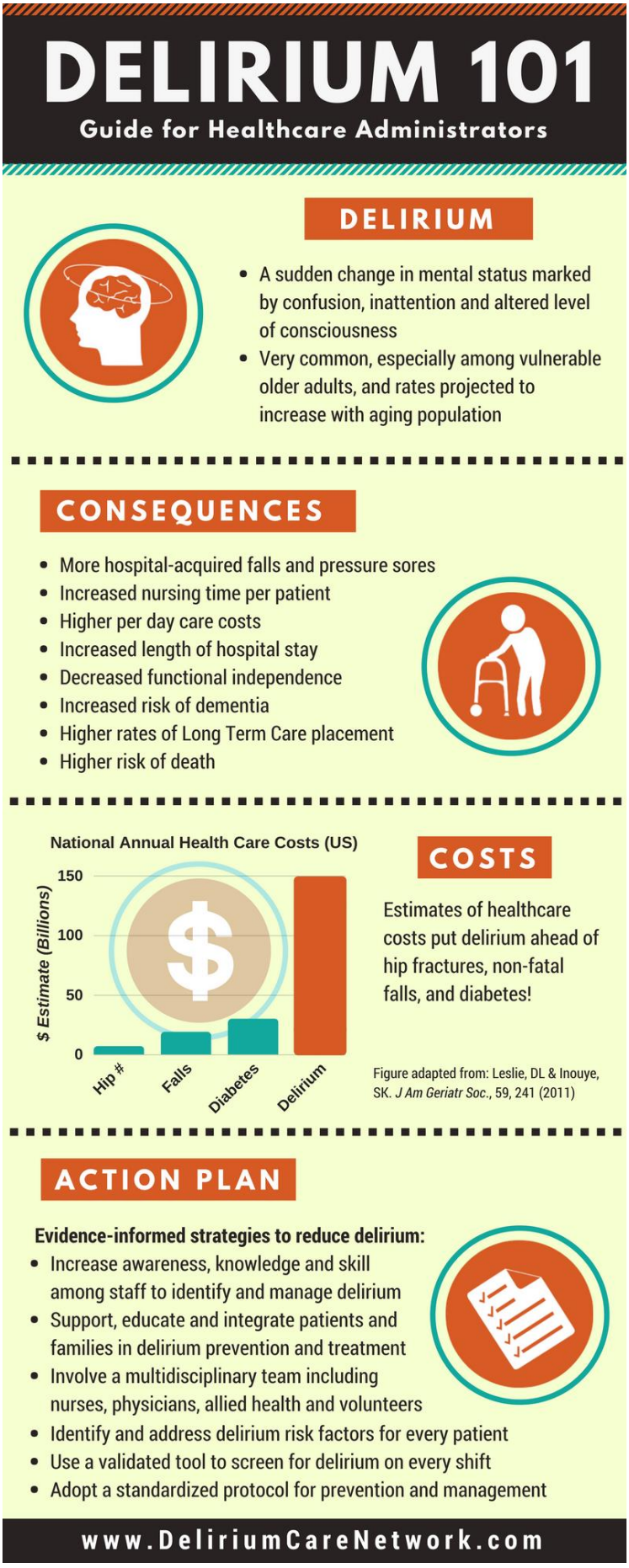
Delirium aware

INPATIENT CARE

SOUTH ISLAND ALLIANCE
best for people, best for system

A toolkit to facilitate quality improvement for hospital teams working with older people

Example resource: infographic From Delirium Care Network (see resource list)



INTRODUCTION

This brief resource is designed to help inpatient care teams working with older people to reflect on their approach and capabilities for delirium. It can help engage and encourage your team to think about what you are doing about delirium and how you can make improvements. It will help you to:

- Identify and celebrate what is working well,
- Help identify key areas and issues to take action,
- Focus on quality improvement, and
- Put delirium on the agenda, where it belongs!

In this document you will find:

- A reflection checklist to fill in (Tick the 'traffic light' for each item as a strength, in progress or needs work)
- An action plan form to record your team's priorities for change.

You will also find supporting material about

- Moving forward.
- General guidelines and implementation tips, and
- Links to further resources.

