Te Whatu Ora
Health New Zealand

28 July 2023

Sarah Brodrick
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Tēnā koe Sarah

Your request for official information, reference: HNZ00024409

Thank you for your email on 1 July 2023, asking for the following under the Official Information Act 1982 (the Act):

> *I would like to get a copy of the most recent Adult Mental Health services policy for outpaitents 1)in the qualifying and access of treatment and care of persons living in the South Auckland community, 2) the treatment and care of outpaitents 3)and the discharge of outpaitents within the Counties Manukau region.*
>
> *I would like to get a copy of the most recent Adult Mental Health services policy 1)in relation to the qualifying & access to treatment and care for persons living in the South Auckland community, 2) the treatment and care of outpaitents within the Counties Manukau region 3) and the discharge of outpaitents within the Rapua Te Ao Waiora clinic.*
>
> *I'd also like to get a copy of the most recent policy that Te Whatu Ora New Zealand has, a policy and/or standards in place around the communication and correspondence of information which include appointments, referrals and assessments of Adult Mental Heath Services between Te Whatu Ora New Zealand and Outpaitents, receiving treatment and care from the South Auckland region, Counties Manukau Health, as well as Rapua Te Ao Waiora Clinic. This includes referrals, appointments and assessments made in Middlemore Hospital, and referrals, appointments and assessments made in the community.*
>
> *I'm only interested in policy, standards and internal processes which would be information avaliable to the general public.I'm not requesting for any details of outpaitents or staff members names.*

Te Whatu Ora – Counties Manukau District Response

For context, Te Whatu Ora Counties Manukau employs over 8,500 staff and provides health and support services to people living in the Counties Manukau region (approximately 601,490 people). We see over 118,000 people in our emergency department each year, over 490,000 outpatient appointments each year, and over 2,000 visitors come through Middlemore Hospital daily.

Our services are delivered via hospital, outpatient, ambulatory and community-based models of care. We provide national, regional and supra-regional specialist services i.e. for orthopaedics, plastics, burns and spinal services. There are also several specialist services provided including tertiary surgical services, medical services, mental health and addiction services.

Please find each of your questions addressed in turn below.

> *I would like to get a copy of the most recent Adult Mental Health services policy for outpaitents 1)in the qualifying and access of treatment and care of persons living in the South Auckland community,*

There is no policy in regards to those who qualify for treatment and care, this is done on an assessment basis of each individual and their needs, once their general practitioner (GP) or other health care professional has made the referral. As such, this part of your request is refused under section 18(e) of the Act, as the information requested does not exist. You can read more on the referral process here: www.healthpoint.co.nz/public/mental-health-specialty/adult-mental-health-counties-manukau-te-whatu/.

2) the treatment and care of outpaitents

There is no specific policy on the care and treatment of outpatients as this is dependent on the individual's specific needs. Attached as **Appendix 1** is the policy for *Acute Community Options for Acute Adult Mental Health Services*, which may provide the information you are seeking.

3)and the discharge of outpaitents within the Counties Manukau region.

As above, there is no policy on the discharge process for outpatients in the Counties Manukau region as this is dependent on the individual, their care plan and progress. As such, this part of your request is refused under section 18(e) of the Act.

I would like to get a copy of the most recent Adult Mental Health services policy 1)in relation to the qualifying & access to treatment and care for persons living in the South Auckland community,

There is no policy in regards to those who qualify for treatment and care, this is done on an assessment basis of each individual and their needs, once their GP or other health care professional has made the referral. As such, this part of your request is refused under section 18(e) of the Act, as the information requested does not exist.

2) the treatment and care of outpaitents within the Counties Manukau region

There is no specific policy on the care and treatment of outpatients as this is dependent on the individual's specific needs. As such, this part of your request is refused under section 18(e) of the Act. Please also refer to **Appendix 1** detailed above.

3) and the discharge of outpaitents within the Rapua Te Ao Waiora clinic.

There is no policy in regards to the discharge of patients specifically from Rapua Te Ao Clinic as this is dependent on the individual's specific needs and care plan. Discharge planning is a multi-disciplinary team standard of practice. As such, this part of your request is refused under section 18(e) of the Act. However, attached as **Appendix 2** is the guideline *Tiaho Mai Multidisciplinary Team standard of Practice*. This mentions discharge planning, which may assist with your query.

