

14<sup>th</sup> April 2022



### **Official Information Act Request for – Mental Health Documentation**

I write in response to your Official Information Act request received by us 11<sup>th</sup> March 2022 by way of transfer from the Ministry of Health, you requested the following information:

- 1. All documentation of system requirements for induction processes including forms, manuals – if these are different for compulsory and voluntary patients please provide both**
- 2. All documentation of system requirements for discharge and transfer processes including forms, manuals.**
- 3. All documentation of system requirements for clinical interventions including observation guidelines/requirements; recovery plan processes and including any relevant forms.**
- 4. All documentation relating to system internal control measures to ensure procedures are followed.**

The request was clarified with you on the 17<sup>th</sup> March and you re-scoped your request to the following:

- 1. Copies of all forms relating to the induction of a client, compulsory or voluntary or moving between status.**
- 2. Copies of all forms relating to a discharge/transfer of a client, compulsory or voluntary or moving between status.**

### **Counties Manukau Health Response:**

For context Counties Manukau Health (CM Health) employs over 8,500 staff and provides health and support services to people living in the Counties Manukau region (approx. 601,490 people). We see over 118,000 people in our Emergency Department 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 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.

In response to your request attached as appendix 1 are the following documents/forms:

- Documents/forms when admitting a service user into Tiaho Mai inpatient facility
- Documents/forms when completing discharge or a transfer of care

I trust this information answers your request. You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at [www.ombudsman.parliament.nz](http://www.ombudsman.parliament.nz) or Freephone 0800 802 602.

Please note that this response or an edited version of this may be published on the Counties Manukau Health website. If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider this.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'P. Watson', with a long horizontal flourish extending to the right.

**Dr Peter Watson**  
**Acting Chief Executive Officer**  
**Counties Manukau Health**

## Tiaho Mai Admission Note (TMADMIT)

### **Reason for Admission / Presenting Problems:**

[Click here to enter text.](#)

### **Mental Health Act:**

**Current MH Act Status** [Click here to enter text.](#)

**Correct MH Act documents received?** [Click here to enter text.](#)

**If no, what action has been taken:** [Click here to enter text.](#)

**Review Date:** [Click here to enter text.](#)

**MHA Tracking Sheet Completed:** [Click here to enter text.](#)

### **Routine physical assessment:**

**Baseline Observations:** [Click here to enter text.](#)

**Blood Pressure** [Click here to enter text.](#)

**Temp** [Click here to enter text.](#)

**Pulse rate** [Click here to enter text.](#)

**RR:** [Click here to enter text.](#)

**O2Sat:** [Click here to enter text.](#)

### **EWS Score:**

**Frequency:** [Click here to enter text.](#)

**Vital Signs next due:** [Click here to enter text.](#)

**Weight:** [Click here to enter text.](#)

**Height:** [Click here to enter text.](#)

**Waist Girth:** [Click here to enter text.](#)

**BMI:** [Click here to enter text.](#)

**Smoking status:** [Click here to enter text.](#)

**Blood & urine specimens:** [Click here to enter text.](#)

**House Officer physical completed:** [Click here to enter text.](#)

### **Mental state**

**Behaviour/Appearance:** [Click here to enter text.](#)

**Affect/Mood:** [Click here to enter text.](#)

**Thought content/Process:** [Click here to enter text.](#)

**Orientation:** [Click here to enter text.](#)

**Memory:** [Click here to enter text.](#)

**Intelligence/Insight/Judgement:** [Click here to enter text.](#)

**Sleep pattern:** [Click here to enter text.](#)

**Medication chart commenced:** [Click here to enter text.](#)

Oral prn medication available: [Click here to enter text.](#)

IMI prn medication available: [Click here to enter text.](#)

**Admission HONOS completed:** [Click here to enter text.](#)

**Risk statement:** [Click here to enter text.](#)

**Aggression Risk Checklist Score:** [Click here to enter text.](#)

**Vulnerability Risk Checklist Score:** [Click here to enter text.](#)

**DASA Score:** [Click here to enter text.](#)

**Level of Observation:** [Click here to enter text.](#)

**NOK Notified of Admission:** [Click here to enter text.](#)

### **Initial Treatment Plan 24-48 hours:**

[Click here to enter text.](#)



