APPENDIX B

EXTERNAL REVIEW MENTAL HEALTH SERVICES
MIDCENTRAL DISTRICT HEALTH BOARD

Introduction

The MidCentral District Health Board (MCDHB) commissioned an external review of the mental health service at the DHB following two serious adverse events three weeks apart in April/May 2014. The two events were similar in nature, namely apparent suicide by hanging within the inpatient unit of the mental health service, and the patients involved had known each other. There was concern that these events might be linked and might reflect underlying problems with the service. There had been pre-existing concerns about the staffing and leadership of the service, particularly the medical staffing and leadership, and about the structure, working relationships and standards of care in the service. Each of the two recent events was itself to be subject to an internal review using Root Cause Analysis (RCA) methodology, as is usual in response to such events, and the purpose of the external review was to look at the broader context of the service, in particular the culture and models of care and related issues. The Terms of Reference for the External Review are attached in *Appendix 1*.

The external review team, recruited in June 2014, comprised:
Heather Casey, Mental Health, Addictions and Intellectual Disability Nursing Director, Southern DHB
Gloria Johnson, Chief Medical Officer, Counties Manukau DHB
Gary Sutcliffe, Peer Support Specialist, East Tamaki Healthcare
Helen Wood, General Manager, Mental Health and Addiction Service, Waitemata DHB

The external reviewers were provided initially by MCDHB with various documents, including outlines of the organisational structure, some previous reviews undertaken regarding adverse events and clinical service issues, data on previous suicides, correspondence between DHB staff and the families of the two patients who had died and brief outlines of the two events and the terms of reference for the internal RCA processes. In addition on request the external reviewers were provided with many more documents, including copies of the clinical records pertaining to the hospital admissions of the two patients who died, additional reports on adverse events in the service, reports considered routinely by the various MCDHB governance groups and additional information on the various teams within the service. Staff whom the reviewers met with were also invited to

provide written submissions and some were subsequently received from individuals and teams. The two families also corresponded directly with the review team regarding their concerns. The incomplete draft initial reports on the two internal RCAs were provided to the reviewers just prior to their second visit to the DHB in July. The full draft report for the RCA on the first event became available just as the external reviewers were completing their draft report and the final report on that RCA was released to the external reviewers on 18 August; the full report on the other RCA was still pending. A summary of the documents received is provided in *Appendix 2*.

The external reviewers spent three days – 25 June, 8 July and 9 July 2014 – in Palmerston North, visiting the facilities at the DHB's main campus there and meeting with a large number of staff, mainly as teams. The reviewers also met with the parents of one of the patients who had died (the other family was unable to meet).

The groups of people met with are listed in *Appendix 3*.

It should be noted that the two families involved expressed concern to the reviewers and to the DHB staff with whom they were in contact about the scope of the external and internal reviews and about how open the DHB would be about any findings from the external review in particular. They had wanted reviews of the entire clinical care of their family members and had been given to understand that the external review would encompass this. However, this was not in the scope of the external review commissioned. The external reviewers clarified this with the MCDHB Operations Director for Specialist Community and Regional Services who had recruited them – it appeared that the DHB had initially considered requesting full clinical reviews of each case and were still open to undertaking that if it were recommended, but the higher level review of the service, which the reviewers had been asked to do, was seen as the more urgent priority. The reviewers also confirmed with the Operations Director that their draft and final reports would be provided by the reviewers to the two families without editing. The reviewers also expected that the final version of their report would be provided on request to other interested parties, such as the Coroner investigating each death and the national Director of Mental Health Services, and the Operations Director agreed that this was his expectation as well.

The reviewers are extremely grateful to the MCDHB staff who were unfailingly helpful throughout the review process. Large numbers of people assembled to meet with the reviewers at short notice and very generously provided information and shared their perspectives on the service. The reviewers were very mindful that each group received only a short amount of time in a very busy schedule to permit contact with as many people as possible and this must have been frustrating for

those who had more to tell than the time allowed. The reviewers hope that their snapshot of the service will provide a helpful stimulus for what must be an ongoing process of quality improvement by a group of people who are clearly dedicated to the people they care for and who want to be able to feel pride in the service they provide.

The reviewers also wish to express their profound thanks and sympathy to the two families, who at a very difficult time have put a great deal of effort into helping the reviewers and the DHB staff to understand their own perspectives and to provide their own suggestions as to how we might all learn from the recent tragic events.

The executive summary outlines briefly the key issues identified by the external reviewers and summarises the associated recommendations. Additional detail regarding the reviewers' findings and the basis for the recommendations is contained under the various headings in the main body of the report.

Executive Summary

The Mental Health and Addiction Service at MCDHB comprises skilled, hard-working and well-intentioned people, who want to provide a high quality service and who expressed concern to the reviewers about those aspects of their service which they thought needed to change.

The external review team identified a number of opportunities for improvement, including:

- A lack of clarity in governance processes and responsibilities
- A confusing service structure with apparent role duplications and mixed reporting lines
- A passive, complacent culture, which impedes learning, innovation, quality improvement and active consumer engagement
- A lack of clinician-manager partnerships and a paucity of clinical leadership roles and skills, especially with regard to medical leadership
- A lack of transparency and consumer engagement in quality and safety processes
- Persistent vacancies, especially amongst medical staff, and a lack of professional and leadership development
- Specific design, utilisation and milieu problems in the inpatient unit (Ward 21), compromising clinical care and working conditions
- A lack of electronic clinical records, compromising efficiency and safety
- Clinical issues and possible linkages between incidents, which warrant some additional review processes for the two recent deaths

The recommendations of the external review team have focussed on:

- Clear articulation of the vision and values of the service
- Clear lines and delegations of authority and accountability
- Clear partnerships to provide leadership
- Reconsideration of some aspects of the current structure
- Comprehensive enhancement of the service culture, to empower staff and consumers, promote change and strengthen standards of care
- Distributed ownership of and adherence to clinical policies which underpin high quality care
- Clinical leadership development
- Development of linkages with personnel at other DHBs, to promote exchange and infusion of new ideas, resources and practical support
- Enhanced transparency and consumer engagement in quality and safety processes, including incident reviews

- Support for professional development of staff and comprehensive team training
- Improvements to the Ward 21 facility and changes to how the facility is used, to reduce over-crowding, enhance the therapeutic milieu and improve safety for staff and patients
- Planning for introduction of electronic clinical records
- Consideration by the RCA teams of possible linkages between the two incidents
- Consideration by the MCDHB executive team of potentially useful longitudinal clinical reviews of each of those two cases

Governance

Observations

Clinical governance, when effectively led and implemented, has a key role in ensuring availability, quality and standardisation of evidence based practice, with the potential to reduce variation of outcome and service user/family experience of care.

Definitions

Clinical Governance is the system through which and health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish…

Clinical governance is the system. Leadership, by clinicians and others, is a component of that system.

Ministry of Health (2009). In Good Hands: Transforming Clinical Governance in New Zealand.

The review team were left with an unclear understanding of what the day to day presence and effectiveness of the clinical governance of the MidCentral DHB mental health and addiction services was actually like. Our overall impression was of some deficiencies in clinical governance, or at least variability of shared understanding and its presence and effectiveness in services.

Over the three day period, we had the opportunity to ask questions of staff and leaders, seek out Terms of Reference and minutes, view structures and review documents.

We met professional leaders, consumer and family reps, managers, clinicians, and continuing education professional development staff. Many of these roles and people would form the foundations of clinical governance structure and partnerships. There did not appear to be a shortage of people or people with on-going interest in wanting to provide good mental health and addiction services.

After our visit we also obtained a set of the monthly reports provided to or by the various groups engaged in governance of the service, including the Operations Director for Community and Regional Services (and thus the MCDHB executive team), the Quality Group for mental health, the Mental Health Executive Group and the governance groups of the various clinical teams. The report of the Operations Director to the MCDHB executive team includes a comprehensive Mental Health

Scorecard. These reports indicated the occurrence of regular meetings at various levels monitoring quality issues and productivity.

However, the review team did not come away with a clear understanding of how the reported information, eg, quality metrics, KPI information, trend reporting on adverse events, progress against performance targets, was actually being used to ensure quality improvement.

Various views were offered on the role of medical leadership and this is covered in a following section. The Nursing voice and authority in decision making was not explicit or transparent with respect to day to day activities, organisational structure, meeting membership etc. The Operational Leadership structures referred to a nursing advisory role, as opposed to the nursing director role, sitting as part of decision making. Consumer and family input was not evident in the organisational structure documents. We were impressed with the nursing and allied health leadership although it was unclear how either of these roles were actively utilised at a mental health service governance level.

Limitations we noted were unclear roles and fit between roles and across services; the quality of partnerships was variable; and the interface between services was ad hoc and often described as "working in silos".

It was a positive development that, following a previous re-structure, one Service Manager now provided oversight for the majority (but not all) of the mental health and addictions service as a whole. However, somewhat confusingly, this role sat alongside two other manager roles (see further detail and comments under Structure below). Furthermore, that role, as with other managers in the service, did not seem to have a clear clinical partner. The Clinical Director was the Service Manager's partner in theory, but also related to the Operations Director.

