

Hokianga Health Enterprise Trust - Hokianga Hospital

Introduction

This report records the results of a Surveillance 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: 27 October 2020 End date: 27 October 2020

Proposed changes to current services (if any): Hokianga Health Enterprise Trust has completed a renovation/refurbishment programme of the inpatient ward. Subsequently there is a decrease in the number of inpatient medical beds by two. There are now eleven beds for medical patients (including one respite bed). There has been an increase of two beds for aged related residential care (ARRC) services, with 12 beds now available for ARRC services. All aged related residential care beds are suitable for either rest home or hospital level of care. The total number of certified beds is unchanged at 26.

Total beds occupied across all premises included in the audit on the first day of the audit: 25

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 Health Enterprise Trust (Hokianga Health) provides hospital services (medical, geriatric and maternity), and rest-home level care for up to 26 patients. There were 25 patients on the day of this audit.

The audit also included verification that appropriate services to support the changes in bed utilisation in the inpatient are in place, and the renovated/refurbished inpatient areas are fit for purpose. The audit process included review of specific policies and procedures, review of staff files, observations and interviews with, managers, and staff. The patients interviewed spoke positively about the care provided.

At the last audit three areas for improvement were raised in relation to documentation of open disclosure, and maintaining records to verify the recruitment and orientation processes. These have been addressed. At this audit no areas have been identified as requiring improvement. The ongoing consultation processes with the community is an area of continuous improvement.

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.		Standards applicable to this service fully attained.
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Communication between staff, patients and families/whanau is promoted and confirmed to be effective. There is access to interpreting services, although this is rarely required.

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.		Standards applicable to this service fully attained.
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The chief executive officer (CEO) and the hospital services manager (HSM) have been in their roles since 2001 and 2008 respectively. Job descriptions detail their roles and responsibilities. The strategic plan for 2020 to 2025 is in development. Consultation is currently occurring with the wider community. The annual health and wellbeing plan is in final draft. The vision, mission and philosophy of the service are documented. Progress towards achieving the organisation's previous goals is monitored.

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.

Human resources processes align with current accepted standards. Mandatory training is identified, and records of attendance/completion are maintained. Staff have 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.

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.

Patients admitted to Hokianga Health are assessed by the multidisciplinary team including the medical officers, registered nurses and registered midwives depending on the services required. Assessed needs are determined on admission and individualised care plans are developed and implemented. Interventions are documented to meet the goals or outcomes set. Comprehensive information and issues that may arise are clearly documented in the patients' records reviewed. Evaluations occur on a regular and timely basis and patients are referred or transferred, due to the nature of the services provided, to secondary care if applicable.

The planned activities are provided for the long-term care patients and parenting educational activities are promoted in the maternity service.

Medicines are safely managed and administered by staff who are competent to do so. Professional prescribing practices by the medical officers and midwives occurs.

The food service meets the nutritional needs of the patients with any special needs being catered for. Food is safely managed, and a food control plan is in place. Patients' verified satisfaction with meals.

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.

A significant renovation and refurbishment programme has been completed of the inpatient ward area. This includes all except eight of the patient bedrooms, installing new bathrooms, office area, laundry and the installation of two negative pressure isolation rooms. There have also been enhancements in security. A certificate of public use has been issued for this work. There is a current building warrant of fitness.

A new fire evacuation plan was approved by the New Zealand Fire Service in January 2020. Staff have been trained in the new fire evacuation plan requirements. Fire drills are conducted six monthly.

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 enablers and two restraints were in use at the time of the audit. Enabler use is voluntary for the safety of patients in response to individual requests. Restraint is only used as a last resort. Staff demonstrated a sound knowledge and understanding of the processes involved.

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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Infection surveillance is undertaken applicable to the services provided on site and the results are communicate to management and staff.

