Draft Standards for Youth Health Services

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Kidz First Centre for Youth Health and the Youth Health Expert Working Group, 2006.

This work was commissioned by the Counties Manukau District Health Board, but builds on extensive work in the youth health sector over some years.

Thank you to the students of Otahuhu College, Auckland for the artwork used in this report.

Disclaimer

Given the changing nature of the environment and the law, the Kidz First Centre for Youth Health, Counties Manukau DHB, and the many people consulted in the preparation of these standards do not take any responsibility for any action taken, or not taken, because of anything contained in, or omitted by, this document.

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INTRODUCTION

In Aotearoa New Zealand, there has been increasing recognition over the past 10 – 15 years that the developmental needs of adolescents, and the health issues facing them, differ from those of children and adults. This has led to youth health becoming a speciality area of knowledge and skills both within secondary and primary care. Speciality youth health services are now provided within mainstream settings, and in 'stand alone' situations.

All health services are expected to be clearly accountable for the public money they receive to provide their services. In addition to contractual accountability, the Health Practitioners Competence Assurance Act 2003 (HPCAA) requires all health practitioners to be involved in ongoing professional development, which must include quality assurance activities. This document aims to help those providing youth health services in Aotearoa in 2006 ask 'what does good youth health service provision look like' and 'how do we measure up to that'. It has been suggested that effective quality improvement requires an understanding of the culture within which the service is provided (Clarke & Yarrow, 1997). This is particularly important in initiatives in the youth health setting, given the wide variety of stakeholders involved in youth health services, and their interdependence in providing such services. However, having a nationally-accepted, common set of standards for the provision of youth health services will support the exchange of learning between services as well as internal learning processes (Groene & Garcia-Barbero, 2005). In addition it supports the systematic implementation of future initiatives.

There is currently no formally recognised professional college that has a mandate to set a suggested minimum standard for youth health care in Aotearoa New Zealand. It is also important to consider who defines quality – in the case of youth services the priority given to youth participation as part of healthy youth development demands that young people be part of the process. The consultation process carried out to formulate the standards suggested in this document has sought input from young people themselves and those able to be identified as leaders in the field of youth health service provision in this country[1]. Thanks to Nick Bohm who as a young person co-ordinated and wrote up the considerations of Youth Health Service Providers who met in 2002 to start the process of writing standards for quality improvement. Amongst these providers were managers, nurses, GPs, young people who worked as peer supporters, counsellors, social workers and youth workers, who all worked in schools or in Community Youth Health services.

PURPOSE OF THESE STANDARDS

The purpose of these standards is to improve the health and well-being of young people by

- establishing a nationally-agreed set of standards for youth health service delivery as determined by literature best practice recommendations, and consultation with providers in the youth health sector Aotearoa New Zealand
- identifying a range of common acceptable solutions that meet the standards while providing safe services[2]

By identifying a nationally-agreed set of standards, those providing services to young people can then

- evaluate the level of their attainment against the standards within a continuous quality improvement framework
- identify appropriate action to meet the standards where necessary, taking into consideration the size and complexity of their organisation, the population it serves and the degree of risk[3] associated with the service it provides.

The principles of best practice will be met in different ways by different services depending on their capacity and stage of development, and also their funding constraints, and this needs to be acknowledged in contractual expectations. Given the collaborative nature of much youth health service provision, standards may also be met by the participation of the service in collective activities, rather than each service independently meeting each standard. This is particularly relevant to community engagement and health promotion activities.

The youth specific standards in this document have been arbitrarily divided into five streams for ease of description. However there is much overlap between the content and nature of the standards within those streams, and each builds on and reinforces the importance of the practices encompassed by the other streams.

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[1] Appendix Two details those involved in the consultation process

[2] Defining health holistically using the Maori Whare Tapa Wha and Pacific Falefono models, and encompassing a developmental perspective, "safety" in the youth health setting thus includes acknowledging young people's increasing autonomy but need for connections with significant adults

[3] As with safety, "risk" is defined holistically and developmentally, considering the potential consequences, and their likelihood, of the standard not being fully met. The risk management matrix attached is that used in the Health and Disability Sector Standards Audit Workbook (Standards New Zealand, 2004).

TWO GRADES OF STANDARDS

1. Generic youth standards: these standards apply to all health services that provide services for young people (e.g. all primary care providers, secondary health services who see young people such as sexual and mental health services / hospital services such as A&E staff, orthopaedic and obstetric and gynaecological services). These standards are identified in this document in blue (i.e. all services who see young people should meet standards in blue)

2. Youth specific services: additional standards are also identified for youth specific services. These standards are identified in red (i.e. youth specific services should meet blue and red standards).

The examples given of activities to meet the generic standards have also been divided by colour into those that could be reasonably expected of any service that sees young people (blue), and those activities considered more particular to youth specific services (red).

These divisions recognise that the overall approach to care that provides a quality service for young people is generic to providing quality care for those of all ages, but there is also specific knowledge about youth health and development that service staff need to enhance the care they provide for young people.

Defining health broadly and holistically recognises that providers in other sectors (e.g. education providers, providers in the justice and social work sectors) impact on the well-being of young people and therefore should also meet basic youth standards.

METHOD

In line with the ALPHA principles for standard development (Groene & Garcia-Barbero, 2005), available evidence and best practice guidelines in the international and local literature were initially sought to provide a basis for a provisional set of youth health service standards.

Both the US Society of Adolescent Medicine, in a position paper on services to improve healthcare access for adolescents (Society for Adolescent Medicine, 1992), and the New Zealand Ministry of Health (Ministry of Health, 1995) have suggested similar features are important in delivering effective health services for young people:

- Accessibility (including affordability, convenience, visibility / service promotion)
- Acceptability (responsiveness - adjusting for cultural, ethnic and social diversity, culturally appropriate, confidential)
- Quality of care (timing, assessment, approaches used, treatment options, safety, monitoring and evaluation)
- Coordination and continuity of care (ensuring comprehensive services are available on site or by referral)

School based health services have perhaps been the youth health service most exposed to 'standards-based thinking', at least in the United States, and it has been suggested that if such services are to be an important part of the primary care system, they should meet standards of care similar to those of community health centres including certification, credentialing of providers and a systematic evaluation of the outcomes of services (Gance-Cleveland, Costin, & Degenstein, 2003). It is also suggested they be judged by the same standards as other primary care systems and could be assessed according to Starfield's framework for primary care (Santelli, Morreale, Wigton, & Grason, 1996). In addition to the criteria above, this framework also considers:

- First contact care (offering adolescents healthcare when needed - so decreasing their use of services such as A&E, reaching high need groups, screening appropriately)
- Comprehensive care (based on what is considered essential and appropriate by adolescents and their communities of interest, and patterns of consultation in other clinics)

- Community-oriented care (involving the community in planning)
- Family-centred care (with a young person's permission whanau and friends can be involved in their care while respecting confidentiality)

