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MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 17 March 2015 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

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PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor
Richard Orzecki
Phil Sunderland
Duncan Scott
Cynric Temple-Camp

Unconfirmed Minutes

In attendance
Mike Grant, Interim General Manager, MidCentral Health & Support
Murray Georgel, CEO
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member, (part meeting)
Anne Amoore, Manager, Human Resources and Organisational Development
Lyn Horgan, Operations Director, Hospital Services
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Michele Coghlan, Director of Nursing
Syed Ahmer, Clinical Director, Mental Health Service
Brad Grimmer, Project Lead, Mental Health Service Review (part meeting)
Janine Ingram, Project Management Team, Mental Health Services (part meeting)
Vivienne Ayres, DHB Planning and Accountability (part meeting)
Kenneth Clark, Chief Medical Officer (part meeting)
Rodney Mackenzie, Manager, Business Support
Mr & Mrs Hume
Communications (1)
Media (1)

1. APOLOGIES

An apology was received from Stephen Paewai. Kate Joblin apologised for lateness.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

There were no amendments to the register of interests.

3.2 Declaration of conflicts in relation to today's business

The following conflicts of interest were noted:

Duncan Scott declared a conflict in relation to reference to the Feilding Integrated Family Health Centres and MRI waiting times, in terms of his employment with Broadway Radiology Limited.

Kate Joblin joined the meeting.

The general declaration of a conflict of interest in relation to the Operations Report was noted for Cynric Temple-Camp due to his coronial duties.

It was agreed that as the papers did not require any decisions, there was no reason why the members should not participate in any discussion.

5.8

Housekeeping

The Chair referred to the poor acoustics of the room, and asked members to speak loudly and clearly.

Mr & Mrs Hume were welcomed to the meeting. Mrs Hume had asked to speak to the committee.

Mrs Hume then spoke to the committee. She wanted to make sure:

- people did what they said they were going to do
- mental health was given its due attention within the health system
- no patient and their rights were overlooked again
- there was staff, management and governance accountability to MDHB.

Mrs Hume elaborated on the above. She felt there was a blockage of information and full disclosure, some key senior management staff were still involved with cover up, concealment and damage limitation rather than accountability and truthfulness. Self harm was now being reported which was progress. They had been told that strangulation wasn't attempted suicide, it was self harm. As there was no ongoing harm from these events, they usually didn't rate a higher SAE coding. But Mrs Hume said there was mental harm. They had noted these points as no description was given to describe self harm events in the latest report. She asked why there was a reluctance to identify publicly that it was possible for someone to die on a hospital ward utilising objects or items. They would have insisted that proper care and attention was paid to their daughter if they had been aware it was remotely possible for that to happen. In conclusion Mrs Hume stressed that committee members ask the tough questions. She also referred to the DBT, asking when it started in March, and how many patients had started that course.

At the conclusion of her address, Mrs Hume was asked if she would provide a copy of her notes for members. She agreed to do this. A committee member suggested further consideration be given to these notes in the public excluded part of the next Hospital Advisory Committee meeting.

4. MINUTES

It was recommended

> that the minutes of the meeting held on 3 February 2015 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

Ward 21 going smoke-free

It was clarified that Ward 21 had been the only area excluded from the smoke-free policy. As from 16 March, the smoke-free policy would apply to that area as well.

6. WORK PROGRAMME

The Chair referred to her suggestion made at the November meeting for a workshop around reporting quality measures, saying it did not seem to have been noted on the work programme. It was to be based on the mental health review. It would be across the organisation, using the review as the case study. She asked that it be added to the programme.

It was recommended

> that the updated work programme for 2014/15 be noted.

7. STRATEGIC PLANNING

7.1 Regional Services Plan Implementation – Quarter 2, 2014/15

It was recommended

that this report be received.

7.2 Mental Health Review update 5

The Operations Director, Specialist Community & Regional Services, briefly spoke to this report, saying the next few months would involve looking to move the focus particularly in relation to future models of care, the adequacy of the current models and how to strengthen them. This could potentially lead to consideration of a home based treatment model. This is an important consideration as it could impact on future utilisation of the inpatient unit. The key to the success of phase 2 would be undertaking engagement with patients, families, staff and the wider sector. Progress was being made with recruitment for the emergency team to start moving towards at 24 hours/7 day service. Meetings with staff and unions were under way in terms of how staff would work. An appointment was being finalised for the new service director position, with an announcement expected later this week. The anticipated start date would be mid April.

Dr Syed Ahmer also spoke to the report, advising the start date for the Dialectic Behaviour Therapy program was 26 March. The date for some clinical records to move to the clinical portal was 11 May. Moving retrospective records would start on 11 July, as the records had to be checked for correctness before they were moved.

The first revised quality report was received at the last Mental Health Service executive meeting. Copies of quality reports from Waikato and Capital & Coast DHBs were considered. They included key performance indicators specific to mental health. Quality reports would be received monthly going forward by the executive meeting, and further consideration on what, if any, additional items should be included. Trends would be considered once the monthly information was available. He went over the strategies undertaken to address concerns in terms of clinical governance. Additional comments included regular meetings with Non Governmental Organisations (NGOs) who provide accommodation (trying to strengthen the process so there was somewhere for patient to go in the community); open disclosure (now immediately make an offer to meet with the family if there is a serious event); self harm/clinical perception of what was self harm. In terms of self harm, people were only admitted if the risk could not be managed safely in the community. Self harm can become a way of coping to relieve distress. Every incident was studied very carefully to ensure the risks were managed actively. Finally, Dr Ahmer confirmed Ward 21 had gone smoke-free from the previous day, with no major issues so far.

