

Whanganui District Health Board - Whanganui Hospital

Introduction

This report records the results of a Certification 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](#).

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: 22 November 2016 End date: 24 November 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:	161

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.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

General overview of the audit

The Whanganui District Health Board (WDHB) provides services to around 62,500 people in the Whanganui region. Hospital services are provided from the 175 bed Whanganui Hospital and include medical, surgical, maternity, paediatric, and mental health and addiction services, supported by a range of diagnostic and support services.

This three-day certification audit, against the Health and Disability Services Standards, included a review of management, quality and risk management systems, staffing requirements, infection prevention and control, and review of clinical records and other documentation. Interviews with patients and their families and staff across a range of roles and departments were completed and observations made.

This audit identified six areas that require improvement across the standards. These relate to ensuring that family violence screening is completed and all patients are kept secure; updating of consents at Stanford House; currency of policies and procedures; documentation; planning of care and medicines management. There are three areas of continuous improvement in relation to development of more responsive services to Māori; continuous quality improvements; and ensuring an appropriately skilled workforce to respond to patient demands.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is visible around all services, and patients and whanau reported an awareness of the Code and that their rights are upheld. All patients spoke positively about their care, treatment and communication with staff. Staff were observed respecting patients' rights, including their privacy.

The organisation supports a whanau centred care approach with a strong commitment to providing services that meet the needs of the Māori population. Other cultural groups have their needs met.

Examples of evidence based practice and innovative approaches to delivering care, along with promoting a safe environment, were noted across services.

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent. Communication with patients and families is open and honest and examples of open disclosure were evident where required. Access to interpreter services is available and known to staff.

The complaints process is well managed and meets the requirements of the Code. Patients know how to make a complaint and complaints have been resolved within the required timeframes. Learning and improvement from complaints was evident.

Organisational management

A well-developed planning process is based around the statutory requirements and adapted to meet the needs of the Whanganui region's people. Values have been updated and are well embedded in the organisation.

The current management and leadership structure is effective with an experienced and stable executive management team.

The quality and risk framework is well established, led by the General Manager of Patient Safety and Service Quality and supported by a well-qualified team. Connections to national projects and a strong culture of quality improvement are strengths of the organisation, as is the focus on inclusion of whanau/family in quality activities. Staff are involved at all levels with improvement activities, in particular, the 'Releasing time to care' programme, and are familiar with audit, data analysis and continuous improvement methodology. Effective systems are in place to integrate the various components of quality and risk management. Data is widely available and well used to monitor patient safety, support projects, make improvements, monitor trends and address issues where they arise. Adverse events, including those of a more serious nature, are being managed as required.

Consumer and family involvement within the mental health services is well developed, with involvement of appointed roles at both a strategic and operational level.

Human resources systems are based on best practice. The developments in the orientation process support integration of the values across the organisation. Staff are well supported with training and education opportunities, with improvements to the recording of training evident. The organisation continues to seek ways to further enhance training, using on line and shared resources with other DHBs in the region and nationally.

Staff numbers and skill mix are clearly defined and based on accurate information. There is a multi-pronged approach to ensuring staff are utilised in the most efficient way to meet changing patient demands.

Clinical records, in general, are well completed, tracking the patient's care. Records are stored securely and easily retrievable. Privacy of information is maintained.

Continuum of service delivery

Patients access services based on their needs and this is guided by policy. Waiting times are managed and monitored. Risks are identified for patients through screening tools which are based on best practice. Entry is only declined if the referral criteria are not met, in which case the referrer is informed of the reasons why and any alternatives available.

Seven patients' 'journeys' were reviewed as part of the audit process and involved the emergency, surgical, medical, paediatrics, critical care, and maternity wards / departments, the acute assessment unit (AAU), mental health (Stanford House and Te Awhina), the acute stroke unit, and the operating theatre suite. Additional sampling was undertaken throughout the audit. Auditors and technical expert assessors worked collaboratively with staff reviewing the relevant documentation and interviewing medical, nursing and allied health team members, patients, and family members.