There appeared to be no clear sense of a common platform for the vision and values of the service as a whole, service objectives, shared learning and action. An overriding comment from many was "We cannot do anything due to money".

It appeared to the reviewers that key leaders of clinical services did not act or have the clear authority to make decisions without referring upwards - thus there was a strong sense of inaction and a bottleneck for decision making at senior leadership levels, with power retained to an unusual extent within the DHB's executive team.

The reviewers were provided with a number of service development plans; however it was difficult to identify who had the responsibility and authority to progress or see evidence of progression of these plans from previous years and going forward. There was evidence of people having ideas, knowledge and plans for improvement, but not a sense of urgency of action or tools for implementation.

The Service Development structure was parallel and not well integrated at team or service leadership level. It was not apparent why this parallel structure had been put in place or what value it added. A repeated theme from staff was a lack of clarity of purpose and value for the Clinical Education and Professional Development (CEPD) roles, which are the key positions in this service development and improvement structure, and their connection with clinical team life. There were also clinical nurse specialists within this team but again their roles were not clear or well connected to clinical activities. The respective roles and relationships of the clinical managers and CEPD personnel were confusing to staff and the reviewers – the CEPD responsibilities were particularly unclear and diffuse and while they were based in clinical teams, they reported to different managers. Some staff and leaders articulated these roles as having responsibility for clinical activity at team level; others were not clear on the roles or the value they added. These concerns were related to the roles not the people in these roles.

It was also unclear who had clinical accountability and who provided leadership at clinical team level for quality and oversight of clinical services provided by the team. The clinical managers were managers, not practising clinicians, and did not appear to have specific clinical partners at their level. Although the Clinical Manager Community Mental Health Teams And Mental Health Emergency Team Job Description requires the incumbents to "work in partnership with the Service Managers, Nurse Director, Clinical Director, Professional Advisors, Clinical Educator/Practice Developments, Nurse Educator and Clinical Nurse Specialist Lead", these roles are at varying, generally higher, levels of the organisation, apart from some of the nursing roles, and there is not a specific clinical partner for the Clinical Manager in the clinical team. In particular, there is not a medical partner for the Clinical Manager of each team - the Clinical Director sits at a higher level, as the medical leader for the whole service, and does not lead the clinical team where the Clinical Manager sits. The fact that the Clinical Managers have qualifications as health professionals, generally in nursing, does not obviate the need for them to have practising clinical leaders in the service as partners if there is to be a true and effective clinician-manager partnership. The arrangements may need to vary from team to team as team size is a consideration and it is reasonable for management roles to span multiple teams but it is still important that each team has both clinical leadership and management, with clear accountability and relevant skills to support the

clinical standards of the service and to ensure that there is adequate support and professional supervision of all clinical staff.

Overall then, in the discussions with staff and leaders, there was no clearly articulated clinical governance model or description of processes to support it; instead there appeared to be a lack of effective partnerships, limited capacity for change and little action. The service leadership currently appeared to be operationally focused with bias towards managers. The feedback we received from staff created an impression of reactive responses, short term views and inertia in addressing issues of quality.

Issues

Effective clinical governance is achieved by ensuring:

- clear lines of reporting and accountability
- authority
- responsibility
- robust systems and structures to identify, implement and report on quality assurance and opportunities for improvement
- quality improvement programmes involving health care staff, patients and public and clearly supported by executive leaders
- ongoing development of a supportive, inclusive learning culture
- clinician-manager-consumer partnerships at all levels to promote clinically informed, adequately resourced, patient-focussed services

The current structure, processes and culture at MCDHB mental health and addiction services, has

- unclear lines of reporting and accountability
- authority for decision-making concentrated in the upper levels of an unclear and unbalanced hierarchy
- financial considerations seen by staff as immovable barriers to change
- limited focus on implementation and measurement for improvement
- culture and clinical governance weaknesses

Recommendations

The organisation needs to provide clear leadership and support for strengthening clinical governance in the mental health and addiction services through:

- Articulating the vision, values and expected behaviours for Mid Central leadership and clinical governance.
- Role modelling effective clinical governance at the executive level
- Giving ownership and accountability back to services, with clear points of accountability.
- Clarifying expectations of accountability but also delegated authority to act
- Establishing consistent forums at all levels, with structures, processes and reporting based on the commonly agreed pillars of clinical governance.
- Improving governance partnerships across the clinical governance leadership group with effective teamwork and clearly valued opportunities for wider contributions, from clinical and professional leaders of all disciplines, managers, consumer and family leads, quality and risk experts and business analysts.
- Clarifying roles, especially the clinical manager roles and CEPD roles, and reporting lines.

Structure

Observations

A set of organisational charts were provided, which helped set out the management and leadership structures. The charts also gave a sense of what services were provided and where. It was our understanding that the structures had been reviewed in the past 12-18 months and previously, about six years ago.

The most recent structural change was put in place to try to integrate across some clinical services under one Service Manager for Mental Health and Addiction Services. We saw this as a positive move. The role itself needed a clearer mandate to act. However, this role sat alongside two other leadership roles. Maori/Pacific services sat under a second Service Manager and that role also had broader responsibility for service-wide quality improvement, for example lead for the KPI project. A third separate leadership role on the same level was established for Service Development. This Service Development manager had oversight of projects, service improvements and the CEPD roles.

As noted under Governance above, the Service Development structure appears to sit alongside the clinical team structure, introducing additional, inconsistent and confusing roles and reporting lines.

Concern was expressed about the way that acute emergency or crisis mental health services are structured. Currently, community teams are expected to deal with all acute clinical problems arising during their daytime working hours, which means that booked clinic appointments, meetings etc are liable to be disrupted unexpectedly. There is a designated Mental Health Emergency Team (MHET), but it is for “after hours” (evenings, overnight and weekends) and so does not commence work until late afternoon on week days. Neither the community teams nor the emergency team saw this as satisfactory, because of the disruption to scheduled community teamwork and the need for repeated handovers of care.

Staff in the hospital’s Emergency Department also expressed a preference for having the Mental Health Emergency Team available 24 hours per day, to ensure more consistent teamwork, processes and communication for them as well. The resourcing of the team was also seen as barely adequate already to cover the entire DHB’s catchment area after hours. There was no medical staff member attached to the team and having to deal with the on-call psychiatrist was seen as often unsatisfactory, so the nursing staff in the service would prefer to have a designated psychiatrist with whom they could review their work.

The Emergency Department staff also described a lack of access to either consultant psychiatrists or registrars, which is at variance with their access to medical staff in all other hospital specialties. They have been given to understand that they may call only the MHET nurses and have experienced extreme resistance when they have tried to get medical staff from the mental health service to see patients in the past, which seems unusual. The reviewers were also given to understand that there is no formal psychiatric consultation-liaison service for patients under the care of other hospital services.

Overall, the current structure is probably too new to assess its effectiveness. There is clearly considerable organisational development work still required, for clinical services to develop a sense of belonging to the whole DHB clinical system and then beyond that into the broader health system – primary care, NGOs and social care supports.

Issues

- Splitting the service leadership across three roles requires very clear articulation of areas of responsibilities and strong relationships to ensure all aspects of service delivery; accountability and improvement are very aligned.
- There is no one clear managerial lead for the service at service level, as there are three managers at that level with separate responsibilities for operational management, service development and service-wide quality improvement as well as Maori/Pacific health. The single point sits at the Operations Director level and we see this as an issue due to the very wide scope of the role, which sits across a number of services. This is a structural issue and not a comment on the person holding the role. The structure does create a bottleneck for decision-making and action.
- Poor clinical governance and a poor sense of being part of a whole system is very evident in every team. The comment “we operate in silos” was made by almost every team. Every team had very positive things to say about the way they operated themselves and considered that issues or problems sat elsewhere.
- The value of the separate Service Development arm in the structure is uncertain and further confuses the reporting lines and accountability for quality.
- We received no clear answer about who or which group was primarily responsible for managing and leading mental health and addiction services. There was a group, the Mental Health Executive Group, which included some clinical leaders as well as managers, but it was

unclear how this operated, how it actually influenced the service and how it related to front line services.

- Although managers are expected to work in partnership with clinical leaders, the structure does not include specific designated clinical partners for all of the managers, with the Clinical Director, Nurse Director and Allied Health Director apparently partnered with the three service-level managers but also expected to work in partnership with team-level Clinical Managers, who do not have designated clinical partners in leadership roles within the teams.

