HE PUNA WAIORA REVIEW REPORT

Undertaken and prepared by: Alison Masters (Chair), Malcolm Stewart, Sarah Gordon, Stu Bigwood, and Jason Cabral-Tarry

December, 2020

CONTENTS

ACKNOWLEDGEMENTS

The review panel acknowledges that the unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers, and staff. This is especially so where the person has died by suicide. We wish to extend our heartfelt condolences to the family and whānau of the people whose deaths led to this report being commissioned. We also wish to thank those family and whānau that met with us. We acknowledge your generosity in the support of change that will benefit others, in spite of the added stress and distress you yourselves experience through involvement in these processes.

We extend our appreciation and thanks to members of the Lived Experience Advisory Council who shared their personal experiences of services to inform the review.

We acknowledge and thank the staff at He Puna Waiora, the unit management, and the senior leaders in the Specialist Mental Health and Addiction Service of Waitematā District Health Board (WDHB), for their willingness to assist with the review, engaging in the interviews and supporting our visits. We wish to acknowledge the time, skill, and aroha they put into their work of protecting and improving the mental health of people in the Waitematā DHB district and beyond.

We also want to thank the Waitematā DHB staff who contributed to organising this review, in particular Jason Cabral-Tarry for his support and management of us and the review process.

DESCRIPTION OF REVIEW

Background and Purpose of Review

This External Review was initiated by the District Health Board soon after the tragic events in He Puna Waiora.

The following information was supplied to the panel prior to the beginning of the review:

> He Puna Waiora (HPW) is an Adult 35-bedded Inpatient Unit located in Takapuna, Auckland, adjacent to North Shore Hospital. It opened 4 years ago and has been in continual use since then. Until last week, there had never been an inpatient suicide in the unit since opening.
>
> On Sunday 12th May 2019, in the late evening, an inpatient, NB, was found deceased.
>
> On Thursday 17th May 2019, in the evening, an inpatient, TH, was found deceased.
>
> As a result of these two most-serious inpatient patient safety events, it has been decided to have an overarching external review of the functioning of He Puna Waiora, chaired by an external nominee of the Ministry of Health, Director of Mental Health.

The terms of reference that were given to the panel were to review:

- The physical safety of the ward environment, including ligature points and to advise about any remediation required
- The clinical governance processes on the ward, to identify any deficits and possible solutions
- The functioning of the clinical teams on the unit, including a review of the clinical culture on the ward, quality-of-care being provided and areas for improvement
- Any other areas for improvement in the oversight of the quality-of-care provided by the mental health leadership team
- The policies concerning communication with families and the practice on the ward of responding to urgent concerns raised and escalated by whānau and family members to staff.

This review aims to provide an overarching and forward-focused review of how He Puna Waiora is functioning now, and make recommendations regarding its function into the future.

This review is not focused on the specific incidents referred to above. Separate external investigations, led by senior psychiatrists, occurred into both deaths at He Puna Waiora. The panel for the current review chose to await completion of those to ensure this review was informed by the results of the individual reviews into the incidents. Other reviews and quality improvement projects, in part a response to the specific incidents and partly related to other quality improvement initiatives, were undertaken at around the same time as this review.

A preliminary report was circulated by Waitematā DHB Specialist Mental Health and Addiction Service management to family and whānau members of the two people who died by suicide within HPW and also to family and whānau members of two other people who had died by suicide when involved with Waitematā DHB services: one who had recently been an inpatient at HPW and one who was in a respite facility at the time of his death, and for whom placement at HPW may well have been appropriate. Upon receipt of feedback from all families in response to the preliminary report, the panel met with each of them to further inform the review of HPW particularly and how it functions within the context of Waitematā DHB Specialist Mental Health and Addiction Service (SMH&AS) more broadly.

DESCRIPTION OF REVIEW PROCESS

Review Panel Members

- Alison Masters - Psychiatrist (Chair)
- Malcolm Stewart – Psychologist
- Sarah Gordon – Consumer / whānau representative
- Stu Bigwood – Nurse
- Jason Cabral-Tarry – Quality-Co-ordinator (WDHB)
- Dame Naida Glavish – Cultural Guidance

The availability of Dame Naida Glavish limited her ability to participate fully in the review. She provided liaison and oversight across the review process, and has had opportunity to review the report prior to its finalisation. Therefore, matters of particular concern or specificity from a Māori perspective have not been identified. The panel feels it would be prudent for this to be addressed through an alternative process.

Review Process

1. 16 Aug 2019: Initial meeting of review panel in person involving:
   a. Briefing by key staff to learn of the situation and events, the specific individual reviews, changes that had already been undertaken, and the quality improvement projects in progress
   b. Visit to He Puna Waiora
2. Review of documents provided by the Specialist Mental Health and Addiction Service (SMH&AS) and accessed by the Panel. This was ongoing throughout the review
3. Oct – Dec 2019: Interviews with staff at HPW and SMH&AS, including consumer and family advisors, undertaken by:
   a. Stu Bigwood and Alison Masters
   b. Sarah Gordon and Malcolm Stewart
4. Dec 2019: Visit by Stu Bigwood and Malcolm Stewart to HPW to review the ward environment and in particular assess ligature risk
5. Consideration of other reviews completed in relation to the specific incidents
6. Further review panel meetings and completion of the preliminary report
7. June 2020: Preliminary report shared with staff and family and whānau for review and feedback

8. September 2020: Meetings with family and whānau members of the four consumers who died while under care of Waitematā DHB SMH&AS (as referred to above) by the panel.
9. September 2020: Meeting with six members of the Lived Experience Advisory Council (LEAC), some of whom had experienced previous admissions to HPW, and others of whom had contact with people who had experienced such admissions, by Sarah Gordon and Stu Bigwood.
10. November 2020 Final draft report shared with WDHB and families.

Documentation

The review panel was provided with the following documents:

1. Terms of Reference
2. Specialist Mental Health & Addiction Services and He Puna Waiora controlled documents (versions in place at the time of the incidents and any later updates):
   a. HPW Welcome book (not dated)
   b. Adult Mental Health (MH) Inpatient Unit Model of Care issued June 2019. Also, an earlier version of the same document issued June 2016.
   c. Therapeutic Engagement Observation – Adult Mental Health Services (MHS) issued July 2019
   d. Ligature Assessment and Audit issued June 2019
   e. Quality Care in Adult Mental Health Inpatient Units Programme Project Plan Phase 1 issued August 2019
   f. Local Coordination Service/Adult Acute Mental Health Inpatient Unit Interface issued November 2016
   g. Whānau and Family Engagement and Participation issued April 2019
   h. He Puna Waiora Operations Manual issued December 2019
   i. Support Needs Assessment and Multi Agencies Plan Guideline issued November 2019
   j. Model of Care - Acute MH IPU issued June 2016
   k. ISBAR Communication Tool issued February 2018
   l. Flexi Bed Use - Adult Inpatient Units
3. Waitematā DHB Ligature Report dated May 2019 by Greet Consulting
4. HPW Ligature audit report dated July 2019
5. Other Documentation:
   a. HPW rosters at the time of the two inpatient events and November 2019

b. HPW clinical governance team meeting minutes for February, March, April, May 2019
c. Adult leadership meeting minutes for February, April, May 2019.

6. Adverse Event Investigation Reports for each of the four deaths. Note: The families and whānau advised they did not have the opportunity to review and feedback on these draft reports prior to their finalisation, and this was confirmed by the panel. From the perspective of the families and whānau, their lack of inclusion in this process - to have the opportunity to review and provide feedback and for the reports to be revised in response to such feedback - resulted in the reports containing factual inaccuracies (at the least) and/or not being satisfactorily reflective of their perspectives generally. They believed that this could have impacted on the conclusions drawn by the individual reports and this overarching report. Both the process and the outcome, in terms of the finalised individual event investigation reports, caused them additional distress.
7. PowerPoint presentation from one of the families presented to the panel on 14 September 2020.

Interviewees

People in the following positions were interviewed for this report. The number in front indicates the number of people in that position who were interviewed.

Consumer and Family	**HPW Clinical Staff**
2 Consumer Advisors	1 Cultural Advisor
1 Whānau Advisor	2 Clinical Psychologists
12 Members of four families and whānau who had been affected by the death of a person at HPW or who at the time of death had, or could have had, a relationship with HPW.	2 Occupational therapists (OT)
	2 Social Workers
	2 Associate Clinical Charge Nurses
6 Members of the Lived Experience Advisory Council (LEAC), including some who had experienced an admission with HPW in the past.	1 Clinical Nurse Specialist
	2 Consultant Psychiatrists

Management and Operations HPW and Adult MH

1 Charge Nurse Manager, HPW

1 Operations Manager, Adult MH

1 Clinical Director, Adult MH

1 Associate Service Clinical Director, Adult MH

1 Clinical Nurse Lead, Adult MH

1 OT Lead, Adult MH

1 OT Professional Lead, Adult MH

1 Social Worker Lead, Adult MH

1 Psychology Lead, Adult MH

Management and Operations SMH&AS

1 Director

1 General Manager

1 Associate Director of Nursing

1 Quality & Improvement Lead

1 Consumer and Family/Whānau Consultant

ORGANISING PRINCIPLE FOR REVIEW: CLINICAL GOVERNANCE

The questions outlined in the terms of reference for this review largely relate to aspects of the broad construct of clinical governance, so this has been used as an organising principle for reporting the information obtained and conclusions drawn, during the review. Clinical governance can be defined as the mechanisms that are in place to ensure that quality and safety of care are maintained and improved. Clinical governance encompasses a wide variety of activities. "Put simply, clinical governance is a collaborative venture between clinicians, managers and consumers to 'create a culture where quality and safety is everybody's primary goal' (Flynn et al., 2015).

