Mary Potter Hospice
With You

Quality & Clinical Governance Report
2017 Year

Showed us so much respect for our family and gave us enough time to make good choices

The people made me feel special, important and genuinely cared for

Given me stability at a time when there was too much change for me to cope with

Teresa O'Toole
Quality & Education Manager

April 2018

1. Summary

Mary Potter Hospice vision:

> ***That people in our community who need palliative care have access to compassionate and quality care, when and where they need it.***

The quality systems and frameworks at Mary Potter Hospice seek to evaluate and validate the quality of care we provide to patients and their families and whānau. This report provides a summary of the quality clinical governance activities for 2017 and provides an overview of annual trends in quality and safety across the Hospice. It provides evidence and accountability regarding the quality of the Hospice's performance.

"All Hospice staff are involved in quality activities across all teams. I would like to acknowledge the teams for their contribution to quality at Mary Potter Hospice.

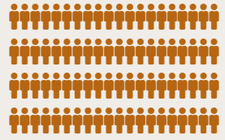
I would like to thank Dr Brian Ensor, Director of Palliative Care, who leaves the Hospice in the coming months. Brian has led the Quality team and chaired the clinical governance group at the Hospice for 14 years. He has led the development of several benchmarking and data definition programmes at the Hospice and is Clinical Advisor for Hospice New Zealand. Thank you Brian for your commitment to us as a team and organisation driving quality and excellence"

Di Pryde, Interim Chief Executive

Monthly activity snapshot

In one month:

80 people were referred to hospice service



Hospice staff paid **592** visits to people in their own homes

Hospice staff made **3,123** contacts with **373** patients

We delivered **52** hours palliative care education to **180** health partners in the community

460 volunteer hours directly linked to care delivery (excludes retail and fundraising volunteer hours)

42 people died with support from our Hospice team (17 people in Hospice inpatient unit)

49 people were admitted to Hospice Inpatient unit and stayed an average of 14 days

Source Palcare data month of September 2017 and Education data Aug 2017

2. Our strategic projects

An update of the Hospice Strategic Plan occurred during 2017 with an emphasis on increasing access to care in the community for those with palliative care needs.

Our care and quality

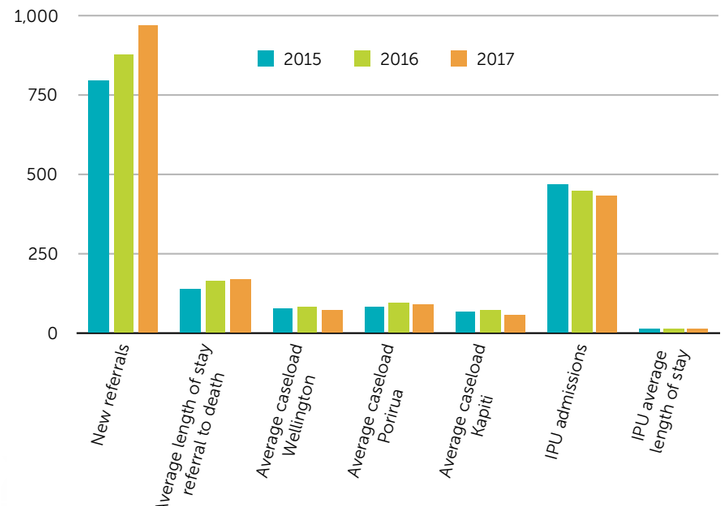
- The effectiveness of our care is measured and reflects our Hospice values and commitment to quality
- Our services are continually adapted to meet the community's changing needs, including psychological, social and spiritual needs
- Our services are free-of-charge, timely and available close to home
- Our service is culturally safe and meets the needs of Maori and Pasifika people
- Our services are equitable and adapt to meet increasing demand
- We listen to families/whānau and empower and support them in the care of their family/whānau member

Project	Achievements 2017
Enhanced Community Service model	Hospice New Zealand Innovative Funding allowed three new roles employed to support aged residential and primary care to enhance services in primary and aged residential care. Introduction of weekend palliative care coordinator role Development of 'Hospice in the Home' model of care to extend services in the community
Education and Training review	Development of a new online registration system for Education services. Increased external education attendees by 22% (n=439 attendees) 2015-2016
Facilities Review	Service facilities exploration of: the Kapiti service, Porirua community hub, and the IPU unit for short and longer term. Commercial development analysis and funding options advanced and resource consent approved including consultation with local community.

