

Hokianga Health Enterprise Trust

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care 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:	Hokianga Health Enterprise Trust
Premises audited:	Hokianga Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services
Dates of audit:	Start date: 26 April 2017 End date: 26 April 2017
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:	20

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

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Hokianga Hospital provides hospital services (medical and geriatric), maternity services, and rest-home level care for up to 23 clients. On the day of the audit 20 clients were receiving services. There were no clients in the maternity services.

This surveillance audit was conducted against a subset of the Health and Disability Services standards. The audit process included the review of policies and procedures, the review of clients' and staff files, observations, and interviews with clients, management, staff, and a medical specialist. Feedback from clients and family was positive about the care and services provided.

At the last audit eleven areas were identified as requiring improvement. These related to policy document control processes, aspects of human resources management and staff orientation records, documenting a staffing policy, records management, and monitoring antimicrobial use. Care planning and evaluation, aspects of medicine management and two areas related to restraint minimisation were also noted. All eleven areas have been addressed. At this audit one area has been identified as requiring improvement relating to the pressure injury policy and procedures. Strategic consultation and communication processes with the wider community are well established. This is an area of continuous improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Clients are provided with information in a timely manner, and where required, interpreter services are accessed to support the communication between staff and patients. Staff understand the process of open disclosure and there was evidence of this occurring.

Staff and clients interviewed were aware of the complaints process. Complaints are investigated and responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The chief executive officer (CEO) and the hospital services (HSM) have both worked in this service for many years. Job descriptions detail their roles and responsibilities. The strategic plan is for 2015 to 2020. Progress is reviewed at least annually and an annual plan developed and implemented. The vision, mission and philosophy of the service are documented.

The quality and risk programme includes internal audits, complaints, compliments, client satisfaction surveys, and incident/accident, hazard and risk identification and management. Policies and procedures are in place that address required aspects of the service, and documents are controlled. The executive committee has oversight of the quality and risk programme. There are formal reporting processes in place between the CEO and the Board of Trustees.

Recruitment selection and appointment complies with good practice. Mandatory training is identified and staff have good access to internal and external training opportunities. New employees are provided with orientation relevant to their roles. Policy details staffing numbers and skill mix requirements. There is a minimum of two nursing staff and two caregivers on duty at all time. A medical practitioner and a lead maternity carer are always on call when not on site.

Clients` information is accurately recorded, securely stored and not accessible to unauthorised people. Up-to-date, legible and relevant clients` records are maintained in an integrated hard copy record and electronic records. The national health index unique identifier numbers are recorded on each page of the clients` records reviewed. The organisation meets the New Zealand Health Information (NZHI) requirements.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Clients` needs are assessed by the multidisciplinary team on admission within the required timeframes. The registered nurses complete all nursing assessments and are supported by allied health staff and a designated medical practitioner. One of two lead maternity carer midwives (LMCs) employed by the organisation, cover the twenty four hour period for the maternity service. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. The respite and long term inpatient client records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. For all services, clients` and families interviewed reported being well informed and involved in care planning and evaluations, and that care provided was well managed. Clients are referred or transferred as required, with appropriate verbal and written handovers. The two lead maternity care midwives employed

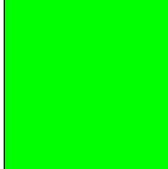
by the organisation ensure all the requirements of Section 88 are effectively met for all stages of service delivery for woman, their partners/support persons and their babies. The shared care option works well with the medical staff offering medical support as required for this primary care setting.

The activities programme is overseen by a diversional therapist and an assistant diversional therapist. The clients are provided with group, individual one on one activities, and links with families and the community are maintained.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses and registered midwives, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the clients and those with special needs are accommodated. The kitchen is well organised and managed by experienced staff and meets all food safety standards. Clients verified satisfaction with the meals provided. Additional food is available for the acute care settings.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. The approved fire evacuation plan has not required any changes.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

