DAA Group

Focus on Quality

Mary Potter Hospice

EQuIP5

Organisation-Wide Survey

January 2016

Wellington admin@daagroup.co.nz
Christchurch info@daagroup.co.nz
www.daagroup.co.nz

Contents

INTRODUCTION 3
CRITERION RATINGS 4
RATING SUMMARY REPORT 5
RISK MANAGEMENT MATRIX 7
OVERVIEW 9
CLINICAL FUNCTION OVERVIEW 10
CLINICAL FUNCTION 12
SUPPORT FUNCTION OVERVIEW 25
SUPPORT FUNCTION 27
CORPORATE FUNCTION OVERVIEW 36
CORPORATE FUNCTION 38

INTRODUCTION

CLIENT NAME	Mary Potter Hospice
ADDRESS	48 Mein Street Newtown Wellington
POSTAL ADDRESS (if different to above)	P.O. Box 7442 Newtown Wellington
INTERNET ADDRESS	www.marypotter.org.nz
SCOPE OF SERVICES	Provision of Medical – Hospice Services
SURVEY TEAM	Robin Steed Glenda Ray Chris Hendry (trainee)
CLIENT REPRESENTATIVES	Teresa Read

Please advise the DAA Group office if any of the details are incorrect.

CRITERION RATINGS

Each criterion is rated by the organisation and the surveyor team with one of the following ratings:

- LA
- SA
- MA
- EA
- OA

The rating levels are:

LA – Little Achievement: Organisations that achieve an LA rating will have knowledge of responsibilities and systems that need to be implemented but may have only basic systems in place. At this level, there will be compliance with legislation and policy that relates to the criterion.

SA – Some Achievement: An organisation that achieves an SA rating will have achieved all the elements of LA and will have implemented systems for the organisation's activities. At this level, there is very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Marked Achievement: An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems for collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement: All the elements of LA, SA and MA must be achieved. Organisations will also be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:

- internal or external benchmarking and subsequent system improvement, and / or
- research that relates to that particular criterion, and/or
- the implementation of advanced systems that relate to that criterion, and / or
- proven, excellent outcomes in that particular criterion.

Some organisations may be able to demonstrate achievement in more than one of these elements.

OA - Outstanding Achievement: The elements of SA, LA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that the organisation is the best in New Zealand. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

High Priority Recommendations (HPR)

These are applied to a particular criterion where:

- consumer / patient care is compromised and / or
- the safety of consumers / patients and / or staff is jeopardised.

Surveyors complete a risk assessment to validate their decision to allocate a high priority recommendation. A HPR should be addressed by the organisation in the shortest time possible.

RATING SUMMARY REPORT

Function	Criterion	Organisation's Rating	Surveyors' Rating
Clinical	1.1.1	EA	EA
Clinical	1.1.2	EA	EA
Clinical	1.1.3	EA	EA
Clinical	1.1.4	EA	EA
Clinical	1.1.5	EA	EA
Clinical	1.1.6	EA	EA
Clinical	1.1.7	EA	EA
Clinical	1.1.8	EA	MA
Clinical	1.2.1	EA	EA
Clinical	1.2.2	EA	EA
Clinical	1.3.1	EA	EA
Clinical	1.4.1	EA	EA
Clinical	1.5.1	EA	EA
Clinical	1.5.2	EA	EA
Clinical	1.5.3	EA	EA
Clinical	1.5.4	EA	EA
Clinical	1.5.5	MA	MA
Clinical	1.5.6	EA	MA
Clinical	1.5.7	MA	MA
Clinical	1.6.1	EA	MA
Clinical	1.6.2	EA	MA
Clinical	1.6.3	EA	EA
Support	2.1.1	EA	EA
Support	2.1.2	EA	EA
Support	2.1.3	EA	EA
Support	2.1.4	EA	EA
Support	2.2.1	EA	MA
Support	2.2.2	EA	EA
Support	2.2.3	EA	EA
Support	2.2.4	EA	EA
Support	2.2.5	EA	EA
Support	2.3.1	EA	MA
Support	2.3.2	EA	MA
Support	2.3.3	EA	MA
Support	2.3.4	EA	MA
Support	2.4.1	EA	EA
Support	2.5.1	EA	MA
Corporate	3.1.1	EA	EA
Corporate	3.1.2	EA	EA
Corporate	3.1.3	EA	MA
Corporate	3.1.4	EA	MA
Corporate	3.1.5	EA	EA

Corporate	3.2.1	EA	EA
Corporate	3.2.2	EA	MA
Corporate	3.2.3	MA	MA
Corporate	3.2.4	EA	MA
Corporate	3.2.5	MA	MA

RISK MANAGEMENT MATRIX

This risk management matrix was used to determine the risk rating for any partially attained or unattained criterion, and the timeframe for the corrective action response.

		Likelihood					
	Level of Risk	The likelihood of this occurring is **almost certain**	The likelihood of this occurring is **likely**	The likelihood of this occurring is **moderate**	The likelihood of this occurring is **unlikely**	The likelihood of this occurring is **rare**	**Action Required**
Consequences	The consequences of these criteria not being met would put consumers at **extreme risk of harm or actual harm is occurring**	**Critical**	**Critical**	**High**	**Moderate**	**Low**	**Critical** This would require immediate corrective action in order to rectify the identified issue including documentation and sign off by the auditor within 24 hours to ensure consumer safety
	The consequences of these criteria not being met would put consumers at **significant risk of harm**	**Critical**	**High**	**Moderate**	**Low**	**Negligible**	**High** This would require a negotiated plan in order to rectify issue within **one month** or as agreed between the service and auditor
	The consequences of these criteria not being met would put consumers at	**High**	**Moderate**	**Moderate**	**Low**	**Negligible**	**Moderate** This would require a negotiated plan in order to rectify issue within **three**

	moderate risk of harm						**months**
	The consequences of these criteria not being met would put consumers at **minimal risk of harm**	**Moderate**	**Low**	**Low**	**Low**	**Negligible**	**Low** This would require a negotiated plan in order to rectify issue within six months
	Risk of harm is **insignificant even if these criteria are not met**	**Low**	**Low**	**Negligible**	**Negligible**	**Negligible**	**Negligible** This would require **no additional action or planning**

OVERVIEW

The organisation wide survey (OWS) against the EQuIP 5 Standards at Mary Potter Hospice took place over three days from 26 – 28 January 2016. At the same time the organisation was audited against the Health and Disability Services Standard (NZ 8134:2008). Located in Wellington the Hospice provides inpatient and community care to the greater Wellington, Porirua and Kapiti Coast communities. The hospice is highly rated in the region and is a very active member of Hospice NZ. A strong clinical and management team deliver quality services to patients and family/whanau. Corporate and support services are effective and efficient in supporting clinical services.

CLINICAL FUNCTION OVERVIEW

The commitment and enthusiasm of the clinical team is evident in so many aspects of care. Staff engagement and willingness to be part of quality improvement projects is commendable. High quality innovations have been put into practice by staff members who are active in achieving the best outcomes for patients. The service is 'values based' and this is evident throughout the projects viewed and staff and patient interviews.

There is a comprehensive assessment process for patients, often with members of their family, to ensure that their needs are identified, planned and managed accordingly. The assessment process includes identifying risk through a variety of risk assessments that are undertaken.

Care is delivered by a specialist multidisciplinary inpatient and community team using a consultative, collaborative approach that actively involves the patient and family. The multidisciplinary team (MDT) contribute to care plans and there is good evidence of these being kept up to date as situations or conditions change.

The process of consent is well understood within the organisation and there is a robust policy and supporting information for clinicians. Patients and families reported being very well informed.

There is a strong sense of evaluation throughout the service, which occurs at multi-levels to ensure that the best possible outcomes for patients are delivered. Formal multidisciplinary patient review meetings occur and the nursing and medical team evaluate care and response to treatments, daily for in-patients and regularly for community patients.

