

Auckland District Health Board

Introduction

This report records the results of a Certification Audit of a provider of hospital services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Auckland District Health Board
Premises audited:	Auckland City Hospital Auckland DHB X 3 Units - Mental Health Tupu Ora Greenlane Clinical Centre Buchanan Rehabilitation Centre
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Residential disability services - Psychiatric; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 18 February 2020 End date: 21 February 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	1116

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

General overview of the audit

Auckland District Health Board (ADHB) provides services to around 554,000 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier. Hospital services are provided from the 1313 bed Auckland City Hospital, Greenlane Clinical Centre, Buchanan Rehabilitation Centre and Tupu Ora residential service (eating disorders unit). Services include medical, surgical, maternity, children's, women's, older persons and rehabilitation, and mental health and addiction services. Approximately 30 percent of the patients come from other DHBs in the Auckland region. The ADHB also provides a wide range of specialist national services including organ transplant, paediatric services, high risk obstetrics and trauma, for example. These services are supported by a range of diagnostic, support and community-based services.

This four-day certification audit, against the Health and Disability Services Standards, included a review of management, quality and risk management systems, staffing requirements, infection prevention and control, and review of clinical records and other documentation. Interviews with patients and their families and staff across a range of roles and departments were completed and observations made. Auditors visited the Auckland City Hospital site (including Starship Hospital) and all three mental health services (Te Whetu Tawera, Buchanan Rehabilitation Unit and Tupu Ora residential service).

This audit identified the following areas for improvement: privacy, credentialing processes, orientation of medical staff, some aspects of training, safe staffing in maternity, some areas of mental health and allied health services, and clinical record keeping. Improvements are also required in relation to clinical assessments, care planning, evaluation of care and discharge planning, medication management, the food service, the physical environment and emergency equipment and supplies. Two areas related to security management and reduction in seclusion are rated as continuous improvement.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights was visible around all areas of the hospital. Patients and families/whānau reported an awareness of the Code and that their rights were upheld. All patients spoke positively about their care, treatment and communication with staff. Staff were observed respecting patients' rights.

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

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

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent. The communication of adverse events through the open communication process is understood and performed well across the organisation at all levels.

Patients and families interviewed knew how to make a complaint. Complaints are reviewed, in the first instance, by the consumer liaison role and a daily 'huddle' meeting supports active and timely response. Complaints are generally resolved within the required timeframes and result in improvements to service delivery. Complaints received via the Health and Disability commissioner are managed appropriately.

Organisational management

The recent appointment of a new Board of Directors has provided an opportunity to refresh the strategy, further develop the understanding of risk management and review planning and reporting. There have been some recent adjustments to the executive leadership team (ELT) which is now well established. The directorate approach encourages accountability at service delivery level supported by a range of organisation wide clinical professional roles and directorates. A regional and Auckland metro approach to planning continues to develop with a shared partnership with Māori iwi and Pacific communities and a strong focus on reduction of inequity. The 2020/21 annual plan is in development. The Clinical Board supports clinical governance across the organisation.

The quality and risk management system is led by the Chief Quality, Safety and Risk Officer and supports quality improvement and patient safety activities within the directorates. Recent changes to the structure are still being embedded as is the formalising of a strategy and plan. Good examples of reporting on quality and patient safety measures were noted supported through the business intelligence team/roles and the Management Operating System (MOS) reporting process. Improvement activity was evident at all levels of the organisation, from large projects using the co-design methodology across the continuum of care, to small ward-based initiatives.

Adverse events are managed through an electronic management system, with review and development of improvement plans where possible. Recommendations are monitored to ensure completion as intended. Risks are reported to the Finance, Risk and Audit Committee and the board.

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

Human resources systems meet current good practice. The staff orientation process occurs at both organisation-wide level and unit level and is specific to the needs of each discipline. Staff report good access to ongoing training.

A range of mechanisms are used to ensure that the right numbers of staff are available to meet the changing needs of patients across the services. The organisation is well progressed with the implementation of the Care Capacity Demand Management (CCDM) programme, which is positively impacting on matching patient requirements to nursing staffing. The developments in the

Integrated Operations Centre (IOC) have seen a reduction in use of external bureau, an improved responsiveness to patient flow, placement of staff where most needed and reduced time where clinical areas are operating above capacity.

