



Waitemata
District Health Board
Best Care for Everyone

Disability Support Advisory Committee Meeting

Wednesday, 03 June 2015

1:30pm

**Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak, Auckland**

He Oranga Tika Mo Te Iti Te Rahi

Healthy Communities, Quality Healthcare

Published 28 May 2015



Waitemata
District Health Board
Best Care for Everyone

Agenda

Disability Support Advisory Committee

03 June 2015

Venue: Training Room, CCS Disability Action
14 Erson Avenue, Royal Oak

Time: 1:30pm

<p>Committee Members Sandra Coney (Chair) Jo Agnew (Deputy Chair) Max Abbott Judith Bassett Pat Booth Marie Hull-Brown Jade Farrar Dairne Kirton Dr Lester Levy Jan Moss Robyn Northey Russell Vickery Shayne WiJohn</p>	<p>Auckland and Waitemata DHB Staff Dr Dale Bramley Chief Executive Officer Waitemata DHB Ailsa Claire Chief Executive Officer Auckland DHB Samantha Dalwood Disability Strategy Coordinator WDHB Aroha Haggie Acting Māori Health Gain Manager Dr Debbie Holdsworth Director of Funding – Auckland & Waitemata DHB Katrina Lenzie-Smith Programme Manager, Health of Older People Kate Sladden Funding and Development Manager, Health of Older People Marlene Skelton Corporate Business Manager Sue Waters Chief Health Professions Officer Tim Wood Funding and Development Manager, Primary Care (Other staff members who attend for a particular item are named at the start of the respective minute)</p>
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Apologies Members: Lester Levy, Pat Booth

Apologies Staff: Tim Wood, Ailsa Claire

Agenda

Please note that agenda times are estimates only

- 1:30pm 1. Attendance and Apologies**
Welcome extended to new Committee members Shayne WiJohn and Jade Farrar
- 1:35pm 2. Register of Interests and Conflicts**
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?
- 1:40pm 3. Confirmation of Minutes 11 March 2015**
- 1:45pm 4. Action Points**
- 1:50pm 5. Chair’s Report (Verbal)**

- 2.00pm** **6. Presentations**
- 6.1 Presentation - Waitakere Emergency Department and Disability Needs
(Kay Hogan, Emergency Department Development Project Manager and Marja Peters, Charge Nurse Manager, Emergency Department Waitakere Hospital)
- 2.30pm** **6.2** Presentation - Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards: Public Spaces Work (Justin Kennedy-Good and Richard Worrall, Consultant Psychogeriatrician)
- 2.40pm** **7. Improvement Activities**
- 7.1 [Health of Older People Quarterly Report on Activities](#)
 Attachment 1: [Waitemata District Health Board Older Adults and Vulnerable Adults Abuse and Neglect Policy](#)
 Attachment 2: [Auckland District Health Board Draft Vulnerable Adults Policy](#)
- 2:55pm** **8. Papers**
- 8.1 [Amendment to Terms of Reference Auckland and Waitemata District Health Boards' Disability Support Advisory Committees](#)
 Attachment 1: [Draft Paper to Auckland and Waitemata District Health Boards: Amendment to DiSAC Terms of Reference](#)
- 8.2 [Update on Collation of Statistics that Identify People with Impairments](#)
- 8.3 [Progress Report on the Disability Implementation Plan](#)
- 3:25pm** **9. Confirm**
- 9.1 Action Points for next DiSAC meeting
- 9.2 DiSAC feedback to CPHAC
- 9.3 DiSAC feedback to Board
- 3:30pm** **10. General Business**
- 3:45pm** **11. [Resolution to Exclude the Public](#)**

Next Meeting:	Wednesday, 26 August 2015 at 1:30pm Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland
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Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare

Attendance at Disability Support Advisory Committee Meetings

Members	12 Mar. 14	04 Jun. 14	27 Aug. 14	19 Nov. 14	11 Mar. 15	03 Jun. 15	26 Aug. 15	18 Nov. 15
Sandra Coney (Chair)	1	1	1	c	1			
Max Abbott	x	x	1	c	x			
Jo Agnew (Deputy Chair)	1	1	1	c	1			
Judith Bassett	1	1	x	c	1			
Pat Booth	1	1	1	c	#			
Marie Hull-Brown	1	1	1	c	1			
Dairne Kirton	1	1	1	c	1			
Lester Levy	x	1	x	c	x			
Jan Moss	1	1	1	c	1			
Robyn Northey	1	1	1	c	1			
Russell Vickery	1	1	1	c	1			
Shayne WiJohn	-	-	-	-	-			
Jade Farrar	-	-	-	-	-			
Key: x = absent, # = leave of absence, c = meeting cancelled								

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full **nature** of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legislation.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

Register of Interests – Disability Support Advisory Committee

Member	Interest	Latest Disclosure
Sandra CONEY (Chair)	Chair – Waitakere Ranges Local Board, Auckland Council	12.12.2013
Max ABBOTT	Pro Vice Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member – AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28.09.2011
Jo AGNEW	Professional Teaching Fellow - School of Nursing, Auckland University Appointed trustee Starship Foundation Casual Staff Nurse - ADHB	01.03.2014
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation	14.05.2014
Pat BOOTH	Consulting Editor – Fairfax Suburban Papers in Auckland	24.06.2009
Marie HULL-BROWN	Employee – Mental Health Foundation of NZ Board Member – Age Concern Auckland Board Member – HOPE Foundation for Research on Ageing Advisory Committee Member – Selwyn Centre for Ageing and Spirituality	11.03.2015
Dairne KIRTON	Northern Regional Representative – CCS Disability Action National Board Grants Committee Member – Variety the Children’s Charity	25.03.2014
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Director - Orion Health (includes Director – Orion Health Corporate Trustee Ltd) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Member – State Services Commission Performance Improvement Framework Review Panel Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	19.02.2015

Jan MOSS	Coordinator – Complex Carer Group Board Member YES Disability Centre, Albany Member – SSOAS Stakeholders Group, WDHB Reference Group Member – MOH Disability Workforce NZ & Choices in Community Living	25.03.2014
Robyn NORTHEY	Self-employed Contractor - Project management, service review, planning etc. Board Member - Hope Foundation Trustee - A+ Charitable Trust	20.06.2012
Russell VICKERY	None declared	12.03.2014



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Minutes Disability Support Advisory Committee Meeting 11 March 2015

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 11 March 2015 in the Training Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1.30pm

<p>Committee Members present</p> <p>Sandra Coney (Chair) Jo Agnew (Deputy Chair) Judith Bassett Marie Hull-Brown Dairne Kirton Jan Moss Robyn Northey Russell Vickery</p>	<p>Auckland DHB and Waitemata DHB Staff present</p> <p>Sue Copas Community Engagement Manager Samantha Dalwood Disability Strategy Coordinator Dr Debbie Holdsworth Director of Funding ADHB/WDHB Marlene Skelton Corporate Business Manager Kate Sladden Funding and Development Manager, Health of Older People Jesse Taylor Corporate Committee Administrator</p> <p>(Other people who attend for a particular item are named at the start of the minute for that item)</p>
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1. ATTENDANCE AND APOLOGIES

Apologies were received from members Max Abbott, Pat Booth, and Lester Levy.

Apologies were received from Ailsa Claire (Auckland DHB Chief Executive), Sue Waters (Auckland DHB Chief Health Professions Officer), and Gilbert Wong (Auckland DHB Director Communications).

2. CONFLICTS OF INTEREST

There were no conflicts of interests for any item of the agenda.

Marie Hull-Brown provided the following updates for the register of interests:

- Board Member, Age Concern Auckland
- Board Member, HOPE Foundation for Research on Ageing
- Advisory Committee Member, Selwyn Centre for Ageing and Spirituality

3. CONFIRMATION OF MINUTES 27 August 2014 (Pages 8 - 20)

Resolution: Moved Sandra Coney / Seconded Marie Hull-Brown

That the minutes of the Disability Support Advisory Committee meeting held on 27 August 2014 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 21 - 22)

Appointed Member Vacancy

Appointment of a Māori representative to the Committee is currently with Lester Levy and Naida Glavish for action. Corporate Business Services will continue to actively follow up on the appointment process, and the Chair will assist if required.

Addition item - care for high-need young patients while in hospital

When young high-needs patients are admitted to hospital their 24/7 care is usually provided by family members for the duration of their stay. When the family members require respite a health care assistant is provided by the DHB however the assistant is unlikely to have the skills required to care for the patient. There is no formal arrangement for community carers who aren't covered by DHB contract to transfer to the hospital to provide care for a patient when required, disadvantaging the patient, family and carer.

It was agreed that Planning, Funding and Outcomes discuss this issue with the Ministry of Health with a view to formalising an arrangement to permit this. Should this be unsuccessful, a report on the issue will be circulated to the Committee with a circular resolution to make a recommendation to the Board on the matter.

Action:

- **Discuss formalising the transfer of community carers to the hospital as required to ensure adequate care is provided for young high-needs patients with the Ministry of Health. If a satisfactory resolution is not reached through these discussions, a report on the issue is to be provided to the Committee for circular resolution.**

5. CHAIR'S REPORT

There was no discussion for this item.

6. PRESENTATIONS

6.1 Suicide and Older People (Pages 23 - 24) [Note: this item was held after Item 8.2]

Dr Gary Cheung, University of Auckland Department of Psychological Medicine, provided the Committee with a presentation on suicide and the older person (appended to these minutes as Appendix 1) highlighting the following:

- To date, very limited work has been done on the issue of late life suicide, despite reports that the rate amongst the elderly population has been disproportionate and continues to rise. The intent of the research is to identify the key contributors to late life suicide and effective and opportune intervention points and methods.

- Of the three suicidal behaviours analysed (completed suicide, attempted suicide, and death wishes) an over representation for both European and Asian ethnicities is reported, and conversely an under representation of Maori and Pacific. An analysis of data recorded through InterRAI identifies key predictors of late life suicidal behaviour as being depression, physical illness or impairment, and loneliness.
- Opportunities for intervention are identified as being GP visits for a physical issue (66% of completed suicides had seen their GP within a month for an unrelated problem), and Emergency Department presentations following a suicide attempt or self-harm.
- Evidence based treatment models are available to inform intervention models, including PROSPECT which is a primary care programme for older people with depression used in the United States. The model involves a time-limited regular treatment programme with a trained interpersonal psychotherapy practitioner who uses specific techniques to look at issues of grief, role transition and/or dispute, and interpersonal sensitivity.

It also involves behavioural health integration in primary care whereby a depression specialist is based within a primary care clinic to see patients as required by the GP. A psychiatrist responsible for overseeing a case is also available by phone should the GP or depression specialist require further advice. This model is cost effective and focuses on training.

- Another intervention model briefly covered was the Tele-help and Tele-check programme run in northern Italy. Since its introduction suicide rates have decreased.

Dr Cheung agreed to provide the Committee with the paper 'A Systematic Review of Elderrlt Suicide Prevention Programme' as sited in the presentation.

The Committee commented on the limited access to mental health services in New Zealand, noting that demand on the public system and cost of private treatment create barriers for patients requiring care. It was also noted that GPs tend to normalise depression amongst the older population which in turn perpetuates feelings of loneliness and lack of purpose.

Guidance was sought from Dr Cheung as to how the Committee could best direct the focus of the DHBs to address the issue; Dr Cheung suggested the focus and investment be on strengthening capability within primary care, with a cross over between secondary and tertiary services, and routine screening with interventions in place to respond.

It was noted that the Auckland and Waitemata DHBs' Suicide Prevention Plan is scheduled to be considered at the next meeting of the Community and Public Health Advisory Committee and that this will provide an opportunity to further conversation on the issue. The Government has been prescriptive in the toolkit that has informed the plan, and DHBs will be required to identify two or three key actions from their plan as key focus areas.

Resolution: Moved Sandra Coney / Seconded Robyn Northey

That the Disability Support Advisory Committee recommend to the Community and Public Health Advisory Committee that the issue of suicide in older people and prevention be included in the Suicide Prevention Plan.

That Dr Gary Cheung, University of Auckland Department of Psychological Medicine, be thanked for his presentation on late life suicide.

Carried

6.2 Putting People First Quality Review (Pages 35 – 36) [Note: this item was held after Item 7.1]

Mark Johansson, Ministry of Health Disability Support Services, provided the Committee with a brief overview of the Putting People First Quality Review highlighting the following:

- The review was commissioned by the Minister of Health following some serious quality issues with a number of residential support services contracted by the Ministry, namely Joslin Enterprises, Mary Moodie Family Trust, and Te Roopu Taurima O Manukau. The review was undertaken by Karen Van Eden, the late Beverley Grammer, and David Russell, and looked at safeguards, support for the monitoring and review of services, and a systems approach to the quality of support services.
- Following major allegations of abuse and growing demand on a site with limited capacity the Ministry terminated its contract for service with Joslin Enterprises. Mary Moodie Family Trust's contract was also terminated, although this was due to the service alienating the families of patients and being unwilling to work to resolution, rather than abuse of patients. In both instances, patients in the care of these facilities were transitioned to other care providers and have subsequently reported improved quality of life.
- The Ministry continues to have an ongoing relationship with Te Roopu Taurima which supports around 200 people with an intellectual disability and is working successfully with the service on quality improvement and family engagement. Where possible the Ministry will actively and intensively work with a provider to manage and resolve any issues.
- 36 recommendations are made through the review which are intended to strengthen Ministry processes and provider performance, and have been categorised into three working groups with approximately 60 monitored actions that are overseen by a steering group led by Pam McNeill.
- The first actions taken were around the residential support services that are delivered on a 24/7 basis for those with the highest support requirements. The review found that a recent shift to a more national structure meant that a regional focus, including relationships with providers, was lost and accordingly a restructure to regain a regional focus was undertaken.
- The first workstream 'support providers to put disabled people at the centre of their service' is focusing on developing an all-encompassing document that identifies what good performance looks like and defines a results based accountability structure.

In response to questions and concerns from the Committee, the remaining discussion on the Review was around 'giving disabled people a voice' in the work that is being done. The Committee noted that, despite there being a dedicated workstream focusing on this issue, no members of the working group directly represent people who have been abused. Such representation should be at a national level and would likely be provided by family members and other people who are intimately involved in the care of those who are the most severely impaired. It was agreed that Mr Johansson reiterate this concern to the Ministry, and provide further information to the Committee on how the involvement of disabled people in the Review work is being facilitated. It was also agreed that Mr Johansson clarify how the sector is engaged in the quality outcomes and report back.

