Hospital Advisory Committee

FROM Operations Director, Specialist Community & Regional Services
Clinical Director, Mental Health & Addiction Services
Director of Nursing

DATE 6 March 2015

SUBJECT **Mental Health Review Update Five**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report provides Update Five on actions underway by the Project Board to address the findings of the external review of the Mental Health Service following the two serious adverse events that occurred in Ward 21 during April/May 2014.

2. SUMMARY

Activity in the current reporting period has focused largely in two areas; firstly, consolidating remedial work initiated since September last year which included reviews of the workforce development needs plus leadership and management structures which is nearing completion. The second focus is on starting to plan for the overall model of care we anticipate putting in place for the future.

The latter work will involve an extensive round of consultation with all key stakeholders, the first of which is getting underway now with the Consumer Participation Working Group meeting on 11 March 2015.

Further efforts are being directed at refining the process by which people enter mental health and addiction services, the quality of service delivered during their episodes of care and how they transition to alternative community based support or back to their home. Some may benefit from assertive home based treatment follow-up or brief crisis resolution options. Consideration of these options is underway.

Finally, initial work has started on planning the re-design of Ward 21. This, plus further narrative on self harm, is provided in Section 5 below.

3. RECOMMENDATION

It is recommended:

that this report be received.

4. BACKGROUND

Two serious adverse events occurred within a short period of time in the acute mental health inpatient unit at Palmerston North Hospital (Ward 21). At the request of the Board, and in consultation with the Ministry of Health's Director of Mental Health, it was determined that a wide external systematic review of the service as a whole be undertaken, referencing the two events. The external review was commissioned to ensure that any underlying issues in relation to the structure, resourcing, or culture of the service be identified and addressed.

5. WORK PROGRAMME PROGRESS

A status report, on Phase One of the Work Programme is provided as Appendix A. This is presented in the conventional format for project management reporting with three sections: *Completed Key Tasks* (green) and *Current Key Tasks* (amber). The status report indicates the extent of progress against each item.

5.1 Phase One - Change Management Update

Establishing the Mental Health Emergency Team on a 24/7 basis to support all Mental Health Services

Recruitment to the additional positions to expand the service across 24 hours per day has commenced; applications close late March. A project scope and terms of reference have been confirmed to progress implementation. Meetings are underway with unions and staff regarding implementation of the changes.

Leadership Structure for Mental Health Services

Recruitment to the new Service Director position is in its final phase, with interviews conducted on 27 February 2015. At the time of writing the final decision regarding the operational leadership positions has received CEO approval, with announcements to affected staff, and the wider service being arranged.

Re-alignment of the Older Adult Mental Health Service with Mental Health Services

Meetings have commenced to consider and develop the operational plan for the future configuration and alignment of this service. The plan is expected to be ready for CEO consideration and approval in late April 2015. Dr Arjun Thampy has accepted the offer of a permanent position at MidCentral DHB as an Old Age Psychiatrist and will take up this post on 7 September 2015. He has specialist qualifications in old age psychiatry, and brings a skill set well suited to supporting the development of our service. He is currently working in a community old age psychiatry post in Leeds, UK. In the meantime a full time locum psychiatrist is providing medical leadership to the service and participating in the service development planning.

5.2 Longitudinal Clinical Reviews

Both reviews continue in progress, with one having been the subject of feedback from the family and MDHB to the reviewer. This feedback is being considered for incorporation, as appropriate by the reviewer. A final draft report is expected by 13 March 2015. The second review commenced mid-February 2015. The file review phase is mostly completed, and a draft report of recommendations should be received for feedback later in March 2015.

5.3 Update on Nursing Plan and Root Cause Analysis Action Plans

Early in the development of the work programme there was considerable work undertaken to develop a detailed Mental Health and Addiction Nursing Plan, particularly in relation to Ward 21, to support our overall work programme. The work plan has seven key areas for development within Ward 21, primarily but not limited to Mental Health Nursing, and covering:

1. Promote a safe patient care environment within Ward 21 (Open ward and HNU);
2. Criteria for admission to, transfer within, and discharge from Ward 21 (Open ward and HNU) developed and agreed in partnership with wider MHS leadership;
3. Staff to patient ratio and skill mix;
4. Patient allocation model;
5. Rostering process;
6. Reducing the use of seclusion ;
7. Embedding a MHN professional practice culture.

For completeness and reference the original nursing plan has been included as Appendix B to this report. The plan is provided as background, as the work is now well underway. We will continue to provide narrative updates regarding progress in future reports, rather than detailed progress against each of the items in the plan.

The update in relation to recent activity is as follows:

- Strengthening of the inpatient admission processes continues. An audit of compliance is due to be completed;
- Ward environment Hazard identification process has been commenced which includes a monthly audit. Three more hazards have been identified and addressed;
- Trend care compliance awaits the implementation of the updated trend care software and relevant training for staff by the trend care coordinator. This has been highlighted as high priority for the nursing staff;
- Recruitment, roster re organisation, increased staffing has improved;
- Staffing FTE (nursing) has been agreed and increased across shifts, which has lead to active recruitment;
- Professional nursing presentation has improved immensely with majority of staff adopting either the nursing uniform or smart dress;
- Leadership of the ward environment is markedly improved with the secondment of the Charge Nurse and Clinical Nurse Specialists;
- An Associate Charge is rostered to work both am/pm seven (7) days per week;
- New design of door handles from Australia has been sourced for patient bedrooms and bathrooms, and has been confirmed as suitable. The procurement process for these has commenced.

5.4 Over Arching Model of Care for Mental Health and Addiction Services

The MH Review Project Board met in workshop late February to consider how to progress the preferred Model of Care for MidCentral MHA Services into the future. Whilst acknowledging the principles and directions espoused in the government policy document The Mental Health and Addictions Service Development Plan; *Rising to the Challenge* 2012-2017, three key themes emerged. MidCentral MHA services should be person centred, recovery focused and promoting independence. The group was able to identify key principles and service elements for future consideration that support an individual in a recovery oriented approach.

Some of that relies on early detection and early intervention in conjunction with primary care services plus family/whanau input rather than a delayed presentation which has reached

crisis stage possibly requiring acute admission. Whereas an acute inpatient service is required where appropriate, future service arrangements could be more responsive, and effective if they are more integrated with community and primary care options.

One option under consideration is the development of an Acute Home Based Treatment Service for MidCentral District, could offer Home Based Treatment as an alternative treatment option to treatment in the acute inpatient unit (Ward 21). It would provide assessment, support and treatment to consumers who are acutely unwell and would otherwise be treated in a hospital setting. It requires careful consideration of clinical risk and the appropriateness of community rather than inpatient care to manage those risks. The service would work collaboratively with community care providers.

Home Based treatment is a rapid response acute service provided to people in their individual place of domicile, by a multidisciplinary team. Several visits and telephone contacts may be made per day as per individual need. The team can provide medication, brief counselling, education, practical assistance, information and support to consumers and their families. The service remains available until the crisis is resolved. The consumer may then be referred to other community services for further care and follow up. (The Acute Crisis; Mental Health Commission, 2006).

The project board has agreed that exploration of options for a home based treatment model need to be progressed as a priority as it will have an impact on the capacity and physical requirements of Ward 21. This potential impact will need to be well understood before detailed planning regarding the reconfiguration of Ward 21 is commenced.

In addition, establishing the preferred model of care is pivotal to implementation of the MH Nursing Plan, the Allied Health Plan and overall staff training calendar looking forward.

This work, and the wider considerations of all aspects of future models of care and service development, is under consideration by the Project Board now with regular updates anticipated. In addition a wide reaching round of consultations is planned with key stakeholders in the weeks ahead. This will also coincide with engagement with the MDHB Clinical Leadership Council, at their request, both over the expansion of the project board to include community and primary participation and the approach to the wider engagement across the mental health sector.

5.5 Ward 21 Facilities and Environment

The Kaumatua group met with the project team early November 2014 to discuss the mental health review and to consider the likely opportunities for physical improvements that would enhance a Maori cultural environment.

The terms of reference for the review were broad with a focus on

- Clinical systems and processes;
- Clinical Leadership;
- Service resources;
- The culture of the service;
- Adherence to policies and established standards of clinical practice;
- Patient pathways (including older adult mental health).

A number of the Terms of Reference affect a patients (and families/whanau) cultural integrity so the recommendations extend beyond the addition of '*taonga to ward 21'*.

For a basis for comparison, visits to the ward 21 and to Te Awhina unit at Whanganui DHB were instigated. The group feedback highlighted aspects that impact significantly on the

wellbeing and culture of all persons irrespective of ethnicity and extend beyond the aesthetics of the building.

The recommendations are that:

- All spaces are separate and adequate and fit for purpose for dining, for recreation, for medication, for receiving and accommodating patients and their families/whanau;
- The building design eradicates as many locked areas as possible and creates safe open spaces;
- That high needs areas including police activities are well separated from the ward and visitor areas;
- Partitions provide security without creating 'us' and 'them' spaces;
- There is free access to safe, open and secure spaces;
- The courtyard is secure to contain but open to the natural environs with protective (rubberized) flooring to prevent injury;
- The entrance is welcoming, and accommodates more than two or three people at a time. The seating is comfortable;
- Furniture will be fit for purpose, sturdy, matching or complimentary.
- The unit is smoke free;
- The entrance is well sign posted and managed professionally – visitors are treated with respect;
- Colours to enhance the use of space – Inspirational, meditative or calming to suit the situation;
- The ability to communicate well with all the individuals/groups and having regard for their difference is paramount. How people perceive they are being treated is important.
- Developing trust and taking care of people confidently;
- Affirmative generic art throughout at Te Awhina was well admired and similar art no doubt will be well received by most if not all people;
- The kaumatua group along with the Director Maori would appreciate continued involvement in the planning of spaces to advise on accommodating Maori models of practice;
- Maori art e.g. carving *poupou* or door *pare* would certainly provide a sense of identification/acceptance. The kaumatua group would be prepared and delighted to be involved in further detail of art work as well.

These recommendations will be incorporated into our plaaning for the improvements to Ward 21, with appropriate further engagement with the Kaumatua group during the detailed planning phase.

5.6 Self Harm Trends

The management of self harm incidents in Ward 21 was highlighted in the review of common themes between the two deaths in Ward 21. This update provides information regarding consideration and actions that are underway regarding the management of risk to self harm in Ward 21.

Self-harm, is the act of deliberately harming your own body, such as cutting or burning yourself. It is typically not identified as a suicide attempt, given the absence of serious harm. In this context self-injury is seen as an unhealthy way to cope with emotional pain, intense anger and frustration. While it may bring a momentary sense of calm and a release of tension, it is usually followed by guilt and shame and the return of painful emotions. While these incidents do not typically involve serious harm, there may be a risk of injury.

Managing the patient at risk of self-harm is one of the more challenging aspects of care for the person affected by mental illness. In an acute ward such as Ward 21 the risk of a client self-harming is reasonably high given the client population admitted for acute inpatient care.

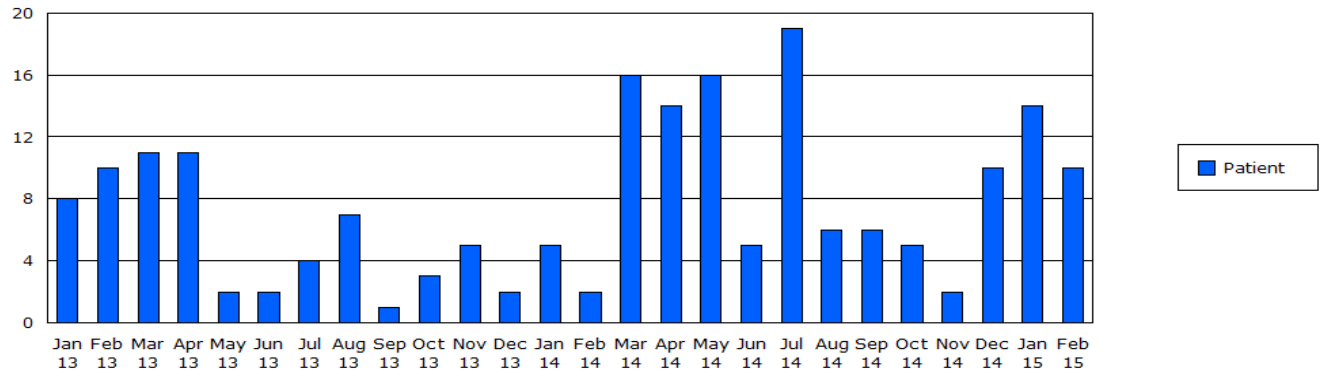
Managing the risk of self-harm in Ward 21 is now carried out in the following ways:

- As part of the multidisciplinary review process, risk assessments are carried out by the clinical team both on admission and as part of the daily patient review round. The daily round includes a clinical psychologist, medical team, nursing, allied health and key workers who together review individual clients and plan their care;
- More comprehensive nursing handover reports between shifts have been introduced. This serves to inform nursing staff at the start of the shift on the current plan of care and level of monitoring required to maintain client safety and deliver therapeutic care;
- Regular reviews of the clinical environment are carried out to maximize a safe and therefore more therapeutic environment;
- The active promotion of a professional culture of openness and transparency in reporting incidents, including self-harm. This has in part contributed to the recent increased reporting of self-harm incidents on 'Riskman' by staff;
- Improved processes for review and monitoring of critical events ensures that there is a feedback loop by which learnings are fed back to inform clinical practice. Self -harm incidents are also monitored by the Serious and Adverse Events Group ensuring critical review and fed back to the ward leadership in the form of corrective actions.

Minimising the risk from self-harm incidents is a key therapeutic goal for the Ward 21 clinical team. Challenges include balancing the need for close monitoring with respecting the privacy of a client, and supporting appropriate self responsibility as a crucial part of recovery. However the clinical leadership of the ward are working hard with the ward team to ensure regular and robust client assessment, maintenance of client safety and reducing the incidents of self- harm to an absolute minimum. The number of incidents is influenced by the needs of an often small number of patients.

Figure 1 below shows the frequency of self harm incidents in Ward 21 for the period January 2013 to January 2015

Self Harm incidents January 2013 to January 2014



The months with higher numbers of incidents reflect multiple patients with self harm activity, with between four to seven incidents for an individual in one month.

March 2014	5 patients	7 incidents related to 1 patient
April 2014	3 patients	6 incidents related to 1 patient
May 2014	6 patients	4 incidents related to 1 patient
July 2015	5 patients	6 incidents related to 1 patient
December 2014	3 patients	5 incidents related to 1 patient
January 2015	5 patients	4 incidents related to 1 patient

5.7 Financial impact of measures to support the Mental health Service

Listed below are costs that have been incurred, in addition to those budgeted for the Mental Health Service associated with activities to improve the service, following the review and establishment of the work programme. These are largely focussed on improving patient safety.

Cost areas	**Additional Costs YTD 31 Jan 2015** (000s)
Nursing	389
SMO Locums	280
Staff Training	24
Minor Purchases/alterations	14
Total	**706**

The nursing costs are largely additional nursing staffing provided to Ward 21. Locum costs relate to ensuring full coverage of SMOs to support patient safety across the service. Training costs have included DBT and suicide prevention training year to date. The minor purchases largely relate to changes in the environment of Ward 21 that were below the capital expenditure threshold of $2000 per item.