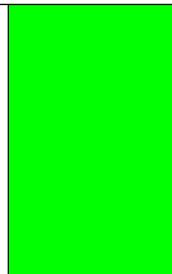


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Two restraints were in use at the time of this audit. There were no enablers being used. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of the clients in response to individual requests. Staff receive training at orientation and training is ongoing. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The Hokianga Hospital's infection surveillance programme is planned and implemented. The surveillance is appropriate to the service setting and the results communicated to applicable staff. Antimicrobial use is now being monitored.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	20	0	1	0	0	0
Criteria	1	43	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The chief executive officer (CEO) is responsible for managing and responding to complaints. There have been two complaints received year to date in 2017. A complaint to the Health and Disability Commissioner in 2016 has been closed. The sampled complaints reviewed for 2016/2017 show that complaints management processes complied with the Code of Health and Disability Services Consumers Rights, in particular Right 10. Clients interviewed indicated they knew how to complain or provide feedback. Suggestions / compliments and complaints forms were sighted and were readily available throughout the hospital. Staff and managers interviewed understood the complaints process. A complaints register was being maintained along with associated documents. Compliments and expressions of thanks are communicated to staff and were displayed on a designated notice board.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff confirmed that interpreter services are available via Language Line if required to assist with communication between the patients and staff. A number of staff speak te reo Maori. Staff advise the Taumata and the Kaimanaaki Tangata assist with translation and communication if required.</p> <p>Open disclosure is understood by staff and was documented as occurring for applicable events sighted during audit. Clients and a family member interviewed confirmed being kept informed of relevant issues / events throughout the client's stay.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Hokianga Health Enterprise Trust is a charitable trust responsible for overseeing the services provided at Hokianga Health. There is a strategic plan for the period 2015-2020. The plan is reviewed with wide consultation at least annually with a review of the previous year's activities, outcomes and needs as well as planning for the next year. This is an area of continuous improvement.</p> <p>The chief executive officer has been employed at Hokianga Health since 1994, and as CEO since 2001. The CEO provides reports to the Board of Trustees (BOT) on a regular basis, and also attends the BOT meetings. Hokianga Health includes hospital and aged related residential care services provided by Hokianga Hospital as well as community based services.</p> <p>The CEO is supported by the hospital services manager who is responsible for the day to day clinical services provided in the hospital. The hospital services manager is an experienced RN, who has been in this role since prior to the last audit. The hospital services manager attends relevant education as required to meet the provider's contract with Whangarei District Health Board.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation includes quality and risk information in the strategic and annual business plans. There are policies and procedures available for staff. These are reviewed and updated every two years or sooner where applicable. Policies sighted during audit were current with the exception of one manual which is in the process of being updated. Copies are available for staff in manuals as well as electronically on the intranet. The quality officer is responsible for document control processes. New or significantly changed clinical policies are circulated to staff for feedback, and then reviewed by the executive committee and amended/approved. Sampled clinical policies sighted by the auditor in clinical services were appropriate for the service, with one exception (refer to 1.3.3.3). The policies selected at random were the same in the different manuals sampled. The shortfalls from the last audit have been addressed.</p> <p>Hokianga Health has a quality and risk management system which is understood and implemented by service providers. This includes a schedule of internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, restraint and complaints management. Regular internal audits are conducted and demonstrated a high level of compliance with organisation policy.</p> <p>If an issue or deficit is found a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored. Quality information is shared with all staff via shift handover as well as discussed at the weekly executive meetings, quarterly health and safety committee meetings and two monthly significant events group meetings. A clinical governance group meets two monthly to review business and strategic outcomes, progress towards achieving health targets and to discuss new quality initiatives. Staff advise they are also given 'information' via fortnightly staff</p>

