# Hokianga Health Enterprise Trust

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Hokianga Health Enterprise Trust

**Premises audited:** Hokianga Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services

**Dates of audit:** Start date: 16 July 2014 End date: 17 July 2014

**Proposed changes to current services (if any):** Nil

**Total beds occupied across all premises included in the audit on the first day of the audit:** 17

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Hokianga Hospital Enterprise Trust provides medical, maternity and residential aged related care services for up to 24 clients via Hauora Hokianga (Hokianga Health). On the first day of this audit 17 clients were receiving services in this facility. This included clients in the maternity service, medical service and hospital geriatric services. There are no clients receiving rest home care at the time of audit. Hauora Hokianga is recognised as being a Māori health provider.

There have been no significant changes to the land and facility since the last audit, with the exception of relocation of the facility’s workshop and installation of new water supply tanks.

This certification audit was conducted against the Health and Disability Services Standards. The audit process included the review of policies and procedures, review of clients’ files, review of staff files, observations, and interviews with clients, family members, staff (including medical practitioners), management, and a representative of the board of trustees.

The chief executive officer is appropriately experienced for the role. There is a coordinated quality and risk programme that is implemented. Feedback from clients and family members is very positive about all aspects of the care and services provided.

The audit identified eleven areas for improvement required to meet these standards. These include: ensuring policies and procedures are sufficiently detailed and current; providing evidence that staff reference checks and interviews have occurred; improving the orientation programme; documenting the rostering requirements; and archiving/tracking of clinical records. Ensuring care plans are sufficiently detailed; that timely and appropriate evaluations are occurring by registered nurses for clients in the maternity service; medication management practices; monitoring of antimicrobial use; and management of restraint also require improvement.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained |

Staff are knowledgeable about client rights and rights are protected, including the right to privacy. Clients’ values and beliefs are respected. Services are particularly effective in supporting the needs of Māori clients. Clients are kept safe from discrimination, harassment, and coercion.

There is an environment which supports good practice. Communication with clients is of a high standard. Interpreter services are available by telephone. Clients are supported to have an advocate of their choice and links to whānau and community services are supported

Clients and family members are aware of a complaint process should they wish to make a complaint. Complaints are investigated and responded to in a timely manner.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The Hokianga Health Enterprise Trust vision, mission and values are well integrated into strategic and business planning. Evaluation of how the vision, mission and values are implemented is monitored by the management team and board of trustees meetings. The chief executive officer has been in the role since 2001 and prior to this was employed as the finance manager.

The quality and risk programme includes compliments and complaints, client surveys, incident management, internal audits and undertaking quality projects. Where areas for improvement are identified, improvements are planned, and implemented. Policies and procedures are available for staff; however, not all policies/procedures are sufficiently detailed or current and document control processes require review. The organisation’s hazards and risks are regularly reviewed and strategies implemented to mitigate these. Hokianga Health continues to meet the Accident Compensation Corporation (ACC) requirements for workplace safety at tertiary level. The organisation benchmarks a range of aged related care indicators with other residential aged care facilities in Northland. Quality and risk topics are communicated at various meetings including the health and safety committee, executive meeting, clinical governance committee and staff/department meetings.

Recruitment and human resources policies detail the recruitment process and these align with current accepted practice. Records are not consistently maintained to demonstrate that reference checks and interviews are conducted. This requires improvement. Orientation of new staff occurs and staff feel well supported. Records of orientation are not consistently retained to provide evidence that staff have completed any role or department specific orientation, and the requirements for registered nurses providing services in the maternity unit are not sufficiently detailed. Performance appraisals occur annually for staff. The ongoing education programme is comprehensive and appropriate to the service.

While the service can identify how staffing is planned to determine staffing numbers and skill mix, this has not been documented and requires improvement.

Clinical records are appropriately detailed and meet current accepted standards. Some improvements are required in relation to archiving and tracking processes.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Information is available regarding services. There is no declined entry.

Care is undertaken by suitably qualified and experienced staff. Service is provided in a timely manner with a strong team approach to care. Clinical assessments are conducted efficiently.

Care plans do not include goals are not sufficiently documented in some case in the medical service. In maternity there is no system to record postnatal care plans and plans are not reliably recorded. This is an area for improvement. Service delivery and activities management are of a high standard.

Evaluations in medical and long term care are consistently completed and are timely. In maternity there are long periods overnight with minimal observation of postnatal clients and this is an area for improvement.

Referral to other services is supported. Transfer and discharge are managed appropriately.

Medicines management meets standards with some exceptions related to monitoring of ambient room temperatures, security of medication in the treatment room and some prescribing practises. Improvements are also required in relation to management of prescribing of Vitamin K for infants and uterotonics for maternity clients, weekly checking of controlled drugs and medicines reconciliation.

Food services are of a high standard and are enjoyed by clients. Individual client’s dietary needs are identified and met.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

There are policies and procedures which guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment are readily available in all areas. The facility manager and another staff member have an approved handling certificate for hazardous substances. Chemicals are stored securely.

The building has a current building warrant of fitness. Clinical and electrical equipment show evidence of current calibration. The sterilisers have evidence of current validation. A detailed maintenance schedule is documented and implemented. The temperature of hot water is verified during audit as being within required parameters.

The security arrangements are appropriate and include use of security cameras.

Fifteen rooms are single occupancy, three rooms are double occupancy and one room has four beds. Four client rooms have full ensuite. Personal space is sufficient for clients, including those mobilising with equipment, or who require staff assistance. The ambient temperature is adjustable to facilitate client comfort.

Smoking is allowed in designated outside areas only.

Environmental cleaning and laundering of client’s personal clothing is provided by staff. Hospital linen is washed off site by contractors.

Emergency policies and procedures cover civil defence and medical emergencies. Clinical staff receive training in managing emergencies and this includes cardiopulmonary resuscitation, fire and other emergencies. The fire evacuation plan has been approved by the New Zealand Fire Service. Fire evacuation drills are being conducted at least six monthly. There are sufficient utilities (including a generator, and water supply) on site for use in the event of an emergency. New water tanks have been installed in the week prior to audit.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk. |

Restraint use is minimised. The use of restraint or enablers is detailed in individual client’s care plans. Forms are present to ensure assessments are conducted appropriately and consent obtained. One resident has bedrails in use to minimise risks of falling out of bed. The client is not competent in decision making and has a current care plan, assessment and consent (signed by a family member) on file. The use of bedrails has been evaluated.

Improvements are required to ensuring monitoring of restraint when in use is occurring as required and that the organisation review of restraint and enablers includes all required components to meet these standards.

