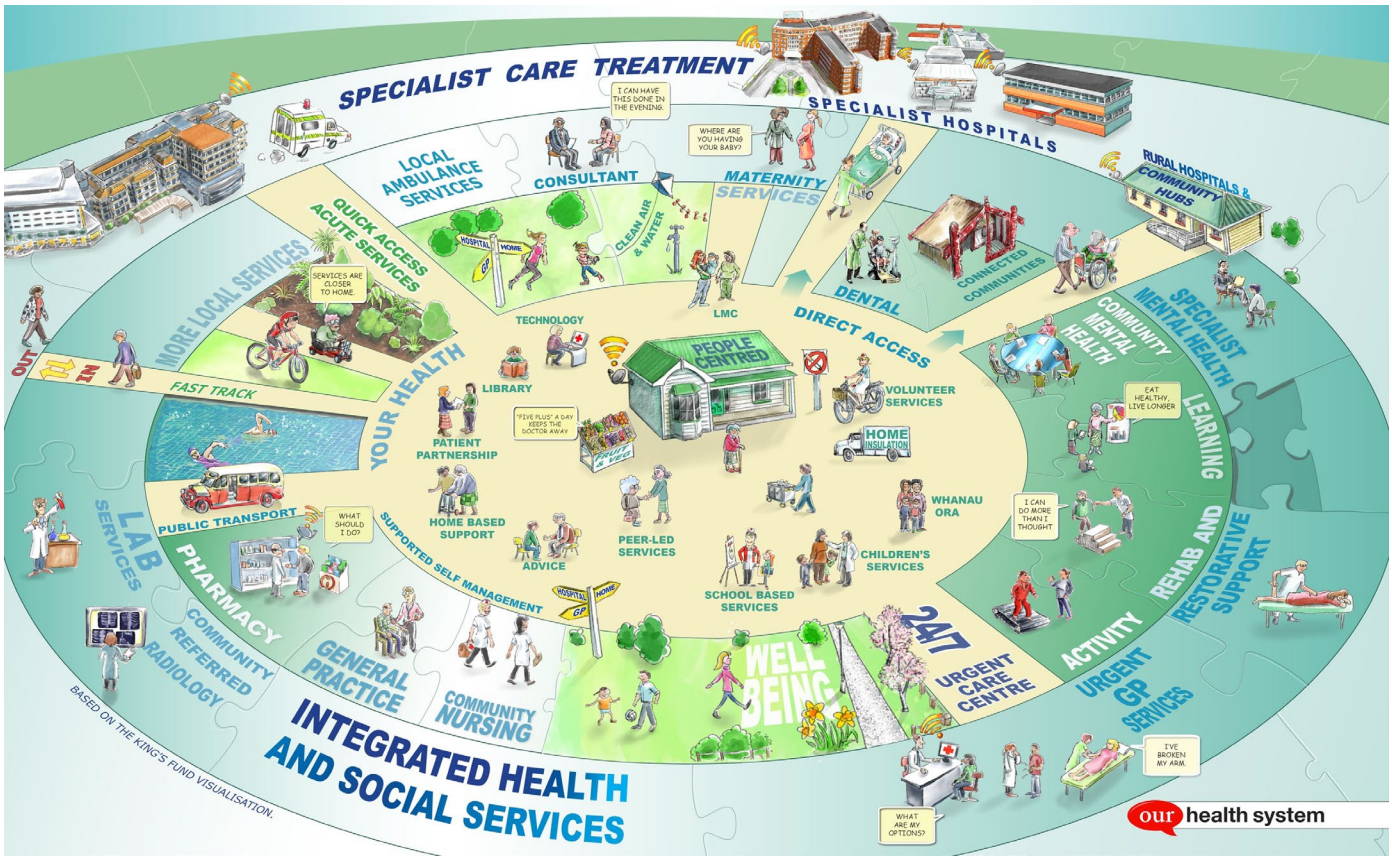
Canterbury DHB Quality Markers

June 2020 – July 2021

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury DHB Quality Markers 2021



Canterbury DHB Quality Markers

Canterbury DHB strives to ensure our services are safe, integrated, focused on evidence-based best practice, and are responsive to consumer needs.