## Vulnerability risk checklist (VRC)

Factors	Yes (score 1)
<b>Cognitive dysfunction/deficits</b> e.g. impaired memory, problems with orientation	
<b>Intellectual disability</b> e.g. established diagnosis, IQ score	
<b>Mania</b> e.g. giving away money, personal belongings etc	
<b>Intrusiveness</b> e.g. interrupting personal space, violating social norms	
<b>Disinhibition</b> e.g. inappropriate clothing, sexual inappropriateness	
<b>Sexual Exploitation</b> e.g. being vulnerable and naïve, limited life experience	
<b>Score of 1 and above = vulnerable client</b>	
<b>Higher the score = higher the vulnerability</b>	

### Guideline for vulnerable service users and their placements within Tiaho Mai Environment/Level of Care

<b>Open ward</b>	<b>Cognitive Dysfunction/ deficits</b>  <b>Intellectual disability</b>  <b>Mania with mild intrusiveness</b>  <b>Sexual safety</b>	<b>Picture on door / name big letters</b> <b>Room close to nurses station</b> <b>Staff aware to orientate 15/60 observations</b>  <b>Female dorm 15/60 checks</b>
<b>ICU</b>	<b>Combination score of 3 and above on VRC and Moderate – High on ARC.</b>	<b>Staffing Management Plan</b> <b>DASA</b> <b>ABG's</b>
<b>HCA</b>	<b>Disinhibition</b> <b>Sexual safety</b> <b>Cognitive dysfunction/ deficit with physical care</b>	<b>Management Plan</b>

The Vulnerability Risk Checklist is to be used in Conjunction with the Aggression Risk checklist

Open wards would be an appropriate placement for a service user who scores 1 – 2 on the vulnerability risk checklist.

HCA would be an appropriate placement for Service Users who score 3 and above

ICU would be an appropriate placement for Service users who score 3 and above and score moderate to high risk on the aggression checklist

## DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION: INPATIENT VERSION (DASA)

- Nursing staff to complete it before the next shift to alert the staff about imminent risk of aggression
- Each item is scored for its presence (1) or absence (0) in the last 24 hours.
- For well-known patients an increase in the behavior is scored as 1, whereas the habitual behavior while being non-violent is scored as 0\*.

\*In each item a score of "0" is given if the patient is demonstrating the identified behavior over seven days with no incidents of aggression. Thereafter, a score of "1" will be assigned again if there is an appreciable increase in the behavior.

Total the score on all items and indicate the level of risk

DASA:IV Score	Level of Risk	Action Required
0 or 1	Low	No remedial action is required
2 or 3	Moderate	The patient should be monitored for additional indicators of inpatient risk. Staff should be alerted to the possibility that the patient will become more agitated. The Safety Plan should be discussed with the patient and preventive measures considered.
>3	High	Remedial action is required. Staff must be alerted and the patient requires some remediation to prevent subsequent aggression from occurring. A risk management plan is required.

### DASA IV

#### 1. Irritability

0	1	Solutions/Actions required
The patient has been calm, tolerant and relaxed. S/he is comfortable and relaxed in the company of other patients and with staff.	The patient is easily annoyed or angered and unable to tolerate the presence of others.	

#### 2. Impulsivity

0	1	Solutions/Actions required
The patient has been affectively and/or behaviorally stable and composed.	The patient has been impulsive and unpredictable in his/her affect or behavior, or was quick to (over-) react to real and imagined slights, insults, and disappointments.	

### 3. Unwillingness to follow directions

0	1	Solutions/Actions required
The patient in the last 24 hours has been compliant with any requests and directions.	The patient has become angry and/or aggressive s/he was asked to adhere to some aspect of her/his treatment or to the ward's routine in the last 24 hours.	

### 4. Sensitive to perceived provocation

0	1	Solutions/Actions required
In the last 24 hours the patient has not become extraordinarily angry or seen everything that occurs around her/him as provocative. S/he is not 'overly sensitive' or 'provocative'.	The patient has tended to see others' actions as deliberate and harmful. S/he may misinterpret other people's behavior or respond with anger in a disproportionate manner to the extent of provocation. S/he has been prickly, overly sensitive and quick to anger.	

### 5. Easily angered when requests are denied

0	1	Solutions/Actions required
The patient has been calm and accepting when s/he is asked to wait whilst her/his request is attended to. S/he has been understanding and accepting that her/his request has been unable to be fulfilled at that time.	The patient has tended to become angry when her/his requests have not been granted immediately. S/he has been unwilling or incapable of accepting delay in gratification of her/his requests, may become surly, angry or aggressive.	

### 6. Negative attitudes

0	1	Solutions/Actions required
No negative attitudes	Definite/serious negative or anti-social attitudes supportive of aggressive behavior exhibited in the last 24 hours. This item does not refer to pessimism.	

