Quality & Clinical Governance Report 2013

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Quality Manager
April 2013
Contents - to be rewritten

Appendices:

1. External audit Summary
1 Foreword

This report provides an overview of the clinical governance activities for 2013.

The 9th April 2013 marked the 100th anniversary of the death in Rome of Venerable Mary Potter. In 1877, Mary Potter when she established the Little Company of Mary, Mary Potter said to her congregation, “our special mission is the dying”. It was Mary Potter’s Little Company of Mary who gave our Hospice to the people of Wellington. Today, the vision of Mary Potter remains very much the vision of our Hospice.

Our vision, like Mary Potter’s, is that all people who are dying will receive high-quality care irrespective of their beliefs, background or where they may be. The quality systems and frameworks endeavour to evaluate and validate quality and best practice at Mary Potter Hospice.

This Quality and Clinical Governance report summarises our activities for 2013. It is designed to open up a dialogue about quality with the users of our service, the public and others who have a stake in our work. The Quality Report cover three key areas:

- Patient safety
- Effectiveness of our care
- Patient experience

In addition to this the Quality Report summarises the Hospice Strategic Plan 2012-2015 that identifies our strategic priorities and goals for the next three years. The report also looks at the work that has or is being undertaken to achieve these priorities.

It is important to be open with people who use our services when safety incidents occur or services do not meet their expectations. At Mary Potter Hospice, we strive to learn from these occurrences to prevent incidents reoccurring and to continuously improve the quality of the care provided. You will see a number of examples throughout our Quality Report of where we have engaged with people who use our services, their families and carers, and our staff to improve quality.

Our achievement as an organisation is dependent upon the professionalism and commitment of our Hospice workforce who strive to provide high quality, effective care, whilst keeping people safe from harm. The aim of this report is to provide assurances to staff, volunteers, the Board of Trustees, consumers and the public, that we are continually working to improve services.
2 Executive Summary

In 2012, Mary Potter Hospice produced its first Clinical Governance Report. The Health, Safety and Quality Commission (the Commission) requires that all district health boards publish ‘Quality Accounts’. These are from health and disability service providers regarding the quality of the services provided. This report aligns with the Commission’s recommendations\(^1\) by outlining how the Hospice, as a provider is progressing in terms of continuous quality improvement, the consumer experience and health outcomes.

Purpose of this report:
- To give the public confidence that the Hospice is providing a quality service.
- To assess the quality of services provided during 2013.
- To share organisational successes, learning’s and future improvements.
- To provide transparency and accountability regarding the quality of the Hospice’s performance.

Principles:
As set out by the Commission the principles that guide the development of this report are:
- Accountability and transparency
- Meaningful and relevant
- Focused on whole of system outcomes
- Continuous quality improvement

The report seeks to provide an annual overview of quality in the organisation. The quality initiatives that we have made are outlined in this report and areas where we need to do better are identified.

At Mary Potter Hospice, we are committed to delivering the highest standards of quality and safety and as an Executive Team are confident of the progress we have made over the last 12 months. This is reflected in the accuracy and our endorsement of the information within this report.

All Hospice staff are involved in quality activities across all teams. We would like to acknowledge the teams for their contribution to the audit and policy processes in the organisation and their readiness to seek new opportunities to improve quality and safety. We would also like to acknowledge the members of the Professional Advisory group for their expert advice and guidance in the management of quality and risk in the Hospice.

3 Statement of Endorsement
The Board of Trustees and the Executive Leadership Team of Mary Potter Hospice endorse that all content is accurate. The content is representative of the Hospice’s quality performance during 2012 and the improvement goals for 2013.

4 Statement of Engagement
This report has been developed in conjunction with the Hospice Executive Leadership Team and the Professional Advisory Group of Mary Potter Hospice.

5 Statement of intent regarding feedback
This report will be:
- Circulated to all Mary Potter Hospice staff for feedback and comment.
- Circulated to the Mary Potter Hospice Consumer Advisory Group for feedback and comment.
- Published on the Hospice website and a formal link developed to enable feedback from the community
- Released to the media
- Displayed onsite across all three geographical locations.

Feedback regarding this report can be directed to:
Teresa.read@marypotter.org.nz

6 What have we achieved during 2013?
What we promised last year:

<table>
<thead>
<tr>
<th>What we said we would do</th>
<th>Rating</th>
<th>Evidence</th>
</tr>
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<tbody>
<tr>
<td>• Increasing the participation of consumers to our service</td>
<td>Achieved</td>
<td>The Hospice Consumer Group reviewed the Hospice Strategic plan and also contributed to the review of several patient brochures</td>
</tr>
<tr>
<td>• Improving information and data management across our services.</td>
<td>Partially achieved</td>
<td>The Hospice developed an IT Strategy that is at implementation phase</td>
</tr>
<tr>
<td>• Publication of patient brochures online</td>
<td>Not achieved</td>
<td>Many new brochures have been developed and are at the publishing/printing stage in the process.</td>
</tr>
<tr>
<td>• Formalising and developing a Clinical Governance framework through the existing Professional Advisory Group.</td>
<td>Achieved</td>
<td>External audit review</td>
</tr>
</tbody>
</table>
- Developing key performance indicators that monitor quality and safety of care. | Partially achieved | The Hospice is working with Hospice NZ to develop national Hospice quality indicators.

- Analysing our high risk areas such as medications and falls. | Achieved | Working groups have developed systems and processes to ensure increased analysis and monitoring of high risk incidents occurs. Staff education has embedded change and raised awareness.

- Preparation for 2013 external audit review. | Achieved | See audit report in Appendix 1

In addition, the Hospice achieved the following quality initiatives:
- Introduction of key indicator for ‘near miss’ falls
- Introduction of key indicator for pressure injury pre admission to Inpatient Unit.
- Introduction of an Infection Control Advisory Group as a sub committee of the Health, Safety and Infection Control Committee (HSICC)
- Conducted an environmental health and safety assessment of the Inpatient Unit.

What we will do during the next 12 months (2013):

<table>
<thead>
<tr>
<th>What we will do</th>
<th>How?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Execution of Hospice Strategic Projects</td>
<td>Work with patients and families and stakeholders in the planning and design of new service models. Integrate national and regional service models/frameworks Team action plans and reporting frameworks</td>
</tr>
<tr>
<td>Quality palliative care</td>
<td>The 2013 external audit review demonstrates improvements in services and we are now preparing for the Hospice NZ standards peer review by Hospice New Zealand.</td>
</tr>
<tr>
<td>Increasing the participation of consumers to our service</td>
<td>Develop Community engagement via team action plans</td>
</tr>
<tr>
<td>Cultural awareness and integration</td>
<td>Roll out of Maori Service Plan Gap analysis of Pacific Service Plan</td>
</tr>
<tr>
<td>Improving information and data management across our services.</td>
<td>Rebranding exercise Publications</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>Benchmark top three incidents with other Hospices Review incident management systems</td>
</tr>
<tr>
<td>Developing key performance indicators that monitor quality and safety of care.</td>
<td>Develop clinical benchmarking</td>
</tr>
</tbody>
</table>
Analysing our high risk areas such as medications and falls. Development of new medication and falls incident forms enables increased analysis of cause, effect and risk.

