MidCentral District Health Board

Current Status: 20 May 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Palmerston North Hospital and the Horowhenua Health Centre (Levin) are part of the MidCentral District Health Board (MDHB). The MDHB is responsible for providing health and disability services to a population of around 158,000 people across the central North Island region. A full range of secondary care services, including medical and surgical services, women's health, child health services, mental health services, elder health, disability support and rehabilitation services are provided, plus a range of regional services. These include cancer treatment, breast screening, haematology, renal, urology and public health services.

Audit Results as at 20 May 2014

Consumer Rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the organisation and the Code and the Nationwide Health and Disability Advocacy Services brochures are available in all areas visited. Patients and their family state there is good communication with staff on the Code and about the care that is provided with opportunities to ask questions. In the surgical area there is a 'nominated contact person' process where the patient can nominate a contact person to have a greater involvement in their care. The practice of open communication and disclosure is evident; however, documentation of this requires improvement.

There is evidence of written consent being undertaken where appropriate. In the surgical ward this is seen for blood products, surgical procedure and anaesthetic and for a patient who was unable to provide consent for a procedure that was deemed essential for this person; appropriate procedures were followed. In the children's area, whilst patients and families state they are fully informed to provide consent, there is an improvement required to ensure consent for anaesthesia is timely and documented.

Improvement is required to ensure family violence screening is undertaken and recorded in the clinical record.

In general privacy and dignity is maintained and no discrimination or coercion is evident. However in the mental health unit personal privacy is compromised in the high needs unit and privacy of clinical records is not always maintained; these are areas requiring improvement.

An external local provider provides cultural supports. Mental health patients are provided with information on the Mental Health (Compulsory Assessment and Treatment) Act 1992. Interpreter services are accessible if required.

MDHB has a complaints process that is known to staff and is available to patients and visitors. An online system for logging complaints is used as the complaints register and includes the dates and activities around the individual compliant. An area requiring improvement relates to ensuring complainants are kept informed of the ongoing investigation into their complaint in a timely manner.

Organisational Management

The MDHB board plans services to meet the needs of the people of the region based on Heath Needs Assessment information and the requirements prescribed by the Minister of Health. There is a close working relationship with the Whanganui DHB, with an increasing number of shared services and management roles.

There is a well-defined Quality Improvement and Outcomes Framework which is aligned to the New Zealand Triple Aim goals and the work of the Health Safety and Quality Commission (HSQC). A range of quality improvement data is gathered and reported. In general, the data is well analysed and displayed with the use of key performance indicators (KPIs), graphs and trending over time. A range of external benchmarking activities allows for comparison of outcomes on a wider scale.

The organisation’s efforts to improve the currency of electronic policies are acknowledged, with good outcomes as a result. In a number of clinical areas staff continue to use out of date paper based policies and procedures and ongoing improvement to address this is required.

Adverse event reporting is carried out through a newly implemented electronic tool which is proving valuable in producing information to identify trends in adverse events and manage the reporting and corrective action planning process. Events of a more serious nature are investigated and improvements made where possible; however, there are examples noted where some events have not been identified through the event reporting system nor fully investigated to ensure the opportunities for learning are realised. This is an area requiring further development.

Risks to the organisation are generally well managed. Risks are reported to the

appropriate level within the organisation based around their significance. An improvement is required to ensure that all risks are being identified and entered on the risk register.

Within the mental health services and across the organisation, there is evidence of increasing consumer participation and involvement in key decision making groups.

Human resources practice is guided by policies that meet current good practice standards. Improvements are required to ensure that checking of previous criminal convictions occurs as part of the recruitment process. Generic and area specific orientation is being undertaken by all new staff. Ongoing education is planned annually and staff are well supported to attend external training. Improvements are required related to the recording of training and to ensure all training requirements are met. Not all staff have participated in the annual appraisal process and this also is an area that needs to be addressed.

There are a number of strategies across the organisation that aim to ensure an appropriate match between patient demand and staffing resources, and in general this occurs. Within the mental health unit (MHU) significant issues are identified in relation to the match of staffing resources to patient demand. This is exacerbated by the poor layout of the facility, the lack of appropriate services available for some patients with complex and long term needs, and at times, high occupancy. This is an area that requires urgent attention to ensure the safety of patients and staff.

Clinical records are well managed with a good standard of documentation noted. Improvements are required to ensure there is an effective system to flag when a second clinical record is available and to ensure all content is secured and well organised.

Continuum of Service Delivery

Seven patient journeys were followed through surgical, medical, paediatrics, maternity, mental health and assessment, treatment and rehabilitation services. Interviews with staff, patients and family members, observation of practice, and additional sampling of files demonstrate that the processes supporting the patient journey and delivery of care are in place and implemented.

The management of acute and elective admissions to ensure patients have timely access to care are defined and demonstrated. On admission triage, medical and nursing assessments are commenced and continued at each point of care. There are comprehensive screening tools, but these are not always used to develop patients' goals or a specific plan where risks are identified. Patients interviewed confirm that goal planning does occur, however, these goals are not always

documented and this process requires improvement.

Care delivery is undertaken in a planned and systematic manner, and in most cases is appropriate to the needs of the patient, and adequately documented in the progress notes. Care needs are communicated through shift handover processes and within the multidisciplinary team. In the MHU there is an ongoing problem related to the lack of access to appropriate services for some people with mental health issues, resulting in several patients being inappropriately placed in the unit. This requires urgent attention to address the current situation and a longer term solution to ensure appropriate services are provided to this group of patients.