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	17	0	0	0	0	0
Criteria	1	39	0	0	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The chief executive officer (CEO) and the quality coordinator are responsible for managing and responding to complaints. Hokianga Health has implemented the recommendations arising from a complaint made to the Health and Disability Commissioner in June 2017.</p> <p>Four complaints reviewed at random and received in 2020, demonstrated that complaints, are reported, investigated and responded to in a timely manner and processes/timeframes complied with the Code, in particular Right 10.</p> <p>Patients 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. Letters/cards of appreciation are received regularly from patients and family/whanau members and displayed for staff.</p>
Standard 1.1.9: Communication Service providers	FA	<p>Patients stated that they were kept well informed about any changes to their status and advised in a timely manner about any outcomes of regular and any urgent medical reviews. This was supported in the patients' progress records reviewed including for the aged related residential care patients. This communication includes advising family/whanau of adverse events/incidents unless a patient, who is competent in decision making, has declined for</p>

communicate effectively with consumers and provide an environment conducive to effective communication.		<p>this to occur. The shortfall from the last audit has been addressed.</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 Māori when needed. There are staff employed who speak te reo and several other languages fluently. There are communication strategies in place for patients with cognitive impairment or who have difficulty communicating.</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. The strategic plan for the period 2020-2025 was under development with community consultation currently underway. A comprehensive review of the Hokianga Health Enterprise Trust (HHET) activities ending June 2020 has been undertaken and report published. The annual review evaluated progress towards achieving goals documented in the 2015-2020 strategic plan and the 2019/2020 annual health and business plan.</p> <p>Community feedback is currently occurring related to the draft annual health and business plan for 2020-2021 and the new strategic plan. These plans are being developed in consultation with staff, iwi, and the community. The strategic and business planning consultation and review processes are an area of continuous improvement.</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 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 contract details the scope and includes acute medical care, respite, surgical rehabilitation, palliative care, maternity inpatient (birthing and post-natal) care, 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. These contracts have been renewed in 2020. The other contracts held that are not applicable to the scope of this audit were not sighted.</p> <p>On the first day of audit there were 25 patients receiving care. This included four residents receiving rest home level of care, eight residents receiving hospital care-geriatric, three women in the maternity unit (and their infants), and ten patients receiving hospital care medical services. This includes one respite patient. The hospital services manager advises the facility has 26 certified beds. This audit included a verification of the changes in how these beds are being used since the inpatient refurbishment/renovation programme has been completed. There is now a total of 12 aged related residential care beds, being an increase of two beds, all of which can be used for either hospital or rest home level care. There are three maternity beds, and 11 beds for acute medical patients, including one bed dedicated 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</p>

		<p>since February 2008. The hospital services manager attends relevant education as required to meet the provider's contract with Northland District Health Board. Two designated registered nurses have responsibilities for providing oversight of care provided to residents receiving aged related residential care (ARRC) services. The HSM has completed interRAI assessment training, along with three registered nurses (RNs) that work in the community services.</p>
<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>Hokianga Health has a quality and risk management system which is understood and implemented by service providers. This includes a schedule of internal audits, various patient satisfaction surveys, 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. Hokianga Health has been benchmarking a range of incident data related to the aged residential care service with other health services in the region. Whilst the data is being collected and evaluated internally, the data has not been benchmarked as yet in 2020.</p> <p>If an issue or deficit is found, remedial/corrective action is taken. Quality information is shared with all staff via shift handover as well as discussed at the weekly executive meetings (occurs three weeks each month), and health and safety committee which has recently reconvened. The clinical governance group meets approximately six weekly to review business and strategic outcomes, progress towards achieving health targets and to discuss new quality initiatives. This committee also reviews infection prevention and control data and the use of restraint. The significant event committee meets quarterly (or sooner if required), and reviews reported incidents/accidents that are considered significant. This includes where emergency events were managed well with positive learnings/feedback communicated, or where there are opportunities for system or process improvements identified.</p> <p>Regular satisfaction surveys are undertaken of the different patient groups in Hokianga Health and the feedback was positive. Staff and patients interviewed expressed a high level of satisfaction about the services provided at Hokianga Health and commented on the holistic, and culturally appropriate approach to service provision. There was a coordinated integration between 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 the BOT, staff and management meeting minutes sighted. Significant work was undertaken in both inpatient and community services in relation to the Covid-19 pandemic. This included implementing a staff/patient and visitor (when allowed depending on the alert level) screening processes, having restricted access points into services, additional staff training on the use of personnel protective equipment, utilising technology rather than having face to face consultations, undertaking car park or telephone triage and assessment for applicable patients. Red and green zones were created. Staff were involved in proactively phoning members of the community for wellbeing checks starting with the elderly and the most vulnerable. Food parcels and hand sanitiser were regularly distributed to vulnerable members of the community.</p> <p>Quality projects are undertaken. Hokianga Health is moving to an electronic medicines management system. This is</p>