I'd also like to get a copy of the most recent policy that Te Whatu Ora New Zealand has, a policy and/or standards in place around the communication and correspondence of information which include appointments, referrals and assessments of Adult Mental Heath Services between Te Whatu Ora New Zealand and Outpaitents, receiving treatment and care from the South Auckland region, Counties Manukau Health, as well as Rapua Te Ao Waiora Clinic. This includes referrals, appointments and assessments made in Middlemore Hospital, and referrals, appointments and assessments made in the community.

Please refer to **Appendix 3**, **Appendix 4**, and **Appendix 5** attached, respectively:

- Coordinated Care Planning - Policy
- Coordinated Care Planning - Procedure
- Information sharing between providers of health services for mental health clients.

Please note these are not specific to certain areas.

How to get in touch

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Te Whatu Ora may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

Dr Vanessa Thornton
Interim District Director
Te Whatu Ora Counties Manukau

Policy: Acute Community Options for Adult Acute Mental Health Services

Purpose

The purpose of this policy is to outline the clinical acute requirements for entry and management of service users who require acute care delivered within Acute Community Options.

Note: This policy must be read in conjunction with the Acute Community Options Procedure.

Scope of Use

This policy is applicable to all CMH employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMH facility.

Background

Acute Community Options services provide active support to mental health service users who are experiencing acute symptoms. The services are acute residential facilities or services based in the community that aim to minimise the need for hospitalisation by supporting the individual in their community. The duration is short term and intermittent or episodic. The acuity must be such that the service user can be safely managed in a community setting and provide consent to receiving care by Home Based Treatment clinicians.

Acute Community Options aims to assist service users in reducing distress, enhance wellness and strengthen their ability to maintain their safety within the community.

Policy

Access to Acute Community Options is via Home based Treatment (HBT) Clinical Team Coordinator or the Acute Clinical Team Coordinator after-hours.

Definitions/Description

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
NGO	Non- government Organisation
HBT	Home Base Treatment
CMH	Counties Manukau Hospital
HBT	Home Based Treatment
LOS	Length of stay
DHB	District Health Board
CLS	Community Living Supports
MDT	Multi- disciplinary Team

CTC	Clinical Team Coordinators

Entry Criteria:

- Residents of the Counties Manukau DHB district
- Under the care of adult mental health services
- Over the age of 18 years
- Experiencing acute symptoms of mental illness or acute psychiatric distress and are assessed as requiring a supportive environment in order to remain in a community setting
- Must have a permanent address to return to on exit

Where possible partners in care, whaanau/family will be involved in a person's care.

All service users in Acute Community Options will be reviewed on a daily basis and the clinical treatment plan measured and reviewed.

The daily face to face review will consist of:

- Face to face assessment with the service user
- Review of treatment provided and any adjustments that may be required.
- Consultation with whaanau/family/partners in care
- Review of exit plans with the service user
- Liaison with the NGO provider staff
- HCC documentation of the assessment
- Update documentation for the NGO provider as required
- Update communication with regular treating team where indicated

All medication is blister packed for safe storage and copies of medication charts and prescriptions must be supplied to the provider.

Length of stay will be limited to 5 days unless clinically indicated. MDT clinical discussions will identify clear plans for any extension to this timeframe and be authorised by the HBT Consultant Psychiatrist.

All service users will have a clear management plan that will outline the goals for the stay in Acute Community Options and anticipated timeframes for exit.

Home Based Treatment Team will take the lead in clinical management and treatment for all service users in Acute Community Options. Regular community treatment team are expected to remain involved and share in care to maintain continuity and support throughout the acute episode of care. Any non-acute function such as social issues, housing, CLS referrals, etc. should continue to be managed by the regular treating team.

A service user will exit acute options when:

- the goals of acute options care are achieved (based on clinical assessment)
- the person no longer requires the level of support provided by the acute option
- they no longer wish to receive services and/or do not agree to stay
- are no longer able to be supported safely and require alternate acute care

Length of Stay Management:

- LOS will be reviewed weekly
- The CTC actively monitors LOS
- The team will review and document any extensions to LOS in the HCC clinical notes through the MDT process
- Where a complex case review is required, the regular treating team will be involved to ensure continuity of care and current information and decisions are shared and discussed.

Escalation process:

The Consultant Psychiatrist for HBT has clinical responsibility for the care and treatment of all service users in Acute Community Options and who are under the service of HBT. If there are any disagreements regarding treatment plans or care provided, the clinical heads of services will be consulted.