### 7. Verbal threats

0	1	Solutions/Actions required
The patient has not been verbally aggressive.	The patient was verbally aggressive or displayed a verbal outburst, which is more than just a raised voice, and where there is a definite attempt to intimidate or threaten another person.	

Date:  
To:  
Dear Doctor

**Re: Name:**  
**NHI:**  
**DOB:**

**Phone:**

---

### Regional Assessment Letter

The above client had contact with the mental health services.

They have now been:

Discharged from our service / Referred for follow up to ... *(Edit as appropriate)*

**Brief reason for assessment / Presenting problems**

**Current Living Situation and current Circumstances:**

**Previous History:** *(Mental Health, Medical, Personal and Substance use History)*

**Problem list / Current Diagnosis:**

**Current Medications:**

1.

**Assessment and Treatment** (Brief Clinical Management Summary)

**Risk Formulation:**

**Pattern of History of  
Risk Behaviours:**

**Current and Recent  
Risk Behaviours:**

**Internal Factors  
Relevant to Current  
Risk:**

**Situational Factors  
Relevant to Current  
Risk:**

**Formulation / Impression:** *(Include formulation of risk)*

**Advice to Patient:**

**Advice to GP:**

**Recommendation and Follow up Plan:**

If you have any queries please do not hesitate to contact me.

Yours sincerely

***This is Confidential information.***

*If you have received this in error please contact the writer or manager at the above service.*



FullName:  
JobTitle:

**Typist:**  
**Date Typed:**

CC:	Copy to Service User	

Other:

## ACUTE COMMUNITY OPTIONS ENTRY FORM

The referring team is to complete the following form and ensure it is received by Tiaho Mai Ward Clerks  
- Fax number 270 4743.

<b>Name of Client:</b>	
<b>NHI Number:</b>	
<b>Date of Birth:</b>	
<b>Address:</b>	
<b>Is a Community Referral open in iPMS?</b>	
<b>Referring Doctor: **</b>	
<b>Community Team providing follow-up:</b>	
<b>Acute Community Options Provider:</b>	<input type="checkbox"/> Affinity Phoenix <input type="checkbox"/> Affinity Tumanako <input type="checkbox"/> Whare Tiaki Hauora <input type="checkbox"/> Tupu Ake <input type="checkbox"/> Pathways Sub Acute <input type="checkbox"/> Pathways Kolmar Road <input type="checkbox"/> Affinity Maternal Respite
<b>Entry Date:</b>	
<b>Entry Time:</b>	
<b>Name of Person Completing this Entry Form:</b>	

Tiaho Mai Ward Clerks

<b>Data entry on iPMS actioned by:</b>	
<b>Date /Time actioned:</b>	

\*\* This is the current community doctor. **Do not use awaiting allocation.** If no allocated doctor, use crisis doctor for the CMHC area, based on client's address.

## ACUTE COMMUNITY OPTIONS EXIT FORM

When the client is to exit, the client's Community Team is to complete the following form. The Acute Community Option provider needs to ensure that it is faxed to Tiaho Mai Ward Clerks upon exit. Fax number:270 4743.

<b>Name of Client:</b>	
<b>NHI Number:</b>	
<b>Acute Community Option provider:</b>	<input type="checkbox"/> <b>Affinity Phoenix</b> <input type="checkbox"/> <b>Affinity Tumanako</b> <input type="checkbox"/> <b>Whare Tiaki Hauora</b> <input type="checkbox"/> <b>Tupu Ake</b> <input type="checkbox"/> <b>Pathways Sub Acute</b> <input type="checkbox"/> <b>Pathways Kolmar Road</b> <input type="checkbox"/> <b>Affinity Maternal Respite</b>
<b>Exit Date:</b>	
<b>Exit Time:</b>	
<b>Exited to:</b>	<input type="checkbox"/> <b>Home</b> <input type="checkbox"/> <b>Tiaho Mai</b> <input type="checkbox"/> <b>AWOL</b> <input type="checkbox"/> <b>Ward 35</b> <input type="checkbox"/> <b>Other</b> (please comment)

### Tiaho Mai Ward Clerks

<b>Data exited on PiMS actioned by:</b>	
<b>Date /Time actioned:</b>	

## **Leave of absence for patients undergoing assessment**

To: *Name of patient*

Patient's date of birth *Date of birth*

You are granted leave of absence from:

*Name & address of hospital, service or other place of treatment*

for a period of: *Number of hours/days leave granted for*

Commencing on: *Date and time leave to commence*

When your leave expires you must return to the address above on: *Date and time patient to return to hospital*