The need for providers to be more responsive and involving of family is recognised by the Ministry, which is working hard to turn around the 'closed rank' culture prevalent through disability support providers. The Committee noted that there needs to be systemic improvements throughout the sector rather than just targeting specific providers, and that a multi-disciplinary approach to how delivery is measured is required.

Resolution: Moved Sandra Coney / Seconded Russell Vickery

That Mark Johansson, Ministry of Health, be thanked for the update on the Putting People First Quality Review, and that the Committee look forward to receiving on-going updates on its implementation.

Carried

7. IMPROVEMENT ACTIVITIES

7.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata District Health Boards (Pages 37 - 40) [Note: this item was held after Item 5]

Kate Sladden, Funding and Development Manager Health of Older People, asked that the report be taken as read. The following points were covered in discussion of the report:

Dementia Care Pathway

- Work on a policy for secure dementia design unit is currently underway. The policy will raise the bar for care facilities, particularly with any new purpose built facilities.

Age Related Residential Care

- A forum with Asian Age Related Residential Care providers has taken place. The key marker of success will be their engagement in DHB programmes such as education sessions and cluster groups.
- All age related residential care providers will be using InterRAI as their primary assessment tool by 1 July 2015. The DHBs will establish a baseline for the proportion of residents with an interRAI assessment during the 2015/16 year. It was agreed that a report be provided to the Committee when baseline information becomes available, which can then be monitored going forward.

Older Adults and Vulnerable Adults

- Waitemata DHB has finalised the Older Adults and Vulnerable Adults Abuse and Neglect Policy, and Auckland DHB's policy is currently out for consultation. It was noted that the two policies will be similar however were not developed in tandem due to differing timing and consultation requirements. It was agreed that the two

finalised policies be provided to the Committee for information.

Home Based Support Services

- A redesigned model for home based support services is under development and the patient journey has been agreed by the working group. Further work on the cost model, categorising of patients, and how NASC fits in the redesign is required. A report on the use of values based contracting is also informing the redesign, however a lot of work is required to ensure there are no unintended consequences through introducing the concept.
- Detail on the In-between Travel Time settlement agreement has not yet been provided to DHBs. It was agreed that when this information becomes available it be included in the regular reporting to the committee. It was noted that the detailed information the Committee had requested with respect to pay rates of support workers cannot be provided as it requires private providers to release information of a commercially sensitive nature.

Quality and Safety

- Concern with the low participation rates of Age Related Residential Care providers in the Regional Falls and Pressure Injury Programme was discussed, with it noted that participation is not a requirement of the current national contract. Providers likely have their own in house programme to manage falls and pressure injuries and opt not to report this on a voluntary basis, and as such their activity in this area is probably much higher than reported. As the programme falls outside of contractual requirements the DHBs must work in partnership with providers on the matter. A direct approach with providers is being taken, and it was agreed that a progress update be provided at the next meeting of the Committee.

Actions:

- **When a baseline for the proportion of residents with an InterRAI assessment during 2015/16 becomes available a report is to be provided to the Committee which can then be monitored going forward.**
- **Once finalised, both the Auckland DHB and Waitemata DHB Older Adults and Vulnerable Adults Abuse and Neglect policies are to be provided to the Committee for information.**
- **Regular updates on the In-between Travel Time settlement are to be provided to the Committee once the information becomes available.**
- **A progress update on provider participation in the Regional Falls and Pressure Injury Programme is to be provided to the next meeting of the Committee.**

Resolution: Moved Robyn Northey / Seconded Dairne Kirton

That the Disability Support Advisory Committee receives the Health of Older People Quarterly Report on Activities in Auckland and Waitemata District Health Boards.

Carried

7.2 Implementation of the Auckland and Waitemata District Health Boards' NZ Disability Strategy (Pages 41 - 49) [Note: this item was held after Item 6.2]

Samantha Dalwood, Disability Advisor, asked that the report be taken as read, highlighting the work that has been done in DHB public spaces to improve way finding for people with cognitive impairments. The Committee asked that some examples of the signage developed through this project be presented at the next meeting.

Action:

- Examples of the signage developed to assist way finding for people with cognitive impairments is to be presented at the next Committee meeting.

Resolution: Moved Robyn Northey / Seconded Dairne Kirton

That the Disability Support Advisory Committee receive the report, which is an update on the Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards, as at 18 February 2015.

Carried**8. PAPERS****8.1 Collation of Statistics that Identify People with Impairments**

Samantha Dalwood, Disability Advisor, asked that the report be taken as read. The following points were covered through discussion and in response to questions:

- Currently information collected of patients does not include whether they identify as having an impairment or disability. Going forward this capability will be a requirement of new systems in order to identify any associated trends and inform future service planning.
- Consideration was given as to the most appropriate language to be used when collecting such information, and it was agreed that the wording used in the previous three Census' be reviewed and a suggestion be brought back to the next meeting of the Committee.

Action:

- **Wording used in the previous three Census' to identify people with a disability or impairment is to be reviewed, and a suggested approach for the Auckland and Waitemata District Health Boards' to be brought back to the next meeting of the Committee.**

Resolution: Moved Sandra Coney / Seconded Robyn Northey

That the Disability Support Advisory Committee:

- **Receive the Collation of Statistics that Identify People with Impairments report.**
- **Note that both Auckland and Waitemata District Health Boards currently collect information and report on sentinel events. However, neither District Health Board captures whether the information relates to a patient, visitor or staff member who identifies as being disabled or having an impaired function.**
- **Note both District Health Boards need to develop a consistent process that enables disability and impairment information to be collected and reported on.**
- **Request a further report on the topic be provided for the next meeting of the Committee.**

Carried

8.2 Disability Support Advisory Committees' Terms of Reference (Pages 53 - 58)

The Committee considered the proposed changes to the Terms of Reference, noting that the United Nations Convention on the Rights of Persons with Disabilities should be included. The proposed changes to the Terms of Reference were agreed as included in Appendix 2.

It was also agreed that in future, wherever the Public Health and Disability Act 2000 is referenced in relation to the functions of the Committee, quotation marks be used to ensure it is clear it is not the language of the Committee or DHBs.

The Committee will be advised if there is any reasons the United Nations Convention on the Rights of Persons with Disabilities cannot be added to the Terms of Reference, otherwise the changes will be made and progressed to the Boards' for adoption.

Resolution: Moved choose member / Seconded choose member

That the Disability Support Advisory Committee recommend that the Auckland DHB Board and Waitemata DHB Board approve the suggested amendments, and amendments made by the Committee, to the Disability Support Advisory Committees' Terms of Reference to better reflect the importance of the New Zealand Disability Strategy and other guiding strategies.

Carried

9. GENERAL BUSINESS

The Committee was advised that staff will develop a work programme for the Committee for the year ahead and will circulate this to members for input and feedback in due course.

10. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 59)

Resolution: Moved Jo Agnew / Seconded Marie Hull-Brown

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 34 for the passing of this resolution
Proposed appointment to the Disability Support Advisory Committee	To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act 1982 s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 4.05pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 11 March 2015

Chair: _____ Date: _____
Sandra Coney

Suicide in Older People:
What We Know, and, is it
Preventable?

Gary Cheung
Department of Psychological Medicine



 **Simon Collins** Simon Collins is the Herald's social issues reporter.

Youth suicide rate falls by a quarter, but elderly rate rises

11:35 AM Wednesday Aug 20, 2014

Health Mental Health

☆ 122 10 0 0





Risk factors for Late-life suicide (international literature)

- Older Age
- Male gender
- Living alone
- Bereavement (especially in men)
- Psychiatric illness (depression, previous suicide attempt)
- Physical illness (pain)
- Social disconnectedness

Previous NZ study on late-life suicide

Increase risk with

- current mood disorders
- psychiatric hospital admission within the previous year
- limited social network

(Beautrais 2002)

Outline

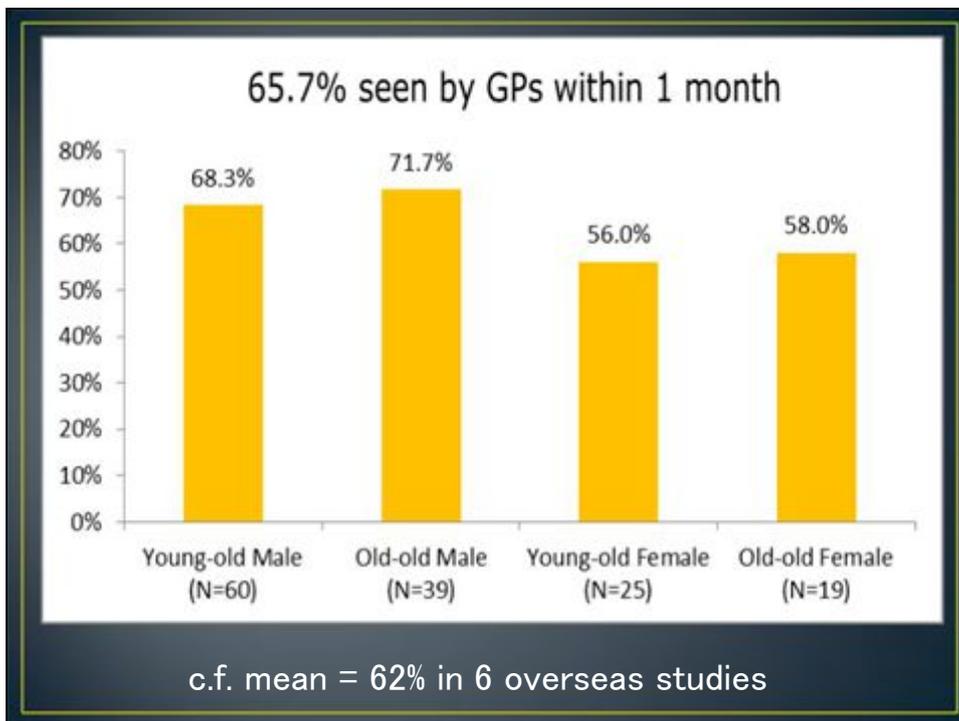
1. What We Know

- i. Completed suicides from NZ coroner records
- ii. Suicide attempt presentations to emergency departments
- iii. Death wishes reported in interRAI assessment

2. Is it Preventable?

- i. Evidence based programmes
- ii. Physical illness and suicidal behaviour

		Coroners' Cohort N=225 (2007 – 2012)	2006 Census	2013 Census
Age	mean	76.6		
	SD	7.8		
	Range	65-96		
Gender	Male	74.2%	44.6%	45.9%
Ethnicity	European	90.7%	79.8%	83.8%
	Maori	1.3%	4.7%	5.3%
	Pacific Islander	0%	2.0%	2.3%
	Asian	6.7%	3.2%	4.5%



Appendix 1

	Male N=167	Female N=58	Total N=225	p-value
Depression	58 (34.7%)	35(60.3%)	93 (41.3%)	0.001
Previous Suicide Attempt	33 (19.8%)	22 (37.9%)	55 (24.4%)	0.009

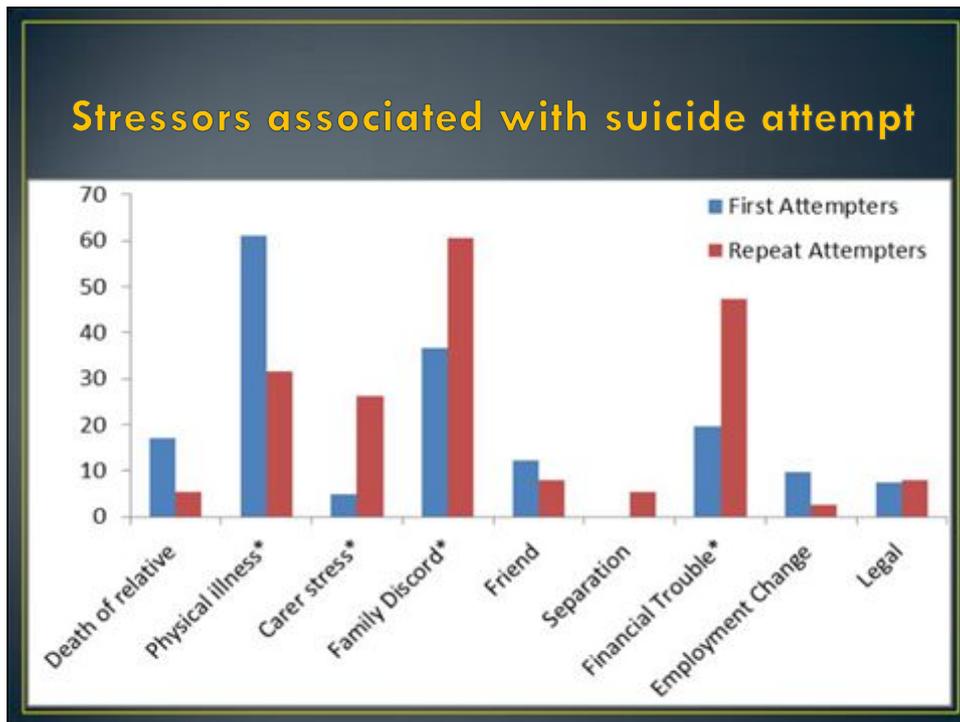
Suicide and Suicide Attempts		
	General Population	Older People
Death	1	1
Hospitalisation	5	2
Emergency Department Visit	30	4

9 to 18% of older people who had made a suicide attempt would make further attempt(s) within 12 months

(Draper, 1996)

Suicide attempt presentation to Emergency Departments in NZ

- Auckland City Hospital, Middlemore Hospital, North Shore Hospital, Waitakere Hospital, Waikato Hospital, Wellington Hospital, Christchurch Hospital
- 3 years period
- 65+



Negative statements reported in interRAI

- The ‘International Resident Assessment Instrument’ (interRAI) was developed by a network of health researchers in over 30 countries.
- Since 2012 the ‘Home Care’ version has been implemented nation-wide
- In the past 3 days,
 - “Nothing matters”; “Would rather be dead”; “what’s the use”; “Let me die”