We encourage you to embrace the opportunity to mark World Delirium Day 13 March 2019 by reflecting on how your team "thinks delirium".

The UK's National Institute for Health and Clinical Excellence has identified three areas key to address for the successful implementation of best practice for delirium:

• creating a culture of delirium prevention

• raising awareness of delirium

• involving patients, relatives and care-partners in the process of delirium prevention and recognition.

This reflection will help you identify what your team is doing well now and what could be strengthened in each of these areas.

DELIRIUM PREVENTION

A third or more of delirium can be prevented. Simple interventions can help prevent delirium in older people who are at risk. The interventions are tailored to the patient's particular needs based on an assessment of the unique preventative risk factors that may contribute to each person developing a delirium.

Identifying people at risk of delirium

Do we know who is at risk for delirium?	We routinely assess risk of delirium when we admit older patients. Our staff know that delirium is more likely for people who have: – Cognitive impairment and/or dementia. – Severe illness, including mental illness and current hip fracture – Dehydration – Uncorrected vision impairment We also check for past episodes of delirium. We record in patient's notes that we have assessed their delirium risk. People are reviewed for any changes in their risk for delirium.
A strength **In progress** **Needs work**	Comments

Interventions to prevent delirium

Do we consider preventable factors for people at risk and adjust the care plan to minimise these factors?	Our staff know the preventable risk factors for delirium. e.g., Pain, Infection, Nutrition, Constipation, Hydration, Exercise, Sleep, Medication, Environment, and emotional needs Our staff understand that simple interventions can help prevent delirium. They know where to access guidance about these interventions. For patients at risk of delirium, we assess preventable risk factors and put in place tailored interventions to help prevent delirium. These are recorded in care plans. We look for ways to improve our systems of care to minimise risk factors.
A strength **In progress** **Needs work**	Comments

AWARENESS OF DELIRIUM

Early detection of delirium is important: it allows supportive care, prompt treatment of any reversible causes, and appropriate clinical decision making. It is important to assess for recent rapid or fluctuating changes in cognition, perception, function, and behaviour.

Recognising delirium

Do we know who has a delirium?	We routinely assess for current delirium when we admit older patients. We recognise that many of our older patients are at risk of developing delirium after admission due to cognitive impairment, severe illness, unresolved sensory impairment, and/or dehydration. For people who are at risk of delirium, our staff confidently monitor them for rapid changes or fluctuations in cognition, perception, physical function, and social behaviour. We have guidance available for staff about the changes that may indicate a person has a delirium. If staff or family are concerned that a patient has developed a delirium, our staff know how to request a clinical assessment. If delirium develops, we clearly document the diagnosis of delirium in patients' notes and communicate this diagnosis to those involved in the care of the patient.
A strength **In progress** **Needs work**	Comments

Responding to delirium

Do we manage delirium proactively?	For patients with a delirium, we identify possible reversible triggers and plan interventions e.g., Pain, Infection, Nutrition, Constipation, Hydration, Exercise, Sleep, Medication, Environment, and Emotional Stress. Our staff understand the possible experience of delirium and can confidently use techniques to help reduce distress or confrontation. We make sure that causes of distress are addressed before we consider giving any calming medication. We record this in patients' notes. We arrange reviews of any medications started during a delirium to see if people need to stay on them.
A strength **In progress** **Needs work**	Comments

Documenting delirium

Do we document who has delirium?	We recognise that what is recorded and communicated will affect clinical care. Our culture of care and systems ensure that the diagnosis of delirium is • Clearly documented in patients' notes and discharge summary, • Communicated with those involved in the patient's care, and • Coded in hospital records and if relevant, as an adverse event.
A strength **In progress** **Needs work**	Comments

Responding to delirium

Do we monitor and report on delirium as part of our quality processes?	We review our delirium care. We monitor how many of our clients are developing delirium. There is a formal system to identify the number of people with a diagnosis of delirium, and these figures are reviewed and reported. We look for possible improvements.
A strength **In progress** **Needs work**	Comments

INVOLVING PATIENTS, WHĀNAU, AND CARERS

The patient and their family, whānau, or care partners are an important resource in recognising signs of delirium, and helping tailor prevention and management intervention. Experiencing delirium can be upsetting, especially if the person experiences hallucinations or delusions, and we can help the patient and those that support them to understand the experience.