The Canterbury DHB Quality Markers aim to provide readers with a snapshot of how we monitor quality and safety using the Health Quality and Safety Commission Markers and Patient Experience Survey feedback. It reinforces our vision of an integrated Canterbury Health System by showcasing examples of what we are doing well and what we need to improve.

Thank you to all consumers and staff who have invested time and effort to ensure the focus on improving our services has continued at a time of extraordinary change for Canterbury DHB. There is immense value and reward in undertaking this work.

Patient Experience Feedback

The Patient Experience Survey is a Canterbury DHB wide survey that canvases patients who have recently spent time as inpatients in our hospitals, or have had an outpatient appointment.

Evidence tells us that patient experience is a good indicator of the quality of our health services. Better experience, stronger partnerships with consumers, patient and family-centred care have all been linked to improved health, clinical, financial, service and satisfaction outcomes.

An invitation to participate in the survey is emailed or sent by text with a link to the survey. Patients are asked to respond to a range of questions about their healthcare experience.

The survey focuses on four areas; the quality of communication experienced, whether the patient felt involved in decisions about their care, coordination of care and how well physical and emotional needs were met.

Next time you obtain healthcare you may like to check your email address is up-to-date or make sure the invitation hasn't gone to your spam folder, so that you can have your say!

Feedback is used by teams to monitor and improve care provided. Understanding how people experience healthcare gives us valuable insight and an opportunity to celebrate our success, do more of what we are doing well and to find ways of how we can do better.

Responses to the surveys are completely anonymous. Comments are reviewed to ensure staff and patient confidentiality. Feedback is considered verbatim (word for word), and comments are published as submitted, including spelling and grammatical errors.

The results of the survey are available on the intranet for all staff to view in the patient experience portal. All staff have access to anonymous inpatient and outpatient feedback.

Canterbury DHB
Patient Experience Survey
Te Rūri Wheako-ā-Tūroro

Ask what matters
Listen to what matters
Do what matters

What are we doing with the Patient Survey Feedback data?

Teams view the patient experience survey feedback at their monthly team meetings to see how well they are doing. The data is used for conversations to identify what can be improved. For example, in the Orthopaedic Outpatient Department, observations from patients about who to contact if they needed information or were worried did not score so well.

Information

"Coordination was great. However, on information from the hospital on how to manage your condition after my discharge – I got verbal information from nursing staff on the prescribed medication and verbal information from the surgeon on exercises, at discharge and later at check-up as out-patient. I would have liked to have received that in writing as well, as a lot is happening around discharge."

"Mostly information was given adequately, however once I got home I realised I had been given no information on when to remove my dressings and I did not know who to contact."

"Although I asked about physiotherapy, I was not given any concrete information on how to arrange it or when, what is required other than that I would need a referral."

As a result – the Orthopaedic Outpatient information is being reviewed and updated to ensure it contains the correct contact details so that patients know who to contact if they are worried or have questions about their care. Henry, Charge Nurse Manager says "It's a great yardstick for our services. Patients tell us about things we don't know are an issue. We can use this information to check up on ourselves and improve our services"

Rethink rehab

Qualitative feedback from the patient experience survey in the Older Persons' Health Service at Burwood Hospital told us patients were not utilising the facilities and rehabilitation opportunities. This gave Burwood an opportunity to 'rethink rehab'.

"There was a lot of sitting around"

"I was unsure about rehabilitation programme"

In response to the feedback in the patient experience survey, a more detailed study was undertaken to capture and understand what patients actually did during the day. Patients were 'followed' from 0800 – 1500 hours.

What their day looked like surprised everyone, including the patients. 51.5% of their day was spent sitting/lying doing nothing.

A 'Rethinking Rehabilitation' workshop was held to improve opportunities for rehabilitation and to improve the patient experience.

The key aims, post the workshop, were to have all patients sitting in a chair for meals, patients to be given the opportunity to walk at least three times a day and to spend time during the day in a social space rather than in their bed space.

