Southern 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:

<table>
<thead>
<tr>
<th>Legal entity:</th>
<th>Southern District Health Board</th>
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<tbody>
<tr>
<td>Premises audited:</td>
<td>Dunedin Hospital</td>
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<tr>
<td>Services audited:</td>
<td>Residential disability services - Intellectual; 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</td>
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<tr>
<td>Dates of audit:</td>
<td>Start date: 5 September 2017   End date: 8 September 2017</td>
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Proposed changes to current services (if any): The organisation is currently undergoing a significant restructure. This is part way complete with Tiers 2 and 3 appointed in most cases and due to start in their new roles on the 11 September. Tier 4 is about to commence the appointment process.
The hospital is part way through a reconfiguration of ICU and HDU to add one ICU bed and to merge the departments to provide a more flexible model of care that can cater to changing patient needs.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 466
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

General overview of the audit

The Southern District Health Board (SDHB) is responsible for providing health services to the approximately 319,200 people living in its district. Approximately 40% live in rural areas that are widely dispersed across the district; the other 60% of the population live in the two main cities of Dunedin and Invercargill. The SDHB services, organised by directorates, include medical; surgical; older persons and community; mental health, addictions and intellectual disability; women’s, children’s, and public health; and clinical support services. The DHB employs approximately 4,500 staff and provides services from a number of facilities. For this surveillance audit, the team visited Southland Hospital (Invercargill), Dunedin Hospital, and the Wakari Acute and Forensic Mental Health and Addictions Services (Dunedin), Helensburgh Cottage, with a teleconference to Lakes District Hospital.

Southern District Health Board have had Commissioner oversight for the past two years. Early in 2017 a new Chief Executive was appointed. Since his appointment, a review of the current position of the DHB has occurred, which included extensive staff, consumer and community consultation; new values have been developed and are being introduced at every level of the organisation; and an organisation restructure to ensure appropriate leadership and clinical governance is in the process of being implemented. Overwhelmingly, staff interviewed were positive about the changes.
This four day surveillance audit, against a subset of the Health and Disability Services Standards, included an in depth review of organisational management systems, eight patients’ care and four clinical systems tracers. 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.

There were thirty areas for improvement at the previous certification audit. Significant work has been undertaken to address these areas; however, many are still in the process of implementation and therefore remain open (23). Two new areas for improvement have been raised.

Areas raised this audit for improvement include ensuring cultural needs are met, gaining informed consent consistently, timely response to complainants, ensuring feedback mechanisms for quality and risk management, continuing to improve document control systems and corrective action planning, identifying and escalating clinical risk, follow up of adverse event recommendations, monitoring of annual practising certificates, ensuring medical staff receive orientation, credentialing is complete and up to date and staff attendance at core training is monitored. In clinical areas improvement is required in assessment and care planning, evaluations being consistently documented, medication management, and in one area, nutritional needs. The environment remains an issue, and water temperature monitoring and waste management also require improvement. Restraint minimisation has improved but requires further work. In relation to those aspects of infection prevention and control reviewed, the last part of an implementation plan for prophylactic and therapeutic antimicrobial management is to be completed.

**Consumer rights**

To meet cultural needs for Maori, additional staffing has been employed in Dunedin, and for the District Health Board a Community Council has been established to facilitate Pacific representation across the organisation. Ensuring individual cultural needs are identified and met has been a focus for the organisation, including use of a cultural assessment form (where appropriate) and regular audits to support good practice.

Significant work has been undertaken to improve practices for open disclosure. Education has created greater awareness by staff and improved practice is to be monitored through an audit programme.
Patients and families/whānau are provided with the information they require at the appropriate times to make informed decisions, which includes consent for treatment and advance directives.

Customer feedback, including complaints, is coordinated centrally by the quality and risk team with a dedicated Patient Affairs Coordinator. A new feedback report has been developed to communicate compliance with the timeframes required by the Code of Health and Disability Services Consumers’ Rights, and the trends across the DHB. Complaint reports are escalated appropriately through the organisation and used to inform improvement projects.

**Organisational management**

SDHB is currently undergoing a review and restructure following the appointment of a new chief executive in February 2017. Wide consultation has occurred with the community, consumers and staff prior to the restructure which is nearing an end. All but one of the executive positions are now filled, and the next tier appointments made. The strategic and governance oversight is provided by three commissioner positions who lead the statutory committees.

