South Canterbury District Health Board - Timaru Hospital

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:	South Canterbury District Health Board
Premises audited:	Timaru Hospital
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 29 January 2019 End date: 31 January 2019

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: 78

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

South Canterbury District Health Board (SCDHB) provides services to around 60,220 people in the South Canterbury region. Hospital services are provided from the 132-bed facility at Timaru and include medical, surgical, maternity, paediatric, and mental health and addiction services. These inpatient services are supported by a range of diagnostic, support and community-based services.

This three-day certification surveillance audit, against a subset of the Health and Disability Services Standards, included a review of quality, risk and reporting management systems, human resources and safe staffing requirements, care delivery, the environment, infection prevention and control, restraint minimisation, and review of the progress made on the corrective actions identified at the last audit.

The audit team interviewed managers and reviewed records, including clinical records and other documentation. Interviews were also conducted with patients, their families, and a range of staff across different roles and departments.

Since the last audit there has been a significant change to the leadership structure including the disestablishment of level 3 operational managers, the appointment of several new positions and changes in the full time equivalent (FTE) hours of the chief medical officer. These changes were seen at audit to still be in a 'settling in' phase.

Ten of the twenty-two previous corrective actions have been closed with improvements made to the legibility of records, completion of service delivery plans and interventions, safe self-administration of medications, fire and emergency training, security, restraint minimisation, clinical assessment and infectious disease isolation precautions. One new area for improvement was identified related to reporting adverse events to the Health Quality and Safety Commission (HQSC) in a timely manner.

Twelve of the previous corrective actions remain open, these relate to family violence screening, quality and risk framework implementation, document control, completion of recommendations from reviews, risk management, staff training, early warning scores (EWS), discharge planning, medication management systems, fridge temperature monitoring, and emergency egress (which has been extended to include electrical equipment compliance).

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.

The complaints process is clear, concise and meets the requirements of the Code of Rights. Complaints are taken seriously, investigated thoroughly, necessary actions identified and taken within acceptable timeframes. The complaints process is well documented.

Organisational management

The clinical governance framework and the quality and risk systems have been reviewed and redefined since last audit. The Clinical Board and the newly formed Patient Safety Operational Leadership Group (PSOLG) are working effectively and the minutes showed good documented providence of events and issues. There are clear reporting pathways within the governance framework to guide staff.

The organisation has made good progress with management and control of documents since the last audit with a slight increase in the number of documents which have been reviewed and are up to date.

The ‘Safety 1st’ reporting system is being used across the DHB, with the migration of the risk management register almost completed. This is used to manage and monitor the adverse event reporting, and compliance with reporting timeframes. The reporting to the Health, Quality and Safety Commission (HQSC) on the serious SAC 1 & 2 events is only occurring in 10% of cases. There has been an improvement in the response and validation of SAC 1&2 events with a new review process introduced since last audit. Some good examples of improvement activity were seen, and a range of tools to support this being developed and available for staff to use.

A workplace development committee was established in 2017 with a learning and development framework available on the staff intranet. The system to identify and record training is now held on HealthLearn. This has markedly improved the education records of all staff and enables managers to easily view completion of staff training under their direction. The staff appraisals are still below the target of 90% which the DHB has set for itself in the policy.

A key focus of the SCDHB is around developing both long and short-term strategies to cope with a steady increase in workload and ensuring enough staff with the right skills can meet the increased demands. Nursing staff numbers and skill mix are defined, with a plan to increase and improve the Trendcare data supporting the Care Capacity Demand Management (CCDM) information. There were many innovative approaches to ensure staff are utilised in the most efficient way to meet changing patient demands. For those areas where recruitment is challenging (e.g., anaesthetic technicians, nursing, pharmacy and allied health), a range of strategies have been put in place to address these on both a short term and longer-term basis, including upskilling and reviewing the skill mix. There is ongoing difficulty recruiting to senior medical officer (SMO) positions, especially in the orthopaedics service.

Continuum of service delivery

Patient care was reviewed and evaluated across services with five patients reviewed using tracer methodology in the areas of maternity, medical, surgical, paediatric and mental 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. Investigations and assessments are undertaken and used to assist with developing patients' plans of care. Interventions are evaluated and care plans changed appropriately when required. The falls prevention programme is well established and there is a clear pathway of care for the deteriorating patient.

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 electronic medication management system 'Medchart' is in use. Allergies are assessed and communicated. Medicines are stored safely and managed effectively throughout the organisation.

Safe and appropriate environment

SCDHB has a reactive and proactive maintenance programme. Although an older facility, refurbishment and reconfiguration has continued to meet the needs of the health service and its users. Emergency management planning is in place, with planning and ongoing exercises to ensure staff remain current. This includes areas specific trial fire evacuations. Emergency equipment is available and checked regularly.

Restraint minimisation and safe practice

There are active processes to minimise restraint use throughout the SCDHB. Documentation is under review to ensure policy and guidelines are current. Episodes of restraint reviewed clearly demonstrated that restraint has been used as a last resort and was approved for use in accordance with the policy. Episodes of both restraint and seclusion continue a downward trend since 2016. There are two fully trained Safe Practice Effective Communication (SPEC) trainers in mental health services and regular training sessions are provided in house and through HealthLearn modules for all staff, with a high level of training uptake. Staff understood the difference between enablers and restraint requirements.

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.