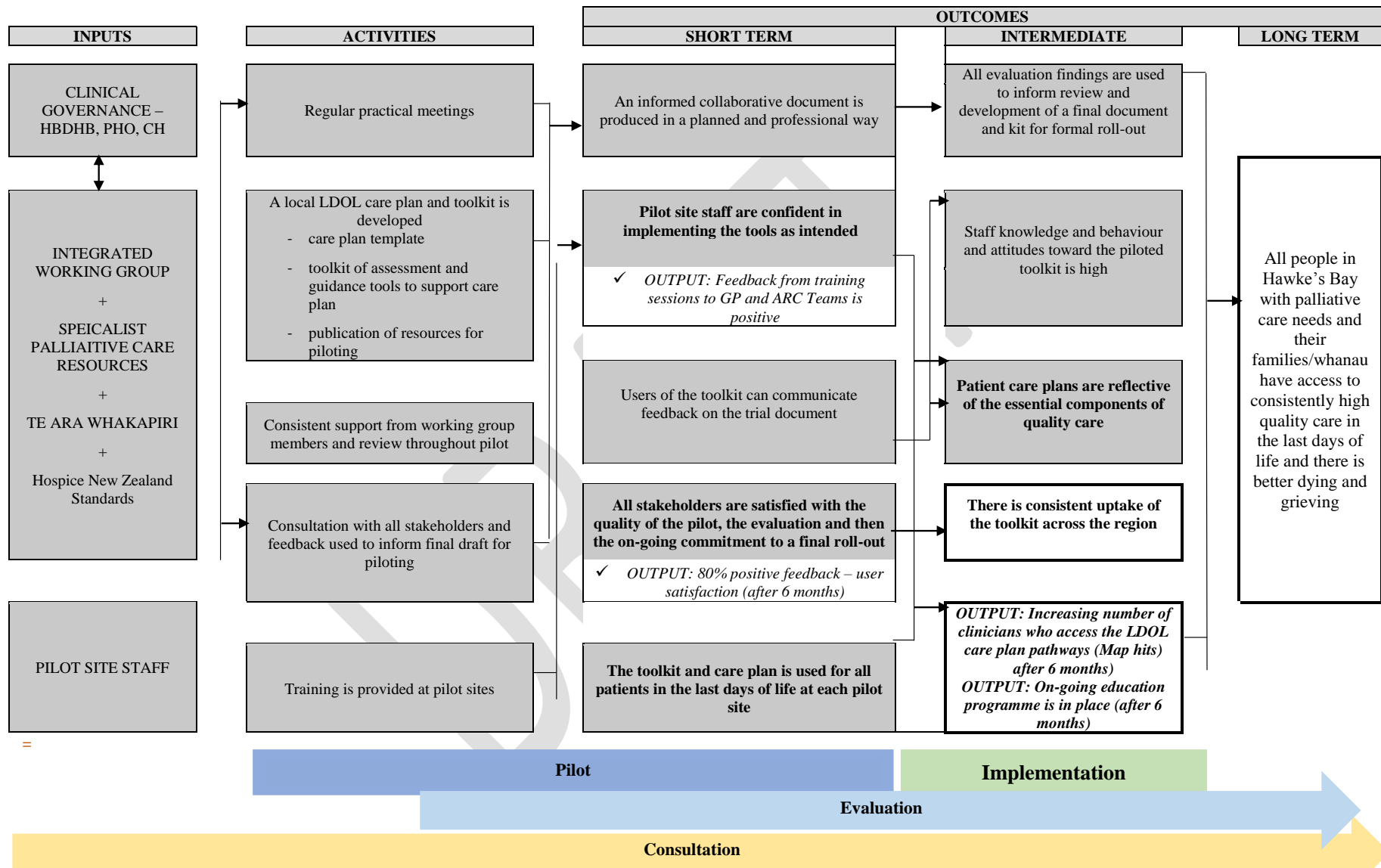
**Next steps**

HBDHB Governance Committees to endorse the work and support implementation of the HBDHB Last Days of Life Care Plan document and toolkit as a replacement for LCP based on Te Ara Whakapiri: Principles and Guidance. The tool has similarities that are already embedded into Palcare the electronic tool used at Cranford Hospice. Note: Medication symptom Management for last days of life algorithms are currently well embedded into general practice and these will not change.

**Milestones to date (Work to be done)****Names****To complete by August 2017****Tool and Toolkit**

15

1	<b>From Evaluation - make recommendations to change master Planning for Last Days of Life Care Plan</b>	Sarah Jo	Plan	Do	Done
2	Liaise with Publishing to gain costs for changes	Leigh	Plan	Do	Done
3	Changes Made with Publisher	Leigh	Plan	Do	Done
4	Implement changes into Map of Medicine.	Leigh	Plan	Do	Done
<b>Advisory Committees</b>					
1	Integrated Steering Group <ul style="list-style-type: none"> <li>Inform them of outcome and share Evaluation report</li> </ul>	Leigh	Plan	Do	Done
2	Provide update to PHO Palliative Care Steering Group/ HB Governance Steering Group	Leigh	Plan	Do	Done
3	LTC Advisory Committee (Present: 15 July 2017) <ul style="list-style-type: none"> <li>Endorse roll out</li> </ul>	Leigh	Plan	Do	Done
4	EMT (9/08/2017)	Leigh	Plan	Do	Done
5	Clinical Council (9/08/2017)/Consumer Council (10/08/2017)/ Maori relationship Board (9/08/2017)	Leigh	Plan	Do	Done
6	PHO Clinical Advisory groups (PHOLT 4/09/2017, CAG 12/09/2017)	Leigh	Plan	Do	Done
<b>Roll out Planning – ARC by Cranford Hospice</b>					
1	Confirm endorsement (Evaluation)	Leigh	Plan	Do	Done
2	Roll out to ARC – confirm with Cranford	Sarah/Jo	Plan	Do	Done
3	Date of Implementation and Socialisation to all ARC	Sarah/Jo/Leigh	Plan	Do	Done
4	QA audit processes – recommend a year post implementation	Sarah/Jo/Leigh	Plan	Do	Done
<b>Roll out Planning – HB Hospital general wards and Rural Wairoa/Waipuk)</b>					
1	Confirm endorsement – Agree Operational within budget	Leigh/Mandy Anne/Emma	Plan	Do	Done
2	Implementation planning – Meeting 11/07/2017 Operational	Leigh/Mandy Anne	Plan	Do	Done
3	Date of Implementation – Ann to Lead/Resource Nurse in wards/staff meetings/Meetings with CNM/Meeting with Education Department (25/07/2017) to script modules to Ko Awatea	Leigh/Mandy Anne	Plan	Do	Done
4	QA audit processes – recommend a year post implementation	Leigh/Mandy Anne	Plan	Do	Done
5	Rural Wairoa/Waipuk – link with Managers		Plan	Do	Done
<b>Socialisation</b>					
1	Link in with other DHBs – what are they doing? Link: Kate Grundy: <a href="mailto:Kate.Grundy@cdhb.health.nz">Kate.Grundy@cdhb.health.nz</a> , being socialised at Canterbury DHB		Plan	Do	Done
2	Educational workshops for ARC (Presented to ARC Forum 25/07/2017)	Sarah/Jo	Plan	Do	Done
3	Grand Round – Date confirmed 23/08/2017	Emma Mary	Plan	Do	Done
4	Update to Primary care	Leigh	Plan	Do	Done
5	Update Map of Medicine		Plan	Do	Done



DRAFT





## Hawke's Bay Last Days of Life Care Plan and Toolkit

Evaluation and Pilot Report April 2017

### ABSTRACT

An integrated Hawkes Bay District Health Board Working Group, was given the task of designing, implementing and piloting a care plan and supporting documents for a person's last days of life. This plan and associated documents are based on Te Ara Whakapiri - The Principles and Guidance for the Last Days of Life. This evaluation report has been prepared to outline the findings of the pilot and inform future recommendations of implementation.

## ACKNOWLEDGEMENTS

This report has been prepared by Sarah Nichol on behalf of the Cranford Hospice Leadership Team. This report was commissioned to evaluate the pilot trial of the Hawke's Bay Last Days of Life Care Plan and Toolkit implemented into five Aged Residential Care Facilities, Inpatient Unit Cranford and a Medical Ward in Hawke's Bay Hospital.

As the author of this report, I would like to thank all the people who have provided information and feedback for the purpose of this evaluation

Thanks to the members of the Integrated Working Group and to the areas that agreed to pilot these tools:

### Integrated working group

- Leigh White (DHB)
- Karen Franklin (Cranford Hospice)
- Sarah Nichol (Cranford Hospice)
- Ann Gray (DHB/Cranford Hospice)
- Joan McAsey (Hastings Health Centre)
- Irene O'Connell (Eversley ARC)
- Jo Loney (Cranford Hospice)
- Sue-Mary Davis (Cranford Hospice)
- Liz Beattie (Masonic)
- Trish Freer (PHO)

### Pilot Sites

- Cranford Hospice In-patient Unit
- HBDHB Ward A1
- Brittany House Residential Care
- Mary Doyle Life Care Trust
- Taradale Masonic Resthome
- Atawhai Lifestyle Care
- Gracelands Lifestyle Care

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## EXECUTIVE SUMMARY

An integrated service working group consulted, designed, produced and after consultation, a Hawke's Bay "Last Days of Life Care Plan" and "Tools and Resources to Guide the Care of People in Their Last Days of Life" (collectively known as "Toolikit").

The toolkit was based on Te Ara Whakapiri – The Principles and Guidance for the Last Days of Life and are practical tools intended to support equal access to the best quality of care for all people with palliative care need regardless of setting. A key point of difference for the Hawke's Bay version is the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient.

This evaluation was commissioned by the Leadership Team at Cranford Hospice, and the Integrated Hawkes Bay District Health Board (HBDHB) working group. The evaluation priorities were limited to short term outcomes, related to feedback on the usability, confidence and satisfaction with the document. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence of care was reviewed.

Nursing and some medical staff (N26) that worked with the document during the trial period provided feedback via focus groups, informal written and verbal interview and in writing through communication journals. In addition, care plans (N19) and patient records were reviewed at each site using a consistent tool developed for in the evaluation.

The evaluation showed that the pilot was successful in achieving its short term goals. The above evaluation methods and data sources provided consistent findings and those key standards were:

- The peer review of the patient files showed that **most of the components of the documentation were completed** as instructed therefore providing evidence that the principles of quality care were applied.
- There were **some suggestions for improvement** to the tool which were mostly for user ease, with few that may have implications on patient care if not rectified.
- **Most of the staff that were involved in the use of the tool were supportive of the permanent use of the tool** as part of their organisational policy. This included 100% support for use in ARC settings; while there was a universal view that it was not suitable for continued use in the Cranford Hospice IPU. There was 100% support for its use in the HBDHB Ward that piloted the tool, however this finding should consider that the tool could only be used in one case.
- The pilot successfully achieved its outcomes within set timeframes apart from the unexpected delays in starting in the HBDHB and the resulting small data pool.

*"it's straight forward, doesn't need instructions....and it is a refreshing stand-out colour"  
'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away....."*

The integrated approach of the tools development, the implementation of the pilot and the evaluation have appeared to enhance relationships across services and provides an opportunity for on-going peer review and data benchmarking which has recently been identified as an outcome measure in the Hawke's Bay Regional Palliative Care Strategic Plan – Live Well Stay Well Die Well 2016-2026.

### Recommendations

- A regional commitment to the consistent use of the localised version of the careplan and toolkit (presented with this report based on changes identified during evaluation)
- Continued resourcing and full 'roll out' in Aged Residential Care settings
- Cranford Hospice to discontinue use of the paper tool and consider alternatives
- Hawkes Bay District Health Board should consider continued use
- On-going integrated peer review and data analysis should be fostered.

## INTRODUCTION

### Background

An international and national review in 2013 resulted in the phasing out the Liverpool Care Pathway (LCP), however many service providers providing palliative care reported that there is still a requirement for a care planning tool for last days of life. It was noted in HB that tools were being used based on the “old” LCP framework and that these tools are not representative of: individualised care planning, not supported by education, quality review, or audit. In response to this, key stakeholders within Hawke’s Bay drafted a localised care plan and toolkit. In May 2016 HBDHB Executive Management (EMT) and respective clinical councils were presented with a proposal to review and consequently endorsed ongoing work as outlined below:

- A proposed pilot to trial the HBDHB Last Days of Life Care Plan and Toolkit (Draft) in five nominated Aged Residential Care (ARC) Facilities, Cranford Hospice Inpatient Unit and a Medical Ward in HB Hospital
- An evaluation review of the pilot was commissioned and to be completed by Cranford Hospice. Key to the evaluation was to measure the HBDHB tools against the national guidance document Te Ara Whakapiri and other national tools.

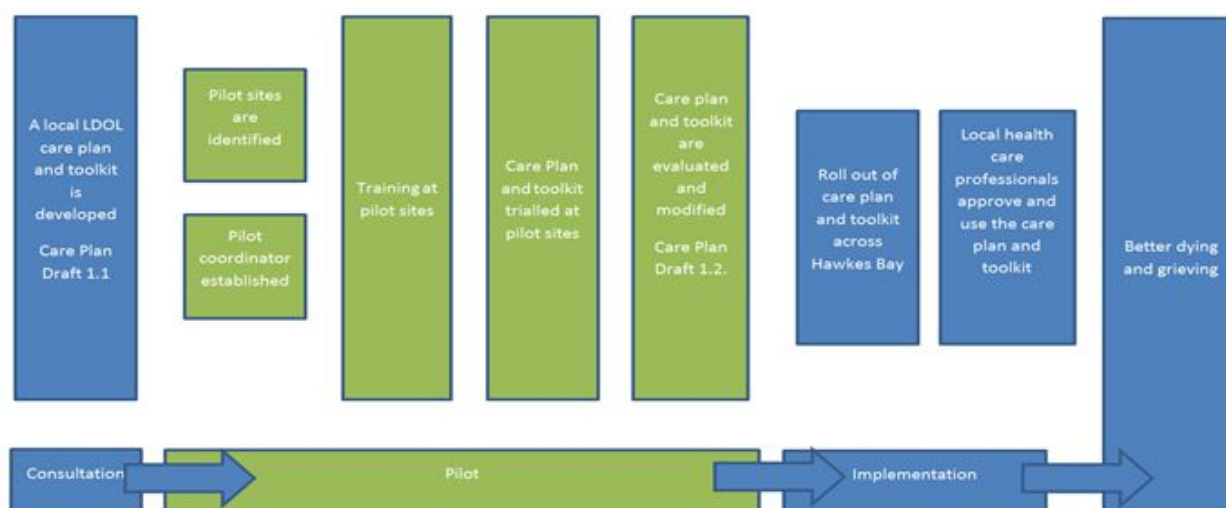
What are we wanting to achieve with the Pilot? (Appendix 1: Logic Model)

- That the HBDHB Last Days of Life Care Plan and Toolkit assists in achieving all the components of care outlined in Te Ara Whakapiri. Note: Outside this scope of evaluation is investigating the quality of care provision and the direct impact on service users was not evaluated.
- Gain learnings from providers and suggestions for improvement

### Description of Pilot

This Pilot was trialled in Cranford Hospice In-patient Unit, HB Hospital Ward A1, Britany House, Mary Doyle Life Care Trust, Taradale Masonic, Atawhai Lifestyle Care and Graceland Lifestyle Care.

The pilot was undertaken by Cranford Hospice, with a key focus on providing education to the workforces on the purpose and the “how to” use the tool. In ARC support in practice was overseen by the Cranford Hospice ARC Liaison Nurses and in HB Hospital support was provided from Clinical Nurse Specialist.



**Figure 1: Demonstrates the pilot processes phases of: sites identified, co-ordinator established, training at sites and evaluation. (FROM ORIGINAL PILOT PLAN)**

## EVALUATION APPROACH

This evaluation was completed as part of the predetermined pilot plan, August 2016 (figure 1). Ultimately, the evaluation seeks to answer the questions:

Evaluation Question 1. How successfully did the pilot achieve its' outcomes?

Evaluation Question 2. How ready is the LDOL Care Plan and Toolkit for final roll-out?