Involving patients and their support people

Do we involve patients and their support people in delirium awareness and recognition?	We provide information about how to reduce the risk of developing delirium. We invite family members and care partners of people at risk of delirium to let us know about any changes that may indicate a delirium. We involve the person and the family in tailoring and delivering delirium prevention interventions. Where there is delirium we involve the individual's support people to help ensure effective communication, reorientation, and reassurance. We provide them with information about how they can help. Staff know where to find written information to give to patients and their support people.
A strength **In progress** **Needs work**	Comments
Do we give patients with delirium and their support people information about delirium?	We routinely provide patients who have experienced delirium and their support people with written and verbal information that: • Explains that delirium is common and usually temporary, • Describes people's experiences of delirium, • Encourages the patient and their support people to tell their care, team about any sudden changes or fluctuations in behaviour, and • Encourages the person who has had delirium to share their experience.
A strength **In progress** **Needs work**	Comments

MOVING FOWARD

Who is going to drive this change?

Once your assessment has identified areas that could be strengthened, the next step is to identify specific actions for possible improvements, and who needs to be involved and how best to engage them. This will need effective communication and clear lines of leadership and responsibility.

How will you know the change is successful?

Ask yourself

- What are you trying to achieve?
- What would tell you that you had achieved it?
- What would you need to have in place to know you were making progress towards that aim?

These questions should help you identify what you need to measure and therefore what data you will need.

How will you share your progress?

Sharing good news stories is a great way to motivate, sustain positive changes, and even inspire new initiatives. Provide feedback to your teams and to management. Share your success through your facility and / or organisation's newsletters and development days. Consider a submission to excellence in care awards. What will you be able to share for World Delirium Day 2020?

The South Island Health of Older People Service Level Alliance (HOPSLA) welcomes feedback about the action plans you develop. We would love you to share your plans, challenges, and progress to encourage others.

DELIRIUM CAPABILITY ACTION PLAN

Action(s) to improve the service to meet the identified gap	**Date action decided** **Nominated lead**	**Deadline for action**	**How will you know the change is successful?**	**Progress** (actions in progress, changes in practices etc)

EXAMPLE RESOURCE: FROM SOUTH ISLAND ALLIANCE INFORMATION BROCHURE FOR OLDER PEOPLE (SEE RESOURCE LIST)

GUIDELINES AND TIPS FOR IMPLEMENTATION

Want to know more about delirium recommendations? Read on….

CREATING A CULTURE OF DELIRIUM PREVENTION

What do the international guidelines recommend?

Give a tailored multicomponent intervention package:

- Within 24 hours of admission, assess people at risk for clinical factors contributing to delirium.
- Based on the results of this assessment, provide a multicomponent intervention tailored to the person's individual needs and care setting.

The tailored multicomponent intervention package should be delivered by the whole care team, who will be trained and competent in delirium prevention. This will involve:

Address **pain**:

- Assess for pain.
- Look for non-verbal signs of pain, particularly in those with communication difficulties (e.g., because of advanced dementia or assisted ventilation). A tool such as the Abbey Pain Scale can be useful (see specific issues /tools resources list).
- Start and reviewing appropriate pain management in any person in whom pain is identified or suspected

Address **infection**:

- Look for and treat infections of all kinds.
- Avoid unnecessary urinary catheterisations.
- Implement infection control procedures.
- Manage aspiration risk - e.g., watch for swallowing problems, tilt bed for meals, and provide regular oral care.

Address poor **nutrition**:

- Ensure adequate nutritional intake.
- If people have dentures, ensure they fit properly.

Address **constipation**:

- Encourage fluids, fibre, mobility, and regular toileting.
- Provide laxatives of required.

Address **hydration**:

- Ensure adequate fluid intake by encouraging the person to drink and monitoring intake.
- If necessary, consider offering subcutaneous or intravenous fluids.
- Take advice if necessary when managing fluid balance in people with comorbidities that mean that fluid overload needs managing as well as dehydration (for example, heart failure or chronic kidney disease).