The Director of Nursing also spoke to the report, specifically appendix 2 – Mental Health Nursing Work Plan. While it was a 12 month plan, a number of its sub-components had already been completed. Points she touched on included support for nurses who were asked to work in Ward 21, working to ensure there was appropriate accommodation for patients to use, support received from the Service Manager, Mental Health Service Whanganui DHB, and feedback from the Ministry of Health's Chief Nurse.

Members acknowledged Mrs Hume's address, noting she had agreed to provide a copy of her notes to the committee and management.

Discussion then turned to the mental health report.

Mental Health Emergency Team – 24/7 basis

Very good information regarding availability of the new service including phone numbers would need to be well advertised to patients, services, outside organisations etc.

Recruitment and Retention of Staff

The issue of double shifts and overtime was raised. Management advised nursing numbers had improved over the last quarter, and there was almost a full complement of staff. There had been some very small numbers of staff who had completed a double shift.

The need to carefully consider this option was emphasized, with members stressing that families must be involved in the development of the service and that it must not become a default service to keep numbers down in Ward 21. Families must be able and willing to look after their family member, who would be unwell.

A member wanted to know what the breaking point would be in terms of looking after someone. Dr Ahmer explained that if it was felt the risk was escalating and the patient could not be safely managed in the home, a referral would be made to the Home Care Team. The primary concern was safety. He explained the Home Care Team would visit a couple of times a day, and that the patient was being assessed at each visit.

Future models of care and service development were being considered. There was a lot of research that clearly showed once occupancy went above 80%, the risks went up. MCH's occupancy was about 75%, so managing the entrances and exits was important. Changing the model of care for the future would be a big piece of work. Having a successful model would rely on hearing from GPs and clinicians in the community around any concerns they might have.

When asked if Ward 21 was big enough according to international standards, Dr Ahmer said the model had moved from a ward based care system to a community based care system. He felt the design of the current ward had to change, rather than increasing the bed numbers.

A member referred to the artwork in the Whanganui DHB mental health service, which had been made by service users. He felt that was good and something MidCentral Health could consider. He also suggested it would be good to find another name instead of Ward 21.

There was reference to the number of incidents of self harm, in terms of whether the same patient's incidents had continued over more than one month. This detail of information was not available at the meeting.

A member referred to the issue of different therapeutic levels of SSRI drugs with individual patients and whether levels should be measured. He drew attention to the different suicide rates between Northern and Southern Europe involving people on these drugs. Whilst he didn't know how New Zealanders would compare, he thought it was something to be aware of.

A member asked what contact MidCentral's mental health services had with social housing providers such as Shepherd's Rest.

Kate Joblin acknowledged the work being done, and made a request for more information around numbers to be routinely reported to the Committee. She asked to see:

- The numbers in seclusion and use of restraint
- Use of the Mental Health Act.
- In terms of self harm, the current information was a good start, but she felt it could be more meaningful
- Overtime - what was happening with that work
- Occupancy
- Referral process - some information about the referral process – were time lines being followed – be good to have a snapshot.

She also asked whether patients were being seen once they were discharged from Ward 21, whether it was within seven days, acutely or planned, as this was a measure of success. Dr Ahmer said it was a national key performance indicator. Patients must be seen within seven days of discharge on a planned basis, and that recent results showed an improvement.

It was recommended

that this report be received.

7.3 Palmerston North Hospital Site Reconfiguration (Living within our means) update

The Interim General Manager, MidCentral Health spoke to this report, saying the changes being made in performance and approach would lead to a change in culture. There was investment in training for leaders, and there was also change around models of care, production and co-design, and how staff engaged with patients in their journey of care. This all led to the culture change across the organisation.

It was recommended

that this report be received.

Diane Anderson, Cynric Temple-Camp and Lindsay Burnell left the meeting.

7.4 Non-financial Monitoring Framework and Performance Measures – Report for Quarter 2, 2014/15 update

Shorter Stays in ED

Management clarified the reference to ED's recruitment process on the second page of this report, explaining a second triage nurse had been recruited for the waiting room.

Lindsay Burnell and Cynric Temple-Camp returned to the meeting.

It was recommended

that this report be received.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report - January 2015

It was noted that the FAST clinic within the orthopaedic clinic had ceased, been reviewed, and restarted with a changed model.

Dr Kenneth Clark joined the meeting.

Falls

Management confirmed the change in falls would be attributed to a number of strategies, eg the multi disciplinary approach with the Falls Group, or the Falls Aware Ward initiative that was also being rolled out across both primary and secondary sectors.

Reference was made to the Faster Cancer Treatment initiative. Dr Temple-Camp felt the numerator should be from the day the diagnosis was picked up by the laboratory rather than when there was a suspicion of it. He thought it would be a struggle to achieve the measure.

It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

28 April 2015

11. EXCLUSION OF PUBLIC

It was recommended

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	

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Operations Report: Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)
2015/16 Annual Plan Development – draft plan	Subject of negotiation	9(2)(j)