The palliative care co-ordinators provide continued support for patients who are discharged home or to aged care facilities, to achieve better outcomes for patients. A triage system for prioritising referrals has been introduced to streamline the process of referral and transfer, and avoid duplication of care from both services.

The organisation uses an End of Life Pathway (EOL) with nurse specialist roles to liaise and support the residential care facilities. This is increasing the effective ongoing care and improving patient outcomes within the residential care services in the area. Individual care plans and the EOL pathway, guide and anticipate the care needs of the dying patient and support for the family/whānau is provided.

Patients' health records are well documented and maintained efficiently. The service's policy ensures that health information is managed in a manner that meets the requirements of appropriate legislation and sector standards.

Advice and support is available 24 hours a day, seven days a week to community care providers/medical staff and patients and families. There has been a focus on developing relationships and partnership with all involved in both day-to-day care of patients and palliative care services. Coordination of care to ensure that patients are followed up in the community is well established. Clear processes are in place with regard to access to hospice services including a comprehensive website with information for referrers.

There are very clear clinical criteria in place for the prioritisation of services. Referral and admission information is monitored and trended to enable the service to identify timeframes for entry to services and determine any improvements or changes that can, or need to be made to improve access to the service. The use of the QPS benchmarking processes allows for some comparisons to be made between Mary Potter and other similar providers. The dedicated triage nurse ensures appropriate and efficient acceptance of referrals.

Mary Potter Hospice is commended on their work to continue to develop services in the in-patient unit (IPU), community, day programme and work with general practitioners (GPs), aged care facilities, the district nursing service, the Capital and Coast District Health Board (CCDHB) palliative care team as well as other community health services. They demonstrate they are committed to providing palliative care services in the most appropriate setting.

Clinical practice is based on research and evidence based practice. The commitment and enthusiasm towards developing policies and guidelines based on this research in commendable.

Medication management is a strength of the organisation. The service has a contracted onsite pharmacist who oversees the medication management processes and is a valuable resource for staff and patients. Review and monitoring of medication management processes is a major focus of the organisation to ensure current best practice and to identify and address areas for improvement.

The organisation has developed a very good infection control programme which is appropriate for the size and type of organisation. Robust policies and processes are implemented. Infection prevention and control information is shared with staff through education sessions, newsletters and handovers. Infection control information is also shared via the national Hospice NZ (HNZ) network.

The audit team was inspired by the work undertaken by the passionate and committed staff who have undertaken outstanding projects in pressure injuries and falls reduction. Attention to detail in these projects and the ability to engage other staff members to achieve the aims of reducing falls and organisation acquired pressure injuries, is achieving results. Both projects are leading the way for hospices in New Zealand but they are yet to be evaluated and there is a recommendation to do this in the future.

The hospitality team, in accordance with Mary Potter's value of hospitality, is commended. This unique service, in addition to the food catering service, is an innovation that is very much appreciated by the patients.

Strong relationships are in place with the local Maori and there are good relationships with other stakeholders in the community. The innovations undertaken to engage Maori with the service and to promote the service to the community and to educational health institutes, is outstanding.

All requirements of the Code of Health and Disability Services Consumers' Rights legislation are being met. Patient and family surveys are undertaken annually and indicate a high degree of satisfaction with the services provided. There is a high level of patient, family/whanau and community input into service planning, however this needs to be strengthened by the development of policy to guide staff actions.

CLINICAL FUNCTION

Standard 1.1: Consumers/patients are provided with high quality care throughout the delivery process.

Criterion 1.1.1 Assessment ensures current and ongoing needs of the consumer / patient are identified.

Organisation Rating: EA Surveyor Rating: EA

Surveyor's comments:
Assessment and care planning policies are appropriate, evidenced based and current. Assessment processes are multidisciplinary, comprehensive, identify the patient's needs and inform the care plan. The physical, psychological, spiritual and social needs of each patient and their family/whanau are assessed during this process and are guided by core care plans.

The assessment process is recorded on what was described as a "living document". Assessments are ongoing and updated regularly and as things change, and care plans are changed accordingly.

A regional project has been undertaken to ensure that all referrers in the region have access to the same referral tool and this is widely available in the Capital and Coast District Health Board (CCDHB) and on the Mary Potter website. Use of a single referral document, ensures consistency of information giving a more efficient and timely response to the referral.

The service has undertaken reviews of assessment tools and has introduced evidence based tools that have been subsequently reviewed. These include considerable work around falls and pressure injury assessment tools. Cultural assessment has been a major project. This work has been shared with other hospices in regards to Palcare application, and further reviews have come from this collaboration.

Criterion 1.1.2 Care is planned and delivered in collaboration with the consumer/patient and when relevant, the carer or family/whanau to achieve the best possible outcomes.

Organisation Rating: EA Surveyor Rating: EA

Surveyor's comments:
There is a focus on ensuring services are planned in partnership with the patient and family/whanau. Policies and guidelines related to care planning are current, evidenced based and comply with legislation and professional standards.

The service is rightly proud of its core care plan guidelines that have been developed, implemented and reviewed on an ongoing basis and these documents have been shared with a number of other hospices.

All care is based on the patient's assessment and changes to the care plan are made when a patient is re-assessed at regular intervals or when a patient's need changes. The daily MDT meeting in the in-patient

unit (IPU) is used to discuss patients' goals and progress towards these. Patients in the community are assessed at each visit and via MDT meetings. Advance care planning (ACP) is documented in the patient's notes.

The care planning process is audited and the outcome of some of these audits have resulted in additional education and more support for the community team, with good outcomes.

The day programme which provides social, recreational and educational activities has recently been reviewed and restructured with more focus on what patients want, and focuses on these goals. There is an annual programme for the service and a wide variety of activities is offered. The Day Services delivers the Carer Education Programme.

Patients receive appropriate and competent care in a timely manner. Patients and family/whanau reported a timely response from staff when they require support. Patients were complimentary of the care they received.

Criterion 1.1.3 Consumers/patients are informed of the consent process, and they understand and provide consent for their health care.

Organisation Rating: EA Surveyor Rating: EA

Surveyor's comments:
There is good knowledge of the principle of consent and patients and families spoken with are comfortable that they are given good information to help with their decision making. There are appropriate policies to guide practice and specific consent processes for some procedures. Informed consent is regularly audited.

Staff education on the consent process, ethics and advance care planning is provided on orientation and at mandatory study days. Staff stated that consent and ethical aspects of care are discussed in case reviews and handovers. Resources are readily available and staff were observed using these.

Mary Potter Hospice has made comparisons of their policy and education on informed consent with other hospices and the local CCDHB.

Criterion 1.1.4 Outcomes of clinical care are evaluated by health care providers and where appropriate are communicated to the consumer/ patient and carer.

Organisation Rating: EA Surveyor Rating: EA

Surveyor's comments:
There is a strong culture of evaluation of services throughout Mary Potter Hospice. There are a number of audits undertaken and patient/family feedback is sought, and utilised, to improve services. Services are

evaluated using the Hospice New Zealand (HNZ) QPS benchmarking programmes. The peer review undertaken by HNZ shows an excellent result. The service incorporates the EQuIP5 criteria in any project work they undertake.

Daily review meeting by the MDT includes evaluation of care of all patients in the IPU. Patient care is also evaluated when a patient's needs change. The evaluation process and rationale for change to care is documented in the patient's notes. Handover and patient notes show that patients have input into all aspects of their care.

Staff reported that case reviews are a major contributor to evaluation of care outcomes and reflective practice. These reviews are not always focused on clinical care but might reflect on all aspects of the service and improvements can be made and awareness heightened as a result of these reviews.

Complaints and incidents are also used for evaluation; one example of a complaint reviewed led to a review of 'place of death'.

Comparisons of aspects of care are often made with other hospices and improvements are made accordingly.

