

Whanganui 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:	Whanganui District Health Board
Premises audited:	Whanganui Hospital
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 7 July 2015 End date: 9 July 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:	121

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

Whanganui District Health Board (WDHB) is responsible for ensuring around 63,000 people living in its district have access to the necessary health and disability support services. Hospital services include medical, surgical, paediatric, maternity, assessment and rehabilitation services and mental health services, which also included the regional forensic service in partnership with the Capital & Coast District Health Board (CCDHB).

This three day surveillance audit, against the Health and Disability Services Standards, included an in depth review of two patients' journeys in the maternity and mental health services and review of four organisational systems (prevention of falls, medicine management, infection prevention and control, and management of the deteriorating patient). Additional sampling of clinical records and other documentation to validate the consistency of information was also undertaken, along with interviews with patients and their families, and staff across a range of roles and departments were also interviewed and observations made.

At the previous certification audit there were 15 areas identified as requiring improvement; 12 of these have been addressed and are now closed. This audit identified seven areas that either require ongoing improvements (three) or are identified as new issues to be addressed (four).

Consumer rights

Patients and their families felt well informed and involved in decisions about their care. The issue of ensuring that patients provide written informed consent was problematic at the last audit and, despite a revision of the forms in use in the general hospital, this is still not fully resolved. In addition, there were gaps in the consent provided by some patients in the mental health service. Other aspects related to consent have been addressed. A previous issue concerning privacy in shared bedrooms is now being managed effectively.

The complaints process is well established, meets legislative requirements and is actively monitored. Complaints reviewed as part of the complaints register showed timely and sensitive management to resolution.

Organisational management

The management of quality and risk across the WDHB is well established with a planned quality improvement programme that supports national priorities. Particular strengths are evident in relation to an integrated approach across the continuum of care, staff involvement, a focus on measurable outcomes and evaluation, a continuous quality improvement approach and well displayed information available to a wide range of stakeholders. These aspects of quality improvement demonstrate a 'continuous improvement' level of achievement. Key components of quality and risk management are linked through unit and ward level forums, management teams, the clinical committees and the Clinical Board. Corrective action planning has improved with a robust system to track completion, which is audited.

Risk management meets requirements with more rigorous review reducing the numbers of risks being monitored since the previous audit. Projects are analysed in relation to risk and relevant risks are reported to the Risk and Audit Committee.

The previous areas requiring improvement related to policies and procedures, has been adequately addressed, with monitoring and reporting in place to track ongoing progress required for the remaining out of date policies.

Adverse events are well managed, reviewed and reported and learning from investigations are evident.

Staff are well supported with training opportunities defining minimum requirements. The previous issues related to completion of specific competencies and training have been addressed. The numbers of nurses on the professional development and recognition programme (PDRP) have been steadily increasing due, in part, to a simplified process. Ongoing issue around accuracy and currency of training records needs to be addressed, as does the low level of completion of performance reviews for staff.

Staffing requirements meet patient demand with examples of good team work and a flexible and responsive approach. Innovative projects to support the care of patients being provided by the most appropriate staff in the most appropriate setting is a particular strength of the organisation and is rated as 'continuous improvement'. This work is well supported by the electronic patient acuity system and 'care capacity demand management' project. Where there are staffing deficiencies identified (eg, physiotherapists) strategies to manage this are evident.

The previous issue related to staff documenting their name and designation in the clinical record has been addressed; however, there are a number of issues related to documentation that still require addressing. These include use of medical staff pager numbers instead of the name of the medical staff member being contacted, completing all forms as required, and ensuring that the correct type of infection isolation details are documented in care plans.

Continuum of service delivery

Patient care was reviewed and evaluated across the services using the two patients reviewed with tracer methodology, the four systems tracers, and the additional sampling. Care is provided by appropriately trained and supported staff. Investigations and assessments are undertaken and used to assist with developing patients' plans of care. Improvements have been noted in the completion of routine admission assessments and ongoing review where required. Identification of individualised patient's goals are still not consistently occurring and require further attention. Care plans in the mental health service are documented, updated and

reflect the current needs of the patient. Previous issues with management of the closed circuit television cameras (CCTV) and locking of the facility have been addressed.

The patient falls risk assessment processes is consistently utilised and interventions are implemented to reduce patients' risk of falling. A strength of the WDHB falls prevention programme is the inclusion of a hospital and community focus. The falls prevention programme has resulted in a steady decline in the numbers and severity of falls.

An early warning score is being used to identify deteriorating patients. There is not always evidence of timely communication about the changing needs of patients. This, in part, is contributed to by insufficiencies in aspects of staff documentation. Other examples were sighted verifying the patient's plan of care was changed in a timely manner in response to the patients' changing needs.

Discharge planning is actively occurring. The multidisciplinary focus of care is an area of strength. All patients and family members interviewed were complementary about services received, advice, and ongoing timely and clear communication with staff.

Improvements in medication management were evident, addressing a number of the areas identified at the previous audit; however, ongoing improvements are required in relation to management of controlled drugs, prescribing of oxygen and some aspects of documentation.

Issues previously raised around the monitoring of temperatures of fridges storing patient food and covering and dating of food remain.

Safe and appropriate environment

All the buildings have current warrants of fitness and there is an effective process to keep essential equipment checked and up to date. Maintenance is monitored. Stanford House, the forensic mental health unit, was renovated in March this year and now provides a much improved environment. There have also been improvements in making the children's ward and emergency department more child friendly, meeting a previous requirement.

Most emergency trolleys in the hospital have recently been replaced and are secure, either locked or within areas with limited access. This also now meets a previous requirement.

Emergency management is well managed including evacuation procedures.

Restraint minimisation and safe practice

Policies and procedures related to restraint minimisation and safe practice meet the requirements of the Standard. Recent improvements to the use of enablers, and in particular the use of bedside rails is evident, with a plan to progress these improvements across all areas of the organisation. Staff interviewed, observation and documentation reviewed indicates that staff are aware of the difference between a restraint and an enabler and are focused on keeping patients safe while ensuring the least restrictive option is used and consent is documented.

Infection prevention and control

Surveillance for infections is occurring. The surveillance programme is appropriate to the service setting and includes significant organisms (including multi-drug resistant organisms), specific surgical site infections, invasive device related infections, blood stream infections and outbreaks. The results are communicated appropriately.

Policies and procedures are available for staff to guide infection prevention and control activities. This includes cleaning related to isolation rooms. Policies have been updated since the last audit to ensure current and consistent information, addressing the previous shortfall. The documents are available to staff on the intranet.

Antimicrobial guidelines provide guidance to prescribers on appropriate antimicrobial use. Monitoring of antimicrobial use is now occurring and demonstrated a high level of compliance with the organisation's policies. This previous issues has been addressed.

The infection control system tracer reviewed in detail the identification, communication and implementation of isolation precautions for relevant patients. Patients who require isolation are being identified in a timely manner and this is communicated to staff. Appropriate precautions are being implemented by staff where required.