Canterbury District Health Board

Current Status: 2 September 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance 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

Canterbury DHB (CDHB) is a large and complex organisation providing secondary services to the 510,000 Canterbury population and tertiary services to much of the South Island. CDHB is part of the Southern Alliance comprising the five South Island DHBs. The CDHB chief executive and senior management and a number of clinical leaders are in joint appointments with the West Coast DHB.

During the audit seven patient journeys were followed. The following hospitals: Christchurch; Christchurch Women's and Children's; Hillmorton; The Princess Margaret Hospital; Burwood; Lincoln; Ashburton and Rural Hospitals; and Turangi Home were visited. The services providing care include surgical, medical, maternity, child health, rehabilitation, spinal, mental health, aged care, along with a range of sub-specialties, emergency departments, operating theatres, intensive care clinical support and ancillary departments.

Consumer Rights

Policies are in place to guide staff on open disclosure and interpreter services and staff are familiar with these. In review of adverse events there is a lack of evidence of open disclosure of minor to moderate incidents, no monitoring of this is occurring and this is an area requiring improvement. There is an interpreter service available in the organisation and available for patients in the maternity ward. However, in CDHB maternity not all patients, for whom English is a second language, have been offered this service and this requires improvement.

Patients and family members in all clinical areas report communication between staff and themselves is open and comprehensive and they receive sufficient information in order to make decisions about their treatment and care. In Christchurch Women's Hospital maternity, there is no routine explanation of patients' rights on admission, including the complaints process, and this requires improvement.

In Christchurch Hospital patient privacy requires improvement. At Lincoln Maternity Hospital and Turangi Hospital patients' names are visible to the general public without written consent being sought; this area requires improvement.

There is a complaints process that meets the requirement of the standard. Brochures on how to make a complaint are seen in clinical areas visited. Patients and family members report general good services and have no reason to complain. In Mental Health Services consumers and their families know the complaints processes and provide examples of a satisfactory resolution of complaints lodged.

The complaints process meets the requirements of the Health and Disability Commissioners Code, data is analysed and trended over time.

A previous area for improvement raised related to maternity has now been met.

Organisational Management

CDHB has a well-established governance and executive management structure. This structure has clinical leadership partnerships at each level. The DHB is leading an innovative vision for the Canterbury health services called 'our health system' an integrated whole of system approach. The CDHB suite of planning documents includes five themes and one focus area for the hospitals and rural services.

The chief executive, who reports to the board, provides evidence of the commitment to quality across the organisation including patient safety that is apparent at the governance level and includes a clinical board. Quality reports provide evidence of the work that is underway to have a 'joined-up' system of activity, measurement and reporting. There are many developments including the measurement of outcomes and specific indicators. Audit activity is occurring within divisions but is not always visible in a consistent way at the corporate level. This, along with the management of corrective action monitoring, are areas for focus.

Work to upgrade the document control system includes the introduction of a new electronic repository. Each policy, procedure or guideline is being reviewed prior to uploading to the shared electronic site. It is estimated that there are approximately 50% of the policies and procedures for review and this requires improvement.

The risk management system is robust and driven at corporate level. There is regular review of the service level risk registers.

Incident management shows variance, while major incidents have comprehensive root cause analysis done the timeliness of response times is considerably outside the 70 day requirement in a number of instances. Minor and moderate incident are managed at the divisional level and there is no organisation-wide coordination and visibility of these for analysis and identifying trends. An improvement has been made to the process around staff being informed of the incident process, which addresses a previous area requiring improvement.

During the audit period occupancy of Christchurch Hospital is at approximately 95% of resourced beds with a peak of 98% on one of the days. Effective daily meetings

are held to assess occupancy and manage patient flow and staffing requirements. The ‘care capacity demand management’ tool is used to assist decision making, however there is no formal acuity system and no indication of the registered nurse skill level on the roster. This needs addressing.

The human resources service coordinates a centralised recruitment system and proactively nurtures candidates so they are ‘work ready’ when vacancies arise. There are excellent induction and education programmes. Areas requiring focus are completion of performance appraisals and having a visible system to identify those who have not completed core competency training.

Some instances of incomplete clinical record documentation exist, including not all pages within the record having the patient identified, entries in the record not having the name, designation and/or signature of the practitioner concerned documented, and incomplete information in some instances. A previous corrective action pertaining to the clinical records not being stored in accordance with the Health Information Privacy Code has been addressed.

