

Hokianga Health Enterprise Trust - Hokianga Hospital

Introduction

This report records the results of a Certification Audit of a provider of aged residential care 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: Hokianga Health Enterprise Trust

Premises audited: Hokianga Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services

Dates of audit: Start date: 20 June 2018 End date: 21 June 2018

Proposed changes to current services (if any): Work is in progress to build a new twin occupancy bed room. This work is still in progress.

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Hokianga Hospital provides hospital services (medical, geriatric and maternity), and rest-home level care for up to 25 patients. On the first day of the audit 19 patients were receiving services.

This certification audit was conducted against the Health and Disability Services standards. The audit process included the review of policies and procedures, the review of patients' and staff files, observations, and interviews with patients, family members, managers, staff, and a medical specialist. Feedback from patients and families was very positive about the care and services provided.

At this audit three areas were identified as requiring improvement. These related to ensuring open disclosure is documented, aspects of human resources record management, and ensuring staff orientation records are consistently maintained. Three areas of continuous improvement have been identified related to continuity of care, how the service meets the needs of patients who identify as Maori, and the strategic / governance consultation and communication processes with the community.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to patients. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs of patients and staff were noted to be interacting with patients in a respectful manner.

Patients who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Maori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff interviewed understood and implemented related policies. Professional boundaries are maintained.

Communication between staff, patients and families/whanau is promoted and confirmed to be effective. There is access to local interpreting services if required. The service has strong links with a range of specialist health care providers which contributes to ensuring services provided to patients are of an appropriate standard.

Staff and patients interviewed were aware of the complaints process. Complaints are investigated and responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The chief executive officer (CEO) and the hospital services manager (HSM) have both worked in this service for many years. Job descriptions detail their roles and responsibilities. The strategic plan is for 2015 to 2020. Progress is reviewed at least annually, and an annual plan developed and implemented. The vision, mission and philosophy of the service are documented.

The quality and risk programme includes internal audits, complaints, compliments, patient satisfaction surveys, and incident/accident, hazard and risk identification and management. Policies and procedures are in place that address required aspects of the service, and documents are controlled. The executive committee has oversight of the quality and risk programme. There are formal reporting processes in place between the CEO and the Board of Trustees.

A new role has been developed for overseeing recruitment and human resources processes. Mandatory training is identified, and staff have good access to internal and external training opportunities. New employees are provided with orientation relevant to their role. Policy details staffing numbers and skill mix requirements. There is a minimum of two nursing staff on duty at all time. Additional staff, including health care assistants, are rostered on morning and afternoon shifts. A medical practitioner and a lead maternity carer are always on call when not on site.

Patients' information is accurately recorded, securely stored and is not accessible to unauthorised persons. Up to date, legible and relevant patient information and records are maintained in using an integrated hardcopy record. The maternity service also uses an electronic record due to the nature of this service and continuing care provided in the community six weeks after a birth occurs at home and/or at the facility.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the long-term care ward is appropriate and efficiently managed. When a vacancy occurs sufficient and relevant information is provided to the potential patient/family/whanau to facilitate the admission. A waiting list exists for this area of service delivery.

The service provides medical geriatric hospital and rest home level care. In addition to this the service also provides primary birthing and acute inpatient medical care services. All patients are assessed appropriately on admission within required timeframes. Registered nurses are on duty 24 hours each day in the hospital. The medical officers are on duty in day time hours, and an on-call system is available for the after-hours.

Care plans are individualised based on a comprehensive range of integrated clinical information. Short term care plans are developed for the long-term care patients to manage any new problems that might arise. The admission to discharge planner is used for the medical patients. All records reviewed for all inpatient services audited reflected that the needs of patients, goals and outcomes are identified and reviewed on a regular basis. Patients and families/whanau interviewed reported being well informed and involved in care planning and evaluations and that the care provided is of a high standard. Patients are referred and/or transferred to other health services if and when required with appropriate handovers being provided.

The planned activities are provided by a diversional therapist for the long-term care patients. The activities provided are a variety of individual and group activities and patients are encouraged to maintain links with the community and the marae.

Medications are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses and midwives all of whom have been assessed as competent to do so. The midwives can prescribe within their scope of practice.

The hospital has a registered food safety plan. Processes are in place to identify and meet individual patient's dietary needs.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

There are policies and procedures which guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment is readily available in all areas and was observed to be used. Two staff members have an approved handling certificate for hazardous substances. Chemicals and other hazardous substances are stored securely, and a register maintained.

The building has a current building warrant of fitness. A building programme is underway to re-roof half of the building and to build a new bedroom. Clinical and electrical equipment showed evidence of current calibration. The temperature of hot water is within required standards. The security arrangements are appropriate and includes use of security cameras.

Some rooms are single occupancy, three rooms are double occupancy and one room has four beds. Four patient rooms have full ensuites. Personal space is sufficient for patients, including those mobilising with equipment, or who require staff assistance. The ambient temperature is adjustable to facilitate patient comfort. Smoking is not allowed on site. Environmental cleaning and laundering of long-term care patients' personal clothing is provided by staff. Hospital linen is laundered off site by contractors.

Emergency policies and procedures cover civil defence and medical emergencies. Clinical staff receive training in managing emergencies and this includes cardiopulmonary resuscitation, fire and other emergencies. The fire evacuation plan has been approved by the New Zealand Fire Service. Fire evacuation drills are being conducted at least six monthly. There are sufficient utilities (including a generator, and water supply) on site for use in the event of an emergency.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three patients had restraints in use at the time of the audit. There were no patients using enablers. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process is occurring. Three monthly reviews of the use of restraint are occurring. Staff demonstrated knowledge and understanding of the restraint and enabler policy and associated processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is led by an experienced and appropriately trained infection prevention and control coordinator and aims to prevent and manage infections for this hospital care setting. There are terms of reference for the infection control committee which meets quarterly. Specialist infection prevention and control advice can be accessed from the Northland District Health Board infection prevention and control nurse specialist. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control which is guided by relevant policies and supported with regular education.

Surveillance is undertaken to cover all services and results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	2	0	0	0
Criteria	3	100	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the in-service and online education programmes. Patients' rights are upheld by staff (eg, staff knocking on patients' doors prior to entering their rooms, staff speaking to patients with respect and dignity, and staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with patients in all services audited being aged related care, maternity and inpatient medical services. The patients reported that they understand their rights. The family/whānau reported that patients are treated with the utmost respect and dignity is maintained.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	Evidence was seen of the consent process for the collection and storage of health information, use of photographs for identification, sharing information with an identified next of kin and for treatment/procedure and influenza immunisation. The patient's right to

choices and give informed consent.		<p>withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, such as in the aged related residential care service, that this is activated appropriately.</p> <p>There is guidance in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the patient wishes if verified by the medical officer at the time of the review. An advance directive and advance care plan are used to enable patients to choose and make decisions related to end of life care. The records reviewed for the long-term care patients (ARRC) identified patient wishes and meet legislative requirements.</p> <p>Patients and family/whanau (where appropriate) are included in care decisions. For maternity patients the women work closely in partnership with their midwife to be able to make informed decisions about themselves and their baby/pepe. In respect of the whenua/placenta being disposed and/or kept to take home, is up to the individual woman to decide. This is usually discussed in partnership with the midwife and the patient and documented on the individual record. If a woman wishes to take her whenua home it is placed in a receptacle and stored in a fridge until discharge or given to whanau to take home.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy services information is readily available in brochure format at the entrance to the facility. Patients and family/whanau were aware of the right to have support persons. Education about the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme for staff. The staff interviewed reported knowledge of patients' rights and advocacy services. A kaumatua and kuia are available if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Patients reported they are supported to remain in contact with the community through outings and activities, especially those in the long term residential care service. Policy includes procedures to be undertaken to assist patients to access community services or to plan for discharge to the community. Women in the maternity service welcome the support of their partner and/or a support person of their choice during all stages of service delivery. In the inpatient medical service family/whanau can stay and support the patient on admission</p>

