PURPOSE

It is the Te Whatu Ora – Health New Zealand Hauora a Toi Bay of Plenty Mental Health & Addiction Service's (MH&AS) aim that services will be developed and improved through the ongoing reporting, monitoring and review of key indicators. This process will form a key part of the quality and patient safety strategy in MH&AS, through co-ordination of the risk management framework.

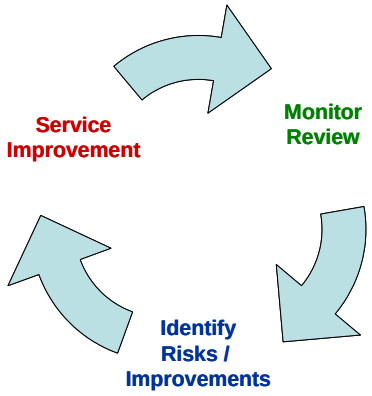
OBJECTIVE

- To monitor and review the delivery of services to ensure they reflect Nga Paerewa Health and Disability Standards NZS 8134:2021 and legal requirements and review and improve outcomes for tāngata whai ora / service users and their families / whānau.
- To ensure that the New Zealand Incident Management System and Te Whatu Ora Hauora a Toi Bay of Plenty's Quality & Compliance Management System are implemented within the MH&AS.
- To provide a framework for ongoing reporting, monitoring, and review of key indicators.
- To provide a process linking audit, evaluation and monitoring to continuous quality improvement activities within the service.
- To implement Te Tiriti o Waitangi articles for meaningful engagement in decision-making with Tangata Whenua at strategic, operational and service levels, partnering with Iwi and Māori to achieve their aspiration for health and wellbeing to eliminate inequities in Māori health.
- To ensure that professional practice development opportunities exist to support clinicians in practice.

STANDARDS TO BE MET

1. Guiding Principles

1.1. MH&AS has a commitment to ongoing service improvement opportunities through event / issue identification / reporting, service improvement actions and monitoring and review of indicators.



1.2. Event monitoring includes but is not limited to the following key indicators:

a) Incident Reports (incidents, accidents and near misses)

i. SAC 1 and 2 High Severity Incidents (Require MoH within 5 days and final reporting within 70 days)

ii. SAC 3 & 4 Incidents (Incidents / near misses of lesser actual severity)
b) Serious Incident Reviews
c) Restraint events
d) Seclusion events
e) Complaints
f) Use of ECT
g) Use of Force (as per section122B Mental Health (CAT) Act 1992)
h) Absconding / Missing patients
i) Staff and Patient accident / injuries
j) Audit findings
k) Ethical Issues
l) Compliments
m) High risk clients
n) Consumer Surveys
o) Research conducted by postgraduate students

1.3. The management and monitoring of service risk in addition to the key indicators identified above will conform to the Te Whatu Ora Hauora a Toi Bay of Plenty Risk Management Framework.
1.4. Participation in this process will occur from all staff, affected tāngata whai ora / service users and their whānau where consent is given .
1.5. Reporting and documentation of key indicators will be through established policy and procedures.

2. Serious Events

2.1 The procedure for reporting and reviewing Serious and Sentinel Events (SAC 1 and SAC 2) will follow the policy 2.1.4 Incident Management.
2.2 MH&AS will also follow the decision making process approach for reporting and reviewing serious and sentinel incidents that occur in MH&AS outlined Healing, learning and improving from harm: National adverse events policy 2023
2.3 In the event of a tāngata whai ora / service user's death by suicide, the MH&AS will follow the pathway relating to the suicide of a service user (Appendix 1).

3 Responsibilities

3.1 Employees
a) All events identified as key indicators will be recorded and reported by the employee, who is first made aware, to their line manager.
b) Employees will use the correct process and documentation when they become aware of events.