		<p>newsletters.</p> <p>Aged related residential care incident, infection and staffing data is being benchmarked with five other facilities within the Whangarei DHB. The results of the 2016 annual benchmarking report was sighted. The hospital services manager reports reviewing this data to see how Hokianga Health aligns with other similar services. Regular satisfaction surveys are undertaken of clients. The feedback from clients in the satisfaction survey was very positive. Staff, clients and family/whānau interviewed expressed a high level of satisfaction about the services provided at Hokianga Health.</p> <p>Actual and potential risks are identified in the business and annual plans. Risks are regularly monitored and reviewed by the CEO and board. Staff confirmed that they understood and implemented documented hazard identification processes. Staff note maintenance / facility issues are promptly attended to. The hazard register sighted was up to date.</p> <p>Hokianga Health holds tertiary level workplace accreditation with Accident Compensation Corporation until 31 December 2018. The service also has current accreditation as meeting 'baby friendly hospital' requirements. The service has also been accredited by Whangarei DHB as meeting national cold chain requirements for vaccines. The cold chain accreditation is for the period August 2016 to August 2019. The general practice aspect of services has been recently re-audited against Cornerstone standards. The service is currently awaiting the draft report.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse or untoward events / incidents are reported in a timely manner by staff. A review of ten reported events selected at random for February 2016 to February 2017 verified these were investigated and actions taken to address the issues. Staff spoken with were familiar with the reporting process. There was evidence of reported events resulting in changes and improvements in practice. All events are reported to be entered into an electronic incident/accident register by the quality officer. This process was not able to be reviewed at audit as the quality officer was on leave.</p> <p>Incidents are analysed and discussed at the executive meeting as evidenced in the meeting minutes sighted and verified by the staff and managers interviewed. Relevant issues are also discussed at the serious event committee as verified in meeting minutes. Staff advised that client related events are discussed at staff handovers. The hospital services manager advises a review is occurring of the incident reporting documentation in use. There is currently four different reporting forms in use. The form used depends on the type of event.</p> <p>Aged related residential care service incident and accident data is benchmarked with other identified facilities in the Northland DHB region. The annual benchmarking report for 2016 was sighted.</p> <p>The CEO and hospital services manager are aware of their responsibilities for essential notifications, and can detail the type of events that are to be reported with the exception of pressure injuries. Policies /</p>

		procedures need to be updated related to pressure injuries (refer to 1.3.3.3). In addition to notifiable diseases which are notified by clinical staff, there has been one event requiring notification and records related to this were sighted.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Current annual practising certificates (APCs) were verified for the general practitioners (GPs), pharmacists, the podiatrist, the lead maternity carers, and the registered and enrolled nurses.</p> <p>Recruitment processes include completing an application form, conducting interviews and reference checks and police vetting. Staff have signed job descriptions on file. The staff sign a confidentiality agreement. Annual performance appraisals had occurred in the applicable staff files sampled.</p> <p>New employees are required to complete an orientation programme relevant to their role. A checklist is utilised to ensure all relevant topics are included for each role. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. Staff advised it can take clinical staff up to twelve months to complete orientation requirements. Records are now being retained to verify recruitment and orientation processes.</p> <p>A staff education programme is in place. Mandatory training was identified and completion monitored. Staff have access to regular ongoing education opportunities (internally and externally), relevant to their role. Records of education were maintained and copies of some education certificates were present in the staff files reviewed. Caregivers are required to complete an industry approved qualification within 18 months of employment. Four staff were currently completing level three qualifications. Hokianga Health is currently reviewing the staff cultural safety training programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A draft policy details staffing levels and skill mix requirements. This is awaiting sign off by the executive which is planned to occur at the next executive meeting.</p> <p>The number of registered and enrolled nurses, and health care assistants vary between shifts. There is always at least two registered nurses or a registered nurse and an enrolled nurse rostered on duty in the inpatient area, and at least two caregivers. An additional RN is on call from 6 pm to 7 am weekdays and over the weekends. A registered nurse and a caregiver staff the ED weekdays, and a RN is rostered on the weekends 9 am to 5.30pm. Afterhours ED is covered by either the ward RNs or on call RN. Nursing staff are required to complete Primary Response in Medical Emergencies (PRIME) training, and the advanced cardiac life support (ACLS) training during alternate years. Attendance is monitored by the hospital services manager and records were sighted. Nursing staff have current ACLS level five or six certificates. Two RNs are booked to complete PRIME training. Medical staff complete both PRIME and ACLS level seven training. Caregivers and other staff complete basic cardiopulmonary resuscitation</p>

