**Self-Assessment & audit preparation guidelines for public hospitals**

# Introduction

Self-assessment by the public hospital is an essential component of preparation for a certification and surveillance audit. This forms part of the Stage 1 audit process which covers documented management systems, collection of information related to processes, environmental requirements and evaluation of internal audits and reviews.

This self-assessment has been updated to align with Ngā Paerewa health and disability standard NZS8134: 2021 (Ngā Paerewa).

# Note the self-assessment is not a self-audit against Ngā Paerewa but is targeted to areas of the Standard that assist the Designated Auditing Agency (DAA) in preparing for the on-site audit and reducing time spent on site reviewing information that is readily available prior to the audit.

In addition to the completion of the self-assessment template provided below, the public hospital should also provide the DAA well in advance of the audit with:

* a copy of the current organisational structure of the public hospital with names of people in key leadership positions
* a map of facilities
* access to policies, procedures, and guidelines for the DAA to review. The DHB could consider providing intranet access for this purpose along with instructions on how to navigate to the policies, procedures, and guidelines.

The public hospital should not provide any confidential patient identifiable information or any other information that is considered confidential to the DAA as part of the self-assessment process and Stage 1 audit. These documents should be provided during the on-site audit (Stage 2).

New/partially new criteria in the new Standard will be assessed, but there will be no punitive outcomes for audits undertaken during the grace period. These criteria are noted in the   
self-assessment form.

Certification and Surveillance audit

The extent and size of these two audits are different. The certification audit includes all   
sub-sections (these are similar to ‘standards’ in the old Standards) and criteria so all aspects of the self-assessment tool will need to be completed. The transition surveillance audit covers all sub-sections, however, it only includes a subset of the certification audit criteria within each sub-section. The surveillance audit criteria are noted in the table below.

The DHB should also alert the DAA to any changes in policies, procedures or guidelines including any newly developed policies, procedures, or guidelines for the DAA to review prior to the on-site audit.

# Instructions for completion

A template is provided by the DAA to the public hospitals for completion at least ten weeks prior to the audit. The template includes a declaration and an indication of the length of time taken to complete the self-assessment. The self-assessment must be returned to the DAA four weeks prior to the audit. The public hospital should involve as many staff as possible when completing the self-assessment.

The DAA will provide the public hospital with a brief report two weeks prior to the audit on the   
self-assessment content and identify what further evidence may be required that will then be reviewed at the on-site audit. The DAA will use a standard template for this purpose.

Please record activities, processes and outcomes against each standard, ensuring comment is made on what is done well, what needs improvement and how improvement can be monitored, achieved and evaluated. The submission of examples of monthly reports/minutes is a minimum of three most recent reports. The self-assessment will focus on organisational system and process with examples of how service areas (and/or satellite facilities) meet requirements. For example, if reporting reportable events information against subsection 2.2:

* the organisation manages reportable events through *xyz* software programme
* events are electronically reported by staff and reviewed by the immediate team manager (eg, charge nurse) to ensure appropriate immediate actions have been taken and escalated to the service manager
* timeframes for completion of any actions to close out events are monitored where a report is produced monthly by the Quality Unit and is distributed to service managers for further follow-up
* dashboard reporting that tracks the number and closure rate of reportable events is reported to the Board (attach an example or reference link to on-line data base)
* serious and sentinel events are reported through the SAC1 and 2 system (attach trend information or reference link to on-line data base)
* comment about the number and type of events, monitoring against these events, any projects initiated as a result (eg, for the last year by quarterly results). Number and type of events where open disclosure has been formally implemented. Number of current outstanding HDC investigations associated with reportable events (attach relevant information at a summary level or reference link to on-line data base if applicable).

The emphasis of the self-assessment is the hospitals own appraisal through narrative reporting which is supported by documents which are referenced or appended.

There is a column in the self-assessment template to embed relevant documents or reference the name of documents such as monthly and quarterly reports, meeting minutes, terms of reference etc. Ensure the public hospital references any external audits completed which may be relevant to the Standard. For example, HAZNO; ACC; Councils or Professional Colleges.

Note policies, procedures and guidelines will be reviewed prior to audit (eg, by remote access). Some policies and procedures may also be viewed while on-site visit as part of the verification process.

Rate each subsection as CI (Continuous Improvement), FA (Fully attained), PA (Partially attained), or UA (unattained). A comment about the level of risk associated with any PA or UA does not need to be made.