In addition to these broad frameworks, the following sources were particularly drawn on for more detailed standards recommendations:

- the synthesis of State standards and the Performance Evaluation guide produced by the US National Assembly on School Based Health Care (National Assembly on School-Based Health Care, 2000, 2003)
- the American Academy of Pediatrics Health, Mental Health and Safety Guidelines for schools (American Academy of Pediatrics, 2004)
- Aiming for Excellence, the quality framework for general practice care in Aotearoa New Zealand (Royal New Zealand College of General Practitioners, 2002)
- the Te Wana Quality programme of the Healthcare Aoteaora Network (Health Care Aotearoa & The Quality Improvement Council of Australasia, n.d.)
- the New Zealand Health and Disability Sectors Standards for Children and Young People (Standards New Zealand, 2004)
- the National Network of Youth Health Service Providers, New Zealand, Draft Standards in Primary Youth Health Care (National Network of Youth Health Service Providers, 2002)

After review and revision of the proposed standards, the Youth Health Expert Working Group identified the standards contained in this document as appropriate for youth health care in any setting in Aotearoa New Zealand. These standards may be met in a variety of ways, and the examples given in this document are not intended to be a checklist. Rather they provide guidance as to the sorts of structures and processes that do contribute to an organisation meeting the standards. As such the examples can help a service identify the ways in which they are already meeting the standards, and/or actions they may take as part of their quality improvement programme so that they do meet the standards in the future.

To continue this process of standards development in line with the ALPHA principles will require pilot testing of the preliminary standards set forth in this document, followed by review and revision before such standards are officially adopted by the sector (Groene & Garcia-Barbero, 2005). Commitment to ongoing review and adjustment of these standards at least 2 yearly, at a national level, is considered appropriate.

DEFINITION OF TERMS

The terms 'standard', 'criteria' and 'indicator' were used in a variety of different ways in the various documents utilised as a basis for the recommendations in this document. The difficulties related to ambiguity about the terms used in the measurement and evaluation of quality have been previously acknowledged (Ovretveit, 1998).

The World Health Organisation describes standards-based evaluation as assessing whether the 'appropriate structures, systems and processes are in place and functioning to achieve consistently favourable outcomes' p 9 (World Health Organisation, 2004), i.e. Is the organisation doing the right thing? Standards have been described as targets (Groene & Garcia-Barbero, 2005), and need to be clearly defined but cannot necessarily be captured by numeric terms. Achievement of a standard can be answered by a 'yes, no, or partly' response, and identifies potential areas for quality improvement. It may be related to a structure (eg a physical setting, competencies of staff), a process (eg the use of a guideline) or an outcome (eg quality of life, number of occupational accidents).

Performance assessment with indicators measures what was done and how well. Indicators are the outcomes it is hoped to achieve when a service meets the standard consistently, and can be used to monitor progress. Indicator reporting requires numerical data that can be expressed as a numerator and denominator.

For example :

Standard: Young people are mentored and trained appropriately to facilitate participation and partnership in the activities of the service

Indicator: the number of young people who have received specific training for their participation in planning of service activities / the total number of young people involved.

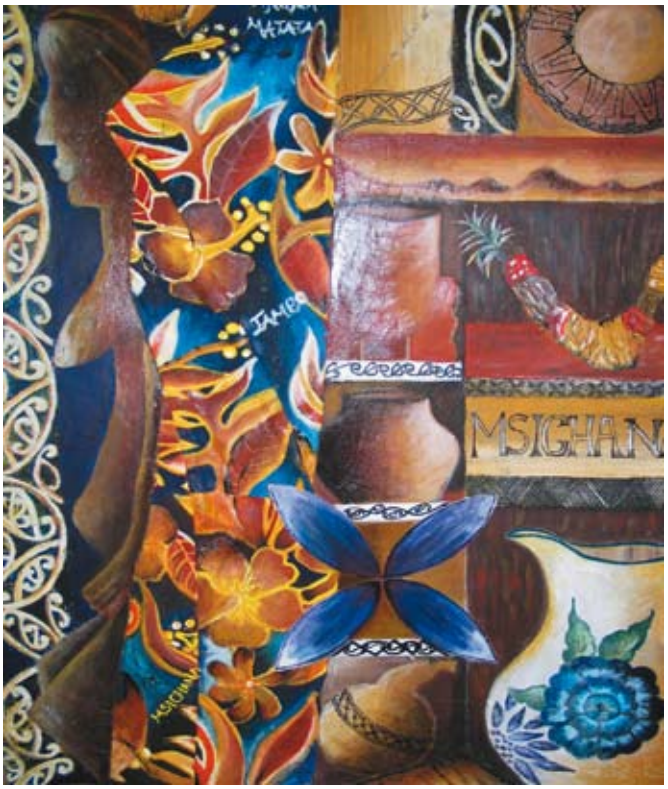
Standard: Comprehensive opportunistic screening for important adolescent health issues is offered to all young people receiving care.

Indicator: the number of patients in a randomly selected sample with evidence in their record that they have been screened/ the number of patients selected in the sample

It can be challenging to collect and analyse the data appropriately to achieve valid indicator measures

(World Health Organisation, 2004), and it has been argued that an 'ecological approach' which includes qualitative as well as quantitative measures and incorporates values and wider views of key players is more appropriate for quality improvement approaches in health care (Hart, 1997). As noted previously, this document suggests activities that could demonstrate a service's structures or processes that contribute to meeting the standards. These are included to provide helpful examples but should not be used as rigorous criteria, nor stifle other innovative means of meeting the standards. It is important that we do not end up focussing only on what is quantifiable and minimally acceptable, rather than what is optimal (Benbassat & Taragin, 1998). The national group involved in formulating these standards has committed to an ongoing process to define appropriate indicators to accompany this document.

The term 'service' in this document is defined as the organisation that provides the service to young people. 'Staff' includes all staff employed by the service who have contact with young people (e.g. including reception staff), while 'clinical staff' are defined as doctors, nurses, youth workers, allied health workers (e.g. social worker, psychologist).



GLOSSARY

Clinical practice guidelines.....

are 'systematic statements to assist practitioners' and consumers' decisions about appropriate health care for specific clinical circumstances' (Didsbury, 2003, p. 318). Groups such as the New Zealand Guidelines Group use a systematic process to produce clinical guidelines, in which they explicitly describe the strength of the evidence supporting their recommendations. The levels of evidence described range from high quality meta-analyses, systematic reviews of Randomised Controlled Trials, through Case-Control/Cohort studies, non-analytic studies, to expert opinion. Grades of recommendation (A to D) are then made on the basis of these levels of evidence. For further detail see the cited article by Didsbury and the New Zealand Guidelines Group website (www.nzgg.org.nz).

Evidenced-based practice…

defined as the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Didsbury, 2003, p. 317).