Staff are provided with training on restraint and enabler use.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control programme is updated annually. The programme is overseen by senior nursing staff. A recently appointed infection control nurse is supported by experienced staff with access to expertise at from DHB IP&C nurse specialist. Policy guidance is sufficient for the programme. Education is appropriate to the service. An active audit programme is undertaken including surveillance of infections. Policy includes guidance and audit requirements for antimicrobial prescribing, however no evidence was provided at audit of antimicrobial monitoring. This is an area for improvement.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 41 | 0 | 7 | 3 | 0 | 0 |
| **Criteria** | 0 | 92 | 0 | 7 | 4 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Hokianga Health Enterprise Trust provides services in accordance with consumer rights legislation. Clients and whānau (family) interviewed in aged care, medical (acute) and maternity services reported high levels of satisfaction with respect for their rights. Staff and managers interviewed, observation at audit and review of clinical records show that staff are knowledgeable about their responsibilities in regard to client rights. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Clients and whānau (family) in all service streams reported that their consent was sought for all care provided and that their decisions are respected. Staff were knowledgeable about consent processes. Written consent is understood and gained where required.  Care of body parts, for example whenua (placentae), in the maternity service, are stored and returned according to policy and as requested by whānau (families).  There is a standard form entitled “Statement of Dignity” to record the wishes of clients in regard to future treatment (advance directives) and clients and whānau (family) indicated at interview that they are confident their wishes will be respected. There are differing understandings amongst staff as to how advance directive should be discussed and recorded. Policy guidance and the format used do not facilitate clear documentation of the client’s wishes. It is recommended that the process for management of advance directives be reviewed using a current best practice approach, however there is sufficient evidence that the standard is met. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Clients and whānau (family) in all service streams reported that the service is supportive of their right to advocacy and presence of advocates as desired. Staff interviewed understand the rights of clients in regard to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | There is a strong culture within the organisation of integration with community based services and of whānau involvement. Clients and whānau (family) in all service streams state they are given information about community services and are supported to maintain links with whānau (family) and community. Clinical records reviewed showed planning for maintaining whānau and community links. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Information about how to make a complaint is easily accessible to clients. Complaints, suggestion and compliments forms are located throughout the hospital. Complaints are received both verbally and in writing. Any complaint received is managed in a sensitive and timely manner and the process meets the requirements of the Code and the hospital’s policy.  The complaints register and a sample of complaints were reviewed and discussed with the chief executive officer (CEO). This demonstrated that complaints are followed up and improvements are made, where required in a timely manner. The actions undertaken in response to complaints are documented and includes when the complaint was closed. A complaint received via the Health and Disability Commissioner (HDC) in 2014 has been closed by the HDC with no action required by the organisation and documentation of this was sighted. Another HDC complaint received in 2015 is also reported to have been closed with no action required.  The clients and relatives interviewed were aware of their right to make a complaint should they wish too. The staff and managers interviewed were able to explain their responsibilities in the event a patient or family member makes a complaint. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Clients and whānau (family) interviewed in all service streams indicated that information about rights was provided and that there is a supportive environment to discuss all aspects of care, including rights. Information about the Nationwide Health and Disability Advocacy Service is accessible. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Clients and whānau (family) in all service streams reported that the service is respectful of all aspects of their privacy. This includes a consumer in a shared room. Clients, (whānau) family and staff members are complementary about the care provider responsiveness towards needs, values and beliefs. Clinical records reviewed are written in a manner which is sensitive and respectful of individual values.  Maintaining independence is reported as being a priority by clients, whānau (family) and staff. This is particularly evident in the documentation regarding the recuperation of a medical client and the documentation and family comments for a long term care client with challenges to independence.  Staff, family and clients indicated that the service takes care to keep clients safe. There is a policy for protection from abuse and neglect, issued in November 2014. The manager states staff are in the process of completing training for screening for and management of family violence. The process is not yet reliably occurring in all service streams (refer criterion 1.3.5.3). |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | A particular strength of Hokianga Health is the commitment to tikanga Māori and support of Māori clients and whānau (family). Clients and family in all service streams were highly complementary about the support of their needs as Māori and of the importance of whānau involvement. Observations at audit showed consistently that the principles of Te Tiriti o Waitangi are practised and that tikanga Māori is lived in everyday interactions between staff, clients, whānau and visitors to the service with warm greetings and use of te reo Māori observed.  The organisation of services supports presence of whānau, including accommodating whānau overnight in the maternity unit. Planning of care is orientated toward a Te Ao Māori (Māori World) view. For example, in medical services the template is based on a tikanga Māori perspective. There is a team of three specialist Kaiāwhina who support and educate staff, using the ‘Te Pu o te Wheke’ teaching model and ‘Takarangi’ competency framework. Staff are required to participate in cultural education. Hokianga Health has a kotahitanga (all inclusive), ‘all of community’ approach to health care and promotion of health. Kaiāwhina are active within hospital services and in the wider community. Community health initiatives include researching and facilitating public health improvements, such as water supply, sewage and power services.  A marae is located on site. All new employees are given a pōwhiri to welcome them into the organisation and community. This helps lay the foundation for new staff to understand the cultural aspects of services. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Interviews with clients, whānau (family) and staff show that clients and their whānau (family) are consulted about their individual values and beliefs. Clinical records include ethnic/cultural/spiritual/religious needs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Clients and whānau (family) interviewed stated that they have not experienced any form of discrimination, coercion, harassment or exploitation. Service providers interviewed and observed showed a commitment towards safe and equitable services. A code of conduct details the conduct expected by staff. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are aspects of services which support a good practice environment. Staff reported that they are supported to attend clinical education. Staff, managers, clients and whānau (family) reported an open collaborative approach to care, which enhances the practice environment. Open supportive staff communication was observed at audit.  Doctors and midwives in the maternity service particularly state that the supportive working environment facilitates good maternity practice in the isolated rural situation. The physical environment is well organised in all areas, well equipped and suited to provision of high standard of care. There are strong links with the Northland DHB (NDHB) facilitating information flow regarding current best practice. Policy guidance requires further clarification in some instances to support the practice environment (refer criterion 1.2.3.4). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Clients and family members in all service streams comment positively about the excellence of communication regarding care. Staff and managers interviewed understand their responsibilities for full and frank information and for open disclosure. A whānau member in long term aged care discussed an incident where staff reported an accident to her in a timely manner.  Staff and managers reported that interpreter services by phone are available as required. The interpreter contact details are located at the front reception. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There is an annual health and business plan for Hokianga Health Enterprise Trust (HHET) for the period ending 30 June 2016 and this was sighted. This detailed the organisations vision, mission and philosophy and the model of care. HHET is a registered charitable trust (formed in May 1992). The board of trustees comprises elected community, Iwi, and staff representatives. Additional members can be co-opted by the board to address ethnic, geographic or skills imbalance. The board of trustees meets monthly. A number of sub committees meet to discuss/plan specific issues. A member of the BOT was interviewed and advises all decisions are made by the whole board. Monitoring the progress in achieving the business/strategic plan is undertaken via the regular reports that members of the management team are required to provide prior to each meeting.  