Associated Documents

NZ Legislation	Mental Health (Compulsory Assessment and Treatment) Act 1992
NZ Standards	Health and Disability Sector Standards Code of Health and Disability Services Consumers' Rights 1996
CMDHB Procedure	Acute Community Options for Adult Mental Health Services – CMDHB Procedure

Guideline: Tiaho Mai Multidisciplinary Team Standard of Practice

Background/Overview

The multi-disciplinary team comprises of psychiatrists, registered nurses, psychologists, social workers, occupational therapists and pharmacists to provide comprehensive treatment and care for people with mental health problems. Multi-disciplinary teams can improve the quality of care by including the perspectives of the service user, their family/whaanau and these disciplines into the treatment plan. Effective and efficient multi-disciplinary team working is the agreed approach for Tiaho Mai to address complex needs in severe mental illness.

Purpose

This guideline is to ensure that the Multi-Disciplinary Team (MDT) establishes membership, roles and procedures that support collaborative treatment planning, with the goal of providing the best possible health outcome for the service user and their family whaanau/partner in care. The MDT will promote comprehensive sharing of information, coordination of services between all disciplines on the team and proactive planning of on-going services in the community.

The meeting is guided by the principles based on the Acute Services Model of Care, Te Whare Tapa Wha (Durie, 1994).

Scope of Use

This guideline is applicable to all members of the inpatient multidisciplinary teams including nursing staff, medical staff, occupational therapy, social work, cultural advisors, house officers, registrars, and all other allied healthcare professionals associated with the team.

Principles/Roles and Responsibilities

The membership of the inpatient MDT will include, at a minimum, nursing staff, medical staff (house officer, MOSS, consultant, registrar), social work staff, occupational therapy, and cultural liaison. It may also include any other professionals (e.g., the pharmacist) who participate directly in the *inpatient* care of the service user. It is expected that each team member will contribute their expertise in their discipline to the planning, coordination, and implementation of service users' treatment. At times the roles of the different disciplines can overlap, and MDT members will need to maintain some flexibility with respect to their roles. However, the goal of the MDT is to maximise benefit from the different perspectives of the various disciplines, so

it is important for team members to also be cognizant of the unique contributions of their discipline to the overall treatment plan.

Each clinical team will have its own MDT meeting for 1½ to 2 hours duration every week on the same day, at the same time. At each MDT meeting the medical team will meet with the designated staff of Kimi Whanaungatanga ward and then with Tui or Ki Te Whai Ao ward to discuss each service user assigned to the team, prioritising those with the most complex needs as follows:

- New admissions
- Service users having acute needs
- Service users who are progressing with treatment uneventfully.

The focus of the MDT meeting is the inpatient management of the service user's care including medical, psychosocial, environmental, functional, risk management, and cultural and spiritual concerns. Each member of the MDT will predicate the interventions in his/her area of expertise upon the goals and preferences of the service user and family/whanau to the greatest extent possible, with the goal of providing all services in the least restrictive and most consumer-guided manner.

Prior to a Service User's Initial MDT Review

- The MDT Form will be initiated by the Admitting Registered Nurse (RN) as part of the admission/initial contact and other MDT disciplines will add their initial clinical impressions and recommendations to the form in the appropriate sections.
- The allocated RN will meet with the service user to hear his/her perspective and his/her identified issues/concerns/goals and will document this on the MDT form.
- The community team's goals for admission will be entered on the MDT form by the allocated RN.
- A family/whanau meeting or discussion will ideally take place prior to the MDT meeting but may be deferred to the second meeting.
- If applicable, the RN will contact the GP and will document his/her treatment recommendations and goals.

MDT Process for a Newly Admitted Service User

- All disciplines involved in the service users' care, that is to say, all members of the MDT, are required to come to the meeting prepared with relevant information and should be present throughout the duration of the meeting.