Health promotion…

Health education, addressing individual behaviours and choices, is part of health promotion but in Aotearoa New Zealand health promotion activities have an emphasis on addressing the contexts of those behaviours (e.g. physical and social environments) and the broader determinants of health.

Youth/young people….

While the terms adolescent and young person may be used loosely and interchangeably, the World Health Organisation (WHO) defines young people as aged 10 – 24 years. This age bracket includes the overlapping categories of adolescents, aged 10 to 19 years, and youth aged 15 – 24 years (WHO in Bennett, 1985).

STANDARDS

1. Treaty of Waitangi Standard: The strategic direction of the service and service delivery are consistent with the Treaty of Waitangi principles of participation, partnership and protection.

Minimum standard	Example activities to attain this standard
The strategic direction of the service, and its planning and monitoring are consistent with the Treaty of Waitangi principles.	Tangata whenua/Maori, both Kaumatua and Taiohi, are included in planning, delivery and monitoring of the service, with policy documentation to support this partnership and participation. The service has a Maori Health Plan, which documents the percentage of patients/clients who are Maori, their state of health, and strategies to improve Maori health status. In a school setting this should be integrated with the school's plan to improve outcomes for Maori students. The service has a process to identify and reduce barriers experienced by Maori to using the service. The service actively supports 'by Maori for Maori' initiatives, and training of Maori staff. The service has a monitoring strategy developed with whanau and iwi to evaluate services for Maori. The service demonstrates commitment to health gain for Maori through data analysis and feedback.
Services are delivered in a manner consistent with the Treaty of Waitangi principles of participation, partnership and protection	The service provides Tiriti o Waitangi training for all staff, with review every 2 years. The service supports whanau involvement in care where appropriate. The service supports access to Maori support and advocacy services. The use of Te Reo Maori is supported where possible

Evaluation[4] and Method used[5]	Level of attainment[6]	Level of risk[7]	Action required

4 How is achievement of this standard demonstrated?

5 E.g. client interview, provider interview, survey, chart audit, documentation review.

6 Not achieved/achieved in part/achieved in full/continued improvement

7 "Risk" is defined holistically and developmentally, considering the potential consequences, and their likelihood, of the standard not being fully met. The risk management matrix attached is that used in the Health and Disability Sector Standards Audit Workbook, and can be used to define the level of risk as critical, high, moderate, low or negligible (Standards New Zealand, 2004)

II. Specific Youth Health Service Standards: Executive Summary

1. Engagement with Community	2. Youth Focus and Participation	3. High Quality Comprehensive Clinical Care and Practice	4. Health Promotion/ Public Health Activities	5. Administrative/ Clinical Systems to Support Service Provision
1.1 Understand the community 1.1.1 Needs analysis 1.1.2 Scope existing services 1.1.3 Understand local systems and drivers in the community 1.1.4 Build comprehensive picture of the community	**2.1 Youth friendly** 2.1.1 Youth friendly staff 2.1.2 Youth friendly facilities 2.1.3 Respect for young people and all of their cultures 2.1.4 Developmentally appropriate care 2.1.5 Facilitation of access for groups identified as underutilising the service	**3.1. Recognise importance of positive youth development, strength-based practices and multidisciplinary care** 3.1.1. Informed by positive youth development 3.1.2. Facilitation of collaborative practice and multidisciplinary care 3.1.3. Transition issues / facilitation of access to a broad range of other services	**4.1 Committed to development of public policies that support the healthy development of young people** 4.1.1. Contribute to development and implementation of policies supportive of health promoting choices for young people	**5.1. Organisational structures** 5.1.1. Clear organisational structure with MoUs where appropriate
1.2 Engage and consult with the community 1.2.1 Forming and maintaining relationships 1.2.2 Ongoing working relationships 1.2.3 Community stakeholder participation 1.2.4 Intersectoral collaborative decision-making 1.2.5 Regular and ongoing networking with relevant professional communities	**2.2 Confidential and Private Care** 2.2.1 Young people and adults are assisted to understand the Code of Health and Disability Consumer Rights, and the Privacy Code as they relate to young people 2.2.2 Client information is treated as confidential and private 2.2.3 Staff understand legal issues related to providing care for young people 2.2.4 Physical privacy is respected	**3.2 Provide core clinical care and minimum youth health services** 3.2.1 Identification of key clinical issues, and management of chronic health conditions common in young people 3.2.2 Ability to provide primary care level assessment of mental health, sexual and reproductive health, and drug and alcohol issues 3.2.3 Clinical contacts viewed as opportunities for screening, preventive care and health education	**4.2.2 Contribute to creation of supportive environments for the well-being of young people** 4.2.1 Work in the community to contribute to the creation of supportive environments for the well-being of young people	**5.2 Administrative/clinical systems** 5.2.1 Standardised templates for data collection and reporting 5.2.2 Clinical records and information, integrated with other providers while protecting data 5.2.3 Prompting/recall systems
1.3 Feedback to the community 1.3.1 Reports, information about services 1.3.2 Appropriate dissemination pathways 1.3.3 Inform community about youth health issues	**2.3 Youth participation in** 2.1.1 Planning/development 2.1.2 Service delivery 2.1.3 Own and whanau/family health care	**3.3 Staff with appropriate training and skills in youth health** 3.3.1 Specific training in youth health and development 3.3.2 Basic youth health skills	**4.3 Committed to strengthening community action to enhance the well-being of young people** 4.3.1 Assist young people in the community to develop skills and resources to take effective action to support their well-being. 4.3.2 Equip parents and those working with young people to build quality relationships with young people.	**5.3 Clinical quality improvement processes** 5.3.1 Guidelines/ accepted best practice (local & international) 5.3.2 Commitment to evaluation
		3.4 Importance of culture in service provision and planning 3.4.1 Recognition and response to cultural values and beliefs of Maori young people and their whanau, and other ethnic cultural groups 3.4.2 Importance of collecting accurate ethnicity data 3.4.3 Holistic cultural models of health influencing practice	**4.4. Support population level health promotion and protection initiatives targeting young people** 4.1.1 Promote national immunisation initiatives that impact on young people 4.1.2 Support health promotion campaigns targeting young people and youth issues	**5.4 Facilitation of professional development and administration responsibilities** 5.4.1 Orientation 5.4.2 Continuing education 5.4.3 Supervision 5.4.4 Resources and time for collaborative work

1. Engagement with the community

It is important that the time necessary for quality community engagement is recognised by those planning and funding youth health services. Best practice consensus suggests that this engagement is likely to take years rather than months.

