

Bay of Plenty 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:	Bay of Plenty District Health Board
Premises audited:	Opotiki Health Care Centre Tauranga Hospital Whakatane Hospital
Services audited:	Hospital services - Psychogeriatric services; 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: 2 February 2016 End date: 4 February 2016
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:	284

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

Tauranga Hospital, Whakatane Hospital and Opotiki Health Centre are part of the Bay of Plenty DHB (BoPDHB) and provide a range of services to the region's population of around 221,000. Hospital services include medical, surgical, child health, mental health, elder health and rehabilitation. BoPDHB is one of five district health boards (DHBs) that make up the Midland region.

This three day surveillance audit, against a subset of the Health and Disability Services Standards, included an in depth review of organisational management systems, two patients' care and four clinical systems. 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 observed practices.

At the previous certification audit there were 27 areas identified as requiring improvement; 10 of these have been addressed and are now closed. This audit identified 19 areas that either require ongoing improvements (17) or are identified as new issues (2) to be addressed.

Consumer rights

There are policies and process to support staff in providing information on the Code of Health and Disability Services Consumers' Rights (the Code) to patients however file reviews and interviews have identified this as an area that requires improvement. The Code pamphlets were easily accessible in te reo Maori and English, and posters were visible at both sites.

Patients and where required their families and whanau are provided with information as required to make informed choices. In the mental health area work is ongoing to improve the consistency of documentation for informed consent. Staff are aware of patient needs and requirements of advance directives and the return of body tissue, where applicable. All patients are offered a discussion on their wishes for their care including resuscitation needs. The content of these discussions are not consistently documented and patients are not offered the opportunity to sign these documents.

The previous audit required that improvements be made relating to privacy issues at Whakatane hospital. This has been addressed. Work has also been completed in relation to accessing interpreters and this previous finding is closed.

There is a robust complaints policy and procedure with specified timeframes which are adhered to. Each complaint undergoes a quality assurance checklist on closure of the complaint, with a link to a feedback website now included into the complaint closure letter to the patient to monitor patient views on the management of the complaint. The service also has a hard copy feedback form; this was not consistently available in the clinical areas of both hospitals visited and is raised as a finding. Staff are kept up to date about patient feedback via a board situated outside the café which is updated every two months.

Organisational management

The management of quality and risk across BoPDHB is well established with a planned quality improvement programme and a quality team that support national priorities, sub-regional and regional projects. The organisation is working regionally to have an integrated approach across the continuum of care (the primary and secondary services) to meet the demands of an increasing

population. Key components of quality and risk management are linked through clinical and non-clinical committees and teams, with clinical staff involved in decision making and monitoring.

A range of quality improvement data is gathered, analysed, graphed and reported to decision making groups. Where trends or opportunities for improvement are identified this is actioned. Staff and project teams use data to monitor progress and outcomes. Evidence existed of good clinical governance linkages, joining the different components together (eg, linking adverse events to the risk management and improvement process). Corrective action planning systems and project improvement initiatives occur in various ways throughout the organisation. These systems include different recommendations registers, varying detail for planning and to track completion of the recommendations especially for the more significant programmes of work. Improved management of corrective action and project improvement is required.

The risk management system is documented and implemented across each level of the organisation. Moderate and high level risks have plans to minimise or mitigate most risks. More formal planning could occur for other risks and this is an area for improvement, as noted above. Monitoring and reporting occurs at appropriate levels in the organisation.

Previous shortfalls identified relating to ensuring consumer participation at all levels in the mental health service remains open, noting significant commitment and that timely progress is being made.

The previous required improvement related to policies and procedures has been partially addressed. The organisation has transitioned to a new web based electronic system for document management and the number of overdue policy is reducing. A project to identify and eliminate barriers to reviewing documents has been undertaken and is being rolled out to departments to ensure timely service level review. Improvements are still required to ensure access to appropriate policies and procedures to guide staff practice.

The credentialing policy, process and register showed a robust system in place with all individuals and services up to date. There are specific processes for locum staff and cross credentialing to other DHBs. Recommendations identified through the credentialing process are formulated into a service specific action plan.

Previous corrective action around the police vetting of medical staff has been closed as a robust process was seen to be in place, however the previous action pertaining to the completion of staff appraisals remains open, the process remains inconsistent however there is a project planned for later this year.