Criterion 1.1.5 Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
Guidelines provide information for the discharge process. The embedded referral processes between services for hospice patients and family and discharge information is well documented. Discharge planning is flagged early for patients, family and clinicians, as evidenced in the patients' records reviewed. The MDT, which may also include external health providers that are appropriate for each situation, review patients with complex needs, to ensure there are adequate supports implemented to address the patient's needs.

Family meetings which are integral to the discharge process, are held, and funding approval for other services is gained prior to discharge. All patients have discharge letters sent to the appropriate services and clinicians that clearly indicate the patient's needs and ongoing care.

The hospice regularly evaluates and reviews its discharge processes, both formally and informally. The hospice has a strong emphasis on working collaboratively with external partners and services, such as GP teams, aged care facilities and district nurses.

The ongoing work with the Enhanced Community Service model facilitates "navigating across providers" to ensure that people do not "fall through the cracks". There is an opportunity to evaluate this model of care, in particular the discharge process, to retain this EA rating in the future.

Criterion 1.1.6 Systems for ongoing care of the consumer/patient are coordinated and effective.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The service developed a triage system in 2015. This means a dedicated process for the triage of referrals to give improved continuity. Referral times are monitored. Palliative Care Coordinators are responsible for the coordination of care in the community and this involves liaison with a variety of service providers.

The multidisciplinary approach to care is a feature of the service. This not only involves Mary Potter staff members but external care providers that may be associated in the care of a patient/family, for example district nurses and oncology district nurses. There is a strong relationship with the DHB and a number of clinical nurse specialists, including community mental health and dietetic services.

The service has been active in providing education for carers. There has been collaboration between Mary Potter Hospice and other hospices to compare this education, resulting in the review of patient information brochures. This training has had excellent feedback from patients and carers.

Staff across the service receive education, updates and information on ongoing management of the patient (such as pain management, cultural support). Education includes MDT debriefs, bereavement support and clinical reviews.

Criterion 1.1.7 The care of the dying and deceased consumers/patients is managed with dignity and comfort and family and carers are supported.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The service's philosophy around preparing patients and family/whanau for the dying process with warmth and dignity is based on patient and family wishes and needs. Mary Potter Hospice provides palliative care and symptom management education and support to the aged care sector and the community. Individual care plans and the End of Life (EOL) pathway guide and anticipate the care needs of the dying patient and support for the family/whānau is provided.

Staff have undertaken extensive education in advance care planning for end of life and provide this education for aged residential providers and home based support workers. Education was delivered around the transition plan from the Liverpool Care Pathway (LCP) to the EOL. Additionally there has been public education on end of life, with a public lecture in 2015, "The Dying Room" which was very well received.

An internal review and external benchmarking processes provide opportunities for improvements to service delivery and ensure best practice. The service continues to evaluate the EOL pathway and makes changes where appropriate.

This aspect of care is a particular strength of the organisation and they are encouraged to further develop their aggregated clinical results to continue to make improvements in this area and demonstrate they are a leader in end of life care in the Wellington area and nationally, thus moving towards an OA rating.

Criterion 1.1.8 The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
All patients have a comprehensive electronic record of care using PalCare. The electronic patient record management system is integrated across the IPU and community team and is also available to GPs.

Any hard copy patient notes e.g. medication charts, referral letters, are scanned and destroyed after discharge. There are good processes around archiving of patient information. Robust auditing of PalCare ensures that only appropriate staff access patients' files, thus protecting patient privacy and confidentiality.

There is good user feedback, weekly, to the PalCare vendor, with one staff member being on the Australasian Palliative Care Users Group (PUG). Feedback is given to staff as training so that all staff are kept up to date with any changes to the programme.

The service recognises that it may not be using PalCare to its best advantage and is encouraged to continue to review, evaluate and make improvements to practice and training in the programme.

Surveyor's recommendation
It is recommended that:
The continued improvements to the PalCare programme and training be evaluated

Standard 1.2: Consumers / patients / communities have access to health services and care appropriate to their needs.

Criterion 1.2.1 The community has information on health services appropriate to its needs.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The service has a website that provides valuable information to referrers as well as access to Healthpoint. Information brochures are supplied to the GPs and other referrers within the community to facilitate appropriate access and a smooth transition into the service. There is a 24 hour, seven day a week, support and advice service to community medical staff and patients and families.

Staff are actively engaged in finding ways to ensure that patients have information about the service, there has been a public meeting, the Maori story telling programme, newsletters, a public quiz night and public speaking engagements. There are many fundraising activities, and hospice shops, that give profile for the service within the community.

There is clear and relevant information provided to patients and their families both from the IPU and community palliative care team. The organisation has evaluated the content of their information brochures to ensure the information provided is current and user friendly.

There is an opportunity to provide referrers with links to the referral form through Healthpoint.

Criterion 1.2.2 Access and admission / entry to the system of care is prioritised according to healthcare needs.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
Policies guide access and admission processes.

The services operates at times to ensure the needs of the patient group are met. Patients are admitted from other services in the referral area, based on assessment from the specialty team they are admitted under, and in accordance with, known entry criteria. There has been regional collaboration, led by Mary Potter, on the referral form which is now used by all referring DHBs. The dedicated triage registered nurse position has reportedly enhanced the triage process and the acceptance of referrals.

Admissions to the IPU are usually planned. Referrers are in communication with the inpatient unit's on call palliative care specialist to determine admission timeframes. Requests for IPU access are triaged if there is a demand on the resources, and timeframes for admission to IPU (if required) are provided (see 1.1.6). There is daily liaison between the community team, the IPU and the hospital palliative care team in regards to patients who may be waiting for admission to the IPU.

Referral information is monitored quarterly through the audit process with QPS benchmarking and the referral criteria statistics have been compared to another hospice.

Standard 1.3: Appropriate care and services are provided to consumers / patients.

Criterion 1.3.1 Health care and services are appropriate and delivered in the most appropriate setting.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The required interventions for each patient are personalised and describe how to achieve the stated goal or outcome, which are based on assessments undertaken. The care plan includes the identification of assessed issues, the action taken and the patient response to the action – this gives a clear indication regarding treatment tried and which actions have worked for the patient. On-going assessments include pain assessments, skin integrity, falls risks, emotional needs and family support to ensure the desired goals are being met. The availability and use of advance care plans for patients is encouraged, to enable them to help communicate their future care wishes.

The multidisciplinary review process is instrumental in the decision making, along with the patient and their family about where the most appropriate place is for them to be receiving care. This question arises in the discharge planning process and is worked through with the patient and family. The work undertaken on the Enhanced Community Model, which has looked at the future demand for palliative services, has reviewed all aspects of where and how care is delivered, both now and in the future. This commendable project has focused on delivering the most appropriate services.

There is an opportunity for future evaluation of project outcomes to maintain this EA rating.

Standard 1.4: The organisation provides care and services that achieve effective outcomes.

Criterion 1.4.1 Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
Clinical staff are committed and enthusiastic about research to ensure best practice and to develop evidence based guidelines. Policies and procedures, guidelines and protocols based on best practice are available to all who staff who use these to direct practice.

The organisation utilises benchmarking with national organisations and provides services that reflect international best practice in palliative care to ensure the best patient outcomes. The service uses

validated, palliative care assessment tools, symptom management guidelines, and medicine management.

Team members are involved regionally and nationally in projects within the sector and are active in presenting project outcomes at conferences and sharing results with other hospices.

Standard 1.5: The organisation provides safe care and services.

Criterion 1.5.1 Medications are managed to ensure safe and effective consumer / patient outcomes.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
Detailed policies and procedures are in place related to management of medications and align with current best practice guidelines.

Medication errors are reported through the incident processes and issues are identified and addressed. A number of initiatives have been put in place over time to eradicate medication errors and there is good compliance shown in regular audits.