Measuring and evaluating our data and quality activities enables us to validate that people are receiving adequate care, that our current service model is improving care, and to compare outcomes² (Casarett, Teno, & Higginson, 2006, p.1765)

7 Mary Potter Hospice Clinical Governance Framework

“Clinical governance is a system through which (healthcare)... organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

During 2013, Mary Potter Hospice further embedded clinical governance systems and processes through the Professional Advisory Group (PAG). The Hospice adapted the Clinical Governance Framework from the Health Service Executive, Ireland that describes the key elements of the quality and clinical governance framework.

The above framework captures the key elements the key elements required to promote Clinical Governance:

- Quality Management systems
- Hospice Values
- Accountability
- Communication and Consultation
- Capacity and Capability

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• Policies, Procedures and guidelines
• Internal/External monitoring and review.

The framework also outlines the systems in place that make Clinical Governance happen:

1. **Service Improvement**: Identifying bottlenecks, reducing inefficiencies, strategic plan, quality assurance

2. **Learning and Sharing environment**: Learning from incident reviews, learning from patient experience, research and development.

3. **Patient/Whanau and Public Community Involvement**: Patient information, Consumer advisory group, patient surveys, complaints feedback, and community partnerships.

4. **Clinical Effectiveness and Audit**: Clinical guidelines, clinical audits, clinical KPIs, policies and procedures monitoring.

5. **Risk Management and Patient Safety**: Complaints/ incidents, health and safety systems, risk management process

6. **Staffing and Staff management**: Staff planning (acuity), recruitment, orientation/induction, continuous professional development.

This report is aligned with the CG framework above.

### 7.1 Service Improvement

#### 71.1 The Hospice Strategic Plan 2012-2015

Late 2011 and 2012, the Hospice developed the Mary Potter Hospice Strategic Business Case that outlined the approach required to improve services and to create a sustainable future for the Hospice ‘Towards 2026’ that increases access to care in the community for those with palliative care need. The immediate challenges of increasing demand for palliative care, workforce shortages, funding uncertainty and fit for purpose facilities have been considered at a strategic level with plans in place that will build sustainable services for the future.

Work during 2013 focused on three strategic projects:

- Enhanced Community Service model
- Education review
- Facilities review
During 2013, a strategic assessment of the current community service was undertaken to ensure a robust options analysis well informed by the needs of patients, stakeholders and by emerging trends in models of care by:

- Gap analysis of services against national policy directions
- Process mapping the ‘patient journey’ to identify opportunities to streamline and build efficiencies
- A time and motion study to understand the community service teams’ pressures and gaps.
- An international literature review
- A series of workshops with key internal and external stakeholders.
- Fact finding visits to UK, Ireland, Australia and NZ to review new service models in palliative care.

All these elements were important to The next phase of the project (in 2014) will define the enhanced community services model of care and outline the key workstreams and resources required to transform community services ‘towards 2026’.

7.1.2 Quality assurance

The highlight for 2013 for the Hospice service in terms of quality and clinical governance was an external Ministry of Health certification audit and EQuiP 4 standards review by the DAA group in January 2013.

The audit was based on the following criteria:
- NZS 8134:2008 Health & Disability Services Standards
- Australian Council of Healthcare Standards (Evaluation and Quality Improvement Programme – EQuIP)

Extracts from the report include:

“One of the more significant changes since the previous survey includes the evolution of the professional advisory group (PAG) which has developed greater responsibility for clinical governance.

The PAG have responsibilities in relation to the incident management process, complaints and patient feedback. There has also been significant improvement in the audit systems and processes and refinement, which include action outcomes and recommendations for improvement”.

The organisation shows a genuine approach to quality and risk management to provide safe care for patients as well as a safe working environment for staff. The quality and risk management system are linked throughout the organisation and comply with legislative requirements. The action plans of each department are linked to the strategic plan, mitigate risk and promote safe patient care. The development and improvement of plans is guided by the strategic and action plans. All levels of the organisation are kept informed about the status of the plans via weekly executive and monthly staff
meetings. Progress is audited and results are reported back to committees and then to teams.

Incident reporting is robust and well managed. The organisation closely liaises with public health and CCDHB staff, City Council, MoH, Pharmac and via clinical networks to remain up to date on notification processes. Staff shows good awareness of quality and risk principles and family members stated at interview that any concerns are addressed immediately.

There is a structured, well planned and comprehensive education programme in place ensuring competence of staff and volunteers. The education plan identifies learning objectives, evaluation, and compliance with education and is linked to the strategic plan. Staff education is actively promoted with paid education time for compulsory study days as well as personal professional development education. Staff are supported with clinical supervision and debriefing sessions and participate in CCDHB and tertiary education. The education records are current and show that education promotes best practice and includes a feedback component.

The organisation is to be commended on their Staff Wellness Policy, promoting and supporting staff to reach their full potential and maintain good health and well-being.

The outcome of the external audit review is summarised in Appendix 1.

The reports and findings have been reviewed and linked to the organisational quality plans (Team Action Plans) and recommendations reviewed by the Executive Team, Team Leaders Forum and the Professional Advisory Committee.

The reports and findings were be linked to the Hospice New Zealand Standards self review later in the year (see page).

7.2 Learning and Sharing Environment

7.2.1 Incident reviews

All accidents/incidents continue are collated and reviewed at the monthly Health, Safety and Infection Control Committee (HSICC) meetings.

During 2013, Key indicators indicators were reviewed and the following indicators added:
  - Falls - near miss
  - Pressure injuries pre admission to Inpatient Unit

This report provides further analysis of all incidents reported in 2013 and includes a comparative analysis with 2012 data.

Total Clinical Incidents 2013 (1 Jan 2013- 31 Dec 2013)

<table>
<thead>
<tr>
<th>Top 3 Clinical Incidents:</th>
<th>2013 (n=457)</th>
<th>2012 (n = 480)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>32% (n= 150)</td>
<td>23% (n=111)</td>
</tr>
</tbody>
</table>
Falls

<table>
<thead>
<tr>
<th>Pressure injury pre admission to IPU</th>
<th>29% (n=131)</th>
<th>32% (n=157)</th>
</tr>
</thead>
</table>

Incidents resulting in Patient Harm

**Medications:**
A breakdown of the Medication incident data indicates that of all reported medication incidents, 11% caused harm to the patient. These errors are related to procedural errors with the majority related to omission of medications. Professional development for the staff involved in these errors has occurred. All nurses complete an annual medication questionnaire. A weekly audit of medication charts is conducted by the pharmacist that has led to an increase in the number of errors reported. Further work also included a review and update of the medication audit tool, including benchmarking tools with other Hospices nationally.