		and as required if admitted to the service. Visitors are welcome to visit patients' during the day and early evening.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The chief executive officer (CEO) and the quality officer are responsible for managing and responding to complaints. A complaint made to the Health and Disability Commissioner is open. The requested information has been provided and the service is awaiting a response. The four complaints reviewed for 2017/18 showed that complaints management processes complied with the Code, in particular Right 10.</p> <p>Patients and family/whanau members interviewed indicated they knew how to complain or provide feedback. Suggestions / compliments and complaints forms were sighted and were readily available throughout the hospital. Staff and managers interviewed understood the complaints process.</p> <p>A complaints register was being maintained along with associated documents. Compliments and expressions of thanks are communicated to staff.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that patients will be provided with the Code information on entry to the service. Copies of the Code and other information related to rights are in the Hauora Hokianga patient information booklet provided to all patients on admission to the facility. Posters and pamphlets are displayed throughout the services provided. Opportunities for discussion and clarification relating to the Code are provided to patients and their families. The lead maternity carer midwives discuss the Code with women at the first point of contact with the primary maternity service and as required through all stages of service delivery. Patients and family/whanau reported that the patients are addressed in a respectful manner that upholds their rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Patients and families/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring patient information is held securely and privately and consideration is given when exchanging verbal information, whether a</p>

		<p>patient is in a single bedded room or in a shared room with another patient). The patients in the long term residential care rooms can bring some of their own belongings into the facility as this is their home/whare.</p> <p>Patients are encouraged to maintain their independence by attending activities in the community and having time with family/whanau. Each care plan for the long-term patients included documentation related to the patient's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each patient's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan.</p> <p>Staff understood the hospital's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect and family violence screening is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori patients which is a strength of the organisation. Staff support the high number of patients in the service who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whanau to Maori patients. There is a current Maori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. The Maori patients and their whanau interviewed reported that staff acknowledge and respect their individual cultural needs and elders are acknowledged. The staff and whanau interviewed reported that there are no known barriers to Maori accessing the services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural and/or spiritual needs of the patient are provided for in consultation with the patient and family/whanau as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally</p>

		<p>and/or spiritually sensitive manner in accordance with the patient's individual values and beliefs. For the medical inpatients, needs are identified on the admission to discharge planner use, and for the maternity service, on the assessment record and care plan sighted. If required, an advisor from the community is contacted to provide advice, training and support for the staff, to enable the facility to meet the cultural/spiritual needs of the patient.</p> <p>Patients interviewed reported that their individual cultural, values and beliefs are effectively met. Staff confirmed the need to respect the individual culture, values and beliefs of the patients in their care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Patients and family/whanau reported that patients were free from any type of discrimination, harassment or exploitation and felt safe. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams as needed. Medical officers are on site and on-call 24 hours seven days a week. For maternity services, the midwives are well supported with a policy to have a medical officer as the second person present for every birth if possible at the hospital.</p> <p>The implementation of the early warning score for the inpatient service is well embedded and the staff can pick up early warning signs of deterioration and act promptly for a patient. Clinical reviews are undertaken as part of the internal quality management process to continually improve all inpatient services. Patient and family/whanau feedback evidenced overall satisfaction with the quality of care and the services provided. A board outside the inpatient ward office was full of letters and cards from patients and family/whanau members verifying the care received.</p>

		<p>Staff reported they receive management support for any external education and access their own professional networks to support contemporary good practice. The staff responsible for the interRAI assessments ensure these are kept up-to-date, and a high standard of care is promoted by the clinical leaders in both the inpatient and long-term care services. Feedback from a patient who had accessed the maternity service was that the service was of a high standard, with 'one on one' care and management. The experience was private and personal, and the fact that the woman's partner could stay and provide additional support was much appreciated.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Patients and family/whanau members stated that they were kept well informed about any changes to their relative's status and were advised in a timely manner about any outcomes of regular and any urgent medical reviews. This was supported in the patients' progress records reviewed for the aged related residential care patients. For the inpatient service this was not so obvious in the records reviewed following accidents and incidents occurring.</p> <p>Staff were aware of how to access interpreter services although reported this was rarely required due to patients being able to communicate effectively in English and te reo Maori when needed. There are communication strategies in place for patients with cognitive impairment or who have non-verbal means of communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Hokianga Health Enterprise Trust (Hokianga Health) is a charitable trust responsible for overseeing the services provided at Hokianga Health. There is a strategic plan for the period 2015-2020. The plan is reviewed with wide consultation at least annually with a review of the previous year's activities, outcomes and needs as well as planning for the next year. This is an area of continuous improvement. An annual health and business plan is developed to detail the focus and goals for the coming year. A draft of the June 2018 to July 2019 annual health and business plan was sighted. This is scheduled to be tabled at the next board meeting.</p> <p>The chief executive officer has been employed at Hokianga Health since 1994 (initially as the finance manager), and as CEO since 2001. The CEO provides reports to the Board of Trustees (BOT) on a regular</p>

		<p>basis, and also attends the BOT meetings. Hokianga Health includes hospital and aged related residential care services provided by Hokianga Hospital as well as community-based services.</p> <p>Hokianga Health has a 'rural health centre – integrated family health centre' contract with Northland District Health Board (NDHB). The 2012 version of the contract details the scope and includes acute medical care, surgical rehabilitation, palliative care, maternity inpatient (birthing and postnatal), accident and emergency, inter-hospital escort, step up/step down secondary care to primary and primary care to secondary, and community nursing. A separate contract covers aged related residential care at hospital and rest home levels of care. Other contracts are held that were not reviewed as they were not relevant to the scope of this audit. On the first day of audit there was one resident receiving rest home level of care, nine residents receiving hospital care-geriatric, one woman in the maternity unit (and her infant), seven patients receiving hospital care medical services, and one respite client. Children can be admitted. There were no children present during audit. The hospital services manager advises the facility has 25 certified beds. This includes 10 aged related residential care beds, (two of which can be used for hospital or rest home level care), three maternity beds, and 12 beds for acute medical patients, including one bed for respite patients.</p> <p>The CEO is supported by the hospital services manager (HSM) who is responsible for the day to day clinical services provided in the hospital. The hospital services manager is an experienced RN, who has been in this role since prior to the last audit. The hospital services manager attends relevant education as required to meet the provider's contract with Whangarei District Health Board. The community services manager is responsible for the maternity services. A senior registered nurse has designated responsibilities for providing oversight of care provided to residents receiving aged related residential care (ARRC) services. The HSM and the RN providing oversight of ARRC clients have completed interRAI assessment training. The community health services manager also has interRAI competency.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p>	FA	<p>There are documented delegation of authority from the Board of Trustees to the chief executive officer (CEO), and from CEO to managers. This is dated August 2017. In the CEO's absence, the</p>

managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		administration manager (who has worked at Hokianga Health for 24 years and has been the administration manager since 2001) is responsible for the services provided with the assistance of the other members of the management team. The CEO advises he is usually available for phone calls if away.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation includes quality and risk information in the strategic and annual business plans.</p> <p>There are current policies and procedures available for staff. These are reviewed and updated every two years or sooner where applicable. Clinical policies are reviewed annually. Policies sighted during audit were current. Copies are available for staff in a paper manual in the clinic and administration manager's office, as well as electronically on the intranet. The quality officer is responsible for document control processes. New or significantly changed clinical policies are circulated to staff for feedback, and then reviewed by the executive committee and amended/approved. Policies are signed off by the applicable service manager.</p> <p>Hokianga Health has a quality and risk management system which is understood and implemented by service providers. This includes a schedule of internal audits, a number of patient satisfaction surveys (including food), incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, restraint and complaints management. Regular internal audits are conducted and demonstrated a high level of compliance with organisation policy.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions are developed, implemented and monitored. Quality information is shared with all staff via shift handover as well as discussed at the weekly executive meetings, and quarterly health and safety committee meetings. The clinical governance group meets two monthly to review business and strategic outcomes, progress towards achieving health targets and to discuss new quality initiatives. Significant adverse events are also reviewed, and associated action plans documented, implemented and monitored for effectiveness.</p>

		<p>Aged related residential care incident, infections and staffing data is being benchmarked with five other facilities within the Northland DHB. The results of the accumulated data for period ending March 2018 were sighted. The hospital services manager reports reviewing this data to see how Hokianga Health aligns with other similar services. The service is working to reduce the number of medicine related events including medicines incorrect time / not given, and not signed as given. Regular satisfaction surveys are undertaken of clients. The feedback from clients in the satisfaction survey was very positive. The feedback related to food services was also very positive. Staff, clients and family/whānau interviewed expressed a high level of satisfaction about the services provided at Hokianga Health and commented on the holistic approach to service and the benefits of integration with primary and hospital care.</p> <p>Actual and potential risks are identified in the business and annual plans. Risks are regularly monitored and reviewed by the CEO and board and were regularly referenced in staff and management meeting minutes sighted. The management team are actively working on strategies for succession planning as part of business continuity, and risk management programmes.</p> <p>Quality projects are undertaken. Recent clinical projects have included the introduction of a paediatric early warning scoring system and adult early warning scoring system, and the introduction of a paediatric patient A to D (admission to discharge) planner. Both projects are reported to have provided tangible positive results.</p> <p>Staff confirmed that they understood and implemented documented hazard identification processes. Staff note maintenance / facility issues are promptly attended to. The hazard and risk register sighted was up to date (dated last reviewed June 2018). The health and safety officer advise the frequency of review is based in the identified level of risk (using a severity assessment code) for each item noted in the register. The CEO is responsible for monitoring oversight of asbestos related risk during the current building programme. Hokianga Health is working on a waste reduction programme. Staff are currently completing a health and safety culture related survey.</p> <p>Hokianga Health holds tertiary level workplace accreditation with Accident Compensation Corporation until 31 December 2018. The</p>
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		service also has current accreditation as meeting 'Baby friendly hospital' requirements. The service has been accredited by Whangarei DHB as meeting national cold chain requirements for vaccines. The cold chain accreditation is for the period August 2016 to August 2019.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The incident policy provides a framework for staff to report all near miss events, incidents, accidents and significant events. Incidents are reported in a timely manner by staff. The documentation used for reporting incidents has been streamlined and simplified. A review of eight reported events selected at random for December 2017 to June 2018 (a fall, a skin tear, chemical storage, medicine events, and diagnosis related events), verified these were investigated and actions taken to address the issues. Staff spoken with were familiar with the reporting process. There was evidence of reported events resulting in changes and improvements in practice. All events are entered into an electronic incident/accident register by the health and safety officer, who provides a monthly report to the executive and health and safety committee detailing new hazards, and the number and type of staff and patient related accidents and incidents, as well as themes and trends over time. The monthly reports for February through to May 2018 were sighted.</p> <p>Incidents are discussed at the executive meeting as evidenced in the meeting minutes sighted and verified by the staff and managers interviewed. Relevant issues are also discussed at the serious event committee as verified in meeting minutes. Staff advised that client related events are discussed at staff handovers.</p> <p>Aged related residential care service incident and accident data is benchmarked with other identified facilities in the Northland DHB region. The benchmarking data for the period ending March 2018 was sighted.</p> <p>The CEO and hospital services manager are aware of their responsibilities for essential notifications and can detail the type of events that are to be reported including unexpected deaths. Notifiable diseases are notified by clinical staff. One patient with a grade two pressure area was notified, as well as when a residential care patient refused admission to an ARRC designated bed. Temporary</p>

		dispensation was obtained for the client to be admitted to an acute bed.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Current annual practising certificates (APCs) were verified for the general practitioners (GPs), pharmacists, the podiatrist, the lead maternity carers, the registered and enrolled nurses (including those in management roles), the radiographer, and the physiotherapist. A data base is maintained that contains this information.</p> <p>Recruitment processes are detailed in policy. Records related to interviews and a summary of the verbal report from referees are not being consistently maintained. While staff report they are provided with a comprehensive orientation programme, records of completion are also not consistently maintained. A new role has been developed for overseeing human resources activities, with the new employee commencing work in this role in May 2018.</p> <p>A comprehensive staff education programme is in place. Mandatory training has been identified and completion is being monitored. Staff have access to regular ongoing education opportunities (internally and externally), relevant to their role. This includes via videoconference, e-learning and in person training. Records of education were maintained and copies of some education certificates were present in the staff files reviewed. Emergency scenario training is now being conducted on a regular basis (approximately monthly). Topics completed to date include burns, motor vehicle accident with a patient suffering a head injury, cardiac events (acute coronary syndrome and infarct), sepsis, anaphylaxis and collapse. Feedback from staff was very positive about the learnings gained.</p> <p>Caregivers are required to complete an industry approved qualification within 12-18 months of employment. One inpatient service health care assistant is currently completing level three qualification requirements. The other nine health care assistants have completed an industry approved qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A draft policy was sighted that details staffing levels and skill mix requirements. This policy is utilised in the development of the roster. Seven of the nursing staff have completed a professional development and recognition programme (PDRP) at proficient level and one staff is nearing completion at this level. One nurse has completed a PDRP at</p>