9.5%

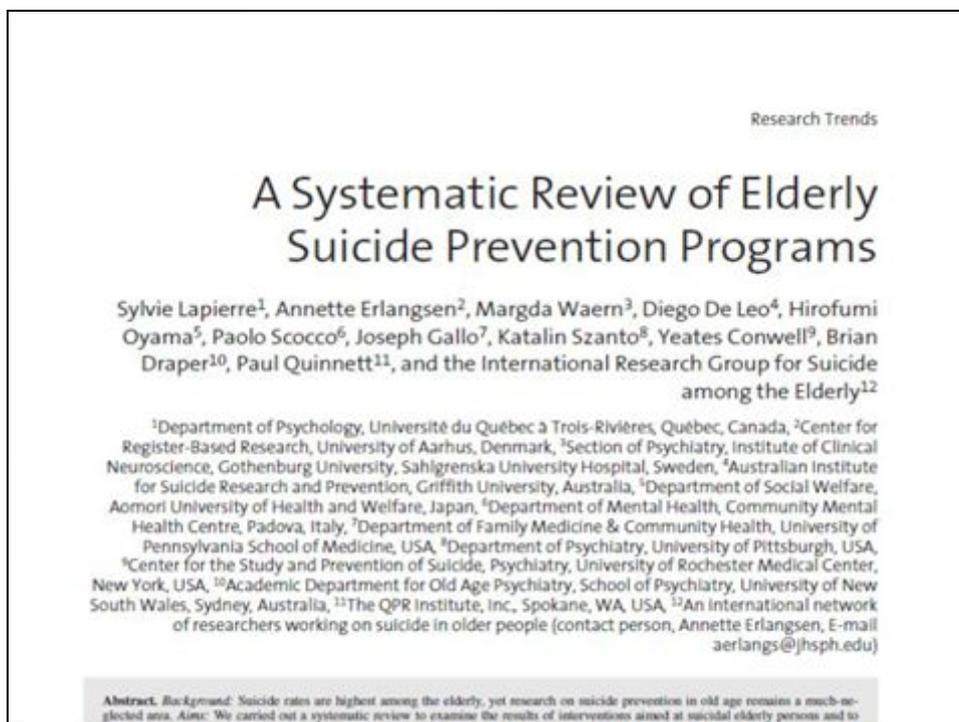
Age	Ethnicity
Gender	Living alone
Marital status	Depression
Pain	Anxiety
Self-rated health	Cognitive skills
Physical activity	Life stressors
ADL status	Social activity
Falls	Family relationship
Fatigue	Loneliness

Odds Ratio ≥ 2

Age	Ethnicity
Gender	Living alone
Marital status	Depression
Pain	Anxiety
Self-rated health	Cognitive skills
Physical activity	Life stressors
ADL status	Social activity
Falls	Family relationship
Fatigue	Loneliness

Summary

1. An over-representation of males, Europeans and Asians
2. Rates of diagnosed depression and past suicide attempt higher in females
3. Older people were more likely to have consulted their general practitioners (primarily for non-mental health issues) than psychiatric services within one month of the suicide.
4. Role of physical illness, self-rated health and perceived loneliness



Potential Late-life Suicide Prevention Strategies in NZ

1. Public health awareness and mental health literacy programmes on depression and suicide targeting older males, Europeans and Asians
2. Collaboration between primary care and mental health services for assertive screening and management of late-life depression
3. Primary care to offer support services similar to the Telehelp/Telecheck service for individuals with a higher risk of suicide.

PROSPECT study (Prevention of Suicide in Primary Care Elderly: Collaborative Trial)
(Bruce et al. 2004)

1. algorithm-driven antidepressant treatment
 2. Interpersonal psychotherapy when indicated
 3. physician, patient and family education;
 4. care management by a depression specialist
- Results – Rates of suicide ideation declined faster in intervention vs. controls

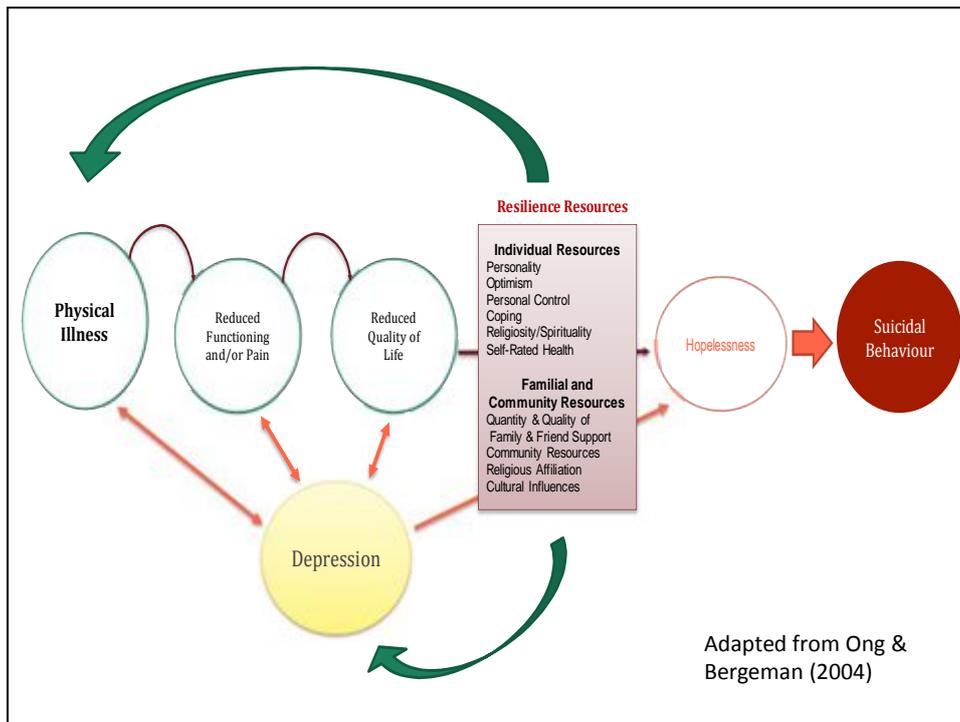
Telephone Counseling: Tele-help/Tele-check
(De Leo et al., 2002)

Tele-help - 24 hr emergency service for older people to call for help

Tele-check – 2x per week telephone support

- After 11 yrs
 - Suicide rate lower than expected
 - Reduced depression scores, hosp admissions, requests for GP home visits.
 - Impact for females only

**Physical illness and
Suicidal behaviour**



Acknowledgements:

Judge MacLean, NZ Chief Coroner

Supervisors: Sally Merry, Fred Sundram

Collaborators: Wayne de Beer, April Clugston, Susan Gee, Matthew Croucher, Adam Sims, Sally Rimkeit, Owen Martin

Psychiatric Registrars: Joanna Wang, Yu Mwee Tan

Medical students: Kody Shaw, Amy Lockwood, Siobhan Edwards, Jenny Yoon

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Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 03 June 2015

Meeting and Item	Detail of Action	Designated to	Action by
Carried forward	The Secretary was to follow up with Colleen Brown on organising a meeting with the Auckland Council Disability Group.	S Coney	Deferred until Committee carries full membership
Item 4 11 March 2015	Care for high-need young patients while in hospital Discuss formalising the transfer of community carers to the hospital as required to ensure adequate care is provided for young high-needs patients with the Ministry of health. If a satisfactory resolution is not reached through these discussions, a report on the issue is to be provided to the Committee for circular resolution.	K Sladden	Complete – see Item 7.1 on this agenda
Item 6.1 11 Mar 2015	Suicide and Older People That DiSAC recommend to the Community and Public Health Advisory Committee that the issue of suicide in older people and prevention be included in the Suicide Prevention Plan.	M Skelton	Draft plan presented to and endorsed by CPHAC 18 March 15 for submission to MoH 20 April. Issues to be given ongoing consideration by CPHAC
Item 7.1 11 Mar 2015	Age Related Residential Care All age related residential care providers will be using InterRAI by 2015. When baseline information becomes available from MoH a report is to be provided to the Committee, focusing on the impact InterRAI has had on outcomes in the community.	K Sladden	Interim Report – see Item 7.1 on this agenda
Item 7.1 11 Mar 2015	Older Adults and Vulnerable Adults Both the Auckland and Waitemata DHBs Older Adults and Vulnerable Adults Abuse and Neglect policies are to be provided to the Committee for information.	K Sladden	Complete – see Items 7.1.1 and 7.1.2 on this agenda
Item 7.1 11 Mar 2015	Home Based Support Services Regular updates on the In-between Travel Time settlement to be provided.	K Sladden	Complete – see Item 7.1 on this agenda

Item 7.1 11 Mar 2015	Quality and Safety A progress update on provider participation in the Regional Falls and Pressure Injury Programme is to be provided.	K Sladden	Complete – see Item 7.1 on this agenda
Item 7.2 11 March 2015	Implementation of the Auckland and Waitemata DHBs NZ Disability Strategy Examples of the signage developed to assist way finding for people with cognitive impairments is to be presented at the next Committee meeting.	Debbie Holdsworth /Samantha Dalwood	Complete – see Item 6.3 on this agenda
Item 8.1 11 Mar 2015	Collation of Statistics that Identify People with Impairments Census wording used to identify people with impairments/disabilities to be reviewed, and a proposed suggestion for Auckland & Waitemata DHB use to be provided to next meeting.	S Dalwood	3 Jun 15 Complete – see Item 8.3 on this agenda
Item 8.2 11 Mar 2015	Disability Support Advisory Committees' Terms of Reference That the Disability Support Advisory Committee recommend that the Auckland DHB Board and Waitemata DHB Board approve the suggested amendments, and amendments made by the Committee, to the Disability Support Advisory Committees' Terms of Reference to better reflect the importance of the New Zealand Disability Strategy and other guiding strategies.	D Holdsworth	3 Jun 15 See Item 8.1 on this agenda
Item 9.0 11 Mar 2015	Draft DiSAC Annual Work Programme Staff will develop a work programme for the Committee for the year ahead and will circulate this to members for input and feedback in due course.	K Sladden, M Skelton	Draft plan with Chair

Health of Older People Quarterly Report on Activities in Auckland and Waitemata District Health Boards

Recommendation

That the Disability Advisory Committee:

1. **Receives the report.**

Prepared by: Kate Sladden (Funding and Development Manager – Health of Older People)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

7.1

Glossary

ARRC	Age Related Residential Care
DHB	District Health Board
DiSAC	Disability Advisory Committee
DSS	Disability Support Services
HBSS	Home Based Support Services
HCSS	Home and Community Support Services
HOP	Health of Older People
IBT	In-between Travel Time
MoH	Ministry of Health
NASC	Needs Assessment Service Coordination
RFP	Request for Proposals

Executive Summary

The purpose of this report is to provide an update to the Disability Support Advisory Committee (DiSAC) on the progress of activities occurring across Auckland and Waitemata District Health Boards (DHB) for Health Older People (HOP).

Home Based Support Services

Home Based Support Services Review

The Home Based Support (HBSS) contracts for Auckland and Waitemata DHBs are being rolled over for 2015/16. During 2015/16 a request for proposals (RFP) will be undertaken for an aligned HBSS model across both DHBs. Currently a series of meetings are being held with the HOP Clinical Directors from both DHBs to ensure the proposed model is clinically robust.

At a national level, two working groups have been established as follows:

- Working Group 1 - to review Home and Community Support Services (HCSS)
- Working Group 2 - to work towards regulation of the workforce.

The Working Groups will develop reports containing recommendations in relation to both HCSS and regulation of the workforce. A Director-General's Reference Group has been set up to provide governance for this work and a final report is due by 30 June 2015.

In-between Travel Time (IBT)

The key focus in this work area at present is to ensure payment for in-between travel time (paying health care assistants for their time travelling between clients) can occur from 1 July 2015. While the Ministry of Health (MoH) and settlement parties have been working to ensure a permanent payment solution for IBT from the 1 July 2015, settlement parties have asked that the MoH consider interim arrangements. This request was largely due to concerns about the full development of the required system change to enable payment to occur throughout the sector.

It is likely that the funding will be dispersed centrally as part of the interim approach using either a travel band model or payment based on hours. Centralised funding would mean the MoH would hold appropriation during the interim phase with funding devolved once the agreed sustainable payment mechanisms is in place.

interRAI – Standardised Clinical Assessments

There has been an increase in the proportion of Waitemata DHB HBSS clients with an interRAI assessment. The most recent report (one quarter in arrears) shows:

- 75.6% of Waitemata HBSS clients have an interRAI assessment (previous quarter – 67.7%)
- 94.6% Of ADHB HBSS clients have an interRAI assessment (previous quarter – 95.1%)

Dementia Care Pathway

Waitemata Cognitive Impairment Clinical Pathway

Waitemata DHB has received the final evaluation report on the Waitemata DHB Cognitive Impairment Clinical Pathway Pilot that ran from 4 November 2013 – 31 July 2014. The evaluation was undertaken by the University of Auckland's Department of Geriatric Medicine. The report will follow formal approval processes at Waitemata and Auckland DHBs before being presented to both Boards with a request for approval to rollout the pathway to general practitioners (GPs) across both districts.

Auckland DHB Hospital Dementia Project

A dementia specialist has been recruited to work on the Auckland DHB Hospital Dementia Project. The specialist will work with key stakeholders to improve the pathway of care for patients with dementia across the hospital through education of staff and implementation of tools, such as the carer assessment tool. To date the project has been rolled out to the four Older People Health wards. The project has also been presented on a grand round.

Age Related Residential Care (ARRC)

interRAI training

All Auckland DHB and Waitemata DHB aged residential care facilities are engaged in interRAI (standardised clinical assessment) training as detailed in the table below.

interRAI Training	ADHB % (n)	WDHB % (n)
Fully competent (required number of nurses trained)	54% (35)	56% (34)
Competent (at least one nurse trained)	35% (23)	39% (24)
Currently training	8% (5)	3% (2)
Booked for training	3% (2)	2% (1)

DHB Shared Services will be providing data on the proportion of ARRC residents in each DHB with an interRAI assessment for quarterly reports in 2015/16. DHBs currently do not have access to this data.