1.1 The service understands its community of interest (for school-based services specifically including the school).

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
1.1.1 The service undertakes a community needs analysis in relation to health issues for young people.		The service accesses and/or collects available local health data, both qualitative and quantitative, about issues related to young people (e.g. regional level data from national surveys like Youth2000 can be a useful contribution initially). The service consults with local young people, those who work with them, and the wider community in a variety of settings about issues impacting on the well-being of young people. For school services: This consultation specifically needs to include the principal, staff, school pastoral team, BOT, students, parents.
1.1.2. The service has knowledge of the scope of existing youth-related services in the wider community.	The service uses a stocktake of existing youth-related health, welfare and education services as part of the needs and gap analyses that inform service design.	
1.1.3 The service has knowledge of the local systems and unique drivers of the community that may influence service provision.	The service uses a systems map of the local community to establish important potential influences on service provision for young people.	
1.1.4. The service uses the information it has to build a comprehensive picture of the community to enhance service provision.	The service uses collected information to identify gaps and issues of concern for local young people. The service forms, and uses, criteria (including criteria generated by legitimate bodies such as the DHB, local bodies) for deciding which initiatives should be resourced and to what level. The strategic plan is linked to national and local priorities for Maori and youth health.	

1.2 The service engages and consults with its community of interest

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
1.2.1 The service forms and maintains relationships within its community.	The service has relationships with tangata whenua, other cultural groups, community groups and networks, other health care providers and uses feedback from these groups to shape service provision.	The service develops and maintains links with local peer support initiatives (e.g. Youthline, SADS, Mentoring programes etc).
1.2.2 The service has ongoing working relationships within its community.	The service demonstrates links to enable it to maintain up-to-date information about, and connections with, other community /school youth-related services. The service uses these links to develop co-ordination and integration with these services. The service, as part of the community, acts collaboratively on issues of concern.	Staff are required to actively seek out opportunities to engage with other adolescent service providers in the community, through training and collaborative activities. For school services: The school health service is integrated with the wider school health program. Health service staff are aware of the school's health curriculum and whole school approaches for improving student and staff well-being, and are available to contribute where requested.
1.2.3 The service has active community stakeholder participation.	The service actively seeks input from an advisory board with broad community (including school where appropriate) representation to shape the planning and provision of services. The minutes of meetings of this advisory board are publicly available. The service's planning process is participatory, based on community development models, involving young people, tangata whenua, staff, the community served and key stakeholders. These links are used to ensure co-ordination and integration with other services.	For school services: Stakeholder participation specifically needs to include the principal, staff, school pastoral team, BOT, students, parents. The service works with the school to develop a shared vision for school-based health services. Ideally a member of the BOT has a health portfolio and provides liaison and advocacy for health issues at BOT meetings.
1.2.4 The service is involved in intersectoral collaborative decision-making.	The service has regular meetings with those from other sectors involved in local youth services.	For school services: There are regular meetings between health service clinical staff and other school personnel to support existing appropriate health initiatives and identify further strategies to enhance well-being of students and identify health issues effecting educational performance.
1.2.5 The service's clinical staff are involved in regular and ongoing networking with their relevant professional communities.	The service supports staff to develop and maintain local, regional and national professional networks to reduce professional isolation and promote standards of youth health care.	For school services: These networks need to include both education management networks, and networks of health professionals. School-based health service staff attend appropriate school functions.

1.3 The service provides feedback to its community of interest

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
1.3.1. The service produces information on its philosophy, services and programmes that is relevant and accessible for the community it serves, continuous and dynamic.	The service provides the community with information about the services it provides for young people and how to access them in languages and cultural settings appropriate to the community.	In a school setting: This includes explicit information about the service at the time of student enrolment, and an opportunity to discuss any concerns about the service with a clinical staff member of the service.
1.3.2. The service distributes this information through appropriate dissemination pathways.	The service has a communications plan to ensure ongoing communication with the community about the services it provides (e.g. newsletters) This communications plan is developed in collaboration with the community.	In a school setting: The vision for the health service is communicated to teachers, parents and the wider community. Visits are arranged for new students; there are presentations at school assemblies.
1.3.3 The service informs the community of youth health issues affecting clients that need intervention at community/society level.		The service uses the information collected in evaluation of its activities to inform the community of gaps and needs for the well-being of young people.

2. Youth focus and participation

2.1 The service sets a high priority on providing a youth friendly service.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
2.1.1 All staff are youth friendly.	All staff genuinely respect and enjoy working with young people. All staff have training in how to engage with and work with young people.	Staff create a positive climate for the involvement of young people, creating working relationships with them that show unconditional positive regard, belief in and respect for them. This relationship is valued as much as the service provided. Young people are involved in all staff recruitment processes.
2.1.2. Service facilities are youth friendly	The service is clearly signposted, physically accessible, and the operating hours are appropriate for needs of young people (e.g. before/after school, lunchtime appointments). The service offers outreach services where appropriate.	The service considers the needs, values and beliefs of young people in deciding on the location of the service, and (where possible) to make it aesthetically appealing to young people. There are non-threatening reasons to access the facility where the service is provided (e.g. a common reception area with other services). In schools, where possible, health services should not be provided next to the offices of those with disciplinary roles.
2.1.3. The service and staff identify and demonstrate respect for the diverse values and beliefs of young people, their families and all of their cultures (e.g. ethnic cultures, sexual orientation, various 'youth cultures').	Where possible and desired by young people, the service employs staff that reflect the community that it serves. Accredited interpreter services are provided where necessary and practical (linking with funded DHB services where possible). The service involves young peoples' parents/significant adults in their care where appropriate. The service has a non-discrimination policy. The service provides a designated person responsible for monitoring issues related to discrimination. Staff consider the influences of gender, culture, age, socio-economic status, religion, sexual orientation, disability and lifestyle in their interactions with young people. Staff address young people by their preferred name. Staff are responsive to feedback from young people and the community in relation to meeting individual values and beliefs.	
2.1.4. The service and staff recognise the developmental changes of adolescence in service provision, and the information provided to young people.	Written information about the service, and other health and disability issues is provided in an appropriate format that young people can understand and take away with them. Staff recognise the developmental changes that young people go through on their way from child to adult and adapt their approach accordingly.	
2.1.5 The service identifies and facilitates access for groups identified as underutilising the service (e.g. males, gay/lesbian/ bisexual/ transgender youth).	Where possible the service provides a choice of gender in the clinical staff available. The service provides posters and reading material for diverse groups (e.g. males, females, LGBT youth) chosen by the young people who attend the service. The service explores the potential for utilising well-informed females (mothers, sisters, friends) to encourage attendance by young males.	

