21 July 2020

Amy Van Wey Lovatt
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Dear Amy

Partial Transfer of Official Information Act Request

The Ministry of Health partially transferred your Official Information Act about policies to district health boards on 23 June 2020.

> *DHB policies in regard to reporting unsafe, harmful, criminal behaviour, including the re-routing and interception of private communications, and policies on how they document such incidents and how they ae to safeguard against such incidents.*

A number of the policies listed below are currently being reviewed and updated.

The following policies are attached:

- Reporting and Managing Adverse Events
- Complaints Management
- Safe Management and Privacy of Personal Information
- Storage and Security of Electronic and Paper Health Information
- Process for Responding to Privacy Breaches
- Code of Conduct
- Managing Unacceptable Behaviour in the Workplace Policy
- Disclosure of Serious Wrongdoing
- Disciplinary Policy
- Family Violence Assessment & Intervention Policy – Child Abuse & Intimate Partner Violence

If you have any queries regarding Northland DHB's response to your information request please contact me.

Yours sincerely

Dr Nick Chamberlain
Chief Executive

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Reporting and Managing Adverse Events

Purpose

The purpose of this policy is to contribute to quality improvement, staff and patient safety through systems that:

- Are consumer and whanau centred
- Provide for early identification and review of adverse events affecting consumers of health and disability services
- Ensure lessons are learned so the risk of repeating preventable adverse events is minimised
- Demonstrate public accountability and transparency
- Promote a safety culture

This policy supports a national approach to promote reporting, reviewing and learning from adverse events and near misses National Adverse Event Policy 2017 (HQSC)

Scope

- All Northland District Health Board (DHB) health and disability service providers who have obligations under the Health and Disability Services (Safety) Act 2001
- All Northland DHB health and disability service providers who voluntarily comply but are not obliged to under the Health and Disability Services (Safety) Act 2001
- All consumer related adverse events and near misses that occur, or have the potential to occur to any person as a result of, or related to, the provision of health and disability services at Northland DHB

Principles

- Transparent and open disclosure
- Open approach to the reporting of adverse events and near misses
- System focused, not individual focused
- Emphasis on learning and improvement
- Obligation to act
- Accountability
- Fairness
- Appropriate prioritisation of action
- National consistency
- Local commitment and action

An Accident Compensation Corporation (ACC) treatment injury claim must be completed for all events that result in unintended harm this may lead to the entitlement of financial support.

Northland District Health Board	
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Method

Roles and responsibilities

All staff

- When appropriate any staff member who identifies an event where unintended harm has occurred must report it immediately (or as soon as patient care and safety allow) to their line/ward/department manager. If the event is identified out of hours, the duty manager must be informed
- Adverse events, including near miss events, must be reported via the Adverse Event Reporting System (Datix)
- Ideally, an event should be reported immediately or at least by the end of the current shift
- The staff member who reports the event is referred to as the reporter in Datix

The Severity Assessment Code (SAC) of the adverse event/near miss must be completed at the time of reporting:

- Severity Assessment Code examples
- Maternity Severity Assessment Code examples
- Document in the patient's record a summary of all adverse events that relate to patient care or treatment
- Openly disclose information and communicate with consumers, their familiy/whānau in line with Open Disclosure Policy
- Participate in an event review as required, either by providing statements or as part of the review team if requested
- Ensure any actions allocated to them, are completed and documented in Datix

All managers have the above staff responsibilities as well as:

- Promoting systems and a culture that supports non-blame event reporting
- Allocation of an event handler for SAC 3&4 events
- Ensure SAC 3&4 events are reviewed and closed with recommendations (if appropriate) within 30 working days of being reported
- Ensure staff receive feedback when the review is complete
- Ensure consumers and family/whānau involved in an adverse event are supported
- Ensure staff members involved in an adverse event are supported. Please refer to the following leaflets:
    - A guide to providing support for staff following an adverse event
    - Self-care following an adverse event.
- If an unreported event (e.g fall with harm) is later identified by coders during reporting, it must be entered retrospectively in Datix

Event handlers is a member of staff who has been nominated (eg by their manager or REC) to manage the process of reviewing the event. This can be amended if required as the review process progresses.

- Ensure information contained within the event is accurate and complete
- Complete a thorough review of the actual event and surrounding processes

- Document information gathered from the review process into the progress notes and/or attach relevant documents in the documents section in Datix
- Assess and confirm the SAC score, justify any variation from the initial score (SAC 1&2 events will be confirmed by the Reportable Events Committee (REC)) SAC rating and triage tool for adverse event reporting
- Document lessons learned and actions taken to prevent reoccurrence
- Performance related management information must not be detailed in Datix
- Should close SAC 3 & 4 events once the review and documentation is complete
- Give sufficient feedback and information to staff (reporter or others affected) when the review is complete

Clinical directors and general managers

- Promote systems and a culture that supports event reporting within a non-blame culture
- Ensure appropriate clinicians are involved in the adverse event review and 'conflicts of interest' are avoided
- Ensure reviews within their service area are completed within the specified timeframes, providing any support as required
- Review and 'sign off' recommendations for Serious Event Analysis (SEA) reports which relate to events that occurred within their service, prior to it being presented to the REC
- Ensure a structured process by which recommendations and corrective actions are completed and evaluated
- Ensure the lessons learnt are shared (anonymised SEA and/or open book)

Patient Safety and Clinical Compliance Manager

- Report all substantiated SAC1 & 2 events, events from the Always Report and Review List (ARR) and significant near misses, to the Health Quality and Safety Commission (HQSC), within 15 working days from the date the adverse event is reported
- Aim for a summary of the review findings and recommendations of all SAC 1 & 2 events to be sent to HQSC, within 70 working days from the date that the event was reported
- Ensure there is clear and comprehensive guidance available for those responsible and accountable for the review of serious adverse events
- Encourage and facilitate sharing of learning from adverse event reviews

Reportable Events Committee (REC)

- Oversee a comprehensive and integrated approach to the management of adverse events particularly SAC 1 & 2 events, events from the ARR list and significant near misses
- Ensure Northland DHB consistently delivers transparent, high level management and appropriate independent and objective reviews of all SAC 1 & 2 adverse events, events from the ARR list and significant near misses, in alignment with the Health Quality and Safety Commission's National Adverse Event Policy

Serious Event Analysis (SEA) team

- Is selected by the REC and consists of senior healthcare professionals who were not directly involved in the event
- Will be supported by the Patient Safety and Quality Improvement Directorate
- Undertakes a robust review, identifying any care and service delivery issues

- Identifies and agrees on robust, effective and reasonable recommendations, with specific and clear actions to deliver the recommendations
- Identifies responsible leads for those actions and timescales for implementation
- Ensures there is open communication with staff, consumers and their family/whanau SEA reports will be presented to the REC

Review process

SAC 1 & 2 events, events on ARR list and significant near misses

All must be reviewed as below:

- The review process for SAC 1, 2 or ARR events will be facilitated by the REC
- A SEA must be used for the review
- All members involved in the event (staff and patient) must receive appropriate support and open communication
- The Mental Health and Addiction serious event committee, will create a SEA report for adverse events of suspected suicide or serious self-harm by community mental health service users, or within 28 days of discharge from the service
- The final SEA report must have recommendations approved/signed off for implementation by the appropriate service area clinical director, service and general manager and clinical nurse/midwife prior to presentation to the REC
- All completed and approved reports are presented to the REC for approval
- An anonymous or a summarised version of the approved report will be made available to the wider organisation to aid organisational learnings. A copy may also be sent to HQSC for wider learning
- All corrective actions are to be recorded on the SEAs and outstanding actions database
- The review should be completed within 70 days
- Recommendations from the SEA will be followed up at 3 and 12 month intervals and progress will be entered into the Datix file

SAC 3 & 4 Events and near miss events

- The review of SAC 3 & 4 events is to be undertaken in the ward/department where the adverse event /near miss occurred
- An investigation tool appropriate to the level of event is to be used. Options include but are not limited to:
    - Mini RCA for medication errors
    - Fall review tool
    - Post fall assessment
- The review and subsequent actions are the responsibility of the line manager (or delegate), advice and support can be sought from the REC
- The review of SAC 3 & 4 events/near miss must identify system issues that need to be addressed and/or appropriate quality improvement action to prevent or reduce future recurrence
- The review should aim to be completed and closed within 30 days
- Corrective actions are to be recorded on Northland DHBs adverse event reporting system (Datix)

- SAC 3 and 4 events may also be reviewed by specialist groups (looking for trends and advising on management), including but not limited to:
  - Medicines Committee
  - Harm Reduction group
  - Lab and Transfusion Committee
  - Patient Identification Committee
  - Occupational Health Service
  - Mental Health Service
  - Infection Control Committee

References

- Health and Disability Services Standards NZS8134:2008 (www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards)

Definitions

Term	Definition
Adverse event	An event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned (also referred to as 'reportable event'). In practice this is most often understood as an event which results in harm or has the potential to result in harm to a consumer.
Always report and review events	The Always Report and Review list is a subset of adverse events that should be reported and managed in the same way as SAC 1 and 2 rated events, irrespective of whether or not there was harm to the consumer.15 Always Report and Review events are events that can result in serious harm or death but are preventable with strong clinical and organisational systems. Reporting Always Report and Review events can highlight weaknesses in how an organisation manages fundamental safety processes. The Always Report and Review list is updated regularly by the Health Quality & Safety Commission.
Datix	Northland DHB's electronic system for reporting, managing and communicating regarding adverse event/ARR events, near miss events and actions.
Harm	Any unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires or prolongs hospitalisation, and/or results in permanent disability or death
Near miss	This is an event which, under different circumstances, could have caused harm to a consumer but did not, and which is indistinguishable from an adverse event in all but outcome.
Open disclosure	Open disclosure, or open communication, refers to the timely and transparent approach to communicating with, engaging with and supporting consumers and their whānau when adverse events occur.
Reportable event	All SAC 1 and SAC 2 events, events that are on the always review and report list and significant near miss events
Review	A review is another name for a formal process that is carried out by the health or disability service provider to analyse an adverse event or near miss and develop recommendations based on the findings. There are a variety of review methodologies. Reviews can be undertaken at different levels, depending on the adverse event (eg, comprehensive, concise, desk-review or single aggregated review of similar events).
Serious Event Analysis (SEA)	Defined as the systematic process whereby the factors which contribute to the event are identified by reconstructing the sequence of events and asking "why?" until the underlying causes (contributing factors/hazards) have been identified.
Severity Assessment Code (SAC)	The SAC is a numerical rating which defines the severity of an adverse event and as a consequence the required level of reporting and review to be undertaken for the event.

COMPLAINTS MANAGEMENT

This document explains the Northland District Health Board policy and accepted practices in relation to Complaints Management.

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COMPLAINTS MANAGEMENT

PURPOSE:

The Complaints Management documents ensure that all complaints about the provision of health and disability services received by Northland District Health Board (NDHB) are managed and responded to in a fair, simple, speedy and efficient manner for resolution, consistent with our obligations under Right 10 of the Code of Health and Disability Services Consumers' Rights (1996). Complaints handing is also an important part of NDHB's Quality Assurance and Quality Improvement activities and is seen as an opportunity for learning and improve quality.

POLICY STATEMENT: NDHB is committed to facilitate the fair, simple, speedy and efficient resolution of complaints so the rights of both the complainant and the identified staff are respected during the complaint process.

NDHB complaints process focuses on the opportunity to develop a culture which provides opportunities to learn

A patient/consumer complaint should not affect the quality of care received by that patient/consumer.

SCOPE:

This policy applies to all NDHB staff, contractors and external personnel including visiting health professionals, students from tertiary institutions, and those having work experience.

DEFINITIONS:

Complaint: Any expression of dissatisfaction from an external source about professional behaviour or quality of service that needs a response from the organisation.

Complainant: Person who makes complaint.

Complaint handler: The person assigned responsibility to investigate the complaint

Patient/Consumer: The user of the service (patient, family/whanau, guardian, advocate or health provider).

Open Complaint: One that has been received by the organisation.

Closed Complaint: One where a response has been sent to the complainant following investigation, detailing the outcome of the investigation, and any action that has or is to be taken as a result. If it does not elicit a further response from the complainant, a closed complaint requires no further response from the organisation to the complainant.

Resolved Complaint: A resolved complaint is one that is resolved to the satisfaction of the consumer as evidenced by written acknowledgment, or verbal acknowledgment that has been documented.

Statutory Complaints: Complaints arriving directly from the offices of the Health & Disability Commissioner, Privacy Commissioner, Human Rights Commissioner, or the Ombudsman

Associated Documents

Type:	Document Title(s)
Legislation	• Health & Disability Commissioner (HDC) Act 1994 • Human Rights Act 1993 • New Zealand Bill of Rights Act 1990 • Privacy Act 1993 • Mental Health (Compulsory Assessment & Treatment) 1992 Act • Health & Disability Service (Core) Standards NZS 8134.1::2008 • Public Records Act 2006 • Protected Disclosures Act 2000
Publications	• Code of Health and Disability Services Consumers' Rights (1996) • Health Information Privacy Code 1994
NDHB Policy	• Informed Consent • Reportable Events • Open Disclosure • Advocacy • Patient/Client Rights and Responsibilities • Disciplinary • Privacy & Confidentiality

Acknowledgments:
Waitemata District Health Board

Complaints Management Process

See Complaints Management Flowchart for non CEO'HDC complaints Appendix 1:

General

To ensure that all NDHB staff follow the correct procedure when receiving consumer complaints about the service.
Any complaint from a consumer directed to a NDHB board member, employee, department or service about professional behaviour or quality of service must be investigated and responded to in the manner outlined in this policy and procedure.

A complaint may be about
- The health care and treatment provided to an individual.
- Health care issues in general, not necessarily specific to an individual.
- Non-health care services for which NDHB has responsibility, provided a person is or was under that services care

A complaint may be received:
- In written or electronic form
- Verbally in person or via telephone

A complaint may be made by any person

- A complaint may be initiated:
- By the complainant (unsolicited)
- By consumer feedback mechanisms such as surveys or through a NDHB suggestion box (solicited)

Note:

a) Where the complainant wishes to remain anonymous the complaint will be referred and investigated through the complaint process.
b) Where the complainant does not wish to have the feedback dealt with in a formal way, the complaint information is entered on the complaint database, and the complainant is acknowledged advising that the feedback has been referred through the appropriate quality improvement process without their name.

1. Accountability for Complaints

Chief Executive Officer (CEO)

Ultimate responsibility for the organisation including complaints rests with the CEO, who is responsible to the Board for legal compliance.

The CEO delegates responsibility to:

- The Patient Safety & Quality Improvement Directorate (PSQID), General Managers, Clinical Directors, and Operations Managers of the District Hospitals who have responsibility for receiving the complaints and are accountable for the complaints process.
- The Chief Medical Officer (CMO) and the Director of Nursing and Midwifery (DONM) to provide professional advice, and Te Poutukomanawa for specialist advice.
- The General Managers and Operations Managers of the District Hospitals are responsible for the effective investigation of complaints in their services and remedial action.

The CEO may exercise discretion regarding the manner in which complaints are responded to and investigated. This is to enable issues of a political, media or otherwise sensitive nature to be responded to as required in each case. All complaints however will be entered on the central complaints database (DATIX held by the PSQID.

Staff

- **All** staff receiving written complaints are accountable for forwarding them to the PSQID or the Operations Manager of the relevant hospital within 24 hours of receipt.
- If the complaint is verbal, staff are required to make a file note and forward it to PSQID or Operations Manager of the District Hospital within 24 hours of receipt. The file note records the date communication occurred, a summary of the complaint, resolution if applicable and any subsequent action taken.
- All staff receiving complaints are required to initiate immediate resolution where practicable.
- All **serious** complaints must be brought to the early attention of the PSQID, Operations Managers District Hospital, General Manager of the Service, CMO, DONM or Duty Manager. This is to protect both staff and the organisation.

Patient Saety & Quality Improvement Directorate and Operations Managers of District Hospitals

The PSQID has responsibility for the complaint management process and are accountable for:

- Ensuring the nature of the complaint is clear to enable an investigation
- Ensuring information pamphlets and posters are displayed throughout the hospital informing consumers about the complaints procedure
- Maintaining a record of all complaints received
- Liaising with relevant staff to ensure the complaint is resolved
- Providing support and advice in complaint resolution process
- Coordinating the investigation in complaints that involve two or more services
- If a facilitated meeting is to be held, facilitating that meeting if required, and keeping notes of that meeting
- Recording all outcomes, follow-up actions and whether they are completed by the set date

- Providing a feedback loop to staff
- Monitoring the complaint resolution process to ensure it is customer focussed, and meets the requirements of the Code

General Managers/Clinical Directors

- General Managers have the responsibility to investigate and follow up, but may delegate as appropriate to operations managers.
- They may investigate and respond to a complaint themselves or delegate this to a manager in their service. The person who has primary responsibility for investigating and responding to the complaint to be the 'Complaint Handler'
- They must ensure that any actions for follow-up resulting from complaints in their services are followed through to maximise customer satisfaction and for quality improvement.