There is a strategic plan for 2015-2020 which details the focus for the annual plans for each year. Specific actions are detailed for the year.  The plan references the Northland Heath Service Plan (NHSP) that sets out the direction for the Northland health sector. Objectives are also aligned with that of Te Tai Tokerau Primary Health Organisation (TTTPHO) of which Hauora Hokianga is a member. The trust is also a member of Te Pū o Te Wheke Whānau Ora (TPOTW) alliance.  The annual plan includes references and commitment to the provision of culturally appropriate care and the principals of the Te Tiriti o Waitangi.  The governance and reporting lines are clearly detailed in an organisation chart.  The chief executive officer has worked at Hokianga Health (HH) since 1994, initially in the role of finance manager and moving to the role of CEO (in addition to finance manager) in 2001. The CEO role and responsibilities are documented in the CEO position description. The CEO performance is reviewed formally by representatives of the board and this is verified in documents sighted.  The hospital services manager (HSM) is a registered nurse and a registered midwife. She commenced at Hokianga Health in 2005 and was appointed to the HSM role in 2006. The HSM participates in relevant ongoing education relevant to the role. This includes completing the training and competency requirements for the interRAI assessment process. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The administration manager performs the CEO’s role in the absence of the CEO. The administration manager has worked at Hokianga Hospital since 1993, initially as an administrator and then as the administration manager in 2001. The administration manager is very familiar with the payroll, finance, human resources, administration and quality systems, and confirms expectations when covering the CEO’s duties are clear. The administration manager works with the medical director and hospital services manager for clinical issues as applicable. The administration manager and CEO advise that staff are informed when the CEO has a planned absence. The administration manager wrote the monthly report for the board in the CEO’s recent absence, as sighted during audit. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The quality policy details a commitment to providing high quality service that reflects best practice and encourages continuous improvement. The quality policy notes that action will be taken to address areas for improvement within an appropriate timeframe. The responsibility for quality is that of each individual staff member as well as the executive, the trust and quality officer.  Quality and risk topics and associated plans are discussed at a variety of meetings, including board of trustee meetings, executive committee meetings, health and safety meetings, the clinical governance committee and ward/department meetings. Number, details and trends for incidents/accidents and infections are discussed at the health and safety meeting. Complaint management is overseen by the CEO directly.  The document control policy details the framework for policy development, review (at least biennially), formatting, approval, archiving, distribution and communication of changes. A designated staff member is responsible for document control processes. A number of policies are overdue for review, some policies are not sufficiently detailed to guide staff practice, and document control processes require review.  Internal audits are scheduled, conducted and the results and follow-up plans communicated to staff at department meetings. Issues are also followed up with individual staff where applicable.  The HSM is contributing data from a range of accidents and incidents within the long term care service to a benchmarking programme that has been developed by Northland DHB. Six aged residential care facilities are currently sharing information. This includes policies/procedures and rates of events/accidents and infections (per 1000 occupied bed days). Information on quality improvement programmes that are making a difference in individual facilities is shared. The HSM advises the communication and collaboration is valuable, along with being able to identify what systems can be reviewed in the event Hokianga Health reported rates is significantly different to the other facilities.  Hokianga Health continues to meet the Accident Compensation Corporation (ACC) Workplace Safety Management Practice Programme (tertiary level) requirements. The current certificate of achievement had just been received by the reorganisation from the recent re-audit.  Client satisfaction surveys are conducted. The food services satisfaction survey, residential care client satisfaction survey, and community day centre (activities programme) satisfaction survey were conducted in September 2014. Some recommendations were made by clients in relation to the food survey (likes/dislikes and temperature of food items. The results are very positive and on all aspects surveyed, including the environment, cleanliness, choice, informed consent, timeliness of services, and availability of cultural supports, privacy and components related to staffing.  The business and strategic plan includes risk management. Risks are categorised as financial, staffing and quality. Ongoing review of risk is occurring and is included in the CEO’s monthly report to the board of trustees, discussions at the executive committee and clinical governance committee. Risks are mitigated and recent examples includes the installation of new water tanks following a regional drought (April 2014), upgrading of other utility infrastructure/systems and the need to upgrade the facilities in one of the community clinics. Contract and financial risks are actively monitored. Relevant risks are also communicated to the community via the community newsletters. Hokianga Health has participated in emergency scenario exercises related to Ebola and a community event, involving methamphetamine, since the last audit.  The occupational health policy details staff and the organisation’s responsibilities for the reporting and management of hazards. Department by department environmental audits are conducted and new hazards identified and mitigation strategies implemented. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Policies detail staff and managers’ responsibilities for the reporting and follow-up of incidents. Staff report incidents via their line manager. Staff interviewed could detail the type of events that require reporting and the reporting process. Items that are to be reported include (but are not limited to) medication errors, falls, skin tears, bruises, pressure areas, episodes of aggression, absconding, or staff injuries. Investigations are conducted and interventions undertaken as required. This is evidenced in the six incident reports sampled during audit for events, including aggression, fall with an injury, mediation errors and falls with no associated injury. A data base is maintained for reported events and this details the incident’s identification number (unique for each incident), the date and time, category of event, location within the hospital where the event took place, description of the event and suggestions for improvement. The data base notes if the complaint is open or closed. Discussion on incidents/accidents is seen to have occurred in the health and safety committee minutes and some executive meeting minutes.  Events reported for the long term care clients are benchmarked with six other residential care facilities (refer 1.2.3).  The CEO and the administration manager are able to detail the type of events that require external notification to meet contractual and legislative requirements. There have been no reported events with the exception of reporting to the NDHB representative when the Hokianga Health Hospital is near or at full occupancy. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | Policies detail the process that is required related to human resources practices. The policy aligns with current accepted practice. Records are not consistently available to evidence that reference checks and interviews have been conducted. Annual practising certificates for registered health professionals are monitored by the quality facilitator and were current at the time of audit. A process is implemented to ensure these are reviewed in a timely manner.  Staff confirmed they are provided with an orientation to Hokianga Health and to their individual role and responsibilities. Records, however, are not consistently available to evidence that department specific orientation has been completed. The orientation programme is not sufficiently detailed to prepare registered nurses on their responsibilities in the care of clients and infants in the maternity unit.  Staff have annual performance appraisals. This process is called ‘touchdowns’ and occur with the line managers. ‘Touchdowns’ have occurred within the last year for staff employed more than 12 months whose file was reviewed during audit. Staff report the process is positive and includes opportunity to identify ongoing learning needs.  Medical specialists working at Hokianga Health have recently undergone an external medical credentialing programme with the chief medical officer at Whangarei Hospital and the clinical leader at the Bay of Islands Hospital. The report for their visit (on the 22 May 2015) was positive and confirmed that the medical practitioners have been credentialed. Very positive feedback was provided about the integrated model of care provided for patients across the inpatient and community services. Medical practitioners are allocated 10 days each per year for participating in relevant ongoing education. All applications for funding are reported to have been approved by the board to-date. The credentialing report notes the medical practitioners also care for patients in the maternity unit. Organisation policy does not detail what is required for ongoing competency management for GP obstetricians (refer to criterion 1.2.3.4).  