Taranaki 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.

The specifics of this audit included:

Legal entity:	Taranaki District Health Board
Premises audited:	Hawera Hospital|Taranaki Base Hospital
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 26 May 2015 End date: 28 May 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: 163

Executive summary of the audit

General overview of the audit

The Taranaki District Health Board is responsible for approximately 118,000 people living in the district. The base hospital in Taranaki provides inpatient services across the specialties of medical, surgical, children's health, maternity and mental health. Hawera hospital provides inpatient beds for medical and maternity patients.

This three day surveillance audit, against the Health and Disability Services Standards, included an in depth review of five patients' journeys and the organisation's systems for managing the deteriorating patient, preventing falls, infection control and medication management. Clinical records and other documentation were reviewed and interviews with patients and families and staff across a range of roles and departments were undertaken, along with observations.

At the previous certification audit there were twenty one areas identified as requiring improvement; six of these have been addressed and are now closed. This audit identified twenty areas that either required ongoing improvement (14) or are identified as new issues to be addressed (6). Some members of the organisation's executive management team have dual roles which is extenuated currently by the absence of the chief executive. Inadequate information technology systems are contributing to the ability to adequately implement quality and risk management systems, and although this is in the process of being addressed, with stretched resources, this is currently a risk for the organisation.

Consumer rights

Areas for improvement were identified at the last audit related to verbal consent being documented, privacy of patients in toilets in the new building and family violence screening in the women's and children's health service. These issues have been addressed and now meet the standard; however, the family violence screening is not occurring in other areas of the hospital and this requires improvement.

Informed consent is seen as being undertaken appropriately in the areas visited and staff are aware of when consent is required.

There is a well documented complaints system with a number of ways patients can give feedback. The organisation has a complaints register which shows the majority of complaints meet the timeframes of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. Complaints are rated based on severity and reported to the appropriate managers and committees.

Organisational management

Issues were identified at the previous audit in relation to quality and management and progress has been slow since then to address these.

The quality and risk systems are limited by technology and work is being undertaken during the second half of 2015 to implement new technology that will assist reporting and document management. The structures for quality and risk management need to be reviewed to ensure that the systems link across the organisation and information is shared, evaluated and actions taken when and where required, in a quality and risk management programme.

The process for adverse events has a number of forms to assist with collecting of the relevant information and reporting up to various committees with corrective actions occurring. The events are severity (SAC) rated with SAC 3 and 4 (lowest) being managed at department level and SAC 1 and 2 by the DHB's Serious and Sentinel Event Committee. The organisation is reporting to the Health Quality and Safety Commission (HQSC).

The credentialing of medical staff is up to date and occurs five yearly by area and includes individual senior medical staff, however the annual review process is still in discussion with the union, and this area raised at the last audit remains open. The organisational human resources database identifies that not all staff have undergone annual appraisal. There were a number of health professionals who's online data base record had not been kept up to date to monitor current annual practising certificates. These areas require improvement.

The patient acuity measurement tool Trendcare and the 'Capacity at a Glance' programme assist the organisation to monitor the day to day bed occupancy and staffing needs. A variety of reviews to establish safe staffing levels, to identify short falls and establish strategies to meet needs have been progressed. All recruitment needs for identified gaps and for winter planning have been approved. The previous area for improvement has been addressed.

Continuum of service delivery

Five individual patient journeys were followed in child health, mental health, maternity services, and medical and surgical services. Incidental sampling occurred at Hawera Hospital and in other wards and departments across the district health board to verify the consistency of the systems and processes used in the care and treatment of patients. In addition, an in-depth review of infection prevention and control, medication management, falls prevention and identification of the deteriorating patient, occurred across the organisation.

Patients received timely, appropriate and competent services from teams of medical, nursing and allied health staff. There is a strong multidisciplinary focus within and across services. Assessment and nursing specific assessment tools, planning, care and treatment interventions are implemented from admission onwards. Medical, nursing and allied health progress notes record and evaluate care provided. Tools such as the early warning score (EWS) and maternity early warning score (MEWS) are used to identify patients whose condition is changing or deteriorating. Verbal handover processes are in use aided by electronic printouts. Electronic whiteboards in use at Taranaki Base Hospital assist the tracking of patient progress, referrals and alerts and planning towards discharge. Medical discharge summaries are provided to the patient and electronically sent to the general practitioner (GP), usually within 24 hours. Patients and family members interviewed reported being involved in the planning of their care, that they are kept well informed of progress and that staff are responsive and respectful. Some patients were particularly complimentary of the care received.

Medication management has been enhanced with the roll out of the 'eMedChart' into the medical wards and the national medication chart implemented in those wards that do not presently use the electronic chart. Work is ongoing to ensure consistent prescribing, dispensing, administration and review of medication. Tracer methodology was used to review the system to manage

high risk opiate medication. Electronic medicine reconciliation (eMedRec) is occurring in 6 of 12 wards and has been utilised by 89% of priority patients in the first quarter of 2015.

Follow up of previous areas requiring improvement indicates that progress is being made. Further action is required to address consistent completion of sufficiently detailed nursing assessments and care planning; complete the EWS and fluid balance documentation to assist with ongoing evaluation of the patient's condition; support patients in the mental health service to make decisions and choices; and to ensure consistent use of discharge checklists and summaries. Action is required to ensure all aspects of medication prescribing details are completed and to address out of range fridge temperatures in the inpatient unit at Hawera Hospital.

Safe and appropriate environment

There have been no changes to the buildings at either hospital since the last audit. Building warrants of fitness are all up to date. An issue raised at the previous audit related to the need for upgrading of the environment in the mental health in-patient area remains open, however plans have been approved and work is planned to start at the end of the year.

Management of hot water temperatures at Hawera remains an area for improvement as does regular testing for safety of body protected areas at both sites.

Regular trial fire evacuation occurs and staff have emergency training at orientation and annually to maintain knowledge. E-learning modules have been introduced since the last audit to compliment the training opportunities provided.

Previous issues related to cleaning, laundry and emergency trolley checking and security have been adequately addressed.

Restraint minimisation and safe practice

The organisation has documented processes and a committee to provide oversight for restraint minimisation and safe practice. The mental health service has an active programme of restraint minimisation that includes review of each episode of restraint and

evaluation of the number of events over time to assist learning. Staff discuss any restraint used to actively maintain awareness and improve practices.

Work has been undertaken to define and implement a process for the safe use of bedsides for adult patients; however, further work is required to ensure documentation and practices align and that adequate reporting occurs. The restraint minimisation committee does review overall restraint use as part of the committee responsibility.

A previous issue related to the use and reporting of seclusion in the mental health service has been addressed.

Infection prevention and control

There is a defined organisational structure for infection prevention and control (IPC). The infection control committee has reports to the clinical board and there is an active and experienced clinical nurse specialist overseeing infection prevention and control across the DHB. Regular reports of activities, issues and progress in meeting key infection surveillance indicators are reflective of the needs and priorities of the organisation and consistent with Health Quality and Safety Commission requirements. No new trends are apparent from the surveillance data reviewed although Clostridium Difficile rates are variable in 2014 when recorded per 100,000 bed days. Additional resourcing for IPC has been approved, and recruitment is again underway following a period of vacancy – this will add some much needed extra support for the role.

Tracer methodology was used to review infection control systems and practices related to transmission based precautions through review of patient flow from admission to discharge, the environment, communication between wards and departments, review of clinical records and infection prevention and control practices. While practices are noted to meet requirements, the review reveals some gaps in communication and documentation about patient's infection status which are raised elsewhere in this report.