Your leave is subject to the following terms and conditions:

*Any terms and conditions as determined by Responsible Clinician*

This leave was approved by: *Name of Responsible Clinician*

of: *Business address and telephone number of Responsible Clinician*

/ /  
*Signature of Responsible Clinician* *Date*

A copy of this notice has been sent to the Director of Area Mental Health Services

**NHI:  
NAME**



### Discharge Checklist (MH In-patient Unit)

*The Administrator is responsible for photocopying and forwarding the appropriate documentation*

<b>Name:</b>		<b>NHI:</b>	
<b>Date of Discharge:</b>		<b>Time of discharge:</b>	
<b>Address on Discharge:</b> «Letter.Patient.AddressStreet» <b>(Check that this is correct – if not, make sure this is changed in IPMs)</b>		<b>Permanent Address</b>	
		<b>Temporary Address</b> (e.g.Respite)	
<b>DISCHARGE METHOD</b>			
<b>Routine - as part of care plan (Destination)</b>			
<b>Respite (complete respite pack)</b>			
<b>Discharge to another Health Care Provider internal or external, Inpatient or Community</b>			
<b>Early Discharge Against Care Plan – due to bed pressure</b> <input type="checkbox"/>			
<b>Self Discharge without Indemnity – Patient AWOL</b>			
<b>Other – State reason :</b>			
<b>Community Team Name:</b>		<b>Community Team Notified:</b>	<b>Yes / No</b>
<b>Community Team Person spoken to (Name)</b>		<b>By Whom</b>	
<b>Community Team Doctor notified</b>		<b>Keyworker Notified / keyworker name</b>	
<b>Nursing staff handover to keyworkers completed by: (Specify)</b>			
<b>Care Plans ( IMI, Relapse Plan, metabolic screening etc) transferred or end series</b>			
<b>HONOS completed:</b>		<b>If No, who to complete?</b>	
<b>After hours or weekend discharge hand over to HBT ( Name of staff member spoken to)</b>		<b>Yes / No</b>	
<b>Staff member who contacted HBT?</b>			
<b>Name of HBT staff spoken to?</b>			
<b>Legal Status On Discharge: (Informal, MHA Section etc)</b>			
<b>MENTAL HEALTH ACT PAPERS</b>			
<b>Section 11 &amp; Section 13 Leave form completed</b>		<b>S31 Copy to patient:</b>	
<b>Section 15 / S31 leave form completed</b>			
<b>MHA Transfer of Care completed</b>			
<b>MEDICATION:</b>			
<b>Script, given</b>		<b>To whom</b>	
<b>Script Faxed</b>		<b>To Pharmacy</b>	
<b>Ward supply given</b>		<b>Amount</b>	

CORE DOCUMENTS UPDATED IN HCC			
Discharge Clinical note with Current Mental State and Plan			
Risk Formulation entered or updated in the History Form			
Tiaho Mai MDT Review Form			
Relapse Prevention Plan		Copy given to patient	
Discharge Summary Completed		Copy given to patient	
Patient property and valuables returned		Copy given to patient	
Family/whanau/caregivers involved in discharge		Name of family members	
Family/whanau/caregivers informed of discharge		Name of family members	
Family/whanau/caregivers unable to be contacted		Specify why:	
Follow up care plan/further information			
Discharge Checklist completed by:		Date:	«Letter.Letter.Today»

**Print and take to the front desk so that the changes can be made in IPIMs and  
The admin staff can discharge the patient from the ward**

**SECTION 2 TO BE COMPLETED BY ADMINISTRATIVE STAFF**

<input type="checkbox"/> Discharge Ward:	
<input type="checkbox"/> Check has staff member completed everything above	
<input type="checkbox"/> G file Merged <input type="checkbox"/> G File Deleted <input type="checkbox"/> M File Tracked to (Destination)	
<input type="checkbox"/> Email Discharge advice to team <input type="checkbox"/> Email Discharge advice to Doctor	
<input type="checkbox"/> Discharge Summary sent to GP      Yes / No	
<input type="checkbox"/> Remove Inpatient Psychiatrist in HCC	
<input type="checkbox"/> Discharged to Respite Yes/ No	<input type="checkbox"/> If 'Yes' admission completed in iPMS
<input type="checkbox"/> Clozapine Yes/ No	<input type="checkbox"/> If 'Yes' email sent
<input type="checkbox"/> S15 Yes/ No	<input type="checkbox"/> If 'Yes' email sent
<input type="checkbox"/> <b>Close Referral in iPMS</b> (Referral closure reasons should reflect selected reasons above)	
<input type="checkbox"/> <b>Close service in HCC</b> (The date of closure and the reason for closure needs to be exactly what is put in IPIMs)	
<input type="checkbox"/> <b>HCC Service Closed</b> Yes / No	If No, Why not?
<input type="checkbox"/> Copy of discharge checklist to MHA Administrator and copy for the file	
Discharge Completed by:	

