Hutt Valley 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:	Hutt Valley District Health Board
Premises audited:	Central Region Eating Disorder Service||Hutt Valley 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; Residential disability services - Psychiatric; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 6 March 2018 End date: 8 March 2018

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: 212

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

Hutt Valley District Health Board (HVDHB), provides services to around 145,000 people in the Hutt Valley district. Hospital services are provided from the Hutt Valley Hospital. Mental health services are managed as a '3DHB' service, which includes Capital and Coast DHB and the Wairarapa DHB. HVDHB manages the Central Regional Eating Disorder Service (CREDS).

This three-day surveillance audit, against a subset of 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. Auditors visited clinical wards and departments at the Hutt Valley Hospital site and the CREDS residential service in Johnsonville.

This audit identified 17 areas that require improvement across the standards. These relate to family violence screening, review of policies, integration of all areas of the quality system, risk management, management of events/incidents, ensuring a systematic approach to checking of yearly practising certificates, completion of performance review and training requirements, clinical record

details and staffing requirements. Within the clinical standards, improvements are required related to assessment of patients' needs, planning of patient care, discharge and transfer management, management of medicines and food services. The acute mental health facilities do not meet contemporary good practice standards and several areas requiring improvement were identified in relation to maintenance and facilities.

Since the previous audit, improvements have been made to support open disclosure, 'not for resuscitation' status and to ensure appropriate disposal of body parts. The organisation now has a full executive leadership team and a clear vision, plan and values unique to the Hutt Valley DHB. The quality and risk management framework and roles to support this are also now in place. Improvements have been made to medical credentialing, timeliness of service provision, activities available in the mental health service, evaluation of care, some aspects of the food service and the management of dangerous goods. The previous four areas related to management of enablers, restraints and seclusion have also been addressed. There have been improvements related to management of patients requiring isolation for infections. Work has been progressed in most other areas requiring improvement, with further work underway.

Consumer rights

Patients and families/whānau are provided with the information they require at the appropriate times to make informed decisions which includes consent for treatment. Services provided support personal privacy, independence, individuality and dignity. Staff interact with patients in a respectful manner.

Processes are in place to acknowledge and respond to complaints and compliments. The complaints process is readily known to patients and family.

Organisational management

Since the previous certification audit the organisation restructure has been completed and there is now a full complement of the Executive Leadership Team and Senior Management Group, specifically for the HVDHB, with increased visibility. Staff reported

increased satisfaction with timeliness of decision making and a more settled environment supported by a renewed vision and values.

The quality and risk management framework is now 'bedding in' with a well-developed and monitored workplan. There is a commitment to clinical governance, shared decision making and increased consumer involvement. Services are supported with appropriately qualified staff with expertise in quality systems. Quality improvement data is gathered and reported to the various committees and service level groups. Staff are involved in quality improvement, as able, in clinical areas. Where shortfalls or areas for improvement are identified, corrective actions, in most cases, were put in place. Several key projects have resulted in a safer environment for patients, in line with regional and national developments. Improvements to planning of care has had positive results with increased involvement of patients in their care. Staff displayed a patient focused approach to care and improvements.

Adverse events are required to be reported by all staff. These are recorded electronically. The number, themes, trends and severity are monitored over time.

There has been progress related to the credentialing of medical staff. There was evidence of area specific training taking place and staff reported good access to a wide range of training. Leadership training for managers is being progressed and those in these roles felt well supported.

A range of mechanisms are used to ensure that the right numbers of staff are available to meet the changing needs of patients across the services. Work is continuing to establish base level full time equivalent numbers for nursing and allied health staff. Staff are well supported across the 24 hours, seven days a week with senior and specialist roles who provide both an overview of the flow of patients through the hospital and specific clinical expertise and direction.

Continuum of service delivery

Patient care was reviewed and evaluated across services with seven patients reviewed using tracer methodology in the areas of maternity, two in mental health, surgical, medical, older persons' health and paediatrics. 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 care. Investigations and assessments are undertaken and used to assist with developing patients' plans of care. The falls prevention programme is well established and has resulted in a reduction in frequency of falls events. The hospital has undertaken a project to review and update documentation and processes for the identification and management of adult deteriorating patients.

Discharge planning is actively occurring. All patients and family members interviewed were complementary about services received and advise ongoing communication with staff was timely and clear.

Policies and procedures provide guidance for staff on medicines management. The national medicine chart is in use. Allergies are assessed and communicated. Medicines are stored safely and managed effectively throughout the organisation.

Safe and appropriate environment

The buildings have a current building warrant of fitness. Clinical equipment in use undergoes annual performance monitoring. Designated staff have completed industry approved training in handling of chemicals and hazardous substances.

Restraint minimisation and safe practice

The organisation has an effective policy on restraint minimisation and safe practice. A Restraint Approval Group actively oversees restraint use, education and monitoring based on collation and analysis of verified restraint data. The mental health service has a restraint reduction plan supported by implementation of the national training programme, and a focus on de-escalation.

Infection prevention and control

Surveillance for infections is occurring. The surveillance programme is appropriate to the service setting and includes significant organisms (including multi-drug resistant organisms), specific surgical site infections, invasive device related infections, blood stream infections and outbreaks. The surveillance results are communicated appropriately. Policies and procedures detail when isolation precautions are required to be implemented. Staff were observed implementing the required policies and ensuring communication occurred with other services/departments as required.