3. Service Activity

Measuring and evaluating our data and quality activities enables us to validate that patients are receiving adequate care, that our current service model is improving care, and to compare outcomes. Overall we have can demonstrate increased numbers of people accessing Hospice services.

Service Activity



**Source of data: Palcare patient electronic database.*

4. Service improvements

- Introduction of mobile devices/iPads for community team enables immediate access to electronic patient record and 'real time' patient information. The Hospice team also have access to CCDHB/hospital records enable sound coordination of care
- Introduction of Zoom video-conferencing between clinical staff and patients in the community
- Review of emergency and disaster plan and testing of telephone/communication tree across teams.
- Introduction of electronic patient assessment tools: ESAS and Karnofsky assessment tools
- Introduction of scheduler, a tool that categorises patient needs/symptoms, has enabled improved coordination of the community services team
- Integration of Te Ara Whakapiri in inpatient unit, a national end of life care framework published in 2017.
- Ambulance management plans updated – to ensure all our health partners are up to date of patients plan of care in the home. This enables the ambulance team to administer emergency medications and care out of hours.
- New dedicated nursing and social work roles to assist a smooth transition post discharge from Inpatient unit
- Implementation of a staff wellness and maturing workforce programme

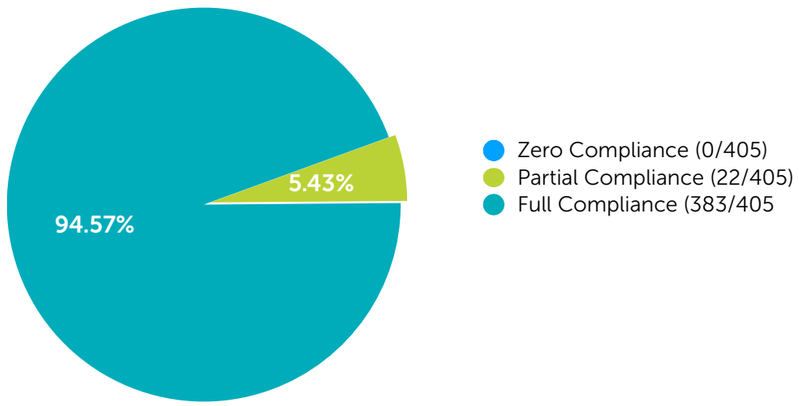
5. Measuring Quality

Legislative Compliance Reporting

In December 2017, we completed our first legislative compliance reporting round using the ComplyWith legislative compliance program. ComplyWith enables the Hospice to efficiently identify and report against its legislative compliance obligations.

The pie chart below summarises the compliance responses reported (405 results). It indicates that overall there is a high level of compliance at the Hospice.

Legislative Compliance Reporting (1 Dec 2016- 30 Nov 2017)



Most compliance issues reported were for obligations arising under the Health and Safety at Work Act 2015 regarding emergency plans, first aid training for staff and provision of first aid kit, as well as obligations for the use of plant in the workplace (retail). All compliance issues have been addressed or have resolution plans in place.

6. Risk Management

6.1 Risk Register

The risk register is updated by the Executive Team six monthly and Board of Trustees annually. A new format increases the monitoring of risks and includes input from internal Hospice groups (e.g. Quality, Health and Safety Committee, and the Medication Management Committee).

Hazards related to the Newtown building (Inpatient Unit) are reported and entered in the Hazard Register. We now have Hazard Registers for all our community bases and one collective register for Retail.