Address **exercise**, immobility or limited mobility:

- Encourage people to walk at least once a day –aim for three if possible. Provide appropriate walking aids if needed – these should be accessible at all times.
- Encourage all people, including those unable to walk, to carry out active range-of-motion exercises several times a day.

Promote good **sleep** patterns and sleep hygiene:

- Avoid nursing, medication rounds, or other carer interventions during sleeping hours, if possible.
- Reduce noise to a minimum during sleep periods.

Minimise **medication** related delirium:

- Carry out a medication review for people taking multiple drugs, taking into account both the type and number of medications.
- Avoid suddenly stopping longer term medications.

Address the **environment**:

Help orientate:

- Provide appropriate lighting and clear signage, and a clock and a calendar that is easily visible.
- Encourage all staff to talk to the person to re-orientate them during every interaction, by explaining where the patient is are, who the staff member is, and what the staff member's role is.
- Avoid changing patients' bedrooms unless it is absolutely necessary.
- Consistently assign staff to help ensure that the patient is cared for by someone who is familiar to them.

Use sensory aids:

- Resolve any reversible cause of the impairment, such as impacted ear wax.
- Ensure hearing and visual aids are available and used by people who need them, and that they are in good working order, every shift, every day.

Engage

- Encourage and enable a range of meaningful activities / cognitively stimulating activities (for example, reminiscence).
- Facilitate regular visits from family and friends.

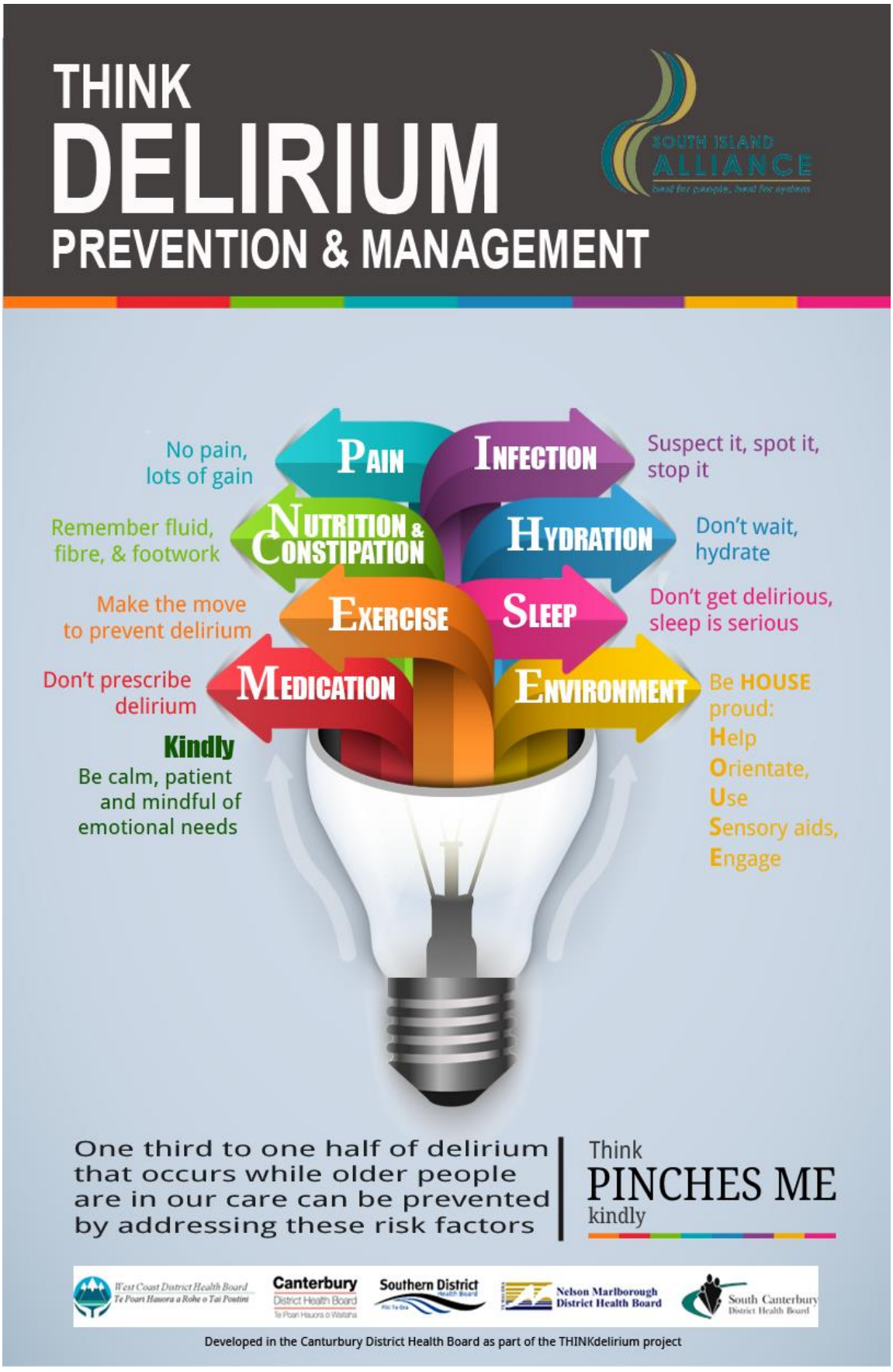
Also assess for hypoxia and good glycaemic control, as clinically appropriate.