		<p>competent level. Nursing staff are being encouraged to complete portfolios. A nurse practitioner is also employed at Hokianga Health and works in the clinic area and is available to inpatient staff for advice and support as required. The nurse practitioner assists the HSM in reviewing nursing staff competency components.</p> <p>The number of registered and enrolled nurses, and health care assistants vary between shifts. There are two registered nurses or a registered nurse and an enrolled nurse rostered on duty in the inpatient area on the afternoon and night shift, with three RNs rostered on morning shift (in addition to the hospital services manager). There are two health care assistants (HCA's) rostered on the morning and afternoon shifts. Healthcare assistants do not work at night. A registered nurse is designated to oversee the aged related care contract patients' needs. An additional RN is on call from 6 pm to 7 am weekdays and over the weekends. The two enrolled nurses work on different shifts.</p> <p>Two nurses staff the ED weekdays 8 am to 5.30 pm, and a RN is rostered on the weekends from 9 am to 5.30pm. Afterhours, ED is covered by either the ward RNs, or if applicable, the on call RN. Nursing staff are required to complete Primary Response in Medical Emergencies (PRIME) training, and the advanced cardiac life support (ACLS) training during alternate years. Staff are required to have competency for the use of standing orders, be able to use the 'Istat' (point of care testing), undertake venepuncture, obtain electrocardiograms, and use a defibrillator. There are processes in place to ensure that RNs complete the initial and the ongoing annual competency requirements. One new RN has been booked to complete the outstanding requirements. Attendance is monitored by the hospital services manager and records were sighted. Nursing staff have current ACLS level five or six certificates (or advanced core). Medical staff complete both PRIME and ACLS level seven or advanced core training. Nursing staff receive training on managing obstetric and neonatal emergencies.</p> <p>There is a lead maternity carer on site or on call. Two LMCs are employed. The maternity staff are currently coping with the increase in birth numbers. There is a doctor rostered in the hospital between 8 am and 1.30 pm daily. A second doctor is in the emergency department</p>
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		<p>(ED) until 5pm. The ED doctor provides cover in the ward if required between 1.30 and 5.30pm. Additional community health nurses and doctors are rostered to cover the GP services / clinics. There is always a medical practitioner on call when not on site for the Hospital. There is a designated doctor on call for maternity, who normally attends all births (refer to 1.3.3.4). Another registered health professional attends the birth in the unusual event the DR is unable to attend for any reason. There is one vacancy for a general practitioner. The existing medical staff are working together to ensure the community needs are being met. There are supervision arrangements in place for medical staff. Medical staff are encouraged to participate in the rural hospital training programme.</p> <p>The current rosters were reviewed and demonstrated that the draft staffing policy was being implemented. A physiotherapist is on site twice a week, and sees patients based on referrals or scheduled appointments. Radiology services are available on-site Monday and Friday day time, however will come in afterhours if clinically indicated. A podiatrist visits regularly.</p> <p>Additional staff hours are rostered for maintenance (three staff), administration, the food / kitchen services, and cleaning services. Facility laundry services is contracted to an offsite provider. There are six members in the Kai Manaaki Tangata team (3.75 full time equivalent positions). This role covers both hospital and community services.</p> <p>The HSM and the RN providing oversight of ARRC clients have completed interRAI assessment training. The community health services manager also has interRAI competency.</p> <p>The staff confirmed the hospital services manager is available out of hours if required. Clients and the family / whanau members viewed confirmed their personal and other care needs are being well met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was completed in the patients' records sampled. Clinical notes were current and integrated with the medical officer, nursing and allied health service provider records. This includes interRAI assessment information for the residential care patients being entered into the electronic data base. Recent records sampled were legible with the</p>

		<p>name and the designation of the person making the entry identifiable. The primary maternity service records were both available and maintained in hard copy and electronically. The midwives require hardcopy records for providing continuity of care and service provision in the community for women during the six weeks post-partum period.</p> <p>Archived records are held securely on site and are readily retrievable. Patients' records are held for the required period before being destroyed. No personal or private patient information was on public display during the audit. Confidentiality was maintained by all staff for this community rural hospital service.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Due to the nature of the services provided at Hokianga Health there are different processes for entry to services. For the long-term care (ARRC) patients they enter the service when their required level of care has been assessed and confirmed by the Needs Assessment and Service Co-ordination (NASC) Service. Prospective patients and/or their families are encouraged to visit the facility prior to admission and meet with the clinical rest home coordinator. They are also provided with information about the service and the admission process. The service currently operates a waiting list for entry for long term care (ARRC) patients.</p> <p>The Hokianga Health does acutely admit children to the inpatient ward if required. Equipment and resources are available and staff are trained to respond to paediatric emergencies if needed. If requiring more than primary care children would be transferred to Whangarei Hospital paediatric service (NDHB) or if requiring tertiary level care, they would be transferred to Starship Childrens' Hospital at Auckland Hospital once stabilised. Appropriate transportation would be arranged when needed. Documentation relevant for paediatric care was observed and early warning score sheets are available which are age-appropriate. Scales are available to weigh babies, toddlers and children if needed. Medication record sheets are available and weights are recorded to use for drug calculations if required. Advice can be sought by the medical staff from Whangarei base hospital paediatricians if required.</p> <p>Women are admitted in a timely manner if in labour to this primary birthing facility and are able to birth and stay for the required length of time post-partum as required. The medical inpatient service admits</p>

		<p>patients either through the acute emergency service or via the medical officers'/nurse practitioner clinics in the community and at the hospital.</p> <p>All entry screening occurs, and family/whanau members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. All patients receive a copy of the 'Hauora Hokianga Patient Information' booklet sighted. Records reviewed contained completed information details, assessments and signed admission agreements in accordance with contractual agreements for the patients admitted under the ARRC agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. There is open communication between all services, the patient and the family/whanau. At the time of transition between services, appropriate information including medication records is provided for the ongoing management of the patient. All referrals are documented in the progress records. An example was a patient being transferred to Northland District Health Board (NDHB) Whangarei Hospital at the time of the audit. The patient was to be transferred from the inpatient medical service by air ambulance service to secondary care. Once stabilised, and weather permitting, they would possibly be transferred onto Auckland City Hospital. Two paramedics attended from the helicopter service, so an escort was not required. Family/whanau were contacted and provided with all relevant information. Staff meet all expectations when caring and arranging the appropriate travel required for this patient. Processes are clearly documented to guide staff but were not required in this instance as all staff acted efficiently and professionally to expedite the patient from this hospital for ongoing care and management.</p> <p>All patients requiring transfers are referred appropriately and relevant contacts are made with the DHB and the transportation services. For women transferring from the primary service contact is made by the lead maternity carer midwife as per the section 88 guide lines. When accepted the woman and partner are told of the process and are fully supported. The LMC accompanies the patient and or baby to the DHB and provides a full handover. If an emergency transfer the LMC use the ISBAR tool to provide the required information to facilitate the transfer.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies were current and identify all aspects of medicine management for all services provided at the hospital.</p> <p>The system for medicine management was observed on the day of audit. The registered nurse demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. Only registered nurses are authorised to administer medications and are competent to perform the function they manage. The medical staff prescribe medications for the acute medical service and for the long-term care patients. For the maternity service, the registered midwives prescribe any medication required (within their scope of practice) and administer this accordingly. After hours, the registered nurse on the ward administers the medication required. There is evidence of the medical officers reviewing the medical patients' medications on a daily basis and the long-term patients (ARRC) three monthly or sooner if required.</p> <p>Medications are purchased and supplied to the facility from a contracted pharmacy. An imprest system is in place so as not to over stock. Medications delivered are checked by a registered nurse. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug record register provided evidence of weekly and six- monthly stock checks and accurate entries. The medication room has key pad access.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. The cold chain process is closely monitored and was discussed as part of the infection control programme. Some registered nurses have completed appropriate vaccinators courses and certificates were sighted in the personal records. Staff have completed intravenous competencies, and this was also verified in relation to medication management.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The national</p>
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		<p>medication record is used at the hospital in all services. There is a one-day medication record available for recording the baby medications administered after birth. There are separate record sheets for administration of topical medications, warfarin and diabetic medicines.</p> <p>There were no patients who were self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported and recorded on an accident/incident form. The patient and/or designated representative are to be advised, although evidence of this communication is not always documented (refer to 1.1.9.1) There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Four staff work in the kitchen, including two cooks. Processes are in place to identify patient's individual dietary needs. Dietary requirements are reassessed at every admission regardless of the time interval from a previous admission. Individual patient dietary needs are displayed in the kitchen. Dietary options available, including but not limited to, diabetic, low salt, low protein, weight reduction, and vegetarian. Patients are able to identify foods they do not want to eat. Ambulant patients are encouraged to eat together in the dining room. Tray service is provided to patients who eat meals in their room. Choices are available in relation to serving size and the texture. A range of nutritional supplements are available and used as required. Food is offered to a family member who is staying on site providing support to a patient.</p> <p>There is a six week rotating menu. A summer and winter menu is available and changes to coincide with daylight saving starting and ending. The menu includes breakfast, morning tea, lunch (a hot meal and a soup) with bread and fresh fruit also available at lunch. The main meal is served in the evening along with dessert. Supper is also provided in the evening. The menu was reviewed and approved by a dietitian in May 2016. Patients and family interviewed were very satisfied with the food choices available and generous food servings were available. A food satisfaction survey conducted also contained positive feedback on food services.</p>