6.2 Health & Safety Education provided

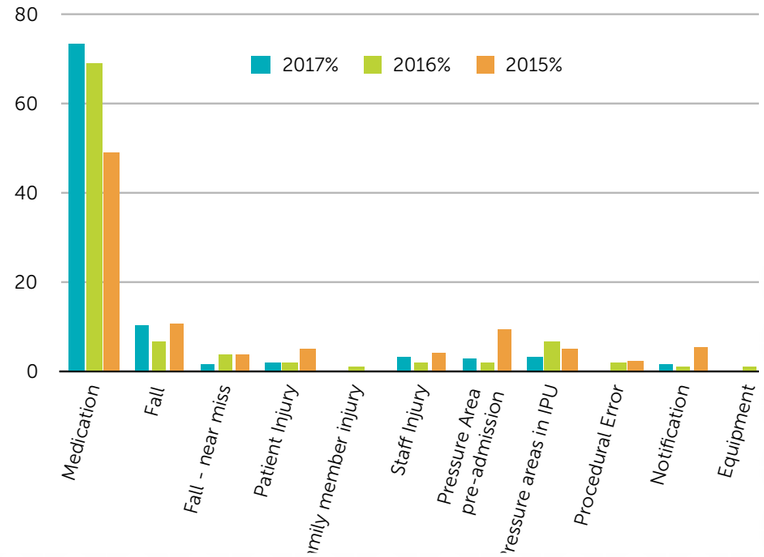
Annual uptake of education by staff on all training via the intranet has been excellent. Bi-Annual Trial evacuations have been held. Topics covered include: disasters overview, armed robbery, restraint, de-escalation and ACC Safety Week.

6.3 Incident Management/ Reportable Events

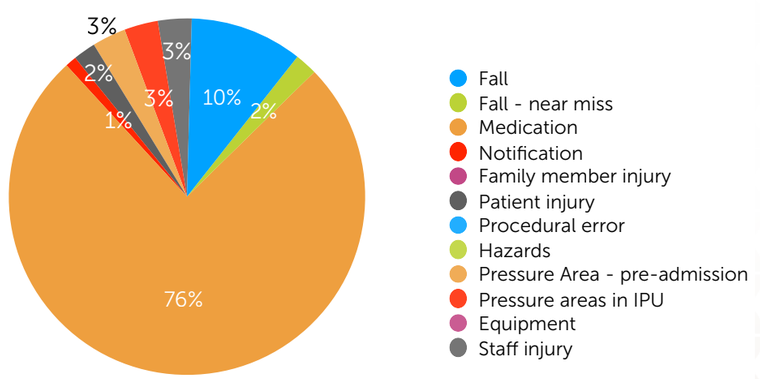
All accidents/incidents are collated and reviewed at the monthly Health, Safety and Infection Control Committee (HSICC) meetings. Incident forms were reviewed in 2017 for high risk areas of medications, falls and pressure injuries to increase monitoring and risk analysis of level of patient harm.

Further analysis of all incidents reported in 2017 includes a comparative analysis with 2016 and 2017 data as set out below:

Clinical incidents by category and percentage of the total 2015 – 2017



% Breakdown of Clinical Incidents for 2017



Top 3 categories of clinical incidents - 2017

Incident category	2017	Potential contributing factors
Total number of reported incidents	601	
Medications*	442	Increased reporting. Increased auditing. Decreased level of harm.
Falls	61	Increased risk assessment, education and surveillance has significantly reduced level of harm from Falls incidents.
Pressure injury in IPU	20	All incidents were low grade pressure injuries.

