

# MidCentral District Health Board

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## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	MidCentral District Health Board
<b>Premises audited:</b>	Te Papaioea Birthing Centre  Horowhenua Health Centre  Palmerston North Hospital
<b>Services audited:</b>	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
<b>Dates of audit:</b>	Start date: 6 October 2020 End date: 9 October 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	363



# Executive summary of the audit

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## 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

MidCentral District Health Board (MDHB) provides services to around 190,000 residents living in the region. Hospital services are provided from the 350-bed facility at Palmerston North, the Te Papaioa eight bed birthing centre and the 24-bed facility at Horowhenua. Services include medical, surgical, maternity, children's and women's health and mental health and addiction services. These services are supported by a range of diagnostic, support and community-based services.

This four-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. Auditors visited both hospital sites.

This audit identified the following areas for improvement: performance appraisals for staff; staffing numbers and skill mix in some areas; patient identification details on clinical records; the placement of patients and patient flow; assessment and evaluation of

care; management of medicines; maintenance of equipment; facilities that are not always suitable for their purpose; and documentation in the clinical record when enablers are being used.

## **Consumer rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) was visible around all areas of the district health board (DHB) in both English and te reo Māori. Patients and families/whānau reported an awareness of the Code and that their rights were upheld. All patients spoke positively about their care, treatment, and communication with staff. Staff were observed respecting patients' rights, including their privacy.

The organisation has a strong commitment to providing services that meet the cultural needs of its catchment area.

Innovative approaches to delivering care and examples of evidence-based practice were evident throughout the services. Promotion of patient safety and a safe environment was noted across services.

Communication with patients and families was reported to be open and honest and examples of open disclosure were evident where required. Interpreter services are readily available and widely used.

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent.

Staff, patients and whānau were informed about the complaints process and information about how to make a complaint was available. Complaints are managed through an electronic system with the consumer experience team acknowledging and managing each complaint.

## Organisational management

The current board of directors has now been in place for around one year and members interviewed were clear about priorities and risks. The chief executive officer (CEO) is experienced in the role and is supported by an organisational leadership team (OLT) using an integrated model of health delivery. At the service provider level, the six clinical service streams (clusters) are supported by three clinical professional executive directors. Several strategic plans support an annual planning process. Locality and cluster wellbeing plans support positive community and clinical engagement and an inter-sectoral approach. A strong focus on equity for Māori with an increased focus on Treaty responsibilities was evident along with good partnerships with the six iwi groups in the region. Reporting to the board on equity outcome actions has been strengthened. There are well-established clinical and consumer councils and increasing consumer involvement at strategic and operational levels.

The quality and risk management system is well established both at the organisation-wide level and clinical level. The clinical governance framework is being reviewed to ensure it meets current needs. Several quality and risk roles support quality activities within the clusters. There has been a focus on developing health intelligence to better identify areas for improvement, monitor progress in achieving strategic goals and provide effective reporting. Improvement activity was evident at all levels of the organisation, from large projects across the continuum of care, to small ward-based initiatives. Risks are well managed and reported to the finance risk and audit committee and the board.

Adverse events are managed through an electronic management system, with improvement plans developed. A serious adverse events governance group (SAEGG) supports a thorough review process and follow-through of recommendations.

Family and consumer advisory services are well established across the mental health and addiction services.

Human resource systems are based on current accepted good practice. Comprehensive orientation programmes are in place for new staff in all disciplines at both organisational and service level. Staff are well supported with training opportunities for mandatory and ongoing training.

A range of mechanisms are used to ensure that the right number of staff are available to meet the changing needs of patients across the services. The organisation is progressing with the implementation of the Care Capacity Demand Management (CCDM)

programme, which is positively impacting on matching patient requirements to nursing staffing. The developments in the Integrated Operations Centre (IOC) are ongoing with improved responsiveness to patient flow and placement of staff where most needed.

Patient records are integrated and easily accessible. Patient information was held securely and not visible to those without the authority to have access.

## **Continuum of service delivery**

Patients access services based on need, guided by policy. Waiting times are managed and monitored. Risks are identified for patients through screening tools. Pre-admission assessment processes are used where appropriate. Entry is only declined if the referral criteria are not met, in which case the referrer and patients are informed of the reasons why and alternatives available.