Complaint Handler

- Is responsible for ensuring resolution of the complaint
- Supports staff in writing of letters
- Reviews the clinical record and other relevant documents
- Meets with affected staff individually or collectively
- Considers whether incident leading to complaint should be the subject of a serious event analysis (SEA) investigation. If a SEA is considered the CMO or the Reportable Event Committee (REC) is to make this decision.
- Any correspondence to complainant is to be signed by the General Manager or his/her delegate. In some instances letters may need to be cleared by the CMO, or the DONM, or the CEO or NDHB's legal advisors

2. Multiple Service Complaints

2.1 When feedback is required from more than one area outside a single service consideration may be given to the PSQID, CMO or DONM as Complaint Handler in some instances

2.2 A meeting may be held to discuss the issues and single letter composed

or

2.3 A complaint response may involve more than one letter with a covering letter from the Complaint Handler included prior to posting.

3. Complaints Review

3.1 Each service and hospital must have a formal meeting / review mechanism for reviewing complaints, e.g. at Service Management meetings.

This process ensures that:

3.2 Complaints presented at Service Management meetings are monitored to ensure compliance with the Code of Health & Disability Services Consumers' Rights, and NDHB's Complaints Management Policy.

3.3 Quality improvement opportunities arising out of the complaint process are identified.

3.4 Recommendations are made to the appropriate senior manager

4 Serious Complaints

A serious complaint is where there is any serious allegation against NDHB. Serious complaints must be brought to the early attention of the PSQID, Operations Managers District Hospital, General Manager of the service, CMO and DONM. This is to protect both staff and the organisation

The following are examples of what may constitute a serious complaint:

4.1 A complaint which has the potential risk of legal action.

4.2 A complaint following a sentinel event or death of a patient as a result of treatment given or omission of treatment

4.3 Any allegation regarding a breach of legislation, regulations, or an ethical code of conduct e.g. breaches of the Code of Rights

4.4 Discrimination according to race, gender, age, etc including allegations about being neglectful, or otherwise having acted improperly.

4.5 Where staff appear to be practicing outside of an agreed policy of NDHB.

4.6 A complaint that has attracted media attention.

Staff

- If the complaint is about a staff member, consideration should be given to informing the service Human Resource Advisor.

5. Complaints involving Maori Cultural Issues

Copies of complaints that specifically refer to Maori cultural issues or service provision will also be forwarded to Te Poutukomanawa by the PSQID. The Complaint Handler will liaise with Te Poutukomanawa for advice or support.

6. Informing Consumers about Making Complaints

Consumers are informed of the NDHB Complaints Management Policy and associated documents through the following means:

6.1 The NDHB pamphlet & posters 'Patient / Client Information on Making a Complaint' which are available extensively throughout the hospitals and in community clinics.
6.2 The Health and Disability Commissioner's Office pamphlets and posters are displayed in hospitals and community clinics
6.3 Individualised hospital Patient Information Booklets are available in patient areas
6.4 Staff

7. Legislative Requirements

5 working days	All complaints are acknowledged in writing within five working days of receipt, by the PSQID, unless resolved to the satisfaction of the consumer within that period Complaint resolution must be documented.
10 working days	After acknowledgement, the decision is made by the Complaint Handler if the complaint is justified or not and more time id required to investigate
20 working days	All complaints are responded to in full, within 20 working days, or the consumer is informed in writing of the need for further time by the PSQID or the Complaint Handler..
Over 20 working days	The consumer is given sufficient monthly written updates by the PSQID to provide a clear understanding of the ongoing plan for addressing the complaint and the timeframes for this. The complaint handler is to liaise with the PSQID at this time.

8. Correspondence

Minimum information in key correspondence

It is important that those staff members who are the subject of the complaint or who are most able to supply an informed response to the complaint write their response in the form of letter to the complainant wherever possible (rather than writing to the complaint handler, PSQID or other staff about it). The respondent should consider carefully the language and attitudes expressed in the letter to ensure that they are addressing the complainant in a respectful, considerate and informative manner.
This letter should be reviewed by the Complaint Handler and General Manager before it is sent to the complainant. In some instances it might also be reviewed by other personnel such as the Clinical Director, CMO, DONM, CEO or legal advisors before it is sent. In such cases the PSQID

will advise the Complaint Handler that this is required. In all cases a copy must be attached to to DATIX and the PSQID must check on the progress of the response if no copy has been logged within the timeframe specified. The Complaint Handler is responsible for ensuring the letter is posted/emailed but the PSQID should confirm that it has occurred.

8.1 **The acknowledgment letter must:**

- Acknowledge receipt of the complaint
- Advise the complainant who will be investigating the complaint
- Inform complainant of the NDHB complaint management process, timeframes and appeal process
- Inform the complainant about the Health and Disability Consumers Code of Rights
- Advise them about the Nationwide Health & Disability Advocacy Service and the Health and Disability Commissioner.

8.2 **The final response letter should:**

Be addressed to the complainant always be tailored to the individual complaint under review but should include the following components:

Include:

- Date
- Complainant's name and address
- Name and designation of person(s) who coordinated/investigated the complaint.
- Acknowledgment of previous correspondence date and/or state that the investigation has now been completed in relation to the concern they have raised
- Identify the issues the complainant complained about and respond to each issue individually, and in chronological order of events/progressively, for example, through admission to discharge, etc. It is helpful to use a generic heading to illustrate clearly to the complainant that each concern is covered, ie. *Discharge note content or Weight loss.*
- All issues/points raised by complainant must be addressed with a brief explanation of what occurred
- Any error/deviation from expected practice/standards of care must have an apology.
- Where there may **not** have been any error/deviation from standards/expected practice an apology must still be given for the distress/frustration/upset cause or **experienced** by the complainant /patient/client care.
- If the findings are quite different to the complainant's perception of events, then state what was different and how this was confirmed, ie. *According to our records* or *the documentation in the clinical notes* ....

-as far as possible the contents should be factual

- State what corrective action will or has been taken as a consequence of this investigation, either for this patient in the future or for others.
- Request the complainant to confirm whether or not they are satisfied with the response
- Finally, state that if there are still concerns for the complainant then they should contact the writer again (state how they can do this).

- The PSQID will forward a copy of the final response letter to Nationwide Advocacy Service if they are involved.

Avoid the following

- Using blunt or dismissive statements and phrases.
- Using negative language, eg. "we can't, we don't, we won't".
- Being overly emotional, evasive, speculative or vague.
- Being defensive or trying to deny everything, eg. "Our staff are highly trained professionals and would not have done/said/treated you……".
- Trying to apportion blame, particularly against the patient/family) eg. "Because of your refusal to follow the nurses' advice……"
- Using medical/technical jargon that a lay person would find confusing, intimidating or difficult to understand.

8.3 Signing of final letters

- Letters must be signed by the writer.
- In some instances it may be appropriate for a covering letter to be written by: the CEO, CMO, DONM or General Manager if not the author of the response.
- Responses to 'Ministerial' complaints (those signed by an MP) and received by the Chief Executive's office must be signed by the CEO
- Complaints forwarded from the CEO's office, to be investigated, response to be signed as directed by CEO
- Final letters to include reference number.

9. Holding a Meeting

Where a complaint is particularly complex or sensitive, the Complaint Handler may consider it appropriate to invite the complainant to a meeting with relevant parties.
If a meeting is convened, the complainant **must** always be invited to bring a support person(s) with them and every effort should be made to accommodate their wishes with regard to date, time, venue, etc.
Staff should consider whether they should have a support person, witness/ note taker.
The venue must offer privacy and freedom from interruptions.

Meetings are more successful when

- Attendees are punctual.
- Pages/cellphones are turned off and phone calls diverted to voice mail.
- Preparation occurs prior to the meeting, ie. Investigations completed, questions/issues and anticipated responses prepared.
- All documentation and relevant notes are available.
- The complainant and his/her support people are not outnumbered by Northland DHB staff.
- NDHB staff are sensitive to the complainant's concerns and avoid becoming defensive or argumentative.

10. Health & Disability Commissioner's (HDC) Complaints

HDC has a number of different options available in respect of complaints

10.1 HDC send email to a distribution list (D.L) that include the CEO, CMO, DONM, Dir. Board Governance & Compliance and the PSQID advising of complaint and request for documentation and a preliminary response within a specified timeframe.
or HDC may propose for formal complaint to go to advocacy- advised via the DL
or a preliminary enquiry is made to allow HDC to decide what steps to be taken if any
or notification of investigation by HDC

10.2 The complaint is entered into DATIX and forwarded to the Complaint Coordinator; generally the CMO who advises who else should be advised.

10.3 PSQID assumes this responsibility and advises Release of Information via the Shared Mailbox of HDC's request for any documentation

10.4 PSQID supplies any other previous complaint history to the Complaint Handler and. complaint copied to GM and DONM (if any nursing issues)

10.5 Service Complaint Handler may discuss complaint with Director of Board Governance & Compliance then instigates investigation (a service may use the Complaint Investigation Procedure to aid the investigation process) Appendix 6 and gains responses from service or clinician.

10.6 Service Complaint Handler sends to CMO's office investigation result and draft response(s) and relevant copies of notes from clinical record and/or Concerto/Jade

10.7 CMO reviews response to HDC signs and forwards to HDC

10.7.1 Where the CMO is not the author of the direct response a covering letter from the CMO should accompany the response.

10.8 The response is loaded into DATIX by the service.

10.9 Complaint is closed when HDC respond they are satisfied with action taken.

11. Public Complaints direct to CEO

11.1 Written public complaints made directly to the CEO, will be scanned by the CEO's office and emailed to the PSQID and to the General Manager of the relevant service.

11.2 Complainants letter acknowledged by PSQID

11.3 PSQID orders clinical record to be sent to the service Complaint Handler and any other previous complaint history. Complaint copied to CMO (medical staff issues) DONM (if nursing issues)

11.4 Service Complaint Handler instigates investigation (a service may use the Complaint Investigation Procedure to aid the investigation process) Appendix 6 and gains responses from service or clinician.

11.5 Service General Manager reviews draft response and sends to CEO's office for signing and forwarding to complainant.

11.6 The response is entered into DATIX and complaint closed

12. Non resolution and Appeal Process

12.1 If the complainant is unhappy with the outcome of their complaint, they can ;

12.1.1 contact the PSQID who will refer the complaint back to the service

12.1.2 or refer the complaint to the CEO for review, as detailed in the information leaflet provided when the complaint was first registered.

Complaints Process 2016.pdf

12.2 The appeal process will include a review of the substance of the complaint, the process of investigation and the facts relied on in reaching the decision.

12.3 If following review by the CEO, the complainant is still not satisfied with the outcome of the investigation, they should be advised to refer the matter to the Health and Disability Commissioner.

13. Habitual or Vexatious Complaints

13.1 The key consideration when dealing with habitual or vexatious complaints is to ensure that the complaints procedure has been correctly implemented and that no material element of a complaint has been overlooked or inadequately addressed. In doing so it should be appreciated that habitual or vexatious complainants may have issues which require investigation. The need to ensure an equitable approach is crucial.

13.2 If it is considered that all aspects of the complaint have been addressed, the complainant has been offered the opportunity to appeal the complaint, and still persists in stating their dissatisfaction; they should be reminded of the opportunity to access the Health and Disability Commissioner for an independent investigation into the complaint.

14. Security and Retention of Information

14.1 Material collected as part of the investigative process is filed in DATIX. Access is limited to the CEO, Operations Managers, General Managers or their delegates, the CMO and DONM

14.2 If a complaint has revealed performance issues with an individual staff member information pertaining to this may be filed with the HR Department (*see 17.5*)

Material is retained for a minimum of fifteen (15) years

Note:
Documentation generated as a consequence to the investigation process must not be placed in clinical record.

15. Privacy Implications

Complaints may contain personal information about the consumer or other people. Under the Privacy legislation, this means that:

15.1 The information should only be used in ways that are necessary to manage the complaint

15.2 Appropriate steps must be taken to keep personal information secure e.g. complaints should not be discussed in public areas, complaint information should be loaded into DATIIX Complaint management module

15.3 Consent for disclosure of personal health information must be obtained from the patient if complaints are lodged by a third party – the consent request will be managed by the PSQID.

15.4 Complaint forms / complainant letters should not as a general rule be photocopied or circulated to other members of the treatment team-only provided to those staff investigating and responding to complaint..

15.5 Complaint forms / complainant letters must not be filed in staff personal files. If a manager deems it appropriate to initiate a performance management / disciplinary process with an employee as a result of a complaint, documentation with regard to this process should be kept on an employee's personal file. Unsubstantiated complaints or those that have not resulted in appropriate investigation processes should not be filed on individual's personal files.

15.6 Once the investigation is completed all documentation relating to the investigation and the responses is to be loaded into DATIX.

16. Complaints Audit

The purpose of complaints audit is to provide assurance regarding the organisations performance regarding complaints management.

Audit occurs through:

16.1 Monthly reporting Complaints review in the Service Committees

16.2 Complaints registered with the Health & Disability Commissioner and the Privacy Commissioner

16.3 Other agencies (e.g. MOH)

16.4 Any issues arising from the audit process are documented and an action plan developed accordingly.

Appendix 1.

Process for all non CEO/HDC Complaints

All public complaints, including those received directly by a service* to be sent directly to Patient Safety & Quality Improvement Directorate (PSQID)

↓

PSQID enters complaint into DATIX Complaints module

↓

PSQID :
1. Determines Complaint Coordinator (CC)
2. Forward complaint for action to CC or person specifically indicated by a service, with copy to DoNM (nursing issues), CMO (medical issues) Te Poutokomanawa (cultural issues)
3. If a complaint involves primary care. PHO Quality Leader to be notified.

↓

Service Complaint Coordinator ;
determines Complaint Handler (CH)

↓

Complaint Handler (CH):
1. Initiates investigation.
2. Refers complaint to staff for draft response(s)
3. Assembles final response (if determined by the service), this may include drafting letter for GM /Ops manager signature)

↓

CH checks all complainants questions / requests answered?

NO → return to Complaint Handler (CH)

YES ↓

Final letter completed viewed by GM

↓

Service sends final response letter to complainant and enter in DATIX Complaints module

↓

CH follow up recommendations, enter progress in DATIX Complaints module

↓

Service closes file

PSQID ensures:
if complaint is received from 3rd party consent is obtained the person patient/consumer.

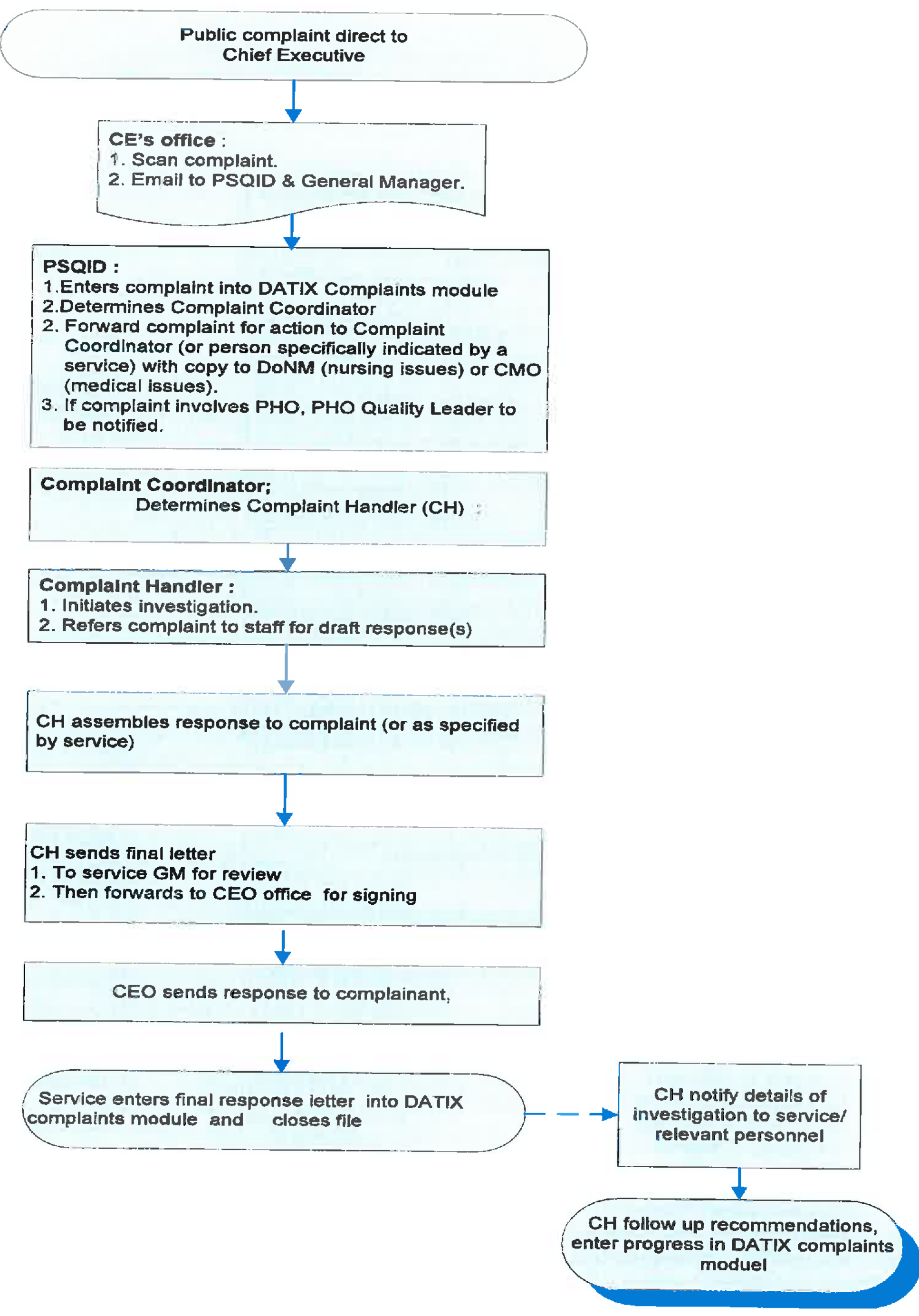
If a complainant wants their name withheld they will be advised an investigation cannot always be undertaken without their name and they may not get a further response other than the acknowledgement of receipt of their complaint. Their comments will be forwarded to the service.