The pharmacist is working collaboratively with another hospice to compare labelling, dispensing, and administration of medication.

A training package, to support care givers to manage emergency sub-cutaneous medication in the home, has been introduced. This was researched amongst other hospices and the outcomes are being shared. The project has led to review of policy, new patient information brochures and a carer competency checklist. Staff reported that the training package has received excellent feedback, but is yet to be formally evaluated.

National input into Palcare regarding medications is ongoing and has resulted in a 'yellow card' reconciliation process on discharge that has a double check process.

Surveyor's recommendation
It is recommended that:
The training resource package for caregivers is evaluated and improvements made where possible.

Criterion 1.5.2 The infection control system supports safe practice and ensures a safe environment for consumers / patients and healthcare workers.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
A comprehensive system is in place to ensure the implementation of an infection control programme and policies. The Infection Prevention and Control Programme is reviewed annually by the infection control coordinator in conjunction with the Infection Prevention and Control Nurse Specialist (IPC CNS) from the CCDHB. There is external training provided from Bug Control. The infection control programme and policies supports safe and best practice. Policies are current and comply with legislative requirements.

Surveillance is conducted as per the programme schedule and is activated for all infections that have a positive laboratory result. Surveillance data is benchmarked with other hospices and via local networks.

The service restructured its committees in 2015 and infection control is now incorporated into the Health and Safety Committee, both of which report to the Clinical Governance Group. The new system is reportedly working well and has improved attendance and feedback to staff.

Mary Potter Hospice infection control network is well established and includes meetings with CCDHB infection control group. There are online infection control forums, staff attendance at conferences, as well as participation in national infection control groups.

Criterion 1.5.3 The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised wound prevention and management programs.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
Mary Potter Hospice has a RN, who is the 'Pressure Injury Champion' resource, and who is passionate about pressure injury prevention. This RN has led the SKINS Bundles of Care Approach as part of her professional development and has gained staff commitment and enthusiasm to managing pressure injuries. The project has been endorsed by the New Zealand Wound Care Society and includes a number of initiatives including, the introduction of health care assistants' core competency skill framework, education for all IPU nurses, and information brochures. All of these resources that have been developed have been shared with other hospices. The project has also featured in the Health Quality & Safety Commission NZ newsletter.

Significantly, results show that in the first quarter of 2015 no patients developed a pressure injury during and IPU admission. There is an opportunity to benchmark this success with other like organisations. The service captures pressure injury data through the reportable event process. This is benchmarked against other hospices through the QPS benchmarking process; however, this clinical indicator does not suitably separate those pressure injuries acquired in the IPU. The medical director is on the Hospice NZ committee that is working towards developing further clinical indicators.

Developed as an in-patient unit project, there is an opportunity for it to be adopted into the community in collaboration with the district nursing service.

Surveyor's recommendation
It is recommended that:
A suitable benchmarking partner to compare data around pressure injuries acquired in the IPU.

Criterion 1.5.4 The incidence of falls and fall injuries is minimised through a falls management program.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
As with pressure injuries there has been considerable commitment and passion expended on the falls programme at Mary Potter Hospice. A group of enthusiastic clinical staff, including the physiotherapist and occupational therapist, have combined their skills to form a falls working party to develop an effective package of resources and education to minimise falls in the IPU.

Key to the process was to re-evaluate the risk assessment tool and adopt the new tool recommended by the Health Quality and Safety Commission (HQSC) called Triple A. Some of the initiatives implemented have been to develop a daily environmental check list for health care assistants, signage, posters, and education for patients, family and staff.

Falls are monitored through the incident management process. Falls management includes reviewing the contributing factors and implementation of corrective actions. Results and outcomes are compared to previous data, trends are noted, and actions implemented where indicated. The IPU has demonstrated that falls have been reduced 48% since the implementation of the falls programme. Results are benchmarked with similar services through the QPS benchmarking process.

Although it appears obvious that this programme has reduced falls, it is yet to be formally evaluated.

Surveyor's recommendation
It is recommended that:
The falls prevention programme be evaluated and further changes be made as a result.

Criterion 1.5.5 The system to manage sample collection, blood, blood components / blood products and patient blood management ensures safe and appropriate practice.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
Policies and procedures are in place to direct practice and are reviewed in collaboration with the blood bank at the hospital.

Mary Potter Hospice has a close working relationship with Wellington Hospital where the blood bank is located. Being just across the road there is no requirement for the hospice to have a blood fridge as blood is delivered and administered according to the cold chain requirements the same as is required in the hospital. The Blood Bank evaluates the processes and reports to Mary Potter Hospice if any issues arise. Likewise staff report they are in communication with the NZ Blood Service should there be any queries or issues with the provision of blood or blood products within the service.

A separate consent form is signed by patients when they require blood. Registered nursing staff are required to have completed appropriate clinical competencies prior to being involved in the administration of blood or blood products. There is an IV resource nurse who is able to guide practice.

Criterion 1.5.6 The organisation ensures that the correct consumer / patient receives the correct procedure on the correct site.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
Policies, procedures and informed consent processes are in place to ensure the patient receives the correct procedure (e.g., medication administration, abdominal paracentesis) on the correct site. There is always discussion with the patient prior to any procedure being undertaken.

An incident reporting system is in place to report any incidents or "near misses" in this area. There have been no such incidents reported.

Criterion 1.5.7 The organisation ensures that the nutritional needs of consumers / patients are met.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
A well-established catering company is contracted to provide the food service. There is an audited food safety programme and they are able to provide dietetic advice. Menus are followed on a five weekly cycle but the focus is giving patients what they want to eat. Staff have access to patient meals after hours.

Mary Potter Hospice has a hospitality team, in accordance with their value of "Hospitality". This is a unique service where dedicated members of the team are the liaison between patient, clinical staff and the kitchen. This is a patient focused approach to the food service. This team member spends time talking to the patients, discussing their likes and dislikes and adapting the day's menu accordingly. There is a facility to make smoothies and the like whenever the patient desires. Patients spoken with talked about the importance of food to them and that they love this service.

There is an opportunity to evaluate this unique service formally and/or compare it externally to take this rating to an EA.

Standard 1.6: The governing body is committed to consumer participation.

Criterion 1.6.1 Consumers / patients, carers and the community participate in the planning, delivery and evaluation of the health service.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The hospice seeks input from consumers, family/whanau and communities in planning, implementing and evaluating the service. There is formal consultation with Te Pou Tau Toko Group (advising on cultural responsiveness), the Consumer Advisory Group and various forums that staff and managers attend. Feedback from surveys from patients, family/whanau and volunteers are also analysed and utilised.

There is clear evidence that information gained from consultation is included and influences hospice actions.

While there is strong input from the parties outlined above, this activity is not co-ordinated or guided by organisation policy or a framework. There is little evidence of education or support for individuals participating in the advisory groups. Development of a framework would provide a safer environment for committee participants.

Surveyor's recommendation
It is recommended that:
A policy and framework to manage patient, family/whanau and community input into service planning, delivery and evaluation is developed and implemented

Criterion 1.6.2 Consumers / patients are informed of their rights and responsibilities.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The organisation encourages patients, and where appropriate family/whanau, to be actively involved in their everyday decisions about their care and how they wish to live.

Patients and family/whanau are informed of their rights and responsibilities upon entry to the service with a comprehensive information pack. Patients' rights are also reinforced on each admission to the IPU.

Patients' rights information is discreetly displayed around the organisation and information in different languages is available when required. Information and support from advocacy services and translation services are also available when required.

All of the patients and family/whanau interviewed at the time of the survey confirm that they understood their rights and can articulate how to make a complaint, how well their dignity is upheld and that privacy needs are met. This is supported in patient and family satisfaction surveys.

Work has been undertaken to compare access to services, focus groups and a consumer research study have been undertaken.