Provide person-centred care that is calm, patient and mindful of emotional needs.

Delirium prevention: Implementation tips

- The aim is to create a culture of care where delirium prevention is the expected standard of care.
- Increase the number of staff trained and competent in delirium prevention. Encourage all staff to attend training to raise their awareness to 'Think delirium' and to educate them on actions to prevent delirium. Help them to see how this might look in day to day practice.
- Encourage access and awareness of delirium prevention resources.
- Review the care plan documentation to ensure that it includes the assessment and documentation of risk factors such as pain, infection, nutrition, constipation, hydration, exercise, sleep, medication, environment, and emotional needs and the interventions that will be put in place. Encourage staff to be alert for any changes in the risk factors for delirium.
- Think about specific ways to minimise the preventable risk factors in your environment.
- Promote a rehabilitative approach to care that involves encouraging patients to be up and moving regularly.
- Consider identifying delirium champions – staff who are trained, competent, and passionate about delirium prevention and can be accessible to others in the facility.
- Think broadly to ensure everyone is on board. For example, consider the documentation / orientation resources given to 'bureau' staff and the staff delivering food and drinks.
- Assess patients for risk factors of delirium at admission.
- Establish regular peer review meetings to examine risk assessment and patient care. Discuss patients with risk factors for delirium to identify how care can be improved.
- Monitor the care provided to patients at risk of delirium.

EXAMPLE RESOURCE –THINKDELIRIUM POSTER (SEE RESOURCE LIST FOR LINK)



RAISING AWARENESS OF DELIRIUM WHEN IT OCCURS

What do the international guidelines recommend?

- Formally assess people thought to possibly have or to be at risk of delirium for recent (within hours or days) changes or fluctuations in behaviour.
- These changes may be reported by the person at risk, or a carer or relative.
- The behaviour changes may relate to cognitive function, perception, physical function or social behaviour.
- If these indicators of delirium are present, a trained healthcare professional should carry out a clinical assessment to confirm diagnosis.
- Observe, at least daily, all people in your care for recent changes or fluctuations in behaviour.
- If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, treat for delirium first.
- Document the diagnosis.

Implementation tips

- Provide clear guidance and support for expectations and processes around detecting and diagnosing delirium
- Set aside time for delirium awareness training and make sure staff know where they can access guidance on what to look for to recognise delirium.
- All care staff should be aware of what indicators to look for and who to approach if they suspect delirium (for example see Don't Discount Delirium, figure 3 and in resources).
- Have systems that encourage staff to observe for changes or fluctuations in usual behaviour (within hours or days) each day for people at risk. Ensure that staff are aware that changes may also be reported by the person at risk, or a carer or relative who may knowledge of the person to recognise these changes.