Staff ongoing education is planned and provided. The education is appropriate to the service setting and includes in-service education on site as well as access to external education. Records of attendance are maintained. The education includes advanced cardiac life support training; Primary Response In Medical Emergencies (PRIME) training; fire safety; infection prevention and control and other appropriate aspects of care. In the maternity unit, the education of RNs is predominantly related to breastfeeding and resuscitation. Other relevant topics are not included. Overall staff interviewed were very positive about the education offered. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | While staff and the hospital services manager (HSM) can verbalise the rostering arrangements that are in place to ensure safe staffing and skill mix, these have not been documented. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | There is a new method of managing admission documentation, with Northland DHB providing a service to record admissions and provide coding services following discharge. While information is recorded through various processes, such as the fire register which is updated daily, there is currently no system to maintain entry and exit information until it is retrospectively reported by the DHB and entered into the Hokianga Health electronic register.  Clinical records are stored in locked, fire protected areas which are environmentally stable. The process to record and track the location of records and the organisation of archived records does not ensure that clinical records can be reliably located. (This does not meet the requirements of ARC 15.1).  Clinical records reviewed in all service streams are legible, integrate entries for all care providers, and in most instances the name and designation of the person writing the entry is recorded. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is information regarding entry processes for all services streams. Detailed information on entry criteria (suitability for admission) to maternity, medical and paediatric care are not fully documented (see 1.2.3.4). Information about the service is available in pamphlet form and on a website. Clients and whānau (family) interviewed for all service streams reported they have full information about the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Processes to manage transfer from the service are well documented. There is robust documentation of discharge management in the medical service stream. The medical tracer client is preparing for discharge during audit and is highly complementary about the efforts made by staff to ensure discharge at the earliest opportunity with robust plans for ongoing care in place.  While the maternity tracer and whānau (family) and a second whānau state they are well informed regarding discharge, documentation for planning and management of discharge are not fully documented and there is no system or template to ensure all aspects of discharge planning and care are considered and completed including aspects of education for managing infant care at home (refer 1.3.5.2). |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There is a medicines management policy, issued October 2014, which cover most aspects of safe medicines management. The national standard medication chart is in use. All medicines are stored in secure storage, though careful monitoring of door closure of the room in which medication is stored is required. Medicines stocks are managed by staff with an effective system to maintain stock quantities, expiry dates and disposal of unused medicines. Temperatures for refrigerated medicines and vaccines are efficiently managed; however the ambient temperature of medication storage is not monitored.  Medication prescribing is of an appropriate standard with some exceptions. These include group dating, not dating when medications are discontinued, recording off dose limits and indications for PRN medications and prescribing of Vitamin K and Syntocinon.  Controlled drug management meets requirements in most instances, however weekly stocktakes are not reliably recorded including the measurement of liquids where the measuring device on the bottle does not provide an accurate measure. The policy does not describe requirements for weekly checks and six monthly quantity stocktake (see 1.2.3.4). It is recommended that ward stocks of controlled drugs are used rather than client’s own supply following admission. In maternity verbal orders from GPs are used for narcotic pain relief in labour. While these are signed in a timely manner, the Ministry of Health has recently clarified the regulations, which do not permit verbal orders for narcotics, except in an emergency situation, and it is recommended that the practice of accepting verbal orders for narcotics ceases.  There is a system for medicines reconciliation; however this is not reliably completed on admission for medical (acute) clients. Staff interviews and clinical records show that staff are competent with medication management. Various medication competency training opportunities are provided for staff and records of medication competency are kept.  Staff and managers state that medications are not self-administered at Hokianga Hospital with the exception of inhalers.  Medicines management is recorded in appropriate levels of detail, including documentation of allergy status, administration of medication, specimen signatures and client response to medication. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food services are well managed. There is a comprehensive policies and procedures manual for the food service, issued in March 2015. There are standard rotating menus for winter and summer, which staff report have been approved by a dietitian, however documentation is not supplied at audit of this. Portion control measures are in place. Client weight is monitored in long term care. Clients, whānau (family) and staff interviewed in all service streams are complementary about the food service. There is a system to notify the kitchen and manage special dietary requirements.  Food ordering and delivery is managed efficiently to reduce storage times and protect food, without overstocking of stored food. Transportation is performed by suppliers and commercial operators. Storage is efficiently managed with stock rotation and monitoring of temperatures of refrigerated and frozen foods. Some out of range temperatures are noted at audit, however staff are responsive to addressing this at audit. There is safe separation of clean and dirty items. The kitchen environment is clean and records show the weekly cleaning audit is reliably completed with good compliance. ‘Hot chain’ management is monitored with checking of temperatures of cooked food. Food is disposed of regularly to avoid waste sitting about. Expressed breastmilk and formula is stored in individual fridges in client’s rooms and are monitored when in use. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service manager, nursing, medical and midwifery staff interviewed stated there are no situations in which entry is declined when care is required. Clients requiring alternative care due to their level of need are referred or transfer arranged by Hokianga Health. There is a waiting list for residential care. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Clinical assessments documented in clinical records in all service stream are thorough. The interRAI assessment process is used in long term care and is completed in all instances within the required timeframe with goals recorded. There is a detailed assessment tool for medical admissions using a tikanga Māori approach to care. Clients, whānau (family) and staff at interview state the processes for admission are conducted with an individualised focus, however these are not reliably documented all aspects of care, including recording of goals (refer criterion 1.3.5.2). Maternity goals are not recorded for postnatal care of mothers and infants as part of the care planning process and planning for aspects of assessment, such as family violence screening are not evident (refer 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care planning documented for long term care clients using the InterRAI assessment process is thorough. The tracer and other client and whānau (family) interviews in the long term care service show planning was comprehensive, individualised and is reviewed in a timely manner in response to changing needs.  In the medical (acute) service there is a comprehensive Tikanga Māori based admission to discharge planning tool. The medical tracer interviewed states that medical and nursing staff discuss all aspects of planning care, however the care planning tool is not completed in some instances.  In the maternity service there is no care planning tool to facilitate robust capture of plans for postnatal care of the mother, including admission processes and assessment (for example, family violence screening), care during the postnatal stay period and planning for discharge and associated processes. Plans of care are not documented with details of care to be provided, including the requirements for postnatal care provided by the nursing team in the absence of the midwife (such as overnight care). |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Interviews with clients, whānau, staff and managers, observations during the audit, including handover between nurses at shift changes, and review of clinical records show that service delivery is consistent with clinical care requirements and with goals and needs, where these are recorded. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Client, whānau (family) and staff interviews, observation and review of clinical notes showed activities care is provided. The service for hospital clients is conducted in conjunction with the day community activities service. The activities area is well equipped and inviting. The activities coordinator interviewed is passionate about her role and is a qualified activities therapist. Individualised needs and planned programmes are recorded in care plans and extensive progress records are kept regarding participation of clients. The aged care client reviewed in detail (the tracer) presents challenges for the activities management and these challenges are creatively and sensitively managed with an emphasis on maintaining independence, movement and stimulation.  The medical tracer client has mobility issues and report staff have assisted her in finding meaningful activities.  Maternity clients and their whānau (family) reported they are supported to be independent, learn parenting skill and involve fathers and other family members in care activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Long Term Aged Care - Evaluation of care for the aged residential care tracer and other clients is comprehensive as shown by client and whānau (family) interviews and review of clinical records. Ongoing evaluation of wellness and risk indicators such as weight, skin integrity, pressure area, falls risk and psychosocial needs are regularly updated for the tracer and other clients. Evaluations reflect client and whānau (family) goals for care. There is a system to manage three monthly medical reviews and these are performed in a timely manner. More frequent medical reviews are recorded as undertaken where required. Nurses and managers are knowledgeable about the evaluation requirements in aged care.  Medical - Evaluation of the tracer and other clients is ongoing and appropriate to their needs as shown at client interview and review of clinical records. Observations are recorded in a timely manner and acted on where there is a change in health status. Review against goals is minimal and it is recommended that this element of evaluation is expanded. While the Early Warning Score (EWS) system is noted by the manager to be available, staff interviewed were unaware of the system and there is no policy to guide its use. Given the acute nature of the service, it is recommended that the EWS system be instituted fully for adults and for children with policy and training to guide use.  Maternity - Evaluation by midwives and GPs are predominantly well documented and clients and whānau (family) reported daily evaluation by the LMC midwife of mother and infant. Evaluations by nursing staff of maternity clients overnight are poorly documented and do not sufficiently verify the health status of the mother and infant. Orientation and education of nurses regarding evaluation of maternity clients is not sufficient and is not documented (refer 1.2.7.4). |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | In all service streams, clients, whānau (family) and staff interviewed and clinical records reviewed showed clients are offered available choices for other health and disability services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | A waste management guideline details the different categories of waste and how these are to be disposed of. The guideline is compliant with current legislation and published recommendations. Waste was sighted to be appropriately disposed of according to policy during audit.  Material safety data sheets are accessible for the used chemicals/hazardous substances checked at random.  Appropriate personal protective equipment (PPE) is available on site. Staff and contractors were observed wearing gloves and other personal protective equipment (PPE) as appropriate. Staff interviewed confirmed there is appropriate supplies of PPE which are readily accessible/available. Training on waste and hazardous substances is provided to new staff during orientation.  The facilities manager and another facilities employee both have a current hazardous substance handler certificate and these were sighted. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness (BWOF) which expires 30 June 2016. A detailed maintenance schedule is in place and is implemented by the facilities manager and contracted suppliers/contractors.  Biomedical equipment is checked at least annually. The majority of equipment sampled at random had a current performance monitoring certificates. The exceptions were noted on the hospital schedule as being overdue.  The sterilisers have been validated within the last 12 months. The generator is regularly checked and noted to comply with required standards. An electrician is employed and undertakes electrical item test and tagging and the checks to maintain body and/or cardiac protection areas.  Tempering valves have been installed at the taps since the last audit. The plumber was on site during audit and verified that the temperature of hot water in patient areas is within required parameters.  Equipment is fit for purpose and appropriate for a health care setting. This included for the provision of acute medical, maternity and aged residential care.  There is a courtyard garden that clients and visitors can use. Two long term care (LTC) clients interviewed confirmed they can enter and exit the building on their own using mobility devices (if these are required). |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Ensuite bathrooms provide toilet and shower facilities as well as hand washing facilities for four clients’ rooms. The three rooms in maternity all have an ensuite and one of the single rooms in the acute ward. There are sufficient other toilets available for clients use as verified by clients and staff during interview. Separate toilets are allocated for staff and visitors. Privacy mechanisms are present on the bathroom doors.  Hand basins are present in all bedrooms sighted. Waterless hand gel was also readily available in patient care areas and bedrooms.  Clients and family interviewed confirmed staff respect their physical and auditory privacy and this includes while completing hygiene cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are 15 single occupancy bedrooms, three double occupancy bedrooms, and one bedroom that have four beds. Privacy curtains are in place. All the beds for clients receiving long term residential care or maternity care are single rooms. The maternity unit is in the lower floor and the other inpatient services are on the upper floor.  The clients receiving aged related residential care have personalised their bedrooms. A sign is noted at the entrance to the long term care area of the ward and advised that the area was a residence and not part of acute care service. This was to minimising unnecessary foot traffic.  There is sufficient space in all bedrooms for clients to mobilise including while using mobility aids, when connected to equipment and when staff assistance is required. This was verified by observation and during interview with staff, the clients and family members. Clients using mobility devices were sighted mobilising independently both inside and outside the facility. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a marae located on the lower floor. Staff advise on occasions this is used by clients and family members for the provision of supported end of life care.  There is a kitchenette and dining area in the maternity unit for use by clients and family members. Mattresses are available for the use of family members who stay over including in the marae.  In the inpatient and long term care area clients are encouraged to attend the central dining room for meals. There is a separate lounge area.  An activities programme is also provided with dedicated space allocated to these activities.  Clients and family members interviewed were complimentary of the facilities available to them. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning services are provided by employees. A cleaning schedule is available and details the cleaning activities to be undertaken, frequency and products to be used. Chemicals sighted were stored securely and labelling of containers was appropriate.  Hospital linen is laundered by an external contractor. The personal laundry of clients receiving long term care or maternity services is washed on site by staff.  Monitoring of cleaning and laundry services is included in internal audits conducted and the client satisfaction survey (September 2014). Clients and family/whānau interviewed were satisfied with these aspects of service and report the facility is kept clean and tidy. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Hokianga Hospital has systems and processes which are appropriate to a hospital environment and which ensure a timely response during emergencies and security situations. Alternative energy and utility sources are in place, with a generator and two uninterrupted power supply (UPS) battery alternatives available to maintain services. The emergency power supply is tested monthly and operational for at last 30 minutes to test functioning. Diesel supply available includes 600 litres in the generator and 400 litres of spare diesel. Two new water tanks have been installed and two more tanks are scheduled for installation the week of audit. This will give 100,000 litres of water on site for emergency. There are additional emergency supplies of medical gases.  The organisation is well prepared to address any emergency. There is a well-documented emergency plan which includes the stages of an emergency, critical equipment, and the contact details of key external contractors and staff. Emergency flip charts are throughout the facility to provide quick guidance for staff on managing emergency events. Emergency management supplies for use in a civil or other emergency are on site. The supplies are checked regularly. An ‘Ebola’ emergency scenario and methamphetamine scenario event have occurred.  The fire evacuation plan has been approved by the New Zealand Fire Service in February 2009. Staff are provided with regular training on fire safety. The last fire evacuation drill was conducted on 16 March 2015.  Clinical staff are required to have completed advanced cardiac life support (ACLS) training that meets the requirements of the New Zealand Resuscitation Council (NZRC). Nursing staff are required to have level 4 or higher ACLS. Medical Staff have completed ACLS level seven. In addition, staff complete PRIME training. Training records are retained and sighted (refer to 1.2.8.1).  