There is an opportunity to evaluate the outcomes of these activities to attain the EA level.

Criterion 1.6.3 The organisation meets the needs of consumers / patients and carers with diverse needs and from diverse backgrounds.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is a strong commitment to reduce any barriers that might occur because of diverse need. Ethnicity data collected on admission has been collated and comparative data collected against similar services. The service has identified the common cultural groups represented and have developed a cultural liaison position for Maori and there is a plan to add a Pacific liaison position in the future.

The Maori Health Plan identifies key performance indicators which are reviewed and progress logged towards these each month.

The service actively works with clinical educational institutions to have an input into educating Maori students about Hospice, thus trying to ensure a diverse cultural staff mix in the future that will match patient needs.

With a large Maori and Pacific population in the community, education has been targeted to meet these requirements. One initiative, 'Storytelling', a public programme of Maori telling their stories about Hospice received wide media coverage on radio and television.

After a review of staff training in the Treaty of Waitangi, the training changed to incorporate a Treaty and Tikanga day on a marae annually, along with utilising Mataraki and Maori language week.

SUPPORT FUNCTION OVERVIEW

The support services are delivered to compliment clinical services and appropriate resource is allocated to allow this to occur.

The quality improvement system and the risk management systems are integrated. Quality improvement activities are prioritised and funded. Progress reports on achievements are reported and this information is circulated to staff. Audits occur with analysis of results leading to practice changes as necessary. Quality improvement is a component of all activity at Mary Potter Hospice with staff, management and the board committed to continuous improvement.

The risk register is regularly reviewed and updated. All new projects have risk assessments undertaken.

Incidents and complaints are well managed, each has an electronic database which holds all relevant information. Staff find incident forms easy to complete and there is evidence of investigation and resolution of incidents. Trending of incidents occur and these are discussed at staff meetings. There are few complaints received and these are managed by the chief executive. Complaints management complies with the Code of Health and Disability Services Consumers' Rights and complainants are informed of the right to independent advocacy.

The Human Resource Management System is effective and there is a low turnover of staff. Results from the 2014 Staff Satisfaction Survey show a high level of satisfaction amongst staff.

Workforce planning ensures adequate resource and skill mix are available to provide services. Recruitment processes are followed by managers who are supported by an HR practitioner. There is little evidence of use of performance measures in workforce planning and a recommendation is made accordingly. Orientation is provided to all new staff including volunteers. This is a mixture of face-to-face sessions, online training programmes and on the job experiences.

Staff performance is assessed formally annually using a standard tool which utilises self-assessment, reflection on performance and future learning needs. All staff interviewed indicated they had participated in a performance review within the last 12 months.

Learning and development is a strength with a large mandatory and core education programme available for staff. The education programme which is offered externally is well recognised and regarded in the region and nationally. The hospice provides training opportunities for nursing and medical students. There is a strong focus on staff health and wellbeing. An employee assistance programme (EAP) is offered as is formal professional supervision.

The IT and communication strategy is at a critical stage of change, moving from paper based to electronic. Resource is dedicated to implementing new systems. Some confusion is occurring with data collected and entered and a recommendation is made in relation to this.

There is a strong research culture with the joint appointment with Victoria University of a research fellow. The organisation is participating in research and undertakes a number of literature reviews. There is a committee to review proposals. The organisation needs to establish formal measures to evaluate its research activity and this is recommended.

Health promotion for staff and the community occur at the hospice. The staff take their organisation to the community, participating in community festivals and speaking at public forums.

A range of initiatives are in place to support staff and to recognise the stressful nature of their work, these include, additional leave, funding to attend specific programmes and free eye testing.

SUPPORT FUNCTION

Standard 2.1: The governing body leads the organisation in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

Criterion 2.1.1 The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is commitment to, and input into, quality improvement activity at all levels at Mary Potter Hospice. The annual board strategic workshop reviews and mandates management recommendations for the following year.

There is resource dedicated to coordinate and facilitate quality improvement activities and all staff have involvement in delivering on quality initiatives.

The quality improvement policy and framework prioritise current activities, which are allocated funding for implementation.

There are three major projects underway in the organisation, each of which have targets to improve the quality of care. These projects are running over a number of years and progress reports and evaluation of activities already undertaken are available.

In addition to these quality improvement activities, there is an extensive audit calendar covering all aspects of the service designed to measure compliance and identify deficits in service delivery. These audits are reviewed by the Professional Advisory Group (PAG) who make recommendations for changes to practices where needed.

The organisation has access to significant amounts of information through evaluation reports and benchmarking information. A natural next step is to undertake analysis of this material and plan and implement changes for the service.

The organisation reports to the board using a balance score card method and should consider reviewing the EQuIP 5 tool to identify areas where the collection of performance measure would provide relevant material for evidence of successfully achieving targets or for improvement activity options.

The hospice participates actively in the Hospice NZ Quality Managers Forum sharing information and working on joint projects.

A quality improvement culture is deeply embedded at Mary Potter Hospice and is the way staff approach their work each day. A future focus is to increase the amount of evaluation occurring especially in relation to systems and frameworks.

Criterion 2.1.2 The integrated organisation-wide risk management framework ensures that corporate and clinical risks are identified, minimised and managed.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is a risk management policy and framework that was reviewed in 2014 and this is linked to both the strategic plan and quality improvement planning.

The risk register covers all aspects of the service and rates risks while giving strategies and actions to manage and reduce each risk.

The register is formally reviewed annually by the board and three monthly by the chief executive. Additions to the register are made as required by resolution of the executive management group.

The register is available electronically to staff and identified risks are discussed at relevant staff meetings.

The three strategic organisation projects utilise the risk management framework and are regularly evaluated.

Risk management information is shared within the Hospice NZ network and the QPS benchmarking system.

Criterion 2.1.3 Healthcare incidents are managed to ensure improvements to the systems of care.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The organisation has an incident policy that guides staff in the management of incidents. The policy was recently reviewed to ensure compliance with national and internal guidelines and legislation and to identify any opportunities for improvement.

Staff report the forms are easy to complete, they are aware of how the system works, and they receive feedback on any incident they report.

Incidents are investigated by relevant managers and resolution actions implemented. The chief executive reviews all incidents and the quality manager collates, trends and analyses incident material which is summarised for the board.

There is an electronic database which holds all relevant information on each incident.

Open disclosure policy requirements are followed in all incidents.

Liaison for purposes of evaluation occur with Hospice NZ and the Health, Safety and Quality Commission.

Criterion 2.1.4 Healthcare complaints and feedback are managed to ensure improvements to the systems of care.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The complaints policy complies with legislation, in particular Right 10 of the Code of Health and Disability Services Consumers' Rights.

Complaints are managed by the chief executive who requests relevant managers to investigate complaints. Staff are trained on receiving and managing complaints.

The complaints register shows few complaints in the last year with all being closed within expected timeframes. Feedback is provided to staff in relation to complaints.

The chief executive trends complaint types and reports to the board. Complaints are all risk rated and changes made if required.

Complainants are informed of the right to independent advocates and information on these services is displayed and given to any complainant. There is an open disclosure policy and review of complaints material shows this is applied.

Complaints are benchmarked externally through the QPS benchmarking system. The organisation is encouraged to increase valuation of the system, perhaps involving complainants.

Standard 2.2: Human resources management supports quality health care, a competent workforce and a satisfying working environment for staff.

Criterion 2.2.1 Workforce planning supports the organisation's current and future ability to address needs.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
There are systems in place to ensure appropriate staff are available to deliver care. Human resources planning is linked to the strategic plan. An annual staff needs assessment occurs. There is a patient acuity tool that guides staff requirements shift by shift. There are minimal staffing levels and mix guidelines. Appropriate levels of delegation are in place to allow shift managers to call in additional staff if required.

As part of workface planning strategies for staff wellness are in place, these include professional supervision, an EAP programme, exit interviews and staff surveys.