The impact of these additional costs leaves the MH Service overall unfavourable to budget by $344K YTD January 2015. Additional resources have been budgeted for 2015/16 taking these and other planned changes into consideration.

5.8 Ministry of Health Director of Mental Health

Dr John Crawshaw, Director of Mental Health visited MCH for a day in late January, and met with the CEO, senior management and clinicians. This was a routine annual visit, as has occurred in the past, most recently March 2014. He was gratified to see the improvement in systems and reporting that Richard Barrass, the newly appointed DAMHS was putting in place. He also noted Richard's commitment and initial progress with establishing appropriate standards of practice relating to the Mental Health Act.

Dr Crawshaw reiterated his desire that we take a whole of system and district wide approach to improving mental health services. He sees the development of models of care as vital, especially to improve the patients experience of services and to reduce reliance on inpatient care. He highlighted the benefit of having secondary clinicians working in primary and NGO settings.

He encouraged us to utilise the improvements that have been successful in personal health, rather than designing MH specific approaches, and to confirm the appropriate metrics to measure improvement in that regard. This advice will be incorporated into our work programme.

5.9 Workshop with Lead Clinician for External Review

Dr Gloria Johnson, CMO Counties Manukau DHB, visited MDHB for a workshop with Board and Committee members, in her role as clinical lead for the 2014 Mental Health External Review. Gloria also spent time in Ward 21 and with nursing leadership to follow-up on progress there. She provided some context to the review findings and recommendations, noting that reviews of this kind focus on areas for improvement, and not all the things that are going well, and that our challenges were typical of those facing many provincial MH Services.

Dr Johnson was positive in her feedback on our progress with the work programme, particularly noting the significant improvements in Ward 21 as a result of the strengthening of nursing leadership. For the future she encouraged greater engagement with patients, families and our staff, to seek feedback on progress. Following the workshop she reiterated her willingness to return in six months or so to spend more time in the service to review our progress.

6.0 GENERAL

Update on other activity that has been undertaken in conjunction with the Mental Health Review Work Programme.

The following items highlight progress on a range of activities underway. These are being incorporated into the wider service development plan Phase Two.

6.1 Dialectic Behaviour Therapy (DBT)

The strengthened Palmerston North DBT program will commence in March 2015 and run through to October 2015, with three eight (8) week modules being provided to clients vulnerable to high risk behaviours, including suicidality. There are three clients on the list

who are awaiting assessment, all referred within the last month, and will be seen within a month of referral. A further two clients have been assessed as suitable, and require allocation to an individual therapist in coming weeks.

The Horowhenua DBT team plan to commence the next round of DBT Skills Group in early April 2015. They have six clients scheduled to attend this group, and have three more clients currently being assessed as to their suitability for DBT. They have not needed to utilise a waiting list to date.

6.2 Referral to Adult Mental Health Addiction Services

A request was made from the last HAC Committee to clarify the process by which people enter and move through the Mental Health and Addiction services, as well as how people transfer from another DHB.

An approach to achieving an improved process for entry to MHA services is a priority piece of work in the MH Review Phase Two Work Plan currently being developed. Establishment of more effective processes for entry into the MHA service is a key piece of work identified within the current MH Review Work Programme. This deliberate tactical decision is based on the idea that what happens first is crucial in ensuring that what follows is appropriate and fulfils our obligations for subsequent parts of the service delivery system.

Beginning the changes with changes to entry into the service is intended to drive clear and consistent processes and behaviour to bring the experience of a service user into the centre of decision processes. Examples of such an approach exist in other DHBs to guide our planning. There should be a low threshold for entry, an effective multi disciplinary team process and clear mechanisms for referring on to the most appropriate clinician all via one process of access into the service. This entry process should operate on a 24/7 basis and would involve triage, assessment and referral to the appropriate clinician (the booked first appointment). It would identify and distinguish between new users, clients with long term needs and those with urgent needs.

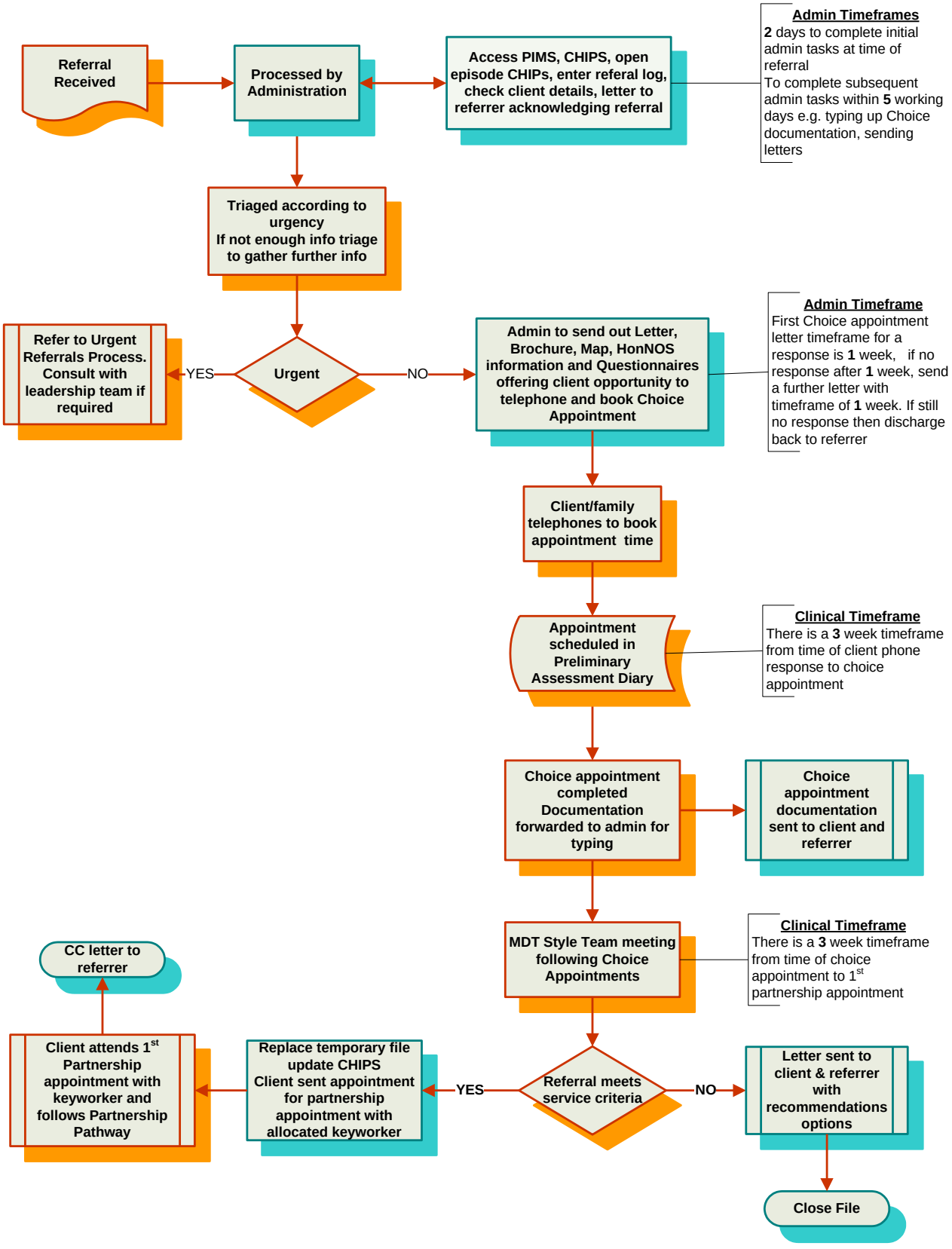
Where triage identifies that the presenting person does not require secondary services, a supported referral is made to a more appropriate provider or agency, including discussion with the patient and family around options. Common assessment processes would be utilised to initiate evidence based integrated clinical pathways designed to maximise clinical outcome and patient safety. The entry process would use a single electronic clinical record and include co-ordination and monitoring functions to ensure that no clients fall through the gaps; rather they receive the appropriate level of care or support.

The benefits to clients are that delays are minimised, especially after hours and there is more certainty of process for clients. As soon as assessment and triage is completed the client, their family/whanau and the referrer can be provided with information on what services they will receive, when, and who will be involved in their care. Of critical importance is oversight of the process from the clinical leadership of the service to ensure that thresholds for assessment, care and treatment are appropriate, and that they meet established standards of practice, along with the expectations of referrers, patients and their families.

The flow chart below outlines the process from receipt of referral (either within or outside our district) for our adult services (other services have similar processes). It is a priority to improve clinical processes for entry into the service, but more importantly ensuring that clinical decision making improves to ensure safe access to services for those that require it.

CHOICE AND PARTNERSHIP APPOINTMENT PATHWAY

General Adult Community Mental Health Service MDHB



6.3 Professional Development

Open Disclosure Training Workshops

Four 3 hour sessions were held in February for clinical staff on the topic of *Mastering Open Disclosure*. These were provided as part of the Cognitive Institute Open Disclosure Series and provide training in essential communication skills for open and honest communication with patients when things go wrong. These sessions are very important for any clinical staff who are leading open disclosure and then others who might be involved not just for SAC 1 and 2 but for any event.

Over 71 of the 75 who attended was staff currently working in the mental health and addictions sector. They learned how to effectively engage with patients when something goes wrong, including as a matter of course:

- an expression of regret;
- a factual explanation of what happened;
- consequences of the event;
- steps being taken to manage the event and prevent a recurrence;
- to genuinely express regret to a patient who has suffered an adverse outcome while Being cognisant of the issues of admitting liability;
- to engage with the psychological and emotional state of patients suffering an Adverse outcome;
- to identify what and why patients want to know about adverse outcomes;
- to effectively deal with patient anger and disappointment, avoiding arguments;
- to connect with and address personal emotional barriers to undertaking these difficult conversations.

Staff feedback from all workshops was very favourable with scores ranging from 95-98% scoring excellent or Very Good on their evaluation sheets.

The Cognitive Institute *Open Disclosure* Series also include a Checklist (A.S.S.I.S.T) which provides 6 prompts for clinical staff to use during client interviews to ensure that their interaction results in clients feeling heard, validated and responded to effectively.

6.4 Strengthening Clinical Governance

While the learnings of the Serious Adverse Events Review Group (SAERG) are shared with the clinical managers and other clinicians who participate in the review process, it is vital that frontline clinicians get a clear understanding of the clinical reasoning and rationale behind the SAERG outcomes, recommendations and directives. It is crucial that they develop a sense of urgency and necessity for the change in clinical practice. To address these concerns the following strategies have been commenced;

- The clinical leadership of the service has commenced road shows with all the clinical teams sharing the six key themes identified by SAERG, and then sharing clinical histories of reviewed cases to illustrate how these themes have been derived from the cases. So far these road shows have been held with the Palmerston North Community MH team, the EIS Team and the Horowhenua CMHT and have generated very good discussion about standards of care;

- From this month we will start Morbidity and Mortality Conferences for the entire service which will be held quarterly. In these meeting we will present and discuss cases reviewed by SAERG;

- A Mental Health Portal is being set up on the intranet. On this Portal there will be two sections. On the first we will upload clinical summaries of all cases reviewed by SAERG along with the SAERG directives coming out of that case so that it becomes an ongoing source of learning for all staff, both current and new. The second part will just contain the SAERG directives so that all new staff can quickly learn what the baseline standards of care expected of them are;

- We are about to start meeting with the clinical leadership of teams around the care of patients whose cases have been reviewed by the SAERG and a clear need for change/ improvement in practice has been identified.

The idea and perceived need for using this multi-pronged approach is that the learnings from case reviews should result in clearly demonstrable and long-term changes in practice and must not end up being purely academic exercises. We have now started asking for audit reports as evidence that the changes recommended in previous SAERG directives have been implemented and have become part of regular practice.

6.5 Suicide Prevention and Suicide Triage & Risk Management Training

A further QPR Suicide training was held on 4 February 2015 with the next one scheduled on 18 March 2015. To ensure maximum staff attendance Clinical Managers are to identify those staff who have not booked or attended a course to date and schedule them into a further training day.
The Project Board intention is that:

- The 1 day QPR advanced Suicide Risk Assessment and Management training becomes compulsory for all staff working in the Mental Health Service;
- That the Service provide 'refresher' training days to those who have already completed the training on a bi-annual basis;
- That the existing risk management documentation be reviewed to ensure alignment with learnings from the QPR training which is consistent with current best practice;
- That an audit mechanism is in place to ensure that our approach to suicide risk assessment is robust.

6.6 Health and Disability Commissioner invitation to use 'Real Time Feedback'

In December 2014 the Health and Disability Commissioner (HDC) wrote to all DHBs inviting expressions of interest to adopt the consumer and family/whanau 'Real Time Feedback' (RTF) programme for mental health and addiction services. This programme uses internet enabled technology to elicit immediate point of contact feedback from consumers and their family/whanau on their experience of using MHA services.

The first workshop held on 17 February 2015 was attended by 19 staff from primary, secondary and NGO services. The presenters were able to describe the software functioning and how mental health consumers would log in to enter feedback on their experience of local MHA services. There was ample opportunity for discussion on the important topics of privacy and security. The intention is for MidCentral DHB to be an early adopter of this electronic consumer satisfaction survey facility. It will be done in partnership with local NGO mental health and addiction providers and a joint working group is liaising with the Marama principals to progress the development locally. There have been some teething problems with the software which is still being sorted by the Marama principals before a start date in 2015 can be determined. The intention is that this system will replace the MOH national consumer satisfaction survey after 2016.

6.7 Clinical Portal

The first meeting of a Working Group re the clinical portal is to be held on 11 March 2015. The Project Scope and Terms of reference have been developed. The preparatory work has mainly to do with educating clinicians in their use of the software and developing information sheets for consumers and their family/whanau on how they can view their clinical record.

6.8 Ward 21 Acute Mental Health Inpatient Unit going smoke-free

March 16 2015 is the day that Ward 21 goes smoke-free. Everything is in place to ensure as smooth a transition as possible for existing patients to a smoke free environment. Staff training is underway including the Chief Pharmacist doing presentations to clinical staff regarding nicotine substitution therapy options.

6.9 Mental Health Adult Supported Accommodation

High occupancy rates in Ward 21 have prompted discussions about the adequacy of alternative support options in the community. Secondary MH and Addictions Services have a dedicated Service Coordination role which liaises closely with NGO supported accommodation providers.

Currently there are 55 high needs mental health clients living in supported accommodation in the Palmerston North area provided by MASH Trust. These are people who are assessed as requiring 24/7 care. The available beds are at full capacity with a waiting list of two.

MidCentral DHB also contracts with MASH Trust to support people with mild to moderate mental illness. These are people who live independently (and pay their own rent) but have a designated support worker who assists with aspects of daily living. Most who live independently are housed in 'special needs' accommodation owned by PN City Council. A small number currently live in Housing NZ properties or rent from private landlords. Obtaining additional units is a challenge in the emerging social housing environment and will require negotiations with private housing providers.

A further 45 high needs clients are living in supported accommodation provided by Dalcam Healthcare (St Dominics) which is located in Feilding. On the Dalcam site there is an eight (8) bed unit for elderly clients with associated mental health difficulties called Yaxley House. This has a waiting list of 18. The wait for a bed can be up to two (2) years.