2.2 The service assures young people confidential and private care, while respecting family values and connections

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
2.2.1. The service makes the Code of Health and Disability Services Consumers' Rights 1996, and the Health Information Privacy Code 1994, known to young people and ensures these Codes are available in formats developmentally appropriate for those young people using the service, and to parents and other adults involved in the lives of young people (e.g. teachers).	The service ensures the Code of Health and Disability Services Consumers' Rights 1996 is readily available/displayed to facilitate young people's access to it. Staff provide opportunities to explain/discuss the Code with young people (eg wellness centre tour). Staff assure young people at the time of the consultation that they understand their obligations under the Codes and the Act (e.g. a poster on the consulting room door provides an trigger to discuss this with young people).	The service takes opportunities to provide education to parents and teachers about the Codes and the Act in relation to the care of young people.
2.2.2. The service and staff keep information confidential and private in accordance with the Health Information Privacy Code 1994 (see Management standard M.2).	The service displays confidentiality policies clearly in the waiting room and these are personally reiterated by staff in their clinical contacts with young people. Confidentiality is explained with reference to situations of harm. Staff explain the desirability of team care to young people so that they understand and can give informed consent to sharing of information within the health team. Staff inform young people of the systems relating to their information so that they can understand the need for formal transmitting of information to other service providers when this is important to their care (and ordinarily where this has their consent). The service acknowledges issues of confidentiality for young people are complex and commits to ongoing training for all staff, with review at least 2 yearly.	
2.2.3 All staff have basic knowledge of the legal issues related to providing care for young people, with the service's privacy officer having specific knowledge about how to access further advice about such issues.	As part of induction staff receive training about the legal issues that may arise when providing care for young people, and related knowledge is reviewed 2 yearly as part of quality improvement practices.	
2.2.4. Staff respect and meet young peoples' need for physical privacy during service provision.	Service areas are designed to provide visual and auditory privacy. Toilets have a locking system to facilitate privacy but allow service provider access in case of emergency. Staff training emphasises the importance of respecting privacy.	

2.3 The service facilitates youth participation in planning and service delivery, and young people to participate in their own health care

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
2.3.1. The service provides structures and processes to facilitate the participation of young people in service planning and development.	The service has or utilises a youth advisory group.	The service provides access to mentoring and training to facilitate the participation and partnership of young people in the service planning. Young people participate in the design of service areas, and selection of furniture and equipment. Young people are involved in staff recruitment procedures. The service recognises, values and rewards appropriately the participation of young people.
2.3.2 The service provides support for young people to participate in service delivery.		The service provides mentoring, appropriate training, supervision and clear roles to facilitate participation and partnership of young people in the activities of the service[8]. The service trains young people to be involved in health promotion/peer support both through physical face-to-face contacts, and electronically (e.g. MSN, email). The service equips adults to work effectively alongside young people.
2.3.3. The service and staff support young people to gain the skills to participate effectively in their own health care and that of their whanau/family and friends.	Staff support young people to be actively involved in their own care, and participate in decisions that affect them. There is information available to help young people understand their right to make informed decisions and give/withhold their consent. Staff inform young people about wider health issues so that they are supported to be enhance the well-being of their family/whanau and friends.	

[8] Refer US National Peer Helpers Assoc programme standards (http://www.peerhelping.org/publications/standards/standards.doc)

3. Delivery of high quality comprehensive care

3.1 The service provides care that recognises the importance of positive youth development, strength-based practices and multidisciplinary care

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
3.1.1 Service provision and delivery of health care at all levels is informed by positive youth development.		All staff have an in-depth understanding of positive youth development and how this informs their practice. Assessments and delivery of health care are grounded in a strengths-based approach (e.g. based on the Ministry of Health Youth Health Action Plan, utilise an assessment tool based on a model such as HEADSS).
3.1.2. The service recognises the broad scope and complexity of youth health needs and facilitates collaborative practice and multidisciplinary care.	Where possible the service has a multidisciplinary team able to deal with the broad range of youth health issues, with the aim to provide as many services on site as possible. Where comprehensive services cannot be provided on site, there is ready access to often needed and important services by well-linked referral systems. Staff advise young people appropriately of their options to access other health and disability services, available resources and support groups where indicated or requested. The service may give consideration to arranging Standing Orders with medical care providers to allow dispensing of some medication by appropriately trained nursing staff, where there is a formalised, established and collaborative working relationship with the medical provider [9]. In such as situation, the medical provider(s) will usually be accessible by phone. The service's information systems enhance linkages between the various people/ services involved in young people's care. Staff record relevant information into the record system in a timely manner to enhance co-ordinated patient care – within 24 hours of service provision or knowledge being acquired. Staff ensure there is a clear delegation of responsibility for the coordination of care and a named, contactable key worker for young people who have complex needs. As far as possible young people with chronic conditions see the same key people each time they visit the service. Clinical staff have caseloads restricted to a size that enables them to provide quality collaborative care. Clinical staff ensure that young people's care is reviewed and evaluated at intervals appropriate to the needs identified.	Clinical staff have the ability to effectively coordinate and facilitate collaborative meetings with young people/ family/whanau/ other health and welfare professionals/ wider community where appropriate. Youth workers/social workers are able to work collaboratively with families to resolve conflicts, set goals and assist them to seek help where appropriate.
3.1.3. The service identifies and actions transition issues / facilitates access to a broad range of other services and activities.	The service has mechanisms structured for the exchange of medical information (with a young person's permission) between the clinical staff and other services such as the young person's family doctor or nurse, referral agencies, in the case of a school service the school pastoral team. Where the service will no longer be providing care for a young person (eg leaving school or town, too old for service parameters, choosing to access mainstream provider), a planned exit is documented and implemented. The service recognises that young people sometimes have difficulties accessing medications and endeavours to facilitate this access when necessary by providing (a) access to medications for acute and minor medical problems and treatment of STIs organised on site (b) additional medications available at a subsidised rate at a nearby pharmacy. The service facilitates access to other health services/education/ training/social welfare agencies/recreation and creative activities where appropriate[10].	The service offers young people and their whanau support to complete referrals – e.g. joint appointments, staff going with them to appointment, shared care arrangements.

[9] There are medicolegal implications in the use of standing orders, and hence arrangements for standing orders rely on there being a sound working relationship between the providers involved, with a good understanding of each others clinical skills, and training and competency needs clearly outlined.

[10] E.g. Dental, mental health, sexual health, drug and alcohol, income support, social work, housing, police/justice, youth employment, legal advice, ethnic youth initiatives.