		<p>Recipes are available for the menu items. The food services manual details policies and procedures for safe food handling and service. The kitchen has a registered food control plan (FCP40209), which was approved by the Far North District Council. It was approved on 4 December 2017 and is current for 12 months.</p> <p>The temperature of one hot dish is checked every day and records maintained to verify the temperature is within the required range. Food is served within 15 minutes of the completion of cooking. Food is ordered from established suppliers. Food is dated, covered and in appropriate containers in the pantry. Stock is rotated. Items in the refrigerator and freezer are appropriately packaged and dated. The temperature of the refrigerators and freezer is monitored and recorded daily and is within the required range. The cooks have completed food safety training. There is sufficient quantities of food available in the event of an emergency.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>For patients admitted via the acute medical process, if they are able to be managed at this primary setting, they will be admitted as required. However, if requiring a higher level of care or if a surgical case the patient will be stabilised and transferred appropriately to a secondary or tertiary level care facility as required. Children acutely admitted requiring a higher level of care will be transferred directly to Auckland's Starship Hospital, depending on the diagnosis, or to Whangarei Base Hospital. Women who do not meet the criteria for primary labour and birthing will be stabilised and transferred to secondary care Whangarei Hospital Maternity Services.</p> <p>For long term care (ARRC), if a referral is received but the prospective patient does not meet the entry criteria or there is no vacancy, the local NASC (based at Hokianga Health) is advised to ensure the prospective patient and family/whanau are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for re-assessment to the NASC is made and a new placement is found in consultation with the patient and family/whanau. Examples of this occurring were discussed with the clinical services manager. This was the case for a patient requiring higher level dementia care who is under the ARRC contract. There is also a clause in the service agreement related to when a</p>

		<p>patient's placement can be terminated.</p> <p>A hospital register is maintained by the ward clerk interviewed. A separate register is maintained for maternity services by the two midwives employed to manage this service and this was reviewed. Any births, transfers out of the unit or transfers in for post-natal care are accurately recorded.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is accurately documented using validated nursing and midwifery tools as needed for patients in each service stream. Tools are used in each care setting as a means to identify any deficits and to inform care planning. The sample of records reviewed evidenced an integrated range of patient-related information. All patients' in long term care have current interRAI assessments completed by one of the three trained interRAI assessors on site. InterRAI assessments and re-assessments reviewed were current and up-to-date. In the medical inpatient service, early warning scores (EWS) forms are utilised and any changes observed are reported to the medical officer and actions taken as needed. EWS sheets are available for paediatrics which are aged appropriate for example nil to three months, three months to one year, one to four years and five to eleven years of age.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reflected the required support needs of patients and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with admission to discharge planners, progress notes, activities notes, medical and nursing and allied health professional's notations clearly documented, informative and relevant. Mother and baby records were maintained separately in maternity services. Continuity of care is promoted in all aspects of service provision. The midwifery progress records are maintained both electronically and in hardcopy form.</p> <p>Any change required is documented and verbally passed on to relevant staff with handovers both verbally and written. Bedside handovers, as required, are provided to oncoming staff in the inpatient service.</p> <p>Patients and staff reported participation in the development and ongoing evaluation of care plans. The interRAI re-assessments inform the changes if needed in the care plans reviewed for the long term care patients. If any patients with mental health problems come through the</p>

		acute care process, they are referred onto secondary and community care services as required. There are no mental health inpatient services.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to patients was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of patient's individualised needs was evident in all areas of service provision. The medical officers interviewed verified that medical input is sought in a timely manner, that medical and midwifery orders are followed, and care is of a high standard. Nursing staff and midwives interviewed confirmed that care is provided as outlined in documentation. A range of equipment and resources for all services was available, suited to the levels of care provided and in accordance with patients' needs. Short term care plans are documented and implemented as needed for patients in the long-term care area.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist holding the national certificate in diversional therapy level 4 who has worked in this role since 2012. An assistant, staff and volunteers assist with the programme. Family members are welcome to join in.</p> <p>A social assessment and history is undertaken on admission to ascertain patients' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the patients. The patient's activity needs are evaluated six monthly and as part of the formal six monthly interRAI and care plan review for the long-term care patients.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect patients' goals, ordinary patterns of life and include normal community activities. Individual and group activities and regular events are offered. Examples included one on one newspaper reading, quiz & prizes, Matariki (fish and stars craft activity), birthday celebrations, comedy session, knitting, duck shooting and music sessions. Trips to Opononi are encouraged in the hospital van and other enjoyed activities.</p> <p>The activities programme is discussed at the minuted patients' meeting</p>

		<p>and indicated patients' input is sought and responded to. Patient and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Patients interviewed confirmed they find the programme fun and stimulating.</p> <p>Activities for the maternity services are based on parenting education and are encouraged by staff at every opportunity. Activities such as baby bathing demonstrations, settling and positioning techniques for baby and promoting safe sleep are promoted. Assistance with techniques and support is provided for breastfeeding by the midwives and the ward staff who cover the service after hours.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Patient care is evaluated on each shift irrespective of the service provided at the hospital and is reported in the progress records. If any changes occur it is reported to the appropriate staff member, being midwife, medical officer/clinical services manager and/or the (ARRC) rest home/hospital coordinator.</p> <p>Formal care evaluations occur for maternity with each contact with the mother and/or the baby/pepe. For the aged care long term care evaluations are documented by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tract infections, wound care and decreased mobility plans. Progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Patients and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>The midwives interviewed in the primary care setting explained that women and babies were reviewed through all stages of service delivery and this was clearly documented. Care was planned at 36 weeks gestation in regard to the labour and birth in partnership with the individual woman and the midwife. Postnatal care is planned and documented in the mother and baby records as the ward staff cover the maternity ward after-hours when the midwife is not present. There is a midwife on call for this service at all times.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Patients are supported through all stages of service delivery. Medical officers are on call twenty-four hours a day, seven days a week. There is a designated referral form. Copies of internal referrals were observed in the patients' records reviewed. Referrals are followed up on a regular basis by the registered nurse or the medical officer on duty. The patient and the family are kept well informed of the referral process as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the patient onto another health and disability service if and when required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policy details the different categories of waste and how these are to be disposed of. The content aligns with current legislation and published recommendations. Waste was seen to be appropriately disposed of according to policy during the audit. The hazardous substances register was updated in June 2018. This details the location of chemicals and hazardous substances on site and the quantities. Spill kits are available.</p> <p>Material safety data sheets are accessible for the used chemicals/hazardous substances checked at random.</p> <p>Appropriate personal protective equipment (PPE) is available on site. Staff and contractors were observed wearing gloves and other personal protective equipment (PPE) as appropriate. Staff interviewed confirmed there is appropriate supplies of PPE which are readily accessible and available. Training on waste and hazardous substances is provided to new staff during orientation.</p> <p>Two maintenance staff have a current hazardous substances handler certificate and these were sighted.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness (BWOFF) which expires 30 June 2019. A detailed maintenance schedule is in place and is implemented by the facilities manager and contracted suppliers/contractors. Half of the building is in the process of being re-roofed. A new bedroom is being developed that can contain two beds. This room has an ensuite. Other building work is planned. The nursing station footprint in the ward has been enlarged. Processes are in place to report new maintenance or equipment issues to the maintenance</p>