- The **MDT facilitator** (usually the Charge Nurse Manager/ Associate Charge Nurse Manager, CNM/ACNM) will initiate the meeting by presenting the schedule and ensuring all members are familiar with each other by offering an introduction (whakawhanatanga) and karakia.
- The **Registrar** assigned to the medical teams (or MOSS, Consultant) will present the client and include:
    - Name, age, ethnicity, gender, employment, marital statuses, background mental health history (1 sentence), MHA status and review date
    - Current presentation
    - Diagnostic assessment
    - Any medical issues
    - Any substance abuse or withdrawal issues
    - Treatment/progress so far (1 sentence)
    - Medications Plan and response, including adverse effects noted by staff or reported by the service user
    - Risk statement (1 sentence) including leave status and AWOL category
    - Discharge plan
- The **assigned RN** will present a brief summary of the service user's events since admission including:
    - Number of admissions in the past 6 months
    - Service user's expressed goals and current motivation for recovery
    - The community team's goals for admission and any feedback from the community coordination meeting
    - Current engagement with plan
    - Nursing observations of behaviour, medication use and side effects, risk to self or others
    - PRN medication use and effects
    - Incidents of restraints/seclusion/assaults since admission
    - Placement recommendations on the unit
- The **Pharmacist** will present pertinent issues regarding medication dosing, administration, and selection
- The **House Officer** will present active medical issues, diagnostic tests, and medical consultations
- The **Social Worker** will briefly present
    - Expressed goals for admission by family/whanau members
    - Support system (tana whanau)
    - Psychosocial report
    - Any planned meetings

- The **Occupational Therapist** will briefly present
  - Initial assessments of function
  - Progress/participation within groups
- **Cultural and Spiritual** Needs perspective will be presented
  - Overview of assessment and recommendations for cultural support and resources
- The **MDT facilitator** will summarise the discussion and comprehensive treatment plan, ensuring all tasks are allocated and the MDT form is updated reflecting the plan before moving ahead to the next service user.
- The comprehensive treatment plan should address the following areas, as appropriate to the individual needs of the service user, and should be organised around the goals and preferences of the service user and his/her family whaanau/support system:
  - Safety and risk management on the ward and after discharge
  - Pharmacologic management, including management of adverse effects of medication
  - Non-pharmacologic treatments
  - Interventions to develop natural sources of support, including interventions and support to the family whaanau
  - Skill-building to support resilience and stress management
  - Health education, including physical and mental health
  - Diagnostic investigation and treatment of medical issues
  - Interventions to address substance abuse and/or withdrawal
  - Legal status, timelines for MHA, consideration for CTO
  - Cultural and spiritual support
  - Support for activities of daily living
  - Anticipated needs in the community
  - Preliminary discharge plans

Post Initial MDT

- The designated health care professional meets with the client to discuss the proposed treatment options.
- The designated health care professional will make contact with the family whaanau to discuss proposed options.
- If there are any concerns raised by the service user or family whaanau then this will need to be entered into HCC notes for discussion at the next meeting.
- A complex case review will be scheduled for service users who are identified to have had 2 or more admissions within the past 6 months.

MDT presentation for on-going service users

- Each discipline will present, in the order above, progress in treatment since the last MDT and this will be documented on the MDT form.
- Changes to the treatment plan will be documented.
- The team will identify if the service user is a candidate for early discharge

Documentation

- The MDT form will be scribed during the course of the MDT meeting, using a new form on each date.
- The presentations of each discipline will be recorded in the appropriate area of the form.
- Each form will indicate the current, up-dated comprehensive treatment plan and who is responsible for each item and the timeline for completion.

Community interface meetings

- In addition to the twice-weekly inpatient MDT meetings, each team will have a weekly meeting, usually via teleconference, with their allocated community teams, for approximately 30 minutes per community team (total of 1 hour).
- Participants will include, at a minimum, allocated nursing staff, the CTC of the aligned HBT team, the medical team, the CMHC manager, and the CMHC psychiatrist, but may also include other inpatient MDT members or outpatient service providers as appropriate.
- The focus of the community interface meeting will be to achieve continuity of care and to promote the sharing of information during the service user's transition to and from acute services.
- The MDT facilitator (usually the Charge Nurse Manager/ Associate Charge Nurse Manager, CNM/ACNM) will initiate the meeting by presenting the schedule and ensuring all members are familiar with each other by offering an introduction (whakawhanaungatanga) and karakia.
- For each service user in turn, the MOSS will briefly summarise the service user's progress and the plan for treatment going forward; in most instances, this should include:
    - Medications and medical treatment
    - Diagnostic concerns
    - Discussion of risk management
    - Legal status under the MHA, including timelines and court dates
    - Anticipated service and support needs after discharge
    - Discharge planning and accommodation
- There will be discussion of each service user concerning disposition and transition to on-going treatment, in order to achieve consensus and coordination between the inpatient and outpatient teams.

- The community team will be informed when a service user has been identified as a potential candidate for early discharge.
- If there is significant disagreement between the inpatient and outpatient teams concerning the treatment plan, a complex case review will be convened at a later time.
- Documentation of salient concerns, tasks, and the staff assigned to those tasks will be documented in HCC by allocated nursing staff. Additions to the treatment plan will be noted, and added to the inpatient treatment plan at the next MDT.