Guidance is also provided in the template.

You may add lines into the template if required (eg, premise names). Ensure you complete a brief summary under then declaration section to the report.

## Outcome areas

In order to focus the planned tracer activities during the onsite event please make particular comment including details of the affected clinical areas within subsection 2.2 (Quality and Risk Management Systems) on the:

* number of avoidable falls
* medication errors
* hospital associated infections
* hospital acquired pressure ulcers.

**Self-Assessment Template**

**Provider details:**

|  |  |  |
| --- | --- | --- |
| **Premise Name** | **Address** | **Capacity** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Contributors to the self-assessment**

| **Name** | **Position** | **Subsections assessed** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Declaration**

I, (full name) [first name, surname], (occupation) [XX] of …. District Health Board hereby submit this self-assessment in preparation for the upcoming certification audit as being as being an accurate reflection of the current status of the District Health Board as at XX date.

**Brief summary**

|  |
| --- |
| Key improvements since the last certification or surveillance audit: |

|  |
| --- |
| Summary of corrective actions remaining outstanding from the last certification or surveillance audit: |

|  |
| --- |
| Improvement projects underway or recently completed: |

|  |
| --- |
| Challenges faced by the public hospital and how these are being monitored and managed: |

|  |
| --- |
| Summary of any PA or UA identified in the self-assessment: |

# Self-assessment information

| **Subsection** | **Self-assessed as**  **CI, FA, PA, UA** | | **Narrative reporting[[1]](#footnote-1)** | **Associated documents[[2]](#footnote-2)** (embed or reference these so they can be reviewed on-site) | **Guidance** (information you may wish to consider reference or comment on in narrative reporting) |
| --- | --- | --- | --- | --- | --- |
| Ō tatou motika - Our Rights  1.1-1.10.5  Surveillance Audit criteria:  1.1.3, 1.2.3, 1.3.5, 1.4.4, 1.4.5, 1.4.6, 1.5.5, 1.5.6, 1.7.9, 1.8.1, 1.8.5  New/partially new  1.1.3, 1.2.3,1.3.5, 1.4.4, 1.4.5, 1.4.6, 1.5.5 1.5.6, 1.7.9, 1.8.5 |  | |  |  | 1. Staff training programmes and attendance records for relevant subsections 2. Policies andprocedures eg, informed consent, abuse, open disclosure Advanced Directives. etc. 3. Patient Information Booklets 4. Screening programmes eg, Family Violence 5. Maori Health Plan, MoUs 6. Maori Services within hospital 7. Pacific Island service plans and services available within the hospital 8. Interpreter Services 9. Ethnicity Data 10. Progress with advanced directives 11. HDC Advocacy services access 12. Complaints process, six months data resolution rates, analysis and reporting of recommendations and actions taken. |
| Hunga mahi me te hanganga – Workforce and Structure |  | |  |  |  |
| 2.1  Mana whakahaere - Governance  *Our governance body is accountable for delivering a high-quality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.*  Surveillance Audit criteria:  2.1.5, 2.1.6, 2.1.7, 2.1.10  New/partially new:  2.1.5, 2.1.6, 2.1.7, 2.1.10 |  | |  |  | 1. Hospital vision statements and statement of care (where is this found & how do patients/consumers find this information) 2. Ministry health targets being met over the last 4 quarterly reporting periods 3. Current District Strategic, Regional and Annual Plans, Operational Policy Framework report, Statement of Intent 4. Annual report 5. Internal Key Performance indicators from the above plans – quarterly/monthly reporting data 6. MOU with Iwi 7. Board structure and meetings – ELT, SLT HAC and Audit & Risk committee reports for last six months 8. Ministry initiatives – review Better Sooner More Convenient 4x quarterly reports 9. How does the structure and linkages with Board, CEO, COO and directorates/clinical services support good governance |
| 2.2  Kounga me te mōrearea - Quality and risk  *We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of the people using the services and our health care and support workers.*  Surveillance Audit criteria:  2.2.2, 2.2.4, 2.2.6, 2.2.7, 2.2.8  New/partially new:  2.2.4, 2.2.7, 2.2.8, |  | |  |  | 1. Quality/Risk Management plan and structure at directorate to ward levels 2. Current ACC Accredited Employer Programme report 3. Consumer Consultation reports and survey results last 4 quarters 4. Document Control Policy and Status Report last 6 months 5. Quality Unit Analysis /Feedback processes to clinical areas 6. Examples of recent Corrective Action Plans developed in ward/service reported to HAC for close out. 7. Evidence of quality indicator collection and reports in the clinical area 8. Monthly Risk Management reports last 6 months 9. Internal Audit schedule for clinical areas – include reports of all audit types – eg, Maintenance, cleaning, environmental and clinical audit activity 10. Hospital Mortality/ Morbidity meeting minutes/reports last 6 months. 