Age Related Residential Care Certification Periods

Certification periods are a reflection of ARRC performance in audits. A facility can be certified for a maximum period of four years. All facilities will have a surveillance audit (unannounced) mid-way through their certification period. All new facilities will only be certified for one year initially. The table below shows the current certification periods for ARRC facilities in Auckland and Waitemata DHBs.

Certification Period	ADHB % (n)	WDHB % (n)
12 months	0	8% (5)
24 months	12% (8)	14.5% (9)
36 months	65% (45)	63% (39)
48 months	23% (16)	14.5 (9)

Regional Falls Programme

The Regional Falls and Pressure Injury Programme has the following elements:

- a relevant assessment tool to identify residents at risk
- intervention guides/plans for use with residents who are identified as being at risk
- participation in approved training e.g. First Do No Harm, NZACA, DHB/CNS training etc.
- data capture and reporting of falls and pressure injuries

To date there has been a low proportion of facilities submitting falls and pressure injury data. It is important to note that this is not a contractual requirement but rather an example of quality improvement where the Funder needs to work in partnership with providers to achieve better outcomes for residents. A review is underway to determine the critical elements that need to be improved in the process to enable more facilities to submit data, for example, a simplified reporting template has been developed.

Asian ARRC Support Group

A forum for Asian owned and operated ARRC facilities has been established. The aim of the forum is to better understand the issues faced by these providers so that appropriate support can be provided.

The forum focuses on increasing Asian owner/operator engagement in DHB ARRC programmes, for example cluster groups, education sessions, study days etc. Areas that have been covered to date include Needs Assessment and Coordination (NASC) processes and the national ARRC Agreement.

Older Adults and Vulnerable Adults

The Waitemata DHB Policy on Older Adult and Vulnerable Adults Abuse and Neglect is attached as Appendix One to this paper. The Auckland DHB Policy on Vulnerable Adult – Elder Abuse and Neglect is attached as Appendix Two. It is in draft, as it is yet to be published.

Response to Item 4 of the Action Points arising from the DiSAC Meeting on 11 March 2015 - care for high need patients while in hospital

At its meeting of 11 March 2015, DiSAC raised the issue that when high need clients (funded by the MoH through Disability Support Services (DSS)) are admitted to hospital, their community carers are not able to transfer to this setting to provide the additional support the patient might require.

This issue was discussed with Amanda Bleckmann, Manager - DSS at the MoH. The MoH's view is that there is flexibility regarding continued funding of carers for DSS clients when they are admitted to hospital and this will be managed on a case by case basis. However, this needs to be balanced out with DHBs' responsibilities in meeting the needs of disabled people, for example access. There are two areas where the MoH would not be prepared to continue funding, these are household management services and respite care. Amanda Bleckmann is able to be contacted about specific cases where continued community carers support may be required in hospital.

Older Adults and Vulnerable Adults Abuse and Neglect

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Older Adults and Vulnerable Adults Abuse and Neglect

1. Overview

This document covers topics relating to the definition, identification and management of abuse and neglect of vulnerable adults and older adults within Waitemata District Health Board (Waitemata DHB).

Abuse and neglect of vulnerable adults is not acceptable.

1.1 Purpose

The purpose of this document is to:

- Promote the rights and well-being of older adults and vulnerable adults.
- Provide guidelines for the identification of abuse and/ or neglect of older adults and vulnerable adults.
- Provide guidelines for the resolution of identified (or suspected) situations of older adult and vulnerable adult abuse.
- Acknowledge that this is a community and social health issue.

1.2 Scope

All Waitemata DHB employees and representatives who have dealings with people who are older adults and/ or vulnerable adults are required to follow the policy outlined herein for all cases of alleged or suspected abuse or neglect of patients/ clients that they become aware of, whether or not that person is under their direct care.

Note:

- This policy applies only to persons aged from 17 years. A separate policy exists for children under this age.
- This policy applies in situations that are outside the scope of the Family-Violence Partner Abuse Screening policy.

1.3 Terms & definitions

Term	Definition
Age Concern North Shore/ Rodney/ Auckland Central/ Waitakere	An autonomous local NGO concerned with all welfare aspects of the older person and is affiliated to a National Body "Age Concern New Zealand" which maintains various service contracts with the Ministry of Health.
Client/Patient	Individual suspected/identified as being the subject of abuse or neglect.
Elder Abuse	See page 3.
EPOA (Property) EPA (Personal Care & Welfare)	Enduring Power of Attorney for Property matters.
EPA (Personal Care & Welfare)	Enduring Power of Attorney for Personal Care & Welfare (special conditions attached).
HCP	Health Care Professional.
PPPR Act	Protection of Personal and Property Rights Act (1988).
MDT	Multi-disciplinary Team - consisting of medical, nursing and allied health professionals involved in the patient's care.

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Older Adults and Vulnerable Adults Abuse and Neglect

Terms & definitions continued

Term	Definition
OAVAAP	Older Adult and Vulnerable Adult Abuse Prevention.
Waitemata DHB OAVA Steering Group	Waitemata District Health Board Older Adult and Vulnerable Adult Steering Group – with membership including senior managers from the Medicine and Health of Older People Service and Allied Health management as well as Funding and Planning management for Health of Older People - provide guidance and support to the OAVAAP Co-ordinator role.
Waitemata DHB OAVA Working Group	Waitemata District Health Board Older Adult and Vulnerable Adult Working Group – with membership including Waitemata DHB, NZ Police, Age Concern, District Inspectors, Disability representatives - a forum where complex situations of abuse are presented by Waitemata DHB members for consideration and guidance
Vulnerable Adult	A person who is unable to withdraw himself or herself from the care of another for reasons specified in section 2.
WART	West Auckland Resource Team for Elder Abuse

7.1

2. Legal Obligations - Crimes Act

- Under the Crimes Amendment Act 2011 Waitemata DHB staff may, in some circumstances, be under a legal duty to take steps to protect vulnerable adults from ill treatment and neglect.
- A vulnerable adult is a person who is 'unable to withdraw him or herself from the care of another, by reason of:
 - detention
 - age
 - sickness
 - mental impairment
 - any other cause.'
 (Crimes Amendment Act (No 3) 2011 Part 1 4 (1) retrieved from <http://www.legislation.govt.nz/act/public/2011/0079/50.0/whole.html#DLM3650006>).
- Section 151 provides that anyone who has actual care or charge of a vulnerable adult is under a duty to 'provide that person with necessaries' *and* to 'take reasonable steps to protect them from injury', (Crimes Amendment Act (No 3) 2011).
Under Section 195 anyone who has 'care or charge' of a vulnerable adult or is a 'staff member of a hospital, institution or residence' where a vulnerable adult resides may be criminally liable if their conduct 'is likely to cause suffering, injury, adverse effect to health or any mental disorder or disability' to the vulnerable adult, (Crimes Amendment Act (No 3) 2011).
- Health care professionals have a duty of care to ensure vulnerable adults and older adults are discharged to a safe environment.
- Section 195A specifies that a person 'who is a member of the same household' as a vulnerable adult or 'a staff member of a hospital, institution or residence' where a vulnerable adult resides *and*
 - has frequent contact with the vulnerable adult *and*
 - knows the vulnerable adult is at risk of death, grievous bodily harm or sexual assault as the result of an unlawful act by another person or an omission by that person to perform a legal duty *and* fails to take reasonable steps to protect the vulnerable adult from that risk may be criminally liable, (Crimes Amendment Act (No 3) 2011).

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Older Adults and Vulnerable Adults Abuse and Neglect

- Criminal liability will only arise if the failure to protect is a 'major departure from the standard of care expected of a reasonable person', (Crimes Amendment Act (No 3) 2011 retrieved from <http://www.legislation.govt.nz/act/public/2011/0079/50.0/whole.html#DLM3650006>).

3. What is 'Older Adult & Vulnerable Adult Abuse & Neglect'?

3.1 Definitions

- Older Adult Abuse and Vulnerable Adult Abuse for the purposes of this document are defined in accordance with the Ministry of Health Elder Abuse – Family Violence Intervention Guidelines, December 2007.

For the purposes of this document *Older Adult and/or Vulnerable Adult Abuse* is defined as:
 "A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to the older or vulnerable person".

- Adult abuse occurs when an older person aged 65 or more, or vulnerable person experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another with whom they have a relationship implying trust.
- A person of any age experiencing any form of abuse is vulnerable. They may or may not fit the Crimes Amendment Act (2011) criteria of 'a vulnerable adult.'

3.2 Types of older adult abuse and vulnerable adult abuse

It is noted that there is a clinical impression of abuse being linked to "carer stress" and "burden of care". A high level of vigilance is required along with attention to carer relief and support.

Type of Abuse	Definition
Physical	Infliction of physical pain, injury or force. Includes medication abuse and inappropriate restraint or confinement.
Psychological/emotional	Behaviour which causes anguish, stress or fear (including verbal abuse, intimidation, harassment, damage to property, threats of physical or sexual abuse and the removal of decision making powers).
Sexual	Sexually abusive behaviours including forced, coerced or exploitive sexual behaviour or threats, including sexual acts imposed on a person unable to give consent or to understand.
Material/financial	The illegal or improper exploitation and/or use of funds or other resources which are the property of the older or vulnerable person and include financial abuse by a person holding Enduring Powers of Attorney (EPOA).
Institutional	Institutional abuse occurs when an institution actively or passively allows, or accepts, any form of abuse or neglect to occur. This may arise from the action or inaction of an individual as an employee, or it may be embodied in organisational systems, which fail to provide adequately for the safety and well-being of the individual patient/client.

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Older Adults and Vulnerable Adults Abuse and Neglect

3.3 Definition: Older Adult & Vulnerable Adult Neglect

Older adult or vulnerable adult neglect occurs when an older (from 65 years) or vulnerable adult experiences harmful physical, psychological, material and/ or social effects as a result of another person failing to perform functions or tasks which are a reasonable obligation of their relationship to the older or vulnerable person and are warranted by the older or vulnerable person's unmet needs.

The table below explains the forms this neglect may take:

Type of Neglect	Description
Active	Conscious and intentional actions by a carer denying/failing to provide basic necessities consequently resulting in harmful physical, psychological, material and/or social effects.
Passive	Refusal or failure by carer, because of inadequate knowledge, infirmity or disputing the value of the prescribed services, to provide basic necessities consequently resulting in harmful physical, psychological, material and/or social effects.

3.4 Definition: Older Adult & Vulnerable Adult Self-neglect

- Older Adult and Vulnerable Adult self-neglect occurs when an older or vulnerable person experiences harmful physical, psychological, material and/ or social effects as a result of failing to provide him/herself with the basic necessities for physical and/ or mental well-being.
- It is necessary to assess whether a situation is one of neglect by others, self-neglect or a combination.
- Self-neglect that is solely the result of an informed choice freely made by a competent person does not fall within the bounds of this policy.

4. Competency

Competent adults are entitled to make choices that have a negative impact on their health and wellbeing, or that may seem to be the 'wrong' choice when measured against the standards and values of others. Where there is any doubt as to a person's capacity to understand the situation they are in or foresee the consequences of their choices, then a competency assessment is likely to be necessary.

5. Enduring Power of Attorney

When the alleged abuser also holds EPOA or Welfare Guardianship for the older or vulnerable person advice will need to be sought from DHB legal services.

6. Principles

6.1 Principles which guide prevention & response to older adult and vulnerable adult abuse & neglect

- The safety of the older or vulnerable person is paramount.
- Any action should not cause more harm than the abuse or neglect, nor should it undermine the rights of the older person/ vulnerable person or their carer.
- The safety of those working with abuse should be protected. Do not work in isolation.
- Actions that are supportive and empowering assist older people and vulnerable people experiencing abuse to take control over their lives.

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Older Adults and Vulnerable Adults Abuse and Neglect

- Each adult has distinctive family/ whānau, cultural and other values that should be respected and appropriately addressed.
- A collaborative and intersectorial approach enables solutions to be found that are meaningful to the person and provides support for those working with older adult and vulnerable adult abuse and neglect.
- Consult, consult, consult. Do not work in isolation.

(Ministry of Health - Family Violence Intervention Guidelines – Elder Abuse and Neglect 2007)

7. Assessing & Reporting Abuse

7.1 Cultural perspective

Appropriate cultural consultative processes will be followed, so that the most skilled and appropriate cultural person is involved in care and proceedings. Client consent will be obtained if client has competency. Appropriate literacy assessment will be conducted to assess English proficiency and also assessment of any hearing impairment. Where required a qualified interpreter will be used when interviewing older people/ vulnerable people with hearing impairment or for those who have limited or no English language skills.

7.2 Sharing Information

Patients are provided with an explanation from staff of how health information is shared with other members of multidisciplinary health teams and General Practitioners (GPs).

7.3 Documentation

- Clearly document concerns regarding possible abuse or neglect, in the patient’s clinical record.
- This could include:
 - Unsolicited statements made by the patient, or others, explaining injuries which are at odds with physical observations of injuries.
 - Behaviours and reactions to treatment.
 - Assessments showing inconsistencies in statements or condition of patient.
 - Statements of others who have observed the patient at or just prior to admission.
 - Direct observation by Waitemata DHB clinical staff of a possible abusive situation between a patient and another person.

Note: All information must be recorded objectively.
Incorrect or unsubstantiated records can potentially lead to legal action.

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Older Adults and Vulnerable Adults Abuse and Neglect

8. Social Work Intervention

8.1 Responsibility

All Waitemata DHB social workers according to their service specifications.

8.2 When to use

In cases where there are indicators of older adult or vulnerable adult abuse or neglect.

8.3 Process

Each case is considered individually, taking into account the specific context in which it is occurring.

- The social worker will act on the premise of 'do no more harm'.
- The social worker will consult with at least one member of the OAVAAP Working Group and with the MDT in all cases where abuse is alleged.
- The social worker will bring any complex case of alleged abuse to the Waitemata DHB OAVA Working Group for consideration and guidance where there is uncertainty about the most appropriate process to follow.