Recommendations

- Consider having a clear single point of accountability and leadership for mental health and addiction services that sits at service level and reports to the Operations Director and is responsible for decision-making in conjunction with clinical partners.
- Review the effectiveness of the Service Development portfolio and where it sits in the structure; consider how the CEPD roles, if they are needed, might add more value to improving quality and effectiveness of the services.
- The separation of daytime and out of hours acute responses needs to be reviewed, given the dissatisfaction with the current model. The evaluation of the model needs to be undertaken in terms of capacity to meet crisis and urgent response needs for communities, the emergency department, primary care and other secondary clinical services; location; effectiveness; and medical staff roles in the service. An opportunity may also arise to formalise the psychiatric consultation-liaison service and strengthen the linkages across clinical services.
- Medical staff in particular should have designated leadership roles at the clinical team level and should function as clinical partners for the Clinical Managers at that level.

Culture

Observations

The review team's overall impression was of a passive, complacent and powerless culture. This came from a number of consistent themes which emerged in discussions with all service areas we met with, including frontline clinical staff and leaders.

Comments had the following themes:

- "Plenty of talk and plans but no action." Ideas, proposals and plans seemed to go into a "dark hole" from which they never emerged. "There is a bottleneck with senior management."
- Lack of accountability for poor performance, not following DHB policy expectations or lack of action: inaction to address poor professional behaviour, and limited recognition of excellence. "Bullying is not addressed."
- Strong demarcation of "them" and "us" with "them" being senior management. Not always clear who that encompassed but it was commonly used language.
- All going in different directions, "We are working in silos," "We have a fleet going around in circles."
- "Staff have worked here for years – never worked anywhere else".
- A lack of connectedness at a clinical and professional level across the DHB. Mental Health is seen to maintain a siloed approach as opposed to clinically and professionally identifying as part of wider health services.
- Money was a major factor in staff members' minds and local decision- making. Managing organisational risk seemed to be the main focus with insufficient sense of balancing that with a clinical quality and safety (patient) focus e.g. "We cannot order additional staff for specials/ close observations, because there is no money."
- Very strong beliefs and examples of medical staff being separate, of poor leadership, and of inertia.
- There were also obvious tensions and mutual criticisms between the inpatient and community teams, with a lack of proactive, collaborative planning to address major service delivery challenges, either for the service as a whole or for individual patients. Hence, for example, there seemed to be a rule that Ward 21 (the adult mental health inpatient unit) must never refuse admissions and the staff responded to increasing demand by simply admitting above the ward's funded bed numbers, using areas not designed to be bed spaces and pulling in casual staff, despite the obvious impacts on clinical safety and staff, and seeing the community teams as

making inappropriate referrals; while from the community teams' perspective, the inpatient teams discharged patients hurriedly without proper involvement of community services. There had been a project to address this issue at some stage but it was thought to have led nowhere – the comment was "Whatever happened to the discharge project?"

- On Ward 21, there are clear policies but apparently a lack of consequences for not following policies so they are seen as optional, resulting in inconsistency, for example for documentation of risk or managing leave for voluntary patients. There appears to be a lack of contribution or buy in from ward leadership or staff regarding policy development.
- The apparent lack of time to care by Ward 21 staff was strongly expressed. They referred to being "run off their feet", high task orientation and minimal 1:1 recovery-focussed time with patients. Unit staff expressed a strong dissatisfaction with current unit culture, support and leadership presence.

The review team's assessment of the MCDHB mental health service and how the staff experience the broader DHB culture would fit the description of a "passive culture" as noted below.

Professor Edgar Schein Model of Organization Culture

Organizations do not adopt a culture in a single day; instead it is formed in due course of time as the employees go through various changes, adapt to the external environment and solve problems. Three distinct features of culture are described as:

Artefacts – The first level is the characteristics of the organization which can be easily viewed, heard and felt by individuals collectively known as artefacts. The dress code of the employees, office furniture, facilities, behaviour of the employees, mission and vision of the organization all come under artefacts and go a long way in deciding the culture of the workplace.

Behaviours/ Values - The next level is the values of the employees. The values of the individuals working in the organization play an important role in deciding the organization culture. The thought process and attitude of employees have deep impact on the culture of any particular organization. What people actually think matters a lot for the organization. The mindset of the individual associated with any particular organization influences the culture of the workplace.

Beliefs / Assumed Values - The third level is the assumed values of the employees which can't be measured but do make a difference to the culture of the organization. There are certain beliefs and facts which stay hidden but do affect the culture of the organization. The inner aspects of human nature come under the third level of organization culture.

http://www.managementstudyguide.com/edgar-schein-model.htm

Robert A Cooke Model of Organization Culture – Passive culture

The characteristics of a passive culture are:

- **Approval:** In such a culture employees can't take decisions on their own. They need to take their boss's approval before implementing any idea.
- **Conventional:** Employees are bound by rules and regulations of the organization and act according to the prescribed standards only.
- **Dependent:** In such a culture, the performance of the employees is dependent on the superior's decisions and they blindly follow their boss's orders.
- **Avoidance:** Employees tend to avoid their own personal interests, satisfaction and simply act according to the company's policies.

http://www.managementstudyguide.com

Issues

- Key people do not appear to feel they have the authority to act, make decisions and act. This creates delays and a sense of inertia.
- There are suggestions that people are exhibiting habitual, shaped beliefs and behaviours that have not been questioned or subjected to serious clinical critique to ascertain if they are reasonable, as exemplified by the limited, automatic responses to the pressure on inpatient beds.
- There is complacency: avoidance of action and learning and a lack of any momentum for change.
- There is no clear sense of vision and direction for the service or how each service area "fits" as part of a whole. This is evident in the sense of working in silos and particularly in the relationship between community and inpatient services.
- Front line staff do not feel as if those senior to them are obliged to take action or care about the pressures they work under or the problems they identify.

Recommendations

- MCDHB needs to undertake a programme of action that re-establishes its vision, values and culture and which clearly articulates that in practical terms. (The two models above could potentially guide that work).
- Mental Health Services need to be more effectively connected to wider DHB structures through clinical and quality activities and professional group activities.
- Clinical governance and stronger leadership need to be visible to clinical teams and to proactively engage clinical teams and consumers in the above process.

- Senior leadership need to work with service users, families and staff to make some clear action-orientated commitment to change and agree where to start – breaking that down into practical achievable steps.
- Innovation and initiative need to be modelled and encouraged by managers and clinical leaders, to create a sense that change for the better is possible and will happen.
- Leadership and governance teams need to ensure that the appropriate level of authority to decide, act and review are delegated, so that when ideas and service improvements are generated, decisions are made and things happen.
- Clinical Directors need to determine professional/clinical issues and actions required; expectations and responsibilities of line managers to act need to be clearly documented.
- Standards of behaviour and standards of clinical practice need to be clearly articulated and addressed, with positive examples acknowledged and problems acted upon appropriately and effectively.
- Encouragement should be provided to all disciplines to work in different clinical areas by offering staff rotations or secondments either within the DHB or external to the DHB. Staff and managers need to collaborate on policy development and implementation with clear buy-in. This should not be a top down process.
- Links should be established with clinical leaders in mental health and addiction services at other DHBs, and staff, particularly from Ward 21, should be sent to visit facilities and to meet with their counterparts at other DHBs, to seek new ideas and resources, which can support quality improvement (the external reviewers could provide contacts if required).

Clinical leadership and partnership

Observations

Medical leadership of the Mental Health service is currently undergoing a major change with the recent resignation of the longstanding Clinical Director and impending appointment of a new Clinical Director from within the existing pool of psychiatrists. The reviewers were told by many of the people they spoke to that this was seen as a critical issue, as it was thought that there was a need for a change of leadership style and development of a stronger respect for the medical leadership of the service and a more effective partnership between the clinical and managerial leaders. It was not in fact apparent to the reviewers that there had been much partnership at all to date. The medical leadership did not appear clearly linked to the nursing or allied health leadership and the managers were linked to other managers rather than clinical leaders. It was not obvious to the reviewers who should, in fact, be the partners for the Clinical Director, as the overall structure of the service was complicated and confusing, as outlined in other sections of the report.

There was no evidence of medical leadership below the level of Clinical Director – there are no other medical leadership roles apart from a role of Clinical Leader for the Mental Health of Older Persons service, which is currently being filled by the previous Clinical Director, although he does not work in the Older Persons service and is therefore not seen as a credible or effective leader for that service by the staff working in it.

The Alcohol and Other Drugs team and the Older Adult Mental Health team were examples of teams which, while proud of their own clinical capabilities and services, felt somewhat disengaged from the rest of the service and powerless to engage more effectively or exert influence over the development of their own service because of a lack of clear leadership.

Issues

- Strong clinical leadership, and in particular medical leadership, is lacking and this means that managers may struggle to ensure that their decision-making is well-informed from a clinical perspective, that clinical staff respect their directions and that clinical quality and safety issues are adequately recognised and addressed.
- Well-respected and effective medical leadership is also one of the necessary factors to overcome the longstanding problems with recruitment and retention of medical staff.

- Medical leadership is also essential for the strengthening of ties between Mental Health and Addiction services and other clinical services, in both secondary and primary care, to develop consultation-liaison services and ensure seamless transitions of care and well-integrated care for patients with complex healthcare needs.
- It is very challenging for provincial DHBs in NZ to attract and retain experienced clinical leaders, particularly in psychiatry which has a scarce national workforce.
- There is evidence of strong nursing and allied health leadership but without clear delegation or authority to act, as all authority to act currently sits within the line management structure.