11. List of policies and procedures that can be reviewed in the on-line data base, role descriptions 12. Copies of recent external audit reports and recommendations eg, ACC, HCCUP IANZ 13. Policies and procedures of Adverse Event reporting. 14. Reporting structure and data analysis and corrective actions developed from events 15. Adverse event reports inclusive of recommendations past 6 months 16. Sentinel Events, SAC 1&2 events, RCA, HDC, Section 95 reports for last 4 quarters 17. Other patient safety initiatives - incidence, monitoring and recommendations eg, falls, medications, pressure, infection, staffing issues 18. Surveillance audit - data and analysis on deteriorating patient and falls programmes 19. Mental Health Services Only – Terms of Reference, policies and procedures, job descriptions and training for staff and consumer advisors. Meeting minutes last 3 meetings, and monthly reports last 6 months |
| 2.3  Whakahaerenga ratonga - Service Management  We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services*.*  Surveillance Audit criteria:  2.3.1, 2.3.3, 2.3.4, 2.3.6, 2.3.7  New/partially new:  2.3.3, 2.3.6, 2.3.7, 2.3.8 | |  |  |  | 1. Board, organisational and/or clinical governance structure and Terms of Reference 2. Service/directorate structure charts 3. Delegated authority policy/process including afterhours management 4. Consumer Engagement Process 5. Safe staffing initiatives - reports last 6 months 6. Management of outlier policy 7. Process to determine service provider levels, skill mixes for safe care, meeting RMO and SMO contract 8. Risk mitigation strategies to manage deficits 9. Staff turnover current vacancies 10. Policies and procedures related to skill mix and rostering nursing, allied health and medical |
| 2.4  Ngā kaimahi tiaki hauora me ngā kaimahi tautoki - Health care and support workers  *We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality and care services.*  Surveillance Audit criteria:  2.4.3, 2.4.4, 2.4.6  New/partially new:  2.4.6, 2.4.7 | |  |  |  | 1. Evidence of recruitment processes, scope of mandatory training, orientation and on-going education plans for all staff processes and reports on activity 2. Policies and procedures for recruitment, orientation, mandatory training performance management. 3. Orientation and Mandatory training schedule and rates of attendance for all health professionals 4. Credentialing Processes – schedule and rates by department and individuals 5. Accreditation for Colleges – most recent report summary and recommendations 6. Learning and Development Plan Initiatives 7. Copy of orientation booklet 8. Training programmes for nursing and allied health. 9. Report on the completion rates for orientation, performance reviews, and staff training. 10. Recruitment and Workforce Development Plan 11. Human resource report to HAC last 6 months 12. Copy of performance review processes and rates for all staff 13. Sample of HR files will be required 14. Staff ethnicity data |
| 2.5  Mōhiohio - Information  *We ensure the collection, storage and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confident.* | |  |  |  | 1. Internal monitoring processes/audit on clinical documentation, coding reports last 6 months 2. Policies and procedures for clinical information management 3. Management strategies for paper and electronic health record activity – security of health information 4. Client record responsiveness audit results 5. Clinical documentation audit reports 6. Privacy and NZHIS audit reports |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ngā huarahi ki te oranga – Pathways to wellbeing |  |  |  |  |
| 3.1 -3.3  Te urunga me te whakakore urunga - Entry and declining entry  *When people enter our service we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau* |  |  |  | 1. Access and entry criteria examples for cardiac, cancer, paediatrics, maternity, and mental health (when applicable) 2. Policies and procedures for prioritisation, and declining entry, EWS systems, falls 3. Examples of assessment tools for Paediatrics, maternity, mental health (where applicable) and aged care including falls and EWS or equivalent 4. Assessment tools for falls, pressure/skin integrity and deteriorating patient 5. Example of current care planning tool or explanation if a variety is used. 6. Note: include patient tracer and sampling data which will also help inform systems tracers. |