A well-known model for considering clinical governance has been the seven pillars of clinical governance—clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning effectiveness. The panel used these to organise the findings of this review.

The review panel has debated at some length how best to produce and record feedback gathered from the combination of direct interviews and/or meetings with family and whānau members, members of LEAC, consumer, and whānau representatives, a range of staff from 'the floor of HPW', clinical leaders and managers of the unit, and executive staff of the SMH&AS; various policy and procedures, our own observations of the unit; and our synthesis of these information sources from our own perspectives.

We have decided that where an issue or experience was raised by more than one source, then we would record that issue.

We want to note that overall we were impressed by the widespread motivation of staff to provide, and improve, the provision of good care for clients of the unit. Family and whānau members questioned this motivation and also described examples of what they regarded as unskilful and unsympathetic care by some staff (including with ongoing risk monitoring, treatment selection, and therapeutic interactions). They also reported there being difficulty for the service in finding or providing treatments to meet the needs of consumers, particularly those with presentations outside those typically seen in an inpatient unit. Some families and whānau also reported experiences of other mental health services (outside Waitematā DHB) and physical health services within Waitematā DHB that served to highlight the differences and

deficiencies of HPW regarding the attitude and professionalism of the approach to care.

OBERVATIONS FROM THE REVIEW

Clinical Effectiveness

On the New Zealand Health Quality and Safety Commission (HQSCNZ) clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to roles and responsibilities, measurement and transparency of clinical outcomes, advance care planning, and evidence-based best practice. It also pertains to the Model of Care used in HPW.

OVERALL MODEL OF CARE

The panel found that the Model of Care is not well articulated, focusing more on what staff roles are rather than how care is delivered ("staff focused" – not "consumer focused"), and reflecting a predominantly biomedical model of care. Care is primarily driven by the nursing plan, often without attention being paid to allied health plans. Psychological assessment and therapy input was well regarded, but noted by staff as not readily accessible and not utilised in the care of most of the consumers with whose family members the panel met. Many staff interviewees considered that good medical care is provided but that the strong reliance on management by medication and a lack of focus on psychosocial distress and intervention impedes (particularly long-term) recovery, consequently increasing readmission rates and impeding the ability to discharge in a timely and ready manner. Individuals from the LEAC group and family and whānau also felt that there was an over-reliance on medication to alleviate consumers' distress and support recovery. They felt that the programme of recovery-focused activities for consumers to participate in during the day was scant. Other activities such as use of the gym, art equipment, and the sensory room are often not accessible when consumers need or want them, due to them being in locked areas and staff not being available to supervise if unlocked. The LEAC group believed it would be helpful to "Find a way to give people some hope and give them some fun." There is a focus on unwellness, which encourages people to take on the identity of being chronically unwell rather than being encouraged towards a more recovery- focused perspective. There was stigmatisation of long-stay people as "bed-blockers".

Key areas identified by different staff that were relevant to this observation were: multidisciplinary team function, bi-directional communication between clinical staff and management, clinical processes, and tailoring care for consumers with complex needs. Areas particularly identified by family and whānau and members of LEAC included the above, and also included disrespectful or uncompassionate treatment of

consumers, lack of time spent with consumers, poor risk assessment and management practices at HPW and in other areas of the mental health service, and a lack of generic and individualised recovery-focused activities available to consumers at HPW. These issues are discussed in more detail below.

THE NURSING MODEL OF CARE

The review panel identified and multiple staff confirmed that there is no effective primary nursing system. Because of the physical layout of the unit consisting of 4 pods, nursing staff are separated into small groups. Each pod has its own dedicated staff for each shift. The assignment of staff to distinct areas and minimum numbers being required for safety, makes release for activities such as meal breaks, training, or input into quality improvement activities difficult. It also adversely affects handover, and means nurses are currently unable to attend medical reviews. As a result of staff shortages, nursing staff are frequently shifted between pods, leading to inconsistency in staffing which impacts on continuity of relationships and care for consumers and family and whānau. Family and whānau described it was difficult to find staff who were knowledgeable about, or responsible for, the support of their family or whānau member when they engaged with HPW. The current rosters are complex and are a source of frustration for management and staff. The review panel recognised that current rostering approaches are an impediment to the effective functioning of the unit.

CLINICAL LEADERSHIP

The clinical leadership and organisation within HPW was described by a variety of staff as improving, but possibly still not fit for purpose. Concerns included frequent difficulties for clinical staff to obtain support or oversight from senior staff in resolving difficulties; ineffective leadership in MDT processes, and difficulty in obtaining support for the accessing of resources required to respond to individual needs.

The families and whānau were critical of all aspects and levels of leadership, particularly in relation to accountability. They felt that improved leadership across the board is required for the transformational change they deem necessary; and that such leadership requires transparency, as was also identified by members of LEAC, in order for them and the community generally to regain trust and confidence in HPW and Waitematā DHB services more generally.

The consistency of this message, and other evidence, suggests to the panel that changes were needed to make leadership processes more robust, accountable, and transparent. Such changes have been partly addressed. In particular, nursing leadership, which was reported as having been reduced with the move to the new unit, was largely re-established post the deaths. The review panel recognise leadership needs significantly more work.

MULTIDISCIPLINARY TEAM (MDT) FUNCTION

All three professional groupings (medicine, nursing, and allied health) described themselves as feeling disempowered by the current ways of working. To some extent, each group also felt that the role currently being played by the other two groups was not optimal to encourage best consumer outcomes and unit function. Examples reported to us included:

- Some nursing staff feeling disconnected from, and reluctant to approach, medical staff for fear of negative reactions
- Front-line nurses feeling devalued because they do not participate in the MDT meetings (only senior nursing staff attend). They thought that as the group who spend the most time with consumers, and deliver much of the care prescribed by the MDT meetings, it was important for them to attend
- Medical staff feeling they had less influence over care in the unit than would be desirable, and feeling discouraged by oppositional interactions from other staff
- Allied health staff feeling that their input is often devalued. Allied health staff thought that their reports or treatment plans are often ignored by nursing staff, and that this led to a decrease in the rate of functional rehabilitation activities and community re-engagement that is necessary for discharge to be timely and adequately supported
- Psychologists relaying positive feedback from consumers about therapy in the unit, but also identifying that access was limited as a result of psychological staff numbers being low and falling due to resignations. Psychologists were also keen to contribute more to in-house staff training, but found the opportunities to do so lacking
- Nursing and other staff highly valuing the sensory modulation initiatives facilitated by the O.Ts. Nursing staff reported that allied health assessments and treatment plans were often not available on the file, and hence they were not able to be implemented.

We consider this to be strong evidence for dysfunction in the MDT. There is a need for a more effective multidisciplinary team approach that values and encourages input from all staff. Also notable in these findings was the limited consideration by the MDT of resources including the family and whānau, community mental health services, and other health, disability and social services in planning and implementing support during and after the inpatient stay. This may partly be due to the absence of, or difficulty in obtaining timely input from, some of these other resources, but may also relate to an insularity which means that external linkages are not maintained to optimise consumer support as strongly as they could be.

ABILITY TO MEET NEEDS OF CONSUMERS

Staff, family and whānau, members of LEAC, and consumer representatives expressed concern that, as an acute mental health inpatient unit, HPW was often required to house and support people for whom it was not really the right kind of service, but for whom more suitable specialist services were not available within the region or nationally. Some groups who were seen as particularly adversely affected by this were:

- Consumers experiencing long-term admissions. Staff, family and whānau, and consumer representatives shared the perception that many consumers stayed at HPW long-term because more appropriate facilities targeted to their particular needs were not available. Some of these consumers have coexisting difficulties such as Intellectual Disability, Autistic Spectrum Disorders, Fetal Alcohol Spectrum Disorder, and Alcohol and Other Drug difficulties that require different environments, specialisation and skills to provide support in a recovery-focused manner. As an acute mental health unit, there is relatively little staff capacity for establishing long-term individualised rehabilitation programmes for consumers with such complex needs.
- Consumers with experience of personality disorders are commonly simply ‘maintained’ in the unit. Staff reported the need for better approaches for supporting consumers with personality disorders. The impression of staff was that other Auckland metro DHB’s have more proactive and immediately available community support for these consumers, whereas, in Waitematā and HPW in particular people have to wait which leads to unnecessary and undesirable, particularly lengthy, admissions for this group of people.
- The absence of suitable services in the community leads to frustration for consumers, family and whānau, and staff alike. A waiting time of six months or

so for people to be able to obtain Dialectical Behaviour Therapy treatment in the Waitematā Community Mental Health Services was indicated.