As previously reported, since May 2014 Secondary Mental Health Services and Central PHO have been able to refer clients to six crisis respite beds, also based at Dalcam in Feilding. These beds provide an alternative to acute admission to Ward 21, where inpatient care is not warranted. The length of stay in the crisis respite beds is five days, in the first instance, subject to review to ensure appropriate use, and ongoing access for new referrals.

In general, any supported accommodation beds are sought after and the process of transition from specialist mental health services depends on when a bed becomes available. Further work will be necessary to develop recommendations for meeting future needs, relative to other options that may be considered as part of the wider model of care development.

7.0 NEXT STEPS

- Confirm approach to engagement and commence consultation with stakeholders on preferred Model of Care;
- Implement new MHET structure
- Finalise the Operational Plan for Older Adult Mental Health Service alignment for CEO approval;
- Finalise appointment of Service Director and Nurse Director positions;
- Implement final decision regarding operational management structure;
- Further develop Home Based treatment options and progress Ward 21 redesign

Nicholas Glubb **Operations Director Specialist Community & Regional Services**	Dr Syed Ahmer **Clinical Director Mental Health**	Michele Coghlan **Director of Nursing**

APPENDIX A

Mental Health Review Work Status Programme
Project Status Report – Phase 1

Reporting Period:	February 2015

Summary Project Status		
Scope	G	Mental Health Review of Clinical Systems and processes; clinical governance; clinical leadership; services resources; the culture of the service; adherence to policies and established standards of practice; patient pathways (including older adult mental health)
Time	G	Two Years

Expected Outcomes	Responsible	Due Date	Completion Date
Establishing the Mental Health Emergency Team (MHET) on a 24/7 basis	Operations Director, Clinical Director, Director of Nursing	March 2015	
Restructuring Leadership to ensure absolute clarity in terms of responsibilities and reporting lines within the mental Health Service	Operations Director, Clinical Director , Director of Nursing	March 2015	
Re-alignment of the Older Adult Mental Health Service with Mental Health services – including a proposed restructure of nursing leadership across Ward 21 and Star 1	Operations Director, Clinical Director , Director of Nursing	April 2015	

Key Updates/Successes
Mental Health Emergency Team (MHET) - Sector wide support to proceed with changes as from 1st March 2015
Ward 21 RCA Action Plans Implementation of recommendations now underway with changes in clinical practice in Ward 21 now being actioned and updates reported 6 weekly.
Suicide Prevention and Suicide Triage and Risk Management Training - Advanced Suicide Triage and Risk Management Training facilitated by QPR NZ have been attended by 81 Nursing and Allied Health Staff. Expected to have 140 staff completing by end of March 2015.
Te Pou, The Mental Health Workforce Development Agency will provide the next '*let's Get Real'* training, as related to values and attitudes on 9 April 2015.
DBT - Recently trained staff commenced therapeutic practice in January 2015, first assessments underway.

Completed Key Tasks-	Responsible	Due Date	Completion Date
Governance			
1.Support Clinical Director – internal milestones established	Chief Medical Officer (CMO)	15.8.14	September 2014

2.Medical Heads appointed – positions developed and job descriptions prepared		Clinical Director (CD)	29.8.14	September 2014
3.Clinical Governance specialties, include clinical leads for all services	Review the clinical governance structure and forums within the Mental Health Service and sub-specialties (Incorporated into proposal being finalised (as per Action 4 below).	C.D/Director of Nursing(DON), Director of Allied Health (DAH)	15.9.14	September 2014
	Incorporate proposed clinical governance structure into mental health service structure review proposal (See 4. below) and consult with staff.			
	Review and confirm the clinical governance framework in conjunction with the service structure review (see 4. below)			
Structure				
4. Review structure and reporting arrangements Meetings with unions held; structure reviewed with agreement that changes are required • Service Management - proposal developed and finalised for consultation with unions and staff 24/7 Mental Health Emergency Team (MHET). Clarify reporting lines/Service Manager/Clinical Educator Practice Development (CEPD)/Integration of Older Adult Mental Health Service with Mental Health Ward 21 leadership. • Clinical leadership - feedback closed • Medical - feedback considered • clerical • Nursing - partial re-issue of proposal considered • Allied Health - consider feedback • Phase 1 decision determined		Manager Human Resources(M.H.R)/ C.D/O.D DON/DAH (others as appropriate)	19.9.14 26.9.14 24.10.14 7.11.14 28.11.14 28.11.14	October 2014 October 2014 October 2014 November 2014 February 2014
5. Daytime and out of hours acute response (including location) Review separation of daytime and out of hours acute responses, including use of new community-based acute respite service; determine proposed model of care and incorporate into Service Structure Review proposal as per(4) above and undertake consultation process 24 hour emergency team confirmed		C.D/DON/OD	19.9.14	September 2014
Culture				
7. Support timely decision making - establish Mental Health Team meeting and determine decision making process.		C.D/DON/O.D	30.9.14 31.10.14	Ongoing ongoing

Completed Key Tasks-		Responsible	Due Date	Completion Date
Clinical Leadership & Partnership				
9. Establish Connections with other services	Complete stock take of opportunities for intra-hospital connections and do gap analysis in respect of Mental Health Service	Director Patient Safety & Clinical Effectiveness (DPSCE)	31.10.14	November 2014
	Encourage and support mental health service participation		28.11.14	Ongoing
	Hospital Advisory Committee: Engage with Whanganui and Waikato DHBs for shared learnings with regard to Mental Health and Addiction Service review			Ongoing
Quality & Safety Process				
10. Review quality and safety • Hospital Advisory Committee: Serious and Sentinel Event Group to review all reported adverse events as an opportunity for service improvement. This procedure has been implemented as mandatory requirement for all serious events		DPSCE	28.8.14	Completed and Ongoing
• Hospital Advisory Committee: Patients and families are routinely informed of adverse events which affect their care. This procedure has been implemented as a mandatory requirement for all serious events				
• Formally request Patient Safety and Clinical effectiveness to consider review team's findings and to develop a plan of action				
• Action plan developed for implementation of recommendations Root Cause Analysis (RCA155) - to provide 6 weekly updates and report on Action Plan to Project Board synchronised with every Hospital Advisory Committee meeting		Nurse Director Mental Health (N.D M.H)	30.0.14	Ongoing
• Action plan developed for implementation of recommendations (RCA156) - to provide 6 weekly updates and report on Action Plan to Project Board synchronised with every Hospital Advisory Committee meeting.		N.D M.H	30.9.14	Ongoing
Ward 21 Facilities & Environment				
12. Upgrade facilities • Commission independent assessment by Waitemata DHB staff		O.D	14.8.14	August 2014
• Review recommendations and identify immediate action items		O.D/DON/CD	5.9.14	October 2014
• Arrange and implement immediate action items		OD	14.9.14	December 2014
• Reiterate with staff process for requesting maintenance work			10.9.14	September 2014
16. Staff Injuries • Meet with unions regarding review findings, action plan and process for staff injury reporting		Human Resource (HR)	12.9.14	October 2014

Completed Key Tasks-	Responsible	Due Date	Completion Date
19. Electronic Records • Stock take completed. Arrangements are underway for the Clinical Portal to be opened for inclusion of Mental Health and Addiction Service clinical notes by end January 2015. This is subject to 'Break the glass' security of access system being applied for first 12 months then reviewed.	CD/Project Team	31.12.14	December 2014
Additional Comments			
20. Independent Clinical review Approach suitably qualified senior clinician • Identify reviewer • Establish TOR • Inform families & seek feedback • Finalise TOR • Provide information to reviewer • Arrange site visit, access to staff, family as required • Report provided • Work programme developed as required • Report copied to families	CMO/OD OD/CD/DON/PL	 22.8.14 5.9.14 5.9.14 12.9.14 17.9.14 19.9.14 19.9.14 31.10,14 14.11.14 14.11.14	Arrangements are completed for the Independent Review to proceed.
21. Incident Reviews • Action plan recommendations from both RCA reviews implemented • Common factors from the RCA review findings Action Plans are implemented • RCA findings and independent review findings have been reviewed to determine policy and other process changes required • Policy and procedure changes have been implemented	DON/CD	 30.11.14 17.10.14 17.10.14 30.11.14	 November 2014 October 2014 October 2014 November 2014
Project Approach & Review			
24. Resourcing • Appointment of Project Lead completed	OD	29.8.14	September 14
25. Review • Arrangements made for review team to revisit in 12 months to evaluate implementation of recommendations	OD	29.8.14	November 14

Current Key Tasks	Responsible	Due Date	Completion Date
Governance			
3.Clinical Governance • Review clinical audit arrangements within mental health services • Review clinical delegations and expectations and re-establish.	C.D/DON/DAH	28.2.15	Commenced
Structure			
4. Review structure and reporting arrangements • Finalise Phase 1 proposal and submit to CEO and CMO • Advise affected staff that a further leadership proposal will be issued for consultation setting out a leadership structure, roles and responsibilities. • Phase 1b decision determined • Appoint to roles • Advise service and staff of appointments as made, reiterating reporting lines, roles, responsibilities	M.H.R/C.D/O.D/ DON/DAH (others as appropriate)	5.12.14 5.12.14 10.12.14 02.03.15 10.12.14 -28.2.15	Commenced
5. Daytime and out of hours acute response (including location) • Ensure documentation and training re: agreed model of care in place • Evaluate arrangements after 6 months	C.D/O.D	30.3.15 30.10.15	Commenced
Culture			
6. Culture Change Programme • Reaffirm mental health vision • Reaffirm mental health values • Embed into Team Development programme (refer 8 below)	C.D/O.D/DON/ HR	19.9.14 15.3.15	Commenced

Current Key Tasks	Responsible	Due Date	Completion Date
7. Support timely decision making • Embed decision making process in Team Development process (refer 8 below) • Ensure barriers to decision-making during project implementation identified and remedied • Currently the project board is addressing any identified barriers to decision making via weekly meetings. • Weekly meetings with Service Leaders identifying any barriers • Weekly walkabouts within the service by (O.D ,CD & DON) • Six weekly meetings with Sponsor and Project Board • Weekly meetings with Project Lead	H.R C.D/DON/OD HR/DAH HR CD DON/DAH	1.3.15 Throughout	Commenced Commenced Commenced Commenced Commenced Commenced
8. Team Development process • Hospital Advisory Committee: Review staff safety in Mental Health Services. Results to inform Mental Health Review work programme • Determine time line with Human Resources for Mental Health Inpatient Service to undertake team development • Commence Team Development Process • Phase1 Develop Plan • Phase 2 Consult on plan • Phase 3 roll out plan • Evaluation completed (six monthly)	M.H.R C.D/DON/DAH/ OD/HR	1.3.15 1.3.15 1.3.15 30.5.15 31.12.15	Commenced Not Started
Clinical Leadership & Partnership			
9. Establish connections with other services • Evaluate mental health participation and effectiveness		30.5.15	Not started
Quality and Safety Process			
10. Review Quality and Safety • RCA process & membership - Clinical Board advised • Consumer/family engagement – plan of action developed • Open disclosure - Plan of Action considered by Clinical Board • RCA communication – Plan endorsed • Mental Health Service ownership and awareness re: RCA- Implementation Plan developed • Consumer & family engagement guidelines – Implementation undertaken	Director Patient Safety Clinical Effectiveness (DPSCE)	2.9.14 30.11.14 2.12.14 2.12.14 3.2.15 30.6.15	Commenced

Current Key Tasks	Responsible	Due Date	Completion Date
Staffing			
11. Professional Development • Mental Health Workforce Training Plan and core competencies reviewed in light of review findings • Suicide Prevention, Suicide Triage & Risk Management Training • Update Mental Health Workforce Training Plan and implement • Clinical leaders develop plan for performance management process, including professional development • Clinical leaders to progressively undertake performance management process with all staff over 12 month period • Team Development (Refer 10 above)	Project Team Project team DON,CD, DAH	 31.12.14 31.12.14 30.6.14 31.3.15 30.3.16	Commenced Commenced Commenced Not Started
11a Dialectic Behaviour Therapy (DBT) • Set up database for quarterly reports on demand, waiting list (if any) and available staff resource.	Project Team	1.4.15	Commenced
Ward 21 Facilities and Environment			
12. Upgrade facilities • Develop timed and prioritised Action Plan to address all other items • Implement Action Plan	Project Team	 31.3.15 31.4.15	 Commenced Not Started
13 Beds • Develop structured plan to manage patient flow within capacity, including discharge planning, length of stay, complex case management for long stay patients, management of non-clinical patients, early identification of barriers to discharge • Plan considered and endorsed by Mental health leadership group • Plan Implemented • Plan Evaluated	DON/ND/ MHA/ CN/CNSs	 31.1.15 28.2.15 31.3.15 30.9.15	 Commenced Commenced Commenced Not Started
14 CCTV • Project Team to meet with Ward 21 leadership to discuss any matters related to CCTV activity • Contact Regional Security manager regarding the process for saving and storage of CCTV footage and how this might be managed in regards to incidents. • Complete a stock take of the Mental Health and Addiction Service's approach to meeting needs of complex and high needs patients and identify other options (including CCTV & Sensory Room use).	OD/CD.DON	 11.12.14 18.12.14 28.2.15	 Commenced Commenced Commenced
15. Use of Sensory Rooms • Undertake site visits to other DHBs and providers • Develop proposal re: approach to complex and high need patient management and submit to service's leadership team • Proposal endorsed • Policies and procedures amended and staff advised • Training provided • Evaluation of new processes		 15.4.15 30.5.15 15.6.15 15.7.15 15.7.15 31.1.16	 Not Started

Current Key Tasks	Responsible	Due Date	Completion Date
17.Debriefing • Develop systemic approach for responding to incidents of this nature, including debriefing, staff support, family advice and support, escalation • Link with work already underway on 'Resilience' which is due to be tabled at Serious Adverse Event Group meeting • Approach considered and endorsed by Service Leadership Group • Implementation	DAH	31.1.15 28.2.15 31.4.15	Commenced Commenced Commenced Not Started
18. Location of Mental Health Emergency Team – Refer (5)			
19. Electronic Record • Post stock take of M.H Clinical records , report findings to mental health leadership • Implement findings • Ensure mental health service represented on WebPAS steering group (as WebPAS is the organisation's long term solution)	CD & Project Team Working Group set up	31.1.15 30.9.14	Commenced Commenced Commenced
Additional Comments			
21. Incident Review • Evaluate changes made to policy and procedures post implementation	DON/CD	30.5.15	Not Started
22. Co-existing conditions • Education re: co-existing condition for services by psychiatrist with alcohol & other drug certification, including site visits and resource development • Project team to talk to Ward leadership to discuss implementation training and development initiatives inclusive of Let's Get Real module for the ward staff. Suggest support be provided by current EPD CEP role and the ward Nurse Educator.	CD Project team	28.2.15 28.2.15	

Current Key Tasks	Responsible	Due Date	Completion Date
23. Vision, Values for MCH This work will be phased to incorporate vision and values components of both the Mental Health Review plus the MDHB Health Charter developments. • SMT consider approach going forward • Vision, Values, Culture programme for MCH development • Implementation • Evaluation • Health strategy/Charter Board workshop • Health Strategy/Charter submitted to Board • Health Strategy/Charter advised to Organisation • Plan for socialisation of Health Strategy/Charter development • Socialisation plan implemented	CEO	30.5.15 30.11.15 TBA TBA TBA TBA TBA	

Planned/Future Key Tasks	Responsible	Due Date	Completion Date
Develop and Resource a Critical Intelligence framework for collection and analysis of all performance metrics to provide evidence of service effectiveness.	Project Team	1 March 2015	1 September 2015

On track/ exceeding target

Outside of target (0-10%)

At risk – exceeding target (>10%)

Key Issues/Progress of current tasks

Item #	Issues/progress	Status	Responsibility
4	**Structure** Review Service structure and reporting arrangements • Finalise proposal and submit to Chief Executive Officer and Chief Medical Officer. - completed • Advise affected staff (if required) service and wider organisation, setting out structure, roles & responsibilities (To be completed once decisions made) *N.B the dates for this work stream are indicative only. The timing is dependent on the extent of change proposed and the impact on the individuals.*		Manager H.R/CD/OD/ DON/DAH
10	**Quality & Safety Process** Review quality and safety considerations • Open disclosure - Work shop held	 ongoing	DPSCE
11	**Staffing** Professional Development • Training and Development calendar has been completed. • Suicide Prevention, Suicide Triage & Risk Management Training – The Agency 'QPR' is mandated by the Ministry of Health to provide suicide training in New Zealand ,who has proposed that from 2015 Suicide and Risk Management training be compulsory. Further Advanced Suicide Triage & Risk Management training are scheduled. • Let's Get Real training – supported by Te Pou (the MH Workforce Development Agency) is included to address development of essential attitudes required to deliver effective MH and Addiction Services.	 ongoing	Project Team
19	Electronic Records • Clinical Portal working Group has been established, Draft TOR completed. • WebPAS Mental Health Representatives have been working with the Business analyst to discuss current processes; they have also attended a training session to view the future system.		Project Team

APPENDIX B

Mental Health Nursing Work Plan for Ward 21, from September 2014

Purpose
The following Work Plan is the MCH Nursing Leadership response to the 2014 External Mental Health Service Review and subsequent Mental Health Review Work programme. The primary objective of the Work Plan is to ensure safe and effective care for Ward 21 patients (inclusive of HNU and Open ward).