<table>
<thead>
<tr>
<th>Category</th>
<th>2013 data</th>
<th>2012 data</th>
<th>Cause and effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Serious</td>
<td>17</td>
<td>8</td>
<td>No harm, confusion, sedation, unsettled/in pain.</td>
</tr>
</tbody>
</table>

Falls:

One in two patients with advanced cancer are at risk of a fall\(^5\) and the ‘Fall rate’ in the IPU is high. In 2012, a retrospective review of all Fall incidents in the Inpatient Unit for 2011 (n=80) was undertaken. During 2013, further analysis of the findings was undertaken. Eighty falls in 4765 bed days (an 8% decrease in bed days from 2010) which makes the number of falls per occupied 1000 occupied bed-days in Mary Potter Hospice is 17, significantly higher than UK Hospice data.

<table>
<thead>
<tr>
<th>Inpatient unit Falls</th>
<th>Stroke rehab</th>
<th>Older peoples health</th>
<th>UK Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.79</td>
<td>18.2</td>
<td>16-22</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Of these Falls, 23% of all Falls were ‘multiple fallers’ (patients whom fall more than once) and 21% of all falls of occurred <10 days pre death. It is worth noting that the majority of Falls results in ‘no injury’. Within this data, 26% of all Falls resulted in an injury such as laceration, bruise, pain and skin tears.

During 2013, a falls working party was reconvened to provide a forum whereby a multi disciplinary team approach facilitates management of falls prevention within the IPU.

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Work progressed to develop a paper for publication summarising the results of the Falls research developed to date. A new incident form specific to falls is currently being piloted in the Inpatient unit.

Principle objectives:
- Research and analyse current literature on falls management particularly relating to palliative care.
- Review the Falls Risk Assessment Tool and make recommendations.
- Review Incident Report Form and make recommendations
- Review audit reports / results
- Identify key areas for improvement and development
- Develop and provide education on falls management to staff, patient and families
- Benchmarking

Falls risk Management
- Appointment of an IPU Falls Champions (Physiotherapist and Health Care Assistant) to drive increased awareness in the IPU.
- Falls Risk Assessment guidelines
- A Falls Risk Assessment is undertaken of all admissions to IPU, and this reviewed by the MDT during a change in health status or following a Fall.
- Increased signage in Inpatient Unit
- An environmental risk assessment within the IPU identified falls risk factors in the design and layout of equipment and furniture.
- Commenced ‘near miss’ reporting of Falls.
- MDT education.
- Worked with the Hospice Consumer Advisory Group and a “Falls’ brochure for patients and families has been developed.

Management of Clinical Incidents recommendations:
- Further analysis of data during 2014 through revised incident forms for medicaions and falls.
- Retrospective review of all patient injuries and incidence of skin tears on IPU.
- Development of a data management system through the IT strategy to increase monitoring and enable increased analysis of data trends.

Case reviews
Development of a case review process and system for all complaints has led to increased

7.3 Patient/Whanau and Public Community Involvement

The Consumer Quality and Research Advisory Group (CRAG) continued its activities this year advising on areas related to quality and research:
- Review and approval of Hospice Strategic Plan
- Review of all new brochures

Future recommendations include expanding the group and developing a Consumer Engagement Plan which will outline key activities that incorporate consumer feedback into our services.
Complaints
The complaints policy was rewritten during 2013. The new policy aims to increase the level of monitoring, reporting and reviewing complaints including review through the Clinical Governance Group (Professional Advisory Group). It introduces a complaints reporting form and flowchart for all staff to use that will prompt timely processes and appropriate authority in the management of complaints.

Formal education was provided across all teams.

Four complaints were received during 2013.

The complaints related to:
- Care in the Community/transition in care
- Care in the Inpatient unit
- The Liverpool Care Pathway
- Access to the Inpatient Unit.

Recommendations
- Repeat the audit in 6 months time.
- Increase the monitoring of complaints through the Clinical Governance Group.

Patient Information

Work continues to improve the current information provided to consumers. The development of a brochure committee in June 2011 has lead to a formalized tracking system for collating and developing brochures and this will be refined during 2012.

New brochures developed during 2013:
- Food for thought
- Falls
- Funeral services (updated in conjunction with all funeral directors)
- Mouthcare information for patients and families
- Prevention of pressure areas.

Further development of information management systems will enhance the development and distribution these resources further on the Hospice website.

Carer Survey (Porirua)
Creekfest
Patient Feedback - Patient Satisfaction Survey

During 2013, the Hospice worked to improve return rates of patient surveys through linking the survey to the discharge planning for all IPU patients (instead of an annual survey).

In October 2013, a patient satisfaction survey was undertaken using QPS benchmarking tool that has been validated with consumers through Hospice New Zealand.
- 227 patients were surveyed (postal questionnaire) in the IPU and the community and 140 patients discharged from Inpatient Unit (IPU).
- The response rate for community patients was 23% (n=52 patients) with an overall satisfaction rate of 98%.
- The response rate for IPU patients was 23% (n=27) with an overall satisfaction rate of 94%.

### Patient Satisfaction - Inpatient Unit (n=6)

A sample of the individual comments from IPU patients:

- ‘I don’t think I’ve ever felt so safe and less worried about the future’.
- ‘I think my pain was managed before I ever got to feel it’
- The quiet caring attitude of everyone. The feeling we matter. Thank you for the wonderful care and sending me home feeling so much better.
- ‘Mary Potter went out of their way to assist by supplying foods I could manage to eat’
- ‘Every aspect of care was professional, caring and always I was treated with dignity and pain was controlled. Symptoms diagnosed and promptly treated’.

Suggestions:
- ‘A few hooks on toilet/shower walls to hang clothes up when having a shower would be good’
- ‘Could I suggest that hot food be served on hot plates. It is a shame to get good quality food on cold plates’
- ‘A less detailed report’ [survey],
- ‘TV reception’ (could be improved).

A sample of the individual comments from Community patients.
Patient Satisfaction - Community Care (n=53)

A sample of the individual comments from Community patients:
*The reputation of May Potter services is high and in my experience well merited*  
Fantastic.  
*Excellent care, meeting needs of both patient and family.*  
A very special and unique service.  
*Very happy with the services.*  
Quicker than expected.

**Suggestions:**
Some way of providing faster access to medication such as [Diazepam] when it is required to calm me down while panicking because of shortness of breath would have been helpful. Got this sorted out at home.

