# Hutt Valley District Health Board

## Introduction

This report records the results of a Surveillance Audit of a provider of hospital 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:** Hutt Valley District Health Board

**Premises audited:** Central Region Eating Disorder Service||Hutt Valley Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Surgical services; Hospital services - Maternity services; Hospital services - Children's health services; Hospital services - Mental health services; Residential disability services - Psychiatric

**Dates of audit:** Start date: 2 February 2015 End date: 4 February 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 232

# 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.

## General overview of the audit

The Hutt Valley District Health Board (HVDHB) is responsible for 146,000 people living in the district. The Hutt Hospital provides inpatient services across the specialties of medical services, regional rheumatology, emergency department, older person’s rehabilitation services, regional plastic surgery/maxillofacial, the burns unit, surgical specialty services, maternity, child and youth health services, and mental health and addiction services, including the central region eating disorder service.

This three day surveillance audit, against the Health and Disability Services Standards, included an in depth review of five patients’ journeys, review of clinical records and other documentation, interviews with patients and their families, and staff across a range of roles and departments, and observation.

At the previous certification audit there were 24 areas identified as requiring improvement; 15 of these have been addressed and are now closed. This audit identified 14 areas that either require ongoing improvements (nine) or are identified as new issues to be addressed (five).

## Consumer rights

Many examples of good practice were seen and discussed with staff during the course of the audit. The issues identified at the previous audit related to use of sensory modulation within the mental health service and use of medical air in the maternity service have been addressed.

Improvements have been made to processes around open disclosure and staff interviewed are familiar with requirements. Documentation of this in the clinical record still requires improvement. Interpreter services are used when required.

Consent processes meet the standard required of a district health board. Verbal consent is now documented as required within the paediatric service.

The complaints process reviewed meets the requirements of legislation. Staff, patients, and family members spoken with are aware of how they can make a complaint or how to assist in this process. The complaints register contains information on complaints, actions taken and responses to the complainant that show a timely and sensitive approach.

## Organisational management

The Board of HVDHB follows the nationally prescribed planning process, based on the district and region’s needs and national targets set by the Ministry of Health. Collaboration between the three district health boards of Capital & Coast, Wairarapa and the Hutt Valley has influenced the planning process with an integrated approach and shared services and personnel across the district health boards in many cases.

The organisation is aware of the need to develop a more formalised, planned and structured approach to the management of quality and risk and the new general manager for quality and risk is working collaboratively with other quality units to support this process. In addition, improvements are required to ensure components of the quality and risk system are integrated and that there are clear lines of accountability and reporting requirements for clinical governance activities that fit the new structure. The Health Quality and Safety Commission provide a focus for improvement activities. The Quality Account 2014/15, about to be released, provides examples of projects completed that have improved outcomes. There is evidence to indicate that reporting of near miss events has improved, as has the utilisation of quality improvement data in decision making, with several notable examples reviewed. This addresses two previous required improvements. Ongoing improvements are still required around corrective action planning to ensure that plans fully address issues identified, that plans are completed as required and that actions implemented are evaluated for effectiveness.

Policies and procedures continue to require further work to ensure they are current and all documents are included in the document control system, which was not the case at this audit.

While improvements have been made to the risk management system, not all risks are being updated or reported on as required. This needs further development.

Within the mental health service improvements have been made related to consumer participation and these areas now meet the requirements of the standard.

Recruitment practices meet good practice standards. Orientation at both organisational level and unit level is occurring for all new staff. The organisation is defining the mandatory training requirements for all staff and this work is incomplete. There is no overarching process for the recording of staff ongoing training. Area specific training for nursing staff and allied health is occurring; however, the evidence provided shows that not all staff have undertaken the training as required. Ongoing credentialing requirements for medical staff and departments is not being completed as required. These are areas for improvement.

A significant project has been completed around ensuring adequate staff with the right skills are available at the right time across the clinical areas. The previous issues related to staffing have been addressed.

Clinical documentation reviewed was accurate and consistently managed and complete, which is an improvement since the previous audit.