PSQID will monitor whether progress letter sent at 20 working days and will remind CH to do so if not done.

August 2017

Appendix 2:

Process for all Complaints via CEO's office



August 2017

Appendix 3

Process for all HDC Complaints

HDC complaints are emailed directly to Chief Executive (CEO)and to a DL mailbox

PSQID HDC Coordinator enters complaint into DATIX (Complaints module)

PSQID HDC Coordinator confirms with CMO and/or Board Governance & Compliance Director(BGCD) to:
a. determine their ownership of complaint
b. determine the Complaint Handler (CH)

PSQID HDC Coordinator refers complaint onto CH for investigation

All records, documentation pertaining to the HDC complaint to be attached/entered into Datix whether the investigation is opened or closed

Complaint Handler:
To discuss complaint with owner of the HDC complaint either CMO or BGCD if required/necessary

CH to forward to CMO or BGCD
a. Results of investigation
b. Draft response(s).
c. Copies of relevant notes from patient file and /or Concerto.

CMO or BGCD to review draft response or be contacted for advice during investigation

Response sufficient? — More information required (returns to CH) / YES

CMO sends response to HDC, copies to CEO, service GM and PSQID office to enter into DATIX Complaints module.

HDC notify DHB: No further action

PSQID office sends copy HDC final letter to service GM and other identified parties.

CH notifies details of investigation to service/relevant personnel

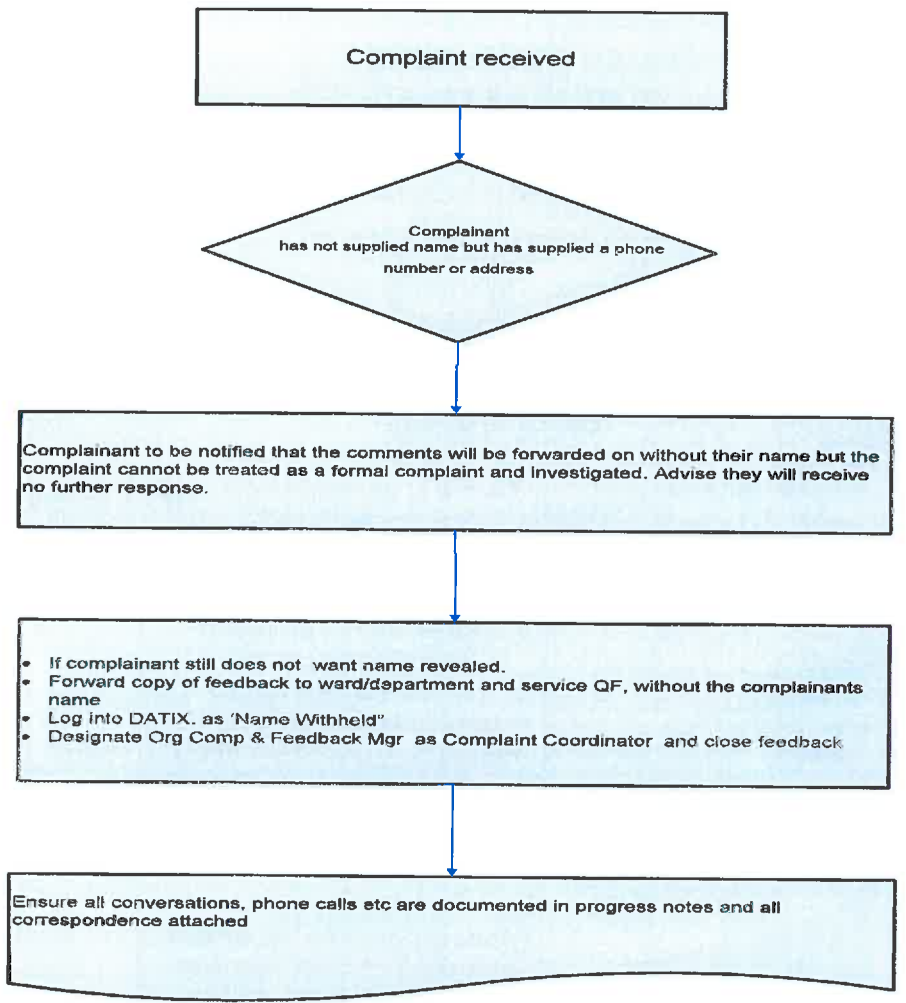
Any recommendations to be followed up? — YES → Recorded and monitored by PSQID HDC Coordinator → CH follow up recommendations, enter progress in DATIX → Recommendation results sent to HDC by PSQID

NO → PSQID close file when HDC advise No Further Action

October 2017

Appendix 4

Complaints from those who want their name withheld or are anonymous



August 2017

Appendix 5

Complaints Involving More Than One Service / Department

Complaint received

Entered into Datix

Involves more than one service

YES → PSQID will determine the primary complaint coordinator and advise the second service & noted in DATIX

NO → Complaint processed in usual way

Determined by > % of complaint

Response from second service/department to be sent to primary complaint coordinator

The primary complaint coordinator or their representative will be responsible for collating the response from all services/ departments.

Final response to be written on behalf of both serviices

Following content approval from service General Manager letter to be sent to the complainant

Appendix 6

Complaint Investigation Procedure

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Process Description

Attribute	Description
Document Name	Commence Complaint Investigation Procedure
Process Description	The tasks and activities involved in investigating complaints
Applications/ Tools	Intranet, Microsoft Outlook, DATIX Complaints module
Assumptions	**1.** Complaints received in this organisation will be dealt with promptly, decisively and with urgency **2.** Major complaints are “owned” by the relevant senior staff and not delegated down the operational line **3.** Complaints and complainants are treated with respect and dignity **4.** Complaints are treated confidentially **5.** Appropriate communication throughout process to ensure the outcomes are as favourable as possible for both the patient/client and their caregivers **6.** Complaints are learning opportunities **7.** Responses are written in a manner that will be easily understood by complainant avoiding “service-speak “wherever possible
Triggers	Complaint received by Northland District Health Board
Outcomes	A comprehensive investigation will be completed in a timely manner addressing all issues raised by the complainant with Correctives Actions in place or to be implemented in a specific timeframe
Functional Areas & Description	Northland District Health Board
Measures	Investigation Commenced within 1-2 working days of receipt of complaint That 85% of complaints are resolved within 20 working days (the remaining 15% being those deemed most complex)

Step	Responsibility	Step Name	Action	Measure

Procedure

1	**Complaint Coordinator**	**Process Step** Determines most appropriate Complaint Handler	Enters complaint handler into DATIX	Within 1-2 days of receipt of complaint
2	**Complaint Handler + Relevant senior clinician**	**Process Step** Gather appropriate resources to assist with Investigation of Complaint Received	Resources required to complete initial investigation include but are not limited to: 1. Complainant/patient/client (telephone/meet face to face) 2. Clinicians and other staff involved in patient/client care 3. Patient/client clinical record both paper file and electronic	Within 1-2 days of receipt of complaint
3	**Complaint Handler + Relevant senior clinician**	**Process Step** Review complaint to ensure complaint issues are clear and understood	Clarifies the issue(s) of concern. This may require a phone call to complainant/patient/client If patient/client is currently an inpatient meet with them and their family/whanau face to face NB: these actions can also provide an opportunity to resolve the issue(s) at this point	Within 1-2 days of receipt of complaint
3	**Complaint Handler + Relevant senior clinician**	**Process Step** Gather appropriate information that will assist in your investigation	Email/telephone Clinical Records to order clinical records of patient involved if appropriate/required, following agreed process to request records.	Within 1-2 days of receipt of complaint
4	**Complaint Handler + Relevant senior clinician**	**Process Step** Initial pre-meeting with staff	Call a initial meeting with relevant clinicians including HOD to discuss complaint issues and Invite other relevant staff members involved to gain further insight and information.	Within 1-2 days of receipt of complaint

5	**Complaint Handler + Relevant senior clinician**	**Process Step** Contact any staff members named in complaints	Always ensure that you provide clinicians, nurses and other allied health staff members the opportunity to answer the complaint issues themselves.	Within 1-2 days of receipt of complaint
6	**Complaint Handler + Relevant senior clinician**	**Process Step** Ensure you have all facts about usual policies/processes	Speak with services to gain facts about usual process if unknown to complaint handler Refer to NDHB Policies and documents or associated national standards	Within 1-2 days of receipt of complaint
7	**Complaint Handler + Relevant senior clinician**	**Process Step** If other service are involved in complaint	One service will be nominated as the primary responder. The initial DATIX notification from PSQID will advise the Complaint Coordinator of other services involvement in the complaint requesting their response to the issue (s) highlighted for that service. The primary responder will collate all responses.	Within 1-2 days of receipt of complaint
8	**Complaint Handler + Relevant senior clinician**	**Process Step** Finalise investigation information	Review all initial information gathered and ensure that you have the appropriate information to address issues raised to satisfactorily respond to the complainant's concerns.	Within 6 working days
9	**Complaint Handler**	**Process Step** Submission of completed investigation report	The completed investigation report (if used) is loaded into DATIX along with the final signed/approved response and any other documentation/emails gathered during the investigation.	

Trouble Shooting

If	This Means	Action
The Investigation will not be completed within the 20 working days	The investigation findings and response to the complainant will breach the 20 working days legislated by the H&D Code of Rights	Notify the complainant either by phone or letter by or on the due date with a reason for the delay and estimated time for final letter
The Incorrect service has been forwarded the complaint	The complainant has incorrectly identified the areas and /or the PSQID has incorrectly assigned the complaint	The Complaint Handler should inform PSQID immediately to allow for reassignment.

Appendix 7

Complaint Investigation Guidelines

1	Are there any immediate safety issues that need to be addressed?
2	Contact the complainant to: • Obtain any additional information to fully understand the complaint and clarify issues of concern • Identify desired outcome-what does the complainant hope will happen as a result of an investigation? • Determine if they have any supporting documentation or witnesses • Offer assistance if additional information is required and the complainant requires support eg Advocacy, language, cultural sight or deafness • Provide information on the investigation process and anticipated time frames • Reassure complainant that their/patients/clients care and treatment provided by NDHB will not be affected as a result of making a complaint
3	PSQID to ensure that if complainant is not patient/client do they have the authority/permission of the patient/client to receive a response on their behalf? If they need next of kin/Enduring Power of Attorney (EPOA) then authorisation will need to be sought from the patient/client by the PSQID.
4	Does the delegated investigator have sufficient experience / knowledge and/or qualifications? Does the investigator have a conflict of interest? Is the investigator assigned to the complaint suitable? Do we need a small team of people with relevant expertise to conduct the investigation?
5	Use other members of service to assist if necessary
6	Check previous complaints from the complainant and identify practitioner or service area. Are there any other issues that we should be aware of?
7	Maintain confidentiality
8	Analyse the complaint, identify each issue raised, identify relevant parties and identify sources of information including policies and guidelines
9	Seek clinical / professional/ cultural advice as applicable.
10	Formulate investigation plan. Utilise the Investigation report Template to guide you.
11	Gather information via meeting with staff involved, clinical records, policies, guidelines, and

	other relevant information.
12	Continuous analysis; -compare information when obtained to identify gaps, inconsistencies or ambiguities in the information. Consult with clinical / professional staff Seek collaborative evidence if conflicts arise in information obtained.
13	If systematic issues identified use systematic investigative methodologies e.g. SEA (Serious Event Analysis)
14	Ensure requirements of procedural fairness are met: • Was the respondent given sufficient details of the complaint? • Was the respondent given an opportunity to respond to the complaint? • Was the respondent informed of any adverse proposed actions and the grounds for these? • Were submissions made by the respondent duly considered?
15	Is there a requirement for a legal opinion from the Board Governance and Compliance Director?

SAFE MANAGEMENT AND PRIVACY OF PERSONAL INFORMATION

Rationale/Purpose

Availability of personal information including personal health information about identifiable individuals is central to the provision of employment and health care. The purpose of this policy is to provide direction for staff on how to manage all personal information including health information safely, as this is an integral part of each employee's role at NDHB. The guidelines are contained in a policy framework, which links the policy statements to the relevant procedures relating to managing health.

Scope

All employees and contractors who have access to personal information including personal health information about identifiable individuals must comply with this policy and related procedures.

Policy

All personal information, collected and stored as required by relevant legislation, including Employment Relations Act 2000, Holidays Act 2003 and the Wages Protection Act 1983, is done so in compliance with the twelve Information Principles embodied in the Privacy Act 1993.

All personal health information relating to identifiable individuals should be managed in accordance the Health Information Privacy Code 1994, on which this policy is based.

Policy Statement – Personal Information

1. Personal Information

Personal information refers to personnel records, including payroll and human resource information, which are maintained as part of a planned systematic approach providing efficient, effective delivery and storage of accurate information to ensure Northland District Health Board (NDHB) meets its obligations in terms of relevant legislation and employment agreements.

Please refer to the '***Documentation – Personnel Records***' policy.

Policy Statements – Personal Health Information

Contents

1. The purpose of collecting and using health information 2
2. Source of health information 2
3. Patient awareness 3
4. Storage and security 3
5. Access by patients to their own Personal Health Information 3
6. Correcting/altering Personal Health Information at the patient's requests 4

7. Accuracy and completeness of health information 4
8. Disclosing or releasing personal health information 4
(a) Disclosing anonymous health information 5
(b) NDHB employee initiated disclosure of health information 5
(c) Third party requests for information 5

1. The purpose of collecting and using health information

Personal health information is obtained and used for the purpose of providing ongoing care and treatment to the patients of NDHB, which includes sharing relevant information with other providers of health services.

When a patient is referred to NDHB by a General Practitioner (GP), midwife or other provider of health services, it is important that the outcome of the referral is documented in the patient's clinical record and communicated back to the referrer.

Communication between health care providers must be accurate and comprehensive, using standardised formats. These include an accurate problem list and clear action plan, which must be documented within the first 24 hours of the patient's admission.

Other purposes for which personal health information may be obtained include:

- Service planning and other administrative functions.
- Training and education.
- Auditing and monitoring of the quality of services.
- Funding and statistical reporting requirements for the Ministry of Health and other agencies (eg ACC).
- Research

If a person wishes to obtain or use personal health information for a purpose other than those outlined above, they must first seek the advice of their service manager or the Privacy Officer.

Important – Health information must not be collected by unlawful or unfair means, or if it will intrude unreasonably on the personal affairs of the patient.

Note – If health information is being collected without the knowledge of the patient (eg by the use of one-way mirrors, etc), the justification for using this method of collecting information must be documented in the patient's clinical record.

2. Source of health information

Health information should be collected directly from the individual concerned. Exceptions to this include:

- When the patient has authorised someone else to provide the information.
- When the patient's representative has authorised someone else to provide the information if the patient is unable to give his/her authorisation.
- When compliance with this directive would prejudice the patient's interests, for example, in an emergency situation.

- When compliance with this directive is not practical, for example, if a patient is unconscious or unable to provide the information.
- When Ethics Committee approval for research has been obtained.
- When compliance with legislation is required, eg Mental Health (Compulsory Assessment and Treatment) Act 1992.

Note – When information is not collected directly from the patient, the source of this information and the identity of the person providing the information must be documented in the patient's clinical record.