During the project and evaluation planning stage, a logic model was developed (refer to Appendix 1) to illustrate the key project pilot activities and the intended outcomes. This model was developed based on the HBDHB and PHO communication documents authored by Leigh White and; the Pilot and Draft Evaluation Plan developed by C. Dempers in August 2016. NOTE: Outputs included on the model link to the Map of Medicine LDOL Pathway Evaluation Plan outputs.

The pilot and evaluation schedule was effected by an unexpectedly low number of deaths in some sites and the medical strike and staffing issues at the HBDHB. Key short term outcomes from the logic model (highlighted in pink) were selected as priorities based on the need for useful data to inform further developments and roll out, and that is most practical to evaluate (Appendix 1). Table 1 shows the evaluation priorities and the methods for obtaining related evidence.

**Table 1. Success definition table (criteria)** – outlines the priorities for the evaluation

Priority	Criteria (what will a successful outcome look like?)	Sources of data	Methods
➤ Measure whether the care plan does indeed promote achieving the aims of the national guidance document Te Ara Whakapiri.	The care plan assists in achieving all the components of care outlined in Te Ara Whakapiri	Patient notes	Data analysis Documentation review
➤ Gather suggestions for improvement of the care plan and toolkit from the pilot users.	Site specific and generic suggestions for improvement are captured	Staff at pilot sites ARC Link Nurses	Interview
➤ Gauge support for the care plan and toolkit before roll-out.	Support for the care plan and tool kit is gauged		

Peer audit of patient files was completed by two to three members of the evaluation team using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (see Appendix 2). Results were analysed as internal audits are using basic descriptive methods looking for trends.

Focus group discussions were facilitated using a discussion guide (see Appendix 2). The discussions at each site were minuted by an objective observer. The observer and facilitator met after each session to establish and record themes and key points from each focus group. The quality of actual care provision was outside the scope of the evaluation, however the level of documented evidence available was reviewed.

Criteria for success (Table 1) were defined by the evaluation team based on a predetermined merit rating rubric of Poor - Moderate - Good - Excellent and methods for obtaining evidence were aimed at measuring the level success – see table 2 below.

## Evaluation Findings

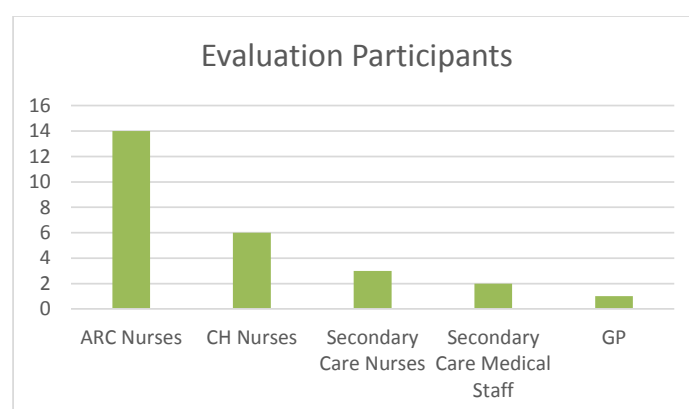
Pilot sites were provided an opportunity to contribute to the evaluation via focus groups (Appendix 2), by informal written, verbal interviews and in writing through communication journals. A total of twenty-six nursing and medical staff that had worked with the documents during the pilot period provided feedback (figure 2). In addition,

nineteen care plans and patient records were reviewed at each site\* using an audit tool specifically developed for the evaluation (Appendix 2). Note: during the trial period in the HB Hospital medical ward one person died, for this reason, the data related to the completion of the document was focused on the feedback from staff.

**Table 2. Standards for determining merit (rubric) – conclusion (SHORE, 2015)**

Rating	Explanation
<b>Excellent</b>	Peer audit of patient files shows almost all of components are achieved. There are very few suggestions for improvement of tool. All are in support of the care plan and toolkit.
<b>Good</b>	<b>Peer audit of patient files show most of components are achieved:</b> <ul style="list-style-type: none"> <li>- completed documents provided evidence of the application of the principles of Te Ara Whakapiri.</li> </ul> <b>Most are in support of the care plan and toolkit:</b> <ul style="list-style-type: none"> <li>- 100% support for use in ARC settings</li> <li>- universal view that it was not suitable for continued use in the Cranford Hospice IPU.</li> <li>- 100% support for its use in the HBDHB Ward that piloted the tool (however this finding should consider that the tool could only be used in one case).</li> <li>- those involved in the pilot appeared engaged and committed to actively and critically use the care plan and toolkit in practice</li> <li>- care plan and toolkit enhanced their ability to plan care for patients in the last days of life</li> </ul> <b>There are some suggestions for improvement of tool (user ease).</b> <ul style="list-style-type: none"> <li>- Almost all the suggested improvements to the tool were repeated by multiple parties and the issues associated with the problems were also confirmed during the review of notes e.g. sections that were unclear were also often not completed fully.</li> <li>- feedback relating directly to the template and toolkit are detailed in Appendix 3. The use of this feedback will contribute to a continued sense of ownership for those using the tool and has the potential to greatly improve the quality of the document.</li> </ul>
<b>Moderate</b>	Peer audit of patient files show at least half of the components are achieved. There is a significant amount of suggestions for improvement of tool. At least half are in support of the care pan and toolkit.
<b>Poor</b>	Peer audit show less than half the components are achieved. There is a significant amount of suggestions for improvement of tool. Few people are in support of the care plan and toolkit.

Focus groups were established and discussions were facilitated using a discussion guide (Appendix 2). A total of 14 ARC Nurses, 6 Cranford Hospice Nurses, 3 secondary care nurses and 2 medical staff and 1 GP participated in face to face feedback sessions or provided written feedback.



**Figure 2: Illustrates breakdown of evaluation participant sources**

The discussions were documented and later, themes and key points from each focus group were agreed by the three working groups members present at each session. Each site was also provided a communication journal to provide feedback and these were collected and collated.

\*Current staff from Brittany House did not participate in the focus groups. The Clinical Lead in place at Brittany House during the pilot moved to another participating facility and provided feedback.

**Evaluation Question 1: How successfully did the pilot achieve its' outcomes?**

→ There was 100% support for its ongoing use in the ARC and HBDHB

*"It's more manageable than the LCP was"*  
*"gives us hints for what to look for in a palliative patient"*  
*"it keeps focus and prompts when you are busy"*  
*"GPs are on board because you can fax their part to them"*  
*"it's straight forward, doesn't need instructions....and it is a refreshing stand-out colour"*

→ There was universal view from Cranford Hospice nursing staff NOT to continue using the tool in the IPU setting.

*"PalCare care plans make more sense for us and we do them well"*  
*"It doesn't really make sense to move to paper notes at that stage"*  
*"I can see how it was be very useful in the ARC setting, but not here"*

→ Completed care plans were most often of a high quality and illustrated a clear understanding and application of the principles of Te Ara Whakapiri. Example below (figure 3) highlights the individualised care component unique to the Hawkes Bay toolkit.

**CARE PLAN PAGE 2 OF 2**

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
MOBILITY / PRESSURE AREA CARE	Person is comfortable and in a safe environment	Mattress: Pressure foam mattress Position changes: 2-3 hourly. Personal Hygiene needs: Check pad twice per shift.
BOWEL CARE	Person is not agitated or distressed due to constipation or diarrhoea	Charted glycerol suppositories 1-2 sips Peps for constipation.
PSYCHOLOGICAL SUPPORT	Person becomes aware of the situation as appropriate  Family/whānau / other are prepared for the person's imminent death with the aim of achieving peace of mind and acceptance	e.g. Person is informed of procedures <input checked="" type="checkbox"/> e.g. Touch, verbal communication is continued <input checked="" type="checkbox"/> Gentle, soft tone of voice, give clear direction, explain all procedures  e.g. Check understanding of remaining family/whānau / other/younger adults / children <input checked="" type="checkbox"/> e.g. Check understanding of family/whānau/other's not present at initial assessment <input checked="" type="checkbox"/> e.g. Ensure recognition that the person is dying and of the measures to ensure comfort <input checked="" type="checkbox"/> Brochure given to Jill's daughter Pam and clinical situation explained and understood
RELIGIOUS / SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	e.g. Support from Chaplaincy team may be helpful <input type="checkbox"/> e.g. Consider cultural needs <input type="checkbox"/> Nil particular spiritual affiliations noted Family are a strong support and comfort to
CARE OF THE FAMILY / WHANAU / OTHER	The needs of those attending the person are accommodated	e.g. Consider health needs and support <input checked="" type="checkbox"/> Orientated to ward, food and drink offered Invited to stay overnight if they would like to
CULTURAL SUPPORT	Consider the cultural needs of the person/family/whānau	Loves the sunshine - ensure curtains are open during the day; loves to see family and friends, chats re staff.
OTHER E.G. COMMUNICATION		Slow to verbalise own wants/needs, prompting required, use directive questions.

Figure 3. Example completed page from care planning section showing individualised care



**Evaluation Question 2: How ready is the LDOL Care Plan and Toolkit for final roll-out**

- Since the completion of the pilot period ARC sites have continued to use the tool and report a general satisfaction that it meets their needs and fills the 'gap' left by the removal of the LCP.
- The key criticisms of the LCP have been addressed with the Hawke's Bay version, including supporting individualisation and other principles outlined in Te Ara Whakapiri (figure 2)
- There are changes required in response to feedback which will require resourcing to make the alterations and produce a final version.
- After each focus group and site visit, the evaluation team debriefed and concurred that there appeared to be a sense of ownership and engagement from staff using the HBDHB document and the evaluation process provided a positive inter-organisational communication opportunity.
- Feedback from HBDHB staff was generally supportive of its use in that setting, while also feeding back some challenges and suggestions (improvements included in appendix 3)

Lead physician: *"most of the paperwork was easy, but..."*  
 House surgeon and Registrar: *"straightforward, easy to follow, but...."*  
*'worked well, leaves no ambiguity i.e. who to ring, what to do post passing away.....'*  
*"found it really good to use.....was easy to use and went in a logical manner."*

- There were several suggestions for improvements for the tool, however few were 'significant' and all of which are outlined Appendix 3 from staff at all sites.

**CONCLUSIONS**

The HB Localised LDOL Care plan and toolkit was developed and trialled successfully per the predetermined plan with only minor delays resulting from uncontrollable factors. The evaluation process showed evidence of a commitment from participants in the trial to engaging in the use of the tool and in the critical analyses of its application. The feedback from participants can be used to directly improve the usability and impact of the tool on care planning for people at the end of life.

The review of the Liverpool Care Pathway found that "generic protocols are not regarded as the right approach to caring for dying people; care should be individualised and reflect the needs and preferences of the dying person and those who are important to them". The Hawke's Bay Localised version includes a care planning section which other versions do not. This evaluation highlighted the value of this added component.

Participants of the pilot expressed universal support for the full roll out of the document across the region in a variety of settings, excluding those that primarily use electronic health records as this was found to be an inefficient way of documenting care.

Due to the engagement of staff that worked with the document and the apparent positive relationship building aspect of this pilot, it is predicted that the modification and roll out of the localised version would be received well and further enhance integration in palliative care across settings

This piece of work supports two significant documents:

- a. Ministry of Health Palliative Care Action Plan: – Priority 3 action (2017): *"Implement Healthy Ageing Strategy action: Support the implementation of the Te Ara Whakapiri Principles and guidance for the last days of life"*.
- b. HBDHB Live well, stay well and die well, Palliative care in HB<sup>1</sup>: actions required: *"Last Days of Life (Te Ara Whakapiri) pathway is developed and implemented across the region"* with an outcome



of “100% of ARC facilities and hospital wards have implemented the Last Days of Life (Te Ara Whakapiri) supported by Specialist Palliative Care services”.

## RECOMMENDATIONS

The evaluation concluded with HB Last Days of Life Integrated Working Group being reconvened to consider findings and contribute to the development of the following recommendations:

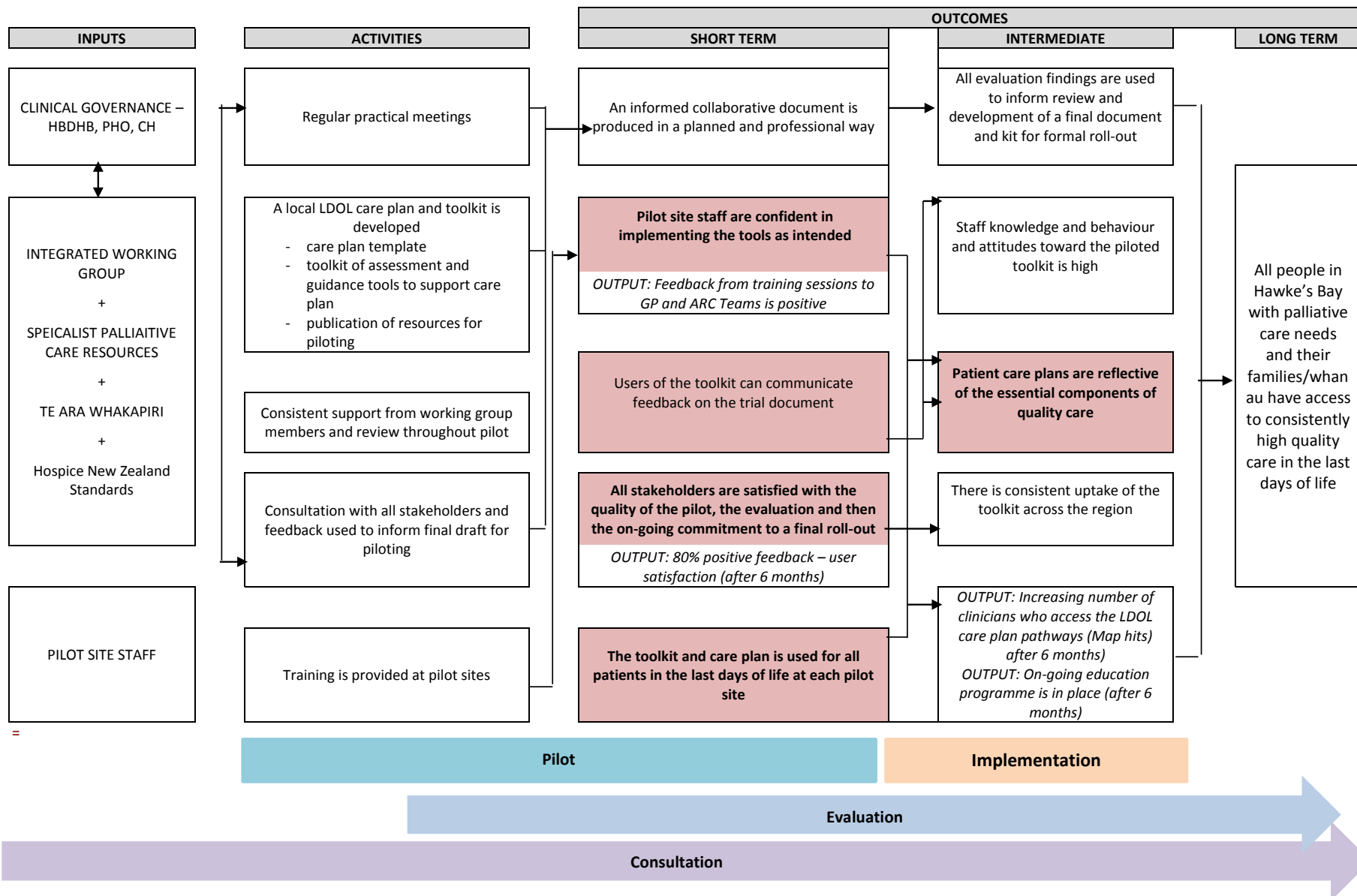
1. During the evaluation (April 2017), a National Toolkit was produced by the Ministry of Health Working Group. The Integrated Working Group considered the new national tool and based on this evaluation, **recommend making the proposed changes the localised version** and making a commitment to rolling out this version. This is due to the inclusion of a planning tool section that involves taking the findings of an initial assessment to develop a plan of care that is individualised to the patient and the sense of ownership that the contribution to its development has resulted in.
2. ARC settings should continue to **resource the permanent use** of a LDOL care plan and toolkit due to the universal support from staff who have or are using it and the evidence of high quality care planning that the tool supports.
3. Cranford Hospice IPU should continue to review the quality of care planning using PalCare alongside the standards outlined in Te Ara Whakapiri **without the use of the paper tool**. Staff should be supported to remain familiar with the toolkit to support and champion its use in other settings. The concept of using the toolkit in the community setting should remain on agenda for consideration.
4. Only one patient died during the very short trial period in the HBDHB ward, for this reason, the data related to the completion of the document was focused on the feedback from staff. The HB Hospital should continue to resource the rollout of the LDOL toolkit across appropriate Hospital wards **if the feedback in this evaluation** is considered sufficient.
5. **On-going peer review and data analysis** should be planned to make use of the valuable information that can be obtained and shared as experienced in this evaluation. This may be useful in informing education and resourcing needs.
6. Commitment by participants to engage in the trial and implement. **Participants need to be commended** for their obvious commitment to the pilot and engagement in the feedback. This resulted in excellent and relevant feedback that will be easily applied to make improvements to the document and supporting education content.
7. The toolkit to be reviewed in 2 years by relevant stakeholders.