The Work Plan outlines 7 key areas for development within Ward 21, primarily but not limited to Mental Health Nursing, and specifically covering:

- Promote a safe patient care environment within Ward 21 (Open ward and HNU)
- Criteria for admission to, transfer within, and discharge from Ward 21 (Open ward and HNU) developed and agreed in partnership with wider MHS leadership.
- Staff to patient ratio and skill mix
- Patient allocation model
- Rostering process
- Reducing the use of seclusion
- Embedding a MHN professional practice culture

Evaluating success
Relevant aspects of the Releasing Time To Care programme (specifically the Knowing How We Are Doing Module) will be used to evaluate that MHN Work Plan improvements remain in place and become 'business as usual'.

Evaluation will focus on improvements achieved by the MHN Work Plan in relation to the MHDB Quality and Outcomes Framework four quadrants. Specifically:

- MHN Services, teams and staff being willing and able to learn
- MHN Services, teams and staff getting it right
- MHN Services, teams and staff being consumer and community focussed
- MHN Services, teams and staff being up to the job

MHN Work Plan Team

- Work plan sponsor, Director of Nursing
- Work plan owner, Nurse Director MHN
- Charge Nurse Ward 21
- MHS CNS Specialist (Lead)
- MHS CNS Specialist
- MHS Nurse Educator

See appendices 1 and 2 for MHN Work Plan team roles and responsibilities

Key Participants:

- Ward 21 MH Nursing team and other relevant staff – including Allied Health
- Consumer and family advisors for MHS
- MH Service Manager
- Mental Health Service Review Work programme Executive Team and Project Leader
- MHS Clinical Director
- Director of Allied and Therapy Services
- MCH Community MHN and wider health care team
- NZNO
- Occupational Health Team
- Human Resources
- Quality and Clinical Risk Team

Key Stakeholders:

- Consumers and families of MHN services
- Acute inpatient mental health staff – including Allied Health
- The wider MH Service and teams – including Allied Health
- NZNO
- PHC services including General Practice Teams and NGO Community Mental Health Service Providers

Key Assumptions underpinning this MHN Work Plan:
A collaborative interface between the MHN Work Plan and the wider Mental Health Service Review and Work programme is in place/will be established.

A regular collaborative interface between the MHN Work Plan and key roles, teams, and services (see those listed under key participants and key stakeholders) is in place/will be established.

Through the wider Mental Health Service Review and Work programme:

1. Best practice will be reinforced and established as ongoing standards for regular evaluation and quality monitoring
2. The MHS model of care, roles and responsibilities, leadership, governance structure, partnerships, delegated lines of authority and reporting lines will be reviewed and confirmed
3. Relevant job descriptions (JDs) are updated and confirmed
4. Knowledge, skills, and performance against updated job descriptions will be reviewed and actions to rectify gaps (e.g. training) put in place
5. Ward 21 bed utilisation will be maximised at 24 and alternatives to admission identified and discharges from the ward are timely.
6. The short term recommendations from the Ward 21 Environment Review will be implemented
7. The Seclusion Reduction Project (including reducing to 4 High Needs Unit (HNU) beds and 2 seclusion rooms) led by nursing, will be completed.
8. Mechanisms will be implemented to evaluate and regularly monitor that improvements remain in place and become 'business as usual'.

Associated Documents and Key Linkages

- Mental Health Service External Review, 2014
- Environmental Review of Ward 21 PN Hospital
- Root Cause Analysis Final Report: Event 155, 2014
- Root Cause Analysis Draft Final Report 156, 2014
- Mental Health Service Review Work programme (MHSRWP), 2104
- MidCentral District Health Board Quality and Outcomes Framework
- 2014 MidCentral Health Certification Corrective Actions Report, DAA Group
- New Zealand Nursing Council Code of Conduct

MHN Work Plan Duration:

- 12 months commencing 15 September 2014

Critical Success Factors:

- Timeframes for implementing the work plan listed below are, to varying degrees, dependant on the above assumptions.

Work Plan Control

Communication
Appendix 3 lists the communication processes that will be followed and facilitated by the MHN Work Plan team to ensure effective, consistent, comprehensive and efficient communication:

- within the MHN Work Plan team
- from and to key participants for the Work Plan
- from and to key interfaces and key stakeholders listed above, and other key information sources

Issues and risk management process
Appendix 4 lists the processes that will be followed and facilitated by the MHN Work Plan team to ensure prompt identification and response to emerging issues and risks that have the potential to impact on successful implementation of the following work plan.

Quality Assurance and Configuration Management Strategy
Appendix 5 lists the processes that will be followed and facilitated by the MHN Work Plan team to:

- Ensure Work Plan implementation is informed by evidence based change management models and methodology
- Ensure and maintain a documentation trail that best practice has informed all aspects of Work Plan implementation.
- Maintain effective and consistent version control of the plan and all documents produced by the Work Plan team.

Appendices

- Appendix 1: Mental Health Nursing Work Plan Project Team Roles and Responsibilities
- Appendix 2: Summary of Work Plan, Key responsibilities, and key milestone times frames
  Appendix 3: Mental Health Nursing Work Plan Communication Strategy
- Appendix 4: Mental Health Nursing Work Plan Issues and Risk Management Strategy
- Appendix 5: Mental Health Nursing Work Plan Quality Assurance and Configuration Management Strategy

Document Information
The following table provides details about this document and file.

Item	Type	Area
Change Control	Version	Final
	Original Author	Nurse Director (ND) Mental Health (MH) and Nursing Projects Lead
	Date updated	30 September 2014
	Updated by	ND MH and Nursing Projects Lead
	Approval	Director of Nursing (DON)
Location	Electronic	Stored on secure nursing portal site MH Nursing Work plan senior team site Access by authorised work plan senior team member

Work plan 1: Promote a safe care environment within Ward 21 Open Ward and HNU – focussing on the following

A. Formal Hand Over Process
B. Compliance with admission process for admissions to Ward 21 (including admission/transfer to HNU)
C. Compliance with assigned levels of observation within Open Ward and HNU
D. Establish secure staff space within HNU
E. Ensure key information available for IDT to support safe, effective care delivery & planning. Support recovery and nursing/patient partnership
F. Environmental hazards identified and escalated promptly for addressing
G. Roster process and template ensures compliance with:
    - NZNO and MECA rules
    - Max. number of shifts available per week for planned leave (annual and education)
    - Current agreed daily levels/formula for Ward 21 RN and HCA resource and skill mix
    - Roles, responsibilities and accountabilities of Ward 21 nurses & nurse leaders re roster
H. Improve Ward 21 Nursing Staff understanding, use and compliance with Trendcare

Work plan Owner: ND, Mental Health

Work plan 1. Focus A: Formal Hand Over Process			**Incorporating recommendations from:** RCA 155 & 155		
Work plan lead: Ward 21 CN **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	Work plan **sub team** established, roles, responsibilities and delegated authority within work plan confirmed	5 Oct	12 Oct	Ward 21 CN
	2.	Review required information: e.g. • Relevant MCH processes, guidelines and standards • Relevant National and International MH standards and guidelines • Relevant processes and protocols from other DHB MH Inpatient services	12 Oct	20 Oct	Sub team
	3.	Confirm all key aspects* that must be included in Ward 21 (Open ward and HNU) Formal Handover process:	20 Oct	31 Oct	Ward 21 CN

		• Current and emerging risks for patients (and staff) • Assigned level of observation • Physical health aspects • Updating of nursing care plan • Documentation of handover *include recommendations from RCA 2014 #155 Consider use of bedside PSAG boards			
	4.	Review against current Ward 21 policy, procedures, tools (SOP) and templates Propose amendments to address gaps (including tools and protocols)	31 Oct	12 Nov	Sub group
	5.	Develop communication plan to Ward 21 and wider MHS staff, managers and key stakeholder including: • Current approach to hand over process • Pros & cons of same, rationale for change – including key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes	5 Nov	12 Nov	
	6.	Propose to the MHN Work plan project team a (i) recommended hand over process (including, roles, responsibilities, location and timing of handover) AND (ii) consultation plan. Gain endorsement from DON	**12 Nov**		
	7.	Consultation with key participants & key stakeholders (including NZNO)	14 Nov	24 Nov	Ward 21 CN
	8.	Review feedback, amend proposed new hand over process and template if required	**24 Nov**	30 Nov	
	9.	Recommend new hand over process (including, roles, responsibilities, location and timing of handover) to MHN Work Plan Project Team and action plan to implement changes– Gain endorsement from DON	30 Nov		Ward 21 CN
IMPLEMENT	10.	Review, update, develop relevant Ward 21 policy and procedures to incorporate endorsed hand over process. Update electronic hand over templates to include all agreed key fields	30 Nov	15 Dec	Sub group
	11.	Review, develop, confirm systems to support individuals to implement required changes, roles and responsibilities	30 Nov	15 Dec	Sub group
	12.	Review, develop, confirm systems to monitor compliance with agreed Formal Handover processes and protocols	16 Dec	8 Jan	Sub group
	13.	Communication to all relevant staff members, key participants and key stakeholders	16 Dec	23 Dec	Ward 21 CN
	14.	Implement new handover process	8 Jan	15 Jan	Ward 21 CN
	15.	Individual education and training to address gaps	8 Jan	8 Feb	Sub group
N	16.	Implement compliance monitoring – report trends	15 Jan	22 Jan	Ward 21 CN

	17.	Review evidence of individual performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	30 Jan	30 Feb	Ward 21 CN
	18.	Establish regular feedback to Ward 21 nursing staff re compliance rates via KHWD board and meetings	30 Mar	30 April	Sub group
	19.	Review effectiveness of Patient Handover Process and tools to determine if other actions required	30 Mar	30 April	Ward 21 CN

Work plan 1. Focus B: Compliance with admission process for admissions to Ward 21 (including admission/transfer to HNU)			**Incorporating recommendations from:** RCA 155 & 155 2014 PNH Certification report item 13		
Work plan lead: CNS Lead MH **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	3 Nov	5 Nov	CNS L MH
	2.	Review required information: e.g. • Relevant National and International MH standards and guidelines • Relevant processes and protocols from other DHB MH Inpatient services • Area specific P & P	3 Nov	8 Nov	Sub group
	3.	Confirm all key aspects* that must be addressed in relation to: • Level of observation for new admissions to Ward 21 Open Ward/HNU who have not yet had their risk assessments completed • Completion of risk assessment upon admission to Ward 21 Open Ward/HNU – including timeframes, documentation and reporting assessment findings • Order of priority for actions to be completed on the Ward 21 Admission checklist – from point of admission through until initial nursing care plan is developed. Key activities prioritised separately for Open ward admissions and HNU admissions • A specific space and location for admissions to be completed in HNU *include recommendations from RCA 2014 #15	8 Nov	15 Nov	CNS L MH
	4.	Review against current Ward 21 policy, procedures, admission/transfer checklists, tools and templates. Propose amendments to address gaps	15 Nov	20 Nov	Sub group
	5.	Develop communication plan to Ward 21 and wider MHS staff, managers and key stakeholder including: • Current admission processes, tools and protocols • Pros & cons of same, rationale for change – including key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes	20 Nov	1 Dec	Sub group
	6.	Propose to the MHN Work plan project team a (i) recommended admission processes etc (including, roles, responsibilities, location, timing etc) AND (ii) consultation plan. Gain	**1 Dec**		CNS L MH

		endorsement from DON			
P	7.	Consultation with key participants & key stakeholders (including NZNO)	2 Dec	18 Dec	CNS LMH
	8.	Review feedback, amend proposed new admissions processes etc if required	20 Dec	8 Jan	Sub group
	9.	Recommend (ii) ongoing admission processes, systems and tools to MHN Work plan project team and (ii) action plan to implement changes. Gain endorsement from MH Executive Project Team	**8 Jan**		CNS LMH
IMPLEMENTATION	10.	Update/develop relevant policies, procedures, documents, forms, tools and templates to incorporate endorsed admission processes	8 Jan	20 Jan	Sub group
	11.	Identify & establish a specific space and location for admissions to be completed in HNU	8 Jan	20 Jan	Sub group
	12.	Develop and deliver a training package that describes: • *Admission pathway from points of anticipating admission through to clinical hand over to Ward 21/HNU staff • Key aspects of the admission procedure into the Ward and HNU from point of handover of the patient from admitting CMH/MHET clinician through until initial nursing care plan completed • *Keys roles and responsibilities relating to: o MDHB 255 Risk Assessment Policy o MDHB 1513 Admission to MH Services Acute Inpatient Unit *To be provided to both Ward 21 and Community based MHS staff	8 Jan	20 Jan	Sub group
	13.	Develop audit tool to measure that all agreed key aspects of admission procedure occur for every admission to Open Ward and HNU – including that HNU admission process completed in agreed location	8 Jan	20 Jan	CNS L MH
	14.	Establish process for above audit to be completed on every patient within 8 hours of admission – including: • system for recording audit findings • system for monitoring and reporting compliance trends	8 Jan	20 Jan	CNS L MH
	15.	Confirm MHN leadership roles and responsibilities in relation to: • Completing admission audit as specified, following up on identified deficits with individual nurses in a timely manner, monitoring and reporting compliance trends • Ensuring patients admitted to HNU remain in clear line of sight and under required level of observations until completion of admission process, and then at level according to identified by completed risk assessments *Update JD accordingly	8 Jan	15 Jan	Ward 21 CN
	16.	Communication to all relevant staff members, key participants and key stakeholders	20 Jan	27 Jan	CNS L MH
	17.	Individual education and training to address gaps	20 Jan	27 Jan	Sub group