Timelines

- MDT entries will be completed at the time of the MDT meeting.
- Documentation of community interface meetings will be completed during or immediately after the meeting.
- As each team will have MDT meetings weekly, the initial treatment plan should be completed and documented within 8 days of admission.
- As the community interface meeting will convene once weekly, the initial documentation of community coordination of care should be completed and documented within 8 days of admission.

Overview

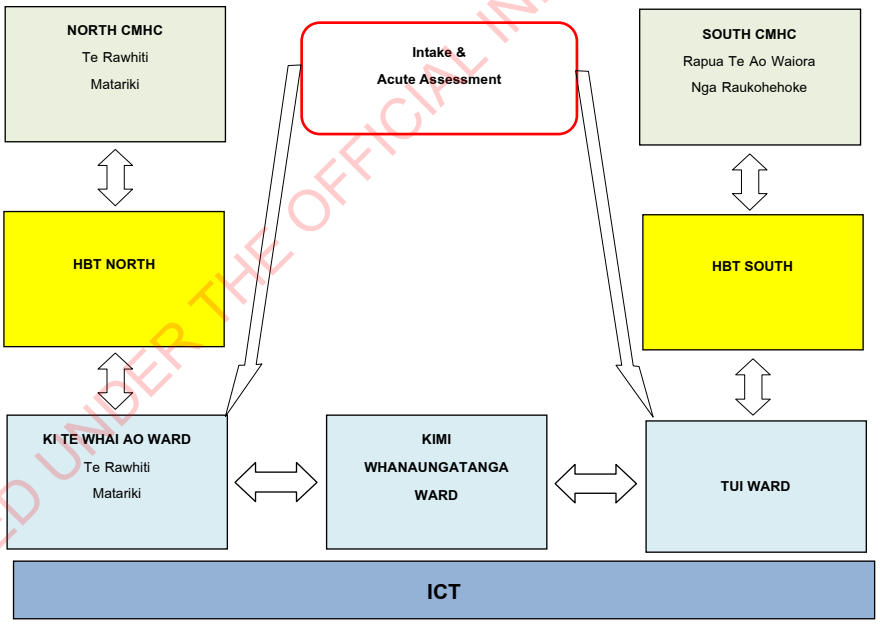
Each multidisciplinary inpatient team will have one MDT meeting and one community interface meeting weekly. These meetings will adhere to the process, content, and timelines described above.

As applied to the treatment of the service user, the following processes are recommended:

Step	Action
1	At the time of admission, the admitting nurse will begin organising the information on the MDT form and will obtain information concerning the goals and perspective of the service user and the family/whanau as well as the goals of the community team.
2	Within 2 days of admission, the team will arrange a family/whanau meeting or discussion, to take place within 1 week of admission. Any obstacles or reasons for delay, or the inability to set up such a meeting, will be documented in HCC.
3	Within 8 days of admission, the initial MDT meeting will be held and documented on the MDT form in the service user's records, resulting in establishment of the initial inpatient treatment plan.
4	Individuals who are identified to have had 2 or more admissions within 6 months will have a complex case review arranged.
5	Within 8 days of admission, the initial community interface meeting will be held and documented in HCC, with any changes or additions to

	the treatment plan.
6	At the MDT meeting following the community interface meeting, modifications to the comprehensive treatment plan will be documented on the new MDT form.
7	Subsequent MDT meetings will document the service user's progress in treatment, up-dates to the treatment plan, and disposition planning.
8	Subsequent community interface meetings will document the development of the discharge plan and transition to on-going services in the community.

The low intensity inpatient wards of Tiaho Mai are aligned with either the North or the South geographic area of Counties Manukau. This allows each geographic region (North and South) to have a defined continuum of care that includes the CMHC, a Home Based Treatment team, and a designated inpatient treatment team on a specific inpatient ward. The purpose of the alignment is to improve consistency and coordination of care as service users' progress in their treatment. The service has as a principle that alignment to a ward should only occur when it benefits the service user. If transfer and alignment is not in the best interest of a service user the team should consider not aligning.



Each ward is assigned medical, allied and cultural staff **except Kimi Whanaungatanga**. Kim Whanaungatanga ward will instead provide high acuity care for service users from all teams

References

Mental health: Effectiveness of the planning to discharge people from hospital Office of the Auditor-General, NZ
https://www.oag.govt.nz/2017/mental-health

Victoria's Mental Health Services (2003, October) A Guide to Mental Health Terminology.