| Taku huarahi ki te oranga - My pathway to wellbeing  *We work in partnership with people and whānau to support wellbeing*  Ngā mahi takitahi - Individualised activites  *We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them*  Surveillance Audit criteria:  3.1.5, 3.1.6, 3.2.3, 3.2.4, 3.2.5, 3.2.6, 3.2.7, 3.3.3, 3.3.4  New/partially new:  3.1.3, 3.1.5, 3.1.6, 3.2.3, 3.2.4, 3.2.6, 3.2.7, 3.3.3, 3.3.4 |  |  |  |  |
| 3.4  Aku rongoā - My medication  *We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice guidelines*  Surveillance Audit criteria:  3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.4.5, 3.4.6, 3.4.7, 3.4.8, 3.4.9, 3.4.10, 3.4.11, 3.4.12  New/partially new:  3.4.7, 3.4.8, 3.4.9, 3.4.10, 3.4.11, 3.4.12 |  |  |  | 1. Explain current medication system and management across satellite services 2. Medication Safety and Advisory Team minutes last 6 months 3. Medication chart audit reports –sample last 6 months 4. Policies and procedures for medications including reconciliation 5. Pharmacy staff resources |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3.5  Taioranga kai hei tautoko I te oranga - Nutrition to support wellbeing  *We ensure people’s nutrition and hydration needs are met to promote and maintain their health and wellbeing*  Surveillance Audit criteria:  3.5.7  New/partially new:  3.5.7 |  |  |  | 1. Food Safety Inspection Certificate Audit report and recommendations 2. Consumer survey reports last 12months 3. In house or external contracted food services audit reports last 6 months 4. Dietitian service provision monthly reports last 6 months 5. Policies and procedures including special diets 6. Staffing levels |
| 3.6  Te takatau, whakawhiti me te whakaputa - Transition, transfer and discharge  *We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate supported transition of care or support*  Surveillance Audit criteria:  3.6.4 |  |  |  | *Refer to 3.1-3.3* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3.7  Haumanu whakahikororo - Electroconvulsive therapy  *We ensure electroconvulsive therapy is safe and effective for the people using our service*  Surveillance Audit criteria:  3.7.4  New/partially new:  3.7.4 |  |  |  | 1. Policies and procedures 2. Internal monitoring processes and audits 3. Evidence of whānau involvement and consultation |
| Te aro ki te tāngata me te taiao haumaru – Person-centred and safe environment |  |  |  |  |
| 4.1  Te whare haumanu - The facility  *Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to move independently and freely throughout. The physical environment optimises people’s sense of belonging, independence, interaction, and function*  Surveillance Audit criteria:  4.1.1, 4.1.7  New/partially new:  *4.1.7* |  |  |  | 1. BWOFs for all facilities 2. Current state of all hospital facilities report 3. Registration and maintenance programme reports last 6 months 4. Biomedical testing schedule and reports last 6 months 5. Copy of Mortuary Certificate 6. BIEMS (or equivalent) and effectiveness from service level monthly reports last 6 months 7. Medical gas management safety reports last 6 months 8. Hot water monitoring 9. Smoking cessation activity within hospital uptake 10. Note internal rooms used for overnight patient stays 11. On site visits to clinical areas - note any particular issues with toilet, shower and bathing facilities, and personal bed space areas 12. Consider dedicated areas for service types – eg, Paediatrics, Long term care |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 4.2  Te haumaru o ngā tāngata me te hunga mahi - Security of people and workforce  *We deliver care and support in a planned and safe way, including during an emergency or an unexpected event*  Surveillance Audit criteria:  4.2.1, 4.2.6 |  |  |  | 1. Fire evacuation plans 2. Methods of keeping patients/public/staff aware of environment hazards 3. Emergency responsiveness, including clinical teams, specific earthquake response teams etc. 4. Security service reports for last 6 months 5. Emergency management plans |
| Te kaupare pokenga me te kaitiakitanga patu huakita – Infection prevention (IP) and antimicrobial stewardship (AMS) |  |  |  |  |
| 5.1  Mahi whakahaere - Governance  *Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern* |  |  |  | 1. Hospital Infection Control Management Team – structure, terms of reference and last 6 months reports to HAC 2. Example of urgent escalation process (outbreak) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5.2  Te hōtaka kaupare pokenga me te whakatinanatanga - The infection prevention programme and implementation  *We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our service*  Surveillance Audit criteria:  5.2.4, 5.2.12, 5.2.13  New/partially new:  5.2.9, 5.2.10, 5.2.11, 5.2.12, 5.2.13 |  |  |  | 1. Infection Control Annual plan reports 2. Hospital national data set reports for last 6 months 3. Describe interface between hospital IC Committee and clinical services 4. Link to satellite sites 5. Describe the interface with contracted services in respect of compliance to organisational infection control programme 6. Describe outbreak management practices/ pandemic or infectious disease plan 7. Policies and procedures to cover all subsections 8. Reports on education training for staff – rates Consider role of infection control service representatives 9. Education formal vs. informal |