## REFERENCES

- i. Palliative Care Council. (2015). *Te Ara Whakapiri – Principles and guidance on the last days of life*. Palliative Care Council: New Zealand
- ii. Last Days of Life Care Plan, Integrated HB DHB Working Group, 2016.
- iii. Tools and resources to guide the care of people in their last days of life, Integrated HB DHB Working Group, 2016.
- iv. SHORE & Whariki Research Centre. (2013). *Evaluation Workbook*. Massey University. School of Public Health
- v. Ministry of Health Te Ara Whakapiri: <http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life>
- vi. HBDHB. (2017) Live well, Stay well, Die well - Palliative Care in Hawke's Bay 2016-2026

## HAWKE'S BAY LAST DAYS OF LIFE CARE PLANNING TOOLKIT PROJECT PLAN 2017 – LOGIC MODEL

## APPENDIX 1



**EVALUATION TOOLS****APPENDIX 2**

<b>Evaluation of the Pilot: Last Days of Life Care Plan and Toolkit – AUDIT TOOL</b>			
<b>Audit tool (based on pg. 44-48 Te Ara Whakapiri) was developed specifically for peer audit of patient records – Summarised for this report.</b>			
<b>Audit criteria</b>	<b>No evidence</b>	<b>Evidence found</b>	<b>Unsure</b>
Has it been recognised that this person is / is at risk of entering the last days of life? Has a lead health practitioner been identified? Has the family been informed of how to contact this person? Physical needs are assessed and documented in care plan Family is consulted in developing the individualised care plan Review of, and anticipatory prescribing for core LDOL symptoms The person is aware of their changing condition? Consideration of food and fluids Consideration of ICD Persons preferences for EOL are assessed Communication barriers are identified and addressed if applicable Family is aware of changing condition Cultural needs are discussed and addressed Info about the facilities is provided to family Spiritual needs of person and family are identified and addressed There is ongoing assessment of the person's care Changing spiritual needs are discussed and addressed Death is verified and communicated to all services involved Family is informed of death. Info given to family about what to do next Family bereavement needs are assessed. Info given to family about support available Environment offers private space to meet needs of family			
<b>The audit initially required a score to be assigned to each question. The evaluation team decided that this data was difficult to complete and did not add to the description of care plan application.            It was not possible to access evidence of prescribing due to the use of electronic prescribing</b>			

**FOCUS GROUP DISCUSSION GUIDE**

- Each pilot site will be offered the opportunity to have a focus group facilitated by the Cranford Hospice ARC Liaison Nurse Team on location at a time and date that is mutually agreed.
- The payment of staff to attend, and which staff members attend, will be at the discretion of the ARC Facility Manager. There is no budget in this evaluation to provide that funding.
- An invitation explaining the intention of the group will be made available for individual participant recruitment as identified.
- Tone is intended to be fun and promote open self-disclosure of feedback and experience related specifically to the Last Days of Life Care Pathway.
- The session will be structured as follows, but flexible enough to allow facilitator to use judgement and moderate as necessary:

**Facilitators:** Jo Loney and Sue Mary Davis **Assistant (notes):** Sarah Nichol

**The following questions will be asked one at a time:**

Opening question: What has your experience of the care plan and the toolkit been?

Introductory question: What are some of the benefits of the care plan and toolkit?

Introductory question: Can you give examples where the tool has worked well?

Transition question: Can you give examples of challenges you have experienced using the care plan and toolkit?

Key question: What would you like to see changed with the care plan and toolkit?

Key question: Is there anything else you would like to say about the care plan and toolkit?

Ending question: Are you supportive of the care plan and toolkit?

Thank you and negotiate to agree on the best way to share with the group the evaluation report and recommendations. Jo, Sue Mary and Sarah to debrief after the session and to identify factors that stood out – notes made.

Krueger, Richard A. and Mary Anne Casey (2000). Focus Groups: A Practical Guide for Applied Research. 3rd Edition. Thousand Oaks, CA: Sage Publications.

**OVERALL FINDINGS – CARE PLAN AND TOOLKIT****APPENDIX 3**

This measurement was evaluated against the national guidance document Te Ara Whakapiri.

- The principles of care for people in their last days of life (pg. 17, Te Ara Whakapiri)
- The minimum components of service delivery required for quality care (pg. 44-48, Te Ara Whakapiri)

**Findings from Aged Residential Care Facilities (ARC)**

A peer review of patient files was completed by Cranford Hospice Quality Coordinator and both ARC Liaison Nurses using a pre-determined audit tool based upon the components of care outlined in Te Ara Whakapiri (pg. 44-48). Each pilot site provided access to patient LDOL care plan notes and between 2 and 4 notes were randomly selected for review. A total of 18 notes from ARC settings were reviewed and some key themes were identified. Detailed findings are recorded:

- Reviewers were unable to assess evidence of anticipatory prescribing in relation to LDOL and the toolkit as it had not been anticipated that the pilot sites use electronic prescribing. Verbal feedback suggested that this was not an area of concern and that generally prescribers are pre-emptively charting medication for symptoms common in the last days of life (sometimes with prompting from the assessing nurse). The initiation of the care plan was at times a prompt for this discussion.
- Many of the care plan examples had sections on cultural and spiritual needs left blank, and did not include evidence of any related conversation or assessment.
- The final page relating to after death actions was inconsistently used, which was predicted, due to each facility having their own checklists. Staff believed that the LDOL tool was of added use (alongside existing forms), but some work is required to ensure it is most effective.
- The progress notes remained thorough and staff did not revert to “Variance Reporting” which is the intention of the tool as it reduces the amount of documentation required.
- Reviewers did not investigate the number of residents that died without the use of the toolkit.
- Some clarity is required about whether a nurse can start the care plan without the approval of the GP.
- There was a clear commitment from nursing staff to use the care plan to its fullest capacity – see example figure 3

**15****Findings from Hawkes Bay Hospital**


Only one patient died during the very short trial period in the HBDHB ward. For this reason, the data related to the completion of the document was focused on the feedback from staff:

- Medical Staff both indicated that “could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer back to the main file to get an idea of what the clinical problems were” “it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan”
- “A challenge is the length (for some who don’t like to document things.) .... “Initially thought it was quite a large document and found it a bit daunting”
- “Liked the resources attached to it and thought the card of how to talk to people and the prompts were really useful especially for younger nurses and new graduates.....”
- “Spent some time going through the resource stuff and there were lots there to be used”.
- “Liked being able to see all the things to monitor i.e., secretions and the variants on the same page”..... “Helped to see the trend of what was happening.”
- “Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them, we would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can’t be too much otherwise the doctors won’t want to fill it out”

**OVERALL FINDINGS – CARE PLAN AND TOOLKIT****APPENDIX 3****Findings from Cranford Hospice IPU**

- During the trial period in the IPU (10 October to 31 December 2016) there were 22 deaths. In 12 of those cases the LDOL care plan document and toolkit was implemented. While there were 3 obviously sudden deaths, this does illustrate that staff did not perceive the care plan as adding value to the care they provided, consistent with verbal feedback.
- Where the LDOL tool was used, the level of completion of the document was variable and in almost all cases the patient's electronic notes continued either as an overlap or in one or other location. A reminder that electronic notes should be discontinued during the trial, however the practice continued. The associated risks with having notes in different locations outweighed the benefits of using the paper tool and the Cranford Hospice Clinical Governance Team elected to urgently remove the tool from use as soon as this was identified as part of the evaluation.

**COLLATED DATA SPECIFIC TO CARE PLAN**

GENERAL FEEDBACK	
	
ARC Focus Groups & Journals	Notes Review
<ul style="list-style-type: none"> <li>• "More manageable than LCP"</li> <li>• "Straight forward – a good thing"</li> <li>• "Gave us hints for what to look for in a palliative patient"</li> <li>• The colour is great – it is a refreshing colour.</li> <li>• Can this decision be made by and RN? At times the care plan was initiated by nurses at times with the doctor coming later and other times the LDOL section is faxed to the doctor to complete.</li> <li>• It doesn't overlap with other forms. It is "not repetitive – great prompts and even if we have the information somewhere else, it is a good way to check the most important things"</li> <li>• Easy to use – don't need instruction</li> <li>• "great, very positive about it"</li> <li>• "it keeps focus and prompts you when you are busy"</li> <li>• "GP's are more on-board with this because you can fax it to them"</li> <li>• "Does the Doctor NEED to be informed?"</li> <li>• "The name LDOL makes so much more sense than the LCP as it actually says what it is"</li> <li>• Reasons for the tool not being used where could have included: <ul style="list-style-type: none"> <li>• Communication with GP</li> <li>• Difficult family</li> <li>• Disagreement with GP that the person is LDOL</li> </ul> </li> <li>• APPEARS that there continues to be people giving the whole document to the family.</li> <li>• "It works well because the assessments page has all the information about the person."</li> </ul>	<ul style="list-style-type: none"> <li>• Patient labels were often not used and instead nurse handwritten details in its place. Is this because their labels are too big or something? Must be time-consuming.</li> <li>• "A few missed opportunities" to initiating the care plan – "waiting for the OK"</li> </ul>
CRANFORD HOSPICE IPU Focus Groups & Journal	Notes Review
<ul style="list-style-type: none"> <li>• Moving to paper notes feels like "a backward step" for many staff. Other negative consequences of using paper notes mentioned included:</li> <li>• Difficulty for FST to access/track down paper notes e.g. communicating with NASC</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple deaths did not apply the LDOL pathway e.g. 10/22 (3 were sudden deaths).</li> </ul>

## OVERALL FINDINGS – CARE PLAN AND TOOLKIT

## APPENDIX 3

- Handwritten notes are harder to read, especially for those staff with English as a second language
- It is “time consuming”
- Bereavement follow up is not as easy to access the notes on how the death was etc.
- Most staff reported preferring the care planning system on PalCare and believe adequate information is held on the electronic notes.
- “a picture builds on PalCare over the course of time and moving to paper notes interferes with that”
- “it is not as easy to track medication changes e.g. doses etc.”
- Acknowledged that there has been an improvement in the quality of information on PalCare since audit 12-24 months ago, with the use of a care plan issue template. *Routine audits still show some inconsistency with that however and still room to improve.*
- General feeling that the LDOL care plan is “less personable than PalCare allows”
- Universal support for this being useful in a non-specialist setting.
- No person providing feedback supported the continued use of the tool in the IPU
- Some support for a one page checklist however.
- “Where does this go on PalCare?” “it is cumbersome and clumsy”

- When LDOL pathway was used, PalCare notes also continued in detail – in both places and referring to each other.
- Not all care plans were completed. Medical staff completed other sections.
- Progress notes remained thorough and multidisciplinary. Pharmacist only wrote in PalCare.

## WARD STAFF FEEDBACK TO HPCT CNS

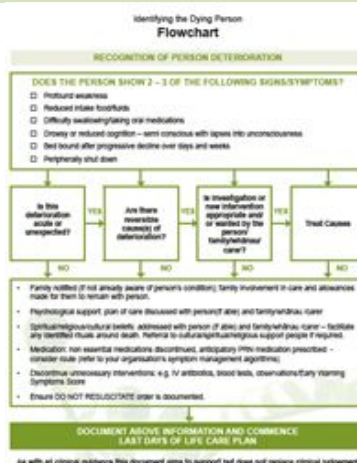
## Notes Review

- ‘worked well, leaves no ambiguity i.e. who to ring, what to do post passing away. A challenge is the length (for some who don’t like to document things.)’
- ‘Worked well. Benefits are specifically asking about the symptoms we need to look at. A challenge was not sure about starting it- otherwise it’s easy to use.’
- (The nurse who completed the initial assessment): “found it really good to use. Initially thought it was quite a large document and found it a bit daunting.
- Took a couple of attempts to fill it out as struggled to find the time. Felt there was nothing to change as it was more an unfamiliarity with the document and that with more use it would get better.
- Was easy to use and went in a logical manner.
- Liked the resources attached to it and thought the card of how to talk to people and the prompts were useful especially for younger nurses and new graduates.
- Spent some time going through the resource stuff and there were lots there to be used.
- We would have to go through the old notes which are often put in a different place. Not a big history just bullet points about how they got to the point they are at. Can’t be too much otherwise the doctors won’t want to fill it out.

- Generally, well completed

15

## FRONT PAGE – DECISION TREE



## ARC Focus Groups

## Notes Review

- No mention of this page in any of the focus groups or journal entries

- Unclear if should be completed or just used as a guidance flowchart.
- At times ticked – others not.

**OVERALL FINDINGS – CARE PLAN AND TOOLKIT****APPENDIX 3****CRANFORD HOSPICE IPU FOCUS GROUPS****Notes Review**

- Some discussion regarding prognostication e.g. Patients admitted for terminal cares and then later discharged

**HBDHB WARD STAFF FEEDBACK TO HPCT CNS****Notes Review**

- From the medics (lead physician): 'most of the paperwork was easy but could have been helpful to have an area to put in a diagnostic summary to date at commencement of the care plan. I felt a little uncomfortable that if anybody needed to see the patient for new symptoms or whatever that would have had to refer to the main file to get an idea of what the clinical problems were. Otherwise seemed good.'
- House surgeon and Registrar: 'straightforward, easy to follow. Main feedback was that it would have been helpful to have a box on the front with diagnosis or the course that led the patient to the LDOL care plan.'
- Also, felt some sort of summary in the front about the patient. On the ward, we put the old notes away. If we needed to know anything about them.

**NOMINATING LEAD PROVIDERS PAGE**

Page 14

**LEAD HEALTH PRACTITIONER/S**

Doctor: \_\_\_\_\_ Page contacts (HBDHB): \_\_\_\_\_  
If GP - See Page 3 for Contact Details

Nurse Practitioner: \_\_\_\_\_

Work number: \_\_\_\_\_ After hours number: \_\_\_\_\_

Primary Nurse: \_\_\_\_\_

**THIS PLAN SHOULD BE REASSESSED EVERY THREE DAYS**

Date of Life Care Plan commencement: \_\_\_\_\_ Signed: \_\_\_\_\_

Reassessment date: \_\_\_\_\_ Reassessment time: \_\_\_\_\_ Signed: \_\_\_\_\_

Reassessment date: \_\_\_\_\_ Reassessment time: \_\_\_\_\_ Signed: \_\_\_\_\_

Reassessment date: \_\_\_\_\_ Reassessment time: \_\_\_\_\_ Signed: \_\_\_\_\_

2 of 13

**CRANFORD HOSPICE FOCUS GROUPS****Notes Review**

- CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed

- Often empty

**SAMPLE SIGNATURE PAGE**

**PLANNING CARE**

**OURHEALTH**  
HAWKE'S BAY

Fill in only if person label is unavailable

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 NHF: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

**ALL PERSONNEL COMPLETING THE LAST DAY OF LIFE - CARE PLAN - PLEASE SIGN BELOW**

You should also have an understood the 'Health Care Professional' label

Name (print)	Full Signature	Initials	Professional Title	Date

**ARC FOCUS GROUPS****Notes Review**

- Several people mentioned the need for this page to be page 1 or 2 instead of page 6.
- CH IPU staff reported that the Lead Health Practitioner concept did not apply in the IPU and by nominating a primary nurse, this was a barrier to other nurses changing the care plan if needed

- Appeared to be completed well
- Often empty

**MEDICAL OFFICER SECTION**



## OVERALL FINDINGS – CARE PLAN AND TOOLKIT

## APPENDIX 3

**MUST BE COMPLETED BY MEDICAL PRACTITIONER**

• Active acute medical treatment is no longer in the person's best interest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• Non-essential medications discontinued and current medications reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• PRN subcutaneous antipsychotic medications charted <i>See Symptom Management Algorithms</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• Inappropriate interventions discontinued e.g. blood tests, routine observations, blood glucose monitoring, oxygen therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• The need for artificial hydration/nutrition has been discussed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• Not for Resuscitation status recorded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• Implantable Cardioverter Defibrillator (ICD) is deactivated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
• Organ donation considered and information given to person/family <i>See Organ Donation Brochure</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Signature: _____
<b>Individual Specific Requests</b>			

## ARC FOCUS GROUPS

- “GP section is not always being used” GP sometimes goes back to the usual medical progress notes.
- GP reported being very pleased that the medical area is condensed compared to the LCP.
- There are too many initial and date sections – it is not necessary.
- Need contact number for pacing radiographer.
- Need N/A option for ICD and organ donation section

## Notes Review

- At times N/A handwritten.
- At times ‘no’ has been ticked – unclear if this is due to interpretation of the question or not. E.g. no regarding hydration – appeared the doctor was say not necessary, when question is “was this considered/discussed”
- Where no was ticked – there is not a prompt to tell the doctor to write explanation in the progress notes.