More money from government to ease pressure on services

A residential Hospice at Kapiti

**Opportunities to improve**
- Upgrade MPH website and increase the amount of information/brochures provided to consumers online.
- Provide opportunities to feedback or complain online.
- Develop Consumer forums/workshops as a way of collecting feedback of the patient experience in addition to postal surveys and comment cards.
- Maintain consistent application and circulation of brochures/templates and communications across all three geographical regions and also wider to key stakeholders and partners in care.
Next steps

- Pilot of A5 comment cards across all three sites to increase level of feedback from consumers.
- Link survey to IPU discharge system and processes (currently an annual survey) so that feedback is sought from all people admitted to IPU.
- Face to face interviews/Focus group via Day Programme and Carer Support groups
- Day programme survey (Porirua)

7.4 Clinical Effectiveness and Audit

Performance indicators are well embedded at Mary Potter Hospice. The Hospice Team Action plans are linked to individual work plans that provide the reporting and monitoring framework for the monthly reports.

As highlighted above, further work is required to analyse the data from these reports to make them more meaningful to measure and evaluate services. The Hospice continues to work with the Central Cancer Network at a regional level, and Hospice New Zealand at a national level, to define performance indicators across regional and national hospice services.

7.1 Patient Activity

The first stage of the enhanced community service strategic project commenced in 2012 with an analysis of current service delivery through a time and motion study across Mary Potter Hospice (Hospice) community teams. The aim of this project was to provide a detailed overview of the activities, services, capacity and pressure across the community. The results have informed this key strategic project for Hospice.

Patient Activity

![Average Length of Time in Service 2009 - 2013](chart.png)

In 2009 the average length of stay was 90 days, and in 2013, 153 days, an increase of 70%. The data validates that people are accessing the Hospice earlier in the disease trajectory. This aligns with the strategic intent of the Hospice to promote earlier access to Hospice services.
*Source of all this data is from Palcare electronic database.

It is acknowledged that fine tuning of data management systems and process are required to enable accurate reporting of service activity.

Patient Safety initiatives
Te Kete Marie
Falls Working Party
Bereavement Care

A review of the service - process mapping, policy etc forms

Risk Management and Patient Safety

Risk Management

The risk register is reviewed by the Executive Team quarterly and Board of Trustees annually. The register was reviewed during 2013 and new risks added. The new format increases the understanding and monitoring of risks. During 2013, the register was linked formally with key groups at MPH e.g. quality, health and safety committee, Team Leaders forum and the medication management committee. This add another check to ensure the risk register is a working document across the organisation. The committees actively advise and review all clinical risks on the register.

MPH monitors safety and quality of service through regular committee meetings focusing on quality and safety, the monthly reports sent to the Board, MPH risk register, the annual review, patient and family satisfaction surveys and review of internal and external audit reports. The Quality and Risk Management Framework (2011, Appendix 1) outlines the key drivers and systems for quality improvement in the organisation. MPH supports a ‘bottom up’ approach to quality where health professionals and clinicians participate in developing and leading quality improvements in the organisation. The Quality Manager supports the team system and processes to align with strategic goals, which ultimately leads to an overall quality implementation plan.

Restraint

An audit of the Restraint Management System (December 2013 to February 2014) shows improved compliance with restraint management systems and practices.

Audit Breakdown

Total number of patients: 24 patient
Total number of days: 263 days of restraint averaging 10.95 days
Average age: 75 yrs (15 males and 9 females)
Consent obtained: 96% compliant
Documented in Care Plan 100%
Types of restraint:
- Bed rails 58%
- Sensor Mat: 21%
- Bed rails and sensor mat: 21%

Reason for Restraint use: Safety 71%, Enabler 29%
Reason Restraint ceased: Death 33.3%, Discharge 46% & Not required 21%

All staff completed Restraint & De-escalation training in 2013. All new staff complete this training during orientation.

In 2013 Restraint became a stand alone issue in the Care Plan resulting in an increased focused in care and ability to analyse and review data.
Infection Control and Prevention

Work during 2013 included:

- Formation of the Infection Control Advisory Group as a sub group of the Health and Safety and Infection Control Committee to advise on infection control matters within the organisation.
- Review and update of the infection control plan
- Review of the Surveillance Policy and a trial of new surveillance for patients on admission to the Hospice
- Monthly infection control audits of IPU environment, kitchen and cleaning areas.
- An environmental audit of the Inpatient facility, Kapiti and Porirua. In the Inpatient Unit, this highlighted risks with cleaning of the patient bedside curtains and resulted in a trial of new curtains for the IPU.
- Flu vaccines for all staff
- Attendance by the Infection Control Nurse to regional infection control conference.
- Education of all clinical staff via MDT study days and orientation.
- Review of the staff health questionnaire
- Participation in Hospice National Infection control survey.

The challenges include the high turnover of patients who are immunocompromised. There is no baseline rate of infection at MPH. It is intended that increased surveillance will enable for meaningful analysis and collation of data.

Fire

Trial Fire evacuations are held six monthly. During February and August 2013, trial evacuations took place and evacuation occurred in 2mins 51secs and 2mins 45secs respectively thus achieving the standard of timely and safe evacuation of all staff. For the purpose of this exercise the patients and their families/visitors are asked to remain in the patient rooms - all staff including volunteers leave the building and move to the designated assembly areas.

During the February trial evacuation exercise it was observed that the Emergency Evacuation Board was missing clear indication of the location of the Lower Ground Floor North & South tags due to the weather/ sun/UV fading out the lettering. As a result the signage on the Emergency Evacuation Board was replaced with permanent materials. Area Warden Training was also completed during 2013.

8 Quality and management

A comprehensive audit calendar (see appendix 4) ensures that quality improvement is a continuous method of upholding and evaluating best practice at MPH. All audits conducted have been reported on and unless otherwise stated in this report achieved excellent standards. Staff are commended for their enthusiasm and commitment to this area of practice in the organisation. Benchmarking of the calendar occurs regionally through a regional Hospice quality group.

The policy review process is robust at MPH and is operated to the highest standard. A policy tracking timetable and review process ensures that all policies are reviewed in a timely manner and all staff has the opportunity to lead and contribute to policy developments. This includes validation of practice through research publications.
Outstanding policies requiring review include Use of Electronic Mail & the Internet. This will be linked to the IT Strategy.

The risk register continues to be updated quarterly. We have recently introduced various committees (Medication Committee and Health & Safety Committee) to the responsibility of reviewing specific aspects of the risk area related to their scope. This has led to increased quality of real data and increased awareness of staff to the formal processes of risk management in the organisation.

Membership of the Quality Manager with the Team Leaders forum, the Medication Committee, Consumer Advisory group and the Publications Committee since 2012 has led to improved understanding of quality issues in specific parts of the organisation and enables Quality to provide extra support and advice to staff in the areas of quality, monitoring and evaluation.