8.4 Safety

- In the community setting do not visit alone a home where you believe there may be violence occurring or where you understand a dangerous person may be present.
- Ensure you have a safety plan when preparing to visit. Tell your team leader of your visiting plan, park your car on the road where you will be able to drive away, lock your car and keep the keys under your control.
- Do not discuss concerns or actions with a carer or family/ whānau member if you are uncomfortable or concerned that doing so will place you or others in danger.
- Be aware of warning signs of aggression, including threatening comments to you or others, attempts to block your exit and increasing agitation or irritation.
- Remove yourself and other support staff who are with you, i.e. cultural staff or interpreter promptly if you feel at risk.
- If you feel you or another person is in immediate danger, phone 111.
- Document concerns and notify incidents.

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Older Adults and Vulnerable Adults Abuse and Neglect

8.5 Procedure

Step	Action
1	If there are indicators of abuse - See Flowchart p.6
2	If the person does not agree to referral, the health care professional consults with their MDT and engages with social work regarding the vulnerable adult and duty of care.
3	If there is doubt as to legal responsibility the health care professional and/or social worker consults with Waitemata DHB legal service.
4	If the person meets the criteria of vulnerable adult the health care professional follows legal advice to report concern to the Police.
5	If the person does not meet the criteria of vulnerable adult, the health care professional is to provide the client with the Age Concern brochure or the Health and Disability Advocate contact information or other as appropriate.
6	If the person consents to referral, the social worker consults with the relevant cultural services as per Flowchart p.6.
7	Complete the <i>Notification of Referral to Social Work for Alleged Older Adult or Vulnerable Adult Abuse Investigation form</i> and post it in the internal mail to the OAVAAP Co-ordinator, Waitemata DHB.
8	Where the assessment is to occur in the community setting the social worker may co-work with a social work colleague and/ or other health care professional including their GP and/ or appropriate community agencies for example Age Concern, IDEA Services, the Health and Disability Commission or the Police in order to ensure the safety of the worker as well as the safety of the client.
9	Consider whether direct action to remove a client from an abusive situation needs to occur.
10	Appropriate to their Service, the social worker conducts an initial risk assessment with the person and whanau/care-giver as indicated. The risk assessment will inform the process.
IF ABUSE AND NEGLECT IS HAPPENING	
11	Where indicated notification to the Police regarding ill-treatment or neglect of an older/ vulnerable adult is to occur.
12	If the person is competent, the social worker works with the client and family/ caregiver/ multi-disciplinary team/ and Waitemata DHB and community agencies as appropriate to develop a safety plan.
13	If the person is not competent the social worker engages with the EPOA, family/whanau, and/or Waitemata DHB legal services to follow the legal processes (EPOA, PPPR Act 1988) in conjunction with MDT to ensure client safety.
IF ABUSE AND NEGLECT IS NOT HAPPENING	
14	Report back to referrer, document findings and discharge client.
15	Documentation is clear accurate and timely throughout this process reflecting Waitemata DHB <i>Clinical Documentation</i> policy.

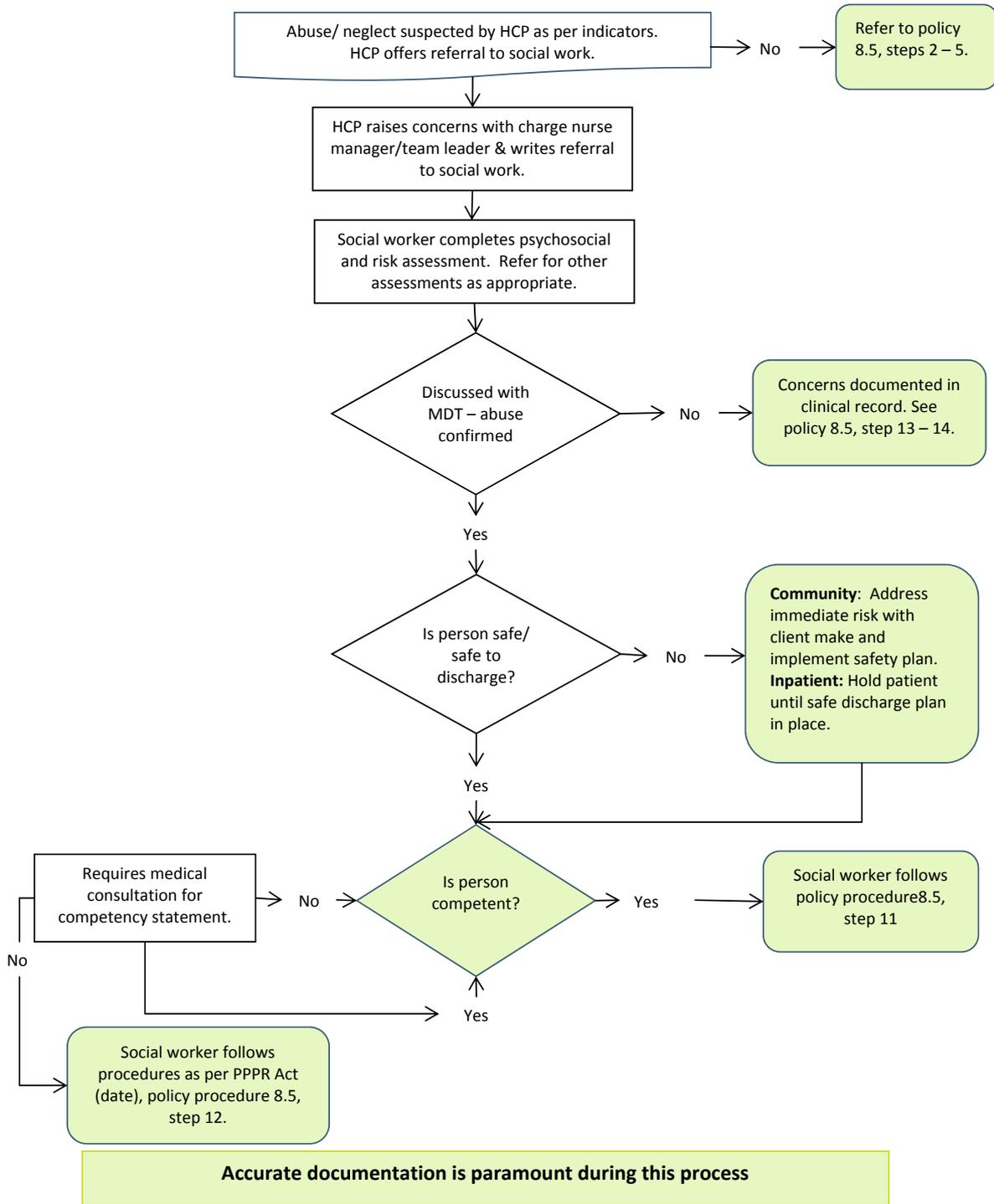
The social worker may bring the client's situation to the Waitemata DHB OAVA Working Group at any time through their intervention for guidance and assistance.

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Older Adults and Vulnerable Adults Abuse and Neglect

9. Assessing & Reporting Abuse - Flow Chart



7.1

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Older Adults and Vulnerable Adults Abuse and Neglect

10. Staff Training to Manage Older Adult & Vulnerable Adult Abuse & Neglect

10.1 Training and education

- **All clinical staff working with older and vulnerable adults** are required to demonstrate competence in responding to people at risk of experiencing abuse.
- Each service will require their staff to complete the e-learning module regarding working with older and vulnerable adults and recognising the indicators of abuse. The on-line CALD competency modules 1 and 4 together with review of the CALD Older Adult training back is essential for clinicians working with older and vulnerable adults.
- Each service will provide adequate training opportunities to enable and support their staff to achieve competence in following procedure regarding older adult and vulnerable adult abuse.
- Social workers working with adults and older adults are required to demonstrate competence in working with patients/clients who are vulnerable and who display indicators of abuse. They are required to be proficient in older adult and vulnerable adult abuse assessment and intervention.
- Clinical leaders or senior clinicians will audit the competency of staff members annually as a part of their clinical practice audit, and provide evidence of education achieved and audits undertaken to the OAVAAP coordinator for reporting purposes.

10.2 Staff Understanding and Awareness

Waitemata DHB Older Adult and Vulnerable Adult Abuse Prevention Steering Group

The steering group has leaders of adult services including the general manager of Medicine and Health of Older People, the head of division Allied Health Medicine and Health of Older People & Surgical and Ambulatory Services, the operations manager of Older Adults and Home Health, and the director of allied health along with the OAVAAP co-ordinator as well as the Health of Older People Funding and Planning manager. This group meets at least quarterly to support the role of the OAVAAP co-ordinator and to ensure that the Ministry of Health Family Violence Intervention Guidelines – Elder Abuse and Neglect (2007) and the Crimes Amendment (No. 3) Act (2011) in relation to the protection of vulnerable adults are woven in to policy and practice within the Waitemata DHB.

Waitemata DHB Older Adult and Vulnerable Adult (OAVA) Working Group

The Waitemata DHB OAVA Working Group will meet monthly and have senior practitioners proficient in working with older adult abuse from each service that work with older adults and vulnerable adults across the Waitemata DHB, and would invite elder abuse coordinators and/or social workers from Age Concern and members of the Police and legal profession for consultative purposes.

The role of the group is to:

To advocate for non-discriminatory practices and policy within the Waitemata DHB and in the wider community.

- Provide a forum for up-to-date information sharing and be a reference point for working with older and vulnerable adults and situations of abuse, and the prevention of abuse for Waitemata DHB services.
- Promote a consistent across-services approach to attending to prevention of abuse and addressing older and vulnerable adult abuse issues.
- Provide advice in the development and review of policy relating to older adults and vulnerable adults and the prevention of older adult and vulnerable adult abuse at a service and organisational level.

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Older Adults and Vulnerable Adults Abuse and Neglect

- Provide guidance in educating staff to be able to:
 1. Identify vulnerable adults and to know their responsibilities to vulnerable adults.
 2. To identify situations which may be older adult abuse or vulnerable adult abuse and know their part in the processes to attend to situations of alleged abuse.
 3. To recognise ageist and discriminatory behaviour –their own or others.
 4. To act to prevent abuse.
 5. To be able to document occurrences and action taken competently.
- Provide guidance on the assessment and audit of staff and service competency in this area.
- Receive, monitor and report to family violence coordinator on the audits of service competency in attending to older adult’s abuse and neglect.
- Develop staff awareness and expertise in vulnerable adult response through publishing committee findings, reports, and minutes.

7.1

10.3 Link with Representation

All services working with adults (17 years and over) and older adults (65 years and over) will follow consistent procedures for referral of suspected older adult and vulnerable adult abuse and neglect to social workers. Social workers will consult with the Waitemata DHB OAVAAP Working Group as required.

11. Emergency Situations

In emergencies where the patient/client is at risk of serious harm (physical, psychological, sexual, financial, consequences of self-neglect, etc), urgent assessment and management is required, potentially involving Police intervention and an immediate safety plan. Any action of this type must be discussed with Waitemata DHB Legal Services and the manager of the service.

12. Consent

- Decisions around the management of the patient/ client, where possible and appropriate, will happen with the consent of the patient/ client.
- Where the patient/ client lacks capacity and the patient/ client has appointed person/s as EPOA Health and Welfare and EPOA Property, the EPOA must be sighted and verified and a copy of this document placed on the patient/client’s clinical record along with proof of activation of the EPOA before the person appointed as EPOA can act in that capacity. Please refer to the Informed Consent Policy.
- Where engagement of services outside Waitemata DHB are to take place, this will not be at a legal risk to Waitemata DHB.

13. Confidentiality/ Information Sharing

An assurance of confidentiality cannot be given to patients/ clients. There are many instances where the organisation is required, or authorised, to disclose confidential information (eg in legal proceedings). Guaranteeing confidentiality, and subsequently breaking that promise, can lead to a breakdown in trust.

It is recommended to state:

*“Where your safety is considered to be at risk we are **legally required, and permitted, to disclose information.**”*

All information sharing will be undertaken with due regard to the Privacy Act 1993.

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Older Adults and Vulnerable Adults Abuse and Neglect

14. Institutional Abuse

14.1 Expectations

- All older adults and vulnerable adults will be treated with respect and dignity.
- All staff providing services are aware of the particular needs of older adults and vulnerable adults and ensure that the care provided is tailored to minimise stress and anxiety.

15. Associated Documents

Type	Description
Legislation	<ul style="list-style-type: none"> • Protection of Personal and Property Rights Act, 1988 • Domestic Violence Act, 1995 • Crimes Act (No. 3) Amendment, 2011 • Health Information Privacy Code, 1994 • Health and Disability Sector Standards Regulations 2001 • Privacy Act, 1993 • Mental Health (Compulsory Assessment and Treatment) Act 1992
WaitemataDHB Policies	<ul style="list-style-type: none"> • Health Information – privacy – general 2012 • Neglect & Abuse Assessment and Reporting 2008 Nov • Family Violence/Partner Abuse Screening March 2014 • Clinical Documentation Policy 2013 • Informed Consent (Summary Oct 2006) • Safety – Clinical Practice 2012 • Discharge of Vulnerable patients from ED/ADU 2013 • Waitemata DHB Values 2014 • PPP&R Competence Assessment Applications Nov 2010 • Elder Abuse and Neglect, 2013 • Violence Management and Code Orange Teams Dec 2012
Articles & Reports	<ul style="list-style-type: none"> • Promoting the Rights & Well-being of Older People & Those who Care for Them – Age Concern, 1992 • Elder Abuse – Its Detection and Management – E.A. Bowie • Living Standards of Older New Zealanders by The Ministry of Social Policy • The New Zealand Positive Ageing Strategy Action Plan, 1 July 2001 to 30 June 2002 by the Senior Citizens • <i>Patient Management</i>, Sept. 1996 • Statement of Government Policy on Adult Safeguarding, Department of Health, United Kingdom 16th May 2011 • International Year of Older Persons 1999 Final Report by the Senior Citizens Unit of the Ministry of Social Policy • Factors Affecting the Ability of Older People to Live Independently. A report for the International Year of Older Persons by Maire Dwyer, Alison Gray and Margery Renwick. • The Social Report Indicators of Social Wellbeing in New Zealand by The Ministry for Social Policy (2001) • “Dementia in New Zealand: improving quality in residential care”: Disability Issues Directorate 2002. • “How should we care for the Carers”, National Health Committee Report, June 1998. • Elder Abuse – Family Violence Intervention Guidelines, Ministry of Health 2007 • Health of Older People Strategy 2002

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Document Title
Vulnerable Adult – Elder abuse and neglect

Document Type	Policy (delete one)
Function	Clinical Service Delivery
Healthcare Service Group (HSG)	Auckland District Health Board
Department(s) affected	all
Patients affected (if applicable)	
Staff members affected	ADHB clinicians and access holders or representatives
Key words (not part of title)	
Author – role only	Social Work Professional Leader
Owner (see ownership structure)	Chief Professions Health Officer
Edited by	Clinical Policy Advisor
Date first published	TBA – office use only
Date this version published	TBA – office use only
Date of next scheduled review	TBA – office use only
Unique Identifier	TBA – office use only

7.1

Contents

1. The purpose of this document is to:

- Promote the rights and well-being of all older and vulnerable adults
- Provide guidelines for the identification of elder abuse and/ or neglect of the older person and all other vulnerable adults
- Provide guidelines for the resolution of identified (or suspected) situations of elder abuse, or abuse and/or neglect of a vulnerable adult
- Acknowledge that this is a social issue with significant health implications

2. Legal Obligations – Crimes Act

- Abuse and neglect of any vulnerable adult is not acceptable. The Crimes Amendment Act (No 3) came into effect in March 2012. It brings forth a new regime of criminal liability for persons caring for and working with vulnerable adults. The new law makes it an offence to fail to protect a vulnerable adult
- Everyone who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty;
 - a. to provide that person with necessaries; and
 - b. to take reasonable steps to protect that person from injury
- As a result of this legislation Auckland DHB staff may, in some circumstances, be under a legal duty to take steps to protect vulnerable adults from ill treatment and neglect.