## CRANFORD HOSPICE FOCUS GROUPS

- Should say “Yes, No or NA”
- “Is pacemaker present” e.g. this does not need to be deactivated.
- “any other implantable device”

## Notes Review

- Doctor handwritten N/A in some instances

## CAREPLAN SECTION

**CARE PLAN PAGE 1 OF 2**

Plan of care developed using information from initial assessment; any known ACP documentation; input from person/ family/whānau.

Person PROBLEM / FOCUS	GOAL	ACTIONS
<b>Te Taha Tinana</b>		
<b>PAIN</b>	Person is pain free • Verbalised by person if conscious • Pain free on movement • Appears peaceful	e.g. Consider need for positional change <input type="checkbox"/>
<b>AGITATION</b>	Person is not agitated • Person does not display signs of distress, terminal anguish, restlessness (thrashing, plucking, twitching)	e.g. Exclude retention of urine as cause <input type="checkbox"/> e.g. Consider need for positional change <input type="checkbox"/>
<b>RESPIRATORY</b>	Excessive secretions are not a problem	e.g. Medication to be given as soon as symptoms arise <input type="checkbox"/> e.g. Consider need for positional change <input type="checkbox"/>

## ARC FOCUS GROUPS

- Several people commented that the size of the ACTIONS boxes are too small
- Suggestion that the “Actions” column should be named “interventions”
- Suggestion that the examples in the action column don’t say “e.g.”

## Notes Review

- Some care plans had symptoms or assessment details rather than actions in the column.
- Some repeated the examples rather than just ticking them.
- No place to indicate if family involved in the development of the care plan.
- NO SECTION FOR FOOD AND FLUID
- Difficult to add specific things like e.g. continue with insulin

## Cranford Hospice IPU

- Not enough ability to document skin integrity e.g. wound care
- “no ability to express care delivered other than progress notes”

## Notes Review

- As above in ARC, with less detail at times

## OVERALL FINDINGS – CARE PLAN AND TOOLKIT

## APPENDIX 3

## FUNERAL DIRECTOR SECTION

Document clearly in <b>PROGRESS NOTES</b> what was said and by whom.	
<b>Preferred Place of Care:</b> <i>Goal: person and family/whānau choice if appropriate</i>	
Person's preferred place of care	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care
Family/whānau preferred place of care <i>If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"</i>	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care
<b>Information and Explanation:</b> <i>Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them.</i>	
Family/whānau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Information brochure "What to expect when someone is dying" explained and given to family/whānau if appropriate.	<input type="checkbox"/> Yes <input type="checkbox"/> No    Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No
Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.	<input type="checkbox"/> Yes <input type="checkbox"/> No    Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Funeral Director (if known) .....	
If for cremation/burial .....	
Specific death certificate questions:	
Previous occupation .....	
Ethnicity..... Marital Status.....	

4 of 13

## ARC FOCUS GROUPS

## Notes Review

- One family "when I went to ask, all family members looking at me like what I am asking as their dad still alive, however the next day family told me that it given a chance for the family to discuss if and make a decision"
- Often not completed – left empty.

## Cranford Hospice IPU

## Notes Review

- "Lots of people don't want to talk about these things at a very stressful time and so it gets left blank".

## CULTURAL/SPIRITUAL SECTION

INITIAL ASSESSMENT PG 2 OF 2	
<b>Cultural:</b>	
If able, the person is given the opportunity to discuss their cultural needs e.g. needs now, at death and after death.	Date and time of conversation: .....
Family/whānau is given the opportunity to discuss their cultural needs at this time e.g. needs now, at death and after death.	Date and time of conversation: .....
Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See WHANAU: Personalising care at end of life.	Names of services involved: .....
	Document clearly in <b>PROGRESS NOTES</b> what was said and by whom.
<b>Religious and Spiritual:</b>	
If able, the person is given the opportunity to express what is important to them at this	<input type="checkbox"/> Yes <input type="checkbox"/> No

PREPARING FOR LAST DAYS

## ARC FOCUS GROUPS

## Notes Review

- Some staff mentioned difficulty in knowing what to ask of the family or patient.
- Incomplete in many notes.
- Some said they felt that they have this information obtained over a long period and therefore is hard to decide what is most relevant.

## Cranford Hospice IPU

## Notes Review

- The HOPE tool is much better
- Empty in most cases.
- In one case the doctor completed the whole tool, but asterisked (\*) this section for the nurse to complete

## OVERALL FINDINGS – CARE PLAN AND TOOLKIT

## APPENDIX 3

## ON-GOING ASSESSMENT SECTION

## ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary. Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved: Codes (please enter in columns)(not a signature)  
A= Achieved – The Goal was achieved and no additional interventions were required in the previous 4 hours  
C= Change – Use this if the goal was not achieved and / or if additional actions were required to maintain the goal  
If code C is used – details **MUST** be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

GOALS FROM CARE PLAN	Date:	Day:	Date:	Day:	Date:	Day:
TIME						
<b>PAIN</b> Person is pain free • Verbalised by person if conscious • Pain free on movement						
<b>AGITATION</b> Person is not agitated • Person does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)						
<b>RESPIRATORY TRACT SECRETIONS</b> Excessive secretions are not a problem						
<b>NAUSEA AND VOMITING</b> Person does not feel nauseous or vomit • Person verbalises if conscious						

ONGOING ASSESSMENT

## ARC FOCUS GROUPS

- Suggestion that there should be one page for each day instead of putting 3 days on one page.
- Some mentioned confusion about the number columns in each day. Some say that they
- HCA's are not able to assess these things.
- HCA's are not often involved heavily.
- "Why aren't there times like there was with the LCP"

## Notes Review

- At times, not all columns were used

## CRANFORD HOSPICE IPU FOCUS GROUPS

- Not always easy to document on the right day. What about times?

## Notes Review

## HBDHB WARD STAFF FEEDBACK TO HPCT CNS

- Liked being able to see all the things to monitor i.e., secretions and the variants on the same page.
- Helped to see the trend of what was happening.

## Notes Review

## PROGRESS NOTES

**PROGRESS NOTES**

If code C is used IN THE ON-GOING ASSESSMENT SECTION – details **MUST** be provided in the persons progress notes – including (PIE) Problem, Intervention and Evaluation

DATE	PROGRESS NOTES	SIGNATURE AND DESIGNATION

## ARC Focus Groups &amp; Journals

- Most did, but some didn't seem aware that these notes were intended to be multidisciplinary.
- Doctors at times reverted to usual medical progress notes despite the use of the sticker stating stop – now LDOL care plan.
- Request that stickers be green also.
- Need extra copies of progress notes with no page numbers

## Notes Review

- Most did not use the code 'c' with issue and then the details of intervention as suggested.
- Progress notes were very detailed. Almost all completed progress notes as they would normal notes e.g. not restricted to variances only. E.g. "no pain, no sob"

## Cranford Hospice IPU

- Page numbers issue noted
- Pages not always dated, which is an issue if they get out of order
- Discomfort with variance based notes as this doesn't feel consistent with "if it is documented, it didn't happen"

## Cranford Hospice IPU

- Notes recorded in both places
- Patient labels not always put on all pages
- Detailed notes showing achieved and changes in total – e.g. not variance based notes as intended

## OVERALL FINDINGS – CARE PLAN AND TOOLKIT

## APPENDIX 3

**FINAL OFFICES PAGE**[illegible]

### ARC Focus Groups

- Some confusion over the term verification vs certification of death.
- Need to add pharmacy to the list.
- Everyone denied that they felt that this form overlapped with other forms in the organisation. Some organisations have a separate form, others not.
- Discussed identification of bereavement support needs etc. and what follow up is possible.

## Notes Review

- Verification of death is being completed, despite official meaning of the term.
- Community providers section not very relevant

### Cranford Hospice IPU

- Cremation / burial information should be on this page
- Cremation forms require information about any surgery in the last 12 months, including the name of the surgeon
- Needs part about coroner's case
- Some felt that an "after death checklist was absent"?

## Notes Review



## INSTRUCTIONS

This toolkit is an integrated care pathway that can be used across all settings, including the home, aged residential care, hospital and hospice

The term “last days of life” defines the period of time in which a person has been assessed and diagnosed as dying by a multi-disciplinary team and that death is expected within hours or days.

The goals of care are optimal symptom management and support for the person/family/whānau. The person should be assessed and a care plan developed in line with the person (if able), family/whānau wishes and needs

### Criteria for the use of the care plan

A health practitioner undertakes assessments when recognising a person may be entering their last days of life, planning priorities of care and continually assessing care needs. Any changes in condition act as a prompt to ensure conversations occur with the person and with their family/ whānau.

### Instructions for use

Document is organised in three parts and must link with the person's clinical records. It is imperative to clearly communicate all decisions leading to a change in care, and document these conversations. This plan does not replace the need for accurate documentation in the persons' clinical records (progress notes).

#### Preparing for last days of life:

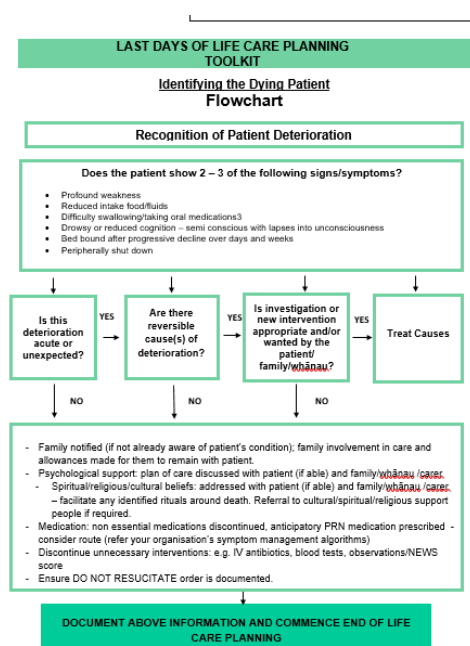
Baseline assessment to identify priorities of care

#### Planning for care:

Person centred priorities of care

#### Ongoing assessment:

Regular assessments (*recommend 4 hourly or more often if required*) of the persons condition to ensure that changes are addressed in a timely manner.



#### References:

Ministry of Health (2015) Te Ara Whakapiri Principles and Guidelines for the Last Days of Life. Wellington. Ministry of Health International Collaborative for Best Care for the Dying Person [www.mcpcil.org.uk](http://www.mcpcil.org.uk)  
Ministry of Health. (2017). <http://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life>



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

## ALL PERSONNEL COMPLETING THE LAST DAYS OF LIFE – CARE PLAN – PLEASE SIGN BELOW

You should also have and understood the 'Health care Professional' leaflet

Name (print)	Full Signature	Initials	Professional Title	Date

### Lead health practitioner/s (this is the person's GP, hospital specialist or Nurse Practitioner)

Doctor: ..... Pager contacts: (HBDHB) .....  
*If GP – See Page 3 for Contact Details*

Nurse Practitioner: ..... Work number: ..... After hours number: .....

Medical Assessment section completed ☐ Date: ..... Time: .....

### This plan should be reassessed every three days

Reassessment date: ..... Reassessment time: ..... Signed \_\_\_\_\_

Reassessment date: ..... Reassessment time: ..... Signed \_\_\_\_\_

Reassessment date: ..... Reassessment time: ..... Signed \_\_\_\_\_

Discontinued date: ..... Time: .....

Reasons why this care plan was discontinued by MDT: .....

.....



Patient name:

NHI:

DOB:

## CONTACTS PAGE

### KEY SERVICE PROVIDERS:

Name of General Practitioner Notified of change in person's condition <input type="checkbox"/> Yes <input type="checkbox"/> No  In what circumstances do they want to be contacted?  If unavailable, who should be contacted?	<div style="text-align: center;"><b>1<sup>st</sup> contact:</b></div> Name:..... Telephone :.....Mobile.....  At any time <input type="checkbox"/> Not at night time <input type="checkbox"/>  <div style="text-align: center;"><b>2<sup>nd</sup> contact:</b></div> Name:..... Telephone.....Mobile .....																																																	
Community Providers are notified of 'Last Days of Life' if applicable	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Cranford Hospice</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/></td> <td style="width: 10%; text-align: center;">N/A</td> </tr> <tr> <td>District Nurses</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>NASC Agency</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>Home Support Agency</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">N/A</td> </tr> <tr> <td>Other</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Yes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">N/A</td> </tr> <tr> <td colspan="7">.....</td> </tr> <tr> <td colspan="7">.....</td> </tr> </table>	Cranford Hospice	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	District Nurses	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	NASC Agency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	Home Support Agency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	Other	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	.....							.....						
Cranford Hospice	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A																																												
District Nurses	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A																																												
NASC Agency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A																																												
Home Support Agency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A																																												
Other	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A																																												
.....																																																		
.....																																																		

### FAMILY / WHĀNAU:

If the person's condition changes, who should be contacted first?   If the person's condition changes, when should they be contacted?	<div style="text-align: center;"><b>1<sup>st</sup> Contact:</b></div> Name:..... Relationship..... Telephone Number:..... Mobile Number.....  At any time <input type="checkbox"/> Not at night time <input type="checkbox"/> Staying overnight <input type="checkbox"/>
If the first contact is unavailable, who should be contacted?   When to contact   Next of Kin if different from above	<div style="text-align: center;"><b>2<sup>nd</sup> Contact:</b></div> Name:..... Relationship..... Telephone Number:..... Mobile Number.....  At any time <input type="checkbox"/> Not at night time <input type="checkbox"/> Staying overnight <input type="checkbox"/>  Name:..... Relationship..... Telephone Number:.....

### Advance Care Plan: *Goal: Both the person/family/whānau are given the opportunity to discuss what is important to them*

Does the person have an existing Advance Care Plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes    Located..... <b><u>Transfer any key actions to the care plan</u></b>
Does the person have an existing Directive?	<input type="checkbox"/> No <input type="checkbox"/> Yes    Located.....
Does the person have nominated Enduring Power of Attorney (EPOA) for Health? Has the EPOA been activated? Copy sighted? <b>Document clearly in <u>PROGRESS NOTES</u> what was said and by whom.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Name.....Relationship..... Contact Number.....  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No





First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Gender: \_\_\_\_\_

**AFFIX PATIENT LABEL HERE**

Date of Birth: \_\_\_\_\_ NHI#: \_\_\_\_\_

Ward/Clinic: \_\_\_\_\_ Consultant: \_\_\_\_\_

**INITIAL ASSESSMENT – FAXABLE SHEET****Physical (Te Taha Tinana):****TO BE COMPLETED BY A SENIOR NURSE OR MEDICAL OFFICER****Diagnosis****Relevant medical history or ☐ refer to full patient records****Baseline information: Is the person:**

- |                                      |  |                                      |  |
|--------------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> Conscious   | <input type="checkbox"/> Semiconscious                   | <input type="checkbox"/> Unconscious |  |
| <input type="checkbox"/> Fully alert | <input type="checkbox"/> Confused                        | <input type="checkbox"/> Delirious   |  |
| In pain                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dyspnoeic                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Agitated                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Experiencing respiratory tract       |  |
| Nauseated                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | secretions                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vomiting                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin integrity                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Continent (bladder)                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Risk of falling                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Catheterised                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Experiencing order symptoms          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Continent (bowels)                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | (e.g. oedema, itch, jerks)           | _____  |
| Constipated                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                      |  |

**Does the patient show 2 – 3 of the following signs/symptoms?***Tick those that apply*

- ☐ Profound weakness
- ☐ Reduced intake food/fluids
- ☐ Difficulty swallowing/taking oral medications
- ☐ Drowsy or reduced cognition – semi conscious with lapses into unconsciousness
- ☐ Bed bound after progressive decline over days or weeks
- ☐ Peripherally shut down (cold hands and feet)
- ☐ Near death awareness (stories, visitations, travel)

☐ **I believe this person is entering the last days of life**

Name:..... Signature:..... Date:.....