**Includes total of Critical, Serious, Significant and Procedural error*

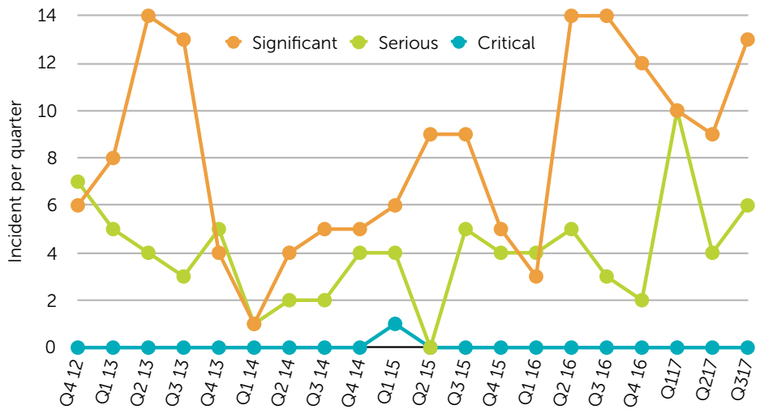
6.3.1. Medication Incidents:

Medication errors continue to be tracked, with a continued decline in the serious and significant errors. Critical errors, which have an actual or very likely significant harm to patient are too small in numbers to comment on trends.

Future work includes consideration to moving towards electronic reporting which is expected to significantly enhance reporting systems and processes..

- Medication incident data is reviewed by the Medication Committee with root-cause analysis occurring with all 'Critical' and relevant 'Serious' errors. The focus for analysis of medication errors has been on those two areas where there is actual or serious potential for patient harm ('Critical' and 'Serious') error. Systems review and/or professional development for the staff involved occurs with these errors.
- A significant error is one with potential harm for the patient, particularly if not picked up and compounded by another error. Significant, serious and critical errors are reported quarterly at Board level. The rate of detection of 'Significant' errors does depend on review of medication charts by the pharmacist as below, and will therefore fluctuate according to the time available to do this.

Medication Error Rates 2012-2017



- Reporting of medication incidents continues to be boosted with pharmacist conducting an audit on a weekly basis the medication charts (which is where the procedural errors occur). The pharmacist then reports their findings (and any recommendations) to the Medication Committee. The bulk of procedural errors being reported include medications not signed for when administered, and medical lapses in signing, dating, or omitting specimen signatures for the drug chart. The introduction of an electronic medication management system called MediMap in 2018 will reduce these errors.
- All nurses completed an annual medication questionnaire which has fed into a mentoring/ education programme for specific nurses.

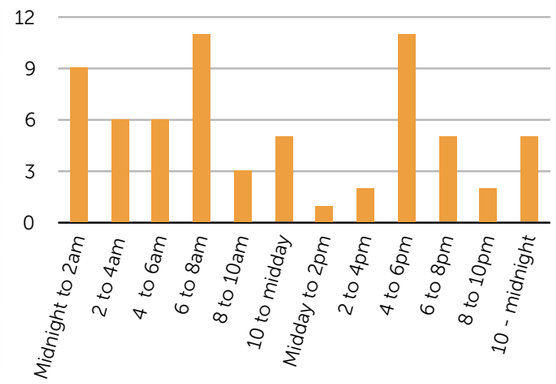
6.3.2. Falls incidents

Falls are one of the top two incidents at Mary Potter Hospice. Published research shows that Hospice patients are at a very high risk of falls due to decreased physical function and weakness, medication side effects and the burden of disease symptoms that can impair cognition/memory/automatic responses and reflexes that keep people safe from falling. The Hospice has a dedicated 'Falls champion' resourced to develop education and resources to drive quality improvement.

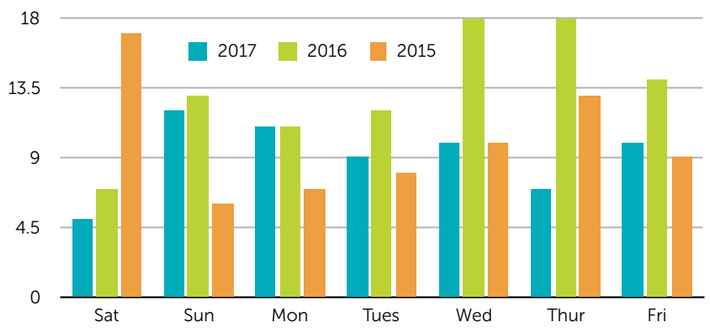
It is worth noting that the majority of falls result in 'no injury' (69%).