EVALUATION	18.	Implement compliance monitoring – report trends	8 Feb	8 Mar	CNS L MH
	19.	Review evidence of individual performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	20 Feb	20 Mar	Ward 21 CN
	20.	Establish regular feedback to Ward 21 nursing staff re compliance rates via KHWD board and meetings	30 Mar	20 April	Sub group

Work plan 1. Focus C: Compliance with assigned levels of observation within Open Ward and HNU			Incorporating recommendations from: RCA 155 & 155		
Work plan lead: CNS Lead MH **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	20 Oct	25 Oct	CNS L MH
	2.	Review required information: e.g. • Relevant National and International MH standards and guidelines • Relevant processes and protocols from other DHB MH Inpatient services • Area specific P & P	22 Oct	30 Oct	Sub group
	3.	Confirm all key safety aspects* that must be addressed in relation to: • Appropriate level of observation within HNU (and HNU patients on Open ward when VRM plans activated) • Observation form on which to record confirmed sighting of patient as per agreed timeframes and protocol *include recommendations from RCA 2014 #15	30 Oct	5 Nov	CNS L MH
	4.	Review against current Ward 21 policy, procedures, and forms Propose amendments to address gaps	6 Nov	8 Nov	Sub group
	5.	Develop communication plan to Ward 21 and wider MHS staff, managers and key stakeholder including: • Current levels of observation processes, tools and protocols • Pros & cons of same, rationale for change – including key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes	8 Nov	15 Nov	Sub group
	6.	Propose to the MHN Work plan project team a (i) recommended levels of observation processes etc (including, roles, responsibilities, location, timing, tools and protocols etc) AND (ii) consultation plan. Gain endorsement from DON	**16 Nov**		CNS L MH
P	7.	Consultation with key participants & key stakeholders (including NZNO)	17 Nov	5 Dec	CNS L MH
	8.	Review feedback, amend proposed levels of observation processes etc if required	5 Dec	10 Dec	Sub group
	9.	Recommend to the MHN Work plan project team	**10 Dec**		CNS L MH

		• agreed levels of observation for HNU patients • required roles, responsibilities, processes, documentation regarding same • action plan to implement recommended changes Gain endorsement from MH Executive Project Team			
IMPLEMENTATION	10.	Update relevant policy, procedure to incorporate the endorsed above factors Develop Patient Observation Form to monitor and record all agreed key aspects of observation	11 Dec	8 Jan	Sub group
	11.	Establish process for auditing that Observation occurs for each HNU patient according to their assigned level of observation and is recorded on their Patient Observation Form – including: • system for recording audit findings system for monitoring and reporting compliance trends	11 Dec	8 Jan	Sub group
	12.	Establish process for auditing that level of observation assigned to HNU patients is appropriate – including: • system for recording audit findings • system for monitoring and reporting audit trends	11 Dec	8 Jan	Sub group
	13.	Confirm MHN leadership roles and responsibilities in relation to: • Completing observation level compliance audit for every HNU patients as specified, following up on identified deficits with individual nurses in a timely manner • Completing fortnightly audit on 5 randomly selected HNU patient files to determine if assigned level of observation was appropriate, following up on identified deficits with individual nurses in a timely manner • Monitoring and reporting compliance trends *Update JD accordingly	8 Jan	15 Jan	Ward 21 CN
	14.	Communication to all relevant staff members, participants and stakeholders	8 Jan	15 Jan	CNS L MH
	15.	Implement amended Observation protocol	10 Jan	17 Jan	CNS L MH
	16.	Individual education and training to address gaps	10 Jan	17 Jan	Sub group
EVALUATION	17.	Implement compliance monitoring – report trends	15 Jan	15 Feb	CNS L MH
	18.	Review evidence of individual performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	20 Jan	20 Feb	Ward 21 CN
	19.	Establish regular feedback to Ward 21 nursing staff re compliance rates via KHWD board and meetings	30 Feb	30 Mar	Sub group
	20.	Review effectiveness of Patient Observation Form and amended policy to determine if (i) policy should continue, (ii) other actions required	30 Mar	30 April	CNS L MH

Work plan 1. Focus D: **Establish secure staff space within HNU - to enable HNU nurses to complete all aspects of role (incl documentation) without need to leave the HNU**	**Incorporating recommendations from:** RCA 155 2014 PNH Certification report item 24
Work plan lead: Ward 21 ACN **Sub group members:**	

Task		Task Descriptor	Task Start	Task Finish	Person Responsible
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	3 Nov	5 Nov	ACN
	2.	Review required information: e.g. • Relevant National and International MH standards and guidelines • Relevant processes and protocols from other DHB MH Inpatient services • Area specific P & P	4 Nov	15 Nov	Sub group

	3.	Confirm all key aspects* that must be addressed in relation to creating a secure physical space within HNU:
		• With ease of access within HNU to:
		  ○ Clinical files
		  ○ Essential hospitality and nursing care items
		• Located in such a manner that it has facility for HNU to:
		  ○ Maintain observations
		  ○ Make clinical entries in a timely manner without need to leave HNU
		*include recommendations from RCA 2014 #15
			15 Nov	25 Nov	ACN

	4.	Propose amendments to address gaps	25 Nov		ACN
	5.	Develop communication plan to Ward 21 and wider MHS staff, managers and key stakeholder including: • Current features of nursing station/practice space within HNU: • Pros & cons of same, rationale for change, key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes	26 Nov	15 Dec	Sub group
	6.	Propose to the MHN Work plan project team a (i) recommended necessary components, layout, processes and changes to the HNU physical space to enable MHN staff to complete all aspects of clinical practice and documentation without need to leave the HNU AND (ii) consultation plan.	**18 Dec**		ACN

		Gain endorsement from DON			
	7.	Consultation with key participants & key stakeholders (including budget holders) and NZNO if required	20 Dec	8 Jan	ACN
	8.	Review feedback, amend proposed changes if required	10 Jan	17 Jan	Sub group
	9.	Recommend to the MHN Work plan project team the (i) necessary components, layout, processes and changes to the HNU physical space features and (ii) action plan to implement recommended changes. Gain endorsement from MH Executive Project Team	**14 Jan**		ACN
IMPLEMENT	10.	Arrange for necessary changes to physical space changes	15 Jan	15 Feb	ACN
	11.	Update relevant policy, procedure relating to roles, responsibilities, storage and management of clinical files, nursing practice within altered HNU environment	15 Jan	15 Feb	Sub group
	12.	Communication to all relevant staff members, participants and stakeholders	15 Jan	22 Jan	ACN
	13.	Commence changed nursing processes in HNU	15 Feb	22 Feb	ACN
	14.	Individual education and training to address gaps	15 Feb	15 Mar	Sub group
E	15.	Review evidence of individual performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	20 Feb	20 Mar	Ward 21 CN
	16.	Facilitate review of effectiveness of secure staff space in HNU and amended processes to determine if other actions required	30 Mar	30 April	ACN

Work plan 1. Focus E: **Ensure key information available for MDT to support safe and effective care delivery and planning. Support recovery and nursing/patient partnership**	**Incorporating recommendations from:** RCA 155 2014 PNH Certification report item 14
Work plan lead: Ward 21 CN **Sub group members:**	

	Task	Task Descriptor	Task Start	Task Finish	Person Responsible
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	3 Nov	5 Nov	Ward 21 CN CNS L MH
	2.	Review required information: e.g. • Relevant MCH processes, guidelines and standards • Relevant National and International MH standards and guidelines • Relevant processes and protocols from other DHB MH Inpatient services • Area specific P & P	3 Nov	10 Nov	Sub group
	3.	Confirm all key aspects* that need to be: • Included on Ward office PSAG board (main patient board) – and best location for Ward PSAG board • Communicated from nursing staff to MDT review *include recommendations from RCA 2014 #155	10 Nov 5 Nov	25 Nov 10 Nov	Ward 21 CN CNS L MH
	4.	Explore use of PSAG board in HNU	25 Nov		Ward 21 CN
	5.	Propose amendments to address gaps: • PSAG • Nursing information to MDT reviews	25 Nov 10 Nov	1 Dec 12 Nov	Ward 21 CN CNS L MH
	6.	Consultation with key participants & key stakeholders (including budget holders): • PSAG • Nursing information to MDT reviews	1 Dec 12 Nov	9 Dec 19 Nov	Ward 21 CN CNS L MH
	7.	Recommend to the MHN Work plan project team the: • Necessary components, layout and changes to main patient board • Necessary components of nursing evaluation form to be completed by nurse with patient prior to MDT review • Action plan to for implementing these changes Gain endorsement from DON and MH Executive project team	**10 Dec** **20 Nov**		Ward 21 CN CNS L MH
	8.	Arrange for necessary changes to main patient board to incorporate the endorsed changes	10 Dec	10 Jan	Ward 21 CN

IMPLEMENTATION					
	9.	Develop nursing evaluation for MDT review form to incorporate the endorses aspects	20 Nov	25 Nov	CNS L MH
	10.	Update relevant policy, procedure, processes, roles, responsibilities related to: • Updating of main PSAG board • Completing nursing evaluation for MDT review form	10 Dec 20 Nov	4 Jan 30 Nov	Sub group
	11.	Communication to all relevant staff members, participants and stakeholders • PSAG • Nursing information to MDT reviews	5 Jan 30 Nov	10 Jan 4 Dec	Ward 21 CN CNS L MH
	12.	Implement use of the updated PSAG board	10 Jan	17 Jan	Ward 21 CN
	13.	Implement use of the nursing evaluation for MDT review form	4 Dec	11 Dec	CNS L MH
	14.	Individual education and training to address gaps • PSAG • Nursing information to MDT reviews	10 Jan 4 Dec	10 Jan	Sub group
E	15.	Review evidence of individual performance with use of (i) PSAG board and (ii) MDT form against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	15 Jan	15 Feb	Ward 21 CN
	16.	Facilitate review of effectiveness of (i) PSAG board and processes (ii) and MDT form and processes to determine if other actions required	30 Mar	30 April	Ward 21 CN CNS L MH

Work plan 1. Focus F: Ward environment/maintenance issues posing risk to patients identified and escalated promptly for addressing				**Incorporating recommendations from:** RCA 155 & 156 2014 PNH Certification report item 24
Work plan lead: Ward 21 CN **Sub group members:**				
Task	**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
1.	Review, update, establish staff process for reporting ward environment/maintenance issues considered to pose risk to patients to CN confirmed and communicated to all relevant staff	3 Nov	10 Nov	CN
2.	Register any identified ward environment/maintenance issues considered to pose risk to patients	3 Nov	10 Nov	Ward 21 staff
3.	Roles and responsibilities with regards to maintaining and updating above register, escalating items for addressing, and reporting progress/barriers to progress in timely manner confirmed.	30 Nov	30 Dec	CN

Work plan 1. Focus G: Establish roster process and template that will ensure compliance with: • **Current NZNO and MECA rules** • **Max. number of shifts available per week for planned leave (annual and education)** • **Current agreed daily levels/formula for Ward 21 RN and HCA resource** • **Current agreed daily skill mix for ward 21** • **Roles, responsibilities and accountabilities of Ward 21 nurses & nurse leaders re roster** **<u>Prerequisites to work plan</u>** • Ward 21 maximum bed numbers (24) agreed and in place • Number of shifts per week available for allocation to planned leave (annual and education) agreed and confirmed	**Incorporating recommendations from:** RCA 155 & 156 2014 PNH Certification report item 11
Work Plan Owner: ND, MH **Work plan lead:** Ward 21 CN **Sub group members:**	

Task		Task Descriptor	Task Start	Task Finish	Person Responsible
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	20 Oct	25 Oct	Ward 21 CN
	2.	Review required information regarding the 5 compliance factors above	22 Oct	30 Oct	Sub group
	3.	Review gaps with current rostering template and rostering processes in relation to ability to achieve compliance with above 5 factors	22 Oct	30 Oct	Ward 21 CN + Sub group
	4.	Propose new roster template and processes to address gaps	30 Oct	5 Oct	Ward 21 CN
	5.	Develop communication plan to staff, their managers and NZNO including: • Back ground info in relation to the compliance factors above • Current rostering approach: o Not based on an agreed max. number of shifts per week that can be allocated to planned leave o social rostering appears to be contributing to: ▪ regular non alignment of roster with MECA rules ▪ level of RN and HCA hours rostered per day regularly not aligning with agreed formula for daily levels of RN and HCA hours and skill mixed o 3 different roles interacting with roster development, independent of each appears	5 Nov	20 Nov	Ward 21 CN & ND MH + HR + Sub group

		to be regularly contributing to non-alignment between allocation of planned leave and ensuring sufficient staff available to roster for care delivery on the ward. ○ current roster template is confusing, and doesn't include required formula to ensure currently agreed daily levels of RN and HCA hours and skill mixed rostered each day • Pros and cons of same and rationale for change – including key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes			
	6.	Propose to the MHN Work plan project team a (i) recommended roster template and (ii) rostering processes AND (ii) consultation plan. Gain endorsement from DON	**20 Nov**		Ward 21 CN
PREPARE	7.	Consultation with key participants & key stakeholders (including NZNO)	22 Nov	15 Dec	Ward 21 CN
	8.	Review feedback, amend proposed new roster template and processes if required	18 Dec	8 Jan	Ward 21 CN & ND MH + HR + Sub group
	9.	Recommend to the MHN Work plan project team (i) new roster template (ii) new rostering processes and (iii) action plan to implement recommended changes. Gain endorsement from DON	**9 Jan**		Ward 21 CN
IMPLEMENTATION	10.	Communicate endorsed decision to relevant Ward 21 nursing staff, key participants and key stakeholders	10 Jan	12 Jan	Ward 21 CN +HR
	11.	Develop agreed policy, processes, roster template, and systems to maintain and monitor new rostering system –including the following to occur in harmony with rostering processes, and to not exceed agreed levels per week • Education planning, requests and booking arrangements • Annual leave planning, requests and booking arrangements Explore establishing a regular annual leave group to assist CN with annual leave approval decisions	10 Jan	19 Jan	Ward 21 CN+Sub group
	12.	Confirm key role and responsibilities in relation to: • Booking staff in for planned education in liaison with CN and rosterer • Roster build and sign off –update JD accordingly	10 Jan	19 Jan	Ward 21 CN
	13.	Communication plan to affected roles, their managers and other key stakeholders re: • Clarification re/changes to particular roles, responsibilities, accountabilities, delegated	10 Jan	19 Jan	Ward 21 CN & ND MH +

		lines of authority			HR
	14.	Review, develop, confirms systems to support individuals implement required role responsibilities and accountabilities – e.g. utilize microster and electronic annual leave calendar (see DNS)	10 Jan	19 Jan	Ward 21 CN+Sub group
	15.	Review, develop, confirms systems to monitor roster compliance with agreed template	10 Jan	30 Jan	Ward 21 CN+Sub group
	16.	Develop and implement new roster and rostering processes	19 Jan	26 Jan	Ward 21 CN
	17.	Individual education and training to address gaps	19 Jan	26 Jan	Sub group
E	18.	Monitor and report compliance of roster and rostering processes with above 5 factors	30 Jan	30 Feb	Ward 21 CN
	19.	Review evidence of performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	10 Feb	10 Mar	Ward 21 CN
	20.	Within the wider MCH CCDM project - review new roster effectiveness to ensure sufficient nursing resource for ward 21 patient care needs	30 Mar	30 April	Ward 21 CN