		<p>staff. A new facility manager was employed in February 2018, and three other staff work in the maintenance service. One of the employees is completing an electrician apprenticeship.</p> <p>Grab rails are present in the bathrooms and corridors.</p> <p>Biomedical equipment is checked at least annually. The equipment sampled at random had current performance monitoring certificates.</p> <p>Electrical test and tagging has been completed.</p> <p>Testing the temperature of hot water has recently re-commenced and several areas noted to be above the required range (eg, the temperature noted in maternity services). On review, it was identified that the hot water being tested that was above range was located in the sluice room. Retesting of all patient area hot water temperatures by a contracted plumber occurred during audit and verified that the temperature of hot water in patient care areas is within the required range of 45 degrees Celsius or less.</p> <p>Equipment is fit for purpose and appropriate for a health care setting. This included for the provision of acute medical, maternity and aged residential care. Children are admitted to rooms nearer the nursing station to facilitate monitoring. The rooms sighted were safe and appropriate for children.</p> <p>There is a courtyard garden that clients and visitors can use. Clients interviewed confirmed they can enter and exit the building on their own using mobility devices (if these are required), and mobilise within the facility as they want. Signage alerts patients to not enter the aged residential care wing as this is a home environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Ensuite bathrooms provide toilet and shower facilities as well as hand washing facilities for four patient rooms. The three rooms in maternity all have ensuites and one of the single rooms in the acute ward. The new two bedded room currently being built also has an ensuite.</p> <p>There are sufficient other toilets available for patients use as verified by observation, and patients and staff interviewed. Separate toilets are allocated for staff and visitors. Privacy mechanisms are present on the bathroom doors.</p>

		<p>Hand basins are present in all bedrooms sighted. Waterless hand gel was also readily available in patient care areas and bedrooms.</p> <p>Patients and family interviewed confirmed staff respect their physical and auditory privacy and this includes while completing hygiene care.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are a number of single occupancy bedrooms, three double occupancy bedrooms, and one bedroom that has four beds. Privacy curtains are in place. All the beds for patients receiving long term residential care or maternity care are single rooms. The maternity unit is in the lower floor and all the other inpatient services, the emergency department and clinic areas are located on the upper floor (which is also at ground level).</p> <p>The patients receiving aged related residential care have personalised their bedrooms. A sign is noted at the entrance to the long-term care area of the ward and advised that the area was a residence and not part of the acute care service. This was to minimise unnecessary foot traffic.</p> <p>There is sufficient space in all bedrooms for patients to mobilise including while using mobility aids, when connected to equipment and when staff assistance is required. This was verified by observation and during interview with staff, the patients and family members. Two patients interviewed who were sharing a room reported they had enough room to move about and their privacy was respected. Patients using mobility devices were sighted mobilising independently both inside and outside the facility.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a marae located on the lower floor. Staff advise that on occasions this is used by patients and family members for the provision of supported end of life care. This unit was temporarily unavailable due to the building work that is in progress.</p> <p>There is a kitchenette and dining area in the maternity unit for use by patients and family members. This unit was under renovation during the audit and is expected to reopen within the next week.</p> <p>In the inpatient and long-term care area patients are encouraged to attend the central dining room for meals. There is a separate lounge</p>

		<p>area.</p> <p>An activities programme is also provided with dedicated space allocated to these activities.</p> <p>Patients and family members interviewed were complimentary of the facilities available to them.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning services are provided by employees. A cleaner is on site from 7 am to 3.15 pm (inpatient areas) and 1 pm to 8.30 pm (administration, clinics, and the entrance area). A cleaning schedule is available and details the cleaning activities to be undertaken, frequency and products to be used. Chemicals sighted were stored securely and labelling of containers was appropriate. An auto dispenser is used to ensure appropriate dilution of chemicals. Material safety data sheets are available for chemicals used. A communication book is used to aid communication between the part time staff who provide cleaning services.</p> <p>Hospital linen is laundered by an external contractor. Staff interviewed were satisfied with this service provider. The personal laundry of patients receiving long term care patients is washed on site daily by the health care assistants.</p> <p>Monitoring of cleaning and laundry services is included in internal audits conducted and the patient satisfaction surveys. Patients and family/whanau interviewed were satisfied with these aspects of service and report the facility is kept clean and tidy.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Hokianga Hospital has systems and processes which are appropriate to a hospital environment and which ensure a timely response during emergencies and security situations. Alternative energy and utility sources are in place, with a generator available to maintain services. The emergency power supply is tested regularly. Diesel supply available includes 600 litres in the generator and 400 litres of spare diesel. The quantity on site will provide power for up to three days. Additional diesel is available locally if required. Four water tanks have been installed. This gives sufficient water on site for use during an emergency. There are additional emergency supplies of medical gases.</p> <p>The organisation is well prepared to address any emergency. There is</p>

	<p>a well-documented emergency plan which includes the stages of an emergency, critical equipment, and the contact details of key external contractors and staff. Emergency flip charts are throughout the facility to provide quick guidance for staff on managing emergency events. Emergency management supplies for use in a civil or other emergency are on site, including outbreak / pandemic. The supplies are checked regularly.</p> <p>The fire evacuation plan was approved by the New Zealand Fire Service in February 2009. Staff are provided with regular training on fire safety and fire prevention activities. The last fire evacuation drill was conducted In March 2018.</p> <p>Clinical staff are required to have completed advanced cardiac life support (ACLS) training that meets the requirements of the New Zealand Resuscitation Council (NZRC). Nursing staff are required to have level 5 or higher ACLS (or advanced core). Medical Staff completed ACLS level seven (or advanced core). In addition, staff complete PRIME training. Training records are retained and were sighted (refer to Standard 1.2.8).</p> <p>Sixteen security cameras are located monitoring the entrance / external areas as well as communal inside areas. Signage alerts that security cameras are in used on site. The images are screened at the nursing station. Intercoms are used to communicate from the afterhour's access door (in the ward) to the nursing station.</p> <p>A radio transmitter (RT) is present in the ward nursing station to enable direct communication with emergency services. A designated staff member conducts security checks of the facility between 5-7 pm at night and checks all doors/exits are locked and closed.</p> <p>Call bells were present at each bed space and bathroom facility sighted. The calls make an audible alert and identify the calling area on a centralised alert panel. A light also illuminates outside the applicable room. Three call bells tested during audit were functioning. The emergency call bell was activated by a patient in maternity during the audit. This alerts to the ward central ceiling mounted panels and has a different alert sound.</p>
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<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Temperatures in the patients' bedrooms can be independently adjusted within the patient room for comfort. Heating is provided via heat pump or wall mounted heaters. New heat pumps have been installed in eight long term care patients' rooms and in the patient lounge in the last year. These can be used to provide cooling as well as heating if required.</p> <p>All rooms have at least one external window.</p> <p>Patients and family members confirmed they are provided with a nice environment, with adequate natural light and ventilation, and confirmed that the environment is maintained at a comfortable temperature day and night.</p> <p>Smoking is not allowed on the hospital grounds, and this is well communicated via assorted signs. Smoking cessation therapy is available to patients that smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to patients, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the infection prevention and control nurse specialist at the Northland District Health Board (NDHB). The infection control programme and manual are reviewed annually.</p> <p>The IPC nurse ensures the service is monitored through environmental audits performed six monthly and clinical audits three monthly. The programme covers the hospital and the community nurse led clinics. The programme is officially signed off by the infection prevention and control nurse specialist.</p> <p>A registered nurse is the designated IPC coordinator whose role and responsibilities are defined in a job description. Infection control matters including infection surveillance results are reported monthly to the clinical services manager and the quality manager and results are tabled at the quality/staff meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long</p>