Monthly Falls/Near Misses 2015-2017

Time of Falls/Near Misses 2017



Falls/Near Misses - Day of the Week



Breakdown/Analysis 2017 data

- 61 Falls and 9 Near misses (12% Near misses)
- 14 people contributed to 42 % of falls/NM
- Of the 70 falls/NM-14 people fell more than 1x i.e. total 56 patients fell/NM
- 9 people fell 2x ; 3 people fell 3x and 3 people fell 4x = 28
- Sex: 33 female and 37 male
- Age range 43 to 99
- 50 years and under= 4- 95.7%; 51 to 65 years= 9- 12%; and over 65 years = 57 – 81%
- Cognition Impaired: 46/70 = 65%
- Not impaired: 19 =27%; Not reported: 5 =7%
- Injuries: 21% (16) received minor injuries including lacerations (n=9), Bruises/grazes (n= 3) and bumps (n=3). One fall resulted In a fracture.

6.3.3. Restraint

Evaluation

Bed occupancy rate in 2017 is 3% less from 2016.

An audit showed that the overall number of days restraint used has increased by 13% and enabler use up by 4%. Consent compliance increased from 96% to 98% and documentation improved by 9%.

Published research shows that Hospice patients are at a very high risk of falls due to decreased physical function and weakness, medication side effects and the burden of disease symptoms that can impair cognition/memory/automatic responses and reflexes that keep people safe from falling.

6.3.4. Recommendations for 2018

- Further analysis of data during 2017 through revised incident forms for medications and falls
- Roll out of ‘Medimap’ an electronic medication administration and control system that will promote increase accuracy in prescribing .
- Retrospective review of all patient injuries and incidence of skin tears on IPU
- Development of incident data management system to increase monitoring and enable increased analysis of data trends

7. Patient/Whānau and Public Community Involvement

7.1. Consumer Rights

An audit of all 2017 complaints showed 100% compliance to policy.

We have improved the current written information provided to consumers with the review and development of patient brochures during 2017 and publications on website. Website hits to ‘publications section/patient brochures’ increased from 152 hits (2016) to 327 hits.

7.2. Consumer Feedback

Feedback surveys enable patients and whānau to express their levels of satisfaction with Hospice services anonymously and are one of our key measure of how well service quality systems are working.

7.2.1. Comment Cards

During 2017, the Hospice continued utilising comment cards: a simple, anonymous and non-time intensive feedback mechanism to enable our consumers to comment on the strengths of our service and suggestions for improvement.

The comment cards ask two specific questions:

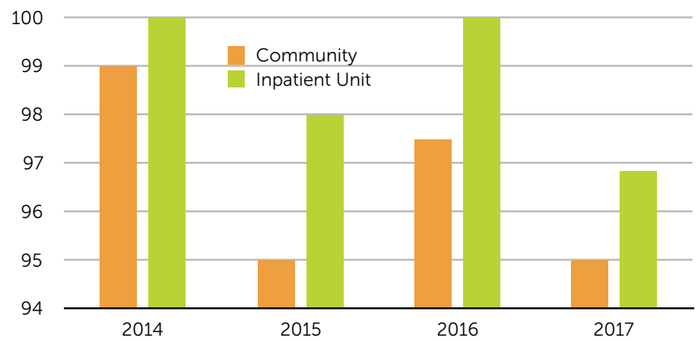
- List two things that we did well
- List two things we could do better

A selection of comments by Visitors provides an insight into how the Hospice is viewed by the wider community.