		<p>training.</p> <p>There is a lead maternity carer on site or on call. There is a doctor rostered in the hospital between 8 am and 1.30 pm daily. A second doctor is in the emergency department (ED) until 5pm. The ED doctor provides cover in the ward if required between 1.30 and 5pm. There is always a medical practitioner on call when not on site. A registered nurse is designated weekdays to oversee the aged related care contract patients. The current rosters were reviewed and demonstrated that the draft staffing policy was being implemented. A physiotherapist is on site twice a week, and sees patients based on referrals or scheduled appointments. Radiology services are available on site where required. The shortfalls from the last audit have been addressed.</p> <p>Additional staff hours are rostered for maintenance, administration, the food / kitchen services, cleaning services, and for washing aged related care clients' personal laundry.</p> <p>Nursing staff participate in a professional development and recognition programme (PDRP). Three staff have completed the competent requirements and five staff have completed the proficient requirements. Three staff have portfolios being assessed at the time of audit. Two other RNs are working on their portfolios and are reported by the hospital services manager to be nearing completion.</p> <p>The staff confirmed the hospital services manager is available out of hours if required. Clients and the family / whanau members interviewed confirmed their personal and other care needs are being well met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The client's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all clients' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the clients' records sampled for review. Clinical notes were current and integrated with medical officer and allied health service provider records. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The entry and exit information is entered in the electronic register. The process to record and track the location of records and the organisation of archived records is now improved for all services provided. The register in the primary maternity service is also available in hard copy and this was sighted. Archived records in the maternity service are dated by year and storage boxes are clearly marked and are more easily able to be retrieved. Bookings for the next six months are stored in a filing box for both midwives to have easy access as required. All clients' records are held for the required period before being destroyed. No personal or private client information was on public display during the audit. The retention and storage of health records now meets the New Zealand health information (NZHI) requirements. The area identified for improvement from the previous audit has been addressed.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and other services and meets all legislative requirements.</p> <p>A safe system for medicine management was observed on the day of the audit. The staff member observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Annual competencies are completed by the registered nurses and midwives. Only registered staff administer medications.</p> <p>Medications are supplied to the facility from two individual contracted pharmacies. One pharmacy covers all medication requirements for the residential care service and one pharmacy for the emergency department, medical inpatients and maternity clients. These medications are checked by the registered nurses against the prescription when delivered to the hospital. All medications sighted were within current use by dates. Clinical pharmacist audits are completed three monthly. Reconciliation of medications is completed by the medical officers when the client is admitted.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two registered nurses for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. The medication/treatment room has key pad access only. The two drug trollies are stored in the locked treatment room when not in use.</p> <p>The records of the temperatures for the medication room and fridges are reviewed within the recommended range. There is a blood fridge which is closely monitored which stores blood and anti-D immunoglobulin, and a vaccine fridge.</p> <p>Records were reviewed (the service now uses the 16 day national medication record), and good prescribing practices were noted for the medical officers and the midwives who have prescribing rights. There are photographs for identification purposes for all clients on the client and medication records. The required three monthly medication reviews were consistently recorded on the medicine records sighted. No clients were self-administering medications, except for one client using inhalers. This was managed in a safe manner.</p> <p>Medication errors are reported to management and recorded on an incident form. The client and/or the designated representative are advised. The standing orders are discussed at clinical governance level and a committee meets three monthly. The current standing orders used are current and comply with guidelines. Maternity service standing orders comply with Section 88 requirements.</p> <p>The areas for improvement from the previous audit are now closed.</p>
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<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an experienced cook, and is in line with recognised nutritional guidelines for older people and clients in the acute medical and maternity services to suit their needs. The menu reviewed follows summer and winter patterns and has been reviewed by a qualified dietitian 28 July 2016. Recommendations made at that time have been implemented.</p> <p>The cook is responsible for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal of kitchen waste. Waste disposal complies with current legislation and guidelines. Food temperatures, including any high risk items, are monitored appropriately and recorded daily. The cook and relief staff have undertaken a safe food handling qualification. Due to the number of clients the cook does not have an assistant kitchenhand. The domestic team leader has completed relevant food handling training and assists with breakfast and for functions.</p> <p>A nutritional assessment is completed for each individual client on admission to the service by the registered nurse. The personal food preferences, any special diets and modified texture requirements are identified and made know to the kitchen staff and accommodated on a daily basis. Special equipment was available to meet the client's individual needs. Additional food is available if required.</p> <p>Evidence of client satisfaction with meals was verified by client and family interviews, satisfaction surveys and client meeting minutes. Clients were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. A trolley is available for the transportation of meals to the maternity unit and to the ward.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of clients, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress records, activities records, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Clients and families reported participation in the development and ongoing evaluations of the care plans.</p> <p>The medical care plans are now fully documented to reflect the individual needs of the clients. Plans are up-to-date and the interRAI six monthly assessments have been completed. The maternity service has developed and implemented admission and discharge checklists for mothers and babies and have added an infant record on the day of discharge to be completed. The baby has a full discharge examination prior to inpatient discharge and transferring to the midwife for postnatal care and management. Continuity of service delivery is promoted.</p> <p>Orientation is provided to ward staff regarding the afternoon and night time cover of the maternity service. The registered nurses in the ward are responsible for checking and providing assistance as needed for any women in the inpatient maternity unit over this time. A call bell system is available and the lead maternity midwife (LMC) is on call if required. For any client and/or baby requiring observations, such as</p>