Work plan 1. Focus H: Improve Ward 21 Nursing Staff understanding, use and compliance with Trendcare – specifically: • All patients within in ward 21 placed on Trendcare AND assigned to appropriate patient type • All ward 21 patient care needs predicted on Trendcare • All ward 21 patient care delivery actualised on Trendcare • Appropriate Trendcare risk assessments utilised for Ward 21 patients • Explore use of Trendcare Shift report and roster function in ward 21	**Incorporating key findings from:** RCA 155 & 156
Work Plan Owner: ND, MH **Work plan lead:** Ward 21 CN **Sub group members:** ACNs	

Task		Task Descriptor	Task Start	Task Finish	Person Responsible
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	15 Nov	30 Nov	Ward 21 CN
	2.	Review gaps with current ward 21 nurses use of Trendcare in relation to (i) placing all patients in trendcare, (ii) completing trendcare risk assessments, (iii) predicting care needs in trendcare (iv) actualising patient care delivery in trendcare	1 Dec	14 Dec	Sub group
	3.	Determine What Trendcare risk assessments should be utilised in Ward 21 Agreed roles, responsibilities, processes and timeframes per shift for: Placing all patients in trendcare Completing trendcare risk assessments Predicting care needs in trendcare Actualising care delivery in trendcare Adjust Ward 21 Policy and procedure etc as necessary	31 Dec	31 Jan	Sub group
	4.	Establish Ward 21 Trendcare super users group • Identify which staff (e.g. ACNs, NE, CNSs, Shift leaders etc) • Train the trainers education session (? utilise Barb Smith)	1 Jan	31 Jan	Ward 21 CN
	5.	Identify Ward 21 nursing champions - preferably across day, evening, weekend, night duty 1. Champions attend Trendcare training with Trendcare co-ordinator 2. Followed up with Trendcare super users spending time with each champion	15Jan	31 Jan	Subgroup
	6.	Ward 21 Super users and champions collaboratively plan and deliver necessary education to remaining Ward 21 nurses Develop visual tools, flow charts etc to promote change in practice	30 Jan	7 Feb	Ward 21 CN
	7.	Establish daily, weekly and monthly use of CN Trendcare reports to monitor Ward 21 nurses	31 Jan	2 Mar	Ward 21 CN

		Trendcare use and compliance			
	8.	Regular updates from CN to Trendcare superusers, champions and all staff re aspects of Ward 21 Trendcare usage that (i) is improving and (ii) need further attention • Support Ward 21 Trendcare champions to be resource and change agent within their teams to promote improved understanding and use of Trendcare	2 Mar	2 April	Ward 21 CN
	9.	Facilitate IRR testing of all Ward 21 nursing staff to identify any learning need gaps/Trendcare use issues that need identifying	15 April	15 May	Ward 21 CN
	10.	Promote understanding and use of VRM capacity indicators and VRM response plan	15 May	30 May	Ward 21 CN
	11.	Explore opportunity to: • add other risk assessments to Trendcare • use Trendcare function for ward 21 Shift report • use Trendcare function for ward 21 roster (including recording allocated annual leave)	30 May	30 June	Ward 21 CN

Work plan 2: Collaborate with the wider MH MDT to develop, agree and implement:

1. Criteria for admission to Ward 21 (Open Ward/HHU)
2. Criteria for patient transfer to and from HNU
3. Criteria for discharge from Ward 21
4. Implement bed utilisation at resourced bed levels (24) including max of 4 beds in HNU so that seclusion reduction project can be implemented

Work Plan Owner: ND, MH

Incorporating recommendations from: 2014 PNH Certification report item 11, 15 & 24

Work Plan Lead: ND, MH
Sub group members:

Task		Task Descriptor	Task Start	Task Finish	Person Responsible
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	3 Nov	10 Nov	ND MH
	2.	Develop TOR	10 Nov	12 Nov	ND MH+Sub group
	3.	Review required information: e.g. • Current level of bed resourcing for Ward 21 • Relevant MCH incident reports, review findings • Relevant literature • Range of community MH services available including admission and discharge criteria for each • Proposal to reduce use of seclusion in HNU	10 Nov	20 Nov	ND MH+Sub group
	4.	Propose: • Criteria for admission to Open Ward and HNU – including prerequisite information required to confirm meets criteria • Criteria for patient transfer into and out of HNU • Criteria for discharge from Ward 21 • Agreed maximum daily bed utilisation in Ward 21	22 Nov	25 Nov	ND MH +Sub group
	5.	Develop communication plan to Ward 21 and wider MHS staff, managers and key stakeholder	22 Nov	25 Nov	ND MH

		including:
		• Current:
		  ○ level of resourced beds and approach to bed utilisation
		  ○ approach to admission, transfer within, and discharge from ward 21
		• Pros & cons of same, rationale for change – including key points from review findings
		• Proposed changes
		• Level of consultation to occur, process for same – including timeframes
					+Sub group

	6.	Propose to the MHN Work plan project team a (i) recommended criteria for the patient admission into, transfer into and out of HNU and discharge from ward 21 and (ii) level of ward 21 daily bed utilisation, AND (ii) consultation plan re this proposal Gain endorsement from DON	**25 Nov**		ND MH
P	7.	Consultation with staff, key participants & stakeholders (including MDT staff, managers and relevant community MH Services)	25 Nov	10 Dec	ND MH+Sub group
	8.	Review feedback, amend proposed entry, transfer and discharge criteria and processes, and level of daily bed utilisation if required	12 Dec	15 Dec	ND MH+Sub group
	9.	Recommend to the MHN Work plan project team: • the ongoing criteria for the patient admission into, transfer into and out of HNU and discharge from ward 21 • level of ward 21 daily bed utilisation to be maintained Gain endorsement from the DON and MH Executive project team	**15 Dec**		ND MH
PREPARATION	10.	Review agreed against current relevant Ward 21 and Community MHS policy and procedure: • Admission, Discharge • Care planning and care management • Documentation and information transfer • Bed utilisation levels	16 Dec	8 Jan	ND MH+Sub group
	11.	Map current Ward 21 and wider IDT practice in relation to: • Decision to admit to Ward 21 • Decision to transfer into/out of HNU • Determining and communicating expected date of discharge • Preparing for patient discharge – including collaborative discharge planning information transfer, liaison and co-ordination with patient, family and relevant community services	16 Dec	8 Jan	ND MH+Sub group

	12.	Identify gaps that require amendment – recommend plan to address to MHN project team. Gain endorsement for proposed action plan from MH Executive Project team	**10 Jan**		ND MH
IMPLEMENTATION	13.	Communicate endorsed decision AND action plan to relevant staff, key participants and stakeholders	12 Jan	19 Jan	ND MH
	14.	Resolve gaps: • Update relevant MHN Policies and procedures • Update relevant MHN roles, responsibilities, delegated lines of authority, accountabilities, reporting lines and JDs • See patient allocation model action plan • Nursing Professional Practice Culture action plan • See mandatory training action plan • Review, update, develop care partnerships, interfaces, liaison and care co-ordination arrangements with relevant community services – including contribution of these services to prevent avoidable admission to ward 21 and promote timely discharge from ward 21	15 Jan	5 Feb	ND MH+Sub group
IMPLEMENTATION	15.	Review, develop, confirm systems to support individuals to ensure patient flow into, through and out of Ward 21 according to above 3 criteria	20 Jan	30 Jan	ND MH + Sub group
	16.	Confirm key roles and responsibilities in relation to admissions, movement within, and discharge from Ward 21 according to the above criteria, service interfaces, amended policies and procedures– update JDs accordingly	22 Jan	25 Jan	ND MH + Sub group
	17.	Communication to all relevant staff members	25 Jan	1 Feb	ND MH + Sub group
	18.	Commence use of new admission, transfer and discharge criteria Commence maintaining agreed daily bed utilisation levels (including 4 beds in HNU to enable seclusion reduction project to be implemented)	25 Jan	15 Feb	ND MH + Sub group
	19.	Individual education and training to address gaps	25 Jan	15 Feb	Sub group
	20.	Review, develop, confirms systems/tools to monitor MHT compliance with agreed admission, transfer and discharge criteria	25 Jan	10 Feb	ND MH + Sub group
	21.	Review, develop, confirms systems/tools to monitor MHT compliance with agreed maximum daily bed utilisation in Ward 21	25 Jan	10 Feb	ND MH + Sub group
E	22.	Implement compliance monitoring – report trends	15 Feb	22 Feb	ND MH + Sub group
	23.	Review evidence of individual performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	25 Feb	2 Mar	ND MH + Sub group
	24.	Establish regular feedback to MHT Governance re compliance rates	1 Mar	7 Mar	ND MH +

					Sub group
	25.	Facilitate review of effectiveness of admission, transfer and discharge criteria and processes to determine if other actions required	30 Mar	30 April	ND MH + Sub group

Work plan 3 - Agree and implement Ward 21 staff to patient ratio and skill mix across Ward & HNU to ensure safe, effective care

Work plan Owner: ND, MH

Prerequisites to work plan

- An agreed criteria for patient placement in Open Ward and in HNU
- Confirmed criteria for patient transfer to and from HNU
- Level of bed utilisation agreed and in place (24 resourced bed) including max of 4 beds in HNU
- Necessary environmental changes to HNU are agreed with plans to progress ease of access within HNU to:
  - Clinical files
  - Essential hospitality and nursing care items

Work Plan Lead: Ward 21 CN **Sub group members:**			**Incorporating recommendations from:** RCA 155 & 156 2014 PNH Certification report item 11, 15 & 24		
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	20 Jan	25 Jan	Ward 21 CN

	2.	Review required information: e.g.
		• MECA requirements
		• Incident Trends
		• Mandatory training requirements
		• Non-mandatory practice development (ed) requirements
		• Relevant literature from Australia, UK and NZ (use Advisory Board) re:
		  ○ Min staff to pt ratio
		  ○ Min skill mix to patient ratio
		• Trend care data
		• Considerations in relation to other roles that contribute to ward-based care: e.g. HCA, Allied health, Medical
			25 Jan	10 Feb	Sub group

	3.	Propose min. nurse to patient ratio & min. skill mix for Ward 21 inclusive of HNU as per agreed level of bed utilisation and admission criteria	10 Feb	17 Feb	Ward 21 CN
	4.	Develop communication plan to staff, their managers and NZNO including: • Current nurse to patient ratio and skill mix approach • Pro's & con's of same, rationale for change, key points from review findings	10 Feb	18 Feb	Ward 21 CN + Subgroup + HR

		• Proposed changes • Level of consultation to occur, process for same – including timeframes			
	5.	Propose to the MHN Work plan project team a recommended (i) ward 21 nurse to patient ratio (ii) min skill mix AND (ii) consultation plan re this proposal Gain endorsement from DON	**18 Feb**		Ward 21 CN
	6.	Consultation with key participants & key stakeholders (including NZNO)	20 Feb	15 Mar	Ward 21 CN
	7.	Review feedback, amend proposed nurse to patient ratio and min skill mix if required	15 Mar	20 Mar	Ward 21 CN + Subgroup + HR
	8.	Recommend to the MHN Work plan project team the (i) min patient to nurse ratio, (ii) min skill mix for Ward 21 as per agreed level of bed utilisation and admission criteria Gain endorsement from DON	**20 Mar**		Ward 21 CN
PREPARE	9.	Review agreed ratio and skill mix against: • current workforce capability and capacity • current roster model and processes • current FTE	20 Mar	30 Mar	Ward 21 CN + Subgroup
	10.	Identify gaps that require amendment – recommend plan to address to MHN Work plan project team. Gain endorsement from MH Executive Project team	**30 Mar**		Ward 21 CN
IMPLEMENT	11.	Communicate endorsed decision re endorsed min pt to nurse ratio and skill mix for Ward 21 AND action plan to relevant key participants and key stakeholders	1 April	7 April	Ward 21 CN+ HR
	12.	Amend gaps: • Update relevant MHN Policies and procedures • Update relevant MHN roles, responsibilities, delegated lines of authority, accountabilities, reporting lines and JDs • See Ward 21 roster action plan • See mandatory training action plan • See patient allocation model action plan • Nursing Professional Practice Culture action plan • If required - Business case to amend FTE/Skill mix	1 April Other times as per action plans	1 May	Ward 21 CN + Subgroup
E	13.	Within the wider MCH CCDM project - review if new nurse to patient and min skill mix sufficient for ward 21 patient care needs	1 May	30 May	Ward 21 CN + Subgroup

Work plan 4: Establish and implement a ward 21 patient allocation model and process that supports continuity of care 24/7 for both Open ward and HNU based patients

Work plan Owner: ND, MH

Prerequisites to work plan

- An agreed criteria for patient placement in Open Ward and in HNU
- Confirmed criteria for patient transfer to and from HNU
- Ward 21 Nursing Leadership roles and responsibilities are confirmed
- Agreed level of bed utilisation in place (24 resourced bed)
- Confirmed staff to patient ratio and skill mix

Work Plan Lead: Ward 21 CN **Sub group members:**			**Incorporating recommendations from:** RCA 156		
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	20 Mar	25 Mar	Ward 21 CN
	2.	Review required information: e.g. • Literature review (use Advisory Board) • Proposal to reduce use of seclusion in HNU	20 Mar	27 Mar	Subgroup
	3.	Map: 1. Current patient pathway into, through and home from Ward 21 unit (including into and out of HNU) 2. Current approach to bed management 3. Current approach for allocating staff to patients 4. Current approach to key patient care & Roles and Responsibilities per shift 5. Current approach to other elements of maintaining continuity (e.g. care plans, nursing handover) 6. Current approach to timely discharge	27 Mar	10 Apr	Subgroup
	4.	Identify pros and cons of above – current gaps that need addressing	10 Apr	17 April	Subgroup
	5.	Agree the key principles and key tasks that the new patient allocation model would need to incorporate:	10 Apr	18 Apr	Subgroup

		• Team and team work principles (including the wider health care team) • Patient management, continuity principles • Key patient care Roles and Responsibilities per shift • Formal ward 21 nursing handover process • Enhanced engagement in patient safety (observations as per RC 155)			
DEVELOPMENT	6.	Develop: 1. a proposed ward 21 patient allocation model and process to support engagement in patient safety 2. a proposed process for patent flow between ward and HNU to enable better Ward 21 bed management, effective care, and appropriate and timely discharge	20 Apr	30 Apr	Subgroup

	7.	Develop communication plan to staff, their managers and NZNO including:
		• Current
		  ○ patient allocation approach
		  ○ approach to bed management
		  ○ approach to ward 21 nursing handover
		• Pro's & con's of same, rationale for change, key points from review findings
		• Proposed changes
		• Level of consultation to occur, process for same – including timeframes
			20 Apr	30 Apr	Subgroup