Recommendations

- The incoming Clinical Director should be actively supported by the DHB to undergo leadership and management training and to receive mentoring, both from other clinical leaders within the DHB and from Clinical Directors in Mental Health services at other DHBs in the region.
- Additional clinical leadership roles should be established within the Mental Health service and in particular there should be a medical leader for each large clinical team or group of teams, with clear responsibilities and partners, and encouragement to use Continuing Medical Education (CME) resources for development of leadership skills.
- Clear partnerships should be established between medical, nursing allied health and management leaders at each level of the service; it should be clear who the Clinical Director's partners are and what the forums and processes are for joint decision-making and leadership.
- The Clinical Director should be expected to develop clear goals for their own role and also with their partners to develop clear goals for the leadership team, to enhance the quality and safety of the service and to strengthen its relationships with other clinical services.
- The leadership team for the Mental Health and Addictions service at Capital and Coast DHB, as the large regional neighbour, should be asked to consider how they might support the team at MCDHB to develop their expertise in leadership and management, for example by means of a mentoring programme, bilateral site visits and staff exchanges.
- DHB delegations and structure should be reflective of effective clinical governance principles.

Quality and safety processes

Observations

The review team were provided with draft reports on the RCAs for the two recent incidents as well as some RCA reports on previous incidents. The review team also met with the Quality and Clinical Risk Manager for the DHB and the Quality and Clinical Risk Coordinator who has mental health service incidents as part of her portfolio. Discussions with other staff also sometimes touched on the quality and safety processes of the service.

Clearly there is an established practice of undertaking investigations into incidents and there is a methodology (called Tap Root) used. After a major incident a team, usually two people, is assigned from amongst those DHB staff who have had training and experience in using this methodology. The aim is to have the investigation done by staff who do not work in the service where the incident has occurred but for it to be informed by expertise from within the service as required by means of discussions with the service staff. There are expectations that reports are completed within the deadlines laid down nationally and the national Severity Assessment Code (SAC) rating system is used to rate incidents and therefore to determine which ones need to be reported to the Health Quality and Safety Commission. The reports are considered at regular meetings and the DHB executive team receives regular updates on incidents. There is a Serious and Sentinel Event review group in the Mental Health service, chaired by the Quality and Risk Manager, but this has been running for only about a year and may not have yet started to be as influential as it could be on the culture and practice within the service. The summary of findings provided to us regarding investigations of previous unexpected deaths of patients under the care of Mental Health and Addictions services in the community over the past year showed that, of eleven deaths for which the investigation was now closed (though still generally awaiting Coroner's findings), only one investigation had resulted in any recommendations at all, which is somewhat surprising.

There is an open disclosure policy which means that patients and families should routinely be informed of adverse events which have affected their care and should also receive reports on the related investigations. The summary reports on incidents note if disclosure has occurred and it appears that this is occurring routinely. However, the reviewers were advised that reports were not actually routinely shared with patients and families and it was apparent that with regard to the two recent incidents, the families had not been invited to meet with the RCA teams until the day before the external team arrived for its first visit and the families were not feeling well-informed or included, so they did not trust the process.

There also appeared to be some mistrust and disconnection between the Mental Health and Addiction service and the Quality and Clinical Risk team. The view was expressed that incident management processes and ongoing review of recommendations arising from them were not so clearly embedded in the Mental Health and Addiction service as in other clinical services.

The review team only became aware in the course of its meeting with the staff of Ward 21 (the psychiatric inpatient unit) that there had been further incidents involving attempted self-strangulation on the ward during the weeks immediately following the two deaths on the ward.We were told at a meeting with ward staff that one of these incidents had resulted in a requirement for the patient involved to be admitted to the intensive care unit; however we later established that this was incorrect: the patient the staff were referring to had actually been admitted to the Coronary Care Unit (CCU) for overnight monitoring. We were provided with data from the Data Quality and Health Information Unit which clearly established that, apart from the patient who was the subject of the second RCA, there had been no patients transferred to ICU from Ward 21 between April 15 and July 31 2014. However, there were a total of four incidents of attempted self-strangulation on Ward 21 during the month (May 7 – June 7 2014) after the incident which led to the second death. While none caused harm requiring medical intervention, apart from the overnight transfer to CCU for monitoring, it might have been expected that any further incidents of attempted self-strangulation, while not necessarily meeting the criteria for SAC 1 or SAC 2 incidents, would have been seen as such important "near misses", forming part of a pattern of related incidents, to have themselves warranted RCA in the current context. This issue of a repetitive and possibly linked pattern of hazardous behaviour in an inpatient unit and what might be required for the ward team to identify and address that risk would certainly warrant consideration by the team undertaking the second RCA.

The final RCA report on the first incident, received by the external reviewers on 18 August 2014, appeared to adequately review that incident, identify a set of relevant root causes and incidental findings and make appropriate recommendations. The review team had seen only an incomplete early draft of the RCA report on the second incident at the time of completing their report but do expect to have an opportunity to comment on that RCA report once it is complete. It is also important that possible linkages between the two incidents and with subsequent similar incidents be explored. While the reviewers were advised that additional staff had been assigned to the ward at least temporarily following the second incident and some bathrooms had been locked, it was not clear that there had been a systematic and urgent attempt to learn from these or previous incidents in

any specific way or to increase the clinical expertise of staff with regard to assessment of risk in similar cases or circumstances, in order to prevent recurrences.

Issues

- Open disclosure is not such well-established custom and practice as it should be at MCDHB and there is insufficient engagement and transparency in review of incidents from the perspective of consumers and families.
- The quality and safety culture is not so clearly established and visible in the Mental Health service as it should be and it is not clear that routine investigations of community deaths and "near miss" incidents are sufficiently rigorous.
- The RCA processes followed at MCDHB appear to lack expert clinical input from the relevant clinical specialties, which means that while they address generic procedural and policy issues well, they may fail to recognise specific clinical issues, which should inform the recommendations.

Recommendations

- The executive team should provide clear expectations and leadership not only around the open disclosure of adverse incidents to those affected but also for routine consumer engagement in review processes and provision of reports to affected patients and families.
- Leaders of the Mental Health and Addictions service and of the Quality and Risk team should develop together, and implement and lead jointly, a plan for clear governance of quality and risk in the Mental Health and Addictions service, including ongoing training in safety and quality principles and practice, regular review of incidents and recommendations arising from their investigation and development of open disclosure and active learning from incidents.
- The Quality and Risk team should consider inclusion of a clinical expert advisor from relevant clinical specialties and/or professional groups on each RCA team, to ensure that specific clinical issues are not missed.
- The Quality and Risk team should also seek advice from other DHBs on additional approaches to the reporting, classification, and investigation of incidents, for example use of the London Protocol, which might be of particular value in the investigation of Mental Health incidents.

Staffing

Observations

Medical staff vacancies have been serious, recurrent and persistent. The shortages mean that those doctors who do work in the service are often under pressure and may stay for only short periods. They express concern about their workloads and the consequent effects on the quality and safety of care. The vacancies also make it difficult to distribute workloads evenly across the various clinical teams. In addition, there are no psychiatrists in the service with the Australasian qualification (FRANZCP), which limits opportunities for the service to develop training positions as well as limiting the knowledge and experience the psychiatric workforce has of the NZ culture and health system. These are common problems in the mental health services of provincial DHBs in New Zealand at the present time, as there is a national shortage of locally trained psychiatrists and provincial DHBs struggle to compete for a limited workforce with the larger urban centres.

There have also been persistent vacancies for psychologists recently and this also creates an uneven distribution of psychologists across services; the sole psychologist position in the inpatient unit has been vacant for some time and there is no cover provided for this by the remaining psychologists in the community teams.

Other professional groups appear to have fewer issues with vacancies but some morale problems are evident. Nursing staff in both the adult inpatient unit (Ward 21) and the Palmerston North-based adult community mental health teams in particular conveyed to us a strong sense of frustration and demoralisation. Staff in the smaller, more specialised teams, by contrast, expressed much more job satisfaction.

Consumer advisors have felt undervalued and have been under-resourced until recently, so need active ongoing support to develop their roles and influence to their full potential.

Issues

- Persistent vacancies compromise the quality of care and become self-perpetuating as well-qualified and experienced staff do not want to work in undermanned services and have options to work elsewhere, so this is a difficult issue for the service to address.
- It is generally more difficult to develop and maintain team spirit in larger teams and less specialised teams do often develop a sense that they are "dumping grounds" or the default teams of last resort for patients who do not meet criteria to get into smaller "elite" teams with specialised resources. This is an important issue for health services to address, to ensure that those more generic large teams do not become progressively more depleted and demoralised.
- Patient and whanau focussed care is increasingly recognised as a key element in developing and maintaining the quality and safety of health services but requires positive support to flourish in environments dominated by health professionals.