7.2.2. Consumer Satisfaction Surveys

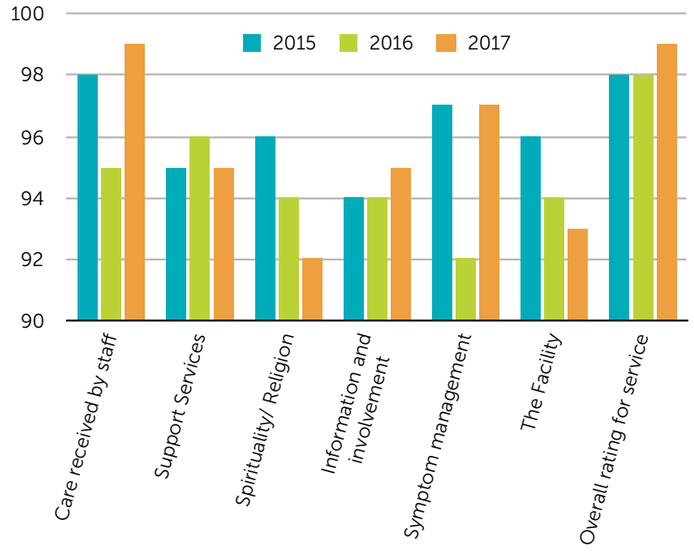
The Consumer Satisfaction Survey, is a more comprehensive questionnaire covering all aspects of care that can be completed by patients and their whānau. The satisfaction survey has served as a key performance indicator of the Quality Performance Systems (QPS) Palliative Care framework which up until July 2017 was benchmarked across 27 hospices in NZ. During 2017, all Hospices elected to review benchmarking systems and QPS benchmarking has ceased as Hospices embark on collecting data via Palcare symptom management assessment tools (electronic notes).

Patient Satisfaction Survey - Overall satisfaction scores



Inpatient Satisfaction Survey

Patient Satisfaction 2015-2017 - Inpatient Unit



8. Conclusion

During 2017 significant work occurred, as demonstrated in this report, embedding clinical governance within the Hospice teams, systems and structures.

Overall, service activity has increased significantly – consumers are satisfied with the Hospice service.

The external audit review findings in 2018 will provide further opportunities for evaluation of services and most importantly, the audit will assist in validating priorities for quality improvement within Mary Potter Hospice.

Opportunities for Quality Improvement in 2018

Focus areas for 2018 include:

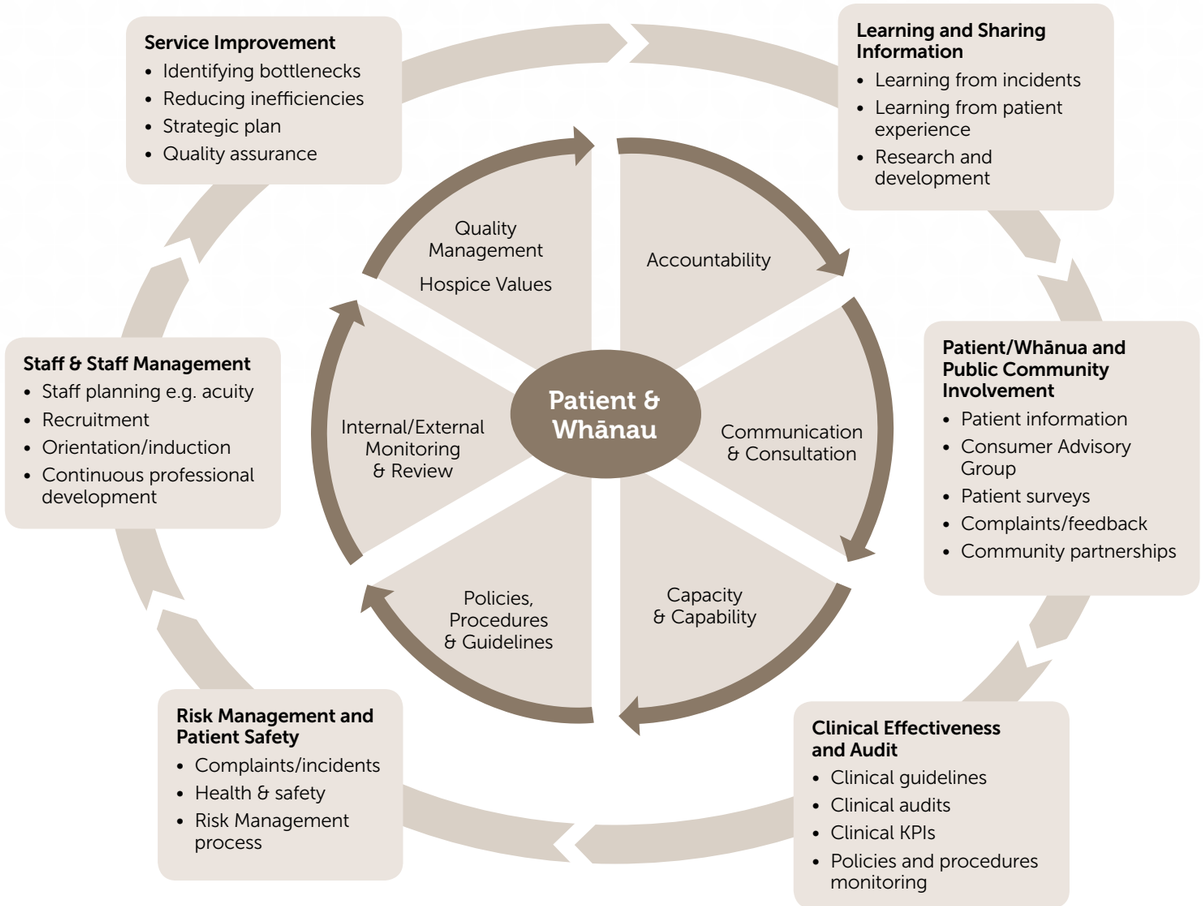
- Review accreditation processes,
- Consolidate quality team structure and staffing roles, and
- Review internal quality management frameworks.

Mary Potter Hospice is absolutely committed to delivering the highest standards of quality and safety for all our patients and their families and whanau. We have a strong ethos of ensuring dignity and privacy at all times. We continue to strive for continuous quality improvement whilst maintaining the high standards we are proud of. Safety and quality are at the heart of our commitment to excellence in all the services we provide and we welcome the opportunity to share our progress and priorities in this report.

8. Appendices

8.1. Mary Potter Hospice Clinical Governance Framework

In 2013, the Hospice adapted the Clinical Governance Framework from the Health Service Executive, Ireland. The framework outlines the key elements of quality and clinical governance at Mary Potter Hospice.



Mary Potter Hospice – Clinical Governance Framework

The above framework was adapted with permission from the Health Service Executive (HSE) Ireland: Framework for Integrated Quality, Safety and Risk management (4).

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

- Service Improvement: Identifying bottlenecks, reducing inefficiencies, monitoring service characteristics, strategic planning, and quality assurance.
- Learning and Sharing environment: Learning from incident reviews, learning from patient experience, research and development.
- Patient/ Whānau and Public Community Involvement: Patient information, Consumer advisory group, patient surveys, complaints feedback, and community partnerships.
- Clinical Effectiveness and Audit: Clinical guidelines, clinical audits, clinical KPIs, policies and procedures monitoring.
- Risk Management and Patient Safety: Complaints/ incidents, health and safety systems, risk management process.
- Staffing and Staff management: Staff planning (acuity), recruitment, orientation/ induction, continuous professional development.

This report is aligned with the Clinical Governance framework above.

The spirit of generosity that every service was delivered with was what made the whole experience of Hospice so special

Expectations exceeded.

Well done.

I feel totally confident leaving my mother in hospice, knowing she feels safe, respected and cared for

48—52 Mein Street, Newtown, PO Box 7442, Wellington 6242
P 04 801 0006 | F 04 389 5035 | E mph@marypotter.org.nz
www.**marypotter.org.nz**