Eight patients' 'journeys' were reviewed as part of the audit process and involved the emergency department, surgical, medical and maternity wards, children's and older persons' health ward, mental health units, department of coronary and intensive care and the operating theatre suite. Auditors and technical expert assessors worked collaboratively with staff reviewing the relevant documentation and interviewing medical, nursing and allied health team members, patients and families/whānau. Additional sampling was undertaken throughout the audit.

A qualified and skilled multidisciplinary team provides services to patients and there were good examples of teamwork throughout clinical areas. Shift handovers were efficiently managed and included a bedside handover.

Assessments were undertaken in a timely manner with results reviewed, discussed and actioned as appropriate. This was supported by patients and family members interviewed. Admission assessment tools utilised were based on best practice. Various care plans and pathways were evident throughout the hospital. Most areas were using the 'early warning score' (EWS, PEWS and MEWS) to prompt triggers when a patient's condition deteriorates, and this tool was well completed. Evaluation was undertaken of patients' progress on a regular basis and included progress towards discharge.

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

Overall, the audit identified a strong focus on meeting patients' needs and good teamwork between the multidisciplinary team members.

Policies and procedures provide guidance for staff on medicines management. The national medicine chart was in use.

At the time of the audit, food services were transitioning to a new provider. Both Palmerston North and Horowhenua hospital services have been verified as complying with a documented food safety programme/plan. Special dietary needs are accommodated. Patients interviewed were satisfied with the food provided.

## **Safe and appropriate environment**

Planning has commenced for a major infrastructure upgrade over the next few years including a new mental health unit.

All MidCentral DHB facilities have a current building warrant of fitness and meet regulatory requirements. Proactive and reactive maintenance occurs. Biomedical testing has fallen behind schedule with planning underway to address this. Electrical checks of equipment are undertaken and are traceable through electronic systems and maintenance requests. Waste is managed under contract in conjunction with cleaning, and the processes are well defined in policies and procedures and effectively implemented.

There are adequate numbers of bathrooms and toilets, communal areas and bed spaces that are suited to the needs of the different patient groups. The patients' personal spaces are adequate for staff movement and equipment use in areas visited. Most wards have adequate communal areas for recreation and receiving visitors. All areas of the hospital have adequate natural light and the whole environment was warm and comfortable.

Emergency management planning is well established with staff trained in current evacuation and emergency responsiveness. There has been detailed planning to manage and respond to the Covid-19 pandemic. Trial fire evacuations are completed six-monthly. Back-up power supplies and emergency water was available across all three sites. There are processes and equipment checked and available for dealing with medical emergencies. Staff are trained in emergency responses relevant to their area of work.

## **Restraint minimisation and safe practice**

Current policies and procedures guide practice for safe restraint and enabler use. Restraint interventions are overseen by the restraint team and restraint approval group (RAG). Staff understood the difference between a restraint and an enabler.

Episodes of restraint reviewed during the audit indicated that restraint was used as a last resort, had been appropriately approved and only applied when required. Any potential restraint events are responded to by trained individuals, including trained security officers. There has been a reduction in incidents and restraint events through use of the managing actual or potential aggression (MAPA) approach and the focus on de-escalation and providing alternative approaches. Mental health staff and security staff are trained in 'Safe Practice Effective Communication' (SPEC).

Restraint events are recorded via the incident reporting system and assessment and evaluation documentation was fully completed. The mental health unit has the zero-seclusion project well underway with no seclusion events for the month prior to the audit.

## **Infection prevention and control**

MDHB has an infection prevention and control programme for 2020-2021. The infection prevention and control committee includes a consumer representative and reports go to the chairperson of the clinical board. The infection prevention and control programme is facilitated by a team comprising a nurse manager, an administrator, a clinical nurse specialist and a registered nurse. They are supported by the infectious disease physician and microbiologist, and clinical pharmacists. All the infection prevention and control team members participate in relevant ongoing education.

Policies and procedures are available electronically to guide staff practice. Orientation and ongoing education are also provided to DHB staff, community health providers, and patients / family members.

Surveillance for infections is occurring. The surveillance programme is appropriate to the service setting and includes significant organisms, surgical site infections following 'clean' procedures, invasive device related infections, blood stream infections and outbreaks. The surveillance results are communicated appropriately. Regular monitoring of compliance with prophylactic and therapeutic antimicrobial use is occurring.