- The locked down nature of the unit may add to the sense of boredom and frustration for many consumers and further impede their progress to being adequately equipped and prepared for discharge.

The absence of external resources that may be required to meet the full range of needs of consumers, particularly consumers with less common presentations or who become longer-term residents of HPW, is clearly an issue which goes beyond the control of HPW to find systemic solutions (although they are able to advocate for individual needs) and extends to both the funder and provider arm functions of the DHB, the Ministry of Health, and other social service ministries and agencies. More detailed gap analysis to ascertain the services that are lacking in the community, which contribute to long-stay or insufficient support of recovery for these consumers within HPW, would be valuable to help identify and advocate for these gaps to be filled.

CLINICAL PROCESSES

Several staff, family and whānau, and members of LEAC, who had worked at or engaged with other acute mental health units, reported that clinical processes that are common in other services are not routine or well-developed at HPW. This included MDT meeting function, risk management, care planning and admission and discharge planning processes.

Clinical administration processes (e.g., meetings, clinical note system) were often described as inefficient and ineffective. Particular concerns about clinical record keeping, identified by multiple interviewees, included reports that clinical notes were often perfunctory, clearly “cut and pasted” from previous entries, without content specific to the most recent status and situation of the client. It was also noted that written Social Work and OT assessments were reported as not readily available on HCC (Health Care Community electronic record system) and therefore not available to staff.

Members of the LEAC group reported that when HPW first opened consumers had scheduled 15 minute sessions with their nurse each day and that this was helpful. This practice no longer continues. They regarded that reinstating these sessions, and making peer support available to consumers, would be useful.

Staff at a variety of levels reported a pattern of decisions being mandated by higher levels of DHB management, which were considered to contribute to adverse events or poorer and less recovery-focused care. This included the decision to consistently lock all of HPW to prevent absence without leave events and resultant harm, but which potentially has an adverse effect on consumer autonomy and sense of recovery.

RECENT QUALITY OF CARE INITIATIVES

A variety of initiatives to improve the quality of care within the ward have been undertaken. These include:

a. The Safewards Programme (Bowers, 2014) has been partially implemented and is seen as a useful approach for generating ideas and approaches to help change unit culture and processes. This had been used to start a number of initiatives to improve interactions between staff and consumers in areas such as relationships (clear mutual expectations, know each other), collaboration (mutual help meeting), communication (positive words, soft words), and distress reduction (calm down messages, bad news mitigation). This programme was described as being in development but, due to busy schedules, its focus and implementation is currently variably applied.
b. The "Safety Huddle", which has the purpose of staff exchanging information with a particular focus on consumers about whom there are safety or other concerns, has been recently established. This has been regarded positively by staff, who find it useful. A question was raised as to how consumers feel about it.
c. Sensory modulation approaches, mostly undertaken by the OTs, are widely seen as a useful therapeutic component that assists consumers with self-soothing and de-escalating. Each consumer entering HPW is given a sensory modulation pack which introduces them to the concept and provides some simple sensory modulation implements. The OTs were keen for other staff to also teach and coach in the use of such practices. Each part of HPW has a Sensory Modulation Room. These are often locked when not in use, which may limit spontaneous use by consumers.

The panel regarded these examples of clinical quality improvement initiatives as valuable and likely to lower risk through improving staff-staff and staff- consumer communication, identification of risk issues, and the strengthening of self-management techniques by consumers appropriate to the consumers' needs.

Members of LEAC did not feel that change as a result of these projects was yet evident, but the panel believes that these projects are worth supporting by ensuring that the staff leading them have adequate capacity to foster their development and implementation. The monitoring of the projects to ensure they are producing the projected gains and are not engendering unintended negative consequences is also important.

The panel also suggests that another level of more fundamental change in the approach to clinical management is needed. This would involve a more client-focused approach to care characterised by: An expectation that all staff interactions with consumers would be kind, empowering, and interpersonally skilful; closer and consistent relationships between individual staff and individual consumers (including, but not only primary nursing); individualised rehabilitation/recovery programmes would be developed for each consumer and provision and outcomes would be monitored by the MDT; and all staff would be skilled and engaged in making all interactions (even casual ones) with consumers to be constructive and recovery-focused. Creating this kind of change will probably require investment in additional staff resource and re-engineering clinical and administrative processes so staff have additional time to spend directly with clients and enhancing the breadth of their skill sets.

Risk Management

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to clinical risk management and having a quality and safety culture. For the purposes of this report we will focus on general risk management within HPW and suicide postvention following a death by suicide or attempted suicide.

RISK MANAGEMENT AT HE PUNA WAIORA

A variety of factors that limit safety in He Puna Waiora and the broader mental health and addictions services were described.

Bed pressure due to high demand and bed closures (due to staff shortages) were identified by staff and consumer representatives as creating a potential risk for HPW clients. This often leads to discharges that are precipitous, without robust discharge planning, hence compromising clients being adequately equipped and prepared for

discharge. Staff believed that there are fewer step-down/respite facilities in the Waitematā DHB area than are available in some other areas.

Family and whānau were critical of the risk assessment and management processes and procedures, particularly in response to their communications alerting staff and services to their family and whānau members being at-risk.

RECENT RISK AND SAFETY-RELATED INITIATIVES

Considerable resources were applied to immediate actions following the inpatient deaths by suicide to address safety, and a longer-term quality improvement programme was put in place to drive proactive change. Immediate actions, centred on ensuring the unit was safe, included:

1. Ligature audit and risk reduction programmes being undertaken, including:
   - A ligature audit which had been completed before the two incidents. Areas for further work had been identified, and efforts to undertake that work have continued.
   - Action to remove the immediate ligature risks, such as removing bathroom doors and replacing these with a safer alternative.
   - The ligature audit having been reviewed and updated, with ongoing remedial work being identified as necessary.
2. Other safety processes have been introduced to improve risk management, including:
   - The Safety Huddles to ensure risk issues are communicated
   - A policy change stipulating that a medical consultation is required before the frequency of observation of at-risk clients is reduced. This includes notifying family and whānau of the change in frequency as appropriate.
   - Inpatient doctors on duty on Saturday mornings
   - Expectation of contact with discharged persons within 24 hours by phone (note: not necessarily by the nurse they knew)
   - New positions having been established to assist with ensuring good practice, including an Associate Clinical Director and an Operations Manager for the service, and a second Associate Clinical Charge Nurse
3. There is ongoing work to further reduce risk, including:
   - Plans for doors to bedrooms to be retrofitted with doortop pressure sensors
   - A business case in progress to improve other physical safety measures
   - Improving the effectiveness of handovers

- Further safety policy revision

The panel reviewed the previous ligature audits and also undertook its own on-site safety review of HPW. Our overall impression was that HPW is operating with appropriate practice standards to minimise risk in the ward environment. The panel notes that there appeared to be a focus and reliance on current risk assessment by staff to mitigate some physical environmental risk. Elimination of any physical environmental risk as far as possible is a much safer option as risk can change quickly and is often difficult to assess accurately with typical patterns of staff-client contact.

Some observations are that:

- Support from the executive for the ligature risk reduction strategies outlined in the business case is critical for reducing risk of further instances of hanging and strangulation within HPW
- "Flax pattern" fences in the exercise areas are aesthetically pleasing and reduce the sense of confinement, but do pose a ligature risk. This is currently managed by not allowing people in these areas without staff supervision, but this has its limitations and drawbacks for clients. Investigating ways of making this safer without removing it would be valuable.

RESPONSE AFTER AN INPATIENT DEATH BY SUICIDE

Inpatient death by suicide is relatively rare. This means that even some of the more experienced staff have little or no recent experience in dealing with a death by suicide and its impacts on other patients, family and whānau, and staff.

Suicide contagion, in which a death by suicide or attempted suicide by one person is followed by suicidal behaviour by others in the same community (e.g., town, school, ethnic community) is widely recognised, and does constitute a significant risk in an inpatient mental health unit. The nature of an inpatient ward means that such events impact everyone involved, whether they had a close relationship or only a more distant relationship to someone who died by suicide or attempted suicide. The nature of the relationship with the deceased and/or the mere fact of being part of a community (which an inpatient ward is) when a death by suicide or a significant suicide attempt has occurred can be highly triggering for some, and particularly those who may already be struggling with suicidal thoughts and actions.

Suicide postvention involves interventions undertaken following a death by suicide or significant self-harm or suicide attempts on the ward to ensure that those potentially

affected by the suicide or attempted suicide are supported and the risk of suicidal behaviour by others is minimised as much as possible.

The panel found there was no document or protocol to guide the staff after a death by suicide. Family and whānau reported both positive and negative experiences of the staff management of their needs after the suicide of their loved one. Some reported that staff had seemed unfamiliar with what to do and had made decisions that were unhelpful and unsupportive. Others reported that when one staff member had taken responsibility for being their liaison with the service and had acted in a supportive, engaged, and reliable way throughout their entire interactions with services following the death by suicide, they had felt well supported.

