

South Canterbury District Health Board - Timaru 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:	South Canterbury District Health Board
Premises audited:	Timaru Hospital
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	Start date: 1 November 2020 End date: 1 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:	94

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

South Canterbury District Health Board (SCDHB) provides services to around 62,000 residents living in the region. Hospital services are provided from the 120-bed facility in Timaru. Services include medical, surgical, maternity, paediatrics, assessment, treatment and rehabilitation and mental health and addiction services. 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, restraint minimisation and safe practice 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 corrective actions, risk management, documentation around planning of care and evaluation of care, management of medicines, maintenance of equipment and facilities, and auditing and monitoring of the use of prophylactic and therapeutic antimicrobials.

Consumer rights

Information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and how to access the National Advocacy Service was visible around all areas of the district health board (DHB) in both English and te reo Māori. Staff were aware of how to access the Code in other languages. Most patients and whānau reported an awareness of the Code and all stated that their rights were upheld. All patients spoke positively about their care, treatment, and communication with staff. Staff were trained in the Code and were observed respecting patients' rights, including their privacy.

The organisation has a strong commitment to providing services that meet the cultural needs of its community. Policies and processes are in place to identify individual cultural and spiritual requests of patients, and these are being met.

Examples of evidence-based practice were evident throughout the services, to promote patient safety.

Communication with patients and families was reported to be open and honest and examples of open disclosure were evident where required. Interpreter services were available and staff were aware of how to access these.

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent.

Complaints are well managed and meet all the requirements of Right 10 of the Code. Complaints were seen as an opportunity for improvement.

Organisational management

The current board has been in place for around one year and members interviewed were clear about priorities and risks. The chief executive officer (CEO) is experienced in the role and is supported by a strategic leadership team (SLT) using an integrated primary and secondary model of health delivery. At the service provider level, the director of patient, nursing and midwifery services

oversees the delivery of inpatient services supported by a chief medical officer, medical lead primary care, a director of Māori health, director of corporate services and director of organisational capability and safety.

Several strategic and operational plans support an annual planning process with increasing community and marae/iwi engagement and an intersectoral approach. A strong 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 a clinical board.

The quality and risk management system is well-established with a recent focus on ensuring an effective clinical governance framework. Quality coordinator roles support quality activities within the wards/units and across the services. 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 smaller ward-based initiatives. Risks are reported to the audit and assurance committee and the clinical board. The risk register is being transitioned from a spreadsheet to an electronic platform. The establishment of a senior leadership group is supporting ongoing developments. Health and safety risks are defined and have been recently reviewed.

Adverse events are managed through an electronic management system, with improvement plans developed. The clinical board monitors the implementation of recommendations, 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 mental health and addiction services.

Human resource systems are based on current accepted good practice. Comprehensive 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 had very few vacancies at the time of audit across all disciplines.

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

Patient's access to services are based on need, guided by policy and process. Waiting times are managed and monitored as required by the Ministry. Risk assessments are carried out from admission using research-based 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 surgical, medical, paediatric, maternity wards and mental health unit. Departments/units visited included the emergency department, neonatal intensive care, post-operative care and intensive care unit. Auditors and technical expert assessors reviewed relevant documentation and interviewed medical, nursing and allied health team members, patients and whānau. Additional sampling was undertaken throughout the audit.

A qualified and skilled multidisciplinary team provide services to patients and there were good examples of teamwork throughout clinical areas. Shift handovers were efficiently managed with staff to staff handovers, in most cases, and use of handover paper documentation.

Assessments were undertaken in a timely manner with results reviewed, discussed and actioned as appropriate. This was supported by patients and whānau interviewed. Various care plans and care pathways were evident throughout the hospital. The electronic 'early warning score' (EWS) is used in most wards, with the paediatric ward and maternity service using appropriate tools to prompt triggers when a patient's condition deteriorates. Evaluation of patients' progress was undertaken 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.

SCDHB has current policies to guide medication management. There were systems to manage the supply, prescribing, storage and administration of medicines across the service. An electronic prescribing system (Medchart) was used effectively and was available in all but one clinical area.

Food was managed safely through an externally contracted service. The menu meets DHB and national specifications. Dietitian support is provided to patients with special needs. A malnutrition screening tool is included as part of the planning tool prompting the need for a dietitian referral. The kitchen has been verified as complying with a documented food safety programme/plan.

Safe and appropriate environment

Building warrants of fitness and certificates of public use were current. Proactive and reactive maintenance, including for bio medical 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 with some improvements underway. 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 active processes to minimise restraint use throughout the organisation. Documentation is reviewed every two years to maintain its currency and relevance. Episodes of restraint reviewed during audit clearly demonstrated that restraint has been used as a last resort and approved for use in accordance with policy. Episodes of both restraint and seclusion continue a downward trend over the past three years and, on the days of audit, there were no examples of restraint being used, one enabler in use, and no seclusion used.

Staff could explain the difference between enablers and restraint requirements. There is one fully trained Safe Practice Effective Communication (SPEC) trainer in mental health services. Efforts are being made to continue the 'train the trainer' model, with plans underway to train at least one further person to deliver the initial training. Weekly training 'practice' updates are held to support staff to maintain their competency.

Infection prevention and control

SCDHB has an infection prevention and control programme that has been approved by the infection prevention and control committee (IPCC) and management representatives. The committee reports to the clinical governance group. The infection prevention and control programme is facilitated by a nurse who is well supported by the committee, the clinical microbiologist and infection control champions. She undertakes ongoing relevant training.

Policies and procedures are available electronically to guide staff practice. Orientation and ongoing education is provided to DHB staff and patients.

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 and outbreaks. The surveillance results are communicated appropriately. Monitoring of compliance with prophylactic and therapeutic antimicrobial use is being re-established.