**SECTION TO BE COMPLETED BY MEDICAL OR NURSE PRACTITIONER**

- ☐ Active acute medical treatment is no longer in the person's best interest
- ☐ Non-essential medications discontinued and current medications reviewed
- ☐ PRN subcutaneous anticipatory medications charted (*See symptom Management algorithms*)
- ☐ The need for artificial hydration/nutrition has been discussed
- ☐ Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is recorded
- ☐ Inappropriate interventions discontinued e.g. blood tests, routine observations, blood glucose monitoring, oxygen therapy.

Implantable Cardioverter Defibrillator (ICD) (Cardiac Services – contact: 878 8109 ext. 6603)

☐ N/A ☐ Deactivated Date:.....Organ donation considered and information given to person/family *see Tissue Donation brochure*☐ Yes ☐ N/A

Is the coroner likely to be involved?

☐ Yes ☐ No**Specific requests or exceptions to the above checklist:***Nurse to transfer any key actions to the care plan*

Doctor Name..... Date..... Time.....

Signature.....





Patient name:  
NHI:  
DOB:

## INITIAL ASSESSMENT Pg. 2 of 3

### Awareness and Mental Health (Te Taha Hinengaro)

**Recognition of Dying:** Goal: Both the person/family/whānau have awareness and understanding of the diagnosis

The person is aware they are dying? <i>See guidelines on "Identifying the dying patient"</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unconscious
Is the family/whānau aware their family member is dying? <i>See guidelines on "Breaking Bad News" and "W.H.A.N.A.U" tool</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <b>Document clearly in <u>PROGRESS NOTES</u> what was said and by whom.</b>

**Preferred Place of Care:** Goal: person and family/whānau choice if appropriate

Person's preferred place of care	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care <input type="checkbox"/> No preference
Family/whānau preferred place of care <i>If going home or to Aged Residential Care from HBDHB see "Discharge Checklist"</i>	<input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Aged Residential Care <input type="checkbox"/> No preference

**Extended family health (Te Taha Whānau) Goal:** Both the person/family/whānau are given the opportunity to discuss what is important to them.

Family/whānau given information of facilities available e.g. visiting times, parking, tea and coffee, quiet area, toilets.  <i>Information brochure "What to expect when someone is dying" explained and given to family/whānau if appropriate.</i>  <i>Give "Bereavement Information" brochure and list of Funeral Directors if appropriate time.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No  Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No  Brochure given <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

### Religious and Spiritual: (Te Taha Wairua)

Which ethnic group or groups does the person identify with.....  You can gain important information at this time, for example, someone's iwi or other cultural affiliations.  <i>Refer to appropriate cultural support e.g. Maori Health Service, Asian Support, Pacific Island Support. See W.H.A.N.A.U: Personalising care at end of life.</i>	Date and time of conversation..... Name of services involved..... <b><u>Transfer any key actions to the care plan</u></b> <b>Document clearly in <u>PROGRESS NOTES</u> what was said and by whom.</b>
If able, the person is given the opportunity to express what is important to them at this time e.g. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No needs expressed Date and time of conversation..... <b><u>Transfer any key information to the care plan</u></b>
The family/whānau is given the opportunity to express what is important to them at this time eg. wishes, feelings, faith, beliefs, values (needs now, at death and after death)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No needs expressed Date and time of conversation..... <b><u>Transfer any key actions to the care plan</u></b>
Religious tradition identified  Person's minister/priest/spiritual advisor/tohunga (Maori spiritual advisor)  Support of facility spiritual advisor / Chaplain Support of facility cultural support or Maori Health Service <i>Refer to Chaplain Service or contact patient's preferred support person if required. See Spiritual care assessment tool based on FICA approach.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes please specify:..... Name:..... Phone:.....  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No  <b><u>Transfer any key actions to the care plan</u></b>

Nurse Name..... Date..... Time.....

Signature.....



Patient name:

NHI:

DOB:

## INITIAL ASSESSMENT – CARE AFTER DEATH

It may be appropriate to complete some of this section before the person's death

### Accommodation and involvement:

Has private space been made available for the family/whanau?  
Provisions are made to ensure family/whanau are able to participate in after-death care if they wish to be involved

☐ Yes      ☐ No      ☐ N/A  
☐ Yes      ☐ No      ☐ N/A

### Funeral plans:

Is the person to be buried or cremated?  
Named of funeral director  
If no funeral director – use Transfer of Body form and follow guidelines

☐ Buried      ☐ Cremated  
Service \_\_\_\_\_

Are valuables to be left on/with the person/tupapaku?

☐ Yes      ☐ No  
Details \_\_\_\_\_

### Bereavement Support:

Does the family/whanau appear to be significantly distressed before, during or after the death?  
Was there evidence of conflict that remained unresolved within the family/whanau?

Consider using the Te Ara Whakapiri Bereavement Risk Assessment Tool

### Care after death

Person has died

Date/Times/signature.....

People in attendance at time of death

.....

Person has been verified dead

Date/Time/signature.....

Person certified (Medical)

Date/Time/Signature.....

Discussed as appropriate with family/whānau procedures following death, e.g. funeral arrangement, viewing of the body/tūpāpaku

☐ Yes      ☐ No

Bereavement support has been discussed  
See Organisation Policy on Care at death and after death

☐ Yes      ☐ No

### Care after death – Checklist (also see organisation documentation as required)

Notify Next of Kin  
Notify Attending Doctor  
Clinical records complete  
Ensure body correctly identifiable  
Sign off Release of Body form (if applicable)  
WINZ notified/form printed (if applicable)  
Ministry of Health (MoH) notification/form printed (Death only)  
Options HB notified (if applicable)

☐ Yes      ☐ No  
☐ Yes      ☐ No  
☐ Yes      ☐ No  
☐ Yes      ☐ No  
☐ Yes      ☐ No      ☐ NA  
☐ Yes      ☐ No      ☐ NA  
☐ Yes      ☐ No      ☐ NA  
☐ Yes      ☐ No      ☐ NA

Community Providers are notified of Death (if applicable)

Cranford Hospice      ☐ Yes      ☐ No      ☐ N/A  
District Nurses      ☐ Yes      ☐ No      ☐ N/A  
NASC Agency      ☐ Yes      ☐ No      ☐ N/A  
Home Support Agency      ☐ Yes      ☐ No      ☐ N/A  
Other      ☐ Yes      ☐ No      ☐ N/A  
.....

Nurse Name..... Date..... Time.....

Signature.....



Patient name:

NHI:

DoB:

**CARE PLAN pg 1 of 2**

**Plan of care developed using information from initial assessment; any known ACP documentation; input from patient/ family/whānau.**

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
<b>PAIN</b>	Patient is pain free • Verbalised by patient if conscious • Pain free on movement • Appears peaceful	Consider need for positional change <input type="checkbox"/> _____ _____ _____
<b>AGITATION</b>	Patient is not agitated • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)	Exclude retention of urine as cause <input type="checkbox"/> Consider need for positional change <input type="checkbox"/> _____ _____ _____
<b>RESPIRATORY TRACT SECRETIONS</b>	Excessive secretions are not a problem	Medication to be given as soon as symptoms arise <input type="checkbox"/> Consider need for positional change <input type="checkbox"/> Symptom discussed with family/other <input type="checkbox"/> _____ _____
<b>NAUSEA AND VOMITING</b>	Patient does not feel nauseous or vomits • Patient verbalises if conscious	_____ _____ _____
<b>DYSPNOEA</b>	Breathlessness is not distressing for patient • Patient verbalises if conscious	Consider need for positional change <input type="checkbox"/> Consider existing oxygen therapy <input type="checkbox"/> _____ _____
<b>OTHER SYMPTOM (E.G. ITCH, HYPER/HYOPGLYCEMIA)</b>	_____	_____ _____ _____
<b>MOUTH CARE</b>	Mouth is moist and clean • See mouth care guidelines	Ensure mouth is kept moist <input type="checkbox"/> Family/whānau/other involved in care given <input type="checkbox"/> _____ _____
<b>BOWEL CARE</b>	Patient is not agitated or distressed due to constipation or diarrhoea	_____ _____ _____
<b>MICTURITION DIFFICULTIES</b>	Patient is comfortable	Observe for distress due to urinary retention <input type="checkbox"/> Urinary catheter or pads, if general weakness creates incontinence <input type="checkbox"/> _____ _____ _____
<b>FOOD/FLUIDS</b>	Oral intake is maintained for as long as person wishes	Minimum of daily reassessment of intake methods <input type="checkbox"/> _____ _____

15



Patient name:

NHI:

DoB:

**CARE PLAN** pg 2 of 2

**Plan of care developed using information from initial assessment; any known ACP documentation; input from patient/ family/whānau.**

PATIENT PROBLEM / FOCUS	GOAL	ACTIONS What should be done to achieve the goal for this particular person?
MEDICATION	All medication is given safely and accurately	If syringe driver in progress check rate and site <input type="checkbox"/> _____ _____
MOBILITY / PRESSURE AREA CARE	Patient is comfortable and in a safe environment.  Family/whānau are given opportunity to assist with personal cares	Mattress _____  Position changes: _____  Personal Hygiene needs: _____ _____ _____
PSYCHOLOGICAL / INSIGHT SUPPORT	Patient becomes aware of the situation as appropriate  Family/whānau / other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance	Patient is informed of procedures <input type="checkbox"/> Touch, verbal communication is continued <input type="checkbox"/> _____ _____ _____  Check understanding of nominated family/whānau/others/younger adults / children <input type="checkbox"/> Check understanding of family/whānau/others not present at initial assessment <input type="checkbox"/> Ensure recognition that the patient is dying and of the measures to ensure comfort <input type="checkbox"/> _____ _____ _____
RELIGIOUS / SPIRITUAL SUPPORT	Appropriate religious / spiritual support has been given	Support from Chaplaincy team may be helpful <input type="checkbox"/> Consider cultural needs <input type="checkbox"/> _____ _____
CARE OF THE FAMILY /WHANAU /OTHER	The needs of those attending the patient are accommodated	Consider health needs and support <input type="checkbox"/> _____ _____
CULTURAL SUPPORT	Consider the cultural needs of the patient/ family/whānau	_____ _____ _____
OTHER E.G. COMMUNICATION		

Health Professional Name:

Signature:

Date:

Please turn over for on-going assessment / outcome monitoring chart



Patient name:  
NHI:  
DoB:

## ONGOING ASSESSMENT - OUTCOMES

The goals and action plan must be monitored a minimum of 4 hourly and more often if necessary.  
Each entry in this monitoring chart indicates the previous 4 hour.

Use the following code to indicate if in the past 4 hours the goals were achieved:  
Codes (please enter in columns)

### A= Achieved

The Goal was achieved and no additional interventions were required in the previous 4 hours

### C = Change

Use this if the goal was not achieved and / or if additional actions were required to maintain the goal  
If code C is used – details MUST be provided on the interventions sheet

GOALS FROM CARE PLAN	Date												
	Time												
<b>Pain</b> <i>Patient is pain free</i> • verbalised by patient if conscious • pain free on movement													
<b>Agitation</b> <i>Patient is not agitated</i> • patient does not display signs of delirium, terminal anguish, restless (thrashing, plucking, twitching)													
<b>Respiratory tract secretions</b> <i>Excessive secretions are not a problem</i>													
<b>Nausea and vomiting</b> <i>Patient does not feel nauseous or vomits</i> • patient verbalises if conscious													
<b>Dyspnoea</b> <i>Breathlessness is not distressing for the patient</i> • verbalised by patient if conscious													
<b>Other symptoms (e.g. oedema, itch)</b>													
<b>Mouth care</b> <i>Mouth is moist and clean</i> • see mouth care guidelines													
<b>Micturition difficulties</b> <i>Patient is comfortable</i>													
<b>Medication</b> <i>All medication is given safely and accurately</i>													
<b>Nurse initials each set of entries</b>													
		AM	PM	N				AM	PM	N			
<b>Mobility / pressure area care</b> <i>Patient is comfortable and in a safe environment</i>													
<b>Bowel care</b> <i>Patient is not agitated or distressed due to constipation or diarrhoea</i>													
<b>Psychological / insight support</b> <i>Patient becomes aware of the situation as appropriate</i> <i>Family/whanau/other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance</i>													
<b>Religious / spiritual support</b> <i>Appropriate religious / spiritual support has been given</i>													
<b>Care of the family /whanau/other</b> <i>The needs of those attending the patient are accommodated</i>													
<b>Cultural support</b> <i>Consider the cultural needs of the patient/ family/whānau</i>													
<b>Other e.g. communication</b>													
<b>Nurse initials each set of entries</b>													

ONGOING ASSESSMENT

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**DoB:**

If code C is used IN THE ON-GOING ASSESSMENTSECTION – details MUST be provided in the patients progress notes – including (PIE) Problem, Intervention and Evaluation

Trial (dates to be decided)



Patient name:  
NHI:  
DoB:

### INTERVENTIONS REQUIRED SHEET

What occurred?		Interventions taken		Was intervention effective?		If no, what further interventions was taken?	Initials
				Yes	No		
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				
Date:	Time:	Date:	Time:				

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# TOOLS AND RESOURCES TO GUIDE THE CARE OF PEOPLE IN THEIR LAST DAYS OF LIFE





### Additional tools

**to assist with decision making and providing information to ensure the physical (tinana), psychological (hinengaro), spiritual (wairua) and family (wairua) wellbeing for all people is upheld.**

Tool:	Where to access
1. Identifying the dying patient – flowchart	Information Pack In hospital: Via Nettie Map of medicine – Node: ?
2. Symptom Management Algorithms Hawkes Bay Algorithms	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
3. Hospital Discharge Checklist	In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
4. W.H.Ā.N.A.U: personalising care	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
5. Spiritual care assessment tool (FICA)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
6. Breaking bad news flow chart (SPIKES)	Information Pack In-hospital – via Nettie General practice – via HHB website Aged Residential care - Information Pack Map of medicine – Node: ?
7. List of cultural support (Be aware of organisations own resources)	??
Brochures available:	Where to access
What to expect when someone is dying -information for family/ whānau	For supplies of brochure contact : ?? Cranford Hospice Telephone 06 8787047
Tissue Donation – information for patients and family/ whānau	For supplies of brochure contact: Donor Co-Ordinator Organ Donation of New Zealand Ph 09 6300935
What to do after death, grief and bereavement support – practical information for family/ whānau	For supplies of brochure contact: Funeral Directors Association of NZ (Inc) P O Box 10888 Wellington 6143 Email: <a href="mailto:info@fdanz.org.nz">info@fdanz.org.nz</a> Website: <a href="http://www.funeralsnewzealand.co.nz">www.funeralsnewzealand.co.nz</a>

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## Breaking Bad News Flowchart