3.2 The service provides core clinical care and a minimum set of youth health services

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
3.2.1. The service identifies key clinical issues, and chronic health conditions common for the young people accessing their service, and develops high quality clinical guidelines and standards of care for these.	The service uses prior needs analysis, and ongoing evaluation to identify key clinical issues and common chronic illnesses for young people accessing their service[11]. Based on available evidence, and in collaboration with youth health colleagues, the service develops specific recommended best practice guides to address these issues. Clinical staff recognise assessment of the psychosocial context of all clinical presentations as a priority. Clinical staff ensure presenting risks (eg sepsis, potential pregnancy, suicidality) are addressed appropriately.	
3.2.2 All clinical staff, regardless of professional qualification, are able to provide primary care level assessments to identify issues related to mental health, sexual and reproductive health and drug and alcohol issues.	All clinical staff are able to identify issues related to physical and emotional safety/well-being, mental health, sexual and reproductive health and drug / alcohol issues. Where those staff are not trained to provide further assessment and services related to issues identified, they have access to well-documented referral pathways, and the ability to work alongside a young person to help them complete assessment and treatment. Medical and nursing staff are expected to be able (a) to take a comprehensive psychosocialassessment (e.g HEADSS) (b) recognise, assess and treat mental health issues, and if necessary facilitate access to a mental health team (c) to screen for STI's and pregnancy, and provide basic contraceptive and STI treatment and follow-up (d) to identify significant issues related to drug /alcohol use, and provide advice/counselling and if necessary further referral.	
3.2.3. The service views all clinical contacts as opportunities for comprehensive psychosocial and health screening, preventive care and health education[12].	Clinical staff offer comprehensive opportunistic screening for important adolescent health issues to all young people receiving care. All clinical staff identify opportunities for preventive care and early intervention in their clinical contacts. Clinical staff promote accepted health education eg quit smoking, asthma action plans, reducing sexual risk, encouragement of regular exercise and healthy diet, mental health promotion.	In liaison with local primary care providers, the service considers offering regular health check ups (e.g. in school setting in Yr 9, 11 and 13).

3.3 All staff have appropriate training and skills in youth health

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
3.3.1. All staff have basic training in youth health and development	All staff have basic training in the knowledge and application of - Youth Health Issues - Youth Development - Holistic Care - The Psychosocial Environment of young people - Youth Friendly Principles	All staff have specific training in the knowledge and application of - Empowerment of young people - Partnership with young people - The Primary Youth Health Care standards Clinical leaders hold, or are working towards, a post-graduate qualification in Youth Health.
3.3.2. All clinical staff have basic youth health skills	All clinical staff are trained in and recognise the importance of appropriate interviewing and psychosocial screening skills.	All clinical staff are adequately trained to provide primary care level (a) assessment of mental health status (b) cognitive approach to the behaviour of young people (c) motivational interviewing. All clincical staff have a working knowledge of the Child, Youth and Family Act 1989, the role of CYFS in the protection of young people, and skills to work with the impact of violence. Given the potential for complex nursing judgements to be required in the school setting, all nurses working independently in the school setting are fully registered nurses.

11 Where data is difficult to obtain, evidence suggests that mental health, substance use, and sexual health services will be important (Winnard, Denny, & Fleming, 2005). Treatment of sports injuries is a good way to attract young males to the service, and primary care access to WINZ benefits is also likely to be important.

12 The term health education is used in preference to health promotion when the intention is 'changes in personal health-related behaviour of individuals' (Mudaly, 1999)) Health education is a part of health promotion but in general in Aotearoa, the term health promotion is seen to refer to broader collective responses that address social and physical environments, 'making the healthy choice the easy choice', and orienting health service organisations to become

3.4 The service addresses the importance of culture in all levels of service provision and planning

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
3.4.1. All staff identify and respond to the cultural values and beliefs of Maori consumers and their whanau, and other cultural groups.	All staff have participated in cultural sensitivity/competence training, and this is regularly reviewed (e.g. two yearly). The service supports cultural groups to define culturally appropriate care for themselves, with input sought from cultural specialists where required. The service and staff support young people's connections to their own cultures, with recognition of cultural practices and events.	
3.4.2. The service acknowledges the importance of collecting accurate ethnicity data.	All staff understand the rationale and purpose for collecting ethnicity data, and gather ethnicity data in a way that ensures accuracy, Staff explain what ethnicity information is collected and why to young people.	
3.4.3. Holistic cultural models of health influence practice, and inform service design and delivery.	The service and its staff consider spiritual, emotional, social health needs of young people in addition to physical and mental health needs.	

4.Health promotion/public health activities

Health education, addressing individual behaviours and choices, is part of health promotion but in Aotearoa New Zealand health promotion activities have an emphasis on addressing the contexts of those behaviours (e.g. physical and social environments) and the broader determinants of health.

4.1 The service is committed to the development of public policies that support the healthy development of young people.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
4.1.1 The service contributes to the development and implementation of policies that are supportive of health promoting choices for young people.		In established working relationships with other agencies and sectors, the service supports the exploration of the extent to which youth well-being issues are being addressed and/or placed on the policy/ strategy agenda. The service and its staff advocate for the needs of young people to influence policy development, so that policies are supportive of healthy youth development in all agencies in the community that deal with young people, including local and central government agencies.

4.2 The service contributes to the creation of supportive environments for the well-being of young people.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
4.2.1 The service works in the community to contribute to the creation of supportive environments for the well-being of young people.		The service works with the community to increase the level of community awareness about healthy youth development and youth health issues. The service works with the community to develop community initiatives that support healthy youth development, including arts – performing and visual, recreation and adventure facilities.

4.3 The service is committed to strengthening community action to enhance the well-being of young people.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
4.3.1 The service purposefully plans to assist young people in the community to develop skills and resources to take effective action to support their well-being.		Staff from the service provide mentoring relationships to foster leadership, and support community leadership by facilitating access to resources such as training opportunities, infrastructure, to enable youth-focused community groups to have more resources and capacities to act independently of agencies. The service supports 'train the trainer' activities that empower young people to work with their own communities to address health and well-being issues. The service is involved in receiving and contributing to resources as they are developed by young people. The service encourages the community to undertake evaluation of initiatives and strategies so that capacity to learn from experience is increased.
4.3.2 The service purposefully plans to equip parents and those working with young people to build quality relationships with their young people.		The service supports or develops resources/initiatives for parents to help them understand youth issues and developmentally appropriate parenting skills. The service supports adults in local businesses, sports clubs and church groups to understand youth issues.

4.4. The service supports population level health promotion and protection initiatives targeting young people.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
4.4.1 The service promotes national immunisation initiatives that impact on young people.	The service actively promotes appropriate immunisation to young people on its register. The service liaises with other agencies to support national immunisation campaigns eg MeNZ B.	
4.4.2 The service supports health promotion campaigns targeting young people and youth issues.	The service uses Ministry of Health resources (eg posters, pamphlets) to support national and local youth health promotion campaigns.	The service supports young people to be involved in planning and implementation of health promotion campaigns eg Hubba campaign.

5.Administration / clinical systems to support service delivery

5.1 The service has effective organisational structures to facilitate service planning and delivery.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
5.1.1 The service has a clear organisational structure, ratified by formal agreements with services with which it works closely.	The service has an organisational structure that has clear lines of responsibility and accountability.	In school settings: There is a formal agreement (e.g. MoU) between the service and the school clearly outlining mutually agreed roles and responsibilities of each party. This should include reference to relevant school policies, financial arrangements, facilities to be provided by the school, key contact people for each organisation, liability coverage for each party, record keeping, liaison between staff in the health facility and teachers and school managements, and reporting requirements. Where the school health service is working with the local PHO(s), there should also an MoU between the service and the PHO. Similarly in community settings there should be formal agreements with services with whom the youth service works closely.

