West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CORPORATE OFFICE

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12 May 2022

9(2)(a)
[redacted]

RE Official Information Act request WCDHB 9672

I refer to your email dated 24 February 2022 to the Ministry of Health which they subsequently transferred to us on 11 March 2022 requesting the following information under the Official Information Act from West Coast DHB regarding Mental Health Procedural Information. We note your request was refined on 17 March 2022 as follows. Specifically:

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

Please refer to **Appendix 1** for the following:

- Page 01 - Admission Checklist – Inpatient
- Page 03 - Admission Checklist – CMHT (Community Mental Health Team)
- Page 05 - Respite & Crisis Admission and Discharge Checklist – Manaakitanga IPU -

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

- Page 06 – Discharge Checklist – Inpatient
- Page 08 – Discharge checklist CMHT
- Page 10 – Transfer of care under the Mental Health (Compulsory Assessment & Treatment) Act 1992.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

APPENDIX 1

001

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Consumer label:

Admission Checklist - Inpatient

To be completed in the first 24 hours of admission

		Date completed	Staff Signature
Admission Form	☐		
Open Referral (iPM)	☐		
MHA Papers (if applicable)	☐		
Pending Admission Form and verbal handover	☐		
Registration Form	☐		
Consent Form and Disclosure of Information	☐		
Smoking Status recorded	☐		
Property Form	☐		
Family notified of admission (where possible)	☐		
Medical Records ordered	☐		
Consumer / Family Information Kit	☐		
Consumer / Family orientated to environment	☐		
Nursing Physical entered onto PatienTrack	☐		
Psychiatrist review	☐		
RMO physical review within 24hrs including bloods	☐		
Medications prescribed	☐		
Urine Drug Screen	☐		
ECG	☐		
Falls Risk Assessment	☐		
Trendcare	☐		
Leave Status / Observation Level	☐		

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

To be completed in the first 48 hours of admission

		Date Completed	Staff Signature
DASA completed	☐		
Primary Nurse allocated: _____	☐		
Risk Assessment completed	☐		
Admission HoNOS completed (within 3 days but NOT on admission)	☐		
Referral: ☐ CMHT ☐ AOD ☐ MMH ☐ SPHC ☐ Cornerstone	☐		
Comprehensive Assessment updated	☐		
Individual Treatment Plan commenced	☐		
Family Focused Questionnaire (FFQ) commenced	☐		

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

003

Consumer label:

Admission Checklist - CMHT

To be completed in the first 3 months of entry to service

		Date completed	Staff Signature
Triage Form completed (if applicable)	☐		
Mental Health Service Admission Form – Outpatient Service	☐		
Open Referral (iPM)	☐		
Diagnosis entered in iPM (within 91 days)	☐		
Registration Form and labels	☐		
Contact details confirmed (phone and email)	☐		
Consent Form and Disclosure of Information	☐		
Consumer / Family Information Kit	☐		
Ethnicity identified	☐		
Smoking Status recorded	☐		
Case Manager allocated and entered in Circle of Care	☐		
MHA/legal Papers completed (if applicable)	☐		
Contacts/Stats entered (matching date of referral being opened)	☐		
Family Focused Questionnaire	☐		
Urine Drug Screen (if applicable)	☐		
Routine Bloods ordered (if applicable)	☐		
Nursing Baseline Physical Observations	☐		
Psychiatrist appointment: _____	☐		
Medications prescribed	☐		
		Date Completed	**Staff Signature**

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Admission HoNOS completed (new referral or assessment only if being admitted to IPU)	☐		
Risk Assessment / Risk Summary completed	☐		
Comprehensive Assessment completed	☐		
Individual Treatment Plan commenced	☐		
Relapse Prevention Plan commenced	☐		
Advance Directive (Mental Health) (if consumer wishes)	☐		
Referral: □ CMHT □ AOD □ MMH □ SPHC □ Cornerstone **□ SW □ OT □ NASC**	☐		

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

005

Consumer label:

Respite & Crisis Admission and Discharge Checklist – Manaakitanga IPU

Admitting Details:	**CMH Team: _____ Case Manager: _____** **Date: _____ Time: _____**