- Under Section 195 anyone who has the care or charge of a vulnerable adult or is a staff member of a hospital, institution or residence where a vulnerable adult resides may be criminally liable if their conduct is likely to cause suffering, injury, adverse effect to health or any mental disorder or disability to the vulnerable adult.
- Health care professionals (HCP) have a duty of care to ensure older and vulnerable adults are discharged to a safe environment
- Section 195A specifies that a person who is a member of the same household as a vulnerable adult or a staff member of a hospital, institution or residence where a vulnerable adult resides *and*
 - has frequent contact with the vulnerable adult *and*
 - knows that vulnerable adult is at risk of death, grievous bodily harm or sexual assault as a result of an unlawful act by another person or an omission by that person to perform a legal duty *and*
 - fails to take reasonable steps to protect the vulnerable adult from that risk may be criminally liable
- Criminal liability will only arise if the failure to protect is a major departure from the standard of care expected of a reasonable person, (2011 Crimes Amendment Act (No 3) retrieved from <http://www.legislation.govt.nz/act/public/2011/0079/50.0/whole.html#DLM3650006>)
- Older Adult Abuse and Vulnerable Adult Abuse for the purposes of this document are defined in accordance with the Ministry of Health Elder Abuse – Family Violence Interventions Guidelines, December 2007

3. Scope

All ADHB employees and representatives who have dealings with people who are older adults and/or vulnerable adults are required to follow this policy for all cases of alleged or suspected abuse or neglect of patients/clients that they are aware of, whether or not the person is the subject of their direct care.

Note:

- This policy only applies to persons aged from 17 years. A separate policy exists for children under this age
- This policy applies in situations that are outside the scope of the Family Violence Partner Abuse policy

4. Definitions

- A vulnerable adult is defined in the law as “a person unable by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person”
- For the purposes of this document elder abuse is defined as; a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person
- Abuse of vulnerable adults occurs when the person experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another with whom they have a relationship implying trust

Types of abuse

It is noted that there is a clinical impression of increased risk of abuse being linked to carer stress and the burden of care. A level of vigilance is required to assess this stress along with attention to carer relief and support

Physical

The infliction of physical pain, injury or force, this includes medication abuse and inappropriate restraint or confinement

Psychological / emotional

Behaviour which causes anguish, stress or fear (including verbal abuse, intimidation, harassment, damage to property, threats of physical or sexual abuse and the removal of decision making powers)

Sexual

Sexually abuse behaviours including forced, coerced or exploitive sexual behaviour or threats, including sexual acts imposed on a person unable to give consent or to understand

Material / financial

The illegal or improper exploitation and / or use of funds or other resources which are the property of the vulnerable adult, including financial abuse by a person holding Enduring Powers of Attorney (EPA)

Institutional

Institutional abuse occurs when an institution actively or passively allows, or accepts, any form of abuse or neglect to occur. This may arise from the action or inaction of an individual as an employee, or it may be embodied in organisational systems, which fail to provide adequately for the safety and well being of the individual patient/ client.

Defining neglect

Neglect occurs when a vulnerable adult experiences harmful physical, psychological, material and / or social effects as a result of another person failing to perform functions or tasks which are a reasonable obligation of their relationship to the older person and are warranted by the vulnerable adult's unmet needs.

The table below explains the forms this neglect may take

Type of neglect	Description
Active	Conscious and intentional actions by a carer denying / failing to provide basic necessities consequently resulting in harmful physical, psychological, material and / or social effects
Passive	Refusal or failure by carer, because of inadequate knowledge, infirmity or disputing the value of the prescribed services, to provide basic necessities consequently resulting in harmful physical, psychological, material and/ or social effects

Type of neglect	Description
Self-neglect	Self-neglect occurs when a vulnerable adult experiences harmful physical, psychological, material and/ or social effects as a result of failing to provide him/ herself with the basic necessities for physical and / or mental well being. In some situations it will be necessary to assess whether a situation is one of neglect by others, self-neglect or a combination

5. Competency

Competent adults are entitled to make choices that have a negative impact on their health and wellbeing, or that may seem to be the ‘wrong’ choice when measured against the values and standards of others. Where there is any doubt as to a person’s capacity to understand the situation they are in or foresee the consequences of their choices, then a competency assessment is likely to be necessary.

6. Enduring Power of Attorney

When the alleged perpetrator of the harm also holds Enduring Power of Attorney or is the Welfare Guardian for the older or vulnerable person advice will need to be sought from ADHB legal services.

7. Assessing and reporting abuse or neglect – best practice assumptions

- The safety of the older or vulnerable adult is to be given paramount consideration in all decisions
- Any action taken should not cause more harm than the abuse or neglect nor undermine the rights of the older or vulnerable adult or their carer/s
- The safety of those working with vulnerable adults in relation to abuse or neglect should be protected, one of the ways to do this is to ensure you do not work alone
- Actions that are supportive and empowering assist older and vulnerable adults experiencing abuse or neglect to make choices and take control over their lives
- Each older or vulnerable adult has distinctive whanau, cultural and other values that should be respected and appropriately addressed
- Appropriate cultural consultation will occur so that the most skilled and appropriate cultural support and guidance is provided to those who are involved in responding to older and vulnerable adults. Ensure issues associated with health literacy, English proficiency and hearing are taken into account when engaging in assessment activity
- Where required a qualified interpreter will be used when interviewing older, or vulnerable adults
- A collaborative and multiagency approach enables solutions to be found that are meaningful to the older or vulnerable adult and provide support for those working in the area
- Each situation is considered individually, taking into account the specific context in which it is occurring
- Every health professional charged with undertaking assessment, and intervention in relation to possible abuse or harm of a vulnerable, or older adult will act on the premise of ‘do no more harm’

- Health Social Workers are likely to take a lead role in the assessment, intervention planning, and monitoring of situations involving possible harm to an older or vulnerable adult. While it is every body's responsibility to act, some professions will be better equipped to respond to the more complex situations, and in these situations a referral to a health social worker is encouraged
- All assessment and intervention planning will occur in the context of the multidisciplinary team – it is critical that all relevant factors are considered when assessing concerns
- An assurance of confidentiality cannot be given to consumers. There are many instances where the organisation is required, or authorised, to disclose confidential information (e.g. in legal proceedings). Guaranteeing confidentiality, and subsequently breaking that promise, can lead to a breakdown in trust. Therefore it is recommended to state that “We will do our best to keep this confidential, but there are occasions when we are legally required, or permitted, to disclose information.” All information sharing will be undertaken with due regard to the Privacy Act 1993
- Clearly document concerns regarding possible abuse or neglect in the patient's clinical record. All information is to be recorded objectively. The types of things you *must* record include the following:
 - Unsolicited statements made by the patient, or others, explaining inquiries that are at odds with your clinical assessment / physical observation of injuries
 - Behaviours and reactions to treatment
 - Assessments that highlight inconsistencies in statements or the condition of the patient
 - Statements for others who have observed the patient during or just prior to the admission
 - Direct observations by ADHB clinical staff regarding a possible abuse situation between a vulnerable adult patient, and another person
- Safety, in the community setting do not visit alone where you believe there may be violence occurring or where you suspect a dangerous person may be present
 - Ensure you have a safety plan when you visit, tell a colleague about your plan
 - Do not discuss concerns or actions with a carer or family/whanau member if you are uncomfortable or concerned that doing so may place you or others in danger
 - Maintain awareness of warning signs of aggression, including threatening comments, attempts to block your exit and increasing agitation or irritation
 - If you feel you or another person is in immediate danger, phone 111
 - Document concerns and notify incidents
 - In emergencies where the patient / client / service user is at risk of serious harm as a result of possible abuse and / or neglect urgent assessment and management may be required. In rare circumstances this may involve the Police, and emergency protection measures. Any action of this type must be discussed and agreed with the service areas Family Safety Facilitator and a senior member of staff from the service area responsible for the consumer at the time the issues are identified

8. Procedure

Step	Actions
1	If there are indicators of abuse – see flowchart p.7
2	If the person does not agree to an assessment consult with your multidisciplinary team, and engage a health social worker to assist you. Consider consultation with the ADHB Older / Vulnerable Adult Multiagency Advisory Group
3	If there is doubt as to legal responsibility ensure consultation with a member of the ADHB Legal Services
4	If the person meets the criteria of being a vulnerable adult consideration must be given to reporting the concern to the police
5	Complete the <i>Notification of Concern</i> to the ADHB Older / Vulnerable Adult Multiagency Advisory Group (ADHB OVAMAG)
6	Where the assessment is to occur in the community you are encouraged to co-work, consider partnering with a social worker, GP and/or appropriate community agencies for example, Age Concern, IDEA Services, Advocates from the health and Disability Commission or the Police in order to ensure the safety of both the patient / client and worker
7	Consider whether direct action to remove the client from an abusive situation needs to occur
8	Appropriate to your service, the health practitioner conducts an initial assessment of the concerns related to the patient/clients safety in the context of their family / whanau / caregiving arrangements. The assessment of the level and extent of the harm will inform the actions you take
If abuse and / or neglect is identified	
9	Where indicated notification to the Police regarding ill-treatment or neglect of an older / vulnerable adult is to occur
10	If the person is competent, the health professional works with the client and family / caregiver/ multidisciplinary team / and community agencies as appropriate to develop a safety plan
11	If the person is not competent engage with the EPOA, family/whanau, and/or ADHB Legal Services to follow the legal process (EPOA, PPPR Act 1988) in conjunction with the MDT to ensure client safety
12	All staff are encouraged to seek guidance for any or all steps in this process from the ADHB Older / Vulnerable Adult Multiagency Advisory Group. This group can be called together at short notice if required. Practice accountability to this group in situations that could be described as complex and/or serious is strongly encouraged
13	Consider the appropriateness of a Family Violence Alert – apply sound clinical reasoning if a decision is made not to place an alert – the summary report below will inform the alert
14	Send <i>summary report</i> (on standard template) of findings to ADHB OVAMAG
If there is no finding of concern	
15	If the situation has been referred to you (in the situation of your being a health social worker), report back to the referrer, document the findings in the clinical record, discharge the client and provide a <i>summary report</i> of the outcome to ADHB OVAMAG

9. Assessing and reporting flowchart

Abuse or neglect suspected, gain consent for assessment

Refer to procedure step 2

Consult with senior colleagues, MDT and if indicators of complexity discuss with the ADHB OVAMAG

Complete the psychosocial and risk assessment. Work in partnership and ensure other assessments occur as required e.g. competence

Abuse and or neglect found (is an family violence alert appropriate?)

Case discharged - see procedure step 13

Is the person safe / safe to discharge?

Community: address immediate risk with client, develop and support client to implement plan
 Inpatient: do not discharge patient until a safe discharge plan has been developed

Requires medical consultation for competency assessment

Is the person competent?