	8.	Propose to the MHN Work plan project team a (i) recommended model, process and framework re the above 3 elements. AND (ii) consultation plan re this proposal Gain endorsement from DON	**30 Apr**		Ward 21 CN
P	9.	Consultation with key participants & key stakeholders (including NZNO)	1 May	15 May	Ward 21 CN
	10.	Review feedback, amend proposed model and process if required	16 May	20 May	Subgroup
	11.	Recommend to the MHN Work plan project team a (i) model, process and framework re the above 3 elements AND (ii) action plan to implement. Gain endorsement from DON	20 May		Ward 21 CN
N	12.	Communicate endorsed decision and action plan to relevant key participants and key stakeholders	20 May	27 May	Ward 21 CN
	13.	Develop agreed policy, processes and tools to maintain and monitor implementation of above 3 elements – update/document accordingly	22 May	15 June	Subgroup
	14.	Review, develop, confirm systems to support individuals implement required role responsibilities and accountabilities	22 May	15 June	Subgroup
	15.	Confirm key role & responsibilities re the above 3 elements –update JD accordingly	22 May	15 June	Ward 21 CN
	16.	Communication plan to affected roles, their managers and other key stakeholders re: • Clarification re/changes to particular roles, responsibilities, accountabilities and	22 May	15 June	Ward 21 CN

		delegated lines of authority			
	17.	Implement new model and processes	1 July	1 Aug	Subgroup
	18.	Individual education and training to address gaps	1 July	1 Aug	Subgroup
E	19.	Review evidence of performance against updated JD, responsibilities and accountabilities - Address residual learning needs/practice gaps	10 July	24 July	Ward 21 CN
	20.	Facilitate review of effectiveness of allocation model and processes to determine if other actions required	1 Aug	14 Aug	Ward 21 CN

Work plan 5 – Establish rostering process and template to support:

- **Agreed ward 21 patient allocation model for both Open ward and HNU**
- **Agreed min nurse to patient ratio and skill mix**
- **Ward 21 patient allocation staff continuity within a rotating roster model**
- **Agreed ward 21 professional practice culture**

Work plan Owner: ND, MH

Prerequisites to work plan

- Ward 21 maximum bed numbers (24) agreed and in place AND maximum HNU bed (4) confirmed in preparation for the Seclusion Reduction Project
- Work plan 1G, 2, 3 & 4

Work Plan Lead: Ward 21 CN **Sub group members:**			**Incorporating recommendations from:** RCA 156 and linkages with 155		
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	20 May	25 May	Ward 21 CN
	2.	Review required information: • Agreed Ward 21 patient allocation model • Agreed minimum nurse to patient ratio for safe, effective care and necessary nursing education • Agreed minimum skill mix • Agreed max bed utilisation in ward 24 (24 including max 4 in HNU)	25 May	30 May	Sub group
	3.	Review gaps with current rostering template and rostering processes in relation to ability to achieve the agreed: 1. Ward 21 patient allocation model 2. Min nurse to patient ratio 3. Min skill mix 4. Staff continuity for pt allocation team within a rotating roster model 5. Support the professional practice culture (see action plan below)	25 May	30 May	Sub group
	4.	Propose new roster template to address gaps	30 May	15 June	Ward 21 CN
	5.	Develop communication plan to staff, their managers and NZNO including:	30 May	5 June	Sub group

		• Current roster
		• Changes that have been agreed and therefore rational to address the roster:
		  ○ min nurse to pt ratio and min skill mix that have been agreed
		  ○ max daily bed utilisation that have been agreed
		  ○ patient allocation model that has been agreed
		• Proposed changes to the roster template
		• Level of consultation to occur, process for same – including timeframes			

	6.	Propose to the MHN Work plan project team a (i) recommended roster template to incorporate the above factors AND (ii) consultation plan. Gain endorsement from DON	**5 June**		Ward 21 CN
	7.	Consultation with key participants & key stakeholders (including NZNO)	6 June	20 June	Ward 21 CN + HR
	8.	Review feedback, amend proposed new roster template and processes if required	22 June	30 June	Sub group
	9.	Recommend the new roster template and processes to the MHN Work plan project team. Gain endorsement from DON	**30 June**		Ward 21 CN
I	10.	Communicate endorsed decision to relevant key participants and key stakeholders	1 July	7 July	Ward 21 CN + HR
	11.	Communication plan to affected roles, their managers and other key stakeholders re: Clarification re/changes to particular roles, responsibilities, accountabilities, delegated lines of authority	1 July	15 July	Ward 21 CN + HR
	12.	Develop and implement new roster template	1 July	15 July	Ward 21 CN
	13.	Individual education and training to address gaps	15 July	29 July	Sub group
E	14.	Continue to monitor roster compliance with agreed template	15 July	29 July	Ward 21 CN
	15.	Within the wider MCH CCDM project - review new roster effectiveness to ensure sufficient nursing resource for ward 21 patient care needs	15 Aug	15 Sept	Sub group

Work plan 6 – Reduce the use of seclusion within Ward 21

Work plan Owner: ND, MH

Prerequisites to work plan

- An agreed criteria for patient placement in Open Ward and in HNU
- Maximum HNU bed (4) confirmed
- Confirmed criteria for patient transfer to and from HNU
- Ward 21 Nursing Leadership roles and responsibilities are confirmed
- Leadership commitment to Seclusion Reduction
- Necessary environmental changes to HNU are agreed with plans to progress ease of access within HNU to:
  - Clinical files
  - Essential hospitality and nursing care items

Work Plan Lead: CNS L MH and ND **Sub group members:**			**Incorporating recommendations from:** 2014 PNH Certification report item 24 & 26		
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	Update project TOR and plan	20 Jan	25 Jan	CNS L MH and ND
	2.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	20 Jan	25 Jan	CNS L MH and ND
	3.	Review required information: e.g. • Relevant national and international literature (use advisory board) regarding use of seclusion in MH Inpatient units • Relevant National MH Standards • Previous proposal and project plan to reduce use of seclusion in HNU • Certification recommendations	25 Jan	10 Feb	Sub group
	4.	Develop draft criteria and protocol for use of seclusion in HNU AND - informed by agreed criteria for patient transfer to HNU: Develop draft: 1. Per shift review process of all current HNU patient status to determine if still meeting HNU criteria 2. VRM plan for circumstances where > 4 pts require transfer to HNU	10 Feb	25 Feb	Sub group

		E.g. open ward nursing management of individual patients 3. Process for smooth allocation and transfer from HNU to open ward team			
	5.	Develop communication plan to key stakeholders: e.g. • Current approach to o agreed daily HNU bed occupancy o review of HNU pt status against HNU criteria o VRM where pts requiring transfer to HNU > 4 o HNU pt transfer in and out and allocation o Care, management and review of HNU patients (both within unit and if transferred to Open Ward, as part of VRM) o appropriate use of seclusion • Pros and cons of same, rationale for change, key points from review findings • Proposed changes • Level of consultation to occur, process for same – including timeframes	25 Feb	10 Mar	Sub group
	6.	Propose to the MHN Work plan project team a (i) recommended criteria and protocol for use of seclusion in HNU (ii) a recommended VRM plan AND (iii) consultation plan. Gain endorsement from DON	10 Mar		CNS L MH and ND
P	7.	Consultation with key participants & key stakeholders (including NZNO)	12 Mar	28 Mar	CNS L MH and ND
	8.	Review feedback, amend proposed new approach, processes, VRM plan etc if required	28 Mar	10 Apr	Sub group
	9.	Recommend to the MHN work plan project team the proposed: ▪ criteria and protocol for use of seclusion ▪ Per shift review of current HNU patient status to determine if meeting HNU criteria ▪ VRM plan for circumstances where pts requiring transfer to HNU > 4 ▪ Process for smooth allocation & transfer from HNU to open ward team ▪ Action plan to implement recommended changes Gain endorsement from MH Executive project team	10 Apr		CNS L MH and ND
	10.	Communicate endorsed decision AND action plan re above to relevant key participants and key stakeholders	12 Apr	19 April	CNS L MH and ND
NOI	11.	Confirm key roles and responsibilities in relation to: • (i) agreed daily HNU bed occupancy, (ii) review of HNU pt status against HNU criteria, (iii) VRM, (iv) HNU pt transfer in and out and allocation, (v) care, management and review of HNU patients (both within unit and if transferred to Open Ward, as part of VRM) and (vi) appropriate use of seclusion *update JD accordingly	12 Apr	30Apr	

	12.	Develop/update agreed policy, processes, protocols and tools relevant to above 6 aspects	12 Apr	30Apr	Sub group
	13.	Review, develop, confirms systems to support individuals implement required role responsibilities and accountabilities re above 6 factors	12 Apr	30Apr	Sub group
	14.	Review, develop, confirms systems to monitor compliance with above 6 factors	12 Apr	30Apr	Sub group
	15.	Communication to affected roles, their managers & other key stakeholders re: Changes to particular roles, responsibilities, accountabilities, delegated lines of authority	1 May	8 May	CNS L MH and ND
	16.	Implement new approach to above 6 factors	8 May	8 June	Sub group
	17.	Individual education and training to address gaps	8 May	8 June	Sub group
E	18.	Review evidence of performance against updated JD, responsibilities and accountabilities - Address residual learning/practice gaps	15 May	15 June	Ward 21 CN and ND
	19.	Establish regular feedback to Ward 21 staff re compliance rates via KHWD board and meetings	15 June	15 July	Sub group
	20.	Facilitate review of effectiveness of processes etc in relation to above 6 factors to determine if other actions required	1 Aug	30 Aug	CNS L MH and ND

Work plan 7 –Embed a MHN Professional Practice Culture that promotes pride, growth and development – focussing on the following

A. Professional nursing presentation
B. Compliance with Mandatory Training
C. Adherence to MHN policies and procedures
D. MHN Professional Practice Development
E. MHN contribute to MH Service Quality and Clinical Governance

Work Plan Owner: ND, MH

Prerequisites to work plan

- Ward 21 Nursing and Leadership roles and responsibilities are confirmed

Work plan 7. Focus A: Key focus: Professional nursing presentation			**Incorporating recommendations from**		
Work Plan Lead: Ward 21 CN **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOP	1.	**Sub team** established, roles, responsibilities, and delegated authority within work plan confirmed.	5 Oct	10 Oct	ACN
	2.	Review required information: e.g. ▪ Relevant MCH Policy	10 Oct	15 Oct	Sub group
	3.	Determine ▪ Who should be in uniform ▪ What are the current gaps and issues	15 Oct	5 Nov	Sub group
	4.	Provide MHN work plan project team with: a) Recommendation re Ward 21 professional nursing presentation expectations b) Summary of current gaps and issues in relation above c) Suggested plan to address. Gain endorsement from DON	**15 Nov**		ACN
IMPLEMENT	5.	Review, develop/update agreed MHS policy	15 Nov	30 Nov	Sub group
	6.	Communication to all MHN – clarifying the uniform, ID and badges expectations for all MHN	1 Dec	7 Dec	ACN

		staff			
	7.	Address uniform and name badge gaps	5 Dec	30 Dec	ACN
E	8.	Monitor professional presentation compliance - address residual gaps with individuals	8 Jan	20 Jan	ACN

Work plan 7. Focus B: Compliance with Mandatory Training			Incorporating recommendations from: RCA 155 & 155		
Work Plan Lead: NE **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	**Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	3 Nov	5 Nov	NE
	2.	Review required information: e.g. • NZ MHC Standards of Practice • MCH P & P and MHS area specific P & P • MHS Training list	5 Nov	15 Nov	Sub group
	3.	Determine: • Mandatory Training List specific for Ward 21 Nurses to ensure safe and effective care across ward and HNU (what core in service training must be completed) • Mandatory Training List for wider MHN workforce (including leadership roles)	15 Nov	30 Nov	NE
	4.	Map current status of MHN workforce education and training against proposed mandatory training list	15 Nov	20 Nov	NE
	5.	Provide MHN work plan project team with: a) Recommendation re mandatory training for MHN staff b) List of each MHN staff members current level of training and education and any identified gaps they have in relation to proposed mandatory training list c) Recommendation re proposed action plan for addressing individual staff training and education to gaps against proposed mandatory training list Gain endorsement from DON re recommended mandatory training list AND plan to address gaps	**20 Nov**		NE
IMPLEMENT	6.	CN and NE confirm their roles and delegated authority of re communicating and addressing current gaps in mandatory training to individual staff members	22 Nov	24 Nov	Ward 21 CN + NE
	7.	Communicate endorsed decision re the future required MHN staff mandatory training to relevant key participants and key stakeholders	22 Nov	28 Nov	Ward 21 CN
	8.	Implement performance plan to address mandatory training gaps	30 Nov	30 Dec	Ward 21 CN
	9.	Implement education plan to address mandatory training gaps as delegated by CN	30 Nov	30 Dec	NE
	10.	Review, develop/update agreed MHS policy	30 Nov	10 Dec	NE
	11.	Review, develop and confirm systems to support recording and monitoring staffs current level of training and education	30 Nov	20 Dec	Sub group
	12.	Confirm MHN leadership roles and responsibilities in relation to recording and monitoring staffs	20 Dec	8 Jan	Ward 21 CN

		current level of training and education and ensuring gaps are addressed in a timely and effective manner. *Update JD accordingly			
E	13.	Establish regular feedback to CN re compliance with completion of mandatory training to support CN to address residual learning/practice gaps	15 Jan	15 Feb	NE
	14.	Review compliance with completion of mandatory training. Address residual performance gaps	30 Feb	30 Mar	Ward 21 CN
	15.	Establish regular feedback to Ward 21 staff re compliance rates via KHWD board and meetings	30 Feb	30 Mar	NE
	16.	Facilitate review of comprehensiveness of updated mandatory training list for MHN staff to determine if other actions required	30 May	30 June	NE

Work plan 7. Focus C: Adherence to MHN policies and procedures			**Incorporating recommendations from:** RCA 156 Links to 2014 PNH Certification report item 6		
Work Plan Lead: CNS MH **Sub group members:**					
Task		**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT	1.	Review relevant information: e.g. • MCH, MHC, Nursing Council, HPCA policies and standards	3 Nov	20 Nov	CNS MH + Subgroup
	2.	Confirm the key MHN policies and procedures that must be adhered to for: 1. Ward 21 Nursing workforce 2. Wider MHN workforce 3. MHN Leadership	20 Nov	20 Dec	CNS MH + Subgroup
	3.	Identify which key MH policies and procedures require updating	3 Nov	20 Nov	CNS MH
	4.	Provide MHN work plan project team with: a) Recommendation re key MHN policies and procedures that must be adhered to by MHN staff b) Summary of relevant gaps in relation to current MHN practice and processes against the proposed list c) Recommendation re action plan for addressing these identified gaps Gain endorsement from the DON for recommended list and proposed AND action plan to address	**20 Nov**		CNS MH
P	5.	Review extent to which current MHN practice & processes comply with proposed key MHN policies and procedures– identify collective and individual gaps	22 Nov	30 Nov	CNS MH
	6.	Present summary of gaps that require amendment – recommend plan to address to MHN project team. Gain endorsement for proposed action plan from MH Executive Project team	30 Nov		CNS MH
IMPLEMENT	7.	CNS and CN confirm their roles and delegated authority re communicating and addressing individual staff members knowledge, skills, practice gaps	1 Dec	15 Dec	Ward 21 CN +CNS MH
	8.	Update key policies and procedures as necessary	1 Dec	30 Dec	CNS MH
	9.	Communication to all MHN – listing key P & P regarding their practice along with their roles and responsibilities and accountabilities in relation to these.	5 Dec	10 Dec	CNS MH + Ward 21 CN
	10.	Implement education plan, learning contracts to address knowledge, skills and practice gaps as delegated by CN	10 Dec	24 Dec	CNS MH + NE
	11.	Implement performance plan, learning contracts to address knowledge, skills and practice gaps	10 Dec	24 Dec	Ward 21 CN
	12.	Design formal audit processes for MHN staff adherence to key policies and procedures	10 Dec	20 Jan	CNS MH