		<p>part of the strategy to reduce medication documentation related errors, including non-signing of administration.</p> <p>There are current policies and procedures available for staff. These are reviewed and updated every two years or sooner where applicable. Hokianga Health is utilising Northland DHB policies, Starship Hospital policies and the Blood Transfusion service policies and procedures. These documents are available electronically. Hokianga Health is now maintaining policies and procedures only for aspects of care that are unique to Hokianga Health or require additional information that is not included in the external policy/procedure documents. The HSM reports this process is working well. In addition, there are a range of governance policies that are reviewed by the BOT. The quality officer is responsible for document control processes. New or significantly changed Hokianga Health clinical policies are provided to staff for feedback, and then reviewed by the executive committee and amended/approved. A register is maintained to assist with monitoring document review processes and timeframes.</p> <p>Staff confirmed that they understood and implemented documented hazard identification processes. The hazard and risk register sighted was up to date (dated February 2020). Staff note maintenance/facility issues are promptly addressed.</p> <p>Hokianga Health has recently been audited against the 'Baby friendly hospital' requirements, and has current cold chain certification (for vaccines) with Northland DHB for the period ending 23 January 2022.</p>
<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. A review of nine reported events selected at random for events reported between 5 May 2020 and the date of the audit (including patient falls, challenging behaviour, medicine events, a facility issue and staff practice/process related events), verified these were investigated (or the investigation was in process), and actions was taken to address the identified issues. Staff spoken with were familiar with the reporting process. There was evidence of reported events resulting in changes and improvements in practice.</p> <p>All events are investigated and followed up by the applicable line manager, then entered into an electronic incident/accident register by the human resource/health and safety officer. The staff member reporting the incident is provided with a copy of the investigation and follow-up plan for the incidents/adverse events they have reported. The human resource/health and safety officer provides a monthly report to the executive team and BOT detailing the number and type of staff and patient related accidents and incidents, as well as themes and trends over time. The last three monthly reports were sighted. The CEO has compiled an annual summary of accidents/incidents and hazards as part of the annual health and safety report. This information was recently presented to the H&S committee.</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 patient related, or other significant events are discussed at staff handovers.</p>

		<p>The CEO and HSM 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 being notified by clinical staff. There has been one notification to WorkSafe related to a staff accident on site. This event occurred around the time of the last audit.</p>
<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>	FA	<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, applicable Kaimanaaki Tangata staff, the contracted employee assistance programme (EAP) counsellor, and the physiotherapist. A data base is maintained that contains this information, with processes in place to monitor that APC's remain current.</p> <p>Recruitment processes are detailed in policy. Records related to interviews and reference checks are now being maintained. Staff advise they are provided with a comprehensive orientation programme relevant to their role. Records of completion are also now being maintained. The two shortfalls from the last audit have been addressed. There is a human resources manager, and a human resource/health and safety officer who support the management team with human resource and recruitment processes.</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.</p> <p>Caregivers are required to complete an industry approved qualification (level three) within 15 months of employment. The three HCAs interviewed have completed requirements. All the cleaning staff have completed a level two training programme, and some were working towards achieving a level three 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</p>	FA	<p>A matrix was sighted that details staffing levels and skill mix requirements. This document is utilised in the development of the roster. A nurse practitioner is employed at Hokianga Health and works in the community.</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 (or two RNs and one EN) 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. Two registered nurses share the responsibilities to oversee the aged related care contract patients' needs. The HSM is currently completing the interRAI assessments until the two RNs have undertaken their training. An additional RN is on call from 6 pm to 7 am weekdays and all hours on the weekends. Staff and managers advise there is a low</p>