Acute Services Model of Care, Te Whare Tapa Wha (Durie, 1994)

Appendix 3

Policy: Coordinated Care Planning

Purpose

To ensure that service users receiving care from CMDHB Mental Health Services, receive optimum care that is co-ordinated, consumer focused and integrated to promote continuity of service delivery. Treatment and Interventions provided will be evidence based and recovery oriented.

Scope

This policy is applicable to all CMDHB mental health employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMDHB facility.

Policy

All service users under the care of the Counties Manukau District Health Board (CMDHB) Mental Health Services will have a current up-to-date Regional Coordinated Care Plan.

Development of the Regional Coordinated Care Plan

The Regional Coordinated Care Plan is developed in collaboration with the service user, their family / whaanau, other service providers, peer, cultural and other support people with consideration of service user's Rights.

The Regional Coordinated Care Plan will be developed in a timely fashion appropriate to the care setting, i.e.

- Inpatient by time of discharge.
- Community Service Users over the course of the first 3 appointments/contacts or within two weeks of acceptance to the service.

The lead Clinician will ensure that the Regional Coordinated Care Plan is completed and recorded in the service user's clinical records in HCC.

Regional Coordinated Care Plan includes:

- **Collaborative Goals** that are written in recovery focused language and include recovery planning resilience, strengths and abilities.
- **Identified Issues** (Consider: Mental Health, Physical Health, Co-existing problems, Psychological, Social, Family/Whaanau, Cultural and Spiritual Work / Vocational, Accommodation needs)
- **A Risk and safety plan**, crisis plan and respite plan as required

Regional Coordinated Care Plan shows

- **Planned Treatment and Interventions** that include service user ownership and responsibilities that are informed by evidence based practice.
- **Service integration and coordination**
- **Expected outcomes**

Review of Regional Coordinated Care Plan

Plans are reviewed and updated every 3 months or sooner as relevant to changes in service user's needs/treatment progress.

Transfer of Care

When transferring the care or discharging a service user to primary care, a copy of the current Regional Coordinated Care Plan, risk assessment and relapse prevention plan must be updated before the change of treatment team occurs.

Documentation of Coordinated Care Planning

Clinical notes in HCC

- All contacts with service user or relating to care planning and processes
- Informed consent to treatment
- Consent to sharing health information

Forms in HCC

Integrated Care Adult	Mental Health Services Regional Coordinated Care Plan Form
Tiaho Mai	Tiaho Mai MDT Review and Regional Coordinated Care Plan
Tamaki Oranga	Tamaki Oranga MDT Review form
MHSOP	Mental Health Services Regional Coordinated care plan
Child and Adolescent Services	Mental Health Services Regional Coordinated care plan

Definitions

Term/Abbreviation	Description
Regional Coordinated Care Plan:	A document that reflects the issues and goals agreed to by the consumer, the treatment team, and family / whaanau as appropriate. This is a working document and the main focus of delivering a continuum of care.

Associated Documents

NZ Legislation	The Code of Health and Disability Services Consumers' Rights Health and Disability Commission (2014).
CMDHB Policies & Procedures	Regional Coordinated Care Planning Procedure Risk Assessment and Management Policy Medication Policy Restraint Minimisation and Safe Practice Relapse Prevention Plan Policy Clinical Documentation in Mental Health Services Policy
NZ Standards	Recovery Competencies for Mental Health Workers. Mental Health Commission New Zealand (2001) New Zealand Disability and Health (Core) Standards NZS 8134.1.2008 Ministry of Health (2008)

Procedure: Regional Coordinated Care Planning

Purpose

The purpose of this procedure is to ensure that staff understand their responsibilities in relation to ensuring that all service users under the care of the Counties Manukau Health (CMH) Mental Health Services have a current, up-to-date Regional Coordinated Care Plan that identify goals for receiving Mental Health Services.
"Outcome 3: Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation." (Standard 3 HDSS 2008)

Responsibility

All CMH mental health employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMH facility who work with mental health service users.

The formulation and writing of a care plan is the responsibility of all disciplines. This is to ensure that there is a coordinated approach to the planning of care with individual service users/whaanau and that this information is accessible to all concerned parties.

The Mental Health Clinician (MHC) will ensure that the regional coordinated care plan is completed and recorded in the service users' clinical records.