While a number of evaluations methods are used, to take the rating to EA, specific performance measures for workforce planning need to be implemented.

The organisation recruits enough volunteers each year to meet organisation need.

Surveyor's recommendation
It is recommended that:
Performance measures for workforce planning are developed.

Criterion 2.2.2 The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is detailed information in the HR policy manual to guide and support recruitment of new staff.

Practices reflect good practice and compliance with legislation. Managers are supported by an HR practitioner through the recruitment processes, with training offered to less experienced managers.

The recruitment process includes, analysis of the replacement need and a review of the current job description. All applicants complete a core application form and police vetting occurs. All applicants are interviewed and have referee checks.

On appointment a comprehensive orientation is provided which includes core organisation induction and role specific orientation. Record of this completed orientation is held on the personnel file.

Evaluation of the recruitment systems occurs which includes feedback from new staff.

Mary Potter Hospice participates in HR benchmarking and uses this information in several areas including setting of salary levels.

There is a formal selection process to recruit volunteers. All applicants have an appointment interview prior to commencing work.

Criterion 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The organisation has a system in place to manage the performance and development of staff.

All staff and volunteers have a written job description that outlines their role, responsibilities and accountabilities. These job descriptions are reviewed annually at performance review and when a replacement appointment is being considered.

Performance review involving the manager and staff member happens formally each year with an initial review occurring three months after appointment. The review process involves a self-assessment, a review of competency and a plan for further education and development.

Staff have registration validated on employment and each year for required staff groups and annual practising certificates are sighted. Team leaders hold these records electronically. Personnel records are stored securely in a central location. They hold consistent and relevant information and are easy to review.

There is policy in place and staff are aware of how to manage a complaint about a clinician or other staff member.

The performance development system was evaluated during 2014 and found to be efficient and effective. External benchmarking occurs through the Hospice HR Managers Forum.

Criterion 2.2.4 The learning and development system ensures the skill and competence of staff and volunteers.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is an extensive leaning and development programme in place.

Core education programmes and sessions are offered to ensure staff competency, to address any performance deficits and to continue leaning for staff.

The organisation offers a comprehensive developmental education programme which is open to external organisations and individuals. It includes an annual symposium leadership programme, a series of tertiary level sessions and professional sessions. Students are offered experience at Mary Potter and formal arrangements exist with Massey University and Whitireia Polytechnic which include performance measures. Medical students from Wellington School of Medicine have training runs at the Hospice.

There is close liaison with Capital and Coast DHB to ensure nurses have access to their professional development pathway. There is significant resource dedicated to education and this is a real strength for Mary Potter Hospice.

Criterion 2.2.5 Employee support systems and workplace relations assist the organisation to achieve its goals.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There is a staff wellness policy which outlines in detail organisation commitment to support staff.

There are a combination of staff employed on individual contracts and other union collective agreements. Union members have ready access to delegates and management meets regularly with union officials. Staff on individual contracts report they are able to contact managers directly with any issues. The board undertakes an annual salary review of all individually contracted staff.

There is an EAP programme in place and information on how to access that service is displayed on staff notice boards.

Management has a positive approach to identifying and supporting "at risk" staff and readily implements plans to address staff issues. The biannual staff survey is due to occur in 2016. The 2014 survey was analysed and recommended changes have been implemented. The results of the 2014 survey have been benchmarked externally.

Standard 2.3: Information management systems enable the organisation's goals to be met.

Criterion 2.3.1 Health Records management systems support the collection of information and meet the consumer / patient and organisation's needs.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
Policy covers both hard copy and electronic record management. The National Health Index Number is being used to identify client records. The organisation uses PalCare as its electronic patient record system. While the service works with both paper and electronic records, they are beginning to move towards the development of a more integrated record, particularly in the hospice setting. As yet community based staff cannot access PalCare when in the client's home and continue to use written notes. As the community note taking is not standardised around the data required in the electronic record, there were some gaps identified during internal auditing of electronic patient records.

Surveyor's recommendation:
It is recommended that:
Material required for the electronic record is standardised.

Criterion 2.3.2 Corporate records management systems support the collection of information and meet the organisation's needs.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
The organisation has begun to systematise their corporate record keeping, much of which is now available on their intranet. The recent recruitment of a nurse to support staff training, particularly in the use of PalCare, demonstrates the organisation's commitment to moving towards the use of a fully electronic system. This is expected to escalate the pace of uptake by nurses in the use of IT.

Evaluation of the corporate record management system be undertaken once updating/installation of all components is completed.

Criterion 2.3.3 Data and information are collected, stored and used for strategic, operational and service improvement purposes.

Organisation rating: MA **Surveyors Rating: MA**

Surveyor's comments:
Data is being extracted and the organisation is beginning to use it for service benchmarking with other hospices. This has identified some problems with lack of a shared terminology, hence it is not yet being used within the service to monitor and evaluate service innovation with confidence. The organisation is monitoring both clinical and non-clinical data. Staff undergo training. The organisation is active at a national level with PalCare software development and has plans to use data more actively within the service in the future.

Surveyor's recommendation:
It is recommended that:
Resolve the identified problems with lack of shared technology.

Criterion 2.3.4 The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
The IT strategy identifies a plan for integration of e-records, but the organisation is, at this time, still reliant on paper as the first source of information for the electronic record. This results in 'double handling' as information gathered in the community needs to be entered into the system at a later date, not necessarily by the person who collected it. The organisation is undergoing rapid change. The strategic plan outlines the future direction of information and communication technology. An analyst is soon to be employed so that more meaningful use can be made of currently available data and inform the development of organisation wide reporting.

Business continuity is in place to recover the organisation's data in case of sudden loss of service.

Standard 2.4: The organisation promotes the health of the population.

Criterion 2.4.1 Better health and wellbeing is promoted by the organisation for consumers / patients, staff, carers and the wider community.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The organisation has a positive approach to health and wellbeing of staff, patients and family/whanau.

Patients and family/whanau are provided with education material and referred to agencies to help support their wellness in addition to the hospice services provided.

There is a very strong focus on staff health and wellbeing guided by policy management and staff provide, participate in and received numerous wellbeing opportunities and experiences.

One initiative involves additional leave to recognise the stress for palliative care deliverers, free eye testing is offered, regular case debriefs, as well as formal supervision occurs.

The hospice values of compassion and empathy are espoused in these and other activities.

A recent event, the Compassionate Community Day, and participation at the Pacifica festival are examples of engaging with the community to promote palliative care in the community.

These activities are all planned and evaluated by the hospice team with newer activities of presentation to the Indian community and updating of brochures showing strong commitment to health and wellbeing of all key stakeholders.

Standard 2.5: The organisation encourages and adequately governs the conduct of health and medical research to improve the safety and quality of health care.

Criterion 2.5.1. The organisation's research program develops the body of knowledge, protects staff and consumers / patients and has processes to appropriately manage the organisational risk associated with research.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The organisation has a positive research culture evidenced best in the joint appointment with Victoria University of a research fellow.

There is a research policy that supports staff in any research activity including submitting of appraisals. While the organisation is not currently leading any research it is participating in one large longitudinal study researching Maori and their palliative care needs.

Research is managed through the Professional Advisory Group (PAG) which has the role of clinical governance and is chaired by the clinical director. The organisation has an extensive education calendar and undertakes a number of literature reviews which are overseen of PAG.

The organisation has a research policy which addresses ethical consideration and applications for research approval. The committee is currently working on the use of performance indicators to monitor research activity and this work will need to be completed if the MA rating is to be maintained.

Surveyor's recommendation
It is recommended that:
A set of performance indicators to evaluate the effectiveness of the governance of research is developed.

CORPORATE FUNCTION OVERVIEW

Mary Potter Hospice is led by a well-qualified board of directors who provide direction and mandate plans for implementation. The chief executive is an experienced health manager who works with staff to provide high quality services to the community.