- Have clear responsibility for assessing indicators of delirium for every new patient who is admitted. The 4AT is designed to be used by any health professional at admission, and at other times when delirium is suspected (see see specific tools/ issues resource list).

- It is useful to 'Name it': use the word delirium and get everyone thinking about delirium.

- Ensure that the diagnosis of delirium is clearly documented in people's notes and is communicated to the care team, and (if relevant) is included in discharge letters or transfer documentation.

- Back up awareness-raising initiatives with a robust pathway of care for those diagnosed with delirium, including continued attention to the preventable risk factors.

- For medical management: if a pharmacological response is deemed appropriate for an individual with delirium as part of the broader care plan after attempting to relieve causes of distress, ensure that a review of this medication is scheduled.

- Monitor the outcomes for patients who have been recorded as having delirium. Use the results of these audits to support initiatives to enhance quality of care. Look at trends over time. Monitoring, measures and reporting can help to raise awareness.

EXAMPLE RESOURCE – PART OF DON'T DISCOUNT DELIRIUM PACKAGE, ROYAL COLLEGE OF NURSING, UK (SEE RESOURCE LIST FOR LINK)

Don't Discount Delirium

Supported by

Royal College of Nursing

Any person can get delirium, but it is more common when a person is older, has cognitive or sensory impairment or is very ill. You can make a difference if you recognise delirium early and escalate it.

Just look for a change in:

AROUSAL (AWAKENESS)	THINKING	PERCEPTION	FUNCTION	BEHAVIOUR
More sleepy than usual	Poor concentration	Seeing things	Less mobility	Refusing to co-operate
More alert or active than usual	Slow responses	Hearing things	Less movement	Withdrawn
Hard to wake up	More confused	Paranoid	Restless/agitated	Change in attitude
			Not eating	Change in communication
			Sleep problems	

ACT IF YOU SUSPECT DELIRIUM – TELL SOMEONE IMMEDIATELY

August 2017 Publication code: 006 015

Don't Discount Delirium

Supported by

Royal College of Nursing

Delirium Escalation Plan

This is not a strategy but a local escalation plan which provides you and your team with instructions regarding what to do if delirium is suspected. Remember to check if your organisation has an existing delirium strategy in place.

Client group:

Circumstances:

What to do/who to contact:

ACT IF YOU SUSPECT DELIRIUM - TELL SOMEONE IMMEDIATELY

September 2017 Publication code: 006 348

INVOLVING PATIENTS, WHĀNAU, AND CARE PARTNERS

What do the international guidelines recommend?

- Offer information to people who are at risk of delirium or who have delirium, and their family and/or care partners that:
    - Informs them about delirium.
    - Encourages people at risk and their families and/or care partners to tell their healthcare team about any sudden changes or fluctuations in behaviour, and
    - Provides guidance on how they can help.

- Utilise support people as a resource for information, and for helping to reduce preventable risk factors.

- Where there is delirium, consider involving family, friends and carers to help ensure effective communication, reorientation and provide reassurance.

Implementation tips

- Involve patients, their family /whānau /care-partner in gathering information for the assessment of delirium risk or diagnosis. Involve them in the delivery of the prevention interventions and in planning treatment for patients with delirium.
- Have written information for those supporting people at risk of delirium about how they can be involved in helping to prevent and recognize delirium. Checkout the resources for older people and for support whānau / care partners in the resources list.
- Support the written information with verbal education / discussion.
- Make time to discuss needs and preferences in relation to their own care with patients, their family /whānau and other care partners. Use the expertise and knowledge of carer

partners of people living with dementia: Talk with carers, Obtain information, Personalise care and develop strategies. This structured in the TOP 5 tool (see specific tools/ issues section in the resource list for link). The top 5 tool questions are also integrated in the South Island Alliance brochure for family / whānau / care-partners (see the resource list for link).