Frequency

For new service users making first contact with mental health services, an initial care plan must be completed within 24 hours by the assessing clinician and a more complete care plan completed by the treating team with the service user in follow up meetings.

The coordinated care plan will be developed in a timely fashion appropriate to the care setting, i.e.

- Inpatient by time of discharge.
- Community service users over the course of the first 3 appointments/contacts or within two weeks of acceptance to the service.

The coordinated care plan will be reviewed at a minimum:

- Weekly within Acute Inpatient setting
- Every three months within community setting.
- When transferring the care or discharging a service user.
- The Regional Coordinated Care Plan can be updated more often if clinically indicated.

Procedure

Step	Action
	Important: Any service user SAFETY issues identified must be included in the care plan and a full risk assessment of that particular risk must be carried out and documented.
1	Following assessment by the Treatment Team and through discussion with the service user, family / whaanau, the identified issues and goals that support the person to manage and maintain their own health and wellbeing will be documented by the lead clinician. • Each goal will be:- **S** – Specific **M** – Measurable **A** – Achievable **R** – Realistic **T** - Timely. • Interventions will, have time frames and a responsible person clearly identified. • Expected outcomes will be defined and reviewed within identified, specified timeframes. • The care plan will be developed with the involvement of the service user and may include family/whaanau/ caregivers and any other service involved in service users' care. • Any comments by the service user will be documented and a copy of the plan will be given to the service user and shared with identified parties.
2	It is intended that this will be a working document and the main focus of delivering recovery orientated care. Clinical notes should reflect progress with interventions to meet the identified goals and resolve issues recorded in the care plan.
3	No decision about me without me Review of goals/issues will be a continuous process, which will be reflected in the clinical notes. • At review the progress of the treatment or intervention will be assessed. • Goals that have been achieved or issues that have been resolved are documented as attained in the clinical notes needs to be included in the regional coordinated care plan. (HCC retains a record of previous versions of the coordinated care plans with changes that can be viewed and compared at any time when required.) • New goals/issues identified will be included in the care plan and will inform service delivery. Reviews will occur within identified timeframes.
4	When transitioning care or discharging the service user, the regional coordinated care plan will be reviewed, updated and incorporated into the care discharge summary or transfer of care

	(TOC) document to be utilised by the next accepting clinician or team.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Mental Health Clinician	Clinician who is the primary person working with the service user.
Coordinated Care Plan:	A working document that reflects the goals, issues and planned interventions agreed to by the service user, the treatment team, and family / whaanau as appropriate. Not required for Service Users if under Acute (I&AA or HBT).
Service user	This term is being used to represent; Client, Consumer, Patient, Tangata Whaiora, Tagata Ola,

Associated Documents

Other documents relevant to this procedure are listed below:

NZ Legislation	The Code of Health and Disability Services Consumers' Rights Health and Disability Commission (2014).
CMDHB Clinical Board Policies	Coordinated Care Planning Policy Restraint Minimisation Policy Relapse Prevention Policy Risk Assessment and Management Policy Medication Policy Clinical Documentation Policy
NZ Standards	Recovery Competencies for Mental Health Workers. Mental Health Commission New Zealand (2001) New Zealand Disability and Health (Core) Standards NZS 8134.1.2008 Ministry of Health (2008)

Policy: Information Sharing Between Providers of Healthcare Services for Mental Health Service Users

Notes: This policy should be read in conjunction with the Privacy – Protecting and respecting personal information policy

Purpose

Personal health information is obtained from mental health services service users to provide ongoing care and treatment. This includes sharing relevant health information with other providers of health care services who are involved in the service user's care and treatment.

This policy outlines the expectations regarding the sharing of information between external healthcare providers (including primary, secondary, community and NGO providers*)* and CM Health Mental Health Service staff.

The purpose is to reduce duplication and encourage good quality information sharing to help improve outcomes for users of mental health services.

Important:

Counties Manukau Health (CM Health) recognises the importance of protecting personal information about our staff and patients in all business activities. Protecting an individual's privacy is about respecting a person's rights and is fundamental to maintaining trust and freedom of expression.

The right to privacy refers to having control over your personal information. It is the ability to limit who can collect this information, how it is kept and what can be done with it.

Service users must be made aware that their health information will be shared with other health professionals who are providing ongoing care and treatment, which may include their GP Rule 3 (Collection of Health Information from Individual) and Rule 5 (Storage and security of Health information) of the Health Information Privacy Code

Scope

This policy applies to all CM Health employees (full-time, part-time and casual (temporary), including contractors, visiting health professionals, and students across CM Health Mental Health Services.