service providers.		<p>threshold for calling in the extra RN if patient numbers or acuity require. The two enrolled nurses work on different shifts. There are currently no RN, EN or HCA vacancies.</p> <p>Two nurses staff the ED weekdays covering 7.30 am to 5.30 pm, and one RN is rostered on the weekends from 9 am to 5.30 pm. 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 of a defibrillator. There are processes in place to ensure that RNs complete the initial and the ongoing annual competency requirements. Attendance is monitored by the hospital services manager and records of this were sighted. Nursing staff have current ACLS advanced core. Medical staff complete both PRIME and ACLS advanced core training. Nursing staff and midwives receive training on managing obstetric and neonatal emergencies.</p> <p>There is a lead maternity carer on site or on call. Two LMCs are permanently employed, and two casual RMs provide cover when required. There is a doctor rostered in the hospital for 8 hours weekdays. A second doctor is in the emergency department (ED) until 5 pm. 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 and backup supports are available during birthing. Staff interviewed confirmed medical staff are available 24/7 to respond to telephone queries or to come to review patients. 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 roster was reviewed (28 September 2020 to 8 November 2020) and demonstrated that the staffing matrix was being implemented, and unplanned absences are covered by other staff. A physiotherapist is on site for set days each week, and sees patients based on referrals or scheduled appointments. Radiology services are available on-site Monday and Friday daytime, however, can be called 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 are contracted to an offsite provider. The HCA's are responsible for washing the ARRC residents' clothes.</p> <p>The staff confirmed the hospital services manager is available out of hours if required. Patients interviewed confirmed their personal and other care needs are being well met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	FA	<p>The medicine management policy is current and identifies all aspects of medicine management. All legislative requirements are managed effectively and met. A safe system of medicine management was observed on the day of the audit. Registered nurses and one enrolled nurse under the direction of a registered nurse administer all medications and are competent to do so. The registered nurse demonstrated sound knowledge and had a good understanding of the role and responsibilities related to each stage of medicine management. Medication is supplied</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>by a contracted pharmacy. For the LTC patients, blister packs are available and these are checked by the registered nurses on arrival from the pharmacy. Controlled drugs are checked weekly by two staff and this is recorded accurately in the register as required. These drugs are stored securely in accordance with requirements. Swipe card access only to the pharmacy is the main security measure.</p> <p>The new medication room since the previous audit is temperature monitored and all stock is checked by a registered nurse. No expired medication was sighted. If nearing expiry the medication is tagged and dated to be used first to ensure minimal medicine waste occurs.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines were met. Medication records were reviewed from all services. The three monthly medication reviews for the LTC residents occurs and at each visit by the medical officer. The midwives have prescribing rights within their scope of practice. Minimal medications are stored in the maternity service; these are ordered as needed.</p> <p>The standing orders reviewed are documented and reviewed annually by a medical officer and authorised by the medical director. The expiry date for the next review is January 2021.</p> <p>There are no patients who self-administer 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 to the clinical services manager and recorded on an incident form. The patient or the designated representative are advised. There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.</p> <p>Hokianga Health has current cold chain accreditation.</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>	<p>FA</p>	<p>The food service is provided on site by a cook and is line with recognised nutritional guidelines to cover all patients and services provided. The cook works 9am to 5pm daily. The menu follows summer and winter seasonal patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>The hospital has a Food Control Plan which is validated from the Far North District Council. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including high risk items are monitored and recorded. The cooks have undertaken a safe food handling qualification and food handling training. Fridge/freezers are all monitored, and temperatures are recorded accurately. The kitchen was clean and tidy. Cleaning schedules were sighted and actioned by the staff.</p> <p>Dietary requirement forms are completed by the registered nurses or midwife when the patient is admitted. Any dietary needs are listed along with any preferences or dislikes and this is displayed in the kitchen for staff. Special</p>

		<p>diets are catered for and any food requiring modified texture are noted and accommodated in the daily menu plan. The cooks have a communication book they use to communicate any additional changes, food deficits or requirements when ordering supplies. All special equipment to meet patients' nutritional needs is available.</p> <p>Evidence of patient satisfaction with meals was verified by patient and family members interviewed, satisfaction surveys and patient meeting minutes. Patients were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty to ensure appropriate assistance is available to patients as needed. Patients in all services including maternity stated that they enjoyed the meals provided.</p>
<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 care provided to patients was consistent with their needs and the plan of care. The attention to meeting a diverse range of patient's individualised needs was evident in all areas of service delivery. The medical officer interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided consistently with a multidisciplinary approach. Registered nurses and care staff confirmed that care was provided as outlined in documentation. The registered midwives interviewed spoke highly of the registered nurses who care for the women and their babies when they stay for postnatal care and management after the birth of their babies. The nurses receive ongoing training to ensure they are confident in caring for women and babies on the afternoon and night shifts as required. Should any changes occur the registered nurses are able to call the midwife on call. Medical staff, midwives and nursing staff are available twenty-four hours a day seven days a week (24/7) to cover this hospital and all services provided.</p> <p>There are adequate wound care, continence, birthing packs and other resources required to meet the needs of the patients accessing all services. Observations on the day of the audit indicated that patients and their family/whanau are receiving appropriate care and support that is consistent with meeting their assessed needs.</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</p>	FA	<p>The activities programme for the long-term care residents and the day care programme is provided by a diversional therapist holding the national Certificate in Diversional Therapy, and an assistant and volunteers as able from the community.</p> <p>A social assessment 'Map of Life' 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 as part of the formal six monthly care plan and interRAI re-assessment review.</p> <p>The planned activities programme matches the skills, likes and interests identified in assessment data. Entertainers from the community are welcome to perform for the patients and special events are celebrated (dependant on the Covid-19 restrictions that in place at the time). Activities reflected patient goals, ordinary patterns of life and include</p>