Senior health professional staff are credentialed and scopes of practice are defined. A recommendation is made around the need to develop a policy and framework to support staff in credentialing processes.

External service providers all have contracts with performance schedules which are monitored. A policy is required to support external service provider processes.

Policy management is comprehensive. A process for development of new and updating of existing policy is in place. Staff are involved in reviews which occur regularly. All policies are current. Policies reference legislation and good practice and there is an audit process to measure compliance with policies. Distribution and removal of policies occurs according to the document control policy guidelines.

Safety management ensures a safe environment for staff, patients and visitors. Policy is in place and on line education supplements face to face education sessions.

The hazard register is reviewed regularly ad provides staff with strategies and actions to manage hazards.

Staff wellness is a strength with organisation activities aimed to promoting the health and wellbeing of staff.

The service has a preventative maintenance plan for all three sites and all requests for repairs are responded to promptly. All equipment requiring calibration is up to date with servicing.

Regular environmental audits occur and the organisation has an alternative emergency power source if mains electricity is lost. Recommendations are made in relation to ceiling repairs and securing of oxygen cylinders.

All waste is labelled, segregated and disposed of according to regulation. Safety equipment is supplied for staff. The cleaners' cupboard was not locked on one day of the survey and a recommendation has been made in relation to this.

Emergency and disaster activity is currently being integrated with business recovery planning. Staff receive education on emergency events, with fire drills six monthly and annual emergency exercises. Policy is in place to guide and support staff.

There is a covert video surveillance system and a security contract with an external service provider. The premises are patrolled overnight once all exits are locked in the evening.

While a large amount of evaluation is occurring on aspects of the corporate function, increased analysis of these findings together with the development of performance indicators would increase the attainment levels of some criteria.

The hospice has a strong culture of benchmarking and sharing information with others inside the Hospice NZ organisation.

CORPORATE FUNCTION

Standard 3.1: The governing body leads the organisation's strategic direction to ensure the provision of quality, safe services.

Criterion 3.1.1 The organisation provides quality, safe health care and services through strategic and operational planning and development.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The strategic plan is reviewed and approved by the board following consultation and a board workshop.

The chief executive leads the organisation through consultation with key stakeholders including staff, Te Pou Toko Group, which provides guidance on being a culturally responsive organisation, the Consumer Advisory Group, which provides guidance on strategic and quality projects, as well as reviewing all feedback given by volunteers, patients and whanau/family.

Services are planned based on community need and the facilities plan is currently being updated and developed based on the latest strategic and service plans.

The hospice is active in Hospice NZ and works closely with others on identified and prioritised projects (e.g., information technology). Communication with the community occurs regularly through publications and the organisation is currently updating its website.

Criterion 3.1.2 Governance is assisted by formal structures and delegation practices within the organisation.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The board of Mary Potter Hospice provides clear leadership through the development and adaption of strategic and operational plans. These documents articulate the values and goals for the service and are reviewed annually. The board receives regular monitoring reports from the chief executive on progress toward achievement of goals.

There is a formal transparent process of appointment of new board members and there is orientation to their role. The board has a manual that provides the framework for activity. Minutes of board meetings and subcommittees provide resolutions for senior managers to carry out. A delegations policy is in place for the chief executive.

The board meets with members of the community at forums during the year and receives feedback on community opinion.

An annual process of board performance is carried out by an external agency.

The board is active in the Hospice NZ chair and chief executive forum and compares and shares information and performance with other Hospice boards.

Criterion 3.1.3 Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The organisation has a process in place to credential medical staff, nurses and allied health profession staff.

The nurses have validation of registration and practising certificates on appointment and thereafter annually. They are encouraged to participate in the professional development pathway of Capital and Coast District Health Board. There is annual assessment of competency undertaken through the performance review process.

Allied health professionals have initial validation of registration and practising certificates and participate in respective professional college programmes.

Medical officers on appointment have validation of registration and scope of practice.

On an ongoing basis their competency is assessed annually through a performance review involving the clinical director. The clinical director is peer reviewed.

While the system for credentialing is well understood in the organisation, there is no policy or framework to ensure consistency of processes. The organisation does reference the 2004 Ministry of Health Guidelines on credentialing senior medical staff, however, its practices do not follow these guidelines.

Policy is in place and there is evidence of good practice in relation to the introduction of new treatments and interventions.

Surveyor's recommendation
It is recommended that:
A policy and framework to credential health professionals is developed and implemented.

Criterion 3.1.4 External service providers are managed to maximise quality, safe healthcare and service delivery.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
There are formal contracts in place with all external service providers. All contracts have performance schedules that are monitored and audited by both the contractor and the hospice. Regular review meetings occur with the hospice contract manager. There is annual review of all contracts. Reference to external service providers is covered in several policies and should be grouped together in a single external service provider's policy.

Orientation is provided prior to contractors entering the facility.

There is no evidence of comparisons with other organisations and therefore the rating is MA.

Criterion 3.1.5 Documented corporate and clinical policies and procedures assist the organisation to provide quality, safe healthcare.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
There are approximately 150 policies in use. The document control system framework mandates all policies are reviewed in stated timeframes, brochures are developed using a standard template and obsolete documents are removed from the workplace and stored.

Policies are written in simple English to a standard template, they reference legislation and good practice. Policies are available to staff electronically and additionally in the case of emergency management, in hard copy at staff stations.

The process for development of new and renewal of existing policies is coordinated by the quality improvement team, is led by the policy "owner" and involves staff reviewing policy content. Where appropriate whanau/family and patients are involved in the policy review process. When reviewed new policy is issued electronically. Managers are informed and staff are notified electronically and through team meetings. A regular policy update memo is circulated.

The audit calendar for policy compliance is up to date with results showing a high level of compliance with policies and that all policies are reviewed within review dates.

The hospice is involved with the hospice network in sharing and benchmarking policy material and willingly provides material for others to use in policy development.

Standard 3.2: The organisation maintains a safe environment for employees, consumers / patients and visitors.

Criterion 3.2.1 Safety management systems ensure safety and wellbeing of consumers/patients, staff, visitors and contractors.

Organisation Rating: EA **Surveyor Rating: EA**

Surveyor's comments:
The organisation has a comprehensive safety management programme in place. There is a dedicated health and safety resource manager who has level one training. Policy is current following a large review during 2015. Policy and processes reference legislation, regulation and good practice. Policies are readily available to staff.

Education is provided to staff at orientation and through on-line packages, which shows good utilisation.

Workplace risks and hazards are identified by staff and during environmental audits. Strategies for safe management are in place with the hazard register available for all staff to view. There is a combined Health and Safety and Infection Control Committee with staff representatives from each site involved. This committee reviews safety management information and coordinates the organisation's responses.

All external service providers have orientation and are supplied with safety management information. Visitors and patients are alerted through signage to any safety hazards.

The annual health and safety week has a planned focus on staff wellness and includes education on manual handling and managing your own health. There is one significant initiative which sees staff receiving additional time off acknowledging the stressful nature of their roles.

There is policy in place relating to dangerous goods and hazardous substances and audits show compliance with this policy. The organisation undertakes evaluation of the health and safety management system and benchmarks with other hospices and this provides evidence of performance, however to maintain EA rating, explicit performance indicators need to be developed.

Criterion 3.2.2 Buildings, signage, plant, medical devices, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The facilities were built in the 1960s and have been well maintained. There are limited external areas for patients and adequacy of dedicated parking spaces is a problem at times.

The campus at Porirua was visited and is well maintained with appropriate building certificates.

Policy is in place to guide staff in building maintenance and management of plant and medical devices/equipment. The preventative maintenance log is comprehensive and implementation of the schedule is up to date. The current building warrant of fitness (WOF) is displayed. Staff interviewed indicated a prompt response to any notified breakdowns or required repairs.