Ward teams have worked hard to provide more opportunities for patients to get up, move around and

socialise. Sarah Hurring, Clinical Director, says "It is important to ask patients what they think will help them with their rehabilitation. This has emphasised to us which aspects of our rethinking rehabilitation programme we need to focus on"

"The staff gave me confidence to realise I could walk with a walker to the toilet and shower without any problem. Someone was always handy if I needed help."

"The people who came to help me walk were just so good – they never growled if I could not get it right the first time, they just helped me along until I got it right."

"Nurses were great, giving me as much autonomy and independence as possible. They guided and showed me how to do things easily. Instruction on 'dos and don'ts' were great."

The lowest scoring areas in 2021 were discharge planning, and discharge medications. 65.9 percent of patients told us that they were definitely involved in decisions about their discharge from hospital, with 59.7 percent telling us they received enough information from the hospital to manage their condition after discharge.

Above: Clinical Director Sarah Hurring helping John (Burwood Hospital patient) with his puzzle.

Medication

The inpatient and outpatient survey feedback for medications are similar. 53.7 percent of inpatients surveyed said a staff member told them about medication side effects to watch for when they went home. 53 percent of outpatients who returned a survey told us that staff discussed their medication, what it was for and how to take it – in a way they could understand.

"There was no conversation on decisions with me or my whānau, I wasn't even told a day I would be discharged. I asked every day and was never told till the lovely nurse on the Sunday pushed for information and when she came back she felt horrible because her answer was 'your being discharged in 1 hour.' How disappointing is this!"

"I was a bit overwhelmed by the amount of medication I was prescribed and would have liked clearer instructions what to take when, instead of having to work this out myself."

"Lack of information being given about medication and its suitability for me, and no follow up – so being left not knowing what I should be doing."

"The nursing staff anticipated questions, went over discharge summary and called on pharmacy staff to further explain medication."

During 2022, our goal is to improve patient experience and communication around discharge and discharge medications.

The Canterbury Clinical Network's Pharmacy Service Level Alliance has established a working group to identify opportunities to improve medication management for consumers as they transfer from the community into secondary care and back home again. The Transfer of Care Working Group brings together diverse perspectives, including prescribers, pharmacists, and nurses from primary and secondary care, together with the consumer's voice.

Feedback from consumers through the Patient Experience Survey has been useful in informing the working group of themes around medication and how they can improve the flow of information between hospital and the community.

Initially, the Transfer of Care Working Group will focus on identifying opportunities to improve medication management and safety for consumers living independently and aged 65 years or older (55 for Māori and Pacific Peoples). The group will draw on a range of different data sources, including inpatient, outpatient and primary care patient experience survey data to support this work. Data from the Patient Experience Survey will be used to inform the focus for improvement and measure the effects of improvement efforts.

Gareth Frew, Clinical Leader and Pharmacy Service Level Alliance Facilitator says, "The Patient Experience Survey provides us with a wealth of information on how we can improve the medication aspect of transfers of care between the GP, community care, outpatients and the hospital."

In 2022, we are also looking at trying to increase the survey response rate. From September 2020 to September 2021, there were 34,158 inpatient invitations to participate in the survey, with 5,758 responding – a response rate of 16 percent.

For the same period there were 87,092 outpatient invitations and 13,316 responses – a response rate of 15 percent.

During 2022, our goal is to increase the number of patients completing the patient experience survey.

Above: Burwood Pharmacist Bevan talking to Burwood nurses about discharge medications.

What are we doing about our low response rate to the survey?

- Prompting patients to keep their details up to date when they check in for an appointment so they get a survey link.
- Encouraging patients to take our survey so that we can get a better sense of how we are providing services for them.
- Refreshing our posters in clinic areas to promote the survey.
- Engaging with our Māori and Pasifika health workers and providers to promote the survey to the patients they engage with.

Outpatient Survey

The Canterbury DHB Outpatient Experience Survey was first introduced in March 2018.

Feedback from patients attending outpatient appointments told us the survey was too long and too complicated. The Patient Experience Team had been disappointed to see the low survey response rate – particularly for Māori and decided it was time to review the survey.