3.2 Line Managers
a) Will ensure all staff reporting to them are familiar with and trained in the process for reporting and recording events.
b) Will carry out investigations at an appropriate level, complete documentation, make recommendations on action to be taken and implement recommendations to reduce or minimise reoccurrence in their area.
c) Will ensure and document appropriate participation of the affected tāngata whai ora and whānau where consent is given.

3.3 Quality Co-ordinator & Quality Improvement Practitioner

a) Will maintain oversight of the Incident Management System (Datix) as it relates to the activity of the MH&AS.
b) Will provide timely notification to service managers about newly generated reportable events and service risks.
c) Will provide reports on activity based on key indicators being monitored.
d) Will in conjunction with service leaders, update and monitor service risks in the Risk Register.

3.4 MH&AS Management Team

a) Will ensure adequate resources are available to log and track information on key indicators.
b) Will implement appropriate recommendations through its continuous quality improvement processes.
c) Will designate the service quality co-ordinator, in conjunction with service leaders, to update and monitor service risks in the Risk Register.
d) Will review documentation of involvement of affected tāngata whai ora / service users and whānau.

4 Monitoring

4.1 Ongoing basic monitoring is established in each service, and across services, at a district management team level. Ongoing monitoring can be at unit level e.g. seclusion events or across the organisation e.g. incident reports.

4.2 Through the establishment of ongoing monitoring of these events / processes and specified key indicators, the MH&AS Quality staff and service leaders will identify trends / issues, these trends / issues which require investigation / response. Following this investigation recommendations will be made to improve service delivery, or for further, more intensive levels of review and audit to be carried out.

5 Reviews / Audit processes

5.1 MH&AS will authorise and / or endorse the initiation of data collection, storage and reporting through forms, audits, patient management systems, projects and research.

5.2 There are differing levels of review and audit, and the particular level of inquiry / review will be determined through established criteria and definitions. Some levels of review have statutory definitions that must be adhered to. The definitions are included in this policy.

5.3 Each level of review / inquiry will be defined according to level of input (internal monitoring as opposed to external inquiry), and intended outcome (to monitor key indicators), and level of risk / concern. Other forms of inquiry will also be defined, e.g. section 95 Mental Health Act, Health and Disability inquiry etc.

6 Reports and Feedback

6.1 MH&AS will ensure that documents approved for publication relating to Serious Incident Investigations, Audits, Projects, Service Utilisation Reports and other monitoring activity will be made available to internal and external stakeholders as necessary within the limits of Privacy and Information Sharing legislation.

6.2 MH&AS Managers and Clinical Co-ordinators will provide feedback to teams and initiate / monitor recommended actions.

REFERENCES

- AS/NZS ISO 31000:2009 Risk management - Principles and guidelines
- Health Quality and Safety Commission Healing, learning and improving from Harm, National Adverse Events Policy. 2023
- Mental Health and Addiction severity Assessment Code (SAC) examples 2021- 2022
- Ngā Paerewa Health & Disability Service Standards NZS 8134:2021
- National Adverse Events Reporting Policy 2017
- Reporting And Reviewing Serious & Sentinel Mental Health Incidents HSQC Commission Board Paper – 20 July 2012 - Serious & Sentinel Mental Health Incidents

ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.3.1 Complaints Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.2.4 Restraint Minimisation & Safe Practice
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.1.4 Incident Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.1.4 protocol 1 Clinical Incident Management Processes
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.4.4. Blood and Body Fluid Exposure
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 3.50.02 protocol 7 Supporting Staff
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 6.6.1 Death of a Patient
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.14 Consumers AWOL
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.27 Seclusion in MH
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.R2.13 Restraint Minimisation – Mental Health Services
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.7 Use of Force
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.4 Change of Clinician
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services Seclusion Incident Report
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services Notification of Death / Serious Incident Form
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services AWOL Internal Notification
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services Missing Person report for Police
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Services Absent Without Leave Cancellation Form
- Te Whatu Ora Hauora a Toi Bay of Plenty Mental Health & Addiction Service Use of Force Report S122(b)

Appendix 1: Pathway following the suicide of a tāngata whai ora / service user