An ‘early warning score’ system is consistently implemented to identify any deterioration in a patient’s condition. Ongoing evaluation of patient responses to the care provided is generally well documented in the progress notes by all members of the health care team; however, in several clinical areas improvements are required to ensure that fluid balance charts are completed and goals are evaluated.

Discharge planning commences early in the hospital stay and discharge from inpatient services occurs when all aspects of the discharge plan are in place and there is a team view that the patient is adequately prepared for discharge. Patients and family members report being actively involved in their discharge planning. Discharge documentation is available to support the planning process, however this is not always well completed and does not include a discharge date. Documentation around transfer of patients within the maternity service also requires improvement.

The national medication chart is in use, with policies and procedures in place to guide the safe management of medications. Medication reconciliation processes are implemented with a prioritisation tool utilised on admission to determine which patients require reconciliation based on their risk factors. Staff training is provided and staff competency is assessed. Ensuring policies are appropriately updated, documentation meets the required standards, weekly controlled drug checks are recorded, reconciliation occurs and medication fridges are monitored have been identified as areas requiring improvement.

Food services are provided on site, with input from dietitians. There are a range of menu options which meet the needs of patients, including access to special supplements. Systems are in place to ensure the service meets the required safety standards. Patient satisfaction with food services is monitored and is reported to be high. Areas for improvement have been identified related to the monitoring of food fridges, the labelling and dating of food, and the actions taken when the temperature is out of range.

Safe and Appropriate Environment

All buildings have current warrants of fitness. In a number of ward areas issues such as poor clean to dirty flow in sluice rooms, management of waste and dirty linen, small work spaces, and walls and furnishings in need of repair, are noted. There is also inadequate access to face protection and aprons in the sluice rooms and these are areas requiring improvement.

The mental health unit and the six bed secure unit within one of the STAR wards are not conducive to current good practice. Staff and managers are well aware of the long standing issues related to the lack of suitable facilities within the mental health unit. The layout and environment in the STAR ward does provide for the special individual needs of this group of patients. Work is in progress around the Master Health Services Plan which will address longer term facility and models of care across the organisation. However interim measures are required to provide a safe and appropriate environment for patients and staff in both of these areas.

All patient rooms have external windows, heating can be controlled at ward level and there are communal areas for patients to sit.

Spotless are contracted to provide facilities and equipment maintenance, security, orderly services, cleaning and food services. All these services have key performance indicators (KPIs) and there is evidence that these are being exceeded. However, during the audit a number of items of equipment are seen being used by staff and do not have a current maintenance/calibration sticker. The documentation of the monitoring of the hot water temperature at patient point of contact at Horowhenua Health Centre is not routinely documented and these are areas for improvement.

MDHB emergency management is part of national and regional processes. There are standby generators at sites, water and food in place for emergencies. There are management plans in place including health emergency and business continuity and staff have generic and specific training pertinent to their roles. Coordinated incident management systems (CIMS) processes have been undertaken when major events occur, such as computer breakdowns and infection outbreaks, to allow for learning from these events to occur. This is seen as strength of the organisation. Not all areas are ensuring that resuscitation equipment is being checked as required, which needs attention.

MDHB is a smoke free area and supports are available for staff and patients.

Restraint Minimisation and Safe Practice

The definitions of an enabler and restraint meet the requirements of the standard. The policies and guidelines for restraint minimisation are currently under review. Forms have been developed to support assessment, monitoring and evaluation processes throughout any episode of restraint. Each episode of restraint is logged in the organisation's incident reporting system allowing analysis and trending of data. The documentation reviewed of episodes of restraint shows that improvements are required in relation to fully documenting assessment and the event. The organisation has a restraint approval group that oversees restraint practices across both the mental health and general hospital. There is restraint co-ordinator role and this person also oversees training requirements. While some training is underway, this is an area that is being reviewed by the organisation and needs improvement.

A working party has been set up to look at reducing the use of seclusion in the mental health unit. There are plans in place to review the current arrangement of bedrooms also being used for seclusion rooms. The plan is for the high dependency unit to have four bedrooms in this area and two of these allocated for seclusion rooms. At the time of audit none of the rooms being used for seclusion have been approved by the director of area mental health services (DAMHS) and this requirement needs to be addressed.

Infection Prevention and Control

There is a defined organisational structure for infection prevention and control (IPC). The infection control committee has links to the clinical board and provides regular reports of its activities and progress to meeting key surveillance indicators. The IPC team have also undertaken a review of surgical site infections (SSI), resulting in a definition update in accordance with health quality and safety commission. There are policies and procedures in place to guide practice, although it is noted that some are overdue for review. Education is a strength of the infection control programme implemented by the team. An antimicrobial stewardship programme is now established although auditing against antimicrobial policies is still to be fully evaluated. There are opportunities for the team to be more involved in organisational decisions which have a potential infection control impact.

Tracer methodology is used to review infection control systems and practices. This involved review of patient flow, the clinical environment, communication, patient records and practices associated with a current outbreak of gastroenteritis. The pathway of patients presenting in the emergency department with symptoms, the assessment and treatment in the wards and the associated communication processes are reviewed to determine their effectiveness. It included review of patients currently in isolation, patients transferred, interviews with members of the infection prevention and control team, and a number of staff, as well as inspection of

the environment, a review of clinical records, observation of processes in clinical practice. There is a resource folder on the wards detailing systematic actions as part of outbreak management procedures, with daily reports and shift updates provided. The kit is comprehensive, with current information, resources and guidance. The review reveals some gaps in communication, practices and the environment which are raised elsewhere in this report.