3. Patient awareness

When collecting personal health information, staff must ensure that patients are aware:

- That the information is being collected.
- Why it is being collected.
- Who will receive the information, eg ACC, GP etc..
- Whether it is mandatory or voluntary to provide the information.
- What the consequences of not providing the information are.

4. Storage and security

Reasonable safeguards must be put in place to protect personal health information against loss, misuse, or unauthorised access, use, modification or disclosure. These safeguards can be:

- Physical (location of patient records and computers).
- Operational (employee confidentiality agreements, auditing access to information).
- Technical (by use of passwords, back-ups, and by ensuring that the systems include the ability to track those who have access information).
- Strategic (privacy impact assessments are done prior to the development of a clinical information system).

Please refer to the '***Storage and Security of Electronic and Paper Clinical Records***' policy.

Important – Health information about patients must not be sent electronically to external health care providers unless a secure email system is in place, or the document is protected by secure password.

5. Access by patients to their own Personal Health Information

Patients have the right to access their own personal health information, and parents and guardians have the right to request access to the personal health information of their children aged under 16 years. Requests for children's information requires careful decision making, and relevant considerations in making such decisions are outlined in the ***How parents and guardians request the personal health information of their children aged under 16 years***' procedure.

Requests may be dealt with at the time the care is being provided or by application to the Release of Information Officer in the Clinical Records Department.

Important – There are only limited grounds to refuse to give patients access to their health information. Before withholding any information, advice from the Privacy Officer should be sought.

Important – Northland DHB staff may access their own records (but not those of family or friends).

Please refer to the '***Release of Patient Information***' Policy.

6. Correcting/altering Personal Health Information at the patient's requests

Patients have the right to request that their personal health information be corrected. Any such alterations made to personal health information must be clearly identifiable, include the date the alteration was made, who authorised the change, and signed (where appropriate).

The information contained in the clinical record reflects clinical opinion and assessment of the patient at the time of their referral or treatment. This information may be relevant for any future care and treatment and must not be deleted from the record when the alterations are made.

If it is decided that the requested correction will not be made, the request from the individual must be attached so that it can be read with the corresponding information.

Important – The original information, which is being corrected, must not be deleted from the clinical record. The changes must be tracked so that it is clear to all users that the correction has been made.

7. Accuracy and completeness of health information

All health information contained in the clinical records must be accurate and comprehensive. This includes electronic acceptance of investigations, medication charting, and other hand-written and electronic health information.

It is essential that the identity and designation of the author, and date and time of entry, is clearly identifiable for all entries into the electronic and paper clinical record.

Inaccuracies which are identified must be corrected, though the original information which is being corrected must not be deleted from the clinical record. All changes must be tracked so that it is clear to all users that a correction has been made.

Important – Before information is used, it should be checked that it is accurate, up to date, complete and relevant. Health information which has not been verified or authorised for release by the author must be clearly marked as "Not verified".

8. Disclosing or releasing personal health information

Relevant personal health information may be disclosed by NDHB employees if it is consistent with the purposes for which it was collected (as outlined in No. 1 above,

The Purpose of Collecting and Using Personal Health Information). For example, disclosing health information to the patient's GP or other healthcare provider is permitted, as sharing information with other health professionals is one of the purposes for which it is collected.

Personal health information can be used by or disclosed to another person or agency if it has been requested under an identified statutory requirement, which include:

(a) Disclosing anonymous health information

If the information being disclosed does not reveal the identity of the particular patient, the information may be released under the provisions of the Official Information Act or s22H of the Health Act.

(b) NDHB employee initiated disclosure of health information

Disclosure of relevant health information to a third party, if this was not one of the purposes for obtaining the information (outlined in No. 1 above, The Purpose of Collecting and Using Personal Health Information'), may occur in limited circumstances.

Important – If staff believe disclosure is necessary to prevent or lessen serious threat to the public or an individual, or for the maintenance of the law, they must give the information to someone who can prevent or lessen the threat. All cases of such potential disclosure must be discussed with the Service Manager and/or the Privacy Officer before such disclosure occurs.

(c) Third party requests for information

Releasing personal information to a third party is permitted provided that the procedures relating to this are accurately followed. For example, third party requests for information may be received from:

- Police
- Oranga Tamariki *(previously Child, Youth and Family Services)*
- An insurance company or a lawyer
- Accident Compensation Corporation
- Health and Disability Commissioner

Please refer to the '***How a Third Party Requests Personal Health Information'*** procedure

Important – All third party requests for personal health information should be referred to the Release of Information Officer in the Clinical Records Department in the first instance. Each request will be considered under the specific legislation, which gives the requestor authority to obtain the information.

Requests may also be received from relatives or friends of a patient note that such requests must be managed in accordance with the '***How relatives/friends obtain personal health information about a patient'*** procedure. This procedure also applies to NDHB staff members who wish to access health information about their family or friends.

Important – If there is any doubt about any third party requests for personal health information, advice from the Privacy Officer must be sought.

Definitions

Terms and abbreviations used in this document are described below:

Health Information relates to information about the following –

- A patient's health including his/her medical history.
- Any disabilities the patient has or has had.
- Any health or disability services that have been provided to the patient.
- A donation made by a patient of any body part or bodily substance of the patient.
- Any body part or bodily substance derived from testing or examination of the patient.
- Any body part or bodily substance that has been collected before, during or incidental to the provision of any health or disability service.

Associated Documents

Other documents relevant to this policy are listed below:

• New Zealand legislation	Privacy Act 1993 Health Information Privacy Code 1994 Official Information Act 1982 Health Act 1956 Public Records Act 2005 Employment Relations Act 2000 Holidays Act 2003 Wages Protection Act 1983
• NDHB policies	All HR and health information related policies
• Acknowledgements	Counties Manukau DHB Safe Management and Privacy of Personal Health Information policy

STORAGE AND SECURITY OF ELECTRONIC AND PAPER HEALTH INFORMATION

RATIONALE:
To ensure that all client/patient records/documents are secure at all times.

POLICY STATEMENT:
Northland District Health Board has a responsibility to ensure that all health information is protected, by such security safeguards as it is reasonable in the circumstances to take, against:

i. Loss.
ii. Access, use, modification, or disclosure, except with the correct authority.
iii. Other misuse

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

DEFINITION:
Health information comprises of any information held by Northland District Health Board or its staff about an individual patient or client's clinical or medical history, diagnosis, condition, treatment, services provided.

PROCEDURE:

A. Off DHB Premises

Where staff are authorised to take health information off DHB premises it must be kept secure, e.g., in a locked case or file. If it is absolutely necessary to carry client information/documents out of the office, documents are to be in a locked bag and kept in the car boot.

When material is printed for case review/supervision purposes it should have name address/DOB/NHI and other identifiers covered with marker pen or white-out.

NDHB does not release the original paper clinical record to other health care providers or any other agency, unless authorised by the Clinical Records Manager or if required by the Coroner. Following the correct guidelines requests for health information can be processed and copies sent out through the Clinical Records Department. Outside of regular working hours, urgent request can be authorised by the Duty Manager under those same guidelines.

B. Mail

When sending health information by post:

- Ensure that postal items safely enter the postal system before they can be intercepted by third parties. Steps might include a locked posting box for outgoing mail or keeping incoming and outgoing mail out of public areas.
- Care must be taken not to display health information on the outside of envelopes. Consider double-enveloping, for example if a return address should not be displayed.
- Postcards should not generally be used.
- Medical records should not be given to third parties to pass onto patients unless this is authorised by the individual concerned or their representative.
- Information on digital media (CDs, memory sticks or similar) should be encrypted.
- No original health information should be sent through external mail unless through the courier with a tracking barcode.

C. Facsimile

When appropriately used, and subject to appropriate security safeguards, fax transmission can provide a quick and satisfactory means of communication. Problems arise if information is transmitted to the wrong number through misdialling or staff changes at the receiving agency. Faxes are also often received at unattended machines. Consider:

- Locating fax machines out of public areas, with controlled access.
- Restricting the use of fax machines to authorised staff and ensuring that there is secure delivery to intended clinical staff.
- Using programmed numbers to avoid misdialling.
- Regularly checking the accuracy of pre-programmed numbers.
- Producing and distributing an official and regularly updated list of fax numbers assigned to commonly used locations (with a clear expiry date for each edition) to ensure that fax numbers are current and accurate.
- Controlling the type of information that may be sent by fax.
- Requiring staff to telephone the intended recipient before transmission to ensure the information can be uplifted immediately.
- Carefully checking fax confirmation reports to ensure correct transmission (and to enable rapid action in the case of incorrect transmission).
- Retaining fax activity history reports to check unauthorised transmissions etc; and using unique identifiers, rather than names, to ensure transmission of confidential information about identifiable individuals does not occur. Carefully controlled, this severance of personal information also permits the faxing of documents, but care is needed to ensure that different documents do not become mixed.

D. Email

Please refer to the Corporate Email Guideline.

E. Destruction/Disposal

Northland District Health Board retains and disposes all personal health information in accordance with the Public Records Act 2005 and the District Health Boards General Disposal Authority.

There is a minimum retention period in relation to health information of 10 years in certain cases this is extended, they are:

- Paediatric Care – Retain for a minimum of 20 years from date of contact or when the child has reached the age of 25 whichever is greater.
- Maternal Health Care – Retain for a minimum of 20 years from birth episode date of discharge.
- Radiotherapy Care – Retain for a minimum of 40 years.
- Mental Health – Retain for a minimum of 20 years.

However these conditions are void if it is 10 years after the date of death of the individual.

Please refer to the Retention and Destruction of Personal Health Information Policy.

F. Disposal of confidential paper waste

- All documents for disposal that meet the definition of confidential waste are placed into the blue confidential bins via a purpose-created slit in the lid which is locked securely.
- The bins are located in a secure environment with no unauthorised access.

G. Physical Security of Paper Clinical Records

The health information must be protected while in use, storage or in transit. Security of Clinical Records when they are stored in locations other than the Clinical Records Department:

- The person receiving the paper clinical record(s) is responsible for the security of the record while they are stored in locations other than the Clinical Records Department.
- Those clinical records which are stored in areas that only allow staff "swipe card" access or that cannot be accessed by the public when left unattended do not have to be locked away.
- However, those clinical records which are held in areas where they could be

accessed by the public when left unattended must be locked away to minimise the risk of unauthorised access.

H. Tracking the Location of the Paper Clinical Records

To ensure that the location of the paper record is known at all times, the following information will be entered using the Tracking System:

- Name of person who has requested or is using the clinical records
- Reason for Use
- Normal storage location of the records
- The current location of the records
- Date of dispatch
- Date required

It is the sender's responsibility to track the record to its next destination and the receiver's responsibility to track receipt of the record on arrival, or as soon as possible thereafter.

I. Who may Access the Clinical Record

Staff of NDHB, authorised students accommodated within NDHB, and staff of approved health providers associated with NDHB may access the clinical records (including the electronic record) of patients for whom they are providing ongoing care and treatment. This includes administrative tasks such as booking patients for appointments etc.

Records must not be accessed or used other than for an authorised purpose related to the care and treatment of patients under the staff member's care in that staff member's role at NDHB.

J. Use of Passwords for Electronic Clinical Records

The security of passwords or electronic identifier is the responsibility of the individual staff member. All authorised staff will be held responsible for any use of their electronic identity and signature. Any security breach or compromise of an electronic identifier must be reported immediately.
All users should use a "strong" password that cannot be easily guessed or identified. Never use names of family members, pets, birth dates or common or generic passwords. Strong passwords should be at least 8 characters long and should have a combination of letters and numbers.
Please refer to the Password Guideline

NZ Legislation:	Privacy Act 1993
	Health Information Privacy Code 1994
	Official Information Act 1982
	Health Act 1956
	Public Records Act 2005
Related Policies and Guidelines:	Corporate Email Guideline
	Retention and Destruction of Personal Health Information Policy
	Password Guideline
Acknowledgement:	Counties Manukau DHB Storage and Security of Electronic and Paper Clinical Records Procedure

Process for Responding to Privacy Breaches

1. Purpose

This document sets out the steps that must be followed when responding to a privacy breach:

1.1 The Chief Information Officer/Chief Medical Officer (CIO/CMO) is responsible for the coordination, investigation, and resolution of privacy breaches.

1.2 All actual or suspected privacy breaches must be reported immediately to your supervisor and to the CIO/CMO or Duty Manager (out of hours).

1.3 The CIO and CMO are responsible for liaising with the CEO regarding an actual or suspected privacy breach.

2. What is a Privacy Breach and what is an Information Incident?

A privacy breach is a collection, use, disclosure, access, disposal, or storage of personal information, whether accidental or deliberate, that is not authorized by the Privacy Act.

A privacy breach is a type of information incident. Information incidents are unwanted or unexpected events that threaten privacy or information security. They can be accidental or deliberate and include the theft, loss, alteration or destruction of information.

3. Process

All known or suspected privacy breaches require immediate remedial action, regardless of the sensitivity of the personal information. Given the varied nature of privacy breaches, no 'one-size-fits-all' response is possible, and actions should be proportional and appropriate to each privacy breach.

The following steps are used to address privacy breaches. Review the flow diagram (last page) "Responding to Privacy Breaches". As the circumstances for each privacy breach vary, these steps might occur concurrently or in quick succession; they do not necessarily need to follow the order given below:

3.1 Report Immediately

Staff must report suspected or actual privacy breaches immediately to their supervisor. The supervisor and/or staff member, also reports immediately to the CMO/CIO or Duty Manager (out of hours).

3.2 Contain the Privacy Breach

Staff should take immediate action to contain the privacy breach and to limit its impact. Appropriate actions will depend on the nature of the breach and may include:

- Isolating or suspending the activity that led to the privacy breach;
- Correcting all weaknesses in physical security;
- Taking immediate steps to recover the personal information, records or equipment from all sources, where safe to do so;
- Determining if any copies have been made of personal information that was breached, and recovering where possible.

Note: Where the privacy breach involves information technology, the direction of the CIO must be sought before taking any containment steps.

3.3 Assess the Extent and Impact of the Privacy Breach

CIO/CMO or delegated staff will ascertain :

3.3.1 Personal Information Involved

- What personal information has been breached?
- Is the personal information sensitive? Examples are health information, social worker case histories, financial information or information that can be used for identity theft. A combination of personal information is typically more sensitive than a single piece of personal information.

3.3.2 Cause and Extent of the Breach

- What was the cause of the breach?
- What programs and systems are involved?
- Is the personal information encrypted or otherwise not readily accessible?
- Has the personal information been recovered?
- What steps have already been taken to minimise the harm?
- Is this a one-time occurrence or an ongoing problem?

3.3.3 Individuals Affected by the Breach

- Who is affected by the breach? For example, employees, public, contractors, clients, service providers, other organizations.
- How many individuals are, or are estimated to be, affected by the breach?

3.3.4 Foreseeable Harm from the Breach

- What possible use is there for the personal information? Can the information be used for exploitation, fraud or other harmful purposes?
- Who is in receipt of the personal information? For example, a stranger who accidentally receives personal information and voluntarily reports the mistake is less likely to misuse the information than an individual suspected of criminal activity.
- Is there a relationship between the unauthorized recipient(s) and the data subject(s)? A close relationship between the two might affect the likelihood of harm.
- Is there a risk of significant harm to the individual as a result of the breach? For example:
  - security risk (e.g., physical safety)
  - identity theft or fraud
  - access to assets or financial loss
  - hurt, humiliation, embarrassment, damage to reputation or relationships
- Is there a risk of significant harm to the public body or organization as a result of the breach? For example:
  - loss of public trust in the public body
  - loss of assets
  - financial exposure
  - risk to public health
  - risk to public safety

3.4 Document the Privacy Breach and Corrective Action Taken

Staff, as delegated by the CIO/CMO, will work to :

3.4.1 Ensure that evidence of the privacy breach is preserved; and

3.4.2 Document the privacy breach in detail, including:

- What happened and when;
- How and when the privacy breach was discovered;
- The personal information involved and scope of the breach;
- Who was involved, if known;
- Individuals interviewed about the breach;
- Whether the breach has been contained and any lost personal information retrieved;
- Who has been notified;
- The corrective action taken, including any steps to assist affected individuals in mitigating harm; and
- Recommendations, including corrective action that still needs to be taken.
- Complete the Reporting form and/or report in Datix.

3.5 Consider Notifying Affected Individuals

The impact of privacy breaches must be reviewed to determine if it is appropriate to notify individuals whose personal information has been affected by the breach. As part of the Incident Management Process, the Lead will work with the CMO/CIO so that they can notify affected parties and take other required actions, as appropriate.

3.5.1 Notifying affected individuals

The key consideration in deciding whether to notify an affected individual is whether it is necessary to avoid or mitigate harm to an individual, such as:

- A risk of identity theft or fraud (usually because of the type of information that has been compromised such as banking information, identification numbers);
- A risk of physical harm (for example, if the compromised information puts an individual at risk of stalking or harassment);
- A risk of hurt, humiliation or damage to reputation (for example, when the compromised information includes medical or disciplinary records, criminal histories or family case files); or
- A risk to business or employment opportunities.