The lodging and monitoring of professional registration and mandatory training as required at the last audit has been addressed and is embedded into the human resources system. The Professional Development and Recognition Programme information has been merged into the Human Resources Information System to enable reporting to the Nursing Council of New Zealand.

Systems to understand and respond to staffing requirements are in place however the region is experiencing continuous growth and this is creating ongoing pressure on beds in Tauranga Hospital that does not now have the seasonal variation once experienced. This was particularly demonstrated in the mental health services during this audit. Review of TrendCare data and reports is steadily trending up. Allied health services frequently report shortages.

The previous areas requiring improvement related to the integration of mental health information into the one electronic system has been addressed. A number of documents continue to have illegible signatures and designations and therefore this issue remains open. A project for patient identification has been undertaken as part of patient safety week activities and a leaflet has been developed and awareness campaign undertaken with staff.

Continuum of service delivery

Patient care was reviewed and evaluated across services with two patients reviewed using tracer methodology in the areas of maternity and mental health. In addition four systems tracers were conducted in relation to management of the deteriorating patient, medication management, falls prevention and infection prevention and control. The information gathered from these tracers was supported by additional sampling.

Care is provided by suitably qualified and experienced staff who work in a multidisciplinary manner to provide timely care. Improvements have occurred in assessment processes and these are now thorough. Improvements have also been made in regard to the process for transfer from the Emergency Department (ED) and to mental health assessment. Investigations and

assessments are undertaken and used to assist with developing patients' plans of care. While work to improve care planning has been undertaken since the previous audit, further improvement is required in documentation of patients' goals as a basis for planning, and plans of care, including mental health patients' care plans.

Service delivery is of a high standard, however improvement is required in relation to management of peak occupancy and insufficient bed spaces. Discharge planning continues to require improvement, however use of discharge letters to inform patients is effective.

The organisation has implemented a number of strategies to support the identification and management of deteriorating patients. Improvement is required to address variable completion and use of the 'Early Warning Score' (EWS) to escalate care. Further development of the overall organisation-wide strategy for deteriorating patients is also needed. Inconsistent stocking of medication in resuscitation trolleys requires improvement.

The falls prevention programme is well established providing numerous initiatives and a reduction in frequency and severity of falls events; however, documentation of strategic oversight of the programme requires further development.

There are effective systems in place for medicines management that are well known to staff. While some improvements have been made, further improvement is required in prescribing and administration details, legibility of specimen signatures, documentation of venous thromboembolism screening, security of resuscitation trolleys and the availability of medicines reconciliation at Whakatane Hospital. The national initiative to manage the care of patients needing opioids is being trialled at the hospital with good success, and this is planned for all areas of the hospital early in 2016. Controlled drug management meets legislative requirements. The medicines management tracer reviewed the introduction of medicines reconciliation and clinical screening for polypharmacy in high risk areas of Tauranga Hospital, which are meeting projected outcomes and providing data for ongoing work.

Safe and appropriate environment

Buildings have current building warrants of fitness. At the last audit, areas for improvement related to storage of chemicals was raised and has now been addressed. Other areas for improvement such as the buildings being unfit for purpose and maternity equipment management remain as issues.

There is evidence of significant work having been completed in the main part of the mental health unit at Whakatane with client involvement in the process. Staff reported that both staff and patient morale has improved with the positive changes, however the low stimulus area at Whakatane was not included in these renovations and needs improvement.

Some equipment in the maternity service needs attention to maintain infection control integrity. No building changes have occurred since the last audit and the New Zealand Fire Service evacuation plan has not required any amendments. Emergency and security policies are in place and training occurs.

Restraint minimisation and safe practice

A policy guides staff on the use of enablers and restraint. Staff understanding is varied. The documentation of enabler use continues to require improvement and systems for monitoring enabler use across the organisation could be enhanced. A previous issue regarding the means to summon assistance for patients in seclusion has been resolved.

Infection prevention and control

A systems approach was utilised to review in detail infection control practices which identify patients with organisms of concern, how this information is communicated to clinical staff, and that appropriate precautions are implemented to manage and treat patients. Infection status is communicated between wards and departments and staff have a good understanding of the correct management of patients requiring isolation.

The DHB has a surveillance programme in place to capture and monitor infections as appropriate to the service setting. Monthly surveillance data is reported to the Infection Control Committee with variances reported on. Surveillance data is available electronically. There is no regular collation of the surveillance data with expert analysis, conclusions and recommendations to guide best prevention practices for the organisation as per the Committee's terms of reference good practice and this needs addressing.