service.		<p>group and individual one on one activities. Attendance and participation are encouraged though not compulsory for patients. Patients interviewed enjoyed the programme and socialising with the other patients.</p> <p>For the maternity service, activities are not organised as such, but all support is provided during the time women and their babies are in the maternity unit. Parenting education is promoted at every opportunity and is a major activity. Educational activities such as safe sleeping, screening procedures, settling babies, baby bathing, positioning and techniques for successful breastfeeding are encouraged. Educational DVDs are also available for couples to access. Pamphlets and booklets are available on every subject and can be accessed at any time. Women interviewed stated that they filled their day by caring for their baby, resting, spending time with family/whanau and other visitors and watching the educational material available and reading written information as time permitted. Staff interviewed enjoyed this aspect of providing and promoting health options to parents.</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 daily by the medical staff and each shift by the nursing staff and is documented in the progress records. If any changes occur the nursing staff contact the medical staff who are present in the day or the after-hours medical staff as needed. The medical officer interviewed has worked at Hokianga Health for 17 years and is pleased with the systems in place and spoke highly of the expertise of the nursing staff working in this rural care setting.</p> <p>For the LTC stay patients' formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessments or as patients' needs change. A schedule was reviewed for when all reviews are due, and these reviews are planned ahead of time so that family/whanau can be involved. Evaluations are documented by the registered nurses. Where progress is different to that expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans in use included wound care, skin tears, after falls have occurred, or for behaviour monitoring. Progress was evaluated as clinically indicated. Other plans such as wound care management plans were evaluated each time the dressing was changed. Patients and family/whanau interviewed provided examples of involvement in evaluation of progress and any changes needed.</p> <p>Acute medical patients are assessed regularly by the medical staff and any investigations, treatments are arranged as needed. If the patient requires stabilising before a transfer to secondary care this is managed effectively. This can occur on a regular basis with road traffic injuries, logging industry accidents and other acute admissions. Some investigations need to be completed in secondary care and referrals are made for patients as needed.</p> <p>The women in the maternity unit are evaluated on a daily basis and at each point of contact during all stages of service delivery. If progress towards outcomes or goals is less than expected for the mother and/or baby an extended stay can be arranged.</p> <p>Clinical progress records are completed each shift by the midwife or registered nurse on duty. On the afternoon and night duty if the registered nurse covering has any concerns the midwife on call can be contacted. If the midwife determines that the condition of the woman and/or baby is no longer suitable for primary care, arrangements are</p>