Recommendations

- Currently employed staff should be actively supported to develop professionally and given responsibilities and opportunities which ensure they feel highly valued by the DHB.
- Planned team training, which we understand is to be rolled out throughout the DHB, should focus particular attention on staff in the large inpatient and adult community teams, which present particular challenges because of their size and roles. It should also include an emphasis on clarifying and enhancing the roles of consumers as members of the healthcare team.
- Discussions should be held with the clinical leaders for Mental Health and Addictions services at the other DHBs in the region to look at how neighbouring DHBs might assist one another to cover gaps, provide additional supervision, arrange secondments or visits to other teams to share and increase clinical experience and explore the use of videoconferencing for clinical consultations and education both within and between DHBs.

Ward 21 facilities and environment

Observations

The adult inpatient unit would not meet current standards for acute mental health units in New Zealand or Australia (see *Appendix 4*). The external reviewers are aware that a review of ward design features in the light of the recent incidents has already been undertaken with input from external consultants who visited the ward on 16 July 2014.. The report on the findings of this review is attached as *Appendix 5*.

The following observations are those made by the external review team on the basis of their own visits to the ward on 8 July 2014. The first observation upon entering the unit is of a ward that is not set up with the needs of mental health services users, family and staff in mind. The unit appears sterile and overly "clinical". There is very limited space for a group of 24-30 mobile services users who are often experiencing acute symptoms that can be heightened with the sense of overcrowding and overstimulation. There is little capacity to provide separate spaces for patients of widely varying ages and needs.The ward has limited appropriate communal space, especially for spending time with family/whanau and other visitors. Rooms that could be available are often used for extra bed capacity. Staff have tried to make some areas more recovery focused and environmentally more appropriate for people whose stay is not just a few days. Mobility, length of stay and intensive impact of symptoms are why acute mental health units need to be purpose designed.

Lack of space is of serious concern in the intensive care area of the unit and is compounded by a "flight deck" nursing observation area. This creates more risk than a clear observation area. Staff need to leave the area to get access to notes, its appearance is very intimidating and it uses up precious space. The ability to observe service users within Ward 21 is extremely compromised. The current layout of the ward has many blind spots. The unit is like a pressure cooker environment, which is not conducive to the type of recovery environment people need to heal in, and staff also expressed concern about their own safety.

The intensive care area is poorly maintained with an overall air of shabbiness and starkness. Graffiti is evident throughout this area. Staff have given up reporting this, as they believe there is no money for maintenance.

The unit is built as a 24 bed unit but frequently and in an ad hoc manner goes up to 30 beds. Use of seclusion rooms, meeting rooms and family rooms as bedrooms is inappropriate. The intensive care area is not adequate for 6 people.

There is a sensory room, which is an important resource in a modern inpatient unit, to enhance self-management of distressing symptoms, assist with de-escalation of hazardous behaviour and provide a tranquil place for practice of mindfulness. This room appears to be under-utilised currently and is kept locked when staff are not available to accompany patients who want to use it. This limits its utility and suggests that staff have not fully understood its potential value.

The mix of staff in uniform and non-uniform is very confusing if the goal of wearing a uniform is to identify staff members. A clear decision is needed on this, and if a uniform is the agreed way to go then it should be consistent and of a street wear variety, not white nurse's smocks.

The Ward 21 area also accommodates the Mental Health Emergency Team. The space is extremely small and away from where they mostly need to do their work, i.e. the Emergency Department and community, and from key resources to do their work, i.e. access to community notes.

Issues

- The physical environment in mental health can be associated with both positive and negative outcomes for service users. Having space specifically designed for activities, interaction and the welcoming of service users and families will support an individual's wellbeing and recovery. It has impacts on the number of incidents involving service users and staff that can result in harm, stressed interpersonal/therapeutic relationships and experience of an adversely "charged" environment.

Recommendations

- Design, layout and ligature points need to be attended to as a matter of priority.
- The focus on security and containment needs to be balanced with care, compassion and recovery.
- Serious consideration needs to be given to the separate environment review and recommendations outlined in *Appendix 5*.. Actions that can be implemented quickly should be implemented quickly.

- A decision is needed and should be firmly implemented on the bed numbers for the unit. Community services staff need to be part of the bed management plan alongside in-patient unit staff.
- Debriefing of service users and staff after a significant event on the ward should happen within 48 hours and with appropriately trained, experienced staff external to the unit, to identify and start implementing processes to care for those affected and to form part of the process of learning from the incident and implementing change as a result.
- A joint union and staff management group should review all staff injuries, with feedback to staff, ensuring that the investigation and review process includes immediate and 1 week follow up of injured staff, review of the environment (inclusive of staffing adequacy) and consideration of patient care issues.
- Regular maintenance of the unit should occur, to ensure that it is and looks like a place where the people using it feel cared for and valued.
- The use of CCTV in the unit should be reviewed: technology of this nature does not replace skilled nursing care and there may be excessive reliance on it as a form of security.
- Clinical leaders and occupational therapy staff should contact their counterparts at inpatient units in other DHBs to find out how sensory rooms may be used more fully (the external reviewers could provide contacts if required).
- The location of the Mental Health Emergency Team should be reviewed, in consultation with that team and the Emergency Department. This needs to be considered in conjunction with a rethink of the clinical model, as noted previously under Structure, and provision of better access to clinical information for this team to operate safely and to provide services in a timely manner, as noted under Resourcing below.

Resourcing

Observations

The review team did not see the service as obviously lacking in resources overall. The impression rather was that resources might be reconfigured to better meet changing or growing needs. However, a prerequisite to bring this about would be the development of a more active, nimble, innovative and learning organisational culture.

Several staff commented that after the two recent suicides additional staff had been found at least temporarily for the inpatient unit whereas previously there had been an assumption that such additional staffing would be unaffordable. This has of course reinforced cynicism about the willingness of senior leaders to provide resources for mental health services.

One specific type of resource notably lacking, and which could support more efficient and higher quality clinical services, was electronic clinical records. Clinical teams noted that having no electronic clinical information system was a major issue for continuity of care, quality, safety, timely access to information and transfer of care. It seemed that a lot of time was wasted locating and conveying paper records across the service, which was a particular concern after hours and for the rural services, and discharge summaries might be received up to three weeks post-discharge from the ward. It is now common in mental health services elsewhere in NZ for electronic records to have replaced paper ones. Staff were not aware of any plans for their introduction at MCDHB.

Issues

- Clear service improvement planning, aimed at using existing resources in new ways to provide more effective and well-coordinated services, is likely to be more productive than simple addition of resources to a dysfunctional service.
- High quality, accessible information is an essential tool for the provision of clinical services. This is particularly important with patients receiving care from multiple teams (for example, emergency, in-patient and community teams) and across a large geographic area.

Recommendations

- The DHB should focus on culture change and development of process analysis and service planning expertise rather than simply adding resources.
- The DHB should develop an Information Management plan for the service, including implementation of electronic clinical records.

Additional comments regarding recent inpatient suicides and related incidents

Observations

The external review team does not seek to replace the internal reviews already underway and we provide the following comments in order to support those reviews, by drawing attention to particular observations which we thought would merit consideration by the internal reviewers.

As noted under the Quality and Safety Processes section above, there may be ways in which the two deaths are linked, given that they occurred just three weeks apart in the same ward and that the two people involved knew each other. The reviewers were advised that the second suicide appeared to have occurred quite soon after that person had learned, as a consequence of her admission to the ward, that the previous suicide had occurred there and something about the method used. Other incidents of similar self-harm occurred subsequently on the ward.

The reviewers were advised that inpatient team staff did not routinely document their own risk assessments on admission of patients to the ward, relying instead on prior risk assessments undertaken by community team staff. It was not obvious that there had been a systematic consideration of risk by the inpatient unit staff in these two cases and there had been a marked reduction in the level of supervision provided to the first patient from the time of his admission to Ward 21, compared to the constant observation he had been until then when in other areas of the hospital. More general concerns about adherence to policies and standards have been noted above in the sections on Culture and on Ward 21 facilities and environment.

It was also suggested to the reviewers that patients with alcohol and other drug use disorders were seen as troublesome and not so worthy of care in the inpatient unit as other patients. Concerns were also expressed by some staff about the quality and safety of the service provided by the Alcohol and Other Drugs team; however, specific examples or other details were not provided to the reviewers.

The families of the two patients who died have expressed dismay that neither the internal RCAs nor the external review are going to examine the whole history of the clinical care of the two individuals by MCDHB Mental Health and Addictions services. This would not be a usual expectation of review processes following suicides, which commonly focus on events immediately preceding the suicide to look for preventable factors. However, the external reviewers can see potential merit in detailed longitudinal clinical review of these two cases, as opportunities to learn more about the

clinical standards of the care they received in the course of their journeys and thus the quality and effectiveness of the particular services which these two individuals used.