Policy

All healthcare providers work in unison towards the common goals of recovery and inclusion. Information sharing includes both the giving and receiving of information. Information given to clinicians is confidential. Information sharing will be open, transparent and intended to increase the quality of care that all parties deliver. It will include a consistent and agreed approach to care planning.

Service users will be informed about how their information will be used and who will have access to it when it is collected from them. This includes being as clear and transparent as possible about who the information will be shared with and what information will be disclosed. These discussions will be accurately documented in the service user's clinical file.

General Principles:

- Service users should be advised that services intend to share information with other healthcare providers involved in their care and be informed why this exchange of information is necessary.
- Information to be shared needs to be explicitly discussed with the service user except in the circumstances of imminent risk to self or others and where it is not possible to discuss with the service user.
- Sharing appropriate information with other health professionals providing care is usual practice and helps mental health services provide the best care and treatment options to our service users.
- A degree of clinical decision-making is required regarding what information is being shared and with whom the information is being shared.
- Information shared will only be accessed and used for the purpose it was intended - to provide health and disability services.
- All staff must maintain the confidentiality of service users' information. This includes staff who become aware of information about service users who are not under their direct clinical care.
- Safeguards must be in place to protect health information against loss, misuse, unauthorised access, modification or disclosure.

Levels of information access

The team working with the service user and in collaboration with them will determine the relevance of health information that is shared. Information may be limited depending on the role of the provider in service delivery.

Information readily available

Right 4 (5) of the HDC Code of Consumers Rights notes that every service user has the right to co-operation among providers to ensure quality and continuity of services.

Information about early warning signs, relapse prevention plans and care planning will be shared with appropriate health care providers. This will help ensure that other services working with the service user are aware of factors that could impact the wellbeing of the service user and other people involved. Information about an individual's goals and strengths can also be shared with the service user's permission. It is important to clarify understanding of the information provided and the information that should be received, including signs/symptoms/behaviours.

Restricted access

In some cases, more detailed information about the service user may be requested or provided. This may include access to the complete service user file, full risk assessments or access copies of other clinical assessment documentation. Careful consideration must be given regarding the appropriateness or need for this degree of access to information. This level of disclosure may not be necessary to provide care to the service user. Discussion with the clinical team allocated clinician and service user should be considered to determine the appropriateness of the disclosure being sought.

Staff and Service User concerns

If a staff member is concerned about the disclosure/non-disclosure of information, they must raise their concerns with their clinical or operational manager. If a service user raises concerns about the disclosure/non-disclosure of information, they can raise their concerns with their allocated clinician or the appropriate service manager.

Verbal information

Sharing information with other health professionals providing care is the usual practice. This may include involving members of other services in team meetings or joint visits/assessments when meeting with service users around similar issues or within similar timeframes, e.g. CSWs, CLS, employment consultants and AOD specialists.

Staff exposed to information about people they do not actively work with must treat that information as 'private and confidential. When providing information over the telephone, staff should ensure they take the appropriate steps to verify the identity of the person requesting the information.

Written information

Health Care providers involved in sharing service user information are responsible for ensuring appropriate safeguards to prevent unauthorised access and use of information.

Associated Documents

NZ Legislation	Privacy Act 1993 Health Information Privacy Code 1994 Official Information Act 1982 Health Act 1956 Archives Act 1952
Quality Health NZ Standards	Information Management (Acute Care, 2001, Version 2)
CM Health Policies	Correcting & Altering Personal Health Information at the Patient's Request - Procedure Checking for accuracy and authorising entries into the clinical record Procedure Correcting inaccuracies in the clinical record Procedure Disclosing Anonymous Health Information Procedure Documentation in the Clinical Record - Procedure Disclosure of Health Information to Relatives, Friends Procedure Employee Initiated Unanticipated Disclosure Procedure How Parents and Guardians Request Personal Health Information Procedure How Patients Access Their Own Information Procedure Retention and Destruction of Personal Health Information Policy Safe Management and Privacy of Personal Health Information Policy Storage and Security of Clinical Records Third Party Requests Procedure
Organisational Procedures	HR Policies – Code of Conduct
Other related documents	Southnet – Privacy and Legal Intranet Site

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
CSW	Community Support Worker
CLS	Community Living Skills Specialist
NGO	Non-Government Organisation
CYFS	Children, Young People and their Families
G.P	General Practitioner
AOD	Alcohol and Other Drugs