Annually the development of team action plans, aligned with MPH Strategic Plan and outlines KPI’s and outcomes across the organisation in the areas of quality and safety. Planning and review processes are aligned with sector standards and we are on track in all areas except for opportunities to improve information management systems and emergency management policies. A comprehensive audit process ensures that quality improvement is a continuous method of upholding and evaluating best practice at MPH.

Summary of Opportunities for Quality Improvement 2014:

- Development of an Information Policy/Strategy.
- Upgrade MPH website and increase the amount of information provided to consumers online.
- Provide opportunities for consumers to feedback or complain online.
- Develop Consumer forums/workshops as a way of collecting feedback of the patient experience in addition to postal surveys.
- Maintain consistent application and circulation of brochures/templates and communications across all three geographical regions and also wider to key stakeholders and partners in care.
- Development of clinical KPIs

It is a pleasure to submit this quality report. The opportunities proposed are challenging pieces of work but with ‘quality’ firmly embedded across the organisation; these opportunities will be supported by staff that are proud that Mary Potter Hospice provides a high quality service.

Priorities 2013/2014 - IDEAS

Patient safety
1. Reduce medication errors and improve prescribing practice
2. Reduce the incidence of hospice acquired pressure injuries
3. Reduce the incidence and impact/harm of patient falls
4. Improve access to services???
5. Consistent access to appropriate health professionals available for patient care 24/7

Patient outcomes
1. Reduce hospital ED admission rates
2. Reduce hospice acquired pressure injuries

**Patient experiences**
1. Improve timely access to all service users
2. Improve discharge planning and reduce delay on date of discharge
   Improve customer service and responsiveness
Appendix 1

Report on Mary Potter Hospice external audit review January 2013

Teresa Read, Quality Manager, May 2013

Introduction

A Ministry of Health certification and an EQuIP accreditation audit were conducted at Mary Potter Hospice on 16 Jan 2013. The audit was based on the following criteria:

- NZS 8134:2008 Health & Disability Services Standards
- Australian Council of Healthcare Standards (Evaluation and Quality Improvement Programme – EQuIP)

The Executive summary (pages 1-7) of this report are a direct copy and paste from the full audit report.

Audit Methodology

The audit team used a common checklist for the audit, which is based on both sets the Standards. The audit findings are based on objective evidence. Interviews with staff and consumers occurred, observation of practice and the environment was made and records, policies and procedures were reviewed. Findings and an attainment level identified for each criterion of the Standards was given.

Executive Summary of Audit

GENERAL OVERVIEW/FINDINGS

Mary Potter Hospice provides specialist palliative care to inpatients and community patients in an appropriate, safe and tranquil environment. Mary Potter Hospice's input into care and strategic planning is regularly sought by health professionals and regional and national organisations. Mary Potter Hospice is situated in Newtown, Wellington and provides a specialised palliative care service made available to residents of the Wellington region. The service offers both community and an inpatient hospice service of 18 beds using an integrated service delivery model.

The service has held EQuIP 4 accreditation status for several years and previously achieved a four year certification with the Ministry of Health. The governing body is supportive and well qualified to guide the organisation through the challenges of health care provision. Patients and their families are treated respectfully and have their needs met appropriately. The strategic plan supports continuity of care for patients and supports staff. Human resources processes are comprehensive and staff are well supported with education and good employment practices. Buildings and equipment are well maintained and emergency procedures are appropriate to the service.
Mary Potter Hospice has continued to provide quality palliative care, seek areas to improve and extend services and retain its profile as a national leader in hospice care. Three required improvements include ensuring hardcopy policy dates are up to date, completing documentation of sample signatures on medication files and ratification of the infection control plan by senior management.

Care delivery is based on best practice evidence in palliative care, in which the organisation demonstrates active engagement in improving assessment processes, the delivery of care, and appropriate evaluation throughout the patient journey.

The policies developed by the service reflect evidence based practice. The provision of an environment which encourages good practice, including evidence-based practices at Mary Potter Hospice is a strength. Good clinical practice occurs within a culture and environment of regular audit and quality improvement activities.

Of particular merit, is the continuing rollout of access to Palcare to the district nursing service and general practices in the region, with ongoing opportunities available to enhance the currency of information for all users and has led to improved communication and coordination of services.

**CLINICAL FUNCTION OVERVIEW**

As a provider of specialist palliative care services in the Wellington region, Mary Potter Hospice continues to provide a high standard of care to both inpatients and to those in the community.

Care delivery is based on best practice evidence in palliative care, in which the organisation demonstrates active engagement in improving assessment processes, the delivery of care, and appropriate evaluation throughout the patient journey. Patients’ cultural, spiritual and individual values and beliefs are identified on admission and a care plan developed to meet these needs. Staff demonstrate awareness of patients’ rights and ensure each person is informed and offered choices related to the care they receive, including through the provision of a wide range of hospice specific brochures. Family/whanau are closely involved where the patient desires this. Patients and family/whanau interviewed understand their rights, feel involved, are supported to make choices about their care and are able to raise any concerns.

A large project undertaken has resulted in the development of core care guidelines which are both comprehensive and detailed. The goal of enabling consistent recording of patients’ assessment, plans, interventions and review, in the Palcare electronic patient management system, is progressing, with the organisation refining aspects of the guideline based on user feedback. Patients and family/whanau express high levels of satisfaction with the quality of care provided in both the inpatient unit and the community. Inpatients have frequently already had contact with the service and received information about the scope of services on offer. Staff provide a strongly integrated and multidisciplinary team approach to service delivery and this is a notable strength of the service.
Registered nurses (RNs) are responsible for the development, planning and evaluation of the nursing care plans, led by an inpatient unit manager, and supported by the multidisciplinary team including palliative care coordinators. The multidisciplinary team, including the medical and allied health team, are all actively involved in planning patient care, with regular discussions about progress for both inpatients and those in the community. Ongoing assessment and review occurs by each member of the medical, nursing and allied health team, with detail entered into the Palcare system to ensure information is current, particularly with those patients whose condition is rapidly changing. Work has been undertaken to evaluate the Liverpool Care Pathway, using a current validated tool, known as the reflective data cycle, with opportunities identified to explore the effectiveness of the model outside the environment of the inpatient unit.

The policies developed by the service reflect evidence based practice. The provision of an environment which encourages good practice, including evidence-based practices at Mary Potter Hospice is a strength. Good clinical practice occurs within a culture and environment of regular audit and quality improvement activities.

Records are maintained in an electronic software system known as Palcare, with minimal hard copy used. This move towards a fully electronic patient management system is reported to have improved efficiencies and reduced duplication of information. Of particular merit, is the continuing rollout of access to Palcare to the district nursing service and general practices in the region, with ongoing opportunities available to enhance the currency of information for all users and has led to improved communication and coordination of services.