A document or protocol to guide staff following a death by suicide would be helpful to ensure that best-practice approaches are implemented in this situation in order to provide support to the family of the person who died by suicide, other patients, family and whānau of other consumers (to ensure they were aware and could provide additional support) and staff. This document would ideally include detail about processes for managing the immediate situation, how to contact and interact with the family and whānau, setting up postvention interventions for the other patients and their family and whānau, and how to support the staff in the aftermath of a death by suicide or similar event.

Patient Experience

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to patient-centred care, shared decision-making, engaging with consumers, and co-design.

Both staff and consumer representatives reported poor continuity of staff relationship and contact for consumers, family and whānau, or external health professionals. For many consumers, lack of staff continuity and other changes are a significant cause of distress and an impediment to developing the kind of trust that can support recovery. Individualised treatment planning, which had been noted by staff and the panel as being inconsistent and under-developed, appears to involve consumers and family and whānau minimally.

The families and whānau interviewed by the panel believed that their loved ones had variously experienced neglect, humiliation, stress, uncertainty, a lack of respect, dignity, compassion, support of recovery and a therapeutic environment. Overall this

was perceived as resulting in a loss of hope. There was some suggestion that a planned or actual return to the ward resulted in loved ones 'giving up'. While positive staff attitudes and interactions were also described, negative experiences leading to the above perceptions of care were predominant.

Family and whānau engagement at HPW is seen as "less than satisfactory" by some staff and by consumer and whānau representatives. This was considered as being due to physical, time, and attitudinal barriers. More specifically, family and whānau contact, liaison, and involvement during inpatient admissions was reported as weak and inconsistent by staff and consumer representatives. Family and whānau members reported experiencing a lack of involvement, communication, acknowledgement (of relationships and intimate knowledge of their loved ones), and a lack of responsiveness to family input, with their concerns not being taken seriously, and reported feeling that they were seen as a distraction and a nuisance rather than an ally that was also working for the benefit of the consumer. The need to balance family and whānau involvement with confidentiality was recognised by the panel, but consistently closer contact with, and involvement of, the family and whānau was seen as an important goal. We consider that a consequence of these issues were feelings of hopelessness and helplessness for consumers, family and whānau, and, at times, staff.

Communication Effectiveness

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to teamwork, transparency (including of consumer outcomes), and open communication. Various communication difficulties were described by staff, consumer representatives, and family and whānau. These included communication between clinical staff and consumers, staff and family and whānau, between different clinical professions, and between staff "on the ground" and HPW management.

A concern for both family and whānau and members of LEAC was that staff spent large amounts of time in the offices with the doors closed, so the consumers felt ignored, and "out of sight, out of mind." This concern was echoed by staff, who felt that administrative requirements such as note-keeping reduced their time for therapeutic interactions with consumers. Members of LEAC also thought that at times staff were engaged in activities other than work (e.g., Facebook) and that consumers' attempts to gain attention were often ignored in ways that were disrespectful. These difficulties

may also be exacerbated by the number of offices around HPW. One family noted that they were left in the admissions suite for two hours with no means of communication with the ward. LEAC members also expressed difficulties with accessing entry to the ward. A means of providing connection between the admissions area and various staff offices would be beneficial, and the panel received later communication that a phone has been installed for this purpose. Responsiveness to front door access also is worth considering to reduce difficulties with accessibility.

Increasing communication and involvement in care planning with the family and whānau would provide staff with access to valuable knowledge that could assist to improve care, and the ability of the family and whānau to support recovery endeavours that the consumer is pursuing.

In terms of relationships between staff "on the ground" and unit management, clinical staff described communication as lacking, with requests related either to clinical issues or personnel issues often going unanswered or being answered inconsistently. The behaviour of some management staff towards clinical staff was described by a number of interviewees as controlling and often unhelpful. Staff acknowledged that a possible reason for this was that the senior staff and managers were stressed and overwhelmed by their workloads.

A level of insularity was described by HPW and external staff, consumer representatives, family and whānau, and other stakeholders. HPW was reported as having poor relationships with the community teams, and this was seen as contributing to more bed pressure and related difficulties, including the limiting of seamless movement between inpatient, community, and NGO services. It was suggested by family and whānau and members of LEAC that staff often did not look at outside notes or seek consultation when medications that were being taken for non-mental health purposes were changed. It was noted that information from outside sources was not routinely captured in the DHB mental health record, one example being the 1737 Mental Health Line and is as such a national issue, so concerns from such sources was not available for risk assessment and other decision making within the SMH&AS Services.

Patient feedback systems have been set up. A *Mutual Help Hui* has recently been established and includes staff and clients from the unit and representatives of the community. This is seen as potentially helpful but there are questions from consumers and family regarding follow-through from suggestions. If the Mutual Help Hui is

intended to have a co-design and service development role that is implicit in the title, it will need a broader representation of HPW staff attending (including those who can directly influence change) and more direct pathways by which it can influence change. Ensuring that a consistent process is established which documents initiatives suggested and details the consideration, decision, and implementation processes related to these initiatives would be a valuable addition to ensure that the Mutual Help Hui realises the kinds of change it is designed to achieve.

Resource Effectiveness

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to organisational and infrastructure systems and processes. It also relates to "Human Resource" matters such as staff morale and enablement.

STAFF ATTITUDES AND MORALE

All staff groups described the HPW staff as passionate and committed, and working there for the right reasons. Many expressed the belief that team members really care. Despite this, at times, negative attitudes towards consumers by some staff were noted. A reactive (unwillingness to change) rather than proactive (transformational) approach was reported by some staff and also, at times, observed by the review panel. Family and whānau were less positive about the level of commitment of the staff, often expressing concerns about a lack of competence and compassion being evident.

It was notable that medical, nursing, and allied health staff all felt disempowered in being able to fulfil their professional roles within the current organisational structure and function. Many staff, particularly nurses, reported or described feeling burnt out. The work culture was regarded as poorer at HPW than at Waiatarau by some stakeholders.

A variety of staffing factors contributed to the poor morale, including:

Staff Numbers

- All staff groups reporting insufficient numbers to feel they could run an optimal or effective service. Family and whānau and members of LEAC reported that staff are often expected to undertake overtime and even double shifts, which could lead to less effective and sympathetic care.
- Insufficient allied health staff to meet the need of supporting clients to be adequately equipped and prepared for discharge

- Staff Retention: High staff turnover leading to rostering difficulties, loss of institutional knowledge and access to experience, and discontinuity for consumers and family and whānau. This also leads to a skew towards a less experienced staff mix, which is undesirable in a high-acuity service
- Staff feeling that little effort is put into staff retention and replacing staff in a timely fashion when they are leaving
- Insufficient staff to support release for professional development
- Resignations of psychologists having led to access to psychological assessment and therapy currently being very limited.

Rostering

- Current rostering is difficult for effective service management. This is particularly exacerbated by variation in shift length (8hrs vs 8hrs 35 min), resulting in people being unable to attend handovers which is a significant departure from accepted care standards.

PHYSICAL RESOURCES

The building opened in May 2015 and, apart from the high care area, was designed to be an open unit. Due to geotechnical issues that were identified after the plans were finalised a large re-design of the property (mainly affecting the high care area) was required. This significantly impacted on the original concept and may have led to the building being more compartmentalised than originally intended.

The layout is unusual for an acute mental health unit but, overall, does provide a pleasant and spacious environment. The ICU is an exception to this, being somewhat cramped for the number of consumers. Nursing staff are concerned about the lack of line of sight, particularly since the recent deaths by suicide. They find it impossible to maintain the balance of observation/engagement and recording, as all documentation is done in the office. This, combined with the multiplicity of small office spaces dotted around the unit, create pressure on nursing staff and inhibit their participation in multidisciplinary team meetings etc. Since the deaths by suicide there has been increased staffing to try and mitigate this.

At the time of opening there were many minor building issues and a couple of high profile absent–without-leaves that created concern. As a result, the decision was made for the unit to be locked. The intent at the time was to build taller courtyard walls with the plan then being to unlock the unit. This has not been achieved and

currently there is not full agreement within the mental health leadership about whether the ward should be open.

Echoing the locked status of HPW, there has been a pattern of other increasing restrictions over time, including client spaces such as the sensory rooms being locked more frequently, and additional institutional and inflexible processes and systems, being established.

While the locked status and more restrictive practises in HPW may afford some additional safety, it can have the unintended consequences of being anti-recovery and increasing agitation and aggression within the ward. This is because a locked ward:

- Engenders frustration and institutional/restrictive attitudes and behaviours in staff and consumers
- Engenders unhealthy power relationships between staff and consumers
- Limits the space for people to utilise physical techniques for improving/managing mental health difficulties, and to be active generally
- Promotes a lack of engagement with people and organisations outside the ward.

The whānau room being outside of the locked doors limits its use.

Particular mention was made by a wide variety of participants in this review about the building manager's careful attention to maintaining the building in good repair and keeping it as fit for purpose as possible.