Security cameras are located monitoring the entrance areas. The images are screened at the nursing station. Intercoms are used to communicate from outside to the nursing station. A radio transmitter (RT) is present in the ward nursing station to enable direct communication with emergency services. A designated staff member conducts security checks of the facility between 5-7pm at night and checks all doors/exits are locked and closed. A record is made in the security books verifying the checks have been completed.  Call bells are present at each bed space and bathroom facility sighted. The calls make an audible alert and identify the calling area on a centralised alert panel. A light also illuminates outside the applicable room. Four call bells were tested including an emergency bell during the audit. The emergency call bell has a different alert sound. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Temperatures in the patients’ bedrooms can be independently adjusted within the patient room for comfort. Heating is provided via heat pump or wall mounted heaters.  All rooms have at least one external window.  Clients and family members confirmed they are provided with a pleasant environment, with adequate natural light and ventilation. The environment is maintained at a comfortable temperature day and night.  Smoking is allowed for clients in designated external areas. Smoking cessation therapy is offered to clients that smoke. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control and prevention policy, issued October 2014, defines involvement of senior nursing staff in oversight of the infection control programme. Infection control review is conducted within the health and safety meeting process rather than as a separate activity. Definitions of the terms of reference relating to infection control oversight are not well defined within policy statements (see criterion 1.2.3.4).  There is a detailed infection control programme which is updated annually and was last updated June 2015. Minutes of meetings show that the senior nursing team including a nurse practitioner were involved in the annual review of the programme.  There a screening processes and procedures to minimise preventable exposure and protection of susceptible persons, including guidance regarding requirements for management of staff who are unwell. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control team includes a newly appointed infection control nurse who is undergoing training for her position. Oversight is provided by a nurse practitioner and hospital services manager. The team have access to expertise through the NDHB infection control team and clinical microbiologist from the regional laboratory service. It is recommended that medical representation be included in the infection control team to ensure the medical expertise is available and the medical perspective considered. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There is a comprehensive set of infection control policies to provide adequate guidance for the programme and infection control procedures. Infection Control Manuals are seen in the medical/long term care and maternity units available to staff. The infection control nurse interviewed is familiar with policy requirements. There is an active internal audit programme which includes environmental and clinical audits, such as intravenous sites, blood stream infections, monitoring of sterilisation processes and infections contracted by long term aged care residents. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | There is an annual education programme sighted, which contains appropriate education for staff sectors. The infection control nurse has not yet completed education for the role. She is currently supported by the nurse practitioner and NDHB infection control department to fulfil her education role. Aspects of consumer education are noted including hand washing education. Records of attendance at education sessions are maintained. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a well organised surveillance plan, appropriate to Hokianga Hospital. Information on infections and treatment is collected in the wards on a template. Minutes of meetings and interviews show that infection data is discussed. The infection control nurse interviewed shows sound knowledge of the information collection process. There is some analysis of data, however it is recommended that further analysis of information is conducted to show rates and trends of infections. |
| Standard 3.6: Antimicrobial usage  Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians. | PA Low | There is a policy for antimicrobial use issued in October 2014. Information for prescribers on antimicrobial current best practice is regularly updated. The antimicrobial use policy states that audit of antimicrobial use will be conducted annually. There is however no evidence available at audit to show this process has occurred. The infection control nurse and a medical officer interviewed state that while best practice advice is followed, they are not aware of a review to verify compliance of antimicrobial prescribing. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff interviewed are able to describe the main difference between restraints and enablers and confirmed that restraint use is actively minimised. A client that is not competent in decision making is identified as having bedrails (both side of the bed) as an enabler as the designated next of kin had given consent. (This is raised as an area for improvement in criterion 2.2.3.4). The restraint minimisation policy is not sufficiently detailed. The policy does not include a definition of restraint, the definition of an enabler does not clearly align with the definitions in the standards and the process for monitoring when restraint is in use is not clearly detailed. (This is included in the area for improvement raised in criterion 1.2.3.4).  Staff confirm being provided with education on use of restraint and enablers as a component of the level three qualification programme and in-service education programme. An in-service education session was provided most recently in June 2014 and was attended by 11 staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The only restraints in use in this service are the equipment that is used as an enabler.  At the time of audit there is one client with restraint in use. The client is not competent in decision making and is at risk of falling out of bed. The use of bedrails when the client is in bed has been requested/consented to by the client’s next of kin but currently as an enabler (refer to 2.2.3.4)  The responsibility for restraint process and approval is overseen by the hospital services manager who is also the restraint coordinator. While staff and managers can detail the approval process for restraint and enablers this is not clearly detailed in the organisation’s policy (refer to criterion 1.2.3.4). The restraint coordinator approves all restraint/enabler use. The RNs have the authority to initiate the use of emergency restraint use, though ongoing restraint use needs to be approved by the restraint coordinator/HSM.  The client’s care plan records the restraint/enabler required and when it is to be applied as detailed in the resident’s file reviewed. Consent from family/whānau, GP and RN is required before restraint is approved. A current consent form for the use of bedrails when the client is in bed was sighted in the applicable client’s file during audit.  All clients with restraint/enablers in use have details noted in the restraint register. A review of restraint/enabler use is conducted quarterly by the HSM. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The one client with bedrails in use to minimise the risk of falling out of bed has an assessment on file that includes all required components to meet this standard. The use of padded bedrails is identified as being the most appropriate intervention. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Low | The restraint coordinator reports that enablers and restraint is only applied after consideration is given to all possible alternatives and appropriate consultation has occurred with the client and/or family, and the general practitioner. Bed rails are padded to minimise risk of injury. A restraint register is in use. This identifies the use of bedrails occurs for between one and three clients each quarterly period.  At the time of audit, one client requires the use of restraint to help maintain the safety of the resident. The client is not competent in decision making and the ongoing use of restraint (bedrails) has been approved by next of kin to promote the client’s safety and help reduce the risk of falls.  The use of bedrails is documented in the resident's file and in the restraint/enabler register as sighted. Whilst there is an ongoing monitoring form that is to be used when restraint is initiated and released, and observation of the client during restraint episodes, this is not being completed by staff on a shift by shift basis. This is because the events are being considered by managers and staff as an enabler rather than a restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The client with bedrails in use has a care plan that details the use of bedrails for safety. The care plan is dated April 2015. The plan notes that bedrail protectors are to be used and fluids kept within reach. Current assessment is on file and a consent form that has been recently re-signed by the designated family member. The care plan for this client has been evaluated in July 2015. The monitoring form has not been competed for this client (refer to 2.2.3.4) and a review of the organisation’s compliance with policy and procedures and ongoing education needs is raised in criterion 2.2.5.1. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | PA Low | The quarterly review of restraint and enablers includes a review of the number and type of events. Some other aspects as required to meet the standards are not explicitly included. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