Patient records are integrated and easily accessible. Patient information was held securely and, with a couple of exceptions, was not visible to those without the authority to have access. Privacy of information is maintained through robust systems.

Continuum of service delivery

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

Twelve patients' 'journeys' were reviewed as part of the audit process and involved the emergency department, surgical, medical and maternity wards, Starship children's hospital, the reablement service (rehabilitation service), and mental health units, and included the clinical decision unit, department of critical care and the operating theatre suite. Auditors and technical expert assessors worked collaboratively with staff reviewing the relevant documentation and interviewing medical, nursing and allied health team members, patients and families/whānau. Additional sampling was undertaken throughout the audit.

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

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

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

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

Policies and procedures provide guidance for staff on medicines management. The national medicine chart was in use. Allergies were assessed and communicated. Clinical pharmacists provided support in most areas. Medicines were generally stored safely and managed effectively throughout the organisation.

Food services are managed through an externally contracted service and overall are meeting the nutritional needs of patients, with some exceptions noted. Dietitians respond to specific individual requirements for those with more complex needs.

Safe and appropriate environment

A major infrastructure upgrade planned to occur over the next ten years has commenced, including an upgrade of lifts across the sites. Work on a new build integrated stroke unit is underway, which is expected to be open later in the year.

All ADHB facilities have a current Building Warrant of Fitness, Code Compliance Certificate or Certificate of Public Use as required. Proactive and reactive maintenance, including functional and electrical checks for biomedical and other equipment is well managed and traceable through electronic systems and maintenance requests. Services visited were observed to be clean and maintained.

There are enough bathrooms and toilets, communal areas in rehabilitation and mental health services, and bed spaces suited to the needs of the different patient groups. The patients' personal spaces were adequate for staff movement and equipment use in areas visited.

Emergency management planning was well established with training and ongoing exercises used to keep staff current. Regional and national emergencies have required activation of the team on several occasions in the past year, with debriefing, reviews and learnings implemented. Trial fire evacuations are completed six monthly. Back-up power supplies and emergency water were available across the sites. Water testing is undertaken regularly. There are processes and equipment available for dealing with medical emergencies. Staff were trained in emergency responses relevant to their area of work.

Cleaning is provided by a team of well-trained staff with cleaners available 24 hours a day, seven days a week. Areas visited were clean and tidy and this was supported in audits reviewed. Laundering of patients' linen occurs through an externally contracted service.

Restraint minimisation and safe practice

Current policies and procedures guide practice for safer restraint use. Restraint interventions were overseen by the restraint coordinator and restraint steering committee, while in mental health and addiction services, the 'Less Restrictive Practice Governance Group' provides oversight.

Episodes of restraint reviewed at audit indicated that restraint is used as a last resort, has been appropriately approved and only applied when required. 'Code orange' alerts are used when security or behavioural events indicate an escalating situation. Any potential restraint events are responded to by trained individuals, including the in-house health care security officers (HSOs) who respond across sites. This new approach has seen a significant drop in incidents and restraint events through use of the managing actual or potential aggression (MAPA) approach. Mental health staff are all currently trained in 'Safe Practice Effective Communication' (SPEC).

Restraint events are recorded via the incident reporting system and this is a reportable indicator for use of physical restraint at Auckland City Hospital and use of force in Te Whetu Tawera. Seclusion rooms, one of which has been decommissioned reflecting a drop in seclusion interventions, have been approved by the director of the area mental health services.

Infection prevention and control

ADHB has an infection prevention and control (IPC) programme that has been approved and implemented. The IPC programme is facilitated by the infection prevention and control nurse manager and other clinical nurse specialists and registered nurses working within the team. The programme is supported by the IPC committee, ward/department representatives, laboratory staff and clinical pharmacists.

The regional approach to infection prevention and control planning is well established and has been implemented recently on at least two occasions.

Policies and procedures are available through the intranet to guide staff practice.

Infection prevention and control is included in the orientation and ongoing education for all DHB staff. Patient/family education occurs appropriately. Nurses responsible for the IPC programme participate in relevant ongoing education.

An established surveillance programme is implemented across the services and includes monitoring of significant multi-resistant organisms, surgical site infections, invasive device-related infections, blood stream infections and outbreaks. Surveillance results are monitored, trended and communicated appropriately.

Ongoing monitoring of compliance with prophylactic and therapeutic antimicrobial use occurs with support from an antimicrobial pharmacist and clinical microbiologist.