		<p>blood sugar levels or temperature and respiration recordings before feeding, this is documented on the white board in the ward and discussed with the staff by the midwives at the time of handover between shifts. Goals are documented on the respective plans reviewed for mother and/or baby as required. This area requiring improvement from the previous audit has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to clients was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of client's individualised needs was evident in all areas of service provision. The medical officer interviewed, verified that medical input was sought in a timely manner, that medical orders were followed, and care was managed appropriately in each service area. Care staff and midwives confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the care setting and level of care provided and in accordance with the clients' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a diversional therapist and an assistant diversional therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain clients' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the clients. The clients' activity needs are evaluated as part of the formal six monthly care plan review, for longer term clients. The six monthly interRAI assessment is also completed by the registered nurse. Input is sought and this was verified in the staff interviews.</p> <p>The monthly planned activities programme reviewed matched the skills, likes, dislikes and interests identified in the assessment data. Activities reflected goals, ordinary patterns of life and included community activities. Individual, group and regular events are offered. One on one activities occurred for the higher needs clients especially those requiring hospital level care. The activities programme is discussed three monthly at the minuted clients' meetings and indicated residents input was sought and responded to.</p> <p>Client and family satisfaction surveys demonstrated satisfaction with the programme and that information was used to improve the range of activities offered. Clients interviewed confirmed that they find the programme interesting and fun.</p> <p>In the inpatient maternity service activities are not organised, as such, but all support is provided during the time the women and their babies are in the unit. Parenting education is a major activity and staff take every opportunity to promote educational activities, such as safe sleep, screening procedures, settling babies, baby bathing demonstrations, positioning and techniques for successful breast feeding. Educational DVDs were also available for couples to access. Family/whanau can choose to socialise and</p>

		<p>watch television or DVDs of their choice in their individual rooms. An information folder was available for women to read all up-to-date information at their leisure. This was provided on admission to the service. Women interviewed stated they filled their days caring for their baby, resting, spending time with family/whanau and visitors. Staff interviewed enjoyed this aspect of providing and promoting healthy options to parents.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Client care is evaluated on each shift and reported in the progress records. The progress records reviewed had been updated and were clearly documented with name, date and designation of the staff member making the entry. This area requiring improvement from the previous audit has been addressed. If any change is noted, it is reported to the registered nurse or the midwife.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or as clients' needs change. Evaluations are documented by the RN where progress is different from expected, and the service responds by initiating changes to the plan of care. Short term care plans sighted were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Clients and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>For clients in the maternity unit, records were completed each shift by the midwife or staff covering from the ward. Any changes for the woman and/or the baby are reported to the midwife on call, if not present in the unit at the time. If the midwife determines that the condition of the woman and/or baby is no longer suitable for primary care, arrangements, with consent, are arranged to attend and transfer the woman/baby to secondary care at the DHB. The plan would be updated and a transfer arranged in a timely manner.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness (expiry 30 June 2017). Electrical and clinical equipment sampled have current performance monitoring and validation stickers. There have been no changes to the facility requiring a change in the fire evacuation plan.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The organisation has a planned surveillance programme for 2016/2017 that is relevant to the service setting. The RN with infection control responsibilities undertakes data collection and reports to the hospital</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>services manager and communicates with other relevant staff. The surveillance programme includes intravenous device site infections, positive blood cultures, outbreaks and infections involving the aged related residential care (ARCC) clients. The ARRC client infection data and use of prophylactic antimicrobials is being benchmarked with other facilities within the Northland DHB area. There have been no outbreaks since the last audit</p>
<p>Standard 3.6: Antimicrobial usage</p> <p>Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.</p>	<p>FA</p>	<p>An annual audit is conducted that samples therapeutic antimicrobial use for acute inpatients. The audit includes detailing the type of infection the patient had and antimicrobials given and the duration of treatment. The service has been working to promote the charting of antimicrobial review or stop dates. This aspect has significantly improved in the most recent audit.</p> <p>Monthly monitoring of therapeutic and prophylactic antimicrobial use is also occurring for aged related residential care clients as part of the surveillance programme. Some of the results are benchmarked quarterly with other facilities in the NDHB region. Rationale is provided for any prophylactic antimicrobial use.</p> <p>The results of audits and the surveillance programme are being communicated to management and other applicable staff. The shortfall from the last audit has been addressed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance for staff on the safe use of both restraints and enablers. The aged care coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice, the role and responsibilities involved.</p> <p>On the day of the audit, two clients were using restraints. No clients were using enablers. When these are required, they are the least restrictive and used voluntarily at the client's request. A similar process is followed for the use of enablers, as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed of those clients who have approved restraints and from interview with staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the client can be safely supported and suitable alternatives, such as sensor mats and low beds, are explored before use of</p>