In summary, the building itself, whilst modern and obviously well cared for, presents some challenges for the safety and support of its occupants. The high care area, in particular, is somewhat cramped and suffers from a lack of an active de-escalation space. There are quiet spaces, but the lack of an area where people can safely vent, both verbally and physically, is keenly felt. The high aesthetic standard of the facility and provision of quiet lounges, sensory rooms and courtyards helps provide a sense of space and a relatively calm ambience for an acute mental health unit. Having the building locked (and/or various sections of it) detracts from this and has proved very challenging. There is a lot of work currently happening (detailed previously and below) to maximise the opportunities for better conditions that the environment is able to provide for and the panel supports the continuation of this effort.

Strategic/Leadership Effectiveness

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to quality and safety culture and measurement

of quality and safety. It also includes strategic and operational management contributions to the service.

Other sections above identify a raft of issues associated with leadership (including clinical, unit and DHB leadership), such as it being limited, inconsistent over time and for different staff and situations, lacking a consistent focus and robustness, lacking sufficient transparency to allow staff to understand the reasons for decisions, unhelpfully controlling approaches, and being unresponsive to issues and views raised by front-line staff. This led to it being seen by some staff as not fit for purpose, although it was also acknowledged by some staff as improving. Staff reported that management decisions often led to poor outcomes being mandated, and resulted in staff feeling disempowered.

Staff who had previously worked in other mental health acute inpatient units indicated that leadership processes at other units, including Waiatarau within Waitematā DHB, often appeared to be more effective and well-developed than those at HPW.

The work culture being regarded as poor by some stakeholders is also of relevance in terms of strategic/leadership effectiveness.

Learning Effectiveness

On the HQSCNZ clinical governance framework (Health Quality and Safety Commission, 2017), this pillar relates to professional development.

Several staff groups reported that the ability to obtain and attend professional development was limited. Barriers included availability of professional development funding, and time for professional development. Several staff groups also talked about having difficulty obtaining release to attend highly relevant courses due to staff shortages or lack of availability of cover on the day. Some staff reported believing this put them at risk of not maintaining the ability to offer best-practice care.

FINDINGS

The main findings of this review are detailed below.

Safety of Service

The deaths by suicide that prompted this and other reviews are deeply regrettable tragedies. Considerable efforts have been undertaken by HPW to learn from these tragedies and take action to reduce the risk of similar events in the future. There is, unfortunately, no way of completely eliminating such risk, but strenuous efforts have been undertaken, and are ongoing, to reduce it.

The review panel suggests that, overall, He Puna Waiora (HPW) is substantially similar to other acute inpatient mental health units in NZ. While the specifics may vary, similar themes often arise. Partly these are to do with the struggle to adapt the model of care to the changing needs of the people admitted to the unit and the changing context of health and social services outside the unit. Often they are also related to running a service at close to, and sometimes above, 100% occupancy, with staff shortages and significant financial constraints. This should not be interpreted to suggest complacency in response. All units, including HPW, should be undertaking continual quality improvement planning and actions. We acknowledge the efforts that have been undertaken by HPW to learn from these tragedies and the actions already taken to reduce the risk of similar events in the future. We commend HPW and SMH&AS leaders for their prompt attention to explore changes that were needed, and in using a quality improvement framework to structure the change programme which is ongoing. We note particularly that there was an increase in key leadership roles in the unit as a response to the initial needs identified by the leadership team. There is, unfortunately, no way of completely eliminating such risk, but continued strenuous efforts and more extensive transformational change are needed to reduce it.

The individual reviews into the deaths by suicide shared similar findings that are consistent with our findings in this overarching review, including limitations relating to the physical environment, the locked ward, the lack of continuity in nursing care, the MDT function, biomedical model dominance, and the unmet needs of long stay patients.

We wish to make the following observations regarding strengths and limitations of HPW at the current time, and going forward. The limitations identified may have been

a contributory factor, although by no means the only factor, in the tragedies that precipitated this and the other reviews.

LEADERSHIP AND CULTURE

Leadership was lacking and inadequate at the time of the incidents. This finding was informed by the various issues staff, and family and whānau reported in terms of leadership at the clinical, unit and DHB levels. It is further supported by the fact that an initial need identified in response to the deaths was an increase in key leadership roles.

Many of the other observations also relate to leadership and culture, particularly given that '*Healthcare organisational culture is a metaphor for some of the softer, less visible, aspects of health service organisations and how these become manifest in patterns of care'* (Mannion & Davies, 2018, p. 2).

3 layers or levels of organisational culture in healthcare have been proposed (Mannion & Davies, 2018). These include visible manifestations, shared ways of thinking, and deeper shared assumptions. Visible manifestations, are defined as including the demarcation between staff groups in activities performed (and the tussles that challenge or reinforce these), the distribution of services and roles between service organisations, and the established pathways through care (see clinical effectiveness and associated subsections, and the communication effectiveness section, above); the physical layouts of facilities and reward systems (pay and pensions, but also the less tangible rewards of autonomy and respect) (see resource effectiveness and associated subsections above); the established ways (both formal and informal) of tackling quality improvement and patient safety, the management of risk, and the accepted ways of responding to staff concerns and consumer or family and whānau feedback or complaints (see risk management, consumer experience, and strategic/leadership subsections above).

'Shared ways of doing things include the values and beliefs used to justify and sustain the visible manifestations above and their associated behaviours, as well as the rationales put forward for doing things differently' (Mannion & Davies, 2018, p. 2), as have been addressed through the recommendations below.

'Deeper shared assumptions are the (largely unconscious and unexamined) underpinnings of day-to-day practice. These might include ideas about appropriate professional roles and delineations; expectations about patients' and carers'

knowledge and dispositions; and assumptions about the relative power of healthcare professionals—collectively and individually—in the health system' (Mannion & Davies, 2018, p. 2). Similarly, these have been addressed through the recommendations below.

MODEL OF CARE

The model of care was inadequate to meet the demands of care in 2019. We consider that the lack of adaptation of the clinical processes and the team function to the changing client profile (especially those consumers experiencing 'long stay' or being 'stuck') and to the high and complex needs of people being admitted, are a limitation of the system. More specifically this includes the model of care not supporting effective MDT function, a predominantly biomedical rather than biopsychosocial model of care, a lack of allied health input to individual consumer care and, at times, to the MDT, a lack of individualised care planning, and discontinuity within ward and between the ward and community care. Strengthening and differentiating the role of different staff groups, at the same time as ensuring the cohesiveness of their overall efforts, is particularly important for ensuring care that is responsive to the needs of all consumers in HPW.

NURSING MODEL OF CARE AND DEPLOYMENT

A primary nursing approach is critical to ensuring that consumers and their family and whānau have a sense of continuity with individual staff with whom they can develop sustained relationships, rapport and trust, and who can get to know them well. Current patterns of nursing rostering, staff shortages, and movement of staff within the unit tends to mitigate against a primary nursing model being operationalised. Other staff groups have variable levels of continuity of their relationship with clients, but due to their 24/7 presence, the nursing role is particularly important for establishing a sense of constancy and certainty for consumers. Providing this can be a significant factor in recovery. Different approaches to rostering and/or staff deployment would make developing a system of primary (or at least team) nursing more feasible, which is likely to improve satisfaction and support for consumers, family and whānau, and staff, and which in turn is likely to improve staff retention. Alongside this, ensuring strengthening of the culture so that all staff see themselves as charged with taking appropriate collective responsibility for all consumers would be advantageous.

PHYSICAL AND ORGANISATIONAL STRUCTURE

The building design issues; together with the issue of the nursing model, were known by staff prior to the incidents. Importantly, some solutions had been developed by the leaders and staff of the unit, who expressed frustrations with getting prompt action.

The approval and timely implementation of the measures proposed in the business case to reduce ligature risk are critical to improving the safety of HPW.

The positive features and potential of the building are currently somewhat nullified by operational measures currently in place to mitigate risk. We believe that with the right attention to physical changes, provision of equipment and changes to operational management the potential of HPW as a recovery environment could be greatly enhanced. This has the potential to improve outcomes for consumers and their family and whānau as well as enhancing the work environment for staff. Critically, this will make HPW safer for all.

STAFF MIX

A movement towards a larger proportion of less experienced staff, partly as a result of relatively rapid staff turnover, is not ideal for a high acuity service. The panel acknowledges that similar challenges of staffing mix exist in many acute inpatient units in NZ. It requires attention to be paid to support, training and professional development in order to maximise staff skills, confidence, satisfaction and retention.

RECOMMENDATIONS TO WAITEMATĀ DHB

1. Prioritise a focus on strengthening the leadership and culture of HPW. This should include:
    a. Undertaking a review of current leadership positions and capacity to ensure they are now satisfactory to support the effective leadership of the unit
    b. Developing procedures for consistent and responsive leadership engagement and communication
    c. Undertaking a widespread and fully inclusive process to develop an organisational cultural framework - the shared patterns of feeling, thinking, and behaving that underpin practice. A growing body of evidence links culture and quality (Mannion & Davies, 2018); and such a process and framework will be essential as the substrate upon which the other recommendations can be progressed most efficaciously and result in transformational change.