Work is nearing end on an extensive repair to the roof; leaking has caused ceiling damage in the area outside the drug room. Funding has been approved for these repairs and the schedule for completion was viewed.

Signage both internally and externally is adequate and a project is scheduled for 2016 to develop further bilingual signage.

Staff have access to appropriate medical devices and clinical equipment with supplies replaced regularly with emergency stock stored on site. All devices requiring calibration were current and the log was viewed. Surveyors noted two oxygen cylinders unsecured and work has begun to secure these cylinders. The capital programme is reviewed annually. Staff are trained to use equipment at orientation and when new equipment is purchased.

The organisation has recently installed a diesel generator which provides power when mains power is lost. The generator was last used in January during a power cut and is tested monthly by the manufacturer.

Environment scanning occurs three monthly and includes monitoring of fridge temperatures, water temperatures, hazard identification of plant and equipment and cleanliness of the facility.

Evaluation of all aspects of the facility and environment occurs and development of a benchmarking tool with other hospices would see the organisation rating move to EA.

Surveyor's recommendation
It is recommended that:
1. Work is completed on the ceiling damage outside the drug room.
2. All oxygen cylinders are safely secured.

Criterion 3.2.3 Waste and environmental management supports safe practice and a safe and sustainable environment.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
The organisation has in place policy to manage wastes and hazardous materials. At orientation there is instruction to staff regarding waste management. There are clearly identified waste streams internally and externally where streams are segregated awaiting pickup. Appropriate safety equipment is provided

for staff when handling wastes. One breach of policy was observed with the cleaners' cupboard not being locked.

There is some activity to improve environment sustainability in the form of recycling but more could be done in this area.

The waste management system is evaluated regularly with audits carried out by health and safety, maintenance and infection control staff, and recommendations from these audits are implemented.

Surveyor's recommendation
It is recommended that:
The cupboard containing cleaning equipment is locked at all times. *(Refer also Health and Disability Services certification report, criterion 1.4.6.3)*

Criterion 3.2.4 Emergency and disaster management supports safe practice and a safe environment.

Organisation Rating: EA **Surveyor Rating: MA**

Surveyor's comments:
The emergency manual has been comprehensively reviewed during 2015 prior to work commencing on integrating the manual and the business continuity plan. The new single document is currently in draft form being reviewed by the Executive Management Team. This plan has a particular focus on response and management of fire and earthquake. The current manual is easily accessible to staff and is online.

The organisation carries out six monthly fire drills; there was no recommendations from the last drill. Annually, a simulated emergency exercise is carried out, the 2015 exercise was an earthquake. The exercise was evaluated with recommendations implemented.

There is a dedicated fire officer and staff are identified. Review of the training register shows all staff have undertaken fire and emergency training.

The organisation has benchmarked and evaluated its emergency management systems and plans with two other hospices and plans have been developed in liaison with local civil defence, District Health Board and Councils. While there is evaluation of systems, plans and events there is minimal use of performance indicators and this will need to be strengthened to maintain the EA rating.

Criterion 3.2.5: Security management supports safe practice and a safe environment.

Organisation Rating: MA **Surveyor Rating: MA**

Surveyor's comments:
Security management provides a safe environment for staff, patients and visitors.

The building has covert video surveillance at all entrance/exit points and key internal corridors. This is monitored from a console located in the reception area. There is a contract with a security firm in place and after the staff do an evening lockup, the security firm undertakes three checks of the facility overnight. There is a security log book where incidents are reported and these incidents are reviewed and logged in the incident system, discussed in relation to risk management with changes authorised by PAG or via risk management mitigation strategies.

Staff receive education to manage security incidents and also undertake de-escalation training.

Minimal evaluation of security, in particular measurement of performance indicators, occurs and this will need to be strengthened to maintain the MA rating.

Recommendations Log: Mary Potter Hospice

Year raised /Event type	Criterion No.	Criterion Requirement
2016 OWS	**1.1.8**	**The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care/service delivery. This is a mandatory criterion.**
	Recommendation	The continued improvements to the PalCare programme and training be evaluated
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**1.5.1**	**Medications are managed to ensure safe and effective consumer/patient outcomes. This is a mandatory criterion.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	The training resource package for caregivers is evaluated and improvements made where possible.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**1.5.3**	**The incidence and impact of breaks in skin integrity, pressure ulcers and other non-surgical wounds are minimised through wound prevention and management programmes.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	A suitable benchmarking partner to compare data around pressure injuries acquired in the IPU.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**1.5.4**	**The incidence of falls and fall injuries is minimised through a falls management programme.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	The falls prevention programme be evaluated and further changes be made as a result.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**1.6.1**	Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health and disability service.

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	A policy and framework to manage patient, family/whanau and community input into service planning, delivery and evaluation is developed and implemented.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**2.2.1**	**Workforce planning supports the organisation's current and future ability to address needs.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	Performance measures for workforce planning are developed.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**2.3.1**	**Health Records management systems support the collection of information and meet the consumer/patient and organisation's needs.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	Material required for the electronic record is standardised.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**2.3.3**	**Data and information are collected, stored and used for strategic, operational and service improvement purposes.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	Resolve the identified problems with lack of shared technology.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**2.5.1**	**The organisation's research programme develops the body of knowledge, protects staff and consumers/patients and has processes to appropriately manage the organisational risk associated with research.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	A set of performance indicators to evaluate the effectiveness of the governance of research is developed.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**3.1.3**	**Processes for credentialing and defining the scope of clinical practice support safe, quality health care. This is a mandatory criterion.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	A policy and framework to credential health professionals is developed and implemented.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**3.2.2**	**Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	3. Work is completed on the ceiling damage outside the drug room. 4. All oxygen cylinders are safely secured.
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**
2016 OWS	**3.2.3**	**Waste and environmental management supports safe practice and a safe environment and sustainable environment.**

Year raised /Event type	Criterion No.	Criterion Requirement
	Recommendation	The cupboard containing cleaning equipment is locked at all times. *(Refer also Health and Disability Services certification report, criterion 1.4.6.3)*
	Client's action plan:	
	Timeframe:	
Year completed	**Surveyor comments at next survey:**	
	Recommendation Closed	**Yes / No**

Appeals Process

The DAA Group follows a standard procedure for managing appeals relating to the certification/accreditation and verification process.

This procedure includes within its scope appeals against decisions made by the DAA Group with respect to granting certification/accreditation of client management systems. This procedure does not include within its scope appeals against decisions made by the Ministry of Health and the Director-General of Health with respect to granting certification of health and disability services for the purpose of the Health and Disability Services (Safety) Act 2001.

Should you wish to appeal the outcome of your recent survey, the appeal will be managed in the following manner:

- A written appeal is to be provided to the DAA Group.
- The DAA Group will acknowledge receipt of your appeal in writing.
- Two independent surveyors will review the relevant documentation and/or information within 15 working days of receipt of the appeal.
- Action will be taken based on the nature of the appeal.
- The outcome of the review will be notified in writing to you. Progress reports may also be made.
- All appeals and disputes will be reviewed by the Impartiality Committee to ensure due process has occurred.

Note: You have the right to complain directly to our independent accreditation agency ISQUA or other regulatory body as appropriate.

Disclaimer

The DAA Group expressly disclaims liability to any person who acts, or fails to act in reliance on any statement in this report. The DAA Group disclaims any liability whatsoever in respect of any losses or damages arising out of the use of this information, or in respect of any action in reliance on the information contained in the Certification/Surveillance audit report.

Wellington Office
p. +64 4 499 0367
f. +64 4 499 0368
admin@daagroup.co.nz
PO Box 5088
Wellington 6145
New Zealand

Christchurch Office
p. +64 3 329 6477
f. +64 3 329 6577
info@daagroup.co.nz
551 Springs Road
Prebbleton 7604
Canterbury

daagroup.co.nz