Yes Follow procedures step 10 to 15

No

No

yes

MDT, with named key worker follows procedures as per PPPR ADHB Practice Guide

10. Training and education

- All clinical staff working with older people (65 and over) are required to demonstrate competence in responding to people at risk of experiencing abuse and / or neglect
- All clinical staff working with a predominance of vulnerable adults (i.e. those working in mental health services) are required to demonstrate competence in responding to people at risk of experiencing abuse and / or neglect
- Each service area will have a procedure whereby the competence of the staff is assessed on an annual basis
- Each service will require and support their staff to attend appropriate training regarding working with vulnerable adults, including recognition and response to indicators of abuse. The on-line CALD competency modules 1 and 4 together with review of the CALD Older Adult training pack is essential for clinicians working with older and vulnerable adults
- Health social workers, who are in a position to receive referrals to assess allegations of abuse or neglect of older or vulnerable adults are required to demonstrate competence in working with patients/ clients / service users who display indicators of vulnerability and risk associated with possible abuse and neglect. This includes competence in the following areas;
 - Assessment, including risk assessment
 - Intervention planning
 - Safety Planning
 - Multiagency working
 - Relationship based practice
 - Cultural competence
- Services will actively monitor the competency of staff members, and the volume of work associated with older and vulnerable adults safety and risk to ensure adequate support, and resources are made available as required
- Each service area that services significant numbers of older and/or vulnerable adults will identify a Family Safety Facilitator who will take responsibility for;
 - Providing support and guidance to others in relation to the assessment and management of these cases
 - Undertaking the work themselves when this is appropriate
 - Providing an annual report to the ADHB OVAMAG on the standard template

11. ADHB Older and Vulnerable Adults Multiagency Group (ADHB OVAMAG)

The role of the ADHB OVAMAG is to develop Terms of Reference which will enable them to undertake the following functions:

- provide clinical advice, support and guidance at a regular forum and ensure capacity to provide urgent advice on a case-by-case basis
- provide guidance in the development and implementation of training programmes for staff that address issues of older and vulnerable adult abuse and neglect – with a primary focus on identification, assessment and proactive multidisciplinary and multiagency case management

- provide guidance, including the development of audit and annual report templates to support the critical review of ADHB's capacity, competence and commitment to services for older and vulnerable adults
- review, analyse and respond to the audits, and annual reports with a focus on continuous quality improvement
- develop and maintain staff awareness, commitment and expertise in relation to abuse and neglect services for older and vulnerable adults by providing annual updates, an annual report to the ADHB Family Safety Governance Group, and on-going educational forums
- ensure active representation of appropriate disciplines, and agencies
- support culturally responsive services for all patients / clients / family and whanau
- support the development of the capacity of Family Safety Facilitators to an advanced level of competence in this field of practice
- represent ADHB OVAMAG on the ADHB Family Safety Governance Group

12. Legislation (sometimes required for a policy)

- Protection of Personal and Property Rights Act, 1988
- Domestic Violence Act, 1995
- Crimes Act 1992
- The Crimes Amendment Act (No 3), 2011
- Health Information Privacy Code, 1994
- Health and Disability Sector Standards Regulations, 2001
- Privacy Act, 1993
- Mental Health (Compulsory Assessment and Treatment) Act, 1992

13. Associated ADHB documents (always required)

- [Partner Abuse Intervention - Family Violence](#)
- Tikanga Best Practice
- Clinical Record Management
- Bicultural Policy

14. Disclaimer (always required)

15. for a guideline - we will add the text for you)

16. Corrections and amendments (we will add the text for you)

Amendment to Terms of Reference - Auckland and Waitemata District Health Boards' Disability Support Advisory Committees

Recommendation

That the Disability Advisory Committee note:

1. The attached draft paper to the Auckland and Waitemata District Health Board Boards, which sets out proposed amendments to the Committees' Terms of Reference to better reflect the importance of the Committees' advice and recommendations aligning with *New Zealand Disability Strategy*, as well as other frameworks that guide the health sector in improving disability support services including the *United Nations Convention on the Rights of Persons with Disabilities*.
2. That the Chair of the Auckland and Waitemata District Health Board Boards intends to advise the Minister of Health of the proposed amendments to the Committees' Terms of Reference.
3. That, subject to the Minister of Health's agreement to the proposed amendments to the Committees' Terms of Reference, the attached draft paper will be submitted to the Auckland and Waitemata District Health Board Boards.

8.1

Prepared by: Dr Debbie Holdsworth (Director Funding)

Glossary

Convention	-	United Nations Convention on the Rights of Persons with Disabilities
DHB	-	District Health Board
DiSAC	-	Auckland and Waitemata District Health Boards' Disability Support Advisory Committees
NZPHD Act	-	New Zealand Public Health and Disability Act 2000
Strategy	-	New Zealand Disability Strategy
TOR	-	Terms of Reference

Executive Summary

In 2014, the joint Auckland and Waitemata District Health Boards' (DHB) Disability Support Advisory Committee (DiSAC) requested its Terms of Reference (TOR) be reviewed, with a view to including specific reference to the New Zealand Disability Strategy (Strategy) and other policies which provide the framework for the direction of the disability sector in improving disability support services.

DiSAC considered a set of suggested amendments to its TOR at its meeting of 11 March 2015, and resolved to recommend to the Auckland and Waitemata DHB Boards that the suggested amendments be approved, along with a number of other changes, including specific reference in the TOR to the United Nations Convention on the Rights of Persons with Disabilities (Convention).

Auckland and Waitemata District Health Boards
Disability Support Advisory Committee, 3 June 2015.

A paper has been prepared to submit to the Auckland and Waitemata DHB Boards. It attaches DiSAC's TOR as Appendix One with the suggested amendments to reference the Strategy, the Convention and other policy documents which provide the framework for the direction of the disability sector in improving disability support services, shown in tracked changes. This opportunity to amend the TOR has also been used to correct other administrative features.

The Chair of the Auckland and Waitemata DHB Boards will advise the Minister of Health of the proposed amendments to the Committees' Terms of Reference.

Subject to the Minister of Health's agreement to the proposed amendments to DiSAC's TOR, the attached draft paper will be submitted to the Auckland and Waitemata DHB Boards.

Draft Paper to Auckland and Waitemata District Health Boards

Amendment to Terms of Reference - Auckland and Waitemata District Health Boards' Disability Support Advisory Committees

Recommendation

That the Board:

1. Note the recommendation from the joint Auckland and Waitemata District Health Boards' Disability Support Advisory Committee that its Terms of Reference be amended to better reflect the importance of the Committees' advice and recommendations aligning with *New Zealand Disability Strategy*, as well as other frameworks that guide the disability sector in improving disability support services including the *United Nations Convention on the Rights of Persons with Disabilities*.
2. Approve the amendments to the Disability Support Advisory Committees' Terms of Reference as set out in Appendix 1.

Prepared by: Dr Debbie Holdsworth (Director Funding)

Glossary

Convention	-	United Nations Convention on the Rights of Persons with Disabilities
DHB	-	District Health Board
DiSAC	-	Auckland and Waitemata District Health Boards' Disability Support Advisory Committees
NZPHD Act	-	New Zealand Public Health and Disability Act 2000
Strategy	-	New Zealand Disability Strategy
TOR	-	Terms of Reference

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DiSAC considered a set of suggested amendments to its TOR at its meeting of 11 March 2015, and resolved to recommend to the Auckland and Waitemata DHB Boards that the suggested amendments be approved, along with a number of other changes, including specific reference in the TOR to the United Nations Convention on the Rights of Persons with Disabilities (Convention).

New Zealand signed the Convention on 30 March 2007 and ratified on 26 September 2008. New policy must be consistent with the Convention, or New Zealand will be in breach of its obligations.

DiSAC's TOR are attached to this paper as Appendix One with suggested amendments to reference the Strategy, the Convention and other policy documents which provide the framework for the direction of the disability sector in improving disability support services, shown in tracked changes. This opportunity to amend the TOR has also been used to correct other administrative features.

Appendix One

AUCKLAND and WAITEMATA DISTRICT HEALTH BOARDS'

Disability Support Advisory Committees Terms of Reference

Establishment

The Disability Support Advisory Committees (DiSAC) are established by the boards of the Auckland District Health Board (Auckland DHB) and Waitemata District Health Board (Waitemata DHB) under section 35 of the New Zealand Public Health and Disability Act 2000 (Act). The Boards may amend the terms of reference for the Committees from time to time. While constituted as each Board's separate DiSAC, it has been agreed that the two committees will meet and act as one.

Functions of Committee

The functions of the DiSACs of the Auckland and Waitemata DHBs are to:

- (a) Give the Boards advice on:
 - the disability support needs of the resident population of both DHBs
 - priorities for use of disability support funding provided.
- (b) The aim of the Committees' advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of disabled people within Auckland and Waitemata DHBs' resident populations:
 - the kinds of disability support services Auckland and Waitemata DHBs have provided or funded or could provide or fund for those people
 - all policies Auckland and Waitemata DHBs have adopted or could adopt, and how these policies could impact on persons or groups of people with a disability.
- (c) The Committees' advice and recommendations to the Auckland and Waitemata DHB Boards must ~~not be inconsistent~~ consider and align with the New Zealand Disability Strategy. The New Zealand Disability Strategy is issued under section 8 of the Act, and provides the framework for the Government's overall direction for the disability sector in improving disability support services.
- (d) The Committees' advice and recommendations to the Auckland and Waitemata DHB Boards must also consider and align with the United Nations Convention on the Rights of Persons with Disabilities (the Convention). New Zealand signed the Convention at the United Nations on 30 March 2007, and ratified it on 26 September 2008. All new policy

should be consistent with the Convention, or New Zealand will be in breach of its obligations.

~~(e)~~(e) In carrying out their functions the Committees must also have regard to other strategies and policy documents that the Government is accountable for implementing from time to time, including the Health of Older People Strategy and the New Zealand Positive Ageing Strategy.

~~(d)~~(f) The Committees are to ensure that the disability support needs of the community are reflected in all of Auckland and Waitemata DHBs' strategic planning processes, including the Northern Region's Health Plan and Annual Plans, and to ensure that appropriate processes, including consultation, are followed in preparation of all documents.

Responsibilities

Note 1 Health of Older People

Because it is difficult to distinguish between disability and personal health issues for older people, it is expected that DiSAC will deal with Health of Older People across the full range of issues and services for this age group.

Note 2 Mental Health Services

Mental Health services are dealt with by the Hospital Advisory Committees (DHB provider aspects) and the Community and Public Health Advisory Committees (funder aspects)

To carry out their functions, the Committees will develop and operate under an explicit philosophy that values diversity and self-determination for people with disabilities. In particular, the Committees will review and advise the Boards on:

- the overall performance of disability support services delivered by or through Auckland and Waitemata DHBs
- the development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the districts. Advice to the Boards must consider and align with ~~having regard to~~ the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities, and when considering older people with the Health of Older People Strategy and New Zealand Positive Ageing Strategy. When carrying out its functions the Committees must also consider other relevant national and international strategies that the Government is accountable for implementing from time to time
- assessment of the disability support services' performance against expectations set in the Annual Plans and other relevant accountability documents, documented standards and legislation

- issues related to the delivery of mainstream health services accessed by disabled people
- contributing the Auckland and Waitemata DHB districts' perspective to the development and implementation of regional and national policies related to disability issues in the Auckland and Waitemata DHBs districts
- developing and maintaining relationships with disability stakeholders to develop district and regional inter-sectoral collaboration and co-ordination
- focusing on the disability support needs of the population and developing principles on which to determine priorities for using disability support funding
- ensuring that the Annual Plans demonstrate how disabled people will access health services and how Auckland and Waitemata DHBs will ensure the disability support services they provide are co-ordinated with services of other providers to meet the needs of disabled people
- advising the Boards on how they can effectively meet their responsibilities under the government's vision and strategies for people with disabilities
- in accordance with the functions of DHBs:
 - establishing and maintaining processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement
 - continuing to foster the development of Maori capacity to participate in the health and disability sector and providing for the needs of Maori
- in accordance with the functions of DHBs:
 - establishing and maintaining processes to enable Pacific people to participate in, and contribute to, strategies for Pacific health improvement
 - continuing to foster the development of Pacific capacity to participate in the health and disability sector and providing for the needs of Pacific people
- improving collaboration and coordination of services between Auckland and Waitemata DHBs to effectively and efficiently provide for the needs of the populations served.

Relationship with Boards and Management

- (a) The Committees are established by and accountable to the Boards. The Committees' role is advisory only, and unless specifically delegated by a Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committees.
- (b) The Committees shall receive all material and information for review or consideration through the respective Chief Executive Officers.
- (c) The Committees shall provide advice and make recommendations to the Boards only.

- (d) The Committees are to comply with the standing orders of the Auckland and Waitemata DHBs based on the model standard standing orders.

Membership

- (a) The membership of the DiSACs will comprise of:
- (i) Three Board members from Auckland DHB
 - (ii) Three Board members from Waitemata DHB
 - (iii) Six members appointed in accordance with (c) – (e) below.
- (b) The Chairperson(s) of both Auckland and Waitemata DHBs will mutually agree upon the appointment of the Chairperson of the DiSACs.
- (c) The Boards will endeavour to appoint, as members of the Committees, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committees to carry out their functions.
- (d) The Boards will ensure that the Committees include representation for Maori in accordance with section 35 of the Act and for Pacific people.
- (e) The Boards will appoint any external appointees as members in accordance with the following process:
- the Chair and Deputy Chair of each Board together with the respective Chief Executive Officer will evaluate potential members in accordance with the criteria determined by the Boards and make recommendations to the Boards as to the proposed appointments
 - the Boards will make the final appointments (if any) to the Committees.

Meeting Procedure

- (a) The Committees shall meet in a combined forum quarterly. Meetings shall be conducted in accordance with:
- the requirements of the Act
 - the Standing Orders of the Auckland and Waitemata DHBs based on the model standing orders.
- (b) Auckland and Waitemata DHB CEOs will ensure adequate provision of management and administrative support to the DSACs' function including attendance of the CEOs and Directors of Funding and Health Outcomes.
- (c) The venue for the meeting will alternate between an agreed Auckland and Waitemata DHB site, with technology (e.g. video or teleconferencing) aiding from remote locations where appropriate.

- (d) The quorum of each meeting shall be, if the total number of members of the Committees is an even number, half that number; but if the total number of members is an odd number, a majority of the members.

Update on Collation of Statistics that Identify People with Impairments

(Collecting Information Which Identifies Disability When Reporting On Serious Adverse Events)

Recommendation

That the Disability Advisory Committee:

1. Agree that the definition of 'disability' and 2013 Census Questions 16 and 17 used by Statistics New Zealand are suitable for use by Auckland and Waitemata District Health Boards as a framework for collecting information that identifies whether a patient, visitor or staff member who has suffered a serious adverse event has a long-term disability
2. Note that subject to 1 above, the Funder will explore with both Auckland and Waitemata DHBs the implications of establishing a mechanism in future reporting systems that uses the definition of 'disability' and 2013 Census Questions 16 and 17 to capture functioning and disability information when reporting on serious adverse events.

8.2

Prepared by: Dr Debbie Holdsworth (Director Funding)

Glossary

DHB	-	District Health Board
DiSAC	-	Auckland and Waitemata District Health Boards' Disability Support Advisory Committees

Executive Summary

At its meeting on 27 August 2014, the Disability Support Advisory Committee (DiSAC) requested a report back on the feasibility of providing data on serious adverse events that have occurred over the last five years and involved people who identify themselves as impaired or disabled.

Currently, neither Auckland nor Waitemata DHB collects information that enables reporting on a person's *functioning* or *disability* in the context of a serious adverse event.

It is envisaged that both DHBs could implement changes to reporting systems, which enable functioning and disability information to be captured.

At its meeting on 11 March 2015, DiSAC considered what standard language or framework could be used to classify a person's functioning or disability. DiSAC agreed that Samantha Dalwood (Disability Advisor, Waitemata DHB) work with Russell Vickery to review whether the definition of 'disability' used by Statistics New Zealand would be suitable. It is:

'a disability is an impairment that has a long-term, limiting effect on a person's ability to carry out day-to-day activities. Long term is defined as six months or longer.'