2. Work towards more focus on consumers and family and whānau, with individualised care and attention to personalised care plans driving recovery.

    a. This could include a specific methodology, such as Know the Person Planning (KPP) type process, where consumers are worked with to identify their individual recovery and rehabilitation needs, prepare a plan, and undertake timely reviews in an effort to ensure that the service is optimally supporting them towards recovery and transition out of HPW. This could also involve a specific review process involving an intensive multidimensional review of the situation and needs of the person that is triggered if they remain an inpatient for two months or more. The focus of this would be on identifying what is needed to further their recovery and appropriate community placement and reintegration.
    b. This includes increasing the involvement of family and whānau in care planning and ongoing delivery. This should not only be during discharge planning, but family and whānau should be invited to be involved in all aspect of planning and support throughout the admission. Making this change may require changes in how the care planning processes in the ward are undertaken (e.g., towards smaller MDT meetings involving mostly the staff directly involved in care of the consumer, and the consumer, and

the family and whānau rather than large meetings in which many consumers are reviewed in front of all staff in the absence of the consumers or family and whānau) but these changes may lead to more effective and inclusive planning processes and outcomes.

c. In particular, any concerns expressed by family and whānau about the safety of a consumer should be taken very seriously and responded to with an appropriate clinical action.

3. Strengthen the model of care, using a collaborative co-design process to map a new way forward, focused on developing more effective MDT systems and improving the expertise and value that all members of the MDT bring to the assessment, planning, and delivery of care for individual consumers, and to the team as a unit. This recommendation includes:
   a. Reviewing the Model of Care document, to focus on the principles of care, putting the consumer, their family and whānau at the centre.
   b. Ensuring that front-line nursing staff are able to contribute directly to the MDT meetings. This may require development of a primary/team nursing approach and reorganisation of the MDT meetings to make it possible for nursing staff to attend.
   c. Ensure that MDT meetings involve the staff who work directly with the individual consumer, the consumer, and family and whānau members unless involvement of consumer and/or family members is clearly contraindicated.
   d. Addressing the role and function of allied health, particularly their role in strengthening the focus on supporting a recovery approach, especially with consumers experiencing longer stays. This includes:
      i. Occupational Therapists strengthening their particular role - focusing on functional gain - to assist consumers with their recovery and rehabilitation.
      ii. Social Workers taking a primary role in ensuring that the social networks (including family and whānau and social services) are strengthened sufficiently to be able to support transition of consumers to appropriate and sustainable settings outside of HPW.
      iii. Psychologists undertaking assessments to identify psychological, cognitive, and behavioural factors that may contribute to difficulties consumers have with managing their health and living in the community,

and either providing appropriate therapy or developing suggested therapy plans for delivery by others inside or outside HPW.

e. Appropriate clinical leadership across nursing, medical and allied health to ensure the model of care is implemented and embedded.

4. A model of primary nursing or at least team nursing should be implemented on the unit. Evidence shows this would provide improved consistent relationships, enhance individual personalised planning and support, and strengthen the MDT collaboration.

5. Improve relationships and integration between HPW and the wider health and social services system to ensure that the continuum of care is more seamless and that the whole-of-system help consumers receive is responsive to their needs. This includes:
    a. Continuing the current efforts to address the needs of consumers experiencing long stays, including those who are readmitted because community supports have been unable to meet their needs.
    b. Undertaking an audit of the range of mental health and co-existing difficulties experienced by consumers at HPW; and services available; to identify gaps in support currently available and/or accessible to clients either through HPW clinicians or through the broader systems accessible from HPW, which may limit recovery

6. We consider that there are further actions that would create a safer environment, and promote recovery. The following need to be considered:
    - Opening the courtyards for more un-escorted use by consumers. This would require making the external walls safe from climbing and ligature hazards.
    - Open the sensory modulation rooms for use by consumers, without supervision, when they need them. Currently a staff member is required to open them. May require door-top sensors and other anti-ligature measures.
    - Investigate drop-down spaces with laptop drop boxes/slam drawers. These are usually kidney shaped table/bench structures in areas where consumers and staff congregate. People often sit around them and converse/do activities etc. There is provision for staff to use mobile devices at these stations for collaborative note writing etc. (can be viewed at Counties Manukau). These are a very effective tool in enabling staff to be “out of the office”, especially when combined with mobile duress and communications.

- Investigate staff communication aids such as Vocera (example at Hillmorton Hospital), Ascom (example at Counties Manukau Health) and enhanced mobile duress (preferably integrated with comms). These, along with the provision of laptops/tablets, may support staff to be safer, more connected, less isolated and office bound.

7. Address training and professional development needs and accessibility.
    - The individual reviews have identified specific areas where there is a lack of expertise in HPW (e.g. Foetal Alcohol Syndrome and severe personality disorder) to meet client needs. Ensure that training is undertaken by appropriate staff to meet these needs; or access to specialists who can support people with these difficulties, from outside sources, is available.
    - There is also a theme of people being unable to get release for training and education due to staff shortages and roster pressure. Staff access to training and education is critical to provision of quality care. It is also a requirement for health professionals to be able to maintain their professional registration.
8. Ensure that strong processes are put in place to guide and plan changes arising from this and other reviews into HPW, to establish clear accountability and support for implementing those changes, and to monitor that the changes are leading to the positive outcomes desired. One aspect of this accountability should be transparency of processes and outcomes with consumers, family and whānau, and the community generally.

RECOMMENDATIONS WIDER THAN WAITEMATĀ DHB

1. Gap analysis is needed to identify specialist services that are lacking and that are needed to support the recovery of people who often are admitted to acute inpatient mental health services but for whom a different kind of service would be optimal. All acute inpatient mental health services tend to have some consumers experiencing long-stays due to the lack of more appropriate services so the gap analysis could be undertaken regionally or even nationally. The necessary resolve and resource allocation to implement provision of appropriate services would be required to ensure that the identified gaps are filled. While there is obviously a significant cost in filling these gaps; the

opportunity cost, both financial and in terms of human suffering, of not doing so, is high.

2. There would be much advantage in having a national centralised approach to designing acute MH inpatient units. We believe that such an approach requires an understanding that whilst environmental safety is critical in saving lives, the delivery of recovery-focused and evidence-based practice is also highly influenced by the environment. We would recommend that this recommendation be made available to the Ministry of Health.

   We strongly urge that national standards and templates be developed, leaving room for innovation, but establishing fundamentally consistent approaches to unit design. Hanging accounts for between half and three-quarters of suicides in UK and US inpatient units. The most common ligature anchor points are bedroom and bathroom doors, followed by hooks, handles and rails. Ligatures include bedding, towels, clothing, belts and cables. NZ data reflects similar figures. Evidence shows that, beyond a certain point, staff vigilance including observation practices, while necessary, are not sufficient to maintain safety[1] (Department of Health and Human Services, 2017); and the most significant impact on deaths in inpatient units can be made through physically safe design and equipment (including ligature-free design throughout, 'duress alarms', safe doors, pressure alarms, etc.). National standards for these facilities should ensure that design of units is informed by best practice in terms of safe and supportive environments.

3. We recommend a national resource be developed that provides guidance for responding to inpatient deaths by suicide, including detailed instructions on undertaking suicide postvention. Given that an inpatient death by suicide is an infrequent event, a resource of this nature would be most helpful in guiding staff as to best-practice approaches to provide support, alleviate some of the suffering caused by such tragic occurrences; and reduce the potential risks to others. In such instances, having a single staff member who actively liaises and

[1] Most people who died by suicide on inpatient units denied suicidal intent when last questioned by staff. Fewer than 2% of inpatients rated at high risk of suicide (using risk factors) died by suicide on the ward. Conversely 14% of those who died had none of these risk factors, and 30% only one

maintains communication with family and whānau was identified as a useful component of the response process.

We recommend that this recommendation be shared with the Director, Suicide Prevention Office.

Many of the issues outlined in this document could also be identified in other acute adult mental health inpatient units in New Zealand. Some drivers of this are due to the dominant care delivery paradigms and others are due to broader systemic difficulties such as shortages of skilled staff prepared to work in the area, potentially under-resourcing of services and limited availability and access to suitable specialist training. It is our hope that this report may assist to guide positive development in other such services in New Zealand.

REFERENCES

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, *21*(6), 499-508. doi: 10.1111/jpm.12129

Department of Health and Human Services. (2017). Chief Psychiatrist's audit of inpatient deaths 2011-2014. Victoria State Government. Retrieved from www2.health.vic.gov.au

Flynn, M. A., Burgess, T., Crowley, P. 2015. Supporting and activating clinical governance development in Ireland: sharing our learnings. *Journal of Health Organization and Management 29(4),* 455–481.

Health Quality and Safety Commission. (2017). Clinical Governance: Guidance for health and disability service providers. Retrieved from www.hqsc.govt.nz

Mannion, R., & Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *BMJ*, 363. doi: 10.1136/bmj.k4

SERVICE UPDATE 01 DECEMBER 2020 - RECOMMENDATIONS FOR HE PUNA WAIORA

In mid-2019 there were two sentinel events at He Puna Wairoa where two men took their own lives within a week of each other. Alongside these significant events, there were two other deaths that occurred in the community. The impact and loss of these people has had a significant, devastating and long-lasting effect on their families. Additionally, those staff involved with the care of these people have also been affected.