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| **Citerion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.4  There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. | PA Moderate | Policies and procedures are available for staff in both hard copy and electronically on the ‘share file’. The review and updating responsibilities are designated. Some of the policies sighted were current and clearly detail staff responsibilities. However there are a number of policy/procedure documents that have not been developed as yet, or were overdue for review. Examples include:  The electronic emergency management policy in the share file is not the current version (dated 2012/2013).  The intravenous therapy manual on the share file is dated 2009 (due for review in 2011).  While there are procedures to guide admission processes this does not include clear criteria regarding the decision making process for suitability of the Hokianga Hospital setting for acute medical, paediatric and maternity care.  Policy relating to medical records does not specify the process for tracking of clinical records.  Policy relating to advance directives does not clearly specify the process and documentation requirements.  There are multiple versions of policy in use for maternity care. One folder provided by nursing staff and stored in the medical ward has policies dated for review in 2011.Other polices were due for review in 2014 and are under review, but this is not yet completed. There are NDHB policies in use for maternity which are not suited for use in the primary care setting. The two midwives interviewed state these are for reference only, however this in not clearly stated in the policy structure.  There are aspects of maternity care for which there is no policy guidance. For example; the expectations of the organisation for the education of nurses and specification of the nursing role and scope of practice in the maternity service. particularly in relation to evaluation of maternity clients. Nurses interviewed state they have not received maternity specific training for their evaluation responsibilities in maternity care nor do they have access to policy documenting their role and expectations for maternity care and evaluation.  The expectations of the organisation for ongoing competency management for GP obstetricians are not documented in policy requirements.  The paediatric policy is dated for review in 2011.  There is no policy to guide the use of early warning scores in the medical/paediatric setting.  The medication policy does not include stocktake requirements for controlled drugs.  The restraint policy does not include the full definition of restraints and enablers; or processes required in the event restraint is used. This includes the ongoing monitoring requirements for the client. | There are examples of policies and procedural manuals in use which are overdue for review. Some updated policies have not yet replaced the previous version of the PDF policy located on the share file and accessible by staff.  There are multiple versions of maternity policies available for staff.  There are insufficient policy and procedures available that detail the organisation’s expectations related to some aspects of practice. The restraint policy does not include the full definition of restraints and enablers, or processes required in the event restraint is used. | Ensure policies are procedures are sufficiently detailed to guide staff practice and document control processes consistently implemented.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Policies detail the process that is required related to human resources practices. The policy aligns with current accepted practice and includes staff completing an application form, interviews, verifying qualifications and experience, conducting police and reference checks. However records are not consistently available to evidence that reference checks and interviews are conducted. These documents are missing in the four staff files sampled where the employee was employed between October 2010 and May 2015. Three of the staff whose files were reviewed were employed since June 2014. Completed police checks were present in the sampled files. | Records to evidence that reference checks or interviews are being conducted are not present in all staff files sampled. This included the three staff employed since June 2014. | Ensure records are maintained to demonstrate that the recruitment process has been followed.  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | Nurses interviewed, including a midwife who no longer holds a practising certificate, have variable to no previous experience in maternity services. Nurses and managers interviewed and clinical records reviewed show that orientation and training for care in the maternity setting relates predominantly to breastfeeding and resuscitation. The RNs advised they have not received orientation and training for their responsibilities for evaluation and other aspects of maternity care. Staff interviewed advised that, with this exception, the orientation programme is comprehensive.  Staff complete the generic orientation to Hokianga Health. Department/role specific orientation is also conducted; however records of completion are not available to demonstrate this, as the records are reported to have been retained by the employee. This included the medical practitioner orientation and the registered nurse orientation records. | While staff confirm a detailed orientation is provided relevant to the staff role and responsibilities, records are not present in some staff files reviewed to demonstrate that the service/department specific component has been completed. For example, the workbooks that are to be completed by medical and nursing staff.  The orientation/ongoing education programme is not sufficiently detailed in relation to the registered nurses’ responsibilities for the care of clients in the maternity unit. | Ensure records are available to verify that staff have completed any department/role specific orientation in a timely manner.  Ensure the orientation and ongoing programme is sufficiently detailed in relation to the registered nurses’ responsibilities during the provision of care for clients in the maternity service.  180 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | The HSM advises there is always a minimum of two nurses on duty. At least one is a registered nurse while the second staff member may be a RN or an enrolled nurse. This is the minimum staff for overnight. In addition there is a senior RN on call for afternoon and night duties who assist with transfers or if the ward is busy. The HSM advises she also lives within twenty minutes of the hospital and will attend if called/required.  There is always at least one RN on duty (often two) who has completed Primary Response in Medical Emergencies (PRIME) training, and at least one nursing staff member with ACLS level four or higher. A number of staff are booked to attend the PRIME training during the week of the audit.  A review of the inpatient unit roster identifies:  - There is normally four nurses (may be a combination RN and ENs) on duty for morning shift and two caregivers.  - There is normally two nurses (may be a combination RN and ENs) on duty for afternoon shift and two caregivers.  - There are two nurses (may be a combination of a RN and one EN) on a night shift.  - Separate hours are allocated for the activities programme.  A medical practitioner is on call if not on site 24 hours a day, seven days a week (24/7). The roster identifies which medical practitioner is on duty in the inpatient service and the medical practitioner on call. Medical practitioners also attend PRIME training and ACLS at level seven. Four of the medical practitioners provide antenatal care and assist with labour and delivery. Two of the medical practitioners work with each midwife in providing care alongside each midwife to women in the antenatal period. One of the doctors will also attend the birth. Staff interviewed advise the medical practitioners and the lead maternity carers are very prompt in coming on site when on call.  Designated time is allocated for kitchen, domestic services and administration staff.  The two lead maternity carers (LMCs) are responsible for the antenatal care of clients, during labour and delivery and have oversight of post-natal care. At least one midwife is on call if not on site 24/7. The hospital services manager and the community services managers are both RNs and RMs. Ward RNs assist with the provision of post-natal care.  Nursing staff are allocated designated clients that they are responsible for. One RN is allocated the responsibility of having oversight of all of the residential care clients’ weekdays on a morning shift.  Additional nursing and medical staff are rostered in the outpatient service, community services and the medical centre. This includes a nurse practitioner. Radiology services are provided on site Monday to Fridays. Inpatient physiotherapy appointments are booked in the ‘ward slots’ on the electronic patient management system/appointment book. A podiatrist visits every six weeks to review residential care clients and other clients by appointment.  While staff and the HSM can verbalise the rostering arrangements that are in place to ensure safe staffing and skill mix, these requirements have not been documented. | Staffing and skill mix arrangements have not been documented. | Develop a documented process that details how staffing is planned and rostered to ensure staffing and skill mix is appropriate to provide safe service delivery.  180 days |