		they must be away from work if they have been unwell. Staff interviewed understood these related responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role and has been in the role for three years. The registered nurse/IPC coordinator is also a trained smear taker and vaccinator and has attended relevant IPC study days as verified in the training records and personal staff record review. Well established networking with the infection prevention and control nurse at the DHB ensures expert advice can be sought. Advice is also available from the medical officers and the contracted community laboratory as needed. The IPC coordinator has access to patients' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator also works closely with the Hokianga Health nurse practitioner. IPC education is provided at the DHB twice a year and staff can attend.</p> <p>The IPC nurse coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no outbreaks of infection since the previous audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as using appropriate hand-sanitisers, good handwashing techniques and use of disposable aprons and gloves as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection prevention and control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. Courses</p>

		<p>accessed on-line include intravenous management, handwashing and infectious diseases and subsequent care and management. Certificates of completion from 'noodle' (the electronic system) are provided to staff. Attendance records of education are maintained.</p> <p>Education with patients is generally on a one-to-one basis and has included reminders about hand washing and about remaining in their own room if unwell especially in the long-term care ward.</p> <p>Staff also receive education relevant to the Cold Chain process and are aware of the responsibilities involved. A new vaccine fridge has been purchased for the hospital for the storage of vaccines. Vaccines are also stored in the clinics in the community. The IPC registered nurse coordinator assists with the temperature monitoring and a regular stocktake is performed by the administrator for home care support services. All nurses have completed audits and vaccinators courses. There are good stocks of vaccine available. The vaccine fridge alarms if the temperature increases over eight degrees. The vaccine register was sighted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care and inpatient hospital services, including primary maternity care settings. All patients are screened on admission for infections, such as hepatitis B, and intravenous lines and blood cultures are monitored. Information is collated over a three-month period, such as when an intravenous line is actually inserted and if any inflammation occurred.</p> <p>For the aged residential care service infection definitions reflect a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified a record of this is documented.</p> <p>The infection prevention and control coordinator reviews all reported infections. Three monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the nosocomial infection surveillance programme is shared with staff via staff/quality meetings and at staff handovers. Graphs are produced that identify any trends for the current year and comparisons against the previous year is noted. The graphs and results are also</p>

		<p>displayed in the staff room.</p> <p>The IPC coordinator reports directly to the hospital's clinical services manager. The surveillance programme is appropriate for the size of the hospital and the inpatient clinical services audited.</p>
<p>Standard 3.6: Antimicrobial usage</p> <p>Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.</p>	FA	<p>Policies and procedures are developed and implemented for the use of antibiotics and to promote appropriate prudent prescribing in line with accepted guidelines. The medical officers seek guidance from clinical microbiologists or infectious disease physicians from the NDHB as required. The laboratory reports monthly on the use of antibiotics utilised to treat diagnosed infections. Results are fed back to the medical director and medical officers at the hospital.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The use of enablers and restraint minimisation policy includes a commitment to minimising the use of restraint. Definitions of restraint and enablers are detailed. There were no enablers being used at the time of the audit. Three aged related residential care patients have restraints in use.</p> <p>Staff interviewed were able to describe the main difference between restraints and enablers and confirmed that restraint use is actively minimised and use of enablers is at the patient's choice/request. Staff confirmed being provided with education on use of restraint and enablers as a component of the level three qualification programme and in-service programme. Restraint minimisation was included in the topics for the rural health seminar provided by videoconference on the first day of the audit. This was attended by six staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>There are three patients with restraint in use. The restraints used includes bedrails (with protective covers), lap belts and 'Elys' chairs.</p> <p>The responsibility for restraint process and approval is overseen by the hospital services manager who is also the restraint coordinator. The restraint approval process is detailed in the organisation's policy. The RNs have the authority to initiate the use of emergency restraint use, though ongoing restraint use needs to be approved by the restraint coordinator/HSM. The restraint coordinator approves all restraint/enabler use.</p>

		<p>The patient's care plan records the restraint required and when it is to be applied as detailed in the patients' files reviewed. Consent from family/whanau, GP and RN is required before restraint is approved. A consent form for the use of restraints was sighted in the applicable patients' files during audit.</p> <p>All patients with restraints in use have details noted in the restraint register. A review of restraint use is conducted quarterly by the HSM. And reported to the health and safety committee and the executive managers' meeting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The three patients with bedrails in use to minimise the risk of falling and enable the patient to sit out of bed safely have an assessment on file that includes all required components to meet this standard. The use of restraints is identified as being an appropriate intervention. If there is an incident related to restraint use, an incident report is required to be completed and the hospital services manager / restraint coordinator informed. Ongoing assessment for restraint is also undertaken during the interRAI assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator reported that enablers and restraint is only applied after consideration is given to all possible alternatives and appropriate consultation has occurred with the patient and/or family and the general practitioner. A restraint register is in use. This demonstrated that when restraints were no longer required for patients they are discontinued.</p> <p>At audit, three patients required the use of restraint to help maintain their safety. The use of restraint has been approved by family/whanau to promote the patient's safety and help reduce the risk of falls. Two of the patients with restraint in use had restraints approved and implemented in November 2017, and one patient in January 2018.</p> <p>The use of restraints (and the types of restraint are specified), are documented in the applicable patient's files, along with the rationale. Alternatives tried prior are also noted.</p> <p>Observation of the patient during restraint episodes is being completed by staff on a shift by shift basis. The requirements are detailed in the patient's care plan. The monitoring forms are reviewed and signed by</p>