Issues

- The pattern of self-harming behaviour over a short period of time on Ward 21 raises questions about the assessment and management of the risks of "copy cat" behaviour, which need to be specifically addressed.
- While clearly there is value in the assessments done by community team staff, who may know patients better because of their longer-term involvement in the care of some individuals, it is of concern if this is seen as a substitute for rather than a supplement to ongoing risk assessment in the inpatient unit.
- Negative or judgemental attitudes to people with alcohol and other drug use disorders are liable to result in failure to understand, recognise and treat underlying and complicating disorders as well inadequate treatment of addictions themselves; the implicit or sometimes explicit rejection of such patients by health professionals may also increase the risk of self-harming behaviour.
- Skills in recognition and management of co-existing mental health and addiction issues and understanding of the complex interactions are important in ensuring adequate risk assessment and confident, competent management.
- The two individuals involved in the recent incidents each used different parts of the MCDHB Mental Health and Addictions community services in addition to their contact with the inpatient unit, which provides an opportunity for further learning about the clinical standards and functioning of these services and about some of the concerns referred to elsewhere in this report, such as availability of psychotherapies and skills in the management of addictions.

Recommendations

- The internal RCA teams should be asked look carefully for evidence of common factors in the two deaths, and also in any preceding or subsequent similar Ward 21 incidents not resulting in death; the likelihood that there may be factors which gave rise to "copycat" behaviour should also be considered by the RCA teams.
- The external reviewers are expecting that both of the internal RCAs will make specific recommendations concerning risk assessment and management, as this is already signalled as an issue in the draft report of the second RCA as well as in the final report on the first RCA; we would hope that improvements in this area would address not just the need for documentation

but also the need for a culture of ongoing, well-informed and meaningful risk assessment and management throughout care. Clinical policies, for example for managing leave from Ward 21, undertaking risk assessments, managing clinical risks and completing clinical documentation to appropriate standards, need to be implemented and valued by clinical leaders and staff, with appropriate consequences if they are not followed.

- A review of the level of training and experience of all staff (medical, nursing and allied health) in the inpatient unit with respect to assessment and management of alcohol and other use disorders and Co-existing Problems, and implementation of ongoing education to strengthen the skills of the inpatient team in this regard, appears warranted.
- Separate clinical reviews of the care provided to each of the two individuals over the course of their whole contact with MCDHB might well provide useful additional insights, as well as providing greater assurance to the families that the DHB has endeavoured to learn as much as possible from the recent incidents. Each longitudinal clinical review could be undertaken by a single experienced senior clinician from another DHB. Capital and Coast DHB, as the large regional provider, might be able to provide personnel who could undertake this.

Appendix 1: Terms of reference for External Review

EXTERNAL REVIEW
MENTAL HEALTH SERVICES
MIDCENTRAL DISTRICT HEALTH BOARD
Terms of Reference

1. PURPOSE/BACKGROUND

There have been two serious adverse events within a short period of time in the acute mental health inpatient unit, Ward 21. The two events were the suicide of two inpatients, three weeks apart in April/May 2014. Families of the two inpatients involved have an allocated contact person within the service and communication is being maintained with them regarding progress with the reviews and any other support and/or information they require. Each event is the subject of a root cause analysis investigation which is now underway.

The Board has requested that management look to commission a systematic review of the Mental Health Service in the light of these events. The purpose of the review is to determine whether or not there are any underlying issues in relation to models of care, the culture of the service, or in any other regard. In addition, advice has been received from the Director of Mental Health, Ministry of Health that a single systematic review, taking into consideration the two cases, but also looking at the functioning of the wider Mental Health Service, is appropriate.

In recognition of the fact that there are always issues under consideration for large and complex services, the wider context for this review includes the following that have had an impact on the effectiveness of the service.

1. There have been long term challenges in recruiting and retaining psychiatrists and resident medical staff, although recruitment has been more successful over the past two years, notably with the recruitment of four full time psychiatrists over 2013/14, the last being an inpatient psychiatrist commencing 16 June 2014.
2. Interface issues between the General Adult Mental Health Service and the Psychogeriatric Service (organisationally part of Elder Health Services) has made the patient pathway for both the "graduate" mental health group and high needs "psychogeriatric" patients difficult. This has Jed to challenges in managing individual cases effectively. A proposal is now being prepared for the Psychogeriatric Service to be clinically and operationally managed as a service within the overall Mental Health Service.
3. Concerns about apparent departures from established standards of practice on the part of individual clinicians have been addressed, and some are the subject of a separate review.
4. Over time, concerns have been voiced by staff regarding clinical leadership for the service and the impact of this on collegiality and effective working relationships amongst senior clinicians. This has been the subject of transparent discussion amongst senior clinicians over the past eighteen months.
5. Recognition that the current service structure across General Adult Mental Health, Maori Mental Health and Adult Addiction Services, and the working relationships between the services does not always facilitate a seamless pathway for patients. Work has been underway to roll out the Choice and Partnership Model across adult services, along with strengthening the approach to the management of coexisting disorders.

2. EXTERNAL REVIEW GROUP

Dr Gloria Johnson, Chief Medical Officer & Psychiatrist, Counties Manukau District Health Board

Heather Casey, Director of Mental Health Nursing, Southern District Health Board

Helen Wood, General Manager, Mental Health Services, Waitemata District Health Board

Gary Sutcliffe, Consumer Advisor, East Tamaki Health, Auckland

3· RESPONSIBILITIES/FUNCTIONS/EXPECTED OUTCOMES

A robust external clinically led review of MidCentral **DHB**'s Mental Health Services, with a scope across the Mental Health Service, and referencing the two events.

This will include:

- An assessment of the current state of clinical leadership, clinical governance and clinical systems and processes, taldng into account the two individual adverse events in Ward 21.
- A comprehensive review of documented policies/ procedures/ structures/ established processes in place to support the delivery of the service.
- Interviews with key staff to identify current arrangements for service delivery, clinical practice, clinical responsibility, service resourcing and the prevailing/underlying culture of the service.

The reviewers will determine appropriate recommendations based on the outcome of their review, covering both recommendations for service improvement and corrective actions where appropriate.

The review will be conducted in a fair and reasonable manner and in accordance with the principles of natural justice. This will include seeking feedback from participants as appropriate.

In the event that any issues concerning an individual's conduct or performance are identified, the reviewers will notify the DHB's Chief Medical Officer, who will communicate appropriately with the relevant Professional Lead. This would be addressed as a separate process.

4· PARTICIPANTS/INTERVIEWEES

- Families of both patients
- Clinical Director & DAMHS
- Senior Medical Staff
- Resident Medical Officers
- Charge Nurse/Clinical Managers
- Nurse Director MH Services
- Director of Allied Health
- Service Manager, Mental Health Services
- Manager Service Development, Mental Health Services
- Manager, Maori Mental Health
- Consumer Advisors, Mental Health Services
- District Inspector

- Relevant Clinical Staff
- Any other staff identified during the review
- Manager Quality
- Chief Medical Officer
- Director of Nursing
- Operations Director, Specialist Community & Regional Services

5· STAKEHOLDERS

- Association of Salaried Medical Specialists
- New Zealand Nurses Organisation
- New Zealand Resident Doctors Association
- Public Service Association
- Association of Professional and Executive Employees

6. ANALYSIS TO INCLUDE

A systematic review of the mental health service in the light of these events, to determine whether or not there are any underlying issues **in** relation to the culture of the service or other issues that need to be addressed.

- Clinical systems and processes
- Clinical Governance
- 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)

7· REPORTING

A draft report is to be provided to the Chief Medical Officer for feedback, within four weeks of review completion.

MidCentral **DHB** will manage the distribution of the final report and the dissemination of the reviewers' findings in an open and fair way, and in accordance with its legal obligations.

AUTHORISED BY:

Dr Kenneth Clark	**Michele Coghlan**	**Nicholas Glubb**
Chief Medical Officer	**Director of Nursing**	**Operations Director**

Appendix 2: Documents received by external reviewers

Note that, to protect the privacy of individuals, in this list personal names of staff members have been omitted or replaced by generic titles, the patient involved in the first incident is referred to as Patient AB, the patient involved in the second incident is referred to as Patient CD and a patient whose care was the subject of a previous independent review is referred to as Patient EF.