"Our outpatient response rate is between 15 – 20 percent. With a shorter survey, we are hoping to get more people attending outpatient appointments to comment on their care. With such a low response rate, we were concerned that we weren't capturing the experiences of all groups, particularly Māori, Pacific People and our disabled patients. Without their feedback on their appointment, we aren't able to measure their experience and make improvements".

Analysis of the current outpatient survey showed that consumers stopped answering questions and dropped out of the survey after 20 questions, contributing to the low response rate.

From March – July 2021, an extensive review of the current outpatient survey was undertaken with the aim to make it much shorter. This included feedback and testing with consumers who told us what was important to them. The proposed new outpatient survey has fewer base questions but includes specific questions to cover the increase in scope – diagnostics/minor procedures, telehealth, questions about cultural safety and sedation. The review group considers the flow of the questions and their intent to be much clearer and they are hoping that will encourage more patients to complete the survey.

Mathew Long – Outpatient Service Manager says "Evidence tells us that patient experience is a good indicator of the quality of our services. We know that a better outpatient experience and stronger partnerships with our patients are linked to improved health outcomes. That's why it is so important to get our outpatient services right".

The new outpatient survey went live in late October 2021.

How are we tracking over the last 4 years?

Scores in the table below are out of ten

Communication	2021-21	2019-20	2018-19	2017-18	2016-17
Hospital care	8.7	8.6	8.4	8.6	8.6
Outpatient care	9.0	9.0	8.9	9.0	-

Partnership	2021-21	2019-20	2018-19	2017-18	2016-17
Hospital care	8.6	8.5	8.6	8.6	8.6
Outpatient care	9.0	9.0	8.9	9.0	-

Coordination of care	2021-21	2019-20	2018-19	2017-18	2016-17
Hospital care	8.5	8.5	8.4	8.5	8.6
Outpatient care	8.7	8.8	8.5	8.8	-

Physical & emotional needs	2021-21	2019-20	2018-19	2017-18	2016-17
Hospital care	8.7	8.6	8.7	8.8	8.8
Outpatient care	8.9	9.0	8.8	9.2	-

Quality and Safety Markers

Health Quality and Safety Markers are designed to track progress to help us improve healthcare and reduce patient harm. Areas of work include falls reduction, hand hygiene, safe surgery, surgical site infections, medication reconciliation, opioids, and the deteriorating patient. The markers measure healthcare processes and outcomes. The thresholds for the markers have been set by the Health Quality and Safety Commission expert advisory groups. The Health Quality and Safety Commission have created a Dashboard of Health System Quality that brings the range of measures together in one place. Below are some of the key improvement initiatives.

Falls Prevention

Canterbury DHB has a 'Whole of System' approach to falls prevention. The DHB is committed to achieving zero harm as falls can have both a detrimental physical, and a psychological impact. Older people who fall are more likely to lose confidence and independence, are at greater risk of falling again, and may stay in hospital longer.

The Canterbury DHB team take safe mobility and falls prevention very seriously, with the focus on the following three key areas: (1) falls prevention in the wider community; (2) falls prevention in rest homes; and (3) falls prevention when receiving care in our hospitals.

In the community and rest homes

Falls prevention is still a key focus for the health of older persons. The Falls and Fracture Service Level Alliance (FFSLA) was established in October 2017 and set up for a three-year period. Oversight for our falls and fracture activity has now transferred to the Community Services – Service Level Alliance (CSSLA) to ensure that the work plans created since 2017 can continue. Falls data continues to be reviewed at SLA meetings and is used locally to ensure that the work plan is targeted towards the right areas.

Our lead agency, Sport Canterbury, is collaborating with other DHBs to look at strategies for engaging rural communities. Our focus for 2022 is to establish classes within the Kaikōura, Banks Peninsula and Hurunui Districts, as well as classes for Māori, Pacific People and other culturally and linguistically diverse populations. A community class was established in Diamond Harbour in April 2021. Physiotherapists had been asking for a local class to support the older members of this community, as they found the logistics of supporting this community difficult.