## Adaption of SPIKES\*

<b>S</b>	<b>SETTING</b> up the discussion	<ul style="list-style-type: none"> <li>• read notes/test results</li> <li>• check who should be present ; involve significant others; is a translator needed?</li> <li>• arrange privacy; think of tissues/water</li> <li>• set time aside with no distractions e.g.pager</li> <li>• mentally prepare self how news will be shared and how to respond to reaction</li> <li>• sit down and make a connection with person/family/whanau</li> </ul>
<b>P</b>	Assessing the <b>PERCEPTION</b> of condition/seriousness	<ul style="list-style-type: none"> <li>• use open ended questions to gather how person perceives the situation e.g. What have you been told so far?</li> <li>• listen to their level of comprehension, accept denial but do not confront at this stage; this can correct any misinformation and tailor breaking news to what they already understand</li> </ul>
<b>I</b>	<b>INVITATION</b> from person to give information	<ul style="list-style-type: none"> <li>• how much do they want to know “Are you the sort of person who likes to know everything?”</li> <li>• accept the person’s rights not to know -“Would you like me to give you all the information or sketch out what has happened and spend more time discussing the treatment plan?”</li> </ul>
<b>K</b>	<b>KNOWLEDGE:</b> giving facts and information to person	<ul style="list-style-type: none"> <li>• warning the person that bad news is coming lessens the shock and can facilitate information processing “I’m sorry to tell you that...” “The results are not as good as we hoped”</li> <li>• use language intelligible to person; use diagrams if helpful</li> <li>• consider their emotional state</li> <li>• give information in small chunks; avoid jargon and acronyms</li> <li>• Avoid excessive bluntness and avoid “There is nothing more we can do” as this maybe inconsistent with their own goals such as good pain relief and control</li> </ul>
<b>E</b>	<b>EXPLORE</b> emotions and empathize	<ul style="list-style-type: none"> <li>• observe and identify emotions expressed by person “You appear sad” “I can see how upsetting this is for you”</li> <li>• what strategies/mechanisms have they used in the past to deal with bad news?</li> <li>• do they have a particular outlook on life/cultural/spirituality that helps</li> <li>• who are the important people in their life</li> </ul>
<b>S</b>	<b>STRATEGY &amp; SUMMARY</b>	<ul style="list-style-type: none"> <li>• draw up plan with person “Your appointment to see Mrs Brown the oncologist is on...” “You are going to contact the funeral director...”</li> <li>• consider immediate plans – what are you doing next; who will you tell/how will you tell them; how will they cope?</li> <li>• have person repeat key points to ensure that they have understanding</li> <li>• does anything need to be clarified or any other questions?</li> <li>• by understanding person’s goals, hope can be fostered to help them accomplish their goals</li> <li>• offer other professional support e.g. Chaplain, cultural support, social work referral, funeral director</li> <li>• document/communicate discussion/plan with other professionals that need to know</li> <li>• close the meeting</li> </ul>

- Baile WF, Buckman R, Lenzi R, Giber G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist* 2000;5(4):302-311.
- Kayleigh Steel, Michael Kennedy, Sean Prendergast, Christina Newton, Andrew MacGillivray and Aileen D'Arcy  
[www.physio-pedia.com/File:SPIKES\\_Table.jpg](http://www.physio-pedia.com/File:SPIKES_Table.jpg)



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

### DISCHARGE CHECKLIST FOR A PERSON IN THEIR LAST DAYS OF LIFE

CHECKLIST	YES	NO	N/A	Signed	Date	Comment
Does the person have a preferred place of care						
Person/family are aware of prognosis						
Person's main nominated contact supports decision for discharge						
Not for Resuscitation complete						
Ambulance booked – aware of Not for Resuscitation						
GP or nominated other aware of discharge and arrangements made for GP to visit.						
Hospice is aware of discharge						
District Nurse updated of care needs and discharge date and time (inclusive of Rural/CHB and Wairoa)						
Aged Residential Care updated of care needs and discharge date and time						
Assessment completed by Needs Assessment Co-Ordination Agency (Options HB) and individual care package in place						
Other MDT members aware e.g. social worker, OT, physio						
Current medication assessed and non essential medication discontinued						
Discharge medication/s ordered:  Appropriate subcutaneous AND anticipatory medication prescribed and faxed to pharmacy.						
If person is being discharged with a continuous infusion pump. Complete appropriate Discharge Checklist.						
Person/family understand the discharge medication						
Equipment delivered/planned e.g. electric bed, mattress,						
Oxygen arranged if applicable.						
Circle of Support has been completed and documented who is the first point of contact.						

## W.H.A.N.A.U: Personalising Care At End-Of-Life

Source: Batten et al (2014)

This has been designed as a prompt card providing potential conversation starter questions to guide conversations about end of life. The background image of Te Whare Tapa Whā (Durie 1985) reminds of the need for a holistic approach to care and W.H.A.N.A.U. guides conversations to ensure that care for people can be personalised.

**'W.H.Ā.N.A.U' - PERSONALISING CARE AT END-OF-LIFE**

- ✓ **WHO TO ASK?** It may be better to talk with a whānau spokesperson, or with the whānau or family all together
- ✓ **HAVE** *time* and *space* to talk and *offer* thinking time
- ✓ **ASK** - don't assume what's important to you is the same for others
- ✓ **NEED** others to join these conversations? – friends, whānau
- ✓ **AGAIN** - people's needs change, so ask again
- ✓ **UNCOMFORTABLE** asking or responding to these questions?  
Ask for help – colleagues, chaplains, cultural advisors

**SOME USEFUL PROMPTS**

What can we do now to help you and those people important to you to feel safe and comfortable?

Do you have beliefs and family traditions that are especially important to you?

What are the important things about you and your whānau that we need to know right now?

The diagram illustrates the Te Whare Tapa Whā model, which is a house-like structure with four pillars representing different aspects of well-being. The pillars are labeled as follows:

- Taha hinengaro** (Mental and emotional well-being)
- Taha whānau** (Social well-being)
- Taha tinana** (Physical well-being)
- Taha wairua** (Spiritual well-being)

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## Spiritual Care Assessment Tool Based on FICA Approach

Source: Puchalski and Larson (1998)

### Background

The FICA Spiritual History Tool was developed by Dr Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with patients. Spiritual histories are taken as part of the regular history during an annual exam or new patient visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

### Suggested questions

These should be adapted to suit each person and revisited as patient circumstances change.

<b>Faith</b>	What things do you believe in that give meaning/value to your life?  <b>and/or:</b> Do you consider yourself spiritual or religious? <b>and/or:</b> <b>and/or:</b> What is your faith or belief?
<b>Importance</b>	In what ways are they important to your life? <b>and/or:</b> What influences do they have on how you take care of yourself?
<b>Influence</b>	<b>and/or:</b> How are your beliefs/values influencing your behaviour during your illness? <b>and/or:</b> In what ways do your beliefs/values help you in regaining your health/wellbeing?
<b>Community</b>	Is there a person or group of people who you love or who are very important to you? <b>and/or:</b> How is this supportive to you? <b>and/or:</b> Do you belong to a religious/cultural community?
<b>Address</b>	Is there anything we can do to help you while you are with us? <b>and/or:</b> Would it help to talk to someone about these issues?

### An example of a spiritual assessment in a non-religious person

F Naturalist


I Feels at one with nature. Each morning she sits on her patio looking out over the trees in the woods and feels 'centered and with purpose'

C Close friends who share her values

A After discussion about belief, she will try to meditate, focusing on nature, on a daily basis to increase her peacefulness

You can refer to the faith leader or Chaplaincy Department at any time, but some specific situations may include:

- When one's own belief system prohibits involvement in the spiritual/religious/cultural care of the patient
- When spiritual or religious/cultural issues seem particularly significant in the patient's suffering
- When spiritual or religious/cultural beliefs or values seem to be particularly helpful or supportive for the patient
- When spiritual or religious/cultural beliefs or values seem to be particularly unhelpful for the patient
- When addressing the spiritual or religious/cultural needs of a patient exceeds your comfort level
- When specific community spiritual or religious/cultural resources are needed
- When you suspect spiritual or religious/cultural issues which the patient denies
- When the patient or family have specific religious needs e.g. Confession, Holy Communion, Sacrament of the Sick, needs a prayer mat or private space to pray, sacred texts, etc
- When the patient's family seem to be experiencing spiritual/emotional pain or trauma
- When members of staff seem to be in need of support.

 <b>HAWKE'S BAY</b> District Health Board Whakawāteatia	<b>Te Ara Whakawaiaora – Mental Health</b>
	For the attention of: <b>Māori Relationship Board, Clinical and Consumer Councils</b>
Document Owner:	Sharon Mason – Executive Director Provider Services
Document Author(s):	Justin Lee – Acting Service Director; Simon Shaw – Medical Director; Peta Rowden – Acting Nurse Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team and Executive Management Team
Month:	August 2017
Consideration:	For Discussion

**RECOMMENDATION****That the Māori Relationship Board, Clinical and Consumer Council:**

Note actions being taken to address continuing issues in :

- Rate of Compulsory Treatment Orders for Maori
- Number of children and youth without a discharge plan
- Wait times for non-urgent Mental Health or Addiction Services

**OVERVIEW**

Te Ara Whakawaiaora (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to ensure improvements are made and sustained.

The Māori Relationship Board identify areas of concern which require action and exception reporting through governance committees and then onto the HBDHB Board.

This report focuses on key actions being taken to improve Mental Health Services for Māori.

**UPCOMING REPORTS**

The following are the indicators of concern in 2017 / 2018.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
<b>Mental Health</b>	Rate of section 29 Compulsory Treatment Orders	81.5%	Sharon Mason	Allison Stevenson	August 2017
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2017
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2017

**WHY ARE THESE INDICATORS IMPORTANT?**

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important to provide data for teams to prepare for clients with CTO and for them to respond appropriately. Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori showing that just less than half the consumers on CTO are Māori.

The percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan is an indicator of integration with primary care. The current data shows improvement needed in the partnership between primary and secondary services.

The proportion of people aged 0 to 19 years requiring non-urgent Mental Health or Addiction Services seen within three weeks, shows that people are not currently receiving services within acceptable timeframes of referral to face-to-face appointment. Where consumers are waiting a long time for appointments this points to services not having been timely and effective in their care.

***Inequality in Outcomes in Mental Health Status for Māori***

***Along with a number of other indicators, this data shows continuing and persistent inequity in quality of care for Maori. This is evidenced by :***

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.



- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

### **First Indicator : Rate of Section 29 Compulsory Treatment Orders**

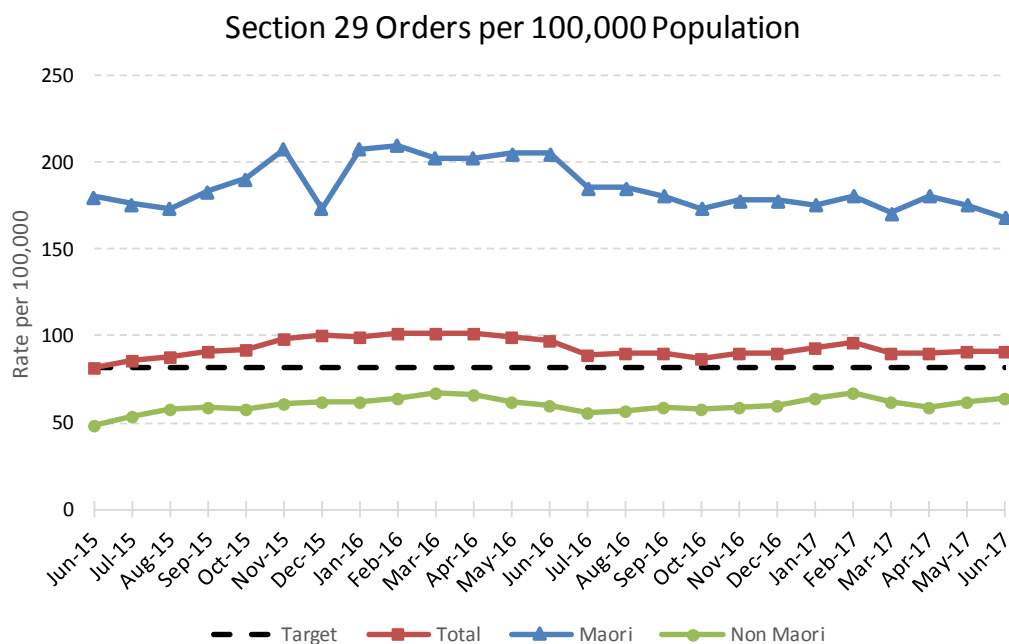
The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies, including cultural and social agencies, so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the “DHB Māori Health Plan Guidance”. However, the guidance document does mention that DHBs are to “reduce the rate of Māori on the Mental Health Act”. The guidance document goes on to state<sup>ii</sup>:

*New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.*

### **HBDHB Section 29 Orders – June 2016 to June 2017**



		Target	Total	Maori	Non-Maori
2016/17	Q1	≤ 81.5	89.7	183.9	57.0
	Q2	≤ 81.5	89.3	176.7	59.0
	Q3	≤ 81.5	93.2	175.9	64.6
	Q4	≤ 81.5	90.7	175.1	61.5

**COMMENTS:**

In Q4 2016/17 the rate ratio of Maori to non-Maori for compulsory treatment orders was 2.8:1 a reduction from 3.2:1 in Q1. This is trending in the right direction however the 95% Confidence Interval for the rate ratio for Hawke's Bay for the calendar year 2015 were approx. 2.8:1 to 5.7:1

Our current target is to achieve reduction to a sustained rate ratio of 2:1 Maori to non-Maori as this would represent a significant change from the current rate ratios.

Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment<sup>iii</sup>. Assertive services, especially at initial onset of psychosis, which support functional gain are crucial to generating positive outcomes.

**Actions being taken to achieve plan include:**

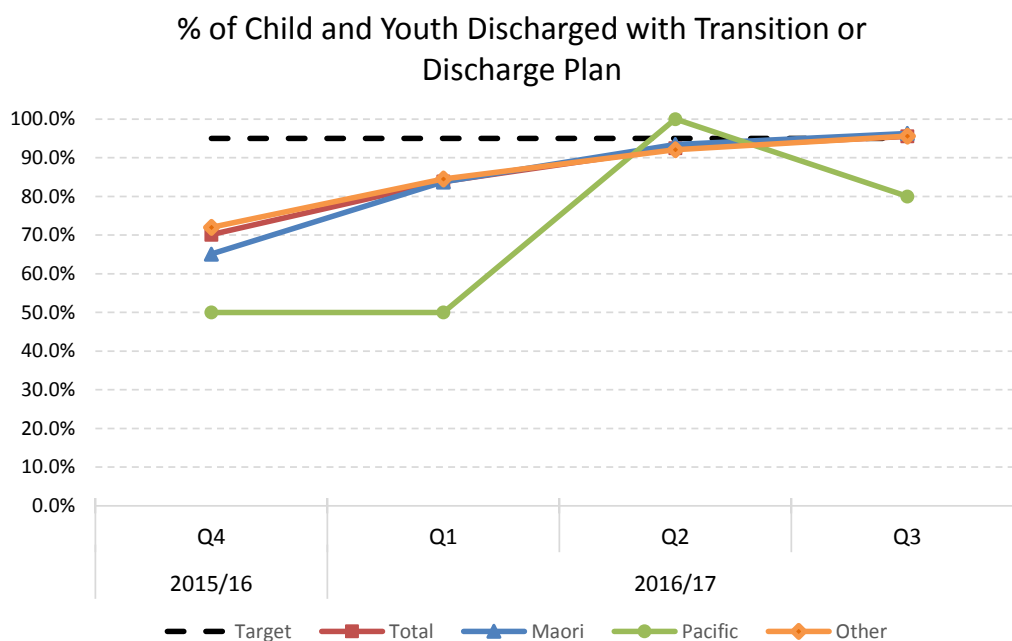
- Home Based Treatment team to provide services closer to home, to prevent mental health conditions worsening and reduce the need for people to be admitted to Nga Rau Rakau when acutely unwell, hence reducing the need for compulsory treatment.
- Provision of Acute Day Service for the community, based in Nga Rau Rakau will be operational in 2017/18, again reducing the need for admission.
- The Clinical Risk Management System is being used to provide expert review of risk management for high risk patients, reducing the need for longer term compulsory treatment.
- Te ara Manapou, the newly founded pregnancy and parenting service for women and whanau with addictions problems who are not engaged with services, will help give children a better start in life and may have impact on compulsory treatment in the long term
- Extended whanau are increasingly being used in reviews of compulsory treatment, by both community key-worker and psychiatrist. This will enable the whole network around the person to provide alternatives to continuing compulsory treatment orders.
- Targeted treatment pathways have been developed with wider availability of evidence-based therapies, such as Dialectical Behavioural Therapy to treat emotionally unstable personality disorder with associated suicide risk. Trauma-based Cognitive Therapy is being used to treat Post Traumatic Stress Disorder and reduce the severity and duration of some conditions.
- Greater use of longer interval injectable antipsychotic medication will well reduce the need for compulsory treatment associated with refusal to continue necessary treatment and subsequent relapse.