Subject to DiSAC agreeing that the Statistics New Zealand definition of 'disability' is suitable, management intends to follow up with both Auckland and Waitemata DHB Executive Leadership Teams to consider the implications of establishing a mechanism in reporting systems, to enable information to be collected that identifies whether a patient, visitor or staff member who has suffered a serious adverse event has a long-term disability.

The Funder will suggest that Questions 16 and 17 from the 2013 Census are suitable for use by the DHBs as a framework for collecting information about a person's functioning or disability. Question 16 is:

'Mark as many spaces as you need to answer this question.

Does a health problem or a condition you have (lasting 6 months or more) cause you difficulty with, or stop you from:

- *seeing, even when wearing glasses or contact lenses*
- *hearing, even when using a hearing aid*
- *walking, lifting or bending*
- *using your hands to hold, grasp or use objects*
- *learning, concentrating or remembering*
- *communicating, mixing with others or socialising*
- *or no difficulty with any of these.'*

Question 17 is:

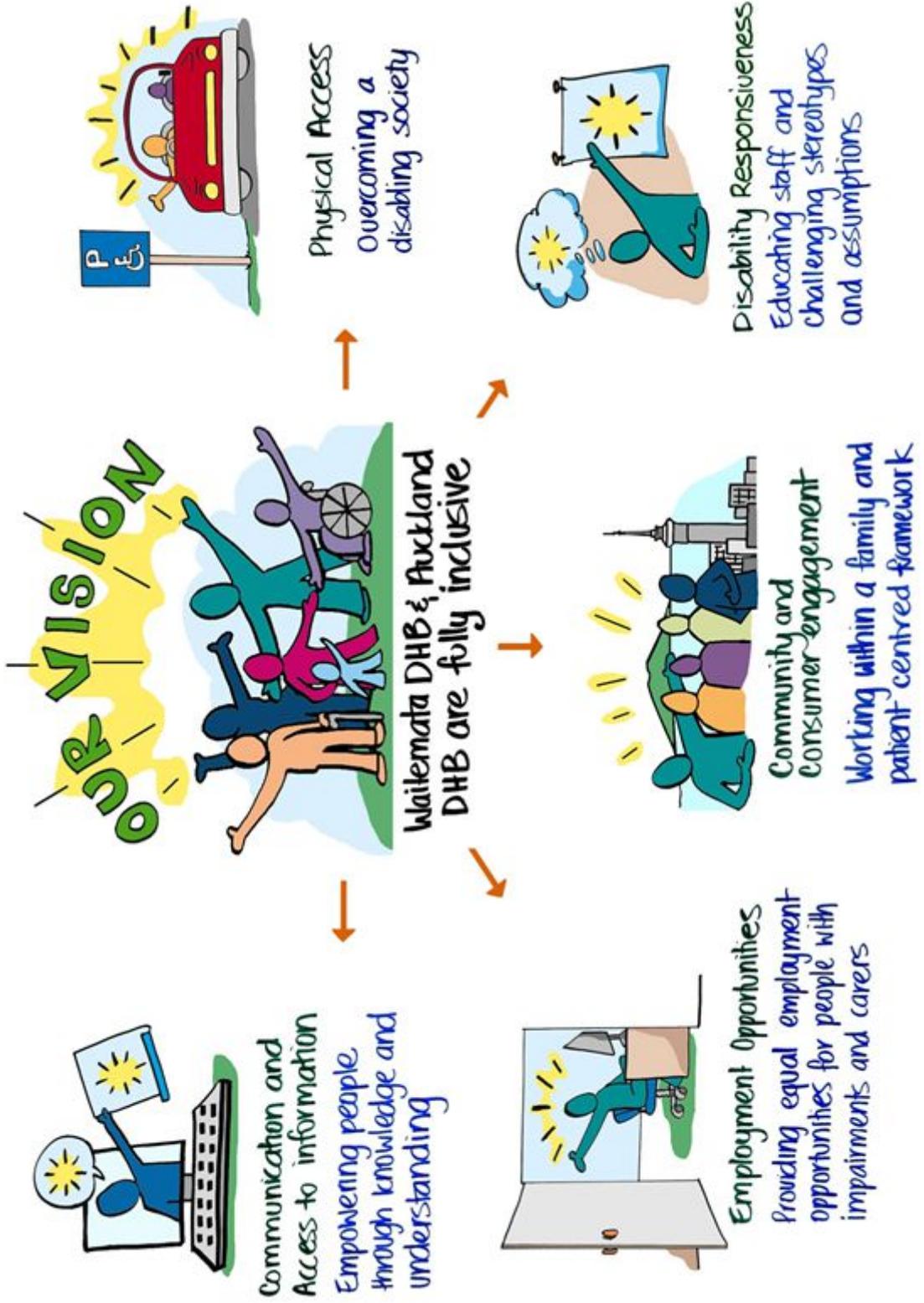
'Do you have a long-term disability (lasting 6 months or more) that stops you from doing things other people can do?'

The Funder considers that collecting responses to questions about a person's difficulties with everyday tasks when reporting on serious adverse events will enable each DHB to monitor trends, and better understand its disabled population. Disability data will also assist the DHBs to make health and disability services safer; report against the Disability Strategy and other policies and conventions; and will support policy analysis, programme development and service delivery that advocates for the rights of disabled people.



Waitemata DHB and Auckland DHB Implementation of the New Zealand Disability Strategy 2013-2016

Current Status at 1 May 2015





Communication and Information Empowering people through knowledge and understanding
Current Status at 1 May 2015

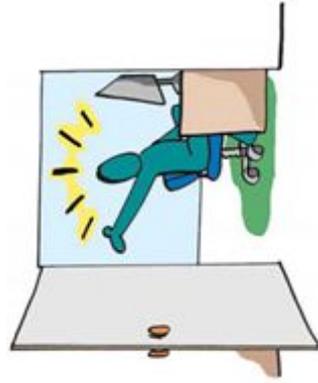
<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Accessible Communication guidelines developed.	February 2015 – this work is part of the proposal that both DHBs become 'Health Literate' healthcare organisations.
Review of Web content and presentation.	<p>May 2015 – Work has started on the development of the new websites and their content.</p> <p>February 2015 – ADHB & WDHB are developing their new websites. Both will have consumer input, which will include evaluation by the Blind Foundation to ensure that information is accessible to screen readers.</p> <p>Feedback from consumers also indicated that it would be useful to be able to complete forms available on the DHBs websites. This is also being looked at.</p>
Increase formats of key documents, e.g. Strategic Plans.	February 2015 – this work is part of the proposal that both DHBs become 'Health Literate' healthcare organisations.
Review the automated telephone system with regard to access for people with disabilities.	<p>May 2015 - A joint service is being established to deliver Contact Centre services to both DHBs. A new technology system is being identified, but the detailed design of the systems is being completed. Consumer input will be sort as part of the system design.</p> <p>November 2014 –Issues raised in consultation feedback relating to comprehension and general dissatisfaction with ADHB's Interactive Voice Response (IVR) have been investigated. As originally planned, a review and final decision regarding a possible change to ADHB's IVR, and consideration of IVR technology for WDHB, will be undertaken as a parallel work-stream of activity, alongside the design and implementation phases for a new technology solution.</p>

<p>Review the possibility of improved text communication to patients.</p>	<p>May 2015 – this will be included in the work identifying the new joint Contact Centre technology.</p>
<p>Continue the implementation of the Health Passport across both DHBs.</p>	<p>May 2015 – HQSC is currently collating feedback sent to them on the Health Passport. February 2015 - The Health Quality & Safety Commission is seeking feedback from people who have used the Health Passport. If you would like to give feedback on the Health Passport, please send your comments to info@hqsc.govt.nz by Friday 30 April 2015 with 'Health passport' in the subject line. The WDH B Disability Advisor and the Health & Disability Commission Disability Advisor will work with HQSC to review the feedback and make recommendations.</p>
<p>Work with the Deaf community to improve access to interpreters.</p>	<p>May 2015 – Deaf Aotearoa delivering training, which includes booking interpreters and using VRI (Video Remote Interpreting). The Ministry of Health is funding free Deaf Awareness training for Health Professionals, so Waitemata DHB will hold a number of sessions throughout the year.</p>
<p>Encourage the use of interpreters for non-English speaking families.</p>	<p>May 2015 – Explaining the system for booking Sign Language interpreters, as part of Deaf Awareness training, encourages the use of all language interpreters. February 2015 - WI-FI is now available for patients at North Shore Hospital. This will allow interpreting to be done across the internet, including NZSL interpreting.</p>



Community and Engagement Working within a family and patient centred framework
Current Status at 1 May 2015

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
<p>Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.</p>	<p>May 2015 – In April the first co-design workshop to look at the redesign and development of Reo Ora Health Voice, the ADHB online community panel. This is joint work with ADHB and WDHB and the next step is to identify people from the community who may be keen to work with the DHBs in a co-design process. This work will also influence the development of a Waitemata DHB online People’s Panel/Community Panel.</p>
<p>Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.</p>	<p>May 2015 – Input into work on stopping violence towards disabled people. This is joint work led by Auckland Council, People First & the Auckland DVD (Domestic Violence & Disability) Group.</p>
<p>Ensure the voice of people with learning/intellectual disabilities, particularly people with high/complex needs, is included in consumer reviews of service planning and development.</p>	<p>February 2015 – The ADHB Public Spaces project have been very mindful to include people with cognitive impairments in their work. This includes people with learning disabilities, dementia, Alzheimer’s, Parkinson’s and other cognitive and physical impairments.</p>
<p>Continue working with Health Links to increase health literacy through fully accessible patient information.</p>	<p>May 2015 – Health Links are part of the Health Literacy Steering Group, as well as having their own Health Literacy group to edit patient information leaflets. November 2014 – Health Literacy Steering Group includes the voice of the Health Links.</p>



Employment Opportunities Equal employment opportunities for people with impairments and carers
Current Status at 1 May 2015

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Encourage the use of supported employment agencies.	<p>May 2015 - ADHB Allied Health recruited a member of staff through the Mainstream programme 2 years ago. This person who has now moved into a permanent role in health Alliance and staff are in the process of recruiting a second person into that role.</p>
Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.	<p>May 2015 – reviewed the ‘Recruitment & Retention of Staff with Disabilities/Impairments’ guidelines to reflect changes in strategic documents and government guidance.</p>
Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	
Work with Hiring Managers to increase disability awareness.	<p>May 2015 – reviewed the ‘Recruitment & Retention of Staff with Disabilities/Impairments’ guidelines to reflect changes in strategic documents and government guidance.</p>
Working with HR to look at how the DHBs support staff with Carer responsibilities.	<p>November 2014 –</p> <ul style="list-style-type: none"> • Carers NZ have completed their Carer Aware staff training – a 20 minute learning resource to be launched at WDHB early 2015. • WDHB are a foundation member of the Carers NZ Employer cluster group. This is a group of employers who are committed to support staff with carer commitments.



Disability Responsiveness Educating staff and challenging stereotypes & assumptions
Current Status at 1 May 2015

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Work with Dieticians to improve the nutritional outcomes for disabled patients.	May 2015 – ‘Protected Mealtimes’ are in place across Waitemata DHB and are now ‘business as usual’. This is improving nutritional outcomes for all patients.
Develop ‘Disability Champion’ roles across the DHBs.	
Promote the Disability Awareness e-learning module to all staff across the DHBs.	February 2015 – This training module is being reviewed and updated in September 2015.
Provide a range of disability awareness training, targeting specific services.	May 2015 – The Ministry of health are funding Deaf Awareness training for health professionals, which means there is no cost to the DHB. Deaf Aotearoa is running two sessions during May (one at North Shore and one at Waitakere) and another session at North Shore Hospital in September. May 2015 - As part of New Zealand Sign Language Week (4 – 10 May), Deaf Aotearoa provided three Sign Language Taster Courses at Auckland DHB. The 45 minutes sessions were specifically health-orientated.
Develop tools to increase staff skills for working with people with communication difficulties.	May 2015 - As part of New Zealand Sign Language Week (4 – 10 May), Deaf Aotearoa provided three Sign Language Taster Courses at Auckland DHB. The 45 minutes sessions were specifically health-orientated.
Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.	February 2015 – The Disability Advisor, with five AUT design students, has completed an access audit as Auckland City Hospital as part of the Public Spaces project. The findings from the audit will add to the consumer feedback to the project. There is also a focus on access for older adults, for example, those with dementia, confusion and other cognitive or physical impairments.



Physical Access Overcoming a disabling society
Current Status at 1 May 2015

<u>What</u> we will do... actions	<u>Where</u> we are now...current status
Encourage the use of symbols and pictograms in signage and way finding.	May 2015 – Waitemata DHB is developing a new Signage and Way Finding policy. This includes the use of symbols and plain English to assist with way finding. ADHB's work on public spaces has accessible way finding as an essential part of the work.
ADHB Disability Champions will complete the 2-day Barrier Free Training.	
An accredited Barrier Free Advisor will be involved in all new Facilities work.	August 2014 - the merger of the two Facilities teams is a great opportunity to standardise ways of working across all sites.
Adoption of Universal Design principles in all Facilities work.	May 2015 – One of the over-arching principles of the Waitemata 2025 building programme is that WDHB facilities are accessible and inclusive for everyone.
Building standards document developed in ADHB.	August 2014 - Waitemata currently has a standardization document. The merger of the two Facilities teams will mean both DHBs can use the same document.
A review of accessible toilets in ADHB buildings to be completed.	Ongoing – Upgrades to toilets will be done on an individual project basis when funding becomes available.
Work with Auckland Transport to improve accessible transport between hospital sites.	May 2015 – the service is ongoing while it is being evaluated if it is meeting the need of patient's family/whanau. August 2014 - a six month trial has commenced for visitors to travel between Waitakere & North Shore Hospitals.
Investigate the reported shortage of wheelchairs available - both numbers and sizes.	Completed – 40 wheelchairs were delivered and are in use across the services.

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 34 and 35, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 34 for the passing of this resolution
Confirmation of Confidential Minutes 11 March 2015	As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000. To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act 1982 s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]