	13.	Confirm MHN leadership roles and responsibilities in relation to identifying MHN practice gaps and ensuring these are addressed in a timely and effective manner • Links with work plan relating to key assumptions 3 – 6 *Update JD accordingly	8 Jan	8 Feb	Ward 21 CN
EVALUATE	14.	Implement auditing process to monitor compliance with key P & P	20 Jan	20 Feb	CNS MH
	15.	Establish regular feedback to CN re compliance with key P & P to support CN to address residual learning/practice gaps	1 Feb	14 Feb	CNS MH
	16.	Review compliance with key policy and procedure. Address residual performance gaps	15 Feb	15 Mar	Ward 21 CN
	17.	Establish regular feedback to Ward 21 nursing staff re compliance rates via KHWD board and meetings	15 Mar	15 April	CNS MH
	18.	Facilitate review of comprehensiveness of list of Key P & P for MHN staff to determine if other actions required	1 June	30 June	CNS MH

Work plan 7. Focus D: MHN Professional Practice Development – specifically, appropriate uptake of clinical supervision & all MHN staff participate in annual PDM		**Incorporating recommendations from:**		
Work Plan Lead: ND, MH **Sub group members:**				
Task	**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
DEVELOPMENT 1.	**Re Clinical Supervision: Sub team** established, roles, responsibilities, delegated authority within work plan confirmed.	20 Jan	28 Jan	ND, MH
2.	**Re Clinical Supervision:** Review required information: E.g. • Relevant National and International MH literature standards and guidelines relating to clinical supervision • Relevant processes and protocols from other DHB MH services • Relevant MCH processes, guidelines and standards • Area specific P & P	28 Jan	20 Feb	Sub group
3.	**Re Clinical Supervision:** • Identify current practice within MHN in relation to: o Roles that have access to clinical supervision o Current level of engagement with/uptake of clinical supervision • Develop a recommended future position of clinical supervision for the MHN team (e.g. clinical supervision expectations in relation to specific MHN roles)	28 Jan	20 Feb	Sub group
4.	Develop communication plan to key stakeholders: e.g. • Current approach to o Roles that have access to clinical supervision o Current level of engagement with/uptake of clinical supervision • Pros and cons of same, rationale for change • Proposed changes • Level of consultation to occur, process for same – including timeframes	20 Feb	30 Feb	Sub group
5.	Propose to the MHN Work plan project team a (i) recommended future position of clinical supervision for the MHN team (e.g. clinical supervision expectations in relation to specific MHN roles) AND (ii) consultation plan. Gain endorsement from DON	**30 Feb**		ND, MH
P 6.	Consultation with key participants and key stakeholders (including NZNO as required)	1 Mar	20 Mar	ND, MH
7.	Review feedback, amend proposed new approach, processes etc if required	20 Mar	30 Mar	Subgroup
8.	Recommendation to MHN Work plan project team re (i) future position of clinical supervision for	**30 Mar**		ND, MH

		the MHN team and (ii) action plan to implement changes. Confirm MHN clinical supervision expectations with DON			
IMPLEMETN	9.	Confirm MHN leadership roles and responsibilities in relation to engagement with clinical supervision and PDM – and ensuring gaps addressed in a timely and effective manner • Links with work plan relating to key assumptions 3 – 6 *Update JD accordingly	30 Mar	14 April	ND, MH
	10.	Update relevant MHS policy and procedures and JDs etc in relation to clinical supervision	14 Apr	20 Apr	Sub group
	11.	Communicate endorsed decision re above to relevant key participants and key stakeholders Communication to affected roles, their managers & other key stakeholders	20 Apr	27 April	ND, MH
	12.	Where identified - re-establish regular MHN engagement with clinical supervision	1 May	14 May	ND, MH
	13.	Establish process for MHN leadership to monitor clinical supervision uptake	20 Apr	30 Apr	Sub group
	14.	Establish process for MHN leadership to monitor and report progress against PDM completion rates	20 Apr	30 Apr	Sub group
EVALUATE	15.	Implement monitoring of uptake of Clinical Supervision	1 May	14 May	Ward 21 CN
	16.	Implement monitoring of completion rates of Annual PDM	1 May	14 May	ND, MH
	17.	Review evidence of MHN and MHN leadership performance against *updated JD, responsibilities and accountabilities	10 May	20 May	ND, MH
	18.	Address both MHN and MHN leadership residual learning needs/practice gaps e.g. Equip with Leadership training	20 May	24 May	ND, MH
	19.	Facilitate review of role and uptake of clinical supervision within MHN to determine if other actions required	30 June	15 July	ND, MH

Work plan 7. Focus E: MHN contribute to MH Service Quality and Clinical Governance		**Incorporating recommendations from:**		
Work Plan Lead: ND, MH **Sub group members:**				
Task	**Task Descriptor**	**Task Start**	**Task Finish**	**Person Responsible**
1.	Review current nursing meetings: • TOR • Alignment with wider MH Services quality and governance forums and communication pathways • Attendance and roles	30 Mar	30 April	ND, MH
2.	Identify gaps that require amendment – propose action plan to address Gain endorsement for proposed action plan from DON	1 May		ND, MH
3.	**Establish/Ensure mechanism in place for:**	1 June	30 June	ND, MH
3.1	• Regular contribution by nursing to wider MH Services quality and governance forums and processes o that aligns with delegated level of authority re nursing practice and service delivery decisions o that enables nursing to participate in service development decisions o that strengthens and develops nursing leadership within the wider MH service	1 June	30 June	ND, MH
3.2	• Appropriate risk man reporting and follow up by MDT on critical incidents	1 June	30 June	ND, MH

Appendix One: Mental Health Nursing Work Plan Project Team Roles and Responsibilities

Role	Responsibility
Work plan Sponsor	• Work plan champion, with ultimate authority regarding authorisation of activities, planning, implementation, close and acceptance criteria; • Appoint the work plan manager; • Approve the work plan and membership of the work plan team; • Sign off key deliverables (milestones & objectives); • Review and approve changes to work plan resourcing, timelines, scope, objectives, costs and quality; • Sustain momentum throughout the planning and implementation of the work; • Ensures strategic alignment.
Work plan Owner	• Oversee work plan and work plan team; • Enables the work of the work plan team; authorise activity; • Report progress to work plan sponsor • Make recommendations to work plan sponsor; • Champion the work plan; ensure whole of organisation approach; influence decision making; • Monitor and manage work plan progress and risks (positive and negative). • Ensure the work plan deliverables meet time, cost and quality parameters. • Ensure all work plan documentation - including meeting minutes – are distributed to members and are kept current and securely filed; • Manage closure of the work plan.
Work plan Lead	• Implement the work plan • Report progress to work plan owner • Make recommendations to work plan owner; • Monitor and manage work plan progress and risks (positive and negative) – escalate to work plan owner where necessary. • Ensure the work plan deliverables meet time, cost and quality parameters. • Maintain the work plan document as a living document.

Role	Responsibility
Work Plan Team **Including sub teams**	• Complete tasks as agreed within delegations established by Work plan owner; • Contribute positively to the functions of the work plan; • Actively participate in meetings and where relevant, putting forward the views of the group(s)/network(s) that the member represents; • Ensure transparent communication including disseminating to their group(s)/network(s) all minutes, action points and regular communications. • Champion the work plan. • Review and monitor the progress of the work plan; • Sustain momentum throughout the planning and implementation of the work;
Work plan support	• Not part of the work plan team. Assist with project support, work plan development and management methodology • Assist Work plan sponsor and owner to prepare work plan and work plan documents

Appendix 2: Summary of Work Plan, Key responsibilities, and key milestone times frames

Work plan Item	Key responsibility	Work Plan Focus	Development Start date	Date for stage recommendation to Project Team	Change Start date	Evaluation Start Date
WP 1:A	CN	Hand over processes and compliance	5 Oct	12 Nov	8 Jan	15 Jan
WP 1:B	CNS L MH	Admission processes and compliance	3 Nov	1 Dec	20 Jan	8 Feb
WP 1:C	CNS L M H	Levels of observation processes & compliance	20 Oct	16 Nov	10 Jan	15 Jan
WP 1: D	ACN	Enable MHN to complete all aspects of role without need to leave the HNU	3 Nov	18 Dec	15 Jan	20 Feb
WP 1:E	1: CN 2: CNS L MH	Key information available on: 1. PSAG board 2. Nursing form for MDT	3 Nov 3 Nov	10 Dec 20 Nov	10 Jan 4 Dec	15 Jan
WP 1:F	ACN	Ward environment hazard issues identified and addressed	3 Nov	ongoing	ongoing	19 Jan
WP 1: G	CN	Roster process & template compliant with: • MECA rules • Max. no. of planned leave shifts per wk • current formula for Ward 21 RN and HCA resource & skill mix	20 Oct	20 Nov	19 Jan	30 Jan
WP1 H	CN	Improve Ward 21 Trendcare compliance	1 Dec			
WP 2	ND, MH	Criteria for: admission to, transfer within, discharge from ward 21	3 Nov	25 Nov	25 Jan	15 Feb
WP 3	CN	Ward 21 staff to pt ratio and skill mix ****requires WP 2 to be completed***	*20 Jan	16 Feb	By work plan 4 & 5	
WP 4	CN	Ward 21 pt allocation model ****requires WP 2 &3 to be completed***	20 Mar	30 Apr	By work plan 4 & 5	
WP 5	CN	Roster template & process to support: • New pt allocation model • Agreed pt to nurse ratio and nursing skill mix • Agreed Ward 21 professional practice activities ****requires WP 2, 3 & 4 to be completed***	20 May	5 June	1 July	15 July

WP 6	ND & CNS L MH	Reduce use of seclusion within Ward 21	20 Jan	10 Mar	8 May *_**requires WP 2**_	15 June
WP 7: A	ACN	Professional nursing presentation	5 Oct	15 Nov	1 Dec	8 Jan
WP 7: B	NE	Compliance with Mandatory Training	3 Nov	20 Nov	30 Nov	15 Jan
WP 7: C	CNS MH	Adherence to MHN policies & procedures	3 Nov	20 Nov	5 Dec	20 Jan
WP 7: D	ND,MH	Appropriate uptake of clinical supervision, Achieve PDM targets	20 Jan	30 Feb	20 Apr	1 May
WP 7: E	ND, MH	Ensure MHN contribute to MHS Quality and Clinical Governance	3 Nov	ongoing	ongoing	19 Jan

Appendix 3: Mental Health Nursing Work Plan Communication Strategy

Communication within Work plan team

1. Secure share point communication site (Mental Health Nursing Workplan Senior Team site) established on nursing portal containing:
   i. MHN Work plan
   ii. MHN Work plan Issues register
   iii. MHN Work Plan Risk register and mitigation/management plan
   iv. MHN Work plan outwards communication log
   v. MHN Work plan key references/key information source log
2. All information contained on site confidential to authorised members, only for wider dissemination as authorised by DON.
3. For version control purposes, communication and dissemination of MHN Work plan documentation between Work plan team members to occur via uploading documents on secure site on nursing portal **rather than by email**. All authorised members of this site will be informed of new information for review by automatic email alert from site when new information added.
4. Mental Health Nursing Work plan team members to bring emerging issues promptly to the attention of the Work plan sponsor, owner and/or to other members of the work plan team (with authorised access to the secure site) using the Issues register on the secure site
   Issues may be **threats** or **opportunities**
   - **And** do not need to be directly related to, or likely to impact on project implementation to be registered below
   - MHN Work plan environment/maintenance issues and actions taken – CN record
5. Twice weekly meetings (Monday and Friday 9am) with work plan Sponsor, Owner and work plan team to review:
   a. Progress against work plan actions b. Registered Issues c. For early warning indicators of identified risks
6. Work plan team members to update status report for delegated action items on shared work plan stored on above secure site prior to each meeting
7. Work plan owner provides Work plan sponsor with monthly written progress summary

Communication from and to key participants

1. All requests for work plan information/liaison with work plan team members to be directed through Work plan owner.
2. Specific communication action points requiring communication to and from key participants noted in work plans below - to include a range of communication strategies in order to ensure broad feedback, engagement and consultation with key participants.
3. To avoid conflicting expectations –communication to key participants to clarify if purpose is:
   a) FYI OR b) Consultation/feedback sought
4. Written communication to key participants in relation to work plan activities to be informed by work plan team (and HR where necessary), endorsed by work plan owner, recorded in outwards communication log and electronic copy stored on secure site.
5. At least bi monthly written updates to MHS key participants.

Communication from and to key interfaces, key stakeholders, key information sources

1. All requests for work plan information/liaison with work plan team members to be directed through Work plan owner
2. Work Plan Sponsor monthly progress updates to Mental Health Service Review Work programme Executive Team and Project Leader
3. Work plan owner monthly progress updates to key interfaces
4. Bi monthly written newsletter/updates/communications to MHS key participants and relevant key stakeholders, content and forum selected according to relevant key stakeholders.
5. Written communication to key stakeholder to be informed by work plan team, developed with assistance from MCH Communications department, endorsed by work plan sponsor, recorded in outwards communication log and electronic copy stored on secure site.
6. Record of all outwards communication (external to work plan team) in communication log.

Appendix 4: Mental Health Nursing Work Plan Issues and Risk Management Strategy

Issues register:

1. On secure site for MH Nursing Work plan team members to bring emerging issues to the attention of the Work plan sponsor, owner and/or to other members of the work plan team (with authorised access to the secure site)

   Issues may be:

   - Threats
   - Opportunities
   - And do not need to be directly related to, or likely to impact on Project Implementation to be registered below
   - MHN Work plan environment/maintenance issues and actions taken – CN record

2. Emerging issues register reviewed by Work plan owner at least weekly –issues requiring significant action plan may be added to the MHN work plan at the discretion of the Work plan sponsor.

Risk register:

Identified issues posing potential/actual risk to successful implementation of the MHN Work plan to be added to the MHN Work plan risk register located on the secure site/riskman register, including early warning indicators and agreed action plan and owner for management/mitigation.

Appendix 5: Mental Health Nursing Work Plan Quality Assurance and Configuration Management Strategy

Work plan quality assurance process

1. The Work Plan will incorporate principles of:
    - The NHS Change Model and Mental Health Productive Wards Series (see figure below)
    - MDHB and Central PHO clinical governance and quality improvement framework
    - The Safe Staffing and Healthy Workplaces Care Capacity Demand Management methodology
    - The Plan, Do, Study, Act cycle
2. Specific work plan action points requiring review and utilisation of information from local, national, and international references and information sources are noted in specific Work Plan Task Descriptors
3. To maintain quality assurance trail – all reference and information sources utilised to contribute to work plan activities and quality assurance to be recorded in MHN work plan reference log

Configuration Management process

1. Changes to MHN Work plan at discretion and authorisation of Work plan Sponsor
2. Maintain consistent, effective version control – label MNH work plan documents in footer Page no, Mental Health Nursing Work Plan, document name, version, author, date created e.g. *Mental Health Nursing Work plan, Issues Register, Version 1, Jane Smith, 21 10 2014*
3. All documents and communications (including all versions) to be stored on secure portal site

Figure 1: NHS Change Model