## Second Indicator

### ***Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan***

This indicator is that after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and/or referrer.

CAFS is now meeting the KPI on transition planning. Improvement over time has largely been driven by regularly reviewing reporting, and correcting occasions when a discharge plan has not been completed. Our Pacific data shows low referral volumes, meaning not completing of a single transition plan tends affect data significantly.



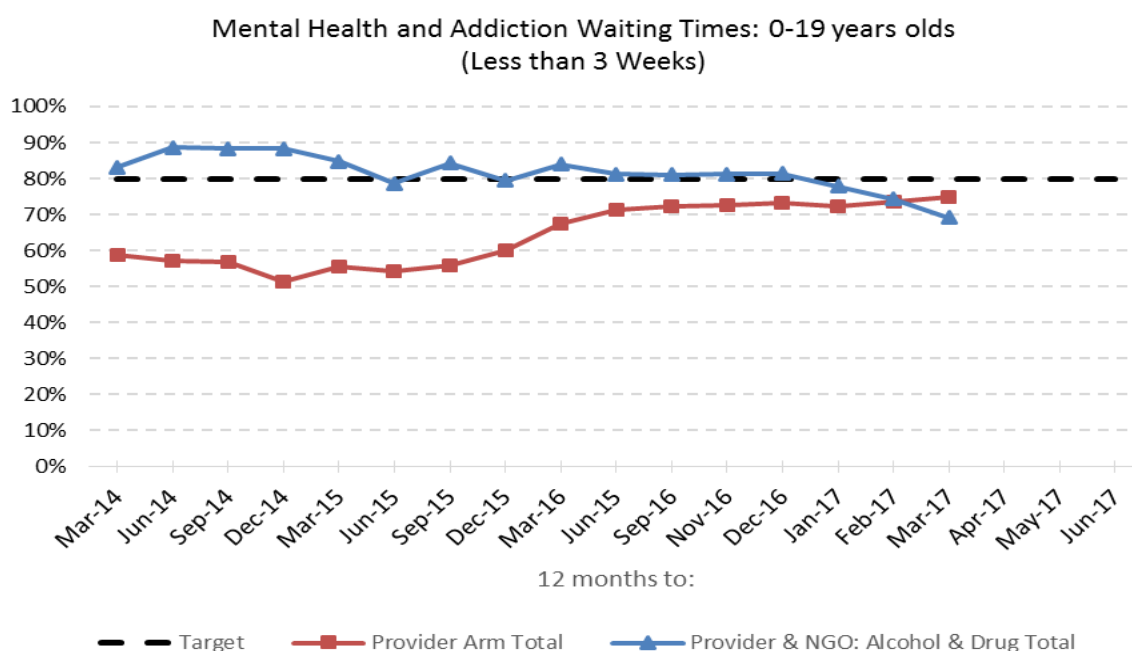
### Third Indicator

#### ***Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years***

This indicator is defined by the time between receiving the referral to the time the child / family are seen face to face by a health practitioner. It should be noted that if there is an acute need, the young person is seen the same day.

Discussion between a number of Child and Adolescent Mental Health providers highlights two significant issues:

- First, some settings have noted a shifting of clinical practice, in that referrals are seen quickly (meeting the KPI) but the subsequent contact is scheduled at a significantly later period. This has led to calls to monitor not just the initial appointment, but also the timeliness of subsequent appointments. Positively, in the Hawkes Bay, subsequent contacts are monitored closely and we are not seeing significant waits between initial contact and subsequent ongoing work.
- Second, the goal of the KPI is largely to provide a measure of service responsiveness. If a family do not attend a planned appointment, then this counts against the KPI. Similarly, family preferences are also considered, which can impact on the KPI (i.e., over school holidays, request is often for later appointments due to travel or other commitments). This encourages our services to be provided in a way that meets whanau needs including in a time and place convenient to them.



Note: the table below reports data to March 2017.

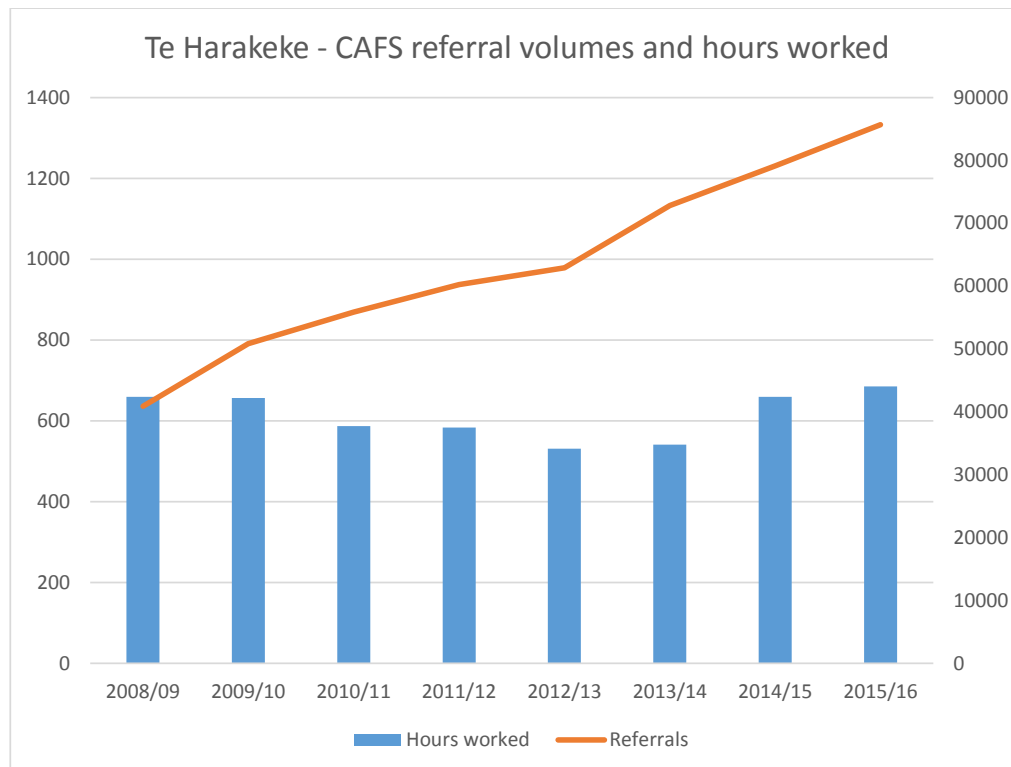
Mental Health Provider Arm										
12 months to Mar-17	<3 weeks					<8 weeks				
	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
	80.0%	74.8%	78.0%	72.2%	72.6%	95.0%	90.9%	92.8%	88.9%	89.7%

As per the graph above, our youth addictions team (1.8 FTE) has an increase in wait times, and is now failing to meet the KPI at 10.8% below the target. Analysis indicates drivers for this include: (a) Access issues in nearly ½ cases (clinical review indicates strong follow-up); and (b) issues around data reporting (i.e., family contacts not appearing to trigger meeting the KPI), which CAFS Clinical Manager will resolve urgently with the health information reporting team. The data errors indicate that performance is being underestimated.

Access issues impact on the wait times KPI. Efforts to address this have included:

- Telephone contact with the family is occurring shortly after referral to introduce the service and to ensure the proposed appointment time works for the family.
- Kaetakawaenga support is available to the team. At referral, families who may benefit from support are identified by the Kaetakawaenga, and their role in engagement facilitated.
- CAFS are seeking to engage with young people in settings familiar to the young person (i.e. at schools, at other agencies where the young person or family already have relationships).

Timeliness and responsiveness are crucially affected by the match of capacity to demand. Of note, CAFS referral volumes have significantly increased since 2008, while hours worked by clinicians has remained stable over time (see graph below). Vacancies impact on wait times KPI, and we expect this to be seen in April – June 2017 (during which several vacancies were present).



It is clear that we need to deliver responsive and clinically sound services for children and young people with moderate to severe mental health difficulties.. Delivering such services not only supports meaningful change in the lives of the most vulnerable whanau, but also represent an opportunity for early intervention, with associated social and economic benefits. We need to ensure that our services have the correct capacity to match the needs of ou communities..

## CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

### ***Compulsory Treatment Orders***

An audit of Mental Health and Addiction Services performance on CTO has given us some baseline understanding of the actions required to reduce the numbers of people under CTO. As a result of this we have implemented a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These have enhanced access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

From Annual Plan 2016/ 2017

Short-term outcome		Activity	Monitoring and Reporting
<b>Māori Health Priority</b>	<b>Reduce the rate of Compulsory Treatment Orders</b>	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	<b>Rate of CTO</b> in Māori and non-Māori <b>100% of intensive service staff</b> trained by Q3 <b>Number of referrals</b> to specific services <b>SI5: WHĀNAU ORA</b> Key Indicator
		Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
		Implement intensive day programme from Q1.	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
		Increase availability of treatment options across community mental health services.	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

**Transition and Discharge Planning**

Every CAFS clinician who has primary responsibility for a case now completes the core transition document. The completed transition plans are communicated to the primary referrer. Regular auditing of exceptions assists in identification of the small number of cases in which transition plans were not completed, and this is corrected.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
<b>Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services</b>	Formalise implementation of Transition Planning Checklist as standard practice in Q1.	<b>PP7:</b> 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Amend discharge documentation to include standard prompt to primary referrer in Q2.	
	Introduce “error flag” in patient administration system to prompt completion in Q3.	
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

**Reducing Waiting Times**

A significant amount of procedural and administrative work has been completed this has included establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This is enhanced with good monitoring of results and attention to the needs of people having difficulty accessing the service.

From Annual Plan 2016/ 2017

Short-term outcome	Activity	Monitoring and Reporting
<b>Improve access to CAFS and Youth AOD Services</b>	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	<b>PP8:</b> 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding “face-to-face” rule for first contact with children and families by Q2.	
	DNA’s and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

### CHAMPION’S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

From the HBDHB Annual Plan 2017 / 2018<sup>iv</sup>, the table below shows the activity that is planned to improve CTO performance.

<b>Mental Health</b>	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	<b>One team</b>	1. Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; partnership with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts.	Q1-4	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.
			2. Explore written material which is used to explain these processes to whānau in other centres, with a view to using locally, if appropriate.	Q2	



To support transition planning there are actions that will be progressed in 2017/18  
CAFS will

- Continue to audit and improve performance against transition plan KPI
- Introduce 'error flag' or discharge checklist into ECA to prompt completion

Actions to improve maintaining waiting for 2017/18 include

CAFS:

- Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.
- Deliver group therapies in primary care by CAFS clinician, to increase access to evidence-based intervention.

## RECOMMENDATIONS FROM TARGET CHAMPION

Further reduction in CTO will be achieved by acting on analysis to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

The intentions in the Annual Plan 2017/18 regarding Compulsory Treatment Orders will deliver ongoing improvement. I will in addition require that the service ensure robust operational performance monitoring of these aspects of service quality to capture the gains.

Transition planning targets are now being met and I will ensure that CAFS undertake regular audit of monitoring to make sure this is maintained.

I will ensure that waiting times in child and adolescent mental health and addictions continue to reduce despite significant increase in demand. As well as continuing to work on improving data quality, and ensuring that services are delivered that are valued by our people I will ensure ensure that we have the capacity to match demand.

The identified areas for improvement and timeframes are outlined in the following table


Description	Responsible	Timeframe
Home Based Treatment: establish framework for regular review of frequent presenters/clients with CTO history	ACM Home Based Treatment Team  Manager Community Mental	June 2018
Acute Day Service fully staffed and operational	ACNM Nga Rau Rakau	December 2017

Te Ara Manapou PPS – Service fully staffed and operational	Service Directorship	July 2018 March 2018
Clinical Risk Management System – review of and focus on CTO	Clinical Team Leader  Manager Community Mental Health	September 2017
Develop Process and Response map for acute presentation under Police MH Partnership strategy	CRMS Committee  Service Directorship  Project Working Group/Quality Improvement Coordinator  Service Directorship	March 2018
<p>Actions to improve maintaining waiting for 2017/18 include CAFS: Deliver group therapies in primary care by CAFS clinician</p> <p>Increase collaboration with NGOs to enhance capability and to reduce demand for secondary services.</p>	CAFS Manager  Service Directorship	December 2017
<p>Actions to improve Transition Planning completion include CAFS: Continue to audit and improve performance against transition plan KPI</p> <p>Introduce 'error flag' or discharge checklist into ECA to prompt completion</p>	CAFS Manager  CAFS Manager	Quarterly  September 2017

## REFERENCES

- 
- <sup>i</sup> Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov; 42(11):941-9
- <sup>ii</sup> <http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance>
- <sup>iii</sup> Diaz-Caneja, C., Pina-Camacho, L., Rodriguez-Quiroga, A., Fraguas, D., Parellada, M., \* Arango, C. (2015). Predictors of outcome in early-onset psychosis: A systemic review. Schizophrenia (2015) March (1): Article number 14005.
- <sup>iv</sup> Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.



	<b>Annual Māori Plan Q4 (Apr- Jun 2017)</b> <b>Dashboard Report</b>
	For the attention of: <b>Clinical and Consumer Council</b>
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, Executive Director, Strategy & Health Improvement
Document Author(s):	Patrick LeGeyt, Acting GM Maori Health; Justin Nguma, Senior Health & Social Policy Advisor Māori Health and Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team
Month:	August 2017
Consideration:	For Monitoring

#### RECOMMENDATION

##### That Clinical and Consumer Council:

Note the contents of this report.

#### CONTENTS OF THE REPORT

This is a report on the Māori health indicators agreed as part of the development of 2016 /17 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 6) to represent this.

As this report is for the period ending June 2017, some results may vary to those presented in other reports.

#### KEY FOR DETAILED REPORT AND DASHBOARD

<b>Baseline</b>	Latest available data for planning purpose
<b>Target 15-16</b>	Target 2015/16
<b>Actual to date</b>	Actual to date
<b>F (Favourable)</b>	Actual to date is favourable to target
<b>U (Unfavourable)</b>	Actual to date is unfavourable to target
<b>Trend direction ▲</b>	Performance is improving against the previous reporting period or baseline
<b>Trend direction ▼</b>	Performance is declining
<b>Trend direction -</b>	Performance is unchanged

## 2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 4 PERFORMANCE HIGHLIGHTS

### **Achievements**

1. Māori Workforce grew from 12.5% in Q1 to 14.3% in Q4 and met the annual target of  $\geq 13.8\%$  for 2016/17 by 15 positions (*Page 61*)

The Māori Staffing Recruitment Plan initiatives this year moved the focus from just Nursing to all occupational groups and has resulted in an increase of Māori staff across all Services. Over the last 12 months 20.1% of the new staff employed at the DHB identified as Māori.

### **Areas of progress**

1. Immunization rates for 8 months old Māori dropped slightly from 94.4% in Q1 to 94% in Q4 but still trending positively towards the expected target of  $\geq 95\%$ .

The disparity gap between Māori and non-Māori in Q4 is 1.6% compared to 2.1% in Q1. This trend can partly be attributed to the growing publicity against immunization. The national coverage has also dropped by 0.4% to 91.9%. (*Page 8*)

Efforts have been focused on raising awareness among whānau through Health HB Whānau Wellness sessions and we are planning to provide education to Family Start workers in the coming quarter. We are also exploring the use of community champions in promoting immunization among the whānau.

2. Ambulatory Sensitive Hospitalization (ASH) for 0-4 year old Māori dropped significantly from 91.7% in Q1 to 79.5% in Q4 but trending positively towards the target of  $\leq 82.8\%$ . The disparity gap between Māori and non-Māori slightly increased from 11.4% in Q1 to 12.6% in Q4. (*Page 46*)

The equity gap between Māori and non-Māori is being addressed through collaborative programmes with key stakeholders. These include: i) the "Under 5 years caries free equity project"; and ii) respiratory initiative focused on exploring respiratory pathway post presentation to secondary care services.