| Criterion 1.2.9.7  Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. | PA Low | Clinical records in current use are stored with primary health outpatient records in a secure area which is well organised. All records in current use are stored in coded folders. There is also an archive store which is poorly organised with some notes stored according to date and others stored in piles with no apparent organisation of their whereabouts. A staff member and a manager confirmed that there is currently no system to record the location of each set of notes, nor is there a tracking system when notes are removed. Managers interviewed show an understanding of the shortcomings of the current storage arrangements.  The process for recording entry and exit from the service has altered and admissions are now processed and clinical records coded by NDHB upon exit. Reports listing information processed by NDHB were sighted, and following discharge and coding, the details of the admission are stored electronically at Hokianga Health. There is a daily ‘fire list’ verifying who is an inpatient. There is however no admission record kept from the time of entry ensuring details are maintained in a timely manner for all clients admitted and discharged. | There is currently no secure manner to maintain entry and exit information until it is retrospectively reported by the DHB and entered into the Hokianga electronic register.  The process to record and track the location of records and the organisation of archived records does not ensure that clinical records can be reliably located. | Ensure that there is an accessible record of the details of entry and exit maintained from the time of admission onwards. Ensure the clinical records storage and tracking system facilitates secure management and reliable access to stored clients’ records.  180 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | All medicines are stored in lockable storage including controlled drugs, however, the door to the room in the medical unit in which medication is stored is observed to be open and unattended on multiple occasions during audit. The medication trolley has liquid medications on the bottom shelf, including paracetamol elixir. There is a sign on the door reminding staff to shut it. The manager states correct closure of the door is an ongoing issue. Given the presence of clients with impaired mental functioning, paediatric clients and visiting children continued vigilance is required to ensure medication is secure.  There is no facility for ambient temperature monitoring of stored medication. The manager states ambient temperatures for stored medications are not monitored.  Review of medication charts shows group bracketing of dates of prescriptions, dates of discontinuation of medication is not recorded, recording of dose limits and indications for PRN medications, prescribing of Vitamin K and syntocinon administered in maternity care. Staff ate interview note variable compliance with these requirements.  Weekly stocktakes are not reliably recorded including the measurement of liquids where the measuring device on the bottle does not provide an accurate measure. It is recommended that ward stocks of controlled drugs are used rather than clients own supply following admission. In maternity verbal orders from GPs are used for narcotic pain relief.  Medicines reconciliation is not competed in three of four clinical records on admission. | The door to treatment room in which medication is stored is repeatedly left open during the audit and is reported by staff as an ongoing problem,  The ambient temperature of medication storage is not monitored.  Medication prescribing is of an appropriate standards with some exceptions which are areas for improvement including:  - group bracketing of dates of prescriptions  - dates of discontinuation of medication is not recorded  - recording of dose limits and indications for PRN medications  - prescribing of Vitamin K and syntocinon administered in maternity care.  Controlled drug - weekly stocktakes are not reliably recorded including the measurement of liquids where the measuring device on the bottle does not provide an accurate measure.  Medicines reconciliation is not reliably completed on admission for medical (acute) clients. | Ensure all aspects of medicines management meet the requirements of best practice and legislation.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Medical - There is a comprehensive care planning tool which has been instituted recently in the medical service. The manager reports that staff are in the process of learning to use the new tool. While there are some extensive entries, with appropriate details, four of four care plans reviewed were not complete. For example, a client at risk does not have a completed VTE (venous thrombosis) risk and plan relating to prevention, is not recorded. Allergies, medication history and weight and plans relating to those factors where required, are not recorded on the admission to discharge planner. Two of four clients do not have a full plan of care recorded relating to the client’s individual clinical needs.  Maternity - In four of four sets of notes there is minimal or no indication from the LMC regarding care to be provided and no system or template to facilitate robust documentation of the care required, including care screening processes, such as family violence screening, general education requirements, elements of care specific to the client, such as observations, and care to be provided by the nursing staff overnight. For the tracer, this included that she had not passed urine since birth and that voiding, blood loss and reporting of issues to the midwife are not documented. There is a plan of care for breastfeeding predominantly relating to client education which is fully documented in two of four sets of notes; however detailed feeding plans are not documented. For example, it is not stated whether the infant is breastfeeding or whether there are time limits for ensuring milk intake. While antenatal goals/needs/desired outcomes are documented for birth, these are not documented to form a basis for postnatal care. While antenatal goals are recorded, there are no goals/needs/desired outcomes for postnatal care documented as a basis for care plans. | Medical – Care plans are not fully documented to reflect the individual needs of clients.  Maternity - Plans for care and discharge are discussed but not documented. There is no system or template to facilitate robust documentation of the plan of care required for mother and infant. Goals/needs/desired outcomes are not recorded for postnatal care. Planning for assessment on admission, postnatal care (including care to be provided by the nursing staff overnight) and education is not documented. There is no system to plan and record care for discharge. | Ensure that there is a system for postnatal admission, care and discharge plans in the maternity service. Ensure that plans for care in maternity and medical services are fully documented.  180 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Maternity- Evaluations by midwives and GPs are predominantly well documented. Clients and whānau (family) report daily evaluation by their LMC midwife. Evaluations by nursing staff are poorly documented, with little or no information recorded about the times of evaluation or features of the evaluation conducted. In four of four records there is a single brief entry for the night (12 hours) stating the mother is satisfactory and that the mother reports that the infant has fed. One record indicates the family were checked twice in the 12 hour period. No times are recorded when the client and infant are checked. In the four records reviewed there is no documentation over the night, or longer in some cases, of the infant’s health status, such as colour, warmth, respiratory status, alertness, sleep and safe sleep positioning, output or details of feeding efforts. In the four records reviewed, there is no documentation overnight, or in some cases longer, of the mother’s blood loss, pain levels, detail of the feeding experience, fluid/food intake, voiding and activity.  The nurses are not in the maternity unit, being largely occupied in the ward upstairs and can be summoned as needed. A family member is required to stay with the client, however there is no documentation of instructions provided to the family member for their role of supervision of the client and infant. Nurses interviewed state they may only visit the unit ‘a couple’ of times overnight unless summoned.  For the tracer client who birthed in the early evening there is no record of voiding until the visit of the midwife the following day.  There is no system for nursing staff or clients to record and evaluate feeding. Given the role of family in self-monitoring and level of staff involvement it is recommended that a feeding assessment and evaluation tool be considered.  Nursing staff and managers interviewed state that there is no education provided specific to the requirements for evaluation of maternity clients. There is no record of education for nurses for the role of evaluation of maternity clients. | Evaluations by nursing staff are poorly documented, with little or no information recorded about the times of evaluation or features of the evaluation conducted. | Ensure evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome  90 days |
| Criterion 3.6.4  Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme. | PA Low | No evidence is available at audit to demonstrate that monitoring of antimicrobial use against best practice has occurred. Best practice advice is sighted available to prescribers and a prescriber, a manager and the infection control nurse state this advice is followed. The infection control nurse and a medical officer interviewed state they are not aware of a review to verify compliance of antimicrobial prescribing. | The standard requires that regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policy will be a component of the infection control programme. While the antimicrobial use policy states audit will be conducted for microbial prescribing compliance, no evidence is available at audit to demonstrate this. | Ensure a robust audit process is conducted to evaluate compliance with antimicrobial policy and best practice requirements  180 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | Health assistants advise they check on the client with restraint in use at least every two hours. A restraint monitoring form is present on site for monitoring of the client throughout the day. This includes identifying when each episode of restraint is initiated and released as well as general observation of the client and summary of cares provided. This monitoring document is not being completed for the client with bed rails in use when the client is in bed. The health care assistants and registered nurses are documenting a general overview of care provided within the progress notes in the client’s file. | The form that facilitates observation and monitoring of the client during each episode of restraint is not being used. | Ensure records are maintained to demonstrate the observations and monitoring of clients during each episode of restraint.  180 days |
| Criterion 2.2.5.1  Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. | PA Low | While there is quarterly review of the use of restraint and enablers it does not include all components to meet these standards. This includes whether changes to policies or procedures are required, compliance with the policy and staff education/training needs. | The quarterly review of restraint and enablers includes a review of the number and type of events. Some other aspects as required to meet the standards are not explicitly included. | Ensure a comprehensive review occurs of restraint practices that includes all components to meet the standards.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.