		made to transfer to a secondary care facility, being the DHB. The plan would be updated and a transfer arranged in a timely manner depending on the circumstances.
<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>A building and renovation programme has been completed in the inpatient unit (excluding the eight beds in the long stay resident wing which has been previously refurbished). The refurbishment/renovation programme included relocating the bathroom areas and building new bathrooms/toilets. This included installing a large bathroom for bariatric patients, that enables patients to be showered laying down if required. The patient bedrooms have been refurbished with the inpatient management office areas being moved for better utilisation of the space. There are call bells at each bedspace/bathroom that alert to centralised panels. Two negative pressure isolation rooms have been installed with a shared anteroom, and each room has a full ensuite bathroom. The nursing station has been expanded and closed in to optimise privacy/security. Security cameras have been installed along with swipe card access including for the medicine room. A new ambulance bay has been created on the ground floor by maternity, and a staff office created in the maternity area. Patients and staff can now walk in a circuit around the entire inpatient ward, and a new corridor lounge area has been created. The HSM and inpatient administrator's office is now nearer the nursing station. The laundry has been refurbished and new washing machine and drier installed. The marae and dining area on the lower floor have been refurbished. Shower and bathrooms facilities have been installed. This area is used for the care of patients who are receiving palliative care and their family members and is also used by community groups. Patients and staff advise the changes in facility/environment have been positive, and overall, the inpatient unit flows very well. The inpatient environment is fit for purpose.</p> <p>A certificate of public use has been issued related to the renovated/refurbished area. The original certificate of public use was issued on 2 March 2020 and has been extended. Hokianga Health has until 2 March 2021 to complete the final requirements so the Code of Compliance can be issued by the Far North District Council. The remaining aspect is expected to be completed by Christmas 2020, having been delayed due to the impact of the Covid-19 pandemic. The functioning of the negative pressure isolation rooms has been checked and aligns with standards. Maintenance is scheduled for these rooms quarterly.</p> <p>There is a current building warrant of fitness - expiry 30 June 2021.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response</p>	FA	<p>A new fire evacuation plan has been developed, and this was approved by the New Zealand Fire Service dated 20 January 2020 (reference EVAC-2019- 430115-03). Staff have been trained on the updated fire evacuation procedures. Fire drills are conducted six-monthly. The most recent fire drill was conducted on 3 August 2020.</p>

during emergency and security situations.		
<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. Intravenous devices and the results of 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. Work has been undertaken to improve the securing of intravenous devices at insertion in response to audit findings earlier in 2020.</p> <p>For the aged residential care service, infection definitions reflected a focus on symptoms of infection, rather than the results of laboratory tests. The infections included in the surveillance programme included urinary tract, soft tissue, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified a record of this is documented. There have been no outbreaks of infection since the last audit.</p> <p>The infection prevention and control coordinator reviews all reported infections, and also does a weekly review of the ARRC patient records to assess if any new antimicrobials have been prescribed. 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.</p> <p>The IPC coordinator is allocated one day a week to undertake the infection prevention and control activities and reports directly to the hospital services manager. The surveillance programme is appropriate for both the size of the hospital and the inpatient clinical services provided.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of patients in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.</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.

No data to display

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 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	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 is currently one co-opted member (a former nursing director) who brings relevant experience to the board. The board members actively represent their community needs. The chairman of	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 health 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. The 2020 round of meetings occurred during October, and the summary of these meetings was sighted. 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), commencing a project to redesign the emergency, outpatient and radiology departments. This will complete the refurbishment/renovation of the entire hospital. The refurbishment of the inpatient unit has been completed with two negative pressure isolation rooms installed to help reduce potential risks

		<p>the HHET BOT has been on the board for 18 years and held the role of chair for the last five years. The chair has a dual representative role representing one of the community areas as well as iwi.</p> <p>The organisation's new strategic plan 2020-2025 is under development with community consultation in progress. There have been some delays due to the Covid-19 pandemic. The plan contains the mission statement, values and philosophy for the organisation. The previous strategic plan (2015-2020) and the associated annual health and business plans were also developed in conjunction with staff, managers, medical specialists, general practitioners, the wider Hokianga community and the Board of Trustees. A comprehensive review of the previous year's activities, outcomes and needs as well as future planning occurs, with the most recent report published for the period ending June 2020. The plan outlines the 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 te reo Māori. The annual report is published and readily available for the community.</p>	<p>related to infectious disease transmission. These rooms were planned and installed before Covid-19 was identified as a pandemic. Hokianga Health is working to improve sustainability with solar power panels being installed. These solar panels are expected to provide approximately one third of the hospitals energy requirements once commissioned. Community groups utilise the Hokianga Health meeting rooms with traditional/complimentary therapies/rongoa being used alongside the existing health services provided. The community meetings provided feedback on the impact of Covid-19 pandemic in the clinic regions with discussion on what worked well and how the pandemic plan/response can be improved.</p> <p>The BOT meeting minutes sighted included reference to community feedback. Patients interviewed expressed a high-level satisfaction about the community consultation processes and that services continued to be developed by the community for the community to meet the changing needs of the community.</p>
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End of the report.