- Document helpful information gained though discussions in the individual's notes and share them with the team.
- Take a look at your facility's visiting policies and culture and identify any changes that would enhance the involvement of relatives and care partners in the care of your facility's patients.
- Commission patient and family /whānau /care-partner satisfaction surveys to assess the care environment and quality of care.
- Offer information to people who have had delirium and the family / whānau / support-partner of people who are experiencing delirium to explain delirium and how to help support someone with delirium. Checkout the resources in the resources list.

RESOURCES

In this section you will find links to helpful free resources. (Click on links to go to resources online)

[R] Registration required

[P] Permission to use may be required

EDUCATION

The South Island online Healthlearn platform has a new delirium course based on the THINKdelirium resource - Fundamental Series: Delirium RGMD009 . The course covers What is Delirium? How do we prevent? How do we assess for delirium? How do we manage it? Any South Island DHB staff member can access Healthlearn for free. [R]

https://www.healthlearn.ac.nz/

EXAMPLES OF DELIRIUM ACTION PLANS

Counties Manakau DHB's "20,000 days"

http://koawatea.co.nz/wp-content/uploads/2014/01/20600-20000days-Delirium_HRonline.pdf

Waitemata DHB's delirium quality initiative

http://2012.qualityaccounts.health.nz/quality-initiatives/reducing-harm/stories/type/view/storyid/22

PREVENTION / ADDRESSING RISK FACTORS

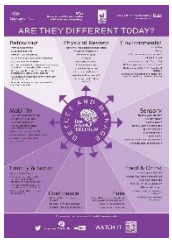
STOP DELIRIUM!

The Stop delirium project, from the European Delirium Association, has supporting materials available including seven 'pathway' handouts for different risk factors and a video.

http://www.europeandeliriumassociation.com/stop-delirium-project_teaching-material.html

A South Island Alliance booklet of tips for hospital staff is available. (The original booklet was developed in the CDHB as part of the THINKdelirium project).

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/



Are they different today? This poster summarising recommendations for addressing risk factors was developed in residential care by a collaboration from Tees in the UK.

https://pbs.twimg.com/media/DVJN9HoX4AYT2f7.jpg

The South Island Alliance THINK delirium poster is available to download (The original poster was developed in the CDHB as part of the THINKdelirium project)

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/

AWARENESS

NICE, UK, has a range of resources to support their guidelines [P for reproducing]

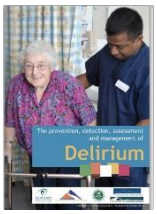
https://www.nice.org.uk/guidance/cg103/resources

"Don't discount delirium", Royal Nursing College of Nursing, has supporting resources including leaflets, poster, and delirium champion information [R]

https://www.rcn.org.uk/clinical-topics/older-people/delirium/delirium-champion

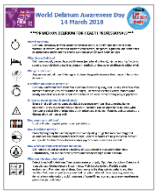
The Delirium Awareness Video (#icanpreventdelirium) is a 5 minute video based on the experience of an individual with delirium with information about recognition and management. "Don't discount delirium" (above) has some suggested discussion questions for this [R].

https://www.youtube.com/watch?v=BPfZgBmcQB8



Midland DHBs, led by Waikato DHB, have made their user friendly guide "The prevention, assessment, and management of delirium" available

https://www.healthnavigator.org.nz/health-a-z/d/delirium/#Clinicians



The World Delirium Day webpage has a downloadable poster

http://www.idelirium.org/

Delirium 101 infographic from the Delirium Care Network. A fabulous website of visual resources.

https://www.deliriumcarenetwork.com/infographics.html/

INVOLVING PATIENTS, WHĀNAU, AND CARERS

A South Island Alliance brochure is available to help you involve and educate the family of inpatients while in hospital called "Preventing delirium while in hospital: Tips for family, whānau, and friends".

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/

A South Island Alliance brochure is available to help you involve and educate the family of patients in the community or aged care called "Understanding and preventing delirium in older people: Tips for family, whānau, and friends".

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/

A South Island Alliance brochure for giving to older people themselves for community or ARC settings: Tips for older people to help prevent delirium.