3.5.2 When and how to notify

If it is determined that notification of individuals is appropriate:

- **When**: Notification should occur as soon as possible following the breach. (However, if law enforcement authorities have been contacted, it may be appropriate to work with those authorities in order not to impede their investigation.)
- **How**: Affected individuals should be notified directly – by phone, email, letter or in person – whenever possible. Indirect notification using general, non-personal information should generally only occur when direct notification could cause further harm, is prohibitive in cost, or contact information is lacking. Using multiple methods of notification – website publication, posted notices, media – in certain cases may be the most effective approach.

3.5.3 What should be included in the notification

Notifications should include the following information, as appropriate:

- Date of the breach.
- Description of the breach (extent).
- Description of the information compromised.

- Risk(s) to individual caused by the breach.
- Steps taken to mitigate the breach and any harms.
- Next steps planned and any long-term plans to prevent future breaches.
- Steps the individual can take to further mitigate the harm, or steps the public body has taken to assist the individual in mitigating harm. For example, how to contact credit reporting agencies to set up a credit watch, or information explaining how to change a personal health number or driver's licence.
- Contact information of an individual within the DHB who can answer questions or provide further information.
- The right to complain to the Office of the Privacy Commissioner and the necessary contact information. If the DHB has already contacted the Commissioner's office, include this detail in the notification letter.

3.5.4 Notifications should not include the following information:

- Personal information about others or any information that could result in a further privacy breach.
- Information that could be used to circumvent security measures.
- Information that could prompt a misuse of the stolen information (for example, if hardware was stolen for simple 'wiping and resale', but the breach notification prompts someone to realize that personal information is on the hardware and could be of some value if accessed).

3.6 Inform Other Parties as Appropriate

3.6.1 As part of the Information Incident Management Process, the Incident Response Lead will work with the Communications Manager to communicate with the Ministry of Health so that they can notify affected parties and take other required actions, as appropriate. Affected parties may include, for example: insurers, professional or other regulatory bodies, third-party contractors, internal business units, or unions.

3.6.2 The Chief Information Officer/CMO is responsible for liaising with the Office of the Information and Privacy Commissioner via the Communications Manager regarding an actual or suspected privacy breach. The following factors are relevant in determining whether to report a privacy breach to the Office of the Privacy Commissioner:

- The sensitivity of the personal information
- Whether the breached information could result in identity theft or other harm, including pain and suffering or loss of reputation
- A large number of people are affected by the breach
- The information has not been fully recovered
- The breach is the result of a systemic problem or a similar breach has occurred before.

3.7 Prevent Future Privacy Breaches

Staff will work with the CIO/CMO to ensure that any corrective actions identified as necessary to mitigate future risks are fully implemented promptly.

Privacy Breach – Reporting Form

Notification to CMO and/or CIO

Instructions :

1. Complete the first two sections of this form.
2. The reporting areas will expand as information is entered.
3. Email completed form to CMO, Dr Michael Roberts michael.roberts@northlanddhb.org.nz and/or the CIO, Darren Manley Darren.manley@northlanddhb.org.nz

	Reporter Information
Reporter name	Click here to enter text.
E-mail	Click here to enter text.
Department	Click here to enter text.
Phone	Click here to enter text.
Line Manager	Click here to enter text.
Date Line Manager notified of beach	Click here to enter a date.
Date of notification to CIO/CMO	Click here to enter a date.
	Privacy Breach Information
Date Privacy Breach discovered	Click here to enter a date.
Circumstances	Click here to enter text.
Staff member(s) involved	Click here to enter text.
Other people involved and relationships	Click here to enter text.
Information accessed (initial best estimate)	Click here to enter text.
Sensitivity of information	Click here to enter text.
How was information accessed (ie programmes/systems involved)	Click here to enter text.
	Guidance for Mitigation
Staff involved notified	☐No ☐Yes – date : Click here to enter a date.
Staff involved interviewed	☐No ☐Yes – date : Click here to enter a date.
Interviewed by	Click here to enter text.
Breach contained and/or information recovered	Click here to enter text.
Any corrective actions taken?	Click here to enter text.
Affected individuals notified	☐No ☐Yes – date : Click here to enter a date.
Recommendations (for completion by CMO/CIO in conjunction with Line Mgr)	Click here to enter text.

Responding to Privacy Breaches – flow diagram

Responding to Privacy Breaches

Staff Member

Privacy Breach detected

Advise Supervisor and advise CIO/ CMO (or Duty Manager if after hours)

Is information technology involved in the breach?

No → Staff member and Manager take steps to contain privacy breach (refer to document "Process for Responding to Privacy Breaches"

Yes → Consult CIO/CMO before any containment steps taken

Complete "Privacy Breach – Reporting Form" and forward to CMO

Advice and support

Review at Privacy Governance Group

CIO/CMO

CIO/CMO notified of privacy breach

CIO/CMO ascertain :

1. Whether personal information is involved?
2. Cause and extent of breach?
3. Whether individuals are affected by the breach?
4. What the forseeable harm from the breach may be?

Document the breach and any corrective action taken

Log incident in Datix

CODE of CONDUCT

RATIONALE/ PURPOSE:

The primary purpose of the Code of Conduct is to **inform.** It sets out agreed expectations and provides employees with a guide to the standards of behaviour required of them by the organisation.

The State Services Commission's Standards of Integrity and Conduct provide the over arching principles for the NDHB Code of Conduct. The foundation is formed by the organisation's Values.

SCOPE: The Code of Conduct applies to **ALL** employees of Northland District Health Board.

DEFINITIONS:

References:
NDHB Disciplinary Policy 2016

Acknowledgments:

NDHB acknowledges the participation of unions in the development of this Code of Conduct.

STANDARDS OF INTEGRITY AND CONDUCT

As a crown entity, NDHB and its employees must comply with the State Services Commission's **Standards of Integrity and Conduct** (Appendix 1). These standards seek to reinforce a spirit of service and set common standards of behaviour required from the diverse range of people and roles across the State Services.

VALUES

NDHB's Values are the organisation's framework for the way we do things, our "guiding beacon" directing the process of organisational development and growth. They relate to how we deal with our beliefs about people and work and they underpin the organisation's vision to ***"create opportunities for improving health and wellbeing, and promoting independence of all the people of Northland/ Te Tai Tokerau."***

Values are "living documents" supported by action at every level of the organisation and translated into measurable outcomes.

Values at work assist us by:

- providing a framework for how we treat one another
- providing a framework for how we treat our consumers and partners
- helping us make sense of our working life and how we fit in the big picture
- providing a framework for achieving the vision and increasing the effectiveness of the organisation
- creating an environment conducive to job satisfaction.

NDHB's Values resulted from a project undertaken in 2007 to determine a set of core Values and Behaviours in collaboration with staff, key partners, union representatives, and stakeholders. Over the project period nearly 500 people participated in workshops and conversations. When collated, the outcomes clearly identified the five core values and behaviours that people want to see in this organisation.

Values	Supporting Statement
People First *Tangata I te tuatahi*	People are central to all we do
Respect *Whakaute (tuku mana)*	We treat others as we would like to be treated
Caring *Manaaki*	We nurture those around us, and treat all with dignity and compassion
Communication *Whakawhitiwhiti korero*	We communicate safely, openly and with respect to promote clear understanding
Excellence *Taumata teitei (hirangi)*	Our attitude of excellence inspires success, competence, confidence and innovation

MEETING EXPECTATIONS

The Code of Conduct was developed through the Bipartite Forum, in consultation and partnership with participating unions and has been endorsed by the Northland District Health Board's Executive Leadership Team. It details the standards of behaviour required of employees to ensure

practical application of the organisation's Values in the day-to-day actions of its employees. It also seeks to meet the State Services Commission's expectation with regard to standards of integrity and conduct.

It does not provide an exhaustive list of circumstances that would be deemed to breach the Code, as it is impossible to foresee every possible situation that may arise. However, the Code of Conduct does define minor and serious misconduct.

Where an employee's performance or conduct fails to meet expectation or falls below the expected standard, the employee will be advised and given appropriate support and assistance to reach the standard required.

If an employee fails to achieve the required standard after being made aware of concerns around the standard of performance or conduct, or is found to be otherwise in breach of the Code of Conduct, disciplinary action, in accordance with NDHB Disciplinary Policy, may be instituted. The purpose of disciplinary action is to prevent recurrence and the degree of such action must be related to the nature of the concerns raised, the employee's work record, the circumstances and any extenuating factors.

The aim is to ensure that the procedure used in each case is fair and follows the principles of natural justice. In addition, the availability of the Employee Assistance Programme (EAP Works) will be advised to the employee in each case that disciplinary action is initiated.

Minor Misconduct: Behaviour that will generally lead to disciplinary action being invoked.

Serious Misconduct: Behaviour that will lead to disciplinary procedures being invoked including the possibility of termination of employment/summary dismissal.

In distinguishing between minor and serious misconduct regard should be given to the consequences and/or risks that the misconduct exposes the Organisation to, including its patients/clients and staff.

REQUIRED STANDARDS OF CONDUCT

Northland District Health Board staff are expected to:

1. Comply with organisation policies and standard procedures, including By-laws and delegations.
2. Comply with Statutory Requirements and the provisions of Individual or Collective Employment Agreements and any applicable variations.
3. Respect other persons and their property. Other persons may include patients, clients, visitors, fellow employees, people officially engaged in organisation business, or people with whom they have dealings on the organisation's behalf.
4. Respect organisation property and use it only as authorised. Property includes buildings, land, tools, equipment, supplies, vehicles, money, credit, signs or notices.
5. Attend work during working hours unless on authorised leave or with a valid excuse. If there is a valid excuse for lateness or absence to notify the Department Head or Manager as soon as possible.

6. Report fit for work.
7. Perform duties properly and be committed to a high quality of work, performed safely.
8. Access and/or disclose confidential information only to the extent specifically authorised to do so, to people directly interested and entitled to the information
9. Ensure that any information provided is accurate, e.g. timesheets, expense claims, reports, job applications, service schedules.
10. Maintain proper standards of integrity and concern for the public interest through being honest and conscientious in performing duties, responsibilities and undertakings given.
11. Report all accidents and near misses, which could have led to personal injury.
12. Ensure that individual's actions do not bring the organisation into disrepute.
13. Maintain the requirements necessary to ensure a legitimate entitlement to be employed in New Zealand, including ensuring a work permit, if required, is valid and current.
14. Maintain Annual Practicing Certificate, Registration and professional development activities or requirements and notify the organisation of any discrepancies.
15. To not engage in any private activity, without the employer's prior agreement which could have an effect on their ability to carry out their duties as an employee.

(Appendix 1)
State Services Commission's **Standards of Integrity and Conduct**

MANAGING UNACCEPTABLE BEHAVIOUR IN THE WORKPLACE POLICY

PURPOSE:

Northland District Health Board (NDHB) has a zero tolerance to workplace violence, bullying and harassment.

The purpose of this policy is to:

- Define violence, bullying and harassment in the workplace.
- Confirm that these behaviours are unacceptable and inappropriate in the workplace.
- Provide procedures and guidelines for dealing with incidents or complaints of violence, bullying and harassment.

RATIONALE:

The NDHB is committed to providing a safe work environment.
The Health and Safety in Employment Act 1992 places obligations on employers to ensure that a safe and healthy workplace is maintained. There is also a requirement that employees are responsible in protecting their own health and safety, as outlined in the NDHB Health and Safety policy.

POLICY STATEMENT:

Healthy and safe workplaces are a measure of successful employment relationships that exhibit mutual trust and confidence, and promote sustainable and productive relationships. In supporting this, NDHB has processes in place to ensure appropriate identification, assessment and management of unacceptable workplace behaviours which constitute violence, bullying or harassment.

Such behaviours do not align with our Values or comply with the NDHB Code of Conduct. They are not acceptable and will not be tolerated.

This policy aims to:

- Provide options to assist in resolving incidents or complaints of violence, bullying and harassment in a timely and responsive manner
- Foster a zero tolerance in line with our organisational Values.
- Ensure that the employer acts fairly and that natural justice is maintained.
- Treat all complaints with respect and sensitivity.
- Ensure appropriate disciplinary action in accordance with the NDHB Disciplinary Policy HUM 110-23.
- Ensure that reasonable and practicable steps are taken to prevent any recurrence.□
- Ensure a confidential and impartial process.

SCOPE:

This policy applies to all NDHB employees and contractors, in all NDHB workplaces.

LEGISLATION:

Human Rights Act 1993
Health and Safety at Work Act 2015

PROCEDURE FOR MANAGING UNACCEPTABLE BEHAVIOUR IN THE WORKPLACE

1 Principles

2 Definitions

3 Responsibilities

- **3.1 Managers**
- **3.2 Employees**
- **3.3 Human Resources**

4 Procedural options

- **4.1 Self help intervention**
- **4.2 Informal intervention**
- **4.3 Formal complaint**

Appendix 1 Proforma complaint form
Appendix 2 Flowchart

1. Principles:

NDHB has a zero tolerance to workplace violence, bullying and harassment and is committed to providing an environment where staff are not subjected to unacceptable workplace behaviour. It is the expectation of this organisation that all staff act appropriately in the workplace by ensuring that their standards of behaviour are aligned to the NDHB Values.

Where an employee has been subjected to such unacceptable workplace behaviour, they may choose to address their concerns directly with the person concerned. Where circumstances or personal preference do not support a direct approach, the employee can seek an informal intervention or make a formal complaint.

Complaints made by or about another employee in regard to unacceptable behaviour, will be taken seriously, treated with sensitivity and investigated as soon as practicable. These complaints can be raised directly with the employee's management line or the HR department. Complaints raised with HR will of necessity be referred to the appropriate line manager (team leader/ manager/ GM)

Further to completing an investigation, any employee found to have committed violence, bullying or harassment in the workplace will be disciplined in accordance with the NDHB Code of Conduct and Disciplinary Policy.

2. Definitions:

Bullying in the workplace is repeated, unwanted, unwarranted behaviour that a person finds offensive, intimidating and/ or humiliating so as to have a detrimental affect upon a person's dignity, safety, wellbeing and functionality.

Reasonable direction or request from the management line, specific performance management or disciplinary action carried out through the proper channels and in an appropriate manner, is acceptable workplace behaviour and does not constitute bullying or harassment.

Complainant:
The employee who is making the complaint in regard to themselves or another employee

Harassment:
Harassment is unwelcome or offensive verbal or physical conduct in relation to sex, gender, marital status, religious beliefs, race, ethnicity, disability, age, political opinion, sexual orientation, physical appearance or family status.

Respondent:
The employee whose alleged unacceptable workplace behaviour is being complained about.

Violence:
Assaults, other violent acts or threats which occur in or are related to the workplace and entail a substantial risk of physical or emotional harm to employees or damage to resources or capabilities.

3 Responsibilities:

3.1 Managers are responsible for:

- Maintaining acceptable standards of behaviour in line with the NDHB Values and taking all practicable steps to discourage unacceptable workplace behaviour.
- Supporting and maintaining a positive work environment which neither condones nor supports violence, bullying or harassment.
- Ensuring that all staff understand that violence, bullying or harassment of any kind will not be tolerated.
- Ensuring that employees are aware of who to contact in the event of wanting to make an enquiry or lay a complaint.
- Creating a work environment that discourages violence, bullying or harassment and is free from discriminatory practices of any kind, and
- Encouraging and making it safe for any employee to come to them for advice.
- Ensuring that a fair, timely and confidential investigation is carried out, as far as is practicable. Where a complaint is raised with the manager in confidence, the manager will advise the complainant about options for limited disclosure, as may be necessary to conduct the investigation.
- Acting impartially and professionally and supporting both parties during the process.
- Offer EAP support to affected employees (complainant and respondent).
- Ensuring that the respondent is aware of their right to have a support person at meetings held in regard hereto.
- Ensuring that accurate records of meetings are kept.

3.2 Employees are responsible for:

- Behaving appropriately in the workplace in accordance with the NDHB Values and Code of Conduct.
- Being aware that reasonable direction or request from their management line, specific performance management or disciplinary action carried out through the proper channels and in an appropriate manner, is acceptable workplace behaviour.
- Taking action if they believe they have been treated unacceptably or if they have seen another employee being treated unacceptably.
- Appreciating that whilst any investigation will be handled confidentially, as far as is practicable, limited disclosure may be required.

3.3 Human Resources are responsible for:

- Providing a safe environment for a complainant seeking advice,
- Providing advice in regard to options and subsequent related procedure.
- Directing complaints received to the appropriate line manager having taken relevant factors into account in so doing
- Provide timely advice and supporting the manager at any investigation meetings as may be necessary.