Following such serious events, the service moved to understand what might have been done differently to improve the care and service provided to reduce the likelihood of such events occurring in the future. The service has continued to undertake an improvement approach to ensure that we provide the best care possible for the people that we are working with. We acknowledge that there were areas of improvement that needed focus and that the key themes of these were related to our engagement with family/whānau, risk assessment and environmental safety, our Model of Care for the service, access to psychological interventions, improving communication within the Multi-Disciplinary Team, building leadership and enhancing relationships with our wider sector services. In response, a number of improvement initiative have been undertaken (outlined below) with the purposes of influencing the culture within the unit so that people who access the service have an experience that promotes their wellness and involves and includes their whānau.

Whilst much has been done to improve the performance and safety of the service, there is further work that requires completion in relation to the Model of Care and the nursing and allied health models within the Inpatient Unit. The following report recommendations have focused on key areas for development, which have also been at the forefront of service planning since July 2019. Over the past 18 months, the following actions related to these recommendations in the overarching report have been undertaken. The table below provides more detailed information about the activities related to each of the recommendations.

Table: Service activities that align with the recommendations from the He Puna Waiora report

Recommendations	Related activities and progress
Leadership and culture	
Prioritise a focus on strengthening the leadership and culture of HPW. This should include: a. Undertaking a review of current leadership positions and capacity to ensure they are now satisfactory to support the effective leadership of the unit	There have been changes to the leadership structure and culture at He Puna Waiora since the events that triggered this review. **Nursing and senior medical staff** From November 2019, the number of nursing leadership positions in senior nursing have increased. This has included 0.5FTE Nurse Educator and 1FTE Associate Clinical Charge Nurse. In addition, the team has introduced shift coordinator training. This has included debrief training to provide a framework for shift coordinators to use with staff as required. A dedicated clinical coach also supports the implementation of enhanced practice. Following job sizing for SMOs the number of SMO FTE has also increased by 0.8FTE. The unit has now fully recruited and the positions will be filled by March 2021.

Recommendations	Related activities and progress
	Cover Model for Nursing Sitting under the Model of Care is the Cover Model which has been reviewed over the past 12 months in partnership with the PSA. The cover model is the budgeting tool used by the District Health Board to identify workforce full time equivalents and the associated costs for each responsibility centre for a financial year. Whilst the cover model was completed in 2015 for He Puna Waiora, the staffing model has since changed. Therefore, a revised cover model has been developed for He Puna Waiora and Waiatarau. The cover model has been agreed and is now in final draft. **Allied Health** A job sizing for Psychology has been undertaken and is in the final stages of review. It is expected to be ready for sign off in February 2021. In the meantime, there has been an initial increase in psychology input to the unit. Further work has been identified for review of the Social Work and Occupational Therapy services for 2021.

Recommendations	Related activities and progress
b. Developing procedures for consistent and responsive leadership engagement and communication	**Communication and Engagement** There has been an increase in the number of staff engagement opportunities and involvement in project work. These have included: • Safety huddles which occur in the middle of every shift • Weekly Mutual Help Hui (patients and staff) • Weekly staff meetings • Bi-monthly joint meetings with union and union delegates • Weekly health and safety meetings • Weekly team leadership meetings • Monthly team quality meetings
c. Undertaking a widespread and fully inclusive process to develop an organisational cultural framework - the shared patterns of feeling, thinking, and behaving that underpin practice. A growing body of evidence links culture and quality (Mannion & Davies, 2018); and such a process and framework will be essential as the substrate upon which the other recommendations can be progressed most efficaciously and result in transformational change	**Organisational cultural framework** An over-arching inpatient unit Clinical Governance group has been established. This group takes a leadership role in monitoring improvement activity and outcomes and in cultural change. This has been supported by the publishing of the Model of Care for He Puna Waiora. Participation in quality improvement activities such as Zero Seclusion, Safewards, Handover Project have provided opportunities for staff to participate in changes from clinicians to managers. The improvement approach has emphasised a “bottom-up” approach for identifying change ideas. The change ideas have been tested and reviewed prior to full implementation. The PSA union and health and safety representatives have also been involved in working groups.

Recommendations	Related activities and progress
	In addition, implementation of the Safewards package has introduced "positive words" which supports staff to engage with one another respectfully and positively and proactively.
Focus on consumers and family/whānau	
Work towards more focus on consumers and family and whānau, with individualised care and attention to personalised care plans driving recovery. a. This could include a specific methodology, such as Know the Person Planning (KPP) type process, where consumers are worked with to identify their individual recovery and rehabilitation needs, prepare a plan, and undertake timely reviews in an effort to ensure that the service is optimally supporting them towards recovery and transition out of HPW. This could also involve a specific review process involving an intensive multidimensional review of the situation and needs of the person that is triggered if they remain an inpatient for two months or more. The focus of this would be on identifying what is needed to further their recovery and appropriate community placement and reintegration.	**Individualised care and care planning** Several improvement streams have supported individualised care planning with the tāngata whai i te ora and family/whānau. The unit's cultural advisor is proactively supporting other staff to develop their skills for working with Māori and the implementation of Safewards (an evidence-based intervention package) has supported individual care planning through a number of interventions. These include: • A weekly Mutual Help Hui (community meetings) with tāngata whai i te ora and staff • A feedback box managed by the Consumer Advisor. Concerns and compliments to the Inpatient Clinical Governance Group. • A 'get to know you' information sheet that the tāngata whai i te ora fills out and is kept in the office at He Puna Waiora for staff to refer to.

Recommendations	Related activities and progress
	There has also been a focus on increasing sensory interventions which support self-calming. These include the provision of sensory packs to all tāngata whai i te ora on open wards and working with staff to identify individual sensory preferences to support self-calming. Additionally, safety huddles have been introduced. These communication mechanisms involve staff meeting in the middle of each shift to raise any concerns about safety, in addition to at the regular face to face handover meetings. Staff face to face handover meetings have integrated interventions from the Safewards package including highlighting events or incidents for tāngata whai i te ora where reassurance will be required. This involves staff being deliberately visible and providing an explanation and support to ensure everyone feels safe and secure. Where support for "bad news" might be needed is also discussed in face to face handover and safety huddles so staff can support anyone who has received, or is going to receive, bad news in recognition of the impact this can have when a person may already be being feeling less resilient. **Nursing care planning** The newly developed Nursing Care Plan is a dynamic process with documented incremental hour-to-hour and day-to-day updates that ensure interventions are carried out and new information is integrated into planning in real time. This includes emerging changes in presentation. The plan is used to capture the tāngata whai i te ora and whānau voice, and this is reinforced by documentation audits.

Recommendations	Related activities and progress
	Recovery planning Recovery planning is facilitated by the tāngata whai i te ora's allocated MDT. This planning informs nursing care plans, discharge plans and longer-term recovery plans. In addition to being reviewed at assessments and family/whānau meetings the inpatient review plan is reviewed each week at a full MDT meeting. The medical, allied health, pharmacy and nursing staff contribute to this plan based on the assessments, observations and knowledge from each professional group. This includes patient-centred and family/whānau-focussed approaches and information. Plans are developed with input and whenever possible agreement from everyone concerned, including any information provided from tāngata whai i te ora and family/whānau.
b. This should also include increasing the involvement of family and whānau in care planning and ongoing delivery. This should not only be during discharge planning, but family and whānau should be invited to be involved in all aspect of planning and support throughout the admission. Making this change may require changes in how the care planning processes in the ward are undertaken (e.g., towards smaller MDT meetings involving mostly the staff directly involved in care of the consumer, and the consumer, and the family and whānau rather than large meetings in which many consumers are reviewed in front of all staff in the absence of the consumers or family and whānau) but these	**Increased involvement of family/whānau in care planning and delivery** To enable more involvement of family/whānau in care planning and delivery the MDT structure has been reviewed resulting in a third team. Increasing the number of MDT's from two to three has achieved a dedicated MDT for a smaller number of tāngata whai i te ora with each professional group being involved in-depth in planning and review alongside the tāngata whai i te ora and their family/whānau.