ASH rates for 45- 64 year olds dropped significantly from 196% in Q1 to 178.5% in Q4 and trending positively towards the target of  $\leq 138\%$ . The disparity between Māori and non-Māori has increased from 87% in Q1 to 110.9 in Q4.

Cardiac admissions continue to be a major concern and there are several initiatives currently in place to address this challenge.

3. Cervical screening for 25-69 year old Māori women in Q4 was 73% up by 0.3% from 72.7% in Q1 and trending positively towards the expected target of  $\geq 80\%$ . On the other hand the disparity gap between Māori and non-Māori has narrowed to 2.2% in Q4 compared to 5.5% in Q1. (*Page 52*)

HB DHB remains the 1st in cervical screening coverage for Māori women out of the 20 DHB's. This success is a result of good collaboration between primary care, population health and Māori providers. The addition of Pacific Community Support worker has also increased our coverage among the Pacific women and we are now looking at the logistics of extending our services to the growing Asian population.

Breast screening for 50-69 year old Māori women has dropped slightly from 67.1% in Q1 to 66.2% in Q4 but still trending positively towards the target of  $\geq 70\%$ . The disparity gap between Māori and non-Māori has grown slightly from 7.4% in Q1 to 8.7% in Q4.

4. The Māori staff cultural competency training has grown by 4% over the year from 77.5% in Q1 to 81.5% in Q4. Medical and Support Staff consistently remain well behind the other areas and at 36.9% are well below the expected target of  $\geq 100\%$ . (Page 63)

Concerns about the low participation of the medical staff in the training have been shared with the CMO. The Strategy & Health Improvement Directorate is working with the CMO to address the attendance bottleneck for the medical staff.

5. Access to referral services for Alcohol and Other Drugs for 0-19 year old Māori within 3 weeks decreased slightly from 81.61% in Q1 to 78% in Q4 but trending positively towards the expected target of  $\geq 80\%$ . (Page 69)

On the other hand, referral services for 0-19 year olds within 8 weeks increased slightly from 91.7% in Q1 to 92.8% in Q4 and trending positively towards the target of  $\geq 95\%$ . There is no disparity gap between Māori and non-Māori in Q4.

This progress is partially attributed to the efforts of the Kaitakawaenga active focus on linking with whānau and continued collaborative work with other providers.

6. PHO enrolment has increased by 1.3% from 96.6% in Q1 to 97.9% in Q4 and trending positively towards the  $\geq 100\%$ . The disparity gap between Māori and non-Māori has gone down from 0.3% in Q1 to 0.2% in Q4. (Page 40)

Within the last quarter the PHO has worked to increase the number of practices that are now open for enrolment.

### Challenges

1. Acute hospitalization for Rheumatic Fever has risen from 4.82% in Q1 to 7.23 in Q4 (one new case for the quarter) and trending away from the expected target of  $\leq 1.5$ . The disparity gap between Māori and non-Māori has grown from 2.96 in Q1 to 6.54 in Q4. (Page 15)

There has been an increasing interest in knowing whether the presentation of the new cases with increased complexity (e.g. presenting with chorea) and among the young adults represents a genuine national trend as overall rheumatic fever rates decline. The information will help us understand this phenomenon better, for effective interventions.

2. Māori under Mental Health Act compulsory treatment orders (CTO) has slightly decreased from 183.9 in Q1 to 175.1 in Q4. This shows a reduction in rate ratio of Māori to non-Māori under compulsory treatment orders from 3.2:1 in Q1 to 2.8:1 in Q4. While still far away from the MOH target of 81.5 the data is trending in the right direction and our aim is to bring it down to a sustained rate ratio of 2:1 Māori to non-Māori as this would represent a significant change from the current rate ratios. (Page 32)

High numbers of patients under CTO is a product of many factors including the problem of schizophrenia. Broadly, with regard to the prognosis in treatment of schizophrenia, there are two key factors which impact significantly, including: (a) longer duration of untreated psychosis and (b) higher functional impairment. Early treatment of initial onset of psychosis is likely to mitigate the impact of functional impairment resulting in less number of patients under CTO. Other measures include: home based treatment; provision of acute day services; targeted treatment pathways; and greater use of longer interval injectable antipsychotic medication.

**Please note:**

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.



## ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL – MAY 2017 DASHBOARD REPORT

Immunisation							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
Immunisation at 8 Months (3m)	92.6%	95.4%	94.0%	95.6%	≥ 95%	-3	↑
65+ Influenza (12m)	68.0%	21.0%	54.0%	59.0%	≥ 75%	-578	↑

Rheumatic Fever							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
Hospitalisation rate (6m)	2.48	7.23	9.64	3.1	≤ 1.5	-1	↓

Breastfeeding								
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data (6m)								
At 6 Weeks	58.0%	66.0%	No new data, waiting for the publication of the QIF	≥ 75%	-		↑	
At 3 months	46.0%	39.0%		≥ 60%	-		↑	
At 6 months	46.0%	50.0%		≥ 65%	-		↑	

Oral Health							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers	Desired Trend
Pre-school enrolment rate (12m)	65.3%	72.7%	Reported Annually in Q3		≥ 95%		↑
% Caries Free at 5yrs (12m)	36.0%	44.0%			≥ 67.0%		↑

Tobacco							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers	Desired Trend
Smokefree 2 weeks postnatal (6m)	53.0%	65.6%	No new data, waiting for the publication of the QIF				↑

Mental Health & Addictions							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers	Desired Trend
Mental Health Act community treatment orders (per 100,000) (3m)	196	175.9	175.1	61.5	≤ 81.5	-	↓

Access to Care							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
PHO Enrolment (3m)	97.2%	97.5%	97.9%	98.1%	≥ 100%	-890	↑

The number in brackets identifies the frequency at which data is updated:  
 (3m) 3 months  
 (6m) 6 months  
 (12m) 12 months

ASH Rates							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
0-4 years (6m)	82.1%	84.9%	79.5%	66.9%	≤ 82.8%	-	↓
45-64 years (6m)	172.0%	211.3%	178.5%	67.6%	≤ 138%	-	↓

Cancer							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers	Desired Trend
Cervical screening (25-69 yrs) (3m)	74.1%	73.1%	73.0%	75.2%	≥ 80.0%	-644	↑
Breast screening (50-69 yrs) (3m)	68.4%	66.7%	66.2%	74.9%	≥ 70.0%	-135	↑

Maori Workforce							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
Medical	2.9%	4.7%	5.2%		≥ 13.8%		
Management & Administration	16.5%	19.1%	19.9%		≥ 13.8%		
Nursing	10.6%	11.6%	12.1%		≥ 13.8%		
Allied Health	12.6%	13.2%	4.3%		≥ 13.8%		
Support Staff	28.2%	29.3%	31.6%		≥ 13.8%		
Māori staff - HBDHB (3m)	12.3%	13.5%	14.3%		≥ 13.8%	-	↑

Cultural Responsiveness							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
Medical	19.2%	37.5%	36.9%		≥ 100.0%		
Management & Administration	79.1%	88.5%	89.4%		≥ 100%		
Nursing	70.0%	85.6%	86.0%		≥ 100%		
Allied Health	77.3%	89.9%	90.8%		≥ 100%		
Support Staff	35.6%	64.9%	64.4%		≥ 100%		
HBDHB (3m)	65.6%	80.9%	81.5%		≥ 100%	-	↑

\*Obesity still to be confirmed

Alcohol and Other Drugs							
Indicator	Baseline	Prior period result	Actual to date		Period target	Individual Numbers to Target (approx)	Desired Trend
% of 0-19 year olds seen within 3 weeks of referral (3m)	63%	74.1%	78.0%	72.6%	≥ 80%	-	↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	86.5%	92.0%	92.8%	89.7%	≥ 95.0%	-	↑

Indicator Legend	
Target attained	
Within 10% of target	
10-20% away from target	
Greater than 20% away from target	





## **TOPICS OF INTERESTS MEMBER ISSUES / UPDATES**



## GLOSSARY OF COMMONLY USED ACRONYMS

<b>A&amp;D</b>	Alcohol and Drug
<b>AAU</b>	Acute Assessment Unit
<b>AIM</b>	Acute Inpatient Management
<b>ACC</b>	Accident Compensation Corporation
<b>ACP</b>	Advanced Care Planning
<b>ALOS</b>	Average Length of Stay
<b>ALT</b>	Alliance Leadership Team
<b>ACP</b>	Advanced Care Planning
<b>AOD</b>	Alcohol & Other Drugs
<b>AP</b>	Annual Plan
<b>ASH</b>	Ambulatory Sensitive Hospitalisation
<b>AT &amp; R</b>	Assessment, Treatment & Rehabilitation
<b>B4SC</b>	Before School Check
<b>BSI</b>	Blood Stream Infection
<b>CBF</b>	Capitation Based Funding
<b>CCDHB</b>	Capital & Coast District Health Board
<b>CCN</b>	Clinical Charge Nurse
<b>CCP</b>	Contribution to cost pressure
<b>CCU</b>	Coronary Care Unit
<b>CEO</b>	Chief Executive Officer
<b>CHB</b>	Central Hawke's Bay
<b>CHS</b>	Community Health Services
<b>CMA</b>	Chief Medical Advisor
<b>CME / CNE</b>	Continuing Medical / Nursing Education
<b>CMO</b>	Chief Medical Officer
<b>CMS</b>	Contract Management System
<b>CNO</b>	Chief Nursing Officer
<b>COO</b>	Chief Operating Officer
<b>CPHAC</b>	Community & Public Health Advisory Committee
<b>CPI</b>	Consumer Price Index
<b>CPO</b>	Co-ordinated Primary Options
<b>CQAC</b>	Clinical and Quality Audit Committee (PHO)
<b>CRISP</b>	Central Region Information System Plan
<b>CSSD</b>	Central Sterile Supply Department
<b>CTA</b>	Clinical Training Agency
<b>CWDs</b>	Case Weighted Discharges
<b>CVD</b>	Cardiovascular Disease
<b>DHB</b>	District Health Board
<b>DHBSS</b>	District Health Boards Shared Services
<b>DNA</b>	Did Not Attend
<b>DRG</b>	Diagnostic Related Group
<b>DSAC</b>	Disability Support Advisory Committee
<b>DSS</b>	Disability Support Services
<b>DSU</b>	Day Surgery Unit
<b>DQIPS</b>	Director Quality Improvement & Patient Safety
<b>ED</b>	Emergency Department

<b>ECA</b>	Electronic Clinical Application
<b>ECG</b>	Electrocardiograph
<b>EDS</b>	Electronic Discharge Summary
<b>EMT</b>	Executive Management Team
<b>Eols</b>	Expressions of Interest
<b>ER</b>	Employment Relations
<b>ESU</b>	Enrolled Service User
<b>ESPIs</b>	Elective Service Patient Flow Indicator
<b>FACEM</b>	Fellow of Australasian College of Emergency Medicine
<b>FAR</b>	Finance, Audit and Risk Committee (PHO)
<b>FRAC</b>	Finance, Risk and Audit Committee (HBDHB)
<b>FMIS</b>	Financial Management Information System
<b>FSA</b>	First Specialist Assessment
<b>FTE</b>	Full Time Equivalent
<b>GIS</b>	Geographical Information System
<b>GL</b>	General Ledger
<b>GM</b>	General Manager
<b>GM PIF</b>	General Manager Planning Informatics & Finance
<b>GMS</b>	General Medicine Subsidy
<b>GP</b>	General Practitioner
<b>GP</b>	General Practice Leadership Forum (PHO)
<b>GPSI</b>	General Practitioners with Special Interests
<b>GPSS</b>	General Practice Support Services
<b>HAC</b>	Hospital Advisory Committee
<b>H&amp;DC</b>	Health and Disability Commissioner
<b>HBDHB</b>	Hawke's Bay District Health Board
<b>HBL</b>	<del>Health Benefits Limited</del>
<b>HHB</b>	Health Hawke's Bay
<b>HQSC</b>	Health Quality & Safety Commission
<b>HOPSI</b>	Health Older Persons Service Improvement
<b>HP</b>	Health Promotion
<b>HPL</b>	Health Partnerships Limited
<b>HR</b>	Human Resources
<b>HS</b>	Health Services
<b>HWNZ</b>	Health Workforce New Zealand
<b>IANZ</b>	International Accreditation New Zealand
<b>ICS</b>	Integrated Care Services
<b>IDFs</b>	Inter District Flows
<b>IR</b>	Industrial Relations
<b>IS</b>	Information Systems
<b>IT</b>	Information Technology
<b>IUC</b>	Integrated Urgent Care
<b>K10</b>	Kessler 10 questionnaire (MHI assessment tool)
<b>KHW</b>	Kahungunu Hikoi Whenua
<b>KPI</b>	Key Performance Indicator
<b>LMC</b>	Lead Maternity Carer
<b>LTC</b>	Long Term Conditions
<b>MDO</b>	Māori Development Organisation
<b>MECA</b>	Multi Employment Collective Agreement
<b>MHI</b>	Mental Health Initiative (PHO)
<b>MHS</b>	Māori Health Service
<b>MOPS</b>	Maintenance of Professional Standards

<b>MOH</b>	Ministry of Health
<b>MOSS</b>	Medical Officer Special Scale
<b>MOU</b>	Memorandum of Understanding
<b>MRI</b>	Magnetic Resonance Imaging
<b>MRB</b>	Māori Relationship Board
<b>MSD</b>	Ministry of Social Development
<b>NASC</b>	Needs Assessment Service Coordination
<b>NCSP</b>	National Cervical Screening Programme
<b>NGO</b>	Non Government Organisation
<b>NHB</b>	National Health Board
<b>NHC</b>	Napier Health Centre
<b>NHI</b>	National Health Index
<b>NKII</b>	Ngati Kahungunu Iwi Inc
<b>NMDS</b>	National Minimum Dataset
<b>NRT</b>	Nicotine Replacement Therapy
<b>NZHIS</b>	NZ Health Information Services
<b>NZNO</b>	NZ Nurses Organisation
<b>NZPHD</b>	NZ Public Health and Disability Act 2000
<b>OPF</b>	Operational Policy Framework
<b>OPTIONS</b>	Options Hawke's Bay
<b>ORBS</b>	Operating Results By Service
<b>ORL</b>	Otorhinolaryngology (Ear, Nose and Throat)
<b>OSH</b>	Occupational Safety and Health
<b>PAS</b>	Performance Appraisal System
<b>PBFF</b>	Population Based Funding Formula
<b>PCI</b>	Palliative Care Initiative (PCI)
<b>PDR</b>	Performance Development Review
<b>PHLG</b>	Pacific Health Leadership Group
<b>PHO</b>	Primary Health Organisation
<b>PIB</b>	Proposal for Inclusion in Budget
<b>P&amp;P</b>	Planning and Performance
<b>PMS</b>	Patient Management System
<b>POAC</b>	Primary Options to Acute Care
<b>POC</b>	Package of Care
<b>PPC</b>	Priority Population Committee (PHO)
<b>PPP</b>	PHO Performance Programme
<b>PSA</b>	Public Service Association
<b>PSAAP</b>	PHO Service Agreement Amendment Protocol Group
<b>QHNZ</b>	Quality Health NZ
<b>QRT</b>	Quality Review Team
<b>Q&amp;R</b>	Quality and Risk
<b>RFP</b>	Request for Proposal
<b>RHIP</b>	Regional Health Informatics Programme
<b>RIS/PACS</b>	Radiology Information System
	Picture Archiving and Communication System
<b>RMO</b>	Resident Medical Officer
<b>RSP</b>	Regional Service Plan
<b>RTS</b>	Regional Tertiary Services
<b>SCBU</b>	Special Care Baby Unit
<b>SLAT</b>	Service Level Alliance Team
<b>SFIP</b>	Service and Financial Improvement Programme
<b>SIA</b>	Services to Improve Access

<b>SMO</b>	Senior Medical Officer
<b>SNA</b>	Special Needs Assessment
<b>SSP</b>	Statement of Service Performance
<b>SOI</b>	Statement of Intent
<b>SUR</b>	Service Utilisation Report
<b>TAS</b>	Technical Advisory Service
<b>TAW</b>	Te Ara Whakawaiora
<b>TOR</b>	Terms of Reference
<b>UCA</b>	Urgent Care Alliance
<b>WBS</b>	Work Breakdown Structure
<b>YTD</b>	Year to Date