The introduction of a Community Health Council and a Clinical Council have provided an improved clinical governance framework and enhanced the consumer voice and participation in the clinical service delivery.

Quality and risk responsibility has been moved from a tier three to a tier two position in the new structure. A quality and risk management team continue to provide a range of services to support the DHB. For example, the document control project has produced a robust and user-friendly platform to start to address the issue of the overdue documents across the district. The ‘Safety 1st’ electronic adverse event reporting is a regional system, with a risk management module to be added. At present the risk management process is still undergoing a review.

Several improvements projects have been commenced over the last 18 months. All are supported by the staff and patient engagement survey and a relaunch of the SDHB values identifying the ‘7+7’ priorities for patients and staff which are visible throughout the organisation.
The current system for recording staff recruitment and training is moving to a programme called ‘Employee Connect’. This system will capture all staff credentialing requirements, training (both mandatory and non-mandatory) and can capture additional needs, such as professional indemnity and performance review. Orientation has been revised and a new programme commenced in January 2017.

Over the last eighteen months, significant work has been undertaken to have improved visibility for the patient flow, bed management and safe staffing. The Capacity at a Glance screens (CaaG) have further developed and show the bed state for Dunedin and Southland and data can be seen electronically regarding bed numbers for rural hospitals in the region and relevant information, such as transfer lists. There is good use of data to inform decisions and this includes consultation with staff involved. Where management staff and data have identified shortfalls in the level of staffing required to meet the need, increased staffing has been appointed or is in the process of appointment. Staffing remains an ongoing focus and challenge.

**Continuum of service delivery**

Patient care was reviewed and evaluated across services with eight patients reviewed using tracer methodology in the areas of maternity, mental health, surgical, medical, paediatric and older person’s health. In addition, four systems tracers were conducted in relation to management of the deteriorating patient, medication management, prevention of falls 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. Investigations and assessments are undertaken and used to assist with developing patients’ plans of care. Service delivery is of a high standard. The falls prevention programme is well established providing numerous initiatives and a reduction in frequency and severity of falls events. Plans are currently being developed to introduce a programme on detection of the deteriorating patient; these plans are well underway and have been underpinned by organisational data on current practices.

Discharge planning is actively occurring. All patients and family members interviewed were complementary about services received and advise ongoing communication with staff is timely and clear.
Documented policies and procedures for areas of medication management are known to staff and include self-administration. Overall the management of medications is of a high standard.

**Safe and appropriate environment**

There are many challenges for the staff and patients at the Dunedin Hospital site, as it is an aging site with a proposed rebuild in 7-10 years. The day to day repairs and development are hampered by the presence of asbestos. The SDHB has a current assessment of the whole site underway to determine where the asbestos is located. This will form the basis of the asbestos management plan which is required to be created by April 2018. The asbestos presence has impacted on SDHB being able to meet its legal obligations of current building warrants of fitness for two Dunedin campus buildings. This has been notified to both the local council and the Ministry of Health (MoH), with the Dunedin City Council issuing a special dispensation, approved by the MOH, to allow time to safely address the buildings in question.

Good examples of multiservice collaboration were noticed, especially across facilities and maintenance, infection prevention and control, health and safety, and ancillary services. Staff spoken to were clear about the processes and responsibilities to ensure that staff, patients and visitors were kept safe.

There is a robust emergency and security management process in place. Staff use learnings from any emergency operation centre activations and debriefs to enhance future response.

**Restraint minimisation and safe practice**

The SDHB have decided to separate the management of restraint into general hospital and mental health services. A restraint committee for mental health and a restraint team for the general hospital have responsibility for the oversight of restraint minimisation for their respective areas.
A restraint policy, guidelines and terms of reference establish the practices to be followed. The areas identified at the previous audit have been responded to and improvement has occurred.

**Infection prevention and control**

SDHB undertake surveillance activities, agreed by the district wide Infection Prevention and Control Committee. These include; participation in the national surgical site infection programme, possible outbreak investigation, hand hygiene audit and issues based clinical area surveillance. The results are taken to the committee where analysis and trending is occurring.

A systems tracer was undertaken to determine the processes in place to identify, communicate and manage patients with multi-drug resistant organisms. This demonstrated good processes are in place that are known to staff.