## Continuum of service delivery

Assessment, planning and the timeliness of service delivery was assessed by tracking five patients’ journey’s from the paediatric, maternity, mental health, surgical and medical departments. All transit areas included in the patients’ journeys were visited to assess communication, coordination and transfer or discharge of care. Areas covered were the emergency department, special care baby unit, general and mental health intensive care units, the coronary care unit, surgical and medical assessment units, theatres and the post anaesthetic care unit.

All areas demonstrated that staff are trained and competent in their roles. Supervision and support is provided to students and new employees.

Patient files sampled identified a range of assessment tools being used, including risk screening tools to identify the immediate, ongoing and long term needs of patients. In the medical and surgical areas there is a need to improve the consistency with which these risk assessments are undertaken and documented. Care planning is supported by the electronic patient management system, set care plans and care pathways, in some clinical areas. Some improvements can be made to ensure the documentation of care planning in all areas is managed in a consistent way and a previous related area identified for improvement remains open. Care provided is patient focused and responsive to identified needs. Good examples to support the timeliness of care delivery were sighted. Patients interviewed expressed their satisfaction with the delivery and timeliness of care.

Evaluation of care is consistently undertaken with identified tools, such as the ‘early warning score’ and acute mental health response plans to support a timely response to changing needs of the patients. Further improvements in this area are needed to improve the documentation of patient identified goals and the ongoing evaluation using risk screening tools.

Planned activities are appropriate to the area of service delivery and to meet the needs of the patients in all areas including mental health where improvements have been made since the last audit.

Patients, families/whanau and staff interviewed expresses satisfaction with the manner in which care is coordinated. A multidisciplinary approach to care is prevalent in all areas visited. Electronic white boards are used in areas to give all team members a ‘real time’ update of the patient’s status, identify teams involved in the patient’s care and visualise the progress of plans made for the patient, resulting in improvements made to the discharge process.

All components of the medicine management system assessed meet legislative requirements. Areas for improvement are identified related to the documentation of prescriptions and the management of medicines reconciliation. Previous areas requiring improvement have been addressed.

Food services meet the needs of patients with specialist dietician input available along with a range of special diets. Patient expressed satisfaction with the food service.

## Safe and appropriate environment

All buildings have a current building warrant of fitness and there have been no building changes since the last audit. The computerised plant management system records all planned and unplanned maintenance, which is current.

Improvements have been made in the paediatric service to ensure good practice related to management of ‘sharps’ containers. Improvements have been made to external areas in the Te Whare Ahuru, mental health service, however overcrowding remains an issue. Areas visited were noted to be clean and tidy and improvements have been made to cleaning schedules, cleaning of toys and the maternity ward environment since the previous audit.

Emergency resuscitation trolleys are being checked consistently, addressing previous shortfalls.

There is a current fire evacuation scheme for all buildings. Trial evacuations have occurred six monthly and areas for improvement in this process have been identified. While some improvements have occurred, a number are outstanding. There are a number of issues related to fire safety known to the organisation and these are identified in the risk register and rated as being of high risk, with related action plans. Addressing these issues in a timely manner is required.

The organisation has sought legal advice on the matter of implementation of the smoke free legislation within the mental health unit. The service believes they are managing this in the best possible way for the safety of staff and patients; however the practice of patients smoking within the area is ongoing.

## Restraint minimisation and safe practice

There is a restraint minimisation policy which defines enabler and safe holding for staff. In review of a sample of relevant patients’ files it was identified that consent for enabler use was not consistently being recorded as required in hospital policy. Currently the organisation is not monitoring or reviewing the use of enabler use in the general hospital. These areas require improvement.

## Infection prevention and control

The current infection control committee has a surveillance plan that is appropriate to the size and scope of the service. The service is currently reviewing a three district health board infection control plan that includes a section on surveillance and the frequency with which it will be undertaken.

The results of surveillance are submitted to the Health Quality and Safety Commission where applicable. Reports and data analysis are circulated widely within the DHB. There have been no reported trends identified in the data for the last year.

The team is proactively assessing the information available to staff in the patient areas to assist with the management of infections and completing daily patient visits to ensure patients with infections are managed appropriately. Electronic systems available to the team are being developed to ensure that there is a good capture of patients needing support by the infection control team. All areas for improvement raised previously are now closed.