Admission		**Date completed**	**Staff Signature**
Pending Admission Form completed	☐		
Property Form completed	☐		
Valuables secured	☐		
Medications charted and personal medications to be keep in Clinic Room	☐		
Check that latest Comprehensive Assessment & Risk Assessment updated by Case Manager	☐		
Orientation to Inpatient Unit if required	☐		
Community Clinical File provided and all IPU documentation to be integrated into Community File	☐		
Discharge		**Date completed**	**Staff Signature**
File Medication Chart	☐		
Property Form completed	☐		
Return valuables	☐		
Return any personal medications (if appropriate)	☐		
Transport arrangements confirmed (if appropriate)	☐		
Case Manager notified (if not present)	☐		
Community Clinical File returned to Community Team	☐		
Marama Real Time survey completed	☐		

To be completed by Discharging Nurse

Name: _____ Signature: _____

Date: _____ Time: _____

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Consumer label:

Discharge Checklist - Inpatient

Checklist to be completed by the nurse involved on the day of discharge

Discharge Details			
Planned date for transfer of care: _____ To: _____ **Case Manager: _____ GP: _____**			
		Date completed	**Staff Signature**
Community Case Manager allocated	☐		
Discharge Meeting Date: _____	☐		
Community Follow Up Apt (within 7 days)**: _____**	☐		
Marama Real Time Survey completed	☐		
Living arrangements confirmed	☐		
Financial arrangements for consumer finalised	☐		
Family to be notified of discharge (where appropriate)	☐		
Transport arrangements confirmed	☐		
Relapse Prevention Plan completed	☐		
Belongings returned to consumer (Property Form)	☐		
Discharge prescriptions provided	☐		
Return of personal medication to consumer or pharmacy	☐		
Mental Health Act processes (if applicable)	☐		
Update Risk Assessment on day of discharge	☐		
Update Comprehensive Assessment PRIOR to day of discharge	☐		

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Discharge HoNOS on day of discharge	□		
PatienTrack vital observations printed and placed in file	□		
		Date Completed	**Staff Signature**
Nurisng Discharge Summary completed on day of discharge	□		
Psychiatrist / RMO Discharge Summary completed	□		
Discharge Plan Form given to IPU Secretary / Main Reception	□		
Discharge signed off by CNM	□		
Consumer File closed and all files (CMH and Medical) given to IPU Secretary	□		
To be completed by Discharging Nurse			
Name: _____ Signature: _____ **Date: _____ Time: _____**			

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Consumer label:

Discharge Checklist - CMHT

Discharge Details			
Planned date for discharge: _____ **To:** _____ **Case Manager:** _____ **GP Practice:** _____			
		Date completed	**Staff Signature**
MDT discharge meeting arranged – all parties involved invited including family / whanau. **Discharge Meeting Date:** _____	☐		
All involved parties involved with Care informed of Discharge (NASC, SW, AOD, Support Worker)	☐		
Discharge prescriptions provided	☐		
Mental Health Act processes (if applicable)	☐		
Marama Real Time Survey information provide and or completed	☐		
Financial arrangements for consumer finalised (if applicable)	☐		
Re-entry to service pathway discussed	☐		
Relapse Prevention Plan completed			
Crisis Plan completed (if applicable)			
Advanced Directive (Mental Health) completed (if consumer wishes)			
Risk Assessment updated			
Comprehensive Assessment updated			
Nursing Discharge / Transfer Summary completed			
Psychiatrist Discharge Letter completed			
Discharge HoNOS on day of discharge	☐		

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

		Date Completed	Staff Signature
Outstanding tasks completed on HCS	☐		
Contacts / Stats entered (service complete)	☐		
Referral: ☐ Emerge ☐ PACT ☐ CCCN	☐		
End of episode completed	☐		
Clinical Files returned to Discharge File room	☐		
To be completed by Case Manager once Discharge completed			
Name: _____ Signature: _____ **Date: _____ Time: _____**			

TRANSFER OF CARE UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT & TREATMENT) ACT 1992

PATIENT DETAILS:

Patient being Transferred	***Full name***
	Date of birth **NHI:**
	Patient's usual residential address
Current Legal Status	*Section of Mental Health Act Patient currently under*
Next Review & Date	*Type of Review due (Judicial or Clinical) & date due*

REFERRING TEAM TO COMPLETE:

	Name of referring team & District Health Board transferring to
Being Transferred from	
DHB Transferred to	
Name of Referring Responsible Clinician	
Responsible Clinician's Signature	
	Business address and telephone number of responsible clinician
of:	
Date:	

ACCEPTING TEAM TO COMPLETE:

DHB Accepted by	
Name of Accepting Responsible Clinician	
Responsible Clinician's Signature	
	Business address and telephone number of responsible clinician
of:	
Date:	