GP Name and address

Date

Dear Doctor

<b>Re:</b>	<b>Name:</b>			
	<b>NHI:</b>			
	<b>DOB:</b>		<b>Phone:</b>	
<b>Admission Date:</b>		<b>Discharge Date:</b>		
<b>Follow up Team:</b>		<b>Discharged to:</b>		

**Discharge Summary Tiaho Mai (Acute Mental Health Unit)**

This is to inform you that the abovementioned has been discharged from our service.

**Problem List / Discharge Diagnosis:**

1.

<b>Medications on Discharge</b>	
<b>Changes to medications</b>	<i>(Dose changes, strength, frequency, form. Those stopped and why? Indication/comments eg: regarding titration, monitoring etc)</i>
<b>Allergies / Adverse drug reactions:</b>	

**Recommendation and Management Plan:**

**Mental Health Act Status on Discharge:**

**Section:**                      **Next MH Act (CAT) Event:**

**Initial Presentation / Brief reason for referral / admission:** *(Brief relevant psychiatric history)*

**Clinical Management:** *(Concise summary of clinical management, events during episode of care and mental state on discharge)*

**Brief Risk Formulation / Statement:**

**Physical health Investigations and management** *(Significant normal or abnormal investigation results)*

**Substance Use:**

**Smoking status:**

**Advice to Client and Family / Whaanau:**

**Advice to GP / other provider:**

If you would like any further information, or have any queries, please do not hesitate to contact me.

**Completed by:**

Full Name:

JobTitle:

Service:

**Final Sign-off by Consultant:**

**(Finalise Document)**

**Date:**

CC:	Copy to Service User	
-----	----------------------	--

--	--	--

Other:



**Copy to:**

GP ASPIRE Details  
GP Name and Address  
GP Name and Address  
GP Name and Address

<b>Re:</b>	<b>Name:</b>	
	<b>NHI:</b>	
	<b>DOB:</b>	<b>Phone:</b>

**Transition of Care to Community Mental Health Team**

<b>Date:</b>	
<b>From Service:</b>	<b>To Service::</b>

**Reason for transition of care to Community Team:** *(Delete as appropriate)*

- Patient.FirstName is new patient to CMDHB or recently moved to your area.
- Currently they are an inpatient at Tiaho Mai in and resides in the team catchment area.

**Suggested discipline for allocation**

Psychiatrist / Registrar / SMO / MOSS	Psychologist	Registered Nurse	Social Work	Occupational Therapist	Peer Support Specialist

**Referring Doctor:**

**Mental Health Clinician:** [Case Manager]

**Mental Health Act Status:**

**Section:** [Legal Status]

**Next MH Act (CAT) Event:**

**Transferring Responsible Clinician:**

**Section 127 Transfer of Care Form:**

**Diagnosis:**

**Axis I:**[Prinicpal Diagnosis]

**Current Medications:**

1. [Usual Medications list]

***This is Confidential information.***

*If you have received this in error please contact the writer or manager at the above service.*

**Reason for this treatment regime:**

**Date of most recent medical review:**

**Clinical Management and Treatment Plan:** *(Concise summary of clinical management, events during episode of care and mental state on TOC)*

<b>Documents / Records updated in HCC:</b>	<b>Yes</b>	<b>No</b>
• <b>If on Depot Medication:</b> Date last given updated on Careplan intervention		
• Living Situation (Clinical Front Page)		
• Occupation and Education (Clinical Front Page)		
• Diagnosis (Clinical Front Page)		
• Medication Record		
• Relapse Prevention Plan (Relapse Prevention Plan Form)		
• Regional History Risk Formulation (Regional History Form)		

**Brief Risk Formulation / Statement:**

**Plan around Transition of Care:**

**Other services currently involved:**

**Discussion has taken place with:**

If you have any queries please do not hesitate to contact me at the number above.

Yours sincerely

Logged On User

Logged On User Job Title

**Team name**

<b>CC:</b>	Copy to «Patient.FirstName»	Y
------------	--------------------------------	---

**CC Other:**

--	--	--