A qualified and skilled multidisciplinary team provides services to patients and there were good examples of teamwork throughout clinical areas. Referrals to other health services in the hospital and the community occur. Shift handovers are efficiently managed and includes an office and bedside handover by nursing staff.

Assessments are undertaken in a timely manner with results reviewed, discussed and actioned as appropriate. This was supported by patients and family / whanau members interviewed. Care planning tools are used across the services, including multidisciplinary team review. Use of early warning scores (EWS) to prompt triggers when a patient's condition deteriorates is generally well completed. Evaluation is undertaken of patients' progress on a regular basis and includes progress towards discharge.

Activities meet the requirements of the individual patients and these are particular to the various specialty settings.

Policies and procedures provide guidance for staff on medicines management and this is supported through ongoing education. The national medicine chart is in use in most wards and departments. Clinical pharmacists provide support in the majority of clinical areas. Medicines are stored safely. Several quality projects are being undertaken related to medicines management.

Food services are provided by an external contractor. The food services have successfully undergone external audit against national food standards in July 2016. Special diets are available if required, meeting the range of patients' needs.

Safe and appropriate environment

Facilities across the site meet the needs of the various patient groups and are well maintained. All sites have a current building warrant of fitness. Patients expressed satisfaction with the environment.

Reactive maintenance of equipment and facilities is prioritised with staff reporting that there is enough of the right equipment to support good practice. All regulatory requirements are met.

Planning for all types of emergencies is well developed and suitable equipment and supplies are available. Evacuation drills have been completed six-monthly, and staff have completed mandatory fire training. Some emergency plans and/or aspects of plans have been tested in real situations over the past eighteen months and improvements integrated where necessary.

Cleaning and laundry services are well managed, with a good standard of cleanliness noted in areas visited.

Management of waste and storage of chemicals and hazardous substances meets requirements with staff trained to manage any related emergencies. Appropriate personal protective equipment is available and used.

There are sufficient toilets and personal spaces available. Patient areas have adequate natural light, heating and ventilation.

Security is well managed across the site with a range of technology and trained personnel available as and when needed.

Restraint minimisation and safe practice

Restraint is overseen by the Restraint Approval Committee which has full representation across WDHB. Policies set out the requirements for safe restraint practice, documentation and evaluation procedures. These are updated as required; for instance, a new policy has been developed on the use of mechanical restraints. There are defined restraint and enablers for different services. There is good summary of information about use of restraints and enablers.

The Mental Health and Addictions Service (MHAS) is about to start using the Te Pou-based Safe Practice Effective Communication (SPEC) training and has incorporated the national six core strategies into its very effective programme to reduce restraint and seclusion use.

There are seclusion rooms in both inpatient units of the MHAS, but those in Stanford House, the medium secure forensic rehabilitation unit, are seldom used. During the audit, there were no patients in seclusion. The Director of Area Mental Health Services has approved the seclusion rooms. Seclusion use is subject to careful monitoring and alternatives are actively sought and implemented.

Infection prevention and control

WDHB has an infection prevention and control (IP&C) programme that has been approved by the IP&C committee. The IP&C programme is facilitated by the infection prevention and control nurse specialist, supported by the infection prevention and control committee, ward/department representatives, clinical pharmacists, the duty managers and laboratory staff. This IP&C committee includes a representative from the Primary Health Organisation (PHO) and from the residential aged care sector.

Policies and procedures are available both electronically and in paper based manuals to guide staff practice. The clinical nurse specialist in IP&C participates in relevant ongoing education. Orientation and ongoing education is provided to DHB staff and community health providers. Patient and family education also occurs.

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 surveillance results are communicated appropriately. Monitoring of compliance with prophylactic and therapeutic antimicrobial use is occurring.