Effective medicine management systems are implemented in the inpatient unit and is supported by a clinical pharmacist contracted 20 hours per week for advice, reconciliation activities and oversight of medicines ordering, supply and storage. Administration record keeping is an area requiring improvement in accordance with legislative requirements and safe practice guidelines. Staff involved in administration of medicines undergo updates and competency renewal annually. A number of recommendations have been made in relation to fully utilising the clinical pharmacists in relation to formal medication reconciliation and administration of records. There are opportunities to evaluate the introduction of ambulance transfer forms.

Volunteers play a significant role in the day to day activities of the inpatient unit, including meal service, general support activities and reception roles. A volunteer coordinator is responsible for recruitment, induction and rostering of these volunteers and those interviewed report they feel well supported and their opinions are valued.

Infection prevention and control activities are an area which the organisation would benefit from a greater focus. Changes made to the structure of the infection control team and the involvement of an external advisor need to be evaluated to ensure the outcomes are achieving the organisation’s goals. In particular, a greater focus on surveillance activities, which are appropriate to the needs of the specialist palliative care service, should be pursued. Use of standardised definitions for this environment and benchmarking with other organisations in relation to the extent and nature of infections occurring for facility acquired infections will enhance achievement in this
criterion. A number of recommendations have been made in relation to infection prevention and control activities.

Other initiatives in relation to pressure injury management and falls risks involve the appointment of resource nurses to help support these roles through education, information and best practice guidance.

A number of recommendations have been made in all key areas which, if adopted, should assist the organisation to consistently achieve excellence ratings for many clinical functions.

**SUPPORT FUNCTION OVERVIEW**

The organisation shows a genuine approach to quality and risk management to provide safe care for patients as well as a safe working environment for staff. The quality and risk management system are linked throughout the organisation and comply with legislative requirements. The action plans of each department are linked to the strategic plan, mitigate risk and promote safe patient care. The development and improvement of plans is guided by the strategic and action plans. All levels of the organisation are kept informed about the status of the plans via weekly executive and monthly staff meetings. Progress is audited and results are reported back to committees and then to teams.

Incident reporting is robust and well managed. The organisation closely liaises with public health and CCDHB staff, City Council, MoH, Pharmac and via clinical networks to remain up to date on notification processes. Staff shows good awareness of quality and risk principles and family members stated at interview that any concerns are addressed immediately.

There is a structured, well planned and comprehensive education programme in place ensuring competence of staff and volunteers. The education plan identifies learning objectives, evaluation, and compliance with education and is linked to the strategic plan. Staff education is actively promoted with paid education time for compulsory study days as well as personal professional development education. Staff are supported with clinical supervision and debriefing sessions and participate in CCDHB and tertiary education. The education records are current and show that education promotes best practice and includes a feedback component.

The organisation is to be commended on their Staff Wellness Policy, promoting and supporting staff to reach their full potential and maintain good health and well-being.

HR policies are comprehensive, outlining roles, responsibilities, succession planning and HR principles. Employment policies outline recruitment and staff performance development. Employment of staff is consistent with best practice and promotes succession planning. The organisation has undertaken comprehensive work to support human resources (HR) management with the appointment of an HR manager to guide staff through HR processes and empower managers to lead their teams.
The recruitment, selection and appointment system ensures that the skill mix and competence of staff meet the needs of the organisation. Skill mix of staff is aligned to patient acuity and need. Staff is experienced and well skilled, with managers and clinical staff holding postgraduate qualifications.

The collection of information is supported by a robust record management system aligned to legal requirements and linking to the organisation’s human resource and patient management processes. The record management system supports effective patient care, organisational management and education and research. Policies include information on privacy, storage, retrieval, retention and destruction and identification, and clinical classifications.

The organisation is commended for their initiative to share their patient management system with the district nurses and GP teams, to ensure continuity of care for hospice patients. Interview with staff and meeting minutes indicate that this has improved patient care.

CORPORATE FUNCTION OVERVIEW

The governing body guides the organisation with strategic planning using a collaborative and coordinated approach. The organisational value of respect, providing care with dignity and providing excellent care, is well embedded throughout all levels of the organisation. Structures and processes are in place to effectively manage the organisation.

Mary Potter Hospice engages in collaborative processes with the public hospital, regional district health board services, GP practice teams, care facilities and non-government organisations (NGOs), to ensure continuous, coordinated care for patients.

The strategic plan 2012 - 2015 describes the skills, knowledge and experience of the management team and the structure of the organisation and is evaluated annually.

The governing body is drawn from a group of well respected and qualified people, with skills and expertise suitable for the organisation. The Board is supported by comprehensive policies. The Boards’ responsibilities are defined and understood by both the Board and management and comply with legal requirements. Board members receive formal orientation and ongoing information and education about governance. The governing body fosters a quality approach. The Board receives quarterly balanced score card and monthly operational reports. An annual assessment process, including clinical, medical, fundraising and operational components is undertaken by the Board.

External providers and contractors are managed by a well defined contracting system which is reviewed annually. Contracts have key performance indicators, which are analysed and changes made as indicated. The Director of Support Services has regular review meetings with contractors. The contract reviews are up to date.
All policy documents support staff in providing safe and appropriate care. Policy management is comprehensive and involves staff at all levels. All policies have links to related documents and are evidenced based. Hard copies and manual holders are available across the organisation in staff offices and the library. The hardcopy policies are not updated as per schedule and this is a recommendation (Refer to HDSS Certification Report, Corrective action required, 1.2.3.4). Benchmarking of policies occurs with Hospice Taranaki.

There is a comprehensive health and safety process in place. Staff receive Health and Safety training on orientation and annually thereafter. Providing a safe environment includes Health and Safety and Infection Control Committee (HSICC) input in refurbishments, renovations and daily patient care. The risk register is current and well maintained with issues identified and appropriate actions. The risk register is reviewed by the HSICC and recommendations made to management, as evidenced by meeting minutes.

The hospice building is on three levels, with the upper and lower level for staff offices and the family flat, and lower level for kitchen, maintenance and storage. A current Building Warrant of Fitness is in place. The environment has a tranquil feel while also being well maintained so that surfaces are safe for patients to use.

All buildings, plant and equipment meet legal requirements and safety management systems align with strategic and risk plans. Buildings, signage, plant, equipment, utilities, supplies and consumables owned or used by the Hospice are managed and operated to support a safe health care environment. Maintenance agreements are in place.

Waste and environmental management is managed appropriately and complies with legislation. Waste management is clearly outlined in the waste management policy, which is organisational wide and compliant with New Zealand legislation. The policies and guidelines show good linkage with risk and strategic plans as well as clinical policies. Waste management is coordinated and links to City Council and CCDHB requirements.