5.2 The service has effective administrative/clinical systems to support service delivery

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
5.2.1. Administrative systems include standardised data collection and reporting templates to facilitate simultaneous reporting on a number of different contracts.	**Staff work with contract funders to establish acceptable reporting processes which minimise duplication of effort.**	
5.2.2 The service's clinical records and information systems comply with appropriate legislation (see Management standards), and facilitate integration with other providers while maintaining protection of data.	The service has a system to track results, notification of results, correspondence sent and received, and the progress of young people who have been referred from the service to another service. The service has systems in place to document when, what and to whom information has been forwarded (e.g. usual GP sent copy of results and informed of referral to hospital clinic). Staff record all phone calls, and non-contact activities related to clients in the client record at the time or within 24 hours. The service has clear agreements with any clinical staff in the service who may want to maintain their own records on how such records will be available to other clinical staff and how young people's permission will be obtained for this. Staff use standardised consultation codes (e.g. READ codes) and recording of referral data to facilitate evaluation.	In a school setting: The service liases with the school to share Age/Sex register data between the school administration and health systems, but with clear protection of clinical records to guard confidentiality. The service liases with the school to ensure essential health information (e.g. allergies, chronic health conditions) is transferred from the school administration system to health system files.
5.2.3 The service's clinical records utilise prompting and recall systems to facilitate quality care.	The service has systems to prompt screening, appropriate documentation of care, tracking of missed and follow-up appointments, and laboratory and referral reports. Recall systems are part of the service's clinical information systems and are used to support young people in their learning about how to use health services.	

5.3 The service demonstrates commitment to clinical quality improvement practices

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
5.3.1. The service adopts generally accepted guidelines and best practice protocols for clinical practice.	The service supports, with adequate training and resources, the implementation of clinical protocols where available, and those for home visits, transporting clients and chaperones, consistent with recognised best practice.	
5.3.2. The service demonstrates commitment to evaluation of its activities.	The service collects qualitative and quantitative data for evaluation, and this data is used as part of the service's quality improvement process. The service allocates resources and time for annual evaluation, which iteratively over time includes measures of processes and experiences as well as outcomes, monitoring of utilisation, content of care (adolescent self-report, and chart audit), quality and appropriateness of referrals, team communication and financial viability. Collection of this data includes surveys of young people, and the community of interest. The effectiveness of consent procedures (consumer input, peer RV, chart audit of documentation) is specifically addressed. The service regularly undertakes a review against external standards as part of its CQI cycle, including occupational health and safety standards. The service takes appropriate action following the identification of areas for improvement. All staff understand the quality improvement cycle and reflective practice. All clinical staff are involved in their own professional quality process through their professional body. Clinical staff are involved in peer and case review opportunities and undertake regular chart reviews for quality assurance annually as part of performance review.	

5.4 The service facilitates staff fulfilling professional development and administration responsibilities.

Minimum standard	Example activities to attain this standard (for all services who see young people)	Example activities to attain this standard (youth specific services)
5.4.1. The service provides appropriate orientation for all staff.	The service has an orientation policy and all staff receive timely orientation which includes roles, functions, responsibilities, services values/philosophies/ goals, and training in how to engage and work with young people.	
5.4.2. Staff training and development needs are met by provision of relevant programmes.	The service identifies gaps in the skills and understandings of staff, and addresses these by appropriate training. This training includes experiences to increase self-efficacy about interacting with young people, psychosocial screening and early intervention. Review ensures knowledge and skills gained in training are applied in the service, with evaluation to determine the extent to which learning has led to changes in practice. All staff have Individual Development Plans based on the principles of reflective practice, and reviewed annually. Staff have dedicated time and resource available for their professional development. Clinical staff are trained to use clinical equipment appropriately, with regular updates.	The service has a training and development plan to ensure all staff, and volunteers have the skills necessary for their work. This plan is linked to community needs, and recognises the need for quality primary care provision in addition to youth specific issues.
5.4.3 The service provides time and resources for all clinical staff to be involved in ongoing external supervision.	The service has a policy outlining the purpose, definition and function of supervision, differentiating peer/colleague clinical oversight and professional supervision. The service utilises and supports external supervision by supervisors trained in professional process supervision, with supervision agreements and a mechanism for evaluation of supervision. The service provides funding for clinical staff to each attend 1 hour of process supervision per month.	
5.4.4. All clinical staff have adequate funded time for the administrative work that accompanies a collaborative, multidisciplinary approach to service provision.		The collaborative team approach is written into service policy and clinical staff have sufficient dedicated time for appropriate case follow-up, and agency collaboration. (An appropriate mix of work responsibilities is seen to be approximately 50% of time in direct contact with clients, 20% followup/work related to these consultations, 30% service development/professional development/ health promotion activities, etc).

III. Management Standards

The following standards relate to generic issues that are important in the provision of quality service but not specifically related to youth focussed services

M.1. General management standards

Minimum Standard	Example activities to attain this standard
M.1.1. The service has a functioning oversight committee (or Trust Board where one exists) operating with sound business procedures, a Treaty of Waitangi and inequalities framework consistent with the NZ Health Strategy, and accountable to key stakeholders.	The service has appropriate selection processes that ensure that members of the oversight committee reflect the community of interest, with appropriate Maori partnership. The service ensures that oversight committee members receive appropriate orientation and on-going training, and know and understand the service's mission and goals and work towards these. The service has developed clear goals and philosophies to guide practice. Equity of access and care is a service priority and written into policies, and the HEAT tool[13] or similar is used to shape service planning. The oversight committee has clearly defined roles and responsibilities, being responsible for strategic planning, and allocation of financial resources. The difference between these responsibilities and management functions is clear. There are clear processes for: · Recording committee minutes, policies and decisions. · Making decisions between meetings. · Communicating information between the oversight committee and staff. The service has a clear budget for each financial year, and financial systems that are consistent with financial accounting standards. The oversight committee has strategies and systems to support long-term financial stability of the service. The service has negotiated agreed outcomes with funding bodies, and meets funder reporting requirements. The service produces an annual report that is useful to readers, and includes the reporting of outcomes of Continuous Quality Improvement activities. The service has risk management systems in place which include: · Documented delegation of authority. · Regular financial reporting. · A system in place to monitor compliance with the Health and Safety Act, the Building Act and fire safety regulations. Service policies are reviewed regularly – at least every 2 years. Where a service is run be a Trust then the Trust Board will be the governing body and their role will be defined in the Trust constitution.
M.1.2. The service has effective and responsive management processes that encourage staff involvement in decision-making.	The service is managed by an appropriately qualified and experienced person. The service has an organisational chart with clear lines of responsibility and accountability. There are protocols for management of staff working from the service but not responsible to the service management with a written MoU between the service and the management of these other providers. Staff participate in management decision-making.
M.1.3. The service has human resource management processes that conform with good employment practice and requirements of legislation.	The service meets legislative and industrial requirements for staff, with written and signed employment contracts in place. Staff and management have current position descriptions. Staff recruitment processes ensure client safety (i.e. Police check, current drivers license if staff are to transport clients). There is a system to ensure all clinical staff have a recognised and current professional qualification. Staff have an annual 360 degree performance review. Staff adhere to professional codes of practice, ethics and conduct. Clinical staff have appropriate liability insurance. The service has an internal complaints system for the expression of concern about colleagues. The service has systems to resolve staff grievance and conflict. The service regularly measures levels of staff satisfaction. The service has systems to address crisis/incident management and debriefing.
M.1.4. The service respects consumer's rights to complain and access independent advocacy.	The service has a documented complaints procedure, which complies with the Code of Health and Disability Services Consumer Rights 1996, and a designated complaints officer. The service communicates to consumers and agencies their rights and how to make a complaint and has an accessible complaints system. Complaints involving Maori are addressed in a culturally appropriate manner. Complaints involving other cultural groups are addressed in a culturally appropriate manner.
M.1.5. The service addresses barriers that discourage access to services.	The service has a system to identify things that make it difficult for disadvantaged people to come to the service and has made changes to make it easier where indicated, including the consideration of outreach services. The facility from which the service operates provides appropriate disability access.