		<p>the RN or EN responsible for caring for the patient every night shift.</p> <p>Staff interviewed confirmed their understanding and knowledge related to safe restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>All restraint use is discussed every three months at the health and safety committee and the executive management meeting. The continued use of restraint is part of the resident's six-monthly evaluation of care and this is documented via interRAI, and clearly shown on the resident's care plan. It is also reviewed during the quarterly review of restraint use. If restraint is no longer required, it is discontinued. Family/whanau are made aware of any changes in the need for restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The quarterly review of restraint and enablers includes a review of the number and type of events. All other aspects as required to meet the standards are included in the review.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Patients' records were reviewed to verify that open disclosure occurred in a variety of care settings. It was evident in the long-term care and maternity services that if any incidents/accidents occurred, that the family and/or patient were provided with full and frank information and this was recorded. The original form is retained in the patient's record and the other copy goes to the quality manager. Evidence of open disclosure was not able to be followed through for four other applicable events sampled. Staff advised the patient or family would likely have been informed, however this communication is not recorded in the patient's records.</p>	<p>Evidence that open disclosure has occurred following incidents and accidents is not consistently recorded on the incident investigation form or in the individual patient's record (with the exception of aged related residential care and maternity).</p>	<p>Ensure open disclosure consistently occurs and records are retained to verify this.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of</p>	PA Low	<p>Recruitment processes include completing an application form, conducting interviews and</p>	<p>Referee checks and interview records are missing from four out</p>	<p>Ensure records are consistently retained</p>

appropriate service providers to safely meet the needs of consumers.		reference checks and police vetting. Staff have job descriptions on file. The staff sign a confidentiality agreement. Annual performance appraisals (called 'touch downs') have occurred in the applicable staff files sampled. The hospital services manager advised these aspects of recruitment are being documented and forwarded to HR for filing. However, the referee checks and interview related records were missing from four out of the eight staff files reviewed (employed from 21 February 2017 onwards). The personnel files of 16 staff and managers were reviewed during audit.	of eight staff files reviewed for staff employed after 21 February 2017.	to verify the recruitment process, including referee checks and interview records. 180 days
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	New employees are required to complete an orientation programme relevant to their role. A checklist is utilised to ensure all relevant topics are included for each role. For clinical staff, a broad 'cradle to the grave' spectrum of learning is required. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. While staff and the hospital services manager advise that staff are completing orientation requirements and records are retained, these records were not present on four out of eight staff files reviewed for staff employed since 21 February 2017, nor were any unfilled records able to be located.	While staff advise they receive a comprehensive orientation programme, records to demonstrate orientation requirements have been completed are missing from five out of eight staff files for employees employed after 21 February 2017.	Ensure records are retained to verify that staff have completed generic and/or roles specific orientation. 180 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.	CI	Hokianga Health has approximately 80% of patients who identify as Maori and approximately 65% of staff identify as Maori. Patients and family/whanau reported that they are ‘very satisfied’ with the way that the staff provide culturally appropriate care and support. The design, decoration and daily living activities inside and outside the hospital are tailored to create a familiar and culturally appropriate environment for all patients and family/whanau. The patients are encouraged with their independence and participation in activities that they have normally participated in. Hokianga Health provides provisions for special foods, cultural activities, spiritual services in te reo Maori if needed, karakia, war veteran support (a new whanau room is currently being built), follow hapu and noa, recognising taonga and kaumatua/kuia input and linkage with the local marae. Over the past 10 years the service has increased the number of staff who identify as Maori.	The achievement of implementing support and services to meet the needs of patients who identify as Maori is rated beyond the expected full attainment. The organisation’s approach and philosophy in provision of culturally appropriate care is gaining positive results in the reduction of patient’s not attending appointments, reducing challenging behaviours and the model of care recognises the importance of whanau in the patient’s care. Positive outcomes have been measured through staff, patient and family/whanau satisfaction surveys. The increase in patients attending the community clinics and those provided at the hospital is increasing as reflected in the hospital register and clinic attendance records maintained. Women attending the midwives’ clinics and accessing the service was reported by the midwives to have increased since the previous audit.

		Increased whanau are returning to the Hokianga region and this was observed with the increase in Maori women accessing the primary maternity service with fourteen (14) births already in June this year. With the proactive approach taken, growing trust within the community and communication with patients and whanau, patients and whanau also choose to stay for their end of life support.	
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>There are currently 24 members on the Board of Trustees. This includes up to two representatives from each clinic location elected as members of the Hokianga Health Enterprise Trust Board of Trustees (HHET BOT), two iwi representatives (there can be up to four), two staff representatives, and up to four additional board members can be co-opted if there is a need for specific skills, experience or for diversity on the BOT. There are currently two co-opted members who bring relevant experience to the board; they are a former medical director (who is the deputy chair), and a former nursing director. Board members actively represent their community needs. The chairman of the HHET BOT has been on the board for 16 years and held the role of chair for the last three years. The chair has a dual representative role representing one of the community areas as well as iwi.</p> <p>The organisation has a strategic plan 2015-2020. The plan contains the mission statement, values and philosophy for the organisation. This plan and the associated annual plans (July 2017 to June 2018 and July 2018 to June 2019) were developed in conjunction with staff, managers, medical specialists, general practitioners, the wider Hokianga community and the Board of Trustees. The plan is reviewed at least annually with a detailed review of the previous year's activities, outcomes and needs as well as planning for the next year. The plan outlines the</p>	<p>Hokianga Health actively seeks extensive feedback from the wider community and staff representatives on the services being provided as well as the future development and implementation of health services. The process includes having ten annual general meetings occurring, one in each of the ten clinic locations to reduce barriers for the population to attend and participate as services are provided over a wide geographical area. Following the annual clinic area meetings, a summary of the community feedback is provided to the board. This wide community-based communication, consultation and representation continues to develop health services aimed at meeting the needs of the local communities and Hokianga as a region. Ideas progressed by the BOT or currently under discussion from the community meetings includes (but is not limited to), increasing the hospital's resourced beds, ensuring that Hokianga Hospital can continue to meet the changing needs of the communities aging population, purchasing a haematology analyser (for point of care testing), reviewing aspects of pastoral supports and cultural supports available, and consideration of whether dialysis services could be provided in the future. The BOT meeting minutes sighted includes reference to community feedback. Patients and family members interviewed expressed a high level satisfaction about the community consultation processes and that</p>

		current key strategy areas for the organisation as well as potential risks. There is ongoing communication with staff and the wider community throughout the year via newsletters written in both English and Maori. The annual report is published and readily available for the community.	services were continued to be developed by the community for the community to meet the changing needs of the community.
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	CI	<p>The services at Hokianga Health are coordinated in a manner that promotes continuity of service delivery and promotes a team approach. This is clearly evident interviewing clinical and non-clinical staff during this audit. A team approach and continuity of care is encouraged at every opportunity and this was verified in the patients' records reviewed from all three service streams. The clinical service manager reported that the nurse and medical staff work collaboratively for the best outcomes for the patients across the services provided, being rest home, hospital medical and geriatric, maternity and medical inpatient. Services are well covered with additional staff being on call if and when required. All staff interviewed felt the staff cover is adequate to meet the needs of the patients. The long term residential care service is at full capacity. The maternity ward has increased service provision and is well supported by two midwives who manage this service. The midwives interviewed spoke highly of the ward nursing staff who cover the maternity inpatient service when the midwives are not present in the unit. In addition to the comments about the ward nursing staff, the midwives spoke highly of the support provided by the medical staff. The doctor on call is notified in the event of a woman giving birth. The doctors have chosen to be present at every birth at the hospital if possible. This collaborative and team approach to service delivery is working efficiently for all concerned in this community hospital to improve outcomes for patients.</p>	<p>A continuous improvement rating is made beyond the expected full attainment for an excellent service that is coordinated in a manner that promotes continuity of care and promotes a team approach to service delivery and to safe health outcomes for patients. Feedback from patients and family/whānau is continually sought with feedback forms and surveys on a regular basis. The service is led by a clinical services manager and the service is effectively managed to a high standard with the best interests of the patients being pivotal and the core focus of service delivery. The staff ensure goals can be met safely, or alternatively goals are collaboratively reviewed by the team to ensure the best outcomes for each individual patient occurs. The input from medical staff at births has raised the confidence of the midwives and relieved the pressure off the midwives who cover this service. The numbers of births have significantly increased, and the quality of care is also reflected in the long-term care ward with no vacancies in the area currently available.</p>

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End of the report.