South Canterbury District Health Board - Timaru Hospital

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:	South Canterbury District Health Board
Premises audited:	Timaru 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: 27 October 2015 End date: 29 October 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: 69

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

South Canterbury District Health Board (SCDHB) funds and provides public health services for the 55, 600 people resident in the South Canterbury District. Timaru Hospital, with 132 beds, provides medical and surgical, maternity, neo-natal and paediatric, mental health and assessment treatment and rehabilitation (ATR) services. It also provides a range of tertiary services through visiting clinicians and outreach services.

This three day surveillance audit, against a subset of the Health and Disability Services Standards, included an in depth review of five patients' care and four clinical systems (medication management, infection control, management of the deteriorating patient and systems to reduce patient falls). During this process auditors reviewed clinical records and other documentation, interviewed patients and their families, interviewed management and staff across a range of roles and departments, and made observations.

At the previous certification audit there were 30 areas identified as requiring improvement; 13 of these have been addressed and are now closed. This audit identified 19 areas that either require ongoing improvements (16) or are identified as new issues to be addressed (3).

Consumer rights

Areas that were identified for improvement at the last audit were followed up. Information about the Code of Rights is available, however consumers interviewed in paediatric and maternity services were unaware of the information and were not offered opportunity for explanation, discussion and clarification of their rights. Family violence screening remains an area for improvement in maternity, paediatrics, emergency department (ED) and mental health services.

The privacy of mental health consumers in seclusion has been addressed satisfactorily.

Work has been conducted in consultation with the Ministry of Health to address the maternity environment with the aim of encouraging good practice. Draft documents are under consideration to guide staff and access holders in regard to ensuring requirements under Section 88 Maternity Notice are met. Initiatives to improve communication with maternity consumers and between health professionals are in place or under development and work is ongoing to ensure midwives are supported to remain within their scope of practice. This area for improvement remains open.

Documentation of written consent has improved, however, documentation of the risks and benefits of procedures is not consistently recorded. Advance directives for ‘not for resuscitation’ orders are not consistently signed by two medical officers, when this is required.

Complaints management processes are operating efficiently and are monitored. Investigations and responses to patients and staff are timely. The form now includes compliments as well as complaints and is freely available.

Organisational management

The management of quality and risk across the SCDHB is well established with a planned quality improvement programme and quality facilitator roles that support national priorities, South Island Alliance projects and local projects. A strength of the organisation is their integrated approach across the continuum of care (the primary and secondary services). Key components of quality and risk management are linked through several forums, including the Clinical Board, Senior Leadership Team and the Patient Safety and System Improvement Committee (PSSI). Information is made available to staff and the public through ward based 'story boards', other well displayed project work, and an accessible Quality Account. The previous required improvement around dissemination of information has been addressed. Corrective action planning has improved with a robust system to track completion of the more significant events and complaints; however, not all quality activity recommendations are being monitored and some corrective actions have not been addressed in a timely manner, requiring further attention.

Risk management meets requirements with the addition of new risks following analysis, discussion and agreement as to significance and controls. Relevant risks are reported to the Board Audit and Assurance Committee.

The previous required improvement related to policies and procedures has been partially addressed but improvements are still required to ensure currency of all documents (eg, forms), that policies are based on best practice and provide sufficient guidance, that staff are aware of new policies, and that only one set of procedures is available at any one time. Monitoring and reporting on the currency of policies and procedures is ongoing and shows good progress.

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

Improvements to departmental orientation have occurred, addressing a previous shortfall. Ongoing issues around performance appraisals for some professional groups and completion of mandatory training requirements continue. Good progress has been made in relation to medical credentialling requirements with plans in place to address those areas outstanding.

Staffing requirements generally meet patient demand with examples of good team work and a flexible and responsive approach. The electronic patient acuity system and 'care capacity demand management' project is supporting work to ensure both short and long term solutions across the services, including the medical ward where staffing levels are at a minimum. SCDHB has a stable

workforce, and where there are staffing vacancies identified (eg, two senior consultant roles and one pharmacy position), recruitment strategies are constantly being reviewed.

The previous issue related to identifiers on the clinical records of babies has been addressed; however, there are a number of areas related to documentation that still require attention. These include ensuring records are legible and the name and designation of the person making the entry is included, and that all records are fully integrated.

Continuum of service delivery

Five patient journeys and four systems tracers were undertaken to review the assessment, planning, delivery and evaluation of clinical care provided to patients. The evidence affirmed the provision of care by trained professionals, using evidence based guidelines for practice. A number of service based projects since the last audit have resulted in practice improvements, for example, multidisciplinary involvement in care planning, clinical guidelines available in patients' files, the e-prescribing format for medicines management and the falls prevention project.

Patients and families interviewed confirmed they are satisfied with the communication, quality and timeliness of care. There is evidence of good multidisciplinary collaboration to develop patient care plans and discharge plans for patients. In the mental health area there is evidence of integration with community services and practitioners to plan inpatient care.

Improvements made have resulted in the closure of a number of corrective actions. Further work is required in the areas of risk assessments, collated care plans, documentation of clinical decision making (including the early warning score), discharge planning, and verification of a registered nurse's oversight of work undertaken by student nurses and enrolled nurses.

Medication management is generally well managed, however there are aspects that require further improvement, including prescribing, clinical pharmacist involvement, medicines reconciliation and vaccine storage. Opioid management was reviewed in detail identifying two areas for improvement: documentation of controlled drug security processes; and holistic pain evaluation as part of opioid management. Secure storage of medication in trolleys, ambient temperatures of stored medication areas and charting of intravenous fluid/medication volumes have been improved since the last audit addressing the required improvements.

Improvements have been made to a number of aspects of the food service, with improved patient satisfaction noted. In the paediatric ward the monitoring of fridge temperatures where food and breast milk is stored continues to be inconsistent.

Safe and appropriate environment

There are current building warrants of fitness for all buildings. There have been no required changes to the fire evacuation plans that have been approved by the New Zealand Fire Service. Trial fire evacuations are conducted, most recently in May 2015. Earthquake strengthening work is nearing completion for the 'Gardens Block'.

Improvements required at the last audit in relation to the environment have been partially addressed. Environmental cleaning in the inpatient service now meets required standards. High dusting is scheduled to re-occur in the laundry, however, it is unclear who is responsible for cleaning above and behind the machinery in the laundry. This area is visibly dusty.

Changes have been made to the environment in the day procedure unit. The remaining aspects will not be completed until the planned redevelopment project is completed. This is scheduled to commence in February 2016 and is expected to take 18-24 months.

Policies and processes have been implemented to minimise infection control risk when adult patients are admitted to the children's ward.

The renovation/refurbishment in the mental health unit has resulted in improvements to the environment. The current stage in progress, when completed, will address the required improvements to the seclusion area.

Restraint minimisation and safe practice

A policy and procedure provides guidance for staff on restraint minimisation practices and the use of enablers. The definitions of restraints and enablers align with the standards. The use of restraint is minimised. Bed rails are no longer approved for use as a

restraint. Staff are provided with education on restraint minimisation and safe practice and the use of enablers as a component of the ongoing education programme.

Stitch gowns are no longer available for use in the mental health service. The Director of Area Mental Health Service has completed the necessary documentation around seclusion rooms.

All four areas requiring improvement from the last audit have been addressed.

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.

A systems approach was used to review infection control systems in detail and practices related to the identification, communication and implementation of isolation precautions for relevant patients. Areas for improvement have been identified and raised in the core standards, where appropriate.

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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