4 Procedural options:

Where an employee feels they have been treated unacceptably in the workplace they are encouraged to consider the following three options, depending on their personal preference and relevant circumstances. In consideration of the choice of options, the intervention/ investigation outcome possibilities of the selected options include no further action, mediation, education, EAP, performance management and disciplinary action.

4.1 Option 1 Self help intervention.
(The employee deals directly with the alleged respondent in a self help resolution)

- Where circumstances permit, an employee can attempt to resolve the situation by approaching the respondent.
- Describes to the respondent the behaviour found to be unacceptable and asks for that behaviour to stop.
- Should have a support person.

4.2 Option 2 Informal intervention (observation/ mediation)
(The employee chooses not to deal directly with the respondent and does not wish to lay a formal complaint)

- Employee addresses their perceived concerns via manager/ general manager
- Employee provides specific details about the alleged unacceptable behaviour including date, time, witnesses and specifically what occurred.

- The manager (with complainant's permission), either speaks to the respondent directly on the employee's behalf, or
- The manager agrees to observe for further unacceptable behaviour and deal directly with those behaviours if observed, or
- The manager takes a mediatory role with the employee present when addressing the respondent.

4.3 Option 3 Formal Complaint.
(The employee chooses to lay a formal complaint)

- Employee complains in writing and provides all relevant information (see proforma complaint form).
- Employee acknowledges and is prepared for an investigation process requiring that the respondent and any witnesses be interviewed.
- Manager initiates an investigation
  - Interviews the complainant
  - Notifies the respondent/s and requests their initial response to the allegation.
  - Interviews witnesses or other people as necessary and provides copies of witness statements to respondent for his/ her further comment.
  - In assessing the facts/ evidence/ information an initial determination is made manager provides a preliminary view.
  - Provides a letter setting out the investigation outcome.

- The investigation, as described above, will observe the principles of natural justice and procedural fairness.
- Where the complaint is found to be substantiated or has sufficient cause for concern in regard to the alleged behaviour, appropriate disciplinary proceedings will be followed.
- Where the complaint is found to be unsubstantiated the parties will be informed accordingly and reminded of their obligations to behave in accordance with the Values of the organisation.
- Where the complaint has been found to be vexatious or frivolous the complainant may be subjected to disciplinary action.

Further information in regard to the options about what to do may be accessed in confidence from the following sources:

- The employee's manager
- The employee's General Manager
- Union organiser/ delegate
- Human Resources manager/ HR Advisor

Appendix 1 Proforma complaint form

Name of Complainant:	
Position:	
Service:	
Manager:	
Workplace contact details:	
Date/ time/place of incident:	
Summary of incident of unacceptable behaviour (what happened- describe the behaviour of the other person/ people?)	
Has this happened before?	
What is your relationship to this person?	
Were there witnesses?	
Background information additional to complaint (if any):	
What effect has the incident had on you? Describe how this incident made you feel?	
What do you want to change? What aspect of their behaviour do you want them to change?	
Is their any other employee to whom you may want us to talk to in regard to this incident?	
Have you got support? Do you know who can you go to for support?	

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

Appendix 2 Flowchart: Managing Unacceptable Behaviour in the Workplace

Advice sought to deal with unacceptable behaviour in the Workplace

Self help intervention → Approach the respondent identifying the behaviour of concern with a request to stop → Resolved?
- Yes → No further action / matter resolved
- No → Informal intervention

Informal intervention (observation/ mediation) → Request informal intervention from appropriate line manager → Agree to raise concern with respondent
- Yes → Manager meets with respondent in regard to behaviour of concern and makes an informal request that the behaviour stops
- No → Manager may agree to observe behaviours and act thereon or considers other options to raise team awareness of appropriate behaviours and/ or a means to eliminate those of concern

→ Complaint resolved
- Yes → Monitor → No further action / matter resolved
- No → Formal complaint option → Formal complaint

Formal complaint → Written complaint to manager → Manager leads investigation supported by HR → Does complaint breach this policy?
- No or not clear → Facilitated session subject to agreement by the complainant and respondent → Did session succeed?
  - Yes → Outcomes agreed to support an appropriate working relationship → Monitor; Respective outcome letters provided
  - No → Line manager decides further action in regard to outcome options → Outcome Options
- Yes → Further investigation carried out → Complaint validated?
  - No → Line manager decides further action in regard to outcome options
  - Yes → Outcome options → Outcome Options

Respective outcome letters provided

Outcome Options: EAP, mediation, education (e.g. communication skills, conflict resolution, de-escalation, anger management, performance management, discipline.

DISCLOSURE OF SERIOUS WRONGDOING

PURPOSE:

To provide a process for Northland District Health Board (NDHB) employees to disclose information about "serious wrongdoing" under the Protected Disclosures Act 2000 ('the Act').

An employee may disclose information under the Act if:

a) the information is about serious wrongdoing in or by NDHB; and
b) the employee believes on reasonable grounds that the information is true or likely to be true; and
c) the employee wishes to disclose the information so that the serious wrongdoing can be investigated; and
d) the employee wishes the disclosure to attract the protection of the Act.

DEFINITIONS:

"**employee**" includes current and former employees, a person seconded to NDHB, an individual who is engaged or contracted under a contract for services to do work for NDHB, or a person involved in the management or governance of the NDHB.

"**serious wrongdoing**" includes any serious wrongdoing of any of the following types:

a. an unlawful, corrupt, or irregular use of public funds or public resources; or
b. an act, omission, or course of conduct that constitutes a serious risk to public health; or
c. an act, omission, or course of conduct that constitutes a serious risk to the maintenance of law, including the prevention, investigation, and detection of offences and the right to a fair trial; or
d. an act, omission, or course of conduct that constitutes an offence; or
e. an act, omission, or course of conduct by a public official that is oppressive, improperly discriminatory, or grossly negligent, or that constitutes gross mismanagement.

METHOD:

1 a) All employees disclosing information about serious wrong doing should do so in writing and provide as much detail as possible of:
   - i) what the serious wrongdoing is;
   - ii) why it fits within the above definition;
   - iii) the persons involved;
   - iv) when it occurred;
   - v) supporting documents or records
   - vi) names of any other persons who may be able to assist the investigation.

b) The persons to whom the disclosure shall be made and the persons responsible for the investigation are as follows:

If the person involved in the serious wrong-doing is:	The employee should report it to:	The person(s) responsible for the investigation
Another employee	Line Manager	CEO
Line Manager	CFO or CEO	CEO
CFO	CEO	CEO and Board Chair
CEO	Board Chair	An appointed Committee of the Board
Board Member	Board Chair	An appointed Committee of the Board
Board Chair	Board Deputy Chair	An appointed Committee of the Board

c) On receipt of information about a protected disclosure, the person(s) responsible for the investigation will:

(i) Promptly acknowledge receipt of the disclosure in writing to the person who made it;

(ii) Carry out a preliminary investigation (including taking legal advice) to:

- determine whether the nature of the information amounts to a protected disclosure under the Act
- Seek clarification and determine whether there is substance to the information ("the preliminary investigation");

(iii) Within 20 days of the disclosure being made notify the person who made the disclosure of the outcome of the preliminary investigation;

(iv) If the outcome of the preliminary investigation is that the nature of the disclosure should be investigated as a protected disclosure under the Act;

- Notify the Minister of Health under the "no surprises" policy
- Where employees are involved make decisions regarding suspension pending completion of the investigation in accordance with NDHB employment policy
- Finalise terms of reference for the investigation
- Appoint appropriate investigator/s to carry out the investigation
- Instruct the appointed investigators to carry out the investigation in accordance with the terms of reference.
- Determine whether it is appropriate to refer information to external enforcement agencies
- Take legal advice throughout.
- Abide by the rules of natural justice
- Maintain confidentiality of the identity of the person who made the disclosure in accordance with the Act
- Provide a written report of the outcome of the investigation to the Board and CEO which includes recommended actions.
- Notify the person who made the disclosure of the outcome of the investigation.

d) If it is believed on reasonable grounds that the people responsible for the investigation are or may be involved in the alleged serious wrongdoing, or because of urgency or some other exceptional circumstance it is not appropriate to make the disclosure according to the above, then you the employee may make the disclosure to an appropriate authority.
An appropriate authority includes:
The Chair of the NDHB
The Commissioner of Police
The Controller and Auditor-General
The Director of the Serious Fraud Office
The Inspector-General of Intelligence and Security
An Ombudsman
The Parliamentary Commissioner for the Environment
The Independent Police Conduct Authority
The Solicitor-General
The State Services Commissioner
The Health and Disability Commissioner

e) An employee may disclose information of alleged serious wrongdoing to a Minister of the Crown or an Ombudsman if the employee making the disclosure—
(a) has already made substantially the same disclosure in accordance with the above; and
(b) believes on reasonable grounds that the person or appropriate authority to whom the disclosure was made
(i) has decided not to investigate the matter; or
(ii) has decided to investigate the matter but has not made progress with the investigation within a reasonable time after the date on which the disclosure was made; or
(iii) has investigated the matter but has not taken any action in respect of the matter nor recommended the taking of action in respect of the matter, as the case may require; and
(c) continues to believe on reasonable grounds that the information disclosed is true or likely to be true.

Confidentiality
Any person to whom a protected disclosure is made or referred must use his or her best endeavours not to disclose information that might identify the person making the disclosure unless:
a) The person making the disclosure consents in writing to the disclosure of that information; or
b) The person to whom the disclosure is made reasonably believes that disclosure of the identifying information is:

(i) Essential to the effective investigation of the allegations in the protected disclosure; or
(ii) Essential to prevent serious risk to public health or public safety or the environment; or
(iii) Essential having regard to the principles of natural justice.

Protection from Retaliatory Action and Liability

An employee who makes a protected disclosure in accordance with this procedure is protected from:

- Retaliatory action by NDHB including dismissal from employment for making the disclosure -s17 of the Act.
- Civil or criminal liability or disciplinary proceedings for making the disclosure -s18 of the Act.

These protections do not apply if the employee makes the allegation knowing it to be false or otherwise acts in bad faith.

Further Information / Assistance

- Chief Executive Officer

References:

- Protected Disclosures Act 2000
  http://www.legislation.govt.nz/act/public/2000/0007/latest/DLM53466.html
- Northland DHB Complaints
- Northland DHB Code of Conduct
- State Services Commission Standards of Integrity and Conduct
  http://www.ssc.govt.nz/integrityandconduct

DISCIPLINARY POLICY

RATIONALE/ PURPOSE:

Northland District Health Board expects all employees to work in an environment that reflects the organisation's values and the standards of integrity and conduct required by the State Services Commission.

The Northland District Health Board Code of Conduct sets out expectations and provides employees with a guide to the standards of behaviour required of them by the organisation.

Where an employee's conduct fails to meet expectations or falls below the expected standard, the employee will be advised and given appropriate support and assistance to reach the standard required.

In the event of an employee not meeting the required standard after being made aware of concerns around their standard of performance or conduct, or is found to be otherwise in breach of the Code of Conduct, disciplinary action in accordance with this Policy may be instituted.

The objectives of this Policy are to ensure:

(i) The principles of fairness and natural justice are applied to individual employees.

(ii) The effective management of health services within Northland.

(iii) That organisational risk, including to its patients/clients and staff, is identified and minimised or mitigated.

The Code of Conduct establishes the standards of behaviour expected of employees. The Code also defines **minor** and **serious** misconduct. This Policy identifies a number of examples of offences that may result in a breach of these standards, resulting in disciplinary action. This is not exhaustive as it is impossible to foresee every possible situation of misconduct.

POLICY STATEMENT:

At all times disciplinary actions must be administered in a fair, equitable and consistent manner regardless of race, sex, age, sexual orientation, disability, religion or national origin. Performance expectations must be established and communicated clearly to each employee. Treatment of employees for similar infractions must be applied consistently.

SCOPE: This policy and procedure applies to all NDHB employees, including employees who have fixed term employment agreements

References:
Health and Safety
NDHB Performance Appraisal
NDHB Collective Agreements
NDHB Individual Employment Agreements
NDHB Code of Conduct

DISCIPLINARY PROCEDURE

1 INTRODUCTION

2 GENERAL PRINCIPLES

3 GROUNDS FOR DISCIPLINARY ACTIONS

3.1 Incompetence or poor performance
3.2 Misconduct
3.3 Conduct detrimental to the best interest of the Organisation

4 INVESTIGATING INCIDENTS AND OCCURRENCES

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6 SUSPENSION

6.1 Definition
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APPENDIX ONE Examples of Minor and Serious Misconduct

1. INTRODUCTION

An effective disciplinary process will ensure confidentiality and fairness to the employee balanced against the efficient performance and exercise of the Organisation's functions.

The following procedures are intended to act as a safeguard for both management and employee, ensuring that disciplinary rules are familiar to both from the outset.

It is expected that work performance will usually be corrected and enhanced through the application of effective day to day supervision. The disciplinary procedures contained in this policy should be applied as a last resort.

In most cases the need for disciplinary action will arise through the poor performance or misconduct of an employee. In these cases it is the responsibility of the manager/supervisor to have regard to the following factors:

(a) To ensure that the employee is aware of the standard of work required of them;

(b) To draw the attention of the employee promptly to any unsatisfactory aspects of their work which do not meet the required standard.

(c) To ensure, in accordance with the principles of fairness that the employee is given an adequate chance to explain their actions.

(d) To ensure that the employee is given adequate counselling, advice and training necessary to enable them to reach the required standards.

If these preliminary measures fail then the disciplinary procedures may be used in accordance with the principles contained in the following sections.

HR Advisors are available to assist both management and employees and may:
- Advise managers of policy and practice across the organisation, ensuring fair and consistent treatment of employees
- Serve as a sounding board and provide guidance for employees who are experiencing work-related problems
- Mediate between managers and employees if required.

Discussions with HR Advisors will be confidential.

2. GENERAL PRINCIPLES

The general principles to be applied in a disciplinary process are:

(a) Promptness

Remedial action must be taken as soon as practicable after the event. The longer the delay, the more it may appear that management is condoning the breach.

(b) Impartiality

It is essential that the disciplinary process be applied in an equitable and fair manner to all employees. Personal considerations must be put to one side. The manager cannot be seen to be favouring an employee or a group of workers in disciplinary matters at the expense of another employee or group of workers.

(c) Consistency

Impartiality implies consistency: similar disciplinary action must be taken in respect of similar offences made in similar circumstances.

(d) Non-punitive

The purpose of disciplinary action is to prevent recurrence and demonstrate consequences for actions rather than to obtain revenge or satisfaction for the wrongs committed.

(e) Confidentiality

The aim is to ensure confidentiality is maintained throughout the investigation and disciplinary process and other parties to any investigation should be asked not to discuss any concerns raised either within or outside the workplace

(f) Fairness

The degree of discipline must be related to the nature of the offence and regard should be had to the following factors:

(i) Seriousness of the problem and/or issue - how severe is the problem and/or issue or infraction.

(ii) Management backing - if the employee or union decides to take their case to senior management - do you have reasonable evidence to justify your decision?

(iii) Frequency in nature of the problem and/or issue - is the current problem and/or issue part of an emerging problem and/or issue or a continuing pattern of breaking rules? Is the employee presently subject to any previous warnings?

(iv) Employee's work history - how long has the employee worked for the organisation and what has been the quality of the performance and conduct?

(v) Extenuating factors - are there extenuating or mitigating circumstances related to the problem and/or issue? The principles of fairness direct that it is imperative that the employee is given opportunity to explain their side of the story and plead any mitigating circumstances.

(vi) Degree of communication - to what extent has management made an earlier effort to educate the person causing the problem and/or issue about the existing discipline rules and procedures and the consequences of violation?

(vii) Implications for other employees - what impact will your decision have on other employees?

(viii) Time span - have there been other discipline problems and/or issues in the past, and over how long a time span?

(f) Advance warning

Discipline which comes as a surprise is invariably felt to be unfair. All employees are entitled to know what kind of job performance is expected of them, and to a warning if their performance is considered unsatisfactory. Only where there has been an instance of serious misconduct may an employee be summarily dismissed. An employee must have notice of a specific allegation of misconduct to which they must answer and of the likely consequence if the allegation is established.

(g) Documentation

It is important to record the disciplinary process by accurately documenting meetings, details of the investigation and keeping copies of relevant documents. This information should be kept securely and must be retrievable to for later reference if required.

3. GROUNDS FOR DISCIPLINARY ACTION

3.1 Incompetence or Poor Performance

When a person is engaged for a position there is an implied warranty that they are reasonably competent for the position and will perform it to a reasonable standard. If they fail to reach and maintain a reasonable standard, even after counselling, then there are grounds for disciplinary action.