Continuum of Service Delivery

Seven patient journeys are followed through surgical, medical, child health, rehabilitation, maternity and mental health services. Reviewing each patient’s care and undertaking additional sampling found that a range of investigations and assessments are undertaken and used to assist with developing individualised plans of care. Improvements are evident since the last audit; however some assessments, (including outcome measures), and identifying patient-centred goals, are not being consistently completed in a timely manner. There is good progress with care planning which is now being developed and updated in a timely manner and meets requirements. Individual patient’s needs are being appropriately met and communicated, including at shift handover and team meetings. The patient's progress, and a summary of care provided, is documented appropriately.

Training and education programmes and competency checklists have been developed to ensure staff are sufficiently experienced to provide the level of care required to meet the needs of patients within their scope of practice. While there is appropriate oversight of health care students providing care, not all entries made by students in patients’ files sampled have been counter-signed by the overseeing registered health professional.

Discharge planning is actively occurring with timely input from relevant members of the interdisciplinary team. The interdisciplinary focus of care is an area of strength. Improvements continue to be required to ensure patient’s needs are effectively communicated when the patient is being transferred between wards or to other hospitals within the DHB. The patients and family members interviewed confirm being actively involved in care and in preparation for discharge.

Activities are available that are planned and appropriate to the service setting. This is an improvement since the previous audit and now meets the standards.

Policies and procedures provide guidance for all components of medication management. Clinical pharmacists are assisting with medication reconciliation. Areas requiring improvement relate to ensuring medication records are sufficiently detailed; monitoring the ambient temperature of medication storage areas; and ensuring, where appropriate, that patients are able to self-administer medications safely.

The food service for the Ashburton and Christchurch Hospitals is out-sourced, while the smaller hospitals manage their own kitchens. The Hazard analysis and critical control points (HACCP) food safety system operates within the large hospitals. Menus are completed by patients with the kitchen staff at the bedside who talk about the menu. Dietary satisfaction surveys are completed six monthly with the August survey having a 100 percent satisfaction result.

Safe and Appropriate Environment

Extensive work is underway to repair the facilities that have been affected by earthquake damage. Essential work is anticipated to be complete by early 2015. This includes repairs to stairwells, foundations and ceiling tiles. There are well advanced extensive rebuilding plans being led by the board.

Building warrants of fitness are current for all occupied buildings. A project management team meet fortnightly to manage the extensive, time framed, prioritised planning for essential and structural work currently occurring. Wards are being closed for periods of two weeks in order to replace and repair the environment.

As a consequence of the earthquake and the remedial work underway some areas have challenging facility issues. Infection control is managed but some surfaces are broken, work areas are cramped, and flow is poor in places. There are some areas where maintenance is required, for example the toilet, bathroom and shower areas in the mental health services area. The previous required improvement remains open.

In the Assessment Treatment and Rehabilitation (AT&R) unit waste is disposed of in grey bags which are left in communal hallways awaiting collection. In Lincoln Maternity Hospital there are fixed radiators without guards that need monitoring for safety purposes. Also in the Children's Ward, some areas can be readily accessed and need to be secured to provide a safe environment for children. These matters require improvement.

In Christchurch Hospital toilet and shower amenities are insufficient for the number of beds and this needs consideration in the redesign of wards.

Fire and emergency planning changes with each piece of building work being undertaken. A range of methods are used to ensure staff are notified of these changes. Emergency planning is a strength of the organisation.

Restraint Minimisation and Safe Practice

Restraint minimisation is managed separately at each site, using different approaches and forms. The forms do not consistently have a focus on the requirements of the Standard in order to ensure areas such as assessment, monitoring and evaluation are completed comprehensively.

Work has been done to improve restraint minimisation practice in Christchurch Hospital with a programme of work on 'bed sides' use. Examples are provided where restraints are not recorded using the restraint documentation.

In the mental health service the Standard is being well met. There is a steady decrease in restraint use throughout mental health services over the past 12 month. Records demonstrate that the required observations are adhered to. An improvement is required in the acute adult inpatient services in restraint assessment and evaluation processes to include specifically the psychological aspects of restraining.

The previous request to provide an assessment that justifies the locking of the ward door in the youth inpatient service has been addressed.

Infection Prevention and Control

CDHB undertakes appropriate infection control surveillance. This is a planned process agreed annually by the Infection Control Committee Canterbury (ICCC), the membership of which includes a microbiologist, infectious disease physician and the divisional infection control nurses. The divisional infection control nurses have access to up to date data and provide monthly reports on a range of infections to divisional infection control committees, infection control link committees and the ICCC. CDHB is also providing data at a national level as part of the Health Quality and Safety Commission work and have undertaken analysis of their data compared to other DHBs.