<p>Services use restraint safely</p>		<p>a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the client remains safe. Monitoring of restraint was reviewed and verified. Records contained the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy were maintained and respected. This was included in the individual client`s care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained, updated every three months and reviewed at each restraint approval group meeting held three monthly. The register was reviewed and contained details of the two clients currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation`s policy and procedures and in related topics, such as positively supporting clients presenting with challenging behaviours. Staff interviewed understood that the use of restraints is be minimised and how to maintain safe use was confirmed.</p> <p>The area requiring improvement from the previous audit has been addressed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a three monthly review of all restraint use which includes all the requirements of this standard. Three monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this occurs and includes analysis and evaluation of the amount and type of restraint use in the facility, whether alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and appropriate education provided. Feedback is sought from the medical officers, staff and families. Policies and procedures are reviewed two yearly. The service benchmarks with other organisations in the region. Restraint is minimised at all times. The area requiring improvement from the previous audit has been addressed.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Staff interviewed were not informed about the pressure injury programme (2016). The policy and procedures reviewed provided a small amount of information relating to pressure injury assessments and subsequent management. No information of the stages of pressure injuries was available to guide staff. The staff did not understand about Section 31 incident notification forms and reporting of stage 3 and stage 4 pressure injuries to HealthCERT. Benchmarking does occur however, with other like organisations in Northland three monthly. Graphs and summaries documented in the records were reviewed.	The organisation`s policy and procedures related to pressure injury prevention and management are not sufficiently detailed to include pressure injury assessment categories (stages) and or information regarding essential notifications.	Review the current policy and procedures to include pressure injury prevention, management and the stages of pressure injuries. In addition, the policy needs to state the reporting obligations and essential notification requirements for stage 3 and stage 4 pressure injuries. 180 days

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The organisation has a strategic plan 2015-2020. The plan contains the mission statement, values and philosophy for the organisation. This plan and the associated annual plan was developed in conjunction with staff, managers, medical specialists, general practitioners, the wider Hokianga community and the Board of Trustees. The plan is reviewed at least annually with a review of the previous year’s activities, outcomes and needs as well as planning for the next year. The plan outlines the current key strategy areas for the organisation as well as potential risks. There is ongoing communication with staff and the wider community throughout the year via newsletters written in both English and Maori. The annual report is published and</p>	<p>Hokianga Health actively seeks feedback from the wider community on the services being provided as well as the future development and implementation of health services. The process includes having ten annual general meetings occurring, one in each of the ten clinic locations to reduce barriers for the population to participate. There is up to two representatives from each clinic location elected as members of the Hokianga Health Enterprise Board of Trustees. There are also four iwi representatives, two staff representatives and up to four additional board members if there is a need for specific skills, experience or for diversity on the BOT. Board members represent their community needs. Following the annual clinic area meetings a summary of the community feedback is provided to the board. This wide community based communication, consultation and representation continues to develop health services aimed at meeting the needs of the local communities and Hokianga as a region. Current projects include ensuring that Hokianga Hospital can continue to meet the identified needs of the communities aging population.</p>

		readily available for the community.	Plans are underway to increase the hospitals resourced beds by two.
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End of the report.