13 A tool to facilitate consideration of equity issues, available from the NZ Ministry of Health website (URL http://www.moh.govt.nz/moh.nsf/0/24474C7464606A5ACC25700B0009D6F8/$File/heattool.doc)

M. 2. Client information standards

Minimum standard	Example activities to attain this standard
M.2.1. The service ensures the Code of Health and Disability Services Consumers' Rights 1996, the Health Information Privacy Code 1994, the Child, Youth and Family Act 1989 and the Care of Children Act 2004 are implemented by its staff.	All staff have a working knowledge of the Code of Health and Disability Services Consumers' Rights 1996, the Health Information Privacy Code 1994, the Child, Youth and Family Act 1989 and the Care of Children Act 2004. The service has a written policy about how it will implement the Health and Disability Consumers' Rights Code, and staff are trained in this implementation. Implementation of these Codes and legislation are monitored as part of the service's quality review processes.
M.2.2. Client information held by the service is uniquely identifiable, recorded correctly, current, confidential, accessible when required, and complies with current legislative and regulatory requirements.	The service has appropriate written policies on consent, confidentiality, collection and use of health information, and protection of records. These must be in line with the New Zealand Public Health and Disabilities Act 2000, the Health Information Privacy Code 1994 and the Privacy Act, the Care of Children Act, OSH regulations. There is acknowledgement of the need for a centralised information management system. Staff are trained in the requirements of the Privacy Code, and the service identifies a privacy officer who monitors privacy issues. The service has systems in place to ensure data is secure. Staff ensure that every entry in the client record is legible, dated and the designation of the worker providing the service is entered. Each client record contains a database, problem list, management plans and progress notes, and accurately documents all services provided to the young person. There is a procedure for inserting incoming results and correspondence into client health records. Staff obtain and document written consent for the release of information and transfer of records. The service complies with computer software licensing requirements. The service has policies for using internet and intranet. The service has a disaster recovery plan for information technology malfunctions. The service has an information technology plan is in place which is in line with current relevant information technology standards and regularly reviewed against service goals.

M.3. Client safety standards

Minimum standard	Example activities to attain this standard
M.3.1. All buildings, plant and equipment comply with legislation (including Smoke-free Environments Act 1990), regulations and the appropriate standard where a standard exists; and are maintained to meet these requirements.	Buildings occupied by the service have a current Building Warrant of Fitness and Fire Evacuation plan and appropriate insurance. The service has a documented equipment maintenance plan including cleaning and calibration of clinical equipment. The service specifies cleaning and laundry processes appropriate to the setting (in a school setting the MoU with the school will need to specify the standard of cleaning required in a health setting). The service has systems to ensure that the goods and services it uses comply with the appropriate standards.
M.3.2. The service provides an appropriate and timely response during emergency and security situations.	Staff have training to provide an appropriate level of first aid and emergency treatment for the service provided, and regular practices of resuscitation procedures. The service has accessible emergency equipment and supplies that are regularly checked to ensure they are stored correctly and not expired. The service has an approved emergency response and evacuation plan, including specific responsibilities of providers during emergency incidents, and a review process for this plan (eg 2 yearly or after incident). The service has an emergency process for dealing with threatening behaviour. The service has an appropriate debriefing process after a significant emergency incident. Fire safety and evacuation training are provided during orientation of staff and at appropriate intervals
M.3.3. The service has documented procedures for the management of waste and hazardous substances (eg sharps, biological and chemical waste), and their implementation is monitored.	Staff involved in the handling of waste and hazardous materials receive training to ensure safe and appropriate storage and handling. The service ensures all hazardous substances are correctly labelled and stored. Protective equipment and clothing is provided and used by staff handling waster or hazardous substances. The disposal of waste and hazardous substances complies with legislation. The management of biological waste considers the cultural practices of Maori.
M.3.4. Consumers, staff and communities are protected from preventable exposure to infection as a result of service provision.	The service has documented infection control policy and procedures, which are monitored regularly by an infection surveillance system. Staff receive appropriate training on infection control and ensure education on reducing the transmission of infection is available to young people. There are facilities to ensure hand hygiene in all patient contact areas (alcohol based cleansers if washing facilities are not available) Staff promote hand hygiene and disposal of body fluid practices. Young people who are more susceptible to infection are identified and staff ensure practices minimise the risk to them, and educate them to protect themselves. Processes are established to ensure notification of infection where required by legislation.
M.3.5. The service identifies and addresses workplace health and safety issues to reduce illness and injury.	The service complies with occupational health and safety legislation, regulations and procedures. All staff are aware of their own and their employer's responsibilities for health and safety in the workplace.
M.3.6. There is a system for exception/significant event reporting and follow-up.	The service records all adverse, unplanned or untoward events, and ensures these are followed up appropriately. The service notifies appropriate statutory agencies of essential information in an accurate and timely manner.
M.3.7. Consumers receive medicines (including vaccinations) in a safe and timely manner that complies with current legislative and regulatory requirements.	The service has a system to manage safe and appropriate dispensing, administration, review, storage and disposal of medications – including vaccine cold chain, and MoH standards for immunisation providers.

M.4. Environmental protection standards

M.4.1. The service promotes conservation of the environment.	The service has systems for recycling and waste minimisation.

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APPENDIX ONE: Those involved in the consultation process to formulate these standards

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