Wairarapa District Health Board - Wairarapa Hospital

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:	Wairarapa District Health Board
Premises audited:	Wairarapa Hospital
Services audited:	Hospital services - Medical services; Hospital services - Children's health services; Residential disability services - Psychiatric; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 17 November 2020 End date: 19 November 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: 66

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

Wairarapa District Health Board (WrDHB) provides services to around 45,000 residents living in the region. Hospital services are provided from the 88-bed facility in Masterton. Services include medical, surgical, maternity, paediatrics and mental health crisis respite and recovery Centre (CRRC). These services are supported by a range of diagnostic, support and community-based services.

This three-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.

This audit identified that improvements are required in relation to implementation of consent in the crisis respite and recovery service, currency of policies and procedures, integration of clinical committee activities into the quality management system, training records and completion of performance appraisals, staffing requirements, documentation around planning of care and

evaluation of care, management of medicines, maintenance of facilities in some areas, and the ability to track sterile equipment used in theatre to each patient.

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.

Complaint processes are in place to meet the requirements of the Code. Information on how to give feedback including complaints was available. Complaints are recorded and managed through an electronic system by the patient experience coordinator, a member of the quality risk and innovation team.

Organisational management

The current board has now been in place for around one year and members interviewed were clear about priorities and risks. The chief executive officer (CEO) has been in the role for around 18 months and is experienced in the role. The CEO is supported by an executive leadership team (ELT) using an integrated primary and secondary model of heath delivery. At the service provider level, the chief operating officer oversees the delivery of inpatient services supported by three group managers, a chief medical officer,

and three other professional leads. Several strategic and operational plans support an annual planning process with increasing community engagement, Māori engagement and an intersectoral approach. A focus on equity for Māori was evident. Reporting to the board on achievement against plans is constantly being refined. There is a well-established consumer council and work is progressing in relation to the clinical board.

The quality and risk management system is well-established with a recent focus on ensuring an effective clinical quality governance framework. A team with varied quality and patient safety roles support service based clinical quality facilitators with quality activities across the services. Improvement activity was evident at all levels of the organisation, from large projects across the continuum of care, to smaller ward-based initiatives. Risks are reported to the finance, audit and risk committee, the clinical board and the board. The risk register is electronic and meets the needs of a smaller DHB. Health and safety risks are defined with a committed health and safety committee and well-trained staff.

Adverse events are managed through an electronic management system, with improvement plans developed. The clinical board and the clinical event review group (CERG) monitors the implementation of recommendations from more serious events, with improvements made to both the timeliness of reviews and the follow-through of recommendations.

Family and consumer advisory services are well established across the '3DHB' mental health addiction and intellectual disability services with additional local roles being recruited too.

Human resource systems are based on current accepted good practice. Orientation programmes are in place for new staff in all disciplines at both organisational and service level. Staff are well supported with training opportunities for mandatory and 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 progressing with the implementation of the Care Capacity Demand Management (CCDM) programme, which is positively impacting on matching patient requirements to nursing staffing. The organisation has a decreasing number of vacancies with less reliance on locum positions.

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 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.

Five patients' 'journeys' were reviewed as part of the audit process and involved the emergency department, surgical, medical, paediatric and maternity wards, the crisis respite service, emergency department 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.

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 teamwork 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. Medicines were generally stored safely and managed effectively throughout the organisation.

Food was safely managed by the new externally contracted service. Special dietary needs can be catered for. Most patients interviewed were satisfied with the food.

Safe and appropriate environment

Building warrants of fitness were current. Proactive and reactive maintenance, including for biomedical and other equipment, was well managed.

There are enough bathrooms and toilets. Communal areas in rehabilitation and mental health services are suited to the needs of the different patient groups. The patient's personal spaces are adequate for staff movement and equipment use.

Emergency management planning is established. Fire evacuation drills are completed. Back-up power supplies and emergency water and food are available. There are processes for dealing with medical emergencies. Emergency equipment is regularly checked. Staff are trained in emergency responses relevant to their area of work.

Restraint minimisation and safe practice

There are processes to minimise restraint use throughout the organisation. Policies support minimisation and safe practice. The restraint advisory group approves all restraints and enablers and monitors any use. The RAG members stated that they review events to identify emerging trends and point to changes in education programmes as a result. The RAG has overseen the introduction of new training, ‘Management of actual or potential aggression’ which is credited with a positive impact on the reduction of restraint events. The training is available to all staff including orderly and security staff who now participate in restraint events.

The documentation on the electronic event reporting system and in the patients’ files reviewed showed that restraint was only used when the patient or staff were in danger and that all requirements were met. There has been a significant reduction is restraint use over the past year.

The crisis respite service does not intervene with restraint. Staff are trained in de-escalation techniques with the 'Safe practice effective communication' training.

Wairarapa does not have any seclusion approved rooms and does not practice seclusion.

Infection prevention and control

Wairarapa District Health Board has an infection prevention and control programme that has been approved by the infection prevention and control committee (ICC). There are clear communication lines to governance. The infection prevention and control programme is facilitated by the clinical nurse specialist, supported by the infection prevention and control committee, and the infectious diseases physician.

Policies and procedures are available electronically to guide staff practice. The infection prevention and control clinical nurse specialist participates in relevant ongoing education. Appropriate education is provided to DHB staff and patients / family where applicable.

Surveillance for infections is occurring. The surveillance programme is appropriate to the service setting and includes significant organisms (including multi-drug resistant organisms), specific surgical site infections, invasive device related infections, blood stream infections, outbreaks, and hand hygiene compliance rates. There have been no outbreaks since the last audit. The surveillance results are communicated appropriately.

Guidelines are available for prescribers related to appropriate antimicrobial use. Monitoring of antimicrobial use is occurring.