| 5.3  Hōtaka kaitiaki patu huakita (AMS) me te whakatinanatanga - Antimicrobial stewardship (AMS) programme and implementation  *We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our service* |  |  |  | 1. Antimicrobial policy implementation 2. Rates of antibiotics usage reports for last 4 quarters. 3. Policies and procedures |
| 5.4  Te āta tirotiro mō te pokenga e pā ana ki te tiakanga hauora (HAI) - Surveillance of health care-associated infection (HAI)  *We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities and methods specified in the infection prevention programme, and with an equity focus*  Surveillance Audit criteria:  5.4.3, 5.4.5  New/partially new:  5.4.3 |  | Infection Control system Tracer evidence |  | 1. Reports of surveillance, types and activity last 6 months 2. *Recommendations and follow up from surveillance activity last 4 quarters* 3. *Processes for culturally safe communication with patients who develop an HAI* |
| 5.5  Taiao - Environment  *We deliver services in a clean, hygienic environment that facilitates the prevention of infections and transmission of antimicrobial-resistant organisms* |  |  |  | 1. Policies and procedures HSNO 2. HSNO management, particularly afterhours, interface with cleaning/orderly staff 3. Substance labelling & decanting process if appropriate 4. Staff Training report rates 5. Access to protective equipment 6. Waste collection, management of spills 7. Staff training rates which staff have compulsory waste management training 8. Current in hours or contracted monthly reports last six months for cleaning, laundry services 9. Audit report of laundry and cleaning last years |
| Here taratahi – restraint and seclusion |  |  |  |  |
| 6.1  He tukanga here - A process of restraint  *We demonstrate the rationale for the use of restraint in the context of aiming for elimination*  Surveillance Audit criteria:  6.1.1, 6.1.2, 6.1.3, 6.1.4  New/partially new:  6.1.1, 6.1.2, 6.1.3, 6.1.4 |  |  |  | 1. Hospital Restraint Committee – Terms of Reference, minutes last 4 quarters 2. Policy and procedures for MH, ED and general hospital areas 3. Clinical service restraint committees terms of reference and minutes last 4 quarters 4. Initiatives and project on minimisation, profile of restraint within organisation reports for last year 5. Restraint training content, rates of attendance and evaluation |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 6.2  Herenga haumaru - Safe restraint  *We consider least restrictive practices, implement de-escalation techniques and alternative interventions and only use approved restraint as the last resort* |  |  |  | 1. Restraint Register last 4 quarters 2. Restraint process for the organisation – how are restraints approved, monitored in terms of the register, role of services – meeting minutes last 6 months |
| 6.3  Arotake kounga o te herenga - Quality review of restraint  *We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities* |  |  |  | 1. Provide 4 examples (two mental health) of patient restraint documentation when restraint has been used. Include approval, assessment, monitoring, and evaluation. 2. Hospital restraint activity reports last 4 quarters Projects to reduce risks associated with restraint 3. Hospital and clinical service restraint committee evaluations, frequency of restraint (and enablers) reports last 4 quarters 4. Hospital and clinical service restraint committee review process – frequency, supporting documentation reports last 4 quarters 5. Reports of reduction of restraint usage strategies 6. Restraint minimisation initiatives |
| 6.4  Taratahi - Seclusion  *We no longer consider seclusion a therapeutic intervention, and it only occurs when our environment is not conducive to the elimination of seclusion*  New/partially new:  6.4.1, 6.4.2 |  |  |  | 1. Seclusion rates and monitoring reports for last 12 months (organisational perspective) 2. Training of staff rates and reports last 12 months 3. Evidence of or statement that approval by DAMHS has occurred 4. Copies of seclusion room inspection reports. |

1. Include how you know this subsection is achieved or not fully achieved. Where not fully achieved, what action is being taken etc.? [↑](#footnote-ref-1)
2. Note: do not embed policies, procedures or guidelines. [↑](#footnote-ref-2)