Mary Potter Hospice has comprehensive emergency protocols in place which link to the strategic and risk plan. Emergency protocols are well known by staff. Safety and security procedures are in place for patients, staff and environment management. The current system was evaluated and revised in 2010 and included input from the MoH, local government as well as meetings with CCDHB emergency management team. Ongoing discussions with Wellington District Council are held to keep staff informed. Emergency business continuity and pandemic plans are reviewed with the leadership group using the experiences from the Christchurch earthquakes. Fire and evacuation drills are conducted every six months and earthquake drills and armed robbery training every 12 months. The most recent health and safety refresher was in January 2013. All staff participated in the national earthquake day.

An organisation wide security policy outlines roles and responsibilities and links to the quality and risk plan. The risk plan identifies security risks with a risk mitigation plan. There is an organisation wide risk assessment to identify security risks. Regular meetings are held with security firm ADT to review and update processes and discuss incidents and mitigation of such. Staff were consulted about best
location for security cameras, and other security measures that would enhance their safety. Staff mention at interview that they feel safe working at the hospice.

Security cameras are installed to monitor entrances and medication room. Automatic door locks are in place between 5.30 PM and 6.30 AM.

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**EQUIP RATINGS**

*SA*: Some achievement  *MA*: Moderate achievement  *EA*: Extensive achievement  *OA*: Outstanding achievement

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### 3.1.4 External service providers

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### 3.1.5 Policies, Legislative compliance

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### 3.2 Safe environment

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#### 3.2.2 Buildings/ equipment

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#### 3.2.3 Waste management

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#### 3.2.4 Emergency management

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#### 3.2.5 Security

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### SUMMARY OF RECOMMENDATIONS FROM EQUIP 4:

No high priority recommendations were made. The recommendations listed below are not compulsory but will promote higher ratings (outstanding achievement) for the next audit.

### CLINICAL FUNCTION

#### Criterion 1.1.1

1. Undertake evaluation of the patient journey, to incorporate transition to and from hospice services and transfer to the LCP where this occurs, as part of the process mapping project.

2. Evaluate the effectiveness of the implementation of increased Liverpool care pathway use in aged residential care on patient assessment and outcomes using appropriate methodologies. Implement changes where indicated.

#### Criterion 1.1.3

1. Evaluate the effectiveness of the informed consent process, its timing of completion and inclusion in Palcare, in particular, where patients are not able to give consent.

2. Implement the planned translation of informed consent forms to reflect the demographic changes occurring within the service and collect data on its usage and externally benchmark this with similar services.

#### Criterion 1.1.4

1. Establish a system to evaluate all Palcare module components in use, in particular, the medication module, to ensure that the content is current and maintained.

#### Criterion 1.1.5

1. Evaluate the effectiveness of any changes made to the discharge process as a result of the mapping undertaken in the patient journey project.
Criterion 1.1.6
1. Evaluate the effectiveness of the introduction of new service/clinical information brochures and the content of existing brochures and use this information to refine and enhance service information available to patients and family/whānau.

Criterion 1.1.8
1. Evaluate the uptake and effectiveness of the emergency planning and ambulance forms implemented in the community and make improvements when necessary.
2. The electronic patient record be audited. Although there are mechanisms for evaluation in place, there is little evidence that formal audits and actions and improvements from these are undertaken. This recommendation remains open.

Criterion 1.2.1
1. Evaluate all new brochures for readability using standardised measures and make improvements where required.

Criterion 1.2.2
1. Evaluate the impact of the introduction of the community liaison role on admission rates and length of stay.
2. Evaluate the effectiveness of service accessibility for the Maori and Pacific Island community and take action to improve this where necessary.

Criterion 1.3.1
1. Review the criteria for allocation of continuing education to non clinical staff. Ensure appropriate education is available as part of every staff member’s individual development plan.

Criterion 1.5.1
1. That the organisation considers including administration compliance records as a regular audit item for medication management. Where non-compliance is noted, this includes evidence that the correct follow up reporting procedures identified in organisational policy have been followed.
2. Undertake evaluation of reconciliation activities by the clinical pharmacist, including collecting data where interventions are required and use this to direct future service improvement.
3. Further develop the medication information brochures provided to patients having a planned discharge and evaluate the impact on patient compliance.
4. Ensure medicine management information is recorded to a level of detail and frequency that complies with legislation and guidelines. (see CAR HDSS 1.3.12.6)

Criterion 1.5.2
1. Review the manner in which the annual infection control programme and plan are developed and make changes where necessary to ensure that this occurs in a timely manner.

2. Evidence based practice guidelines relevant to the scope of the service e.g. APIC guidelines should be accessed and implemented to enable monitoring and measurement of the outcomes of the infection control programme in each of the identified surveillance priority areas. Such information should inform the progress, education needs and any improvements needed.

3. Establish parameters for and evaluate the effectiveness of the infection prevention and control resource role and its impact on improved infection prevention and control practice.

4. Investigate use of an electronic “suspected infection” form to aid reporting and data collection into Palcare, evaluate its effectiveness and make changes where necessary.

5. Investigate the standards associated with the cleaning of the Linen Shute in line with good infection prevention and control practice and make any changes necessary.

Criterion 1.5.3

1. Consider collaborating with the district nursing service to extend the pressure injury risk assessment audit to include community patients.

Criterion 1.5.5

1. Complete policy review in relation to transport of blood, evaluate compliance with policy and make improvements where necessary.

Criterion 1.5.6

1. Evaluate compliance with the current policy and initiate improvements where required.

Criterion 1.6.2

1. Evaluation of staff training in relation to protection of patients’ rights is still to be evaluated. This recommendation remains open.

Criterion 1.6.3

1. Seek and implement a range of culturally appropriate means to evaluate the effectiveness of the Maori service plan and Maori liaison role and make improvements is necessary.

Criterion 3.1.5

1. The organisation ensures all hard copy policies in manuals are updated.
1. The development of performance indicators to evaluate security systems are in progress. This recommendation from previous survey continues.
MINISTRY OF HEALTH CERTIFICATION RATINGS

Corrective Action Requests
### Corrective Action Requests (CAR) Report

**Provider Name:** Mary Potter Hospice  
**Type of Audit:** Certification audit  
**Date(s) of Audit Report:** Start Date: 16-Jan-13  
**End Date:** 16-Jan-13  
**DAA:** The DAA Group Limited  
**Lead Auditor:** Sylvia Meijer