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/

SPECIFIC ISSUES / TOOLS

SCREENING FOR SUSPECTED DELIRIUM: THE 4AT

The 4AT is a tool that can be used to screen for delirium.

https://www.the4at.com/

The Think Delirium toolkit from Health Improvement Scotland provides guidance on the 4AT.

http://www.knowledge.scot.nhs.uk/improvingcareforolderpeople/resources.aspx

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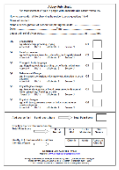
PAIN



The Abbey pain scale can be a useful measure of pain when someone is not able to talk.

http://www.grpcc.com.au/wp-content/uploads/2016/05/Abbey-Pain-Scale.png

The See change think pain campaign has a 4 minute video on better pain recognition.

https://youtu.be/EYCpPkblvzk

The Social Care Institute of Excellence, UK, has an overview and [R] a case study activity.

https://www.scie.org.uk/dementia/advanced-dementia-and-end-of-life-care/end-of-life-care/pain.asp

KNOWING THE PERSON LIVING WITH DEMENTIA

TOP 5: This is a well evaluated Australian initiative to gather simple information from carers of people living with dementia to help reduce distress. It is available as toolkits for hospitals, residential care facilities, and hospitals

http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/person-centred-care/top5

The sunflower chart records background information about the individual on a single sheet. See:

https://edu.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Pages/default.aspx

Alzheimer's UK offers a "This is me" booklet.

https://www.alzheimers.org.uk/download/downloads/id/3423/this_is_me.pdf

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EVIDENCE BASE

There is a huge research literature on delirium. Some useful reviews that are openly accessible are provided below.

OVERVIEW

NICE supporting evidence (to 2011) and evidence update (2014)

https://www.nice.org.uk/guidance/cg103/evidence

PREVENTION

Hshieh, T. T., Yue, J., Oh, E., Puelle, M., Dowal, S., Travison, T., & Inouye, S. K. (2015). Effectiveness of multicomponent nonpharmacological delirium interventions: a meta-analysis. *JAMA Internal Medicine, 175*(4), 512-520.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4388802/

Martinez, F., Tobar, C., & Hill, N. (2015). Preventing delirium: Should non-pharmacological, multicomponent interventions be used? A systematic review and meta-analysis of the literature. *Age and Ageing, 44*(2), 196-204.

https://academic.oup.com/ageing/article/44/2/196/93749

MANAGEMENT

Oh, E.S., Fong, T.G., Hshieh, T.T., & Inouye, S.K. (2017) Delirium in older persons advances in diagnosis and treatment. *JAMA, 318*(12):1161-1174.

bit.ly/2hwF3vj

British Geriatrics Society Comprehensive Geriatric Assessment (CGA) Toolkit: Acute confusion / delirium

https://www.bgs.org.uk/resources/resource-series/comprehensive-geriatric-assessment-toolkit-for-primary-care-practitioners

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FINDING MORE

Delirium Bibliography: the Hospital Elder Life Program has a searchable index of over 2,000 delirium-related research articles, updated on a monthly basis. It is primarily intended for clinicians and researchers.

http://www.hospitalelderlifeprogram.org/for-clinicians/bibliography/

SOUTH ISLAND ALLIANCE
best for people, best for system

Gee, S., Large, J., Croucher, M. and Whitehead, A. (2019). Delirium aware inpatient care. A toolkit to facilitate quality improvement for hospital teams working with older people. Christchurch, NZ: South Island Alliance.

This booklet was developed for the South Island Alliance. It is intended to provide general information and is not a substitute for individual clinical advice.

This brochure is available to download:

https://www.sialliance.health.nz/our-priorities/health-of-older-people/useful-resources/

Acknowledgements

We gratefully acknowledge valuable comments on the draft from Health of Older People Service Level Alliance, Palliative Care Service Level Alliance, and individuals / delirium groups from each South Island DHB.

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National Institute for Clinical Excellence, UK (NICE)

East Midlands Health and Science Network.

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Christchurch, New Zealand.

West Coast District Health Board Te Poari Hauora a Rohe o Tai Poutini
Canterbury District Health Board Te Poari Hauora o Waitaha
Southern District Health Board Hāpai Te Ora
Nelson Marlborough District Health Board
South Canterbury District Health Board