

# Bay of Plenty District Health Board

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bay of Plenty District Health Board
<b>Premises audited:</b>	Tauranga Hospital  Whakatane Hospital
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services
<b>Dates of audit:</b>	Start date: 10 August 2020 End date: 13 August 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	430

# Executive summary of the audit

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## Introduction

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

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

## General overview of the audit

Bay of Plenty District Health Board (BOPDHB) provides services to around 240,000 residents living in the Bay of Plenty region. Hospital services are provided from the 361-bed facility at Tauranga and the 96-bed facility at Whakatāne. Services include medical, surgical, maternity, children's and women's health, health in aging and rehabilitation, and mental health and addiction services. These services are supported by a range of diagnostic, support and community-based services. Since the previous audit a new model of care has been developed in Ōpōtiki with all services now being delivered 14 hours a day, seven days a week from the Ōpōtiki Community Health Centre by the three GP practices working together with registered nurses. There are no inpatient beds.

This four-day certification audit, against the Health and Disability Services Standards, included a review of management, quality and risk management systems, staffing requirements, infection prevention and control, and review of clinical records and other documentation. Interviews with patients and their families and staff across a range of roles and departments were completed and observations made. Auditors visited both hospital sites. At mid-day on day three of the audit, the Covid-19 alert levels (level 3 for the Auckland area and level 2 for the rest of New Zealand) unexpectedly came into force. While this did not impact significantly on

the audit process, there were some minor changes made to accommodate restrictions and maintain safety. The organisation responded promptly and efficiently to the change in alert level.

This audit identified the following areas for improvement: documentation of consents and advance directives; quality and risk management systems; management of adverse events; and documentation in the clinical record. Improvements are also required in relation to the provision of timely care, assessments, care planning, including relapse prevention planning within the mental health services, evaluation of care, transfer and discharge planning, medication management, the physical environment and documentation of restraint/seclusion.

## **Consumer rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) was visible around all areas of the hospitals. 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.

Complaints received via the Health and Disability Commissioner are managed appropriately.

## Organisational management

Several changes to the board and executive management team have recently occurred with an acting board chair and interim chief executive officer (CEO) in place at the time of this audit. A new CEO has been appointed and will commence at the end of August 2020. At the service provider level, the four clinical services and Māori health service are supported by three clinical professional directors, a general manager Maori health gains and development and other support services. Two key strategic documents guide the annual planning process: the Strategic Health Services Plan and the Te Toi Ahorangi Strategy, which is supported by a well-established Māori Health Runanga with representatives from the 17 regional iwi. There is a strong focus on reduction of inequity. The 2020/21 annual plan is in development. The clinical governance committee is now established with further refinements being discussed.

The quality and risk management system is spread across four members of the executive management team with several new appointments to the health quality and safety service. Quality and safety coordinators support quality improvement and patient safety activities within the clinical services. Recent changes to the structure are still being embedded as is the formalising of a strategy and plan. There has been a focus on developing health intelligence to better identify areas for improvement, monitor progress in achieving strategic goals and provide effective reporting. Improvement activity was evident at all levels of the organisation, from large projects across the continuum of care, to small ward-based initiatives. Risks are reported to the finance audit and risk committee and the board.

Adverse events are managed through an electronic management system, with improvement plans developed.

Family and consumer advisory services are well established 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 reported good access to ongoing training and being well supported from dedicated educator roles.

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) are ongoing with improved responsiveness to patient flow, placement of staff where most needed and reduced time when clinical areas are operating above capacity.

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

## **Continuum of service delivery**

Patients access services based on needs and this is guided by policy. Waiting times are managed and monitored. Risks are identified for patients through the use of 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 any alternatives available.

Ten patients' 'journeys' were reviewed as part of the audit process and involved surgical, medical, paediatric, maternity, health in aging and mental health wards and departments, including the emergency department, intensive care unit, 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 are efficiently managed.

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

Activities, in most cases, meet the requirements of the individual patients and these are particular to the various specialty settings.

Medication is generally well-managed. Staff are competent to perform the function for each stage of medication management. Medication is recorded to a level of detail that complies with legislative requirements and good practice.

Food services are delivered 'in-house' at Whakatane and by a contracted service at Tauranga. Food was safely managed. A range of diets and special needs can be accommodated. Satisfaction with food is monitored through surveys and other feedback.

## **Safe and appropriate environment**

Waste disposal is managed and complies with regulations. A new initiative supports recycling, sustainability and waste minimisation. Laundry and cleaning services are outsourced to contractors that have been providing services for many years. Good practices were observed. Staff training is kept up to date and well documented. Regular audits are undertaken with follow up of any issues identified.

All buildings and plant comply with statutory and legislative requirements. Building warrants of fitness were current and asset management systems are well monitored.

The two hospitals and other community-based services have approved emergency evacuation schemes. The most recent six-monthly trial evacuations were deferred due to Covid-19 restrictions. There is emergency training for staff and appropriate back up services and utilities available at both hospitals in the event of emergencies.

The physical environment in most clinical areas was of a good standard with adequate toilet and bath facilities for patients. Planning is underway for the development of new mental health inpatient services. There is sufficient space around beds to allow for safe patient access and equipment use. Each part of the hospital has communal areas appropriate to the needs of the patient group. The hospitals were well ventilated and warm and patient areas have natural light. A review has recently occurred of the security arrangements in place.

## **Restraint minimisation and safe practice**

All episodes of restraint and seclusion are reported by staff via the electronic incident reporting system. The line manager is responsible for investigating and evaluating each reported event and patient outcome, with the input of other staff as required.

Restraint policy and practices are readily available to guide staff practice. The documents have been approved by the director of nursing. Seclusion is also governed by specific policy and procedures in the mental health services and these align with Ministry of Health guidelines and current accepted practice. During the audit period there were no consumers in seclusion.

A quarterly review of all restraint and seclusion use is undertaken and a report provided to the clinical governance committee which functions as the restraint approval group. A review has been undertaken related to the recent increase in the use of seclusion.

Staff are provided with training on the use of enablers and restraint minimisation practices as a component of the orientation and ongoing education programme. This includes safe practice and effective communication (SPEC) training for identified staff.

## **Infection prevention and control**

The BOPDHB provides a managed environment to minimise the risk of infection. The infection control programme is signed off and implemented by staff with the necessary skills and expertise. Policies and procedures are available online and comply with good practice standards. Pandemic planning and preparedness was sighted and implementation occurred during the audit when level two was announced by the government.

Staff education is delivered to meet need and support clinical practice and strengthen knowledge.

The surveillance programme meets the size and complexities of the services provided and complied with required reporting. Data is analysed and evaluated with appropriate recommendations made. There was guidance available for effective and appropriate antimicrobial use.