3.2 Misconduct

Misconduct comprises unacceptable or irresponsible actions or omissions. Every act or omission amounting to misconduct must be assessed objectively and the appropriate disciplinary action taken on the basis of that assessment. The examples provided in Appendix One outline those actions that may constitute minor or serious misconduct. This must not be regarded as an exhaustive list. Behaviour that is deemed to be serious misconduct may result in summary dismissal.

A second instance of minor misconduct within a twelve-month period without mitigating factors or breach of a written warning without mitigating factors may constitute **serious** misconduct.

3.3 Conduct Detrimental to the Best Interest of the Organisation

Unless the employee's off duty behaviour seriously brings the standing of their profession or trade or the organisation into disrepute, it is not considered to be the business of the organisation. The main consideration should be whether the offence is one that makes the individual unsuitable for their type of work, or disqualifies them from performing it. Conduct considered to be detrimental to the best interests of the organisation includes the following:

(a) Behaviour, either on or off duty, which in the view of the employer could bring the organisation or the standing of the employee's profession into disrepute
(b) Behaviour, either on or off duty, which brings the organisation or the standing of the employee's profession into disrepute
(c) Failure to follow Northland District Health Board procedures for resolving an ethical dispute that brings the organisation into disrepute
(d) Conviction in a Court of Law of an offence which is punishable by a penalty of one or more years imprisonment and/or where conviction impairs the employee's ability to perform the duties for which they are employed.
(e) Conviction of an offence relating to the possession, receiving and/or supply of drugs or any other offence under the Misuse of Drugs Acts.

4. INVESTIGATING INCIDENTS AND OCCURRENCES

No disciplinary action should be considered until the Head of Department/Manager has the relevant facts and has sufficiently evaluated and considered them, including any explanation, which the employee offers.

A careful, thorough investigation must be made of each allegation of misconduct or poor performance, particularly if disciplinary action may result as an outcome of the investigation.

Professional and technical expertise must be sought if the investigation is about a matter of professional or technical misconduct e.g. the Chief Medical Officer, the Director of Nursing and Midwifery or other allied health Professional Advisors.

Advice on disciplinary procedure and grounds should be sought from the appropriate Human Resources Advisor and must be taken before any action is entered into.

The investigation should normally include:

- Interviewing the employee and giving them a chance to explain.
- Interviewing other people, if appropriate. If there are witnesses to an alleged breach they must be interviewed promptly before memories fade.
- Checking records, or verifying facts by other means.

The following process should be followed:

- Following initial verbal advice to the employee (for example, that a complaint has been received and that a letter will be coming advising of an investigation), the employee is to be given written advice of the nature and subject of the allegations being investigated;
- The employee is to be advised that they are welcome to be accompanied at the investigation meeting/s by a representative/support person/s.
- The employee is to be given the opportunity (during the initial investigation meeting) to explain the incident/concerns raised or deny the occurrence.
- The employee is to be advised of the availability of the Employee Assistance Programme (EAP) and informed that up to three confidential counselling sessions may be paid for by the organisation.
- Following the initial investigation meeting (usually within a few days) an investigation outcome meeting should be held at which the employee should be given clear advice as to the result of the investigation, and of the conclusions reached. If the outcome meeting is held on the same day as the initial investigation meeting, there must be an adjournment prior to this advice being given to enable the Head of Department/Manager to consider the employee's explanation, and any other evidence gained from witnesses, before making a decision.

- Following the investigation outcome meeting, the Head of Department/manager will provide written confirmation of the outcome /result and the reasons for it dispatched as soon as possible following the meeting. Any additional advice provided by the employee at the investigation outcome meeting may also be reflected in the letter advising of the investigation outcome.

The person conducting the investigation should be accompanied by another suitable person (e.g. an associate, superior, Human Resources Advisor) so that the course and outcome can, if necessary, be corroborated later. A written record of the proceedings must be kept, for organisational purposes. The manager conducting the investigation must take into account any mitigating factors warranted relating to the employee's explanation.

Consideration may be given to placing an employee on special paid leave (where there are genuine concerns for the employee's health and/or welfare) while an investigation of alleged misconduct is being investigated. This will occur only after a formal documented meeting has been held with the employee to consider whether special paid leave is appropriate and to consider any views that the employee may have regarding a proposal to place them on special paid leave.

Where **special paid leave** is being considered, the person conducting the investigation should discuss with the employee the avenues through which the organisation may provide support for the employee including the possibility of an occupational health assessment and/or the Employee Assistance Programme (EAP).

The person conducting the investigation should ensure the General Manager is consulted in every instance regarding the provision of special paid leave.

Consideration may also be given to suspending an employee from duty on pay or transferring the employee to other work while an investigation of alleged misconduct is being investigated. Only the Chief Executive Officer or a General Manager may suspend an employee and then only after a formal documented meeting has been held with the employee to consider whether suspension is warranted and to consider any views that the employee may have regarding a proposed suspension.

Where **suspension** is being considered, the Chief Executive Officer or the General Manager should refer to the provisions of section 6 of the Disciplinary Policy and seek the assistance of the HR Advisor.

Note: _Where an incident or occurrence is reported to management and is found to be vexatious or frivolous, the complainant involved will be the subject of an investigation and possible disciplinary action._

5. WARNINGS

5.1 General Principles

Except when summary dismissal is justified, by reason of the nature and severity of an incident or offence, an employee whose performance or behaviour is unsatisfactory must, before disciplinary action is taken, be:

- Informed about the grounds for concern about their performance or behaviour (the aspect in question, the nature of the fault etc);
- Allowed to reply or respond;
- Warned of the consequence of failure to improve;
- Given reasonable opportunity to correct their performance.

5.2 Verbal Warnings

The objective of a verbal warning is to avert future more serious disciplinary action. The emphasis should therefore be on counselling the employee and seeking an improvement in work performance.

A verbal warning should be preceded by an interview in which the employee is:

- Informed of the standard of behaviour broken e.g. "On two days of this week you were late for work".
- Allowed to explain their reasons for the breach.

After all the relevant facts have been obtained and evaluated against the employee's past record, the worker should be informed of the disciplinary action to be taken against them on this occasion or warned of the consequence of further rule violations.

Another representative of the Organisation should witness the giving of a verbal warning. The employee should be invited to have a representative attend.

The fact that a verbal warning has been given should be recorded on the personal file. A warning may generally not be relied on after 12 months, but should not be removed from the file as it forms part of the employment history of the employee concerned.

The employee must be advised in writing that a verbal warning has been recorded and that it has been placed on their personal file.

5.3 Authority to Issue Verbal Warnings

Verbal warnings may be issued by the:
- Chief Executive Officer
- General Manager
- Operations Manager

- Service Manager
- Nurse Manager
- Clinical Nurse Manager,
- Team Manager
- Head of Department

5.4 Written Warnings

If the severity of the offence warrants it, a written warning should be issued. If following the issuing of a verbal warning there are further breaches, a further investigation may be required. The employee should again be formally interviewed at an initial investigation meeting and if necessary a written warning issued at the following investigation outcome meeting. Managers who are contemplating issuing written warnings are required to consult with the Human Resources Department.

The written warning must state:

(a) the date;

(b) the grounds for concern;

(c) identification of the rule;

(d) corrective action required by the employee;

(e) the consequences of failing to improve (if dismissal is a consequence, this should be clearly stated);

(f) reference to the previous verbal or written warning and the date it was given;

(g) period allowed for improvement and the date of the follow-up review.

The written warning should also include any commitment that the employee is prepared to give to improve their conduct.

Copies of the written warning must be given to the employee and their representative. The employee must be offered the opportunity to have a representative attend the meeting.

5.5 Authority to Issue Written Warnings

- Written warnings may be issued by the:
- Chief Executive Officer
- General Manager
- Operations Manager
- Service Manager
- Nurse Manager
- Clinical Nurse Manager,
- Team Manager
- Head of Department.

5.6 Employee's Rights to Respond

An employee who is in receipt of a warning (written or verbal) may, if they wish, respond in writing and have a copy of the response placed in their personal file;

5.7 Written Warnings: Placement on Personal File

A copy of a written warning must be placed on the employee's personal file. Written warnings cannot be relied upon after 12 months, but should not be removed from the employee's personal file as this forms part of the employment history of the employee concerned.

6. SUSPENSION

6.1 Definition

An employee is suspended when, though employment is not terminated, the employee is required not to carry out normal duties. Suspension should normally be on full pay, though suspension without pay may be appropriate in certain circumstances. Suspension is not, of itself, a disciplinary action; it is a step which may be taken in order to investigate whether or not disciplinary action is needed. Nevertheless the employee must be afforded all the procedural rights associated with a disciplinary interview before a decision to suspend is taken.

As noted earlier, only the Chief Executive Officer or a General Manager may suspend an employee and then only after a formal documented meeting has been held with the employee to consider whether suspension is warranted and to consider any views that the employee may have regarding a proposed suspension.

6.2 Use of Suspension Provisions

Suspension is to be used only where the allegations raised are considered to be serious and where it would be inappropriate in the circumstances for the employee to remain on duty.

Such circumstances shall be:

- The presence of the employee would be detrimental to the investigation
- The presence of the employee in the workplace is considered a risk to the employee or the health and/or safety of others and there are no suitable alternative duties available
- The presence of the employee is considered to be an impediment to the effective functioning of the service.

The decision to dismiss or return the employee to the workplace following suspension should be made as soon as possible.

At the conclusion of the suspension the employee shall be returned to the workplace or dismissed. Where investigation into the circumstances is continuing the employee should be notified of the organisation's actions and when it expires to inform the employee of the decision.

Any decision to dismiss shall only result following allegations being put to the employee, providing an opportunity to explain and the investigation of any explanations that are given by the employee, i.e. the procedure in 7.1 shall be followed.

6.3 Payment While on Suspension

Employees shall be suspended on pay. Employees may be suspended without pay only where:

- Suspension without pay is provided for specifically in the relevant collective or individual contract;

- As a result of strike action by others, and while the strike continues normal work ceases to be available for those at work.

6.4 Authority to Suspend

A staff member may only be suspended by the Chief Executive Officer or a General Manager.

6.5 Procedure

Initially, verbal advice will be provided to an employee that consideration is being given to suspending them and that they are required to attend a meeting with the Chief Executive Officer or General Manager to discuss this. The employee should also be informed that they are welcome to invite a representative/support person/s to attend the meeting.

At the meeting, the Chief Executive Officer or General Manager will explain the reasons that suspension is being considered and the proposed duration of the suspension. The Chief Executive Officer or General Manager will also discuss with the employee the practicality of any options such as working from home or being placed in a different work environment. These options should not compromise the specific circumstances or investigation that has resulted in suspension being considered. The employee will have the opportunity to respond to the suspension proposal before the Chief Executive Officer or General Manager makes a final decision.

Following a decision by the Chief Executive Officer or General Manager to suspend the employee, and advice to that effect being provided to the employee at the meeting, this must be followed by written confirmation of the suspension and the reasons for it dispatched within one working day of the suspension. A copy of the written advice must be sent to the Human Resources Department to be placed on the employee's personal file.

A staff member who has been suspended from duty should normally be required to report regularly and at specified intervals to his or her place of employment.

A staff member must also advise as to their whereabouts, i.e. where they can be contacted.

The employee's file should be annotated to record the final decision made in regard to the employee suspended, and whether or not any disciplinary action was considered necessary.

7. DISMISSAL

Only the Chief Executive Officer or a General Manager or other senior manager (Operations Manager or Service Manager with delegated authority from the responsible General Manager), may dismiss an employee as this is a serious matter which should occur only when the organisation is satisfied there is no other appropriate means of resolving the situation.

7.1 Methods: Giving Notice/Summary Dismissal

A person's employment may be terminated by:

(a) Notice of Termination, i.e. by giving notice in accordance with the disciplinary and suspension procedures and in accordance with the relevant contract, or

(b) Summary Dismissal, i.e. immediate cessation, without notice. Summary dismissal is justified only where there are substantial reasons, e.g. serious misconduct.

Whether dismissal is summary or by giving notice, a full investigation must be made and there must be sound reasons for the actions taken, in particular in accordance with the principles of fairness the employee must be allowed to state their reasons for the breach. Except in cases of summary dismissal, no employee will be dismissed without previous warning(s) and following a reasonable opportunity to improve.

7.2 Procedure

Where termination of employment is proposed following an investigation, the following process should occur:

(a) A meeting should be held with the employee at which the Chief Executive Officer or the General Manager or other senior manager (Operations Manager or Service Manager with delegated authority from the responsible General Manager), provides their preliminary view of the outcome of their investigation that their employment being terminated is an appropriate outcome taking into account all the factors considered and taking into account the explanation provided by the employee.

(b) **Notice of Termination** – the employee should be advised that this option is by giving notice in accordance with the disciplinary policy (including suspension procedures where applicable) and in accordance with the relevant employment agreement notice provisions.

(c) **Summary Dismissal** – the employee should be advised that summary dismissal is immediate cessation, without notice. Summary dismissal is justified only where there are substantial reasons, e.g. serious misconduct.

(d) The **preliminary view** meeting provides the employee with an opportunity to respond to the view about an appropriate outcome from the Chief Executive Officer or General Manager or other senior manager (Operations Manager/Service Manager with delegated authority from the responsible General Manager). The Chief Executive Officer or General Manager or other senior manager (Operations Manager/Service Manager with delegated authority from the responsible General Manager), will take the employee's views into account before a final decision is made. The final decision is conveyed to the employee at the following investigation outcome meeting.

(e) **The reasons for the decision** - the reasons given to the employee must be factual and should be brief, and regard must be had to the fact that it is not possible to give one reason at the time of dismissal and another (or additional reasons) at a subsequent appeal hearing.

7.3 Notice of Termination

Written notice of termination must always be given, by means of a letter to the employee. The letter may be either handed to the employee in person or delivered by registered mail. Letters should be mailed only if it is impractical to hand them personally.

For instances other than summary dismissal, employees shall receive as a minimum the period of notice specified in the collective or individual employment agreement. When leaving the organisation premises, dismissed employees should have all moneys and outstanding remuneration due to them made up promptly and paid at the time of termination unless agreed otherwise with the employee or their representative.

In instances of summary dismissal, the dismissed employee is entitled only to all moneys owed up to the time of dismissal.

7.4 Authority to Dismiss

Only the Chief Executive Officer or General Manager has the outright authority to dismiss an employee. However, an Operations Manager or Service Manager, who has been provided with delegated authority from the responsible General Manager, may also dismiss an employee.

No dismissal shall be effected without:

(a) Discussion of the matter being held with the Human Resources Department.

(b) Consultation with the Chief Medical Officer and/or the Director of Nursing and Midwifery where relevant.

7.5 Delegated Authority

Only the Chief Executive Officer or a General Manager has the outright authority to suspend or dismiss an employee. However, an Operations Manager or a Service Manager may dismiss an employee provided they have received delegated authority to do so from the Chief Executive Officer or responsible General Manager.

APPENDIX ONE – Examples of Minor and Serious Misconduct

1 EXPECTED BEHAVIOUR: COMPLIANCE WITH THE ORGANISATION'S POLICIES AND STANDARD PROCEDURES, INCLUDING BY-LAWS AND DELEGATIONS

(a) Minor Misconduct

- Failure to comply with organisation policies or standard procedures as required by a Head of Department/ Manager or organisation's officer or supervisor without valid excuse.
- Failure to comply with organisation By-laws.
- Insubordination - disobedience or disregard of or wilful default relating to any lawful instruction or order.

(b) Serious Misconduct

- Deliberate breaches of organisation policies and/or standard procedures, and/or By-laws.
- Where a complaint is deemed to be vexatious or malicious or frivolous.

2 EXPECTED BEHAVIOUR: COMPLIANCE WITH STATUTORY REQUIREMENTS AND THE PROVISIONS OF INDIVIDUAL OR COLLECTIVE EMPLOYMENT AGREEMENTS AND ANY APPLICABLE VARIATIONS

(a) Minor Misconduct

- Breaching statutory requirements and provisions of Individual or Collective Employment Agreements or variations to Collective Employment Agreements.

(b) Serious Misconduct

- Deliberate breaches of statutory requirements and provisions of Individual or Collective Employment Agreements or variations to Collective Employment Agreements.

3 EXPECTED BEHAVIOUR: RESPECT FOR OTHER PERSONS AND THEIR PROPERTY

(a) Minor Misconduct

- Preventing or interfering with another employee carrying out their work functions.
- Use of abusive or offensive language to other persons while on duty or on organisation property (NB what is offensive depends on the situation).
- Inappropriate offensive behaviour at place of work or on organisation property.
- Any act while working for the organisation that constitutes harassment, sexual harassment or illegal discrimination.
- Insubordination - disobedience or disregard of or wilful default relating to any lawful instruction or order.