Recommendations	Related activities and progress
changes may lead to more effective and inclusive planning processes and outcomes.	The MDT meetings are for the purpose of clinical review of diagnostic formulation and clarification, treatment and medication efficacy, side effect monitoring, comprehensive psychosocial-cultural-occupational planning that is MDT-collaborative and joined up, and problem-solving barriers or delayed progress. The tāngata whai i te ora and their family/whānau are involved with the MDT in dedicated care planning meetings, as well as discharge planning meetings with a focus on shared goals and agreement to plans. In addition, the family/whānau engagement working group is looking at key milestones and change ideas to support further involvement of family and the length of stay working group is reviewing the family/whānau meeting structure and the involvement of family/whānau in the care journey.
c. In particular, any concerns expressed by family and whānau about the safety of a consumer should be taken very seriously and responded to with an appropriate clinical action.	**Concerns raised by whānau** There were immediate changes to policies and procedures about the response that needed to occur after a family/whānau member contacts the units with concerns about safety. Any imminent concerns for safety now result in an immediate increased level of care and observation until a medical review occurs. In addition, any

Recommendations	Related activities and progress
	concerns raised by family/whānau are discussed in the mid-shift safety huddle and in handover.
Strengthen the model of care, using a collaborative co-design process to map a new way forward, focused on developing more effective MDT systems and improving the expertise and value that all members of the MDT bring to the assessment, planning, and delivery of care for individual consumers, and to the team as a unit. This recommendation includes: a. Reviewing the Model of Care document, to focus on the principles of care, putting the consumer, their family and whānau at the centre.	**Model of Care and Operational Manuals** Following the completion of the Model of Care for Adult Inpatient Units (July 2019), there has been a process of aligning the service practice with the new model. The He Puna Waiora Operations Manual outlines the detail of the model, which has required a number of change initiatives and projects, particularly focusing on placing the tāngata whai i te ora and family/whānau at the centre of care. Changes have included: • A Handover Project to enable registered nurses to hand over their cases face to face to the incoming shift of staff • Completion of the implementation of Safewards • The implementation of safety huddles

Recommendations	Related activities and progress
	• We have reviewed the admissions process, including allocation of a registered nurse to manage each admission process • Implementation of a pre-admission prescribing protocol to reduce delays in accessing medication
b. Ensuring that front-line nursing staff are able to contribute directly to the MDT meetings. This may require development of a primary/team nursing approach and reorganisation of the MDT meetings to make it possible for nursing staff to attend.	**Frontline nursing** Primary nursing has been identified as the preferred model of nursing care to fulfil the core organising and coordinating function on behalf of the MDT. An options paper has been prepared by the nursing model of care working group and has identified primary nursing as one option with a second option where team nursing is the predominant framework, with primary nurses allocated where there are complex needs or stays of a long duration
c. Ensure that MDT meetings involve the staff who work directly with the individual consumer, the consumer, and family and whānau members unless involvement of consumer and/or family members is clearly contraindicated.	**MDT meetings** The MDT structure and function have been adapted, with an extra MDT added, so that MDTs are smaller and work consistently with a group of tāngata whai i te ora who are in identified parts of the unit. This has enabled MDTs to meet more frequently. A further stand-alone MDT is planned for the High Care Area. As noted above, MDT meetings continue to be professional meetings, but the new

Recommendations	Related activities and progress
	structure means more team members are available to meet with tāngata whai i te ora and family/whānau.
d. Addressing the role and function of allied health, particularly their role in strengthening the focus on supporting a recovery approach, especially with consumers experiencing longer stays. This may include: I. Occupational Therapists strengthening their particular role - focusing on functional gain - to assist consumers with their recovery and rehabilitation. II. Social Workers taking a primary role in ensuring that the social networks (including family and whānau and social services) are strengthened sufficiently to be able to support transition of consumers to appropriate and sustainable settings outside of HPW. III. Psychologists undertaking assessments to identify psychological, cognitive, and behavioural factors that may contribute to difficulties consumers have with managing their health and living in the community, and either providing appropriate therapy or developing suggested therapy plans for delivery by others inside or outside HPW.	**Allied health** To date the occupational therapy and social worker job sizing has not been reviewed, however, there have been refinements made to OT and social worker roles to ensure these professions are maximising their scope of practice. Assessments are provided early on in the stay to inform planning and interventions that will contribute to successful timely discharges and maintaining community tenure to avoid readmissions. This includes a focus from OTs on living and coping skills and community participation, and social workers on family work and resources for community living including housing, support and finances. Two allied health assistants have been employed to support evening and weekend activities and groups to enable registered professionals to have more of an assessment and planning focus. For all allied health professions proposals for increased staffing if a review of the job size indicates this is appropriate. There is currently a psychology framework review and specialist psychologist job-sizing exercise underway. Once new positions are

Recommendations	Related activities and progress
	funded and recruited to there will be increased options for assessment and therapy with psychologists.
Primary/team nursing	
A model of primary nursing or at least team nursing should be implemented on the unit. Evidence shows this would provide improved consistent relationships, enhance individual personalised planning and support, and strengthen the MDT collaboration.	Primary nursing is the preferred model for nursing identified in the model of care for He Puna Waiora. An options review has identified primary nursing is possible within an expanded FTE and split rosters or an adapted team nursing model is able to function within existing staff levels. In this model tāngata whai i te ora who have stays of longer durations or who have complex needs would be allocated a primary nurse and other tāngata whai i te ora would be allocated to team nursing.
Relationships with the wider health and social services system	
Improve relationships and integration between HPW and the wider health and social services system to ensure that the continuum of care is more seamless and that the whole-of-system help consumers receive is responsive to their needs. This should include: a. Continuing the current efforts to address the needs of consumers experiencing long stays, including those who are readmitted because community supports have been unable to meet their needs.	A Long Stay meeting has been set up between the service, mental health needs assessment and coordination service, the funder and the provider of disability support services for the region to further the

Recommendations	Related activities and progress
	efforts to address the needs of tāngata whai i te ora experiencing long stays or readmitted because of inadequate support in the community.
b. Undertaking an audit of the range of mental health and co-existing difficulties experienced by consumers at HPW; and services available; to identify gaps in support currently available and/or accessible to clients either through HPW clinicians or through the broader systems accessible from HPW, which may limit recovery	An audit of the needs of the tāngata whai i te ora and the services available has also resulted in care pathway planning for HPW. Development of a care pathway is underway. The service is also an active participant in the regional long stay working group. The service recognises that in addition to not meeting the needs of the affected tāngata whai i te ora, with having fewer funded beds per 100,000 populations than other DHBs, stays of longer duration are also a driver of high occupancy rates.
Safer environment	
We consider that there are further actions that would create a safer environment and promote recovery. The following need to be considered: a. Opening the courtyards for more un-escorted use by consumers. This would require making the external walls safe from climbing and ligature hazards. b. Open the sensory modulation rooms for use by consumers, without supervision, when they need them. Currently a staff member is	Currently the main ward courtyards are open. A proposal to remove ligature risk points from other areas where ideally tāngata whai i te ora who present with a high risk could be unsupervised has been accepted by the WDHB Board. This includes remediation of fixtures and fittings

Recommendations	Related activities and progress
required to open them. May require door-top sensors and other anti-ligature measures. c. Investigate drop-down spaces with laptop drop boxes/slam drawers. These are usually kidney shaped table/bench structures in areas where consumers and staff congregate. People often sit around them and converse/do activities etc. There is provision for staff to use mobile devices at these stations for collaborative note writing etc. (can be viewed at Counties Manuka). These are a very effective tool in enabling staff to be "out of the office", especially when combined with mobile duress and communications. d. Investigate staff communication aids such as Vocera (example at Hillmorton Hospital), Ascom (example at Counties Manukau Health) and enhanced mobile duress (preferably integrated with comms). These, along with the provision of laptops/tablets, may support staff to be safer, more connected, less isolated and office bound.	in a number of areas including some bedrooms, comfort rooms, sensory modulation rooms, art rooms and high care courtyards. A modified proposal is to be submitted, including mitigation of the external walls (decorative panel fencing). The installation of door-top sensors is already nearing the end of the approvals process. In the interim higher levels of therapeutic engagement observation are employed as required and there is an hourly audit of the safety of the environment. Staff communication aids, including enhanced mobile duress options, have been investigated. Infrastructure modifications are underway with Facilities and healthAlliance. Investigation of drop-down workspaces will build on this work. In addition, staff also receive training on talk down strategies as part of the Safewards intervention. This includes skills for redirecting people who are distressed using "soft words" so that situations can be managed without aggression.

Recommendations	Related activities and progress
Training and professional development needs	
Address training and professional development needs and accessibility. a. The individual reviews have identified specific areas where there is a lack of expertise in HPW (e.g. Foetal Alcohol Syndrome and severe personality disorder) to meet client needs. Ensure that training is undertaken by appropriate staff to meet these needs; or access to specialists who can support people with these difficulties, from outside sources, is available. b. There is also a theme of people being unable to get release for training and education due to staff shortages and roster pressure. Staff access to training and education is critical to provision of quality care. It is also a requirement for health professionals to be able to maintain their professional registration.	A Foetal Alcohol Syndrome training has been provided to HPW staff. The session was recorded and is a resource on the e-learning platform. The planned increase in psychologist FTE, the change to a primary role for social workers, a greater role in assessments by OTs, smaller MDTs and access to consult with the regional Dual Disability service will all support meeting specific tāngata whai i te ora needs. Several options for increasing access to clinical supervision were reviewed. To increase access to clinical supervision, zoom facilities have been arranged. In addition, senior nursing staff are preparing to train as clinical supervisors In addition, the cover model that has been completed for the unit allows for release for training and supervision for all staff.

Recommendations	Related activities and progress
Recommendations implementation	
Ensure that strong processes are put in place to guide and plan changes arising from this and other reviews into HPW, to establish clear accountability and support for implementing those changes, and to monitor that the changes are leading to the positive outcomes desired. One aspect of this accountability should be transparency of processes and outcomes with consumers, family and whānau, and the community generally.	An improvement programme established in 2019 continues to implement changes identified by the service and the external panels. The programme is led by the Adult Mental Health leadership group, with support from a quality improvement specialist.