- 2013/14 Line / Service Plan – Mental Health and Addiction Services
- 2014/16 Service Development Plan – Secondary Mental Health and Addiction Services
- 3-5pm Doctors Meeting – Record of Attendance 2014
- Area Representatives for Quality Group – Mental health Agenda 4 August 2014 and Minutes 7 July 2014
- Certification Audit 19-23 May 2014 – Draft Corrective Action Requests (CAR)
- Charge Nurse Report, Ward 21 Psychiatric, June 2014
- Day 1 – Interview Schedule 25 June 2014
- Day 2 – Interview Schedule 8 July 2014
- Day 3 – Interview Schedule 9 July 2014
- EIS, Child Adolescent including Family Mental Health and Co-existing Disorder Services Business Meeting Agenda 10 July 2014
- Email response to questions regarding deliberate self-harm events on Ward 21, 20 Aug 2014
- Flowchart – Mental Health Services for Older Adults Referral flowchart
- General Adult Community Mental Health Governance Group, Agenda 29 July 2014
- ICU – Ward 21 Discharges/Admits during period 15 April – 31 July 2014
- Independent reviewer's letter and report of 24 July 2013 to CMO – re Investigation of the care and treatment received by Patient EF at MidCentral DHB
- Key correspondence between families and DHB re external review
- Meeting – Meeting Ward 21 on 17 March 2014 - safety issues on Ward 21
- Meeting – NZNO meeting on 17 March 2014
- Memo (dated 1 December 2010) – TapRoot Analysis Report: Incident #62421
- Memo (dated 13 April 2013) – Root Cause Analysis for Incident #63674
-
- Memo (dated 23 July 2013) – Root Cause Analysis: Event #146
- Memo (dated 23 September 2013) – Realignment of MH Service Management Responsibilities
- Memo (dated 26 March 2014 – Service Manager and others) – Changes to Mental Health & Addiction Executive. Introduction of Mental Health and Addiction Leadership Operational meeting.
- Memo (dated 3 June 2014) – Hospital Advisory Committee re Mental Health update
- Memo (dated 18 June 2014 – Operations Director and others) – Mental Health Services - External Review
- Memo (dated 4 July 2014) – Root Cause Analysis: Event #155 - Draft Report
- Memo (dated 4 July 2014) – Root Cause Analysis: Event #156 - Draft Report

- Memo (30 July 2014) - Root Cause Analysis: Event#155 - Draft Report
- Memo (12 August 2014) – Root Cause Analysis: Event#155 - Final Report
- Mental Health & Addiction Services – FTEs (Budget *vs* Actual) / Client numbers
- Mental Health & Addiction Services, Clinical Managers Meeting Agenda 13 June 2014
- Mental Health & Addictions District Group – Work Programme 2013/15
- Mental Health Executive Group – 12 December 2013 meeting Minutes
- Mental Health Executive Group – 13 February 2014 meeting Minutes
- Mental Health Executive Group, Agenda 12 June 2014
- Mental health suicides 2013/14
- MH Ward 21 Serious and Sentinel Events (SAC 1 & 2)
- MHET feedback to External Review
- MHS overdue documents
- MHS Serious and Sentinel Events Review Group - TOR
- MidCentral DHB – Demographics of the region serviced by DHB
- MidCentral DHB – Organisation Charts for DHB and Mental Health Services
- MidCentral DHB Mental Health Emergency Team (MHET) - presentation 25 August 2012
- MidCentral Health Community Rural Horowhenua Mental Health Service High Level Non-Financial Monthly activity Report, June 2014
- MidCentral Job Descriptions –
  - *Service Manager Mental Health*
  - *Manager Maori Mental Health*
  - *Clinical Director*
  - *Clinical Educator / Practice Development (CEPD)*
  - *Clinical Manager – Community Mental Health Teams and Mental Health Emergency Team*
  - *Clinical Manager - Oranga Hinengaro / Specialist Mori MH*
  - *Clinical Manager - Alcohol and other drugs*
  - *Clinical Manager - Child Adolescent and Family*
  - *Clinical Manager - Horowhenua Community MH Team*
  - *Clinical Manager - Community MH Team and MH Emergency Team*
  - *Clinical Manager - Tararua Community MH Team*
  - *Clinical Educator / Practice Development - Rural MH*
  - *Clinical Educator / Practice Development - Alcohol & other drugs co-existing disorder service*
  - *Clinical Educator / Practice Development - Primary / Secondary interface*
  - *Clinical Lead - Child, Adolescent and Family including Oranga Hinengaro*
  - *Charge Nurse Inpatient MH*
  - *Ward Charge Nurse*
  - *Nurse Educator Ward 21 Acute Inpatient Services*
  - *Addiction Medicine Specialist / Psychiatrist Alcohol & other drugs*
  - *Consultant Child and Adolescent Psychiatrist*
  - *Specialist Psychiatrist*
  - *Manager Service Development*
- Pamphlet – Oranga Hinengaro

- Policy – Open Disclosure
- Policy – Serious and Sentinel Event Reporting
- Report of Operations Director, Community and Regional Services – Mental Health, June 2014
- Root Cause Analysis resource booklet v2 draft
- Patient AB - clinical notes including ED report and restraint approval paper, observation chart
- Patient AB – Doctor's report (dated 30 May 2014) to Coroner Carla na Nagara
- Patient CD – Photograph
- Patient CD – short term management of CMHT A+ OD Consumers by Mental Health Emergency Team (MHET)
- Patient CD – clinical notes
- Patient CD – Intensive Care Unit Discharge Summary
- Patient CD – Risk assessment form
- Submission – Early Intervention in Psychosis MidCentral Health
- Submission – RN, Intensive Rehabilitation and Treatment Service
- Submission – RN, Primary-secondary liaison
- Submission – Alcohol and Other Drugs service
- Submission - Psychiatric Social Worker
- Submission – Tararua team
- Terms of Reference - External Review Mental Health Services, MidCentral DHB
- TOR – Severity Assessment Code - Event Analysis - Ref No: RCA155#2014
- TOR Severity Assessment Code - Event Analysis - Ref No: RCA156#2014
- Training Calendar June-Dec 2014 NGOs and community
- Ward 21 Internal audit – clinical record
- Ward 21, Mental Health Services Governance Group, Agenda 8 August 2014

Appendix 3: Groups of staff met with by external reviewers

- Nurse Director MH Assessment, Treatment & Rehabilitation
- Clinical Director / DAMHS
- Service Manager, MH & Addiction Services
- Manager, Service Development, MH & Addiction Services
- Service Manager Oranga Hinengaro Maori MH
- Operations Director, Specialist Community & Regional Services
- Chief Medical Officer, MidCentral Health
- Director of Nursing, MidCentral Health
- Parents of Patient CD
- Family & Consumer Advisor
- Consumer Advisor, Addictions
- Manager, Quality and Clinical Risk
- Coordinator, Quality and Clinical Risk
- Early Intervention Psychosis Team
- DBT Team
- Clinical Manager, Alcohol & Other Drug Services
- Clinical Manager, Horowhenua MH Team
- Clinical Manager CAFS
- Clinical Manager, MH, Community & MH Emergency Team
- Clinical Manager, Oranga Hinengaro, Maori MH
- Charge Nurse, Ward 21, Acute Adult Inpatient Unit
- Ward 21 staff
- Clinical Educator Practice Development x3
- MH Emergency Team Staff
- Alcohol and Other Drugs team
- Oranga Hinengaro, Maori MH team
- Clinical Educator, Ward 21
- Clinical Nurse Specialist Lead MH
- Star 1 – Older Adult MH (Senior Staff)
- ED Charge Nurse
- Consultant Emergency Physician Acting Clinical Director
- Community MH Team
- Child, Adolescent and Family Service
- Director Allied Health
- Addiction Specialist

Appendix 4: Reference Material for acute inpatient unit design and culture

1. Environmental factors and outcomes in mental health and addiction clinical settings: A review of the literature Te Pou

environmental-factor
s-and-outcomes-in-m

2. Australian health facility guidelines

MOH Criteria for
Design 2002.pdf

Appendix 5: Review of Ward 21, Palmerston North Hospital

Review of Ward 21 Palmerston North Hospital

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Introduction

Helen Wood, General Manager, WDHB asked us to assist with a review of Ward 21 Acute Adult Mental Health Unit Palmerston North. We are Kirsten Norris, Clinical Specialist Acute Service Redevelopment, and Don MacKinven, Operations Manager Adult Mental Health Services. Sue Ellis provided us with a focus for the evaluation.

We would be grateful if your staff could visit Ward 21 and carry out an evaluation in terms of:

1. Safety for patients and staff – noting aspects of the environment that increase risk to patients and staff
2. The functionality of the ward as an adult acute mental health inpatient facility
3. Provide recommendations on changes to:
    - Existing fixtures and fittings that would result in greatest immediate gain in reducing risk to patients associated with these fixtures and fittings
    - Any additional fixtures and fittings that would result in immediate risk reduction for patients and staff
    - Make comment on any other features of the ward that warrant further evaluation from a safety and functionality perspective.

We visited the unit on Wednesday, 16 July 2014, were provided with a floor plan and met with a number of staff and toured all areas of the unit.

Background

Ward 21 opened 13 years ago. It was purpose built as an Adult Acute Admission unit and there have been no substantial alterations to the ward during these years. The ward does not meet the current standards expected of an acute admission unit in NZ across a range of areas. These include observation of service users, communal areas for service users, safe fittings and fixtures and general ward layout. Ward 21 has 24 beds, 6 high care beds and 18 open ward beds. The fabric of the building appears sound and in many areas the ward appears to be in very good condition, especially in open ward bedrooms. The staff we met identified a range of issues they were keen we heard about, which have helped to inform this report.