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<th>Std</th>
<th>Criteria</th>
<th>Rating</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>1.2.3</td>
<td>1.2.3.4</td>
<td>PA Low</td>
<td>Finding: The Standard requires that the document control system ensures documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. Four policies in the hospice inpatient staff office have an out of date policy review date. Although the content is appropriate, the 'for review date' on the hard copies is not current. Action: The organisation are to ensure that all hardcopy policies are current.</td>
<td>6 months</td>
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<tr>
<td>1.3.12</td>
<td>1.3.12.6</td>
<td>PA Low</td>
<td>Finding: Three of eight medication files reviewed do not include completed records of administration for the times prescribed in accordance with organisational policy. This related to 3 different medications in each of two of two files reviewed. It is reported that omissions and administration records are reported through the incident reporting system, however no records of this could be located. Documentation of sample signatures is incomplete in two of eight files reviewed. Action: Medicine management information is recorded to a level of detail and frequency that complies with legislation and guidelines.</td>
<td>6 months</td>
</tr>
<tr>
<td>3.1</td>
<td>3.1.4</td>
<td>PA Negligible</td>
<td>Finding: The Mary Potter Hospice has an established infection control programme due for review in August 2012. A report from the infection control nurse was prepared in July 2012 to inform the development of the 2012-13 programme and to establish a plan and priorities for implementation of infection prevention and control in the organisation. This document is yet to be ratified by senior management. Action: The infection control programme is current and approved by senior management.</td>
<td>6 months</td>
</tr>
</tbody>
</table>
## Continuous Improvement (CI) Report

**Provider Name:** Mary Potter Hospice  
**Type of Audit:** Certification audit  
**Date(s) of Audit Report:** Start Date: 16-Jan-13  
**End Date:** 18-Jan-13  
**DAA:** The DAA Group Limited  
**Lead Auditor:** Sylvia Meijer

<table>
<thead>
<tr>
<th>Std</th>
<th>Criteria</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| 1.1.8 | 1.1.3.1 | Finding:  
The provision of an environment which encourages good practice, including evidence-based practices at Mary Potter Hospice is rated beyond the full attainment due to implementation of a researcher role and research projects, the establishment of a resource role focused on implementing clinically accepted good practices, particularly in relation to falls and pressure injury prevention and use of benchmarking data to inform practice as well as the implementation of a number of quality action plans. Good clinical practice occurs within a culture and environment of regular audit and quality improvement activities. |
| 1.3.3 | 1.3.3.4 | Finding:  
The coordination of services which promotes continuity of service delivery at Mary Potter Hospice is rated beyond the full attainment due to the integration of the electronic patient management system (Falcare) into the daily practice and its utilisation as an effective tool for ensuring currency of patient information across the wider service as well as for planning, evaluating and reviewing patient care needs. |
| 1.3.5 | 1.3.5.3 | Finding:  
The integration of service delivery plans is beyond the full attainment level, with evidence of a close working relationship and input between the multidisciplinary team members as they work collaboratively to identify and establish goals and appropriate interventions for individual patients. |
NEXT STEPS:

- The reports and findings have been circulated to the Executive Team, Team Leaders Forum and the Professional Advisory Committee requesting review of recommendations.
- Approved action items from the recommendations will be linked to team action plans as appropriate.
- Work with the Communications Team to publish findings of audit on website and through media.
- Reports and findings will be linked to the annual Clinical Governance report and linked to the current Hospice NZ self assessment.

Teresa Read, Quality Manager

May 2013
### How? Quality and Risk Management Framework

The Governing Body of Mary Potter Hospice leads the Organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

<table>
<thead>
<tr>
<th>PLANNING</th>
<th>SETTING STANDARDS</th>
<th>SERVICE DELIVERY</th>
<th>MONITORING</th>
<th>EVALUATING AND REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are we going to do?</td>
<td>What are we trying to achieve?</td>
<td>What change can we make that will result in an improvement?</td>
<td>Did we meet our standards and targets?</td>
<td>How will we know that change is an improvement?</td>
</tr>
</tbody>
</table>

#### Guidance from the Board through the Chief Executive and the Executive Team.

- MPH Strategic Plan (including specific reference to quality and risk management issues)

- Quality Plans promote a culture of quality improvement and are influenced by:
  - MPH philosophy and values
  - Patient and family satisfaction surveys
  - Risk identification and analysis framework (assists prioritisation of improvements)
  - Evidence of outcomes so data can be used for evaluation

- External Factors Influencing planning:
  - CC DHB Palliative Care Strategy
  - National PallCare Strategy
  - MoH Service Specs for Specialist Pall Care
  - EQuIP4 Accreditation
  - OPS Hospice Benchmarking
  - Hospice NZ standards
  - Health and Disability Sector Standards
  - Research publications in Palliative Care

- Provider Quality
  - Contract with CC DHB
  - Leadership in quality that is devolved to all teams

- Credentialeding
  - A process is in place for credentialing and defining the scope of clinical practice

- Policies & Guidelines developed by MPH to ensure:
  - Compliance with legislation, external standards, internal requirements
  - Evidence-based best practice
  - Evidence of evaluation and comparative analysis

- Establishing measures and setting targets
  - KPIs linked to all policies
  - Benchmarking
  - Quarterly Incident Management Analysis

- Clinical Support
  - Diagnostic Services
  - Infection Control
  - Pharmacy
  - Equipment

- Non-clinical Support
  - Facilities, Information Services, Human Resources, Finance, Business Support / IT, Quality and Risk

- Projects
  - As set out by xxx plan

- Risk Management
  - A well coordinated, organization-wide risk management system is documented, implemented and integrated into services.

- Emergency Management

- External Factors that influence our standards:
  - Legislation and regulations
  - MoH Certification Standards
  - Accreditation Standards
  - Evidence-based best practice

- External Factors
  - Information flows with patients and their families
  - Other providers e.g. referral and discharge information
  - Supplier contracts

- CliniCal ServIceS
  - Quality recruitment & orientation
  - Staff Continuing Professional Development
  - Policies and research to ensure evidence-based care

- Audits
  - Clinical
  - Quality and risk
  - External e.g. certification, accreditation
  - Infection Control
  - See Audit Calendar

- Patient Satisfaction
  - Compliments and complaints
  - Satisfaction surveys
  - Caregiver surveys
  - Consumer representation.
  - Pall Outcome Scores

- Reportable Events
  - Incidents, accidents, near misses
  - Root Cause Analysis

- Staff satisfaction surveys

- Performance Monitoring
  - Performance reviews
    - Individual and organisation
    - peer reviews
    - Supplier contract compliance

- External Factors that influence our monitoring and reporting:
  - MOH Quality and Risk
  - Reporting Requirements
  - Balanced scorecard reporting
  - OSH requirements

- Risk Management
  - Quarterly review of Risk Register
  - Present register to Board annually.

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**Appendix 1**

- CCDHB contract reports
- External Audit & Accreditation reports
- MPH Annual Report

- Quality & Risk Management
  - Quality and Risk reporting occurs:
    - Internally for key committees and the Executive team
    - Risk Register reviewed quarterly by Executive team
    - At appropriate intervals to Board

- Reporting informs the next annual planning round and results in changes to service level Quality and Risk Plans as needed to address negative trends or adverse outcomes.