Supporting our Muslim class-leaders to reinstate their class for Muslim women is also a priority. This quarter, Sport Canterbury re-engaged with the Muslim community of Christchurch to support an exercise class for women. Prior to the Christchurch terror attack, an accredited class had been offered for women at Al Noor Mosque.

Our Fracture Liaison Service (FLS) continues to identify those at risk of a fall. Automatic reporting has been setup to advise the FLS of any potential fragility fractures that have been seen in our secondary care system. In addition, ACC is now funding additional nursing and admin FTE nationally to support the Fracture Liaison Service, with new reporting requirements as advised by Osteoporosis NZ.

ACC has already assessed Canterbury's FLS as gold standard; work is underway to make this ranking and good service sustainable and address improvements across Canterbury and the West Coast. We will be recruiting to the newly created positions by the end of October 2021. They will support the fracture liaison service in Canterbury and the aim is for the West Coast service to reach a gold standard too.

In the 2020-21-year, 11,856 people identified as a falls risk received group community strength and balance training (against an annual target of 12,020). Given the challenges of community classes in the year of COVID-19, this result is acceptable. 1,889 people received in-home strength and balance training (against a target of 1,800). Given that there is a three-

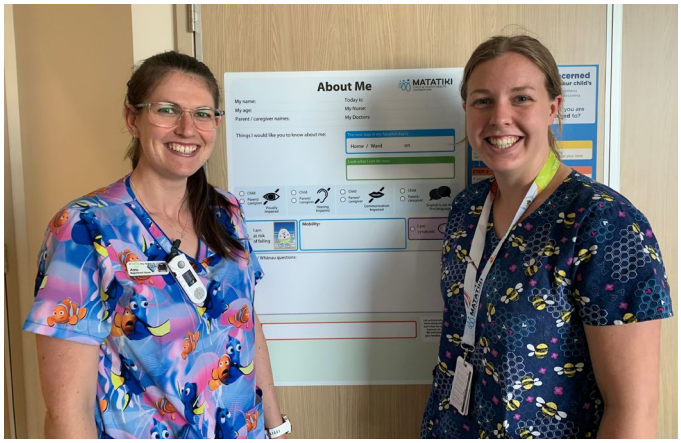
month lag in our data source, we are very pleased to find that the target has been met with three months to spare.