(b) **Serious Misconduct**

- Behaviour calculated to cause unreasonable distress to, harassment of, sexual harassment of, any person while on duty or on organisation property.
- Insubordination - disobedience or disregard of or wilful default relating to any lawful instruction or order.
- Threatening to assault or assaulting other persons while on organisation property or meeting with them on the organisation's behalf.
- Physical fighting or bullying with any person while on duty or on organisation property.
- Wilful or grossly negligent damages of a patient's. client's, resident's, fellow employee's or visitor's property.
- Possession of a patient's, client's, resident's, fellow employee's or visitor's property without the consent of that person(s).
- Where a complaint is deemed to be vexatious or malicious or frivolous.

4 EXPECTED BEHAVIOUR: RESPECT FOR ORGANISATION PROPERTY

(a) **Minor Misconduct**

- Defacing Board property, or posting offensive or unauthorised notices on notice boards, electronic media or elsewhere without the appropriate consent.
- Wasting time or materials.
- Being in any part of the organisation premises without specific authorisation or a legitimate reason.
- Smoking in organisation vehicles or in any part of organisation buildings and premises except in designated smoking areas.

(b) **Serious Misconduct**

- Possession of, unauthorised use and/or removal of organisation property, supplies or stores without authorisation.
- Improper use of organisation property, supplies or stores.
- Wilful or grossly negligent damage of organisation property supplies or stores.
- Being without authorisation in a part of the organisation's premises to which there is restricted access.
- Gambling on organisation premises during working hours that is prejudicial to the maintenance of good staff relationships.

- Possession or consumption of alcohol on organisation premises without the consent of management.
- Use of recreational drugs or other unauthorised drugs on organisation premises.
- Unauthorised use of prescription drugs, or possession, consumption, sale, or use of illegal drugs on organisation premises.
- Misuse of chemical solvents on organisation premises.
- Smoking in areas of the organisation's premises where there is a danger of explosion.
- Unauthorised use of organisation fire protection or safety equipment.
- Unauthorised possession of offensive weapons on organisation premises.
- Deliberate acts detrimental to the quality and/or efficiency of Northland District Health Board services or detrimental to the safety of patients, clients, residents, fellow employees or visitors.

5 EXPECTED BEHAVIOUR: ATTENDANCE AT WORK DURING WORKING HOURS UNLESS ON AUTHORISED LEAVE OR WITH A VALID EXCUSE

(a) Minor Misconduct

- Being late or absent from the place of work during working hours without leave or valid excuse for part of a day, or a whole day.
- Failing to notify the Department Head or Manager if unable to commence work at the usual time, without good reason.
- Illegally on strike, without knowing that the strike is illegal.
- Being in a place of work without proper purpose after normal working hours.

(b) Serious Misconduct

- Being absent from work for 3 consecutive days without 'reporting in' (check relevant Agreement first to see if other provisions apply).
- Being habitually late for work.
- Knowingly striking illegally.

6 EXPECTED BEHAVIOUR: REPORTING FIT FOR WORK

(a) Minor Misconduct

- Reporting to work in a standard of dress inappropriate to the duties to be performed.

(b) **Serious Misconduct**

- Reporting to work in such a condition that the employee is unable to perform their duties to the satisfaction of their Head of Department/Manager.

7 **EXPECTED BEHAVIOUR: PERFORM DUTIES PROPERLY AND SAFELY**

(a) **Minor Misconduct**

- Negligence, carelessness, indolence, inefficiency or incompetence in discharge of the employee's work.
- Sleeping during working time without permission.

(b) **Serious Misconduct**

- Negligence, carelessness, indolence, inefficiency or incompetence in discharge of the employee's work which seriously affects quality of work, or the efficiency of a service.
- Sleeping during working hours in a situation, which affects residents', patients', clients' or employees' safety.
- Behaviour affecting or likely to affect the safety and/or cause injury to other persons.
- Improper conduct in the employee's official capacity.
- Failure to observe posted or recognised safety procedures, working in an unsafe manner or failing to make proper use of safety equipment where such equipment is installed or provided.
- Where a complaint is deemed to be vexatious or malicious or frivolous.

8 **EXPECTED BEHAVIOUR: ACCESSING AND/OR DISCLOSING INFORMATION ONLY TO THE EXTENT SPECIFICALLY AUTHORISED**

Serious Misconduct

- The unauthorised accessing of any confidential information concerning present, past or future employees, patients, clients or residents
- The disclosure to any unauthorised person of any confidential information concerning:
  - (a) Present, past or future employees, patients, clients or residents;
  - (b) Discussion of confidential organisation business without the express authorisation of the Chief Executive, or the employee's authorised representative (especially with the News Media)

9 **EXPECTED BEHAVIOUR: ENSURING THAT ANY INFORMATION PROVIDED IS ACCURATE**

Serious Misconduct

- Provision of false information on written reports, records, applications or other documentary material or knowingly making false statements. **(This includes deliberately with-holding relevant information when requested)**

- Where a complaint is deemed to be vexatious or malicious or frivolous

10 **EXPECTED BEHAVIOUR ; MAINTAINING PROPER STANDARDS OF INTEGRITY AND CONCERN FOR THE PUBLIC INTEREST**

(a) **Minor Misconduct**

- Engage in other employment without the prior approval of the General Manager.

- Failure to record a note setting out grounds of proceeding without consent for surgical procedures or major invasive diagnostic procedure (see organisation's By-laws).

(b) **Serious Misconduct**

- Attempt to extract, extraction or acceptance from any person any fee, reward or gratuity or remuneration or gift (directly or indirectly) other than the agreed salary, wages or allowance or conditions pertaining to the employee's office i.e. bribery.

- Use of working relationship to engage in financial transactions with fellow colleagues, patients, clients or relatives of friends of patients.

- Improper conduct in the employee's official capacity.

- Surgical procedures or minor invasive diagnostic procedure with known hazards performed without patient consent where there is no emergency and where consent could have been obtained.

11 **EXPECTED BEHAVIOUR: REPORTING ALL ACCIDENTS AND NEAR MISSES WHICH COULD HAVE LED TO PERSONAL INJURY**

(a) **Minor Misconduct**

- Failure to report to the employee's controlling officer and safety officer any incident at work involving personal injury, or damage to property or any 'near miss' that could have resulted in personal injury or damage to property.

(b) **Serious Misconduct**

- Failure to record and report any accident affecting patients, clients, residents or visitors.

12 EXPECTED BEHAVIOUR: ENSURE THAT INDIVIDUAL'S ACTIONS DO NOT BRING THE ORGANISATION INTO DISREPUTE

(a) **Minor Misconduct**

- Behaviour, either on or off duty, which in the view of the employer could bring the organisation or the standing of the employee's profession into disrepute.

(b) **Serious Misconduct**

- Behaviour, either on or off duty, which brings the organisation or the standing of the employee's profession into disrepute.
- Failure to follow Northland District Health Board procedures for resolving an ethical dispute that brings the organisation into disrepute.
- Conviction in a Court of Law for an offence punishable by a penalty of one or more years imprisonment and/or where conviction impairs the employee's ability to carry out the duties for which they are employed.
- Conviction of an offence relating to the possession, receiving and/or supply of drugs or any other offence under the Misuse of Drugs Acts.

As noted under **Rationale/Purpose**, it is not possible for the lists above to be exhaustive and they may be amended from time to time as deemed necessary by the Northland District Health Board. Where an employee carries out an act which is not specifically covered by the list above but is of a similar nature, Northland District Health Board reserves the right to implement disciplinary procedures.

Family Violence Assessment & Intervention Policy - Child Abuse & Intimate Partner Violence

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1. PURPOSE

This policy provides Northland District Health Board (NDHB) community and hospital-based staff with a framework to identify, assess, provide brief intervention and manage actual and/or suspected family violence; intimate partner violence (IPV); child abuse and neglect, in accordance with the Ministry of Health's Violence Intervention Programme (VIP) and Family Violence Assessment and Intervention Guideline[1].

POLICY STATEMENT:

NDHB is committed to reducing the health and social impact of family violence and child abuse by supporting NDHB staff to identify, assess and provide brief intervention and referral.

2. PRINCIPLES

- Family violence is violence or abuse of any type, perpetrated by one family member against another family member which includes, child abuse, intimate partner violence and elder abuse.
- When managing issues of child protection and/or family violence the rights, welfare and safety of the child/tamariki, young person/rangatahi are our first and paramount consideration.
- When there are no children in the home the rights, welfare, physical, emotional and cultural safety of victims of family violence is paramount.
- Staff will be competent in identification, assessment, management and referral of actual or suspected child abuse and neglect; intimate partner violence / family violence through the organisation's violence intervention programme infrastructure e.g. policies, procedurural structures, workforce development, standardised documentation, education programme and access to consultation.
- In the case of mental health clients support and advice is available from Child Adolescent and/or Community Adult Mental Health Services.
- Health services that care for and protect victims of child abuse and / or family violence are built on a bicultural partnership in accordance with the Treaty of Waitangi. All people using the services of the Northland District Health Board are assessed and managed in a culturally safe environment through active involvement of the Maori Health Unit. All staff are to recognise and be sensitive to other cultures, and reflect the principles of the Treaty of Waitangi.
- Northland DHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection, family violence, intimate partner violence and elder abuse.
- Northland DHB staff will ensure their practice is conducive with NDHB's values and behaviours – people first, respect, caring, communication and excellence.

1. Fanslow JL, Kelly P, & Ministry of Health. 2016.

3. SCOPE

This policy applies to all cases of actual and/or suspected child abuse and neglect, and/or family violence encountered by employees, students and people working at NDHB or under contract for service.

4. TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined. (Refer to:

- Child Abuse and Neglect Management
- Intimate Partner Family Violence Intervention

5. ORGANISATIONAL RESPONSIBILITIES

5.1 Executive Responsibilities

NDHB is committed to:

- Ensuring there is an organisation-wide policy for the management of child abuse and neglect, family / intimate partner violence and elder abuse, and associated policies as indicated
- Engaging with interagency processes such as Memorandum of Understanding between DHB, Child Youth and Family (CYF) and the Police that support effective collaboration
- Regular mandatory training in violence intervention and workforce development for staff on the policy, and where VIP is implemented
- Mandatory reporting of child abuse to statutory agents in all areas of NDHB
- Mandatory routine enquiry for intimate partner / family violence in areas where VIP is implemented
- Community collaboration to support safe families
- Processes to ensure the policy is adhered to, such as quality improvement activities
- Providing adequate support (e.g. access to consultation) and supervision for staff.
- Provide cultural training for all NDHB staff

These activities need to be properly resourced and evaluated.

5.2 Service Responsibilities

All services/departments will support the implementation of the policy within services as coordinated by the Violence Intervention Programme (VIP) Co-ordinator(s).

5.3 Employee Responsibilities

All NDHB employees have a responsibility for the assessment, intervention and management of actual or suspected child abuse and neglect, family violence, intimate partner violence.

Responsibilities include:

- To be conversant with NDHB management of actual or suspected child abuse and neglect, family violence, intimate partner violence and related policies
- To understand and take action to identify, manage and refer victims of suspected or disclosed child abuse and neglect, intimate partner violence
- To attend initial mandatory training and regular updates appropriate to their area of work (e.g. within areas in which VIP is implemented and supported)
- To routinely enquire for intimate partner / family violence once NDHB training has been completed within areas where VIP is implemented and supported
- To notify VIP Coordinator/s of any and all disclosures, or identifications made of child protection family violence incidents
- Make a report of concern to CYF where indicated for a child/ren or unborn baby at risk
- Complete relevant NDHB documentation where indicated as per NDHB Family Violence Assessment and Intervention Policy - Child Abuse and Intimate Partner Violence (e.g. NDHB's report of concern to CYF; Intimate Partner Violence (IPV) / Family Violence Assessment and Intervention form)
- Document as per NDHB Clinical Documentation Policy
- To provide or access NDHB specialist health services, that may include:
  - Consult with senior colleagues
  - Offer brief interventions
  - Cultural assessments
  - Mental Health assessments
  - Diagnostic medical assessments
  - Social work services, counselling and therapy resources
  - Paediatric assessment for any children who may be at risk
- To notify statutory agents when there is imminent threat to life or wellbeing (e.g. Police)
- To practice safely, for example consulting with a senior colleague during the intervention and seeking peer-support/supervision when child abuse is suspected or identified, or after each disclosure of intimate partner violence.
- This includes situations where child abuse is disclosed but the child may not be present (e.g. child of an adult patient).

5.4 The provision of culturally safe and competent interactions

- Engage the Northland District Health Board Maori Health Unit to provide cultural advice during the planning, implementation and evaluation of VIP
- All NDHB staff are required to attend cultural training

5.5 Human Resource Responsibilities

Northland DHB recruitment policies will reflect a commitment to child protection by including comprehensive pre-employment screening procedures (in accordance with the Vulnerable Children's Act 2014).

Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be dealt with in accordance with the Human Resource disciplinary procedures. (Refer http://staffcentral.nhl.co.nz/IntranetDocs/HRToolkit.pdf)

5.6 Violence Intervention Programme Co-ordinator Responsibilities

- Coordinate Violence Intervention Programme (VIP) implementation within services, working with service leaders to ensure the system supports are available
- Ensure the DHB-wide policy is current and aligned with national standards
- Ensure provision workforce development in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically
- To be available to staff for consultation regarding child protection family violence concerns
- To facilitate communication with Child Youth and Family (CYF), Police and other key community agencies
- Engage the NDHB Maori Health Unit to provide cultural advice during the planning, implementation and evaluation of VIP
- Ensure quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.

6. MAORI AND THE VIOLENCE INTERVENTION PROGRAMME

Maori are significantly over-represented as both victims and perpetrators of whanau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, violence is not acceptable within Maori culture. This NDHB Family Violence Assessment and Intervention Policy - Child Abuse and Intimate Partner Violence, has been developed in partnership with the NDHB Maori Health Directorate, and in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and tikanga principles. This is consistent with cultural training offered and mandated within the NDHB.

Family violence intervention for Maori is based on victim safety and protection being the paramount principle. Ensure practice is safe clinically and culturally. Affirm with the person(s) being abused of their right to be safe in their home. Have Maori staff available to offer support to the family whenever possible.

Routinely enquire about intimate partner violence for all Maori women over the age of 16 year; ask men and adolescents when signs and symptoms are present. If abuse is disclosed talk about possible plans of action they would like to take, including appropriate referral options. (*See Appendix 2 for Maori and family violence.)*

7. PACIFIC PEOPLES AND THE VIOLENCE INTERVENTION PROGRAMME

The complexity of family violence is also evident with Pacific peoples' culture for similar reasons.

(See Appendix 3 for Pacific peoples and family violence.)

8. ASSOCIATED DOCUMENTS / RESOURCES

8.1 Northland District Health Board Organisational Documents:

- National child protection alert policy
- Workplace violence prevention policy:
- Elder abuse policy
- Employee support: http://staffcentral.nhl.co.nz/Pages/Employee-Assistance-Programme.aspx
- MOU – CYF / Police

8.2 Legislation:

- Health Act (1956)
- Children's Young Persons and their Families Act (1989) (and Amendments 1994/95)
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Summary Offences Act (1981)
- Care of Children Act (2004)
- Vulnerable Children's Act (2014)
- Health Information Privacy Code (1994) Rule 11 subsection 2(d) (ii)
- Health and Safety in Employment Act 1992
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961)
- The Crimes Amendment Act (3) (2011)
- Domestic Violence Act (1995) (and Amendments 2013/14)

8.3 Associated Documents:

Fanslow JL, Kelly P, & Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence. Wellington: Ministry of Health.

Glasgow K, Fanslow J. Family Violence Intervention Guidelines: Elder Abuse and Neglect. Ministry of Health. 2007.

An Interagency Guide - Working Together To Keep Children And Young People Safe, CYF, February 2011

Children's Commissioner. Safety of Children in Hospital. Wellington: Office of the Commissioner for Children, 2006.

Family Violence Death Review Committee. 2014. Fifth Reportl Report: January 2013 to December 2013. Wellington: Health Quality & Safety Commission.

8.4 Guidelines, flowcharts and forms accessible via the Clinical Knowledge Centre (CKC).

Child Protection Flowchart	
Child Protection Checklist – Safety Assessment (Paediatric Injury Assessment Flowchart) - DRAFT	PDF ED child safety assessment form (Dra
Child Body Maps	
Report of Concern to Child Youth and Family	
Child Protection Alert System	
Memorandum of Understanding Police CYF NDHB	
Paediatric Video Surveillance	
Shaken Baby Prevention	
Family Violence Flowchart	
Adult Body Maps	
Adult Genitalia Maps	
Clinical Photography Request and Consent	
• Family Violence Identification Documentation Form	PDF IPV Assessment Intervention Form - F
• Elder Abuse and Neglect Policy	
• Strangulation Documentation Form	PDF Strangulation Documentation Form

8.5 Ministry of Health Resources

A number of resources (Ministry of Health screening cue cards) have been developed by the Ministry of Health to support safe practice. These are available via the Violence Intervention Programme Coordinators when attending the Violence Intervention Programme Core training.