Discussion

Safety for service users and staff

There are a number of ligature points within Ward 21 which are accessible to Service Users. These include coat hooks, door returns, slide shower fittings, disability rails and window latches. Extensive use of hospital high/low beds was noted on our visit. All these beds pose a potential risk with multiple ligature points. The staff toilets were identified by staff as easily accessible by service users using something as basic as a 20c coin. The staff toilets have an 'engaged' sign that would mean if a Service User managed to get into them, no one would be aware they were in there. Within these toilets there are multiple ligature points. In the large open courtyard the camera and downpipes provide both ligature points and an exit means. There is extensive use of windows that open for natural ventilation, all of these have multiple ligature points and if opened suddenly bang the head of the person opening them.

Functionality

The design of the ward does not provide for easy observation by staff in a range of areas. Staff need to be present or immediately adjacent to these areas before they have any view of them. There is no centralised hub from which to observe the ward's corridors. The ward relies on CCTV for observation of many of these areas, including outside courtyard space and bedroom corridors. We were shown two places where staff could see the view from these cameras. When we visited it was notable that neither location had anyone observing these screens.

The main clinical staff area within the ward appeared to be an area called "the flight deck". This area is completely closed in and looks into the high care area at one end and resembles a medieval castle at the more open end. This area is raised several steps above the general ward floor level and staff look down from it onto Service Users and visitors. Staff mentioned to us they felt this particular part of the ward was an extremely poor feature. Also noted there is no immediate access from the "flight deck" into the high care area.

It was drawn to our attention male and female service users had a clear view into each other's bedrooms in the open ward and alterations to the grounds outside ward 21 have meant some bedrooms are clearly visible from an adjacent car park.

Within ward 21 the designers have made some areas very large for their apparent function and other areas disproportionately small. An example of this is the admin area off the entry corridor to the ward where the space designated for 2 staff would appear to be adequate to house many times that number of people. An example of an area disproportionately small would be the occupational therapy/ day programme space.

Ward 21 has very little communal space in the form of lounges where service users could relax, read or meet with visitors.

In the centre hub of the ward adjacent to the "flight deck" is a large staff review room that also houses the video conferencing facility. This appears to be a very poor use of a space which is in the main intersection of the ward.
Staff reported to us the unit capacity was 24 beds and went on to say a number of other rooms were used for bedrooms if more than 27 Service Users needed hospitalisation. Should these rooms be used for bedrooms their original functions were clearly compromised or simply failed to exist. Example is the whanau room.
Staff also identified the fire system in ward 21 was flawed in the sense that should the fire alarms be activated all external doors to the unit became unlocked and required a staff presence at each and every one of them.
We were surprised to observe there were 3 distinctly different staff alarm systems functioning within the unit with no clear rationale as to which particular alarm system any staff member would be using on a daily basis. We counted 4 different keys or locking systems within the ward and staff mentioned there were probably more we hadn't observed.
Service Users have their own rooms and the bedroom wings are separated on the basis of gender, Service Users cannot create their own privacy by securing their own bedrooms.
The staff we talked to explained it was a staff choice whether to wear uniform or mufti and there appeared to be no consistent approach re what was appropriate dress at all.
Of note ward 21 is not a Smokefree environment which is commonly the case for other units of this kind in NZ.
In addition to the lack of dedicated space for certain functions there is no waiting or meeting area for families that attend Court days within the unit.
The ceiling height and ceiling fixtures are all very easily reached by Service Users with lights which can be easily interfered with and sprinkler heads that provide ligature points
There is a toilet directly observable at the end of the main entrance corridor when entering the unit.
Staff reported to us that 20% of the catchment population for this unit are Maori and there appeared to be opportunity to develop a predominantly Maori led service that reflected this population and the high admission rate of Maori.

High Care Area

The six bedrooms in the high care area are all constructed, decorated and furnished to be used as seclusion rooms. Five of the six bedrooms have ensuites and the fittings in these ensuites are also built to a seclusion room standard. The overall impression of this area is dire with minimal furnishings, minimal decorations and minimal lighting. When we visited a small alcove area was being used as the lounge space and staff and Service Users were sitting and watching television.
We were shown large foam mattress/beds that were used extensively and had clearly been designed for safety purposes. Two of these mattress/beds were in the circulation space and were being used in lieu of other furnishings for people to sit on. The combination of a raised observation area from the "flight deck" and the austere environment focussed heavily on seclusion use, is a very intimidating environment and it is hard to imagine Service Users recovery is enhanced by this area.
In the bedroom/ seclusion rooms there were a variety of fittings made of stainless steel and immediately adjacent to these domestic, plastic fittings were being used. Staff could not give an explanation for the variety of fittings in such close proximity.
There is no ability in the high care area to provide tea and coffee for Service Users, staff need to leave the area and go to the very end of the open ward to make these drinks.
The entrance way directly into the high care area is observable from a public car park and turn around.
The treatment room is a through point from an interview room to a corridor and is too small to meet its function
There is no suitable storage space in the high care area

Conclusion

There are a number of fittings fixtures and layout design features which could be altered, short term and long term, to extend the safety and functionality of Ward 21 as an Adult Acute Admission Unit. In the time we had we made many observations which have resulted in the recommendations in this report. We would recommend a full review of the room allocation and design of the unit which will require the input of an experienced architect and potentially other building consultants.
Ward 21 is similar to many other Mental Health Services in that over time a number of decisions appear to have been made to improve the function of the service. What appears to be missing is a review of the overall function at one time of the environment i.e. the collective pieces that make up the whole. There is obvious potential in Ward 21 for such a review to significantly extend the life of this facility for its current use.

Recommendations

We recommend a number of changes some short term and relatively easily and inexpensively achieved, others for consideration in the longer term would require significant investment in the existing ward.

Existing fittings and fixtures (short term)

- Coat hooks – all require maintenance so they move easily with weight as designed
- Staff toilets – easily accessible by clients. Change the current locks to key locks same as staff keys
- Rationalise the number of slide shower fittings and disability rails within bathrooms
- Review the need to use hospital beds for something more domestic (Appendix 1)
- Review number of door returns within the unit
- Remove and replace, with suitable alternative, the window latches throughout the unit (see longer term fix)
- Suitable couches and furnishings for the high care area be accessed for more extensive seating than the alcove/ lounge area
- Landscaping or other suitable barriers are provided between the two bedrooms wings and to block the view from the newly created car park.
- Decommission the toilet in the entrance corridor – potentially storage and cupboard space
- A clear decision needs to be made by the DHB on how to manage its bed needs for this unit as flexing the available beds from 24 to 27 or even 30 changes the function of the unit, its safety and spaces for Service Users and their visitors
- Some consistency in the dress code for the unit that reflects Service Users and family's needs to be able to identify staff easily but reduces the impression of hospital institutional garments.
- We would encourage the DHB to pursue a Smokefree strategy as the presence of lighters and combustible material in the unit increases the risk of fire. Other DHB's in NZ have taken this course of action to help improve overall health outcomes for Mental Health Service Users.
- A review of ceiling fixtures and fittings, replacing sprinkler heads where they are easily accessible and hard to observe with institutional sprinkler heads. Where light fittings are

easily removed or able to be interfered with consideration should be given to permanently fixing diffusers.

- Development of a working group with local Maori, DHB or community representatives with the aim of developing a service focussed on the particular needs of Maori.

Existing fittings and fixtures (long term)

- That four or five of the rooms in the high care area be designated as standard bedrooms and redecorated accordingly and have standard plywood plinths as bed bases (see appendix 1).
- Where ensuites remain in use in seclusion rooms provision should be made for the doors to be fixed open and accommodated in a recess.
- That a beverage bay be created in the high care area (see appendix 1)
- The "flight deck" be removed in its entirety and be replaced with a small staff base which has direct access to the high care area. These areas would double as write up areas for staff completing their clinical notes
- Investigate possibility in "flight deck" alteration to create more storage space for high care area
- The opening windows in the open ward are replaced with fixed glass panes with ventilation ducting underneath these windows. (see appendix 1)
- The staff review area be investigated for a central staff hub or part thereof
- By reducing the size of the staff review area to a staff base and removing the "flight deck" a large communal area/ lounge space would become available in the very centre of the unit for Service Users and Visitors. Other review space would clearly need to be investigated but could be the court room as this is only used for this purpose for short periods of time.
- A suitably qualified and experienced architect be engaged to look at options for changing room functions/ layout.
- The admin area in the entry corridor to the ward be reduced to a reasonable size which accommodates the staff that work in there, with the remaining space converted to interview room(s)
- Options need to be investigated to review the building emergency plan so that a resolution is found to the doors opening when the fire alarms are activated.
- We suggest a rationalisation of both the alarms and locking systems within the unit with an aim to reducing the variation.
- Door hardware options should be investigated to enable Service Users to close their bedrooms in a manner which prevents other Service User access but enables easy staff access
- A more suitable treatment/ physical examination space needs to be found within the unit which adequately supports staff and respects Service Users privacy and safety

Appendix 1 – Photos

Figure 1: Bed Base

Figure 2: Bed Base

Figure 3: Fixed window with under vents

Figure 4: Tea Bay