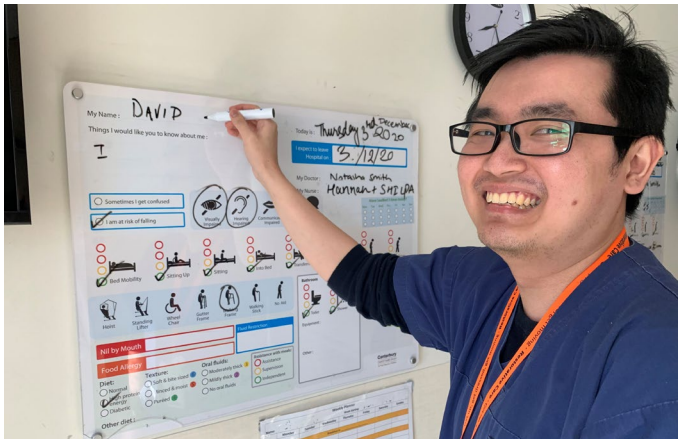
In our Facilities

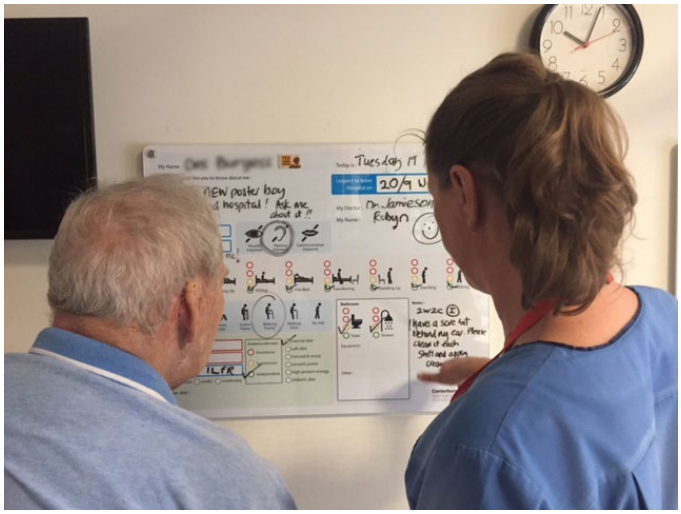
In 2020/2021 we treated 121,154 patients over 375,823 bed days. From a total of 2,222 inpatient falls across all our hospital facilities, a quarter of patients were injured (568). The rate of falls resulting in injury per 1000 inpatient bed days has increased from 1.41 to 1.51 compared to the 19/20 year.

Of the fall events, 42 patient injuries were confirmed as resulting in a fracture or head injury (classified as serious harm) during the 2020/21 year. Each fall that results in serious harm has an independent file review to determine contributory factors and identify if there are any aspects of care management that could be improved. These reviews are moderated by a multidisciplinary Review Panel and recommendations are made as required.

There continues to be a focus on safe mobility, identifying risk factors, and tailoring falls prevention strategies to meet the needs of individual patients







while they are in hospital, and at home. There is an ongoing focus on encouraging patients to wear appropriate footwear in hospital and bring their own walking aides, which they are used to.

Partnering with the patient/whānau and empowering them to keep safe while in hospital continues to be an important part of our hospital safe mobility strategy. This includes discussions around the patient's potential risk of falling and prevention strategies as well as providing them with educational material.

Improvement activities include standardising process and practice, such as the use of visual aids to indicate a patient's safe mobility level (e.g. wrist bracelet) and visible bedside safe mobility plans for all inpatients.

Bedside handover and the use of Bedside Boards are examples of how we encourage and enable patients and whānau to be more involved. Partnering with new māmā and their whānau and empowering them to keep safe while in Christchurch Women's' Maternity Ward continues to be an important part of our safe hospital strategy.

The Bedside Boards highlight and initiate discussions around a woman's potential risks during her stay as well as providing wāhine with a tool to communicate their needs and wishes to the team.

Bedside Boards have several alerts that give staff useful information 'at a glance' to aid communication and patient safety.

Midwife Urunumia says "The boards are awesome. For me, I have an unusual name so it's nice to be able to put it up on the board, so māmā and their whānau know I am looking after them. It gives me a chance to have a kōrero about the plan for the day and any risks or concerns they might have".

The boards allow the care team to convey the plan of care on a day-to-day basis. They are a way of introducing members of the care team to the māmā, and māmā to members of the team. Having this information readily available is important as a lot of people come and go from ward rooms every day.

Patient information boards at the bedside are now in all our facilities. They are a visual tool that indicate to wāhine, whānau, and staff the essential information and assistance a patient requires to maintain their safety in our hospital environment 'at a glance'.

ARE WE DOING THINGS RIGHT?

Canterbury DHB has consistently achieved the HQSC 90 percent target for patients aged 75+ (55+ Māori and Pacific People) who received a falls risk assessment, with the range for quarters in the 1 Jul 2020 to 30 June 2021 year being 94 to 100 percent. The quarterly results for patients at risk with an individualised care plan ranged from 93 to 98 percent for the same period

Above: Midwife Urunumia updates the Bedside Board for a new māmā and pēpi coming from the Birthing Suite.

We are listening to what our patients are telling us. Patient feedback is regularly reviewed and shared with clinical teams to celebrate what is being done well and to give teams a heads up if things are not going so well. Christchurch Hospital teams are monitoring feedback from patients or their family member's experience with delirium. There had been some feedback from patients (and their families/whānau) with dementia, delirium or confusion about how they navigate the hospital system. Looking at the comments from the Patient Experience Survey gives a good insight in to how we can improve their stay with us.

"My wife was not contacted during the night the delirium started, leading me to be in a very agitated state that resulted in me pulling out my catheter. If my wife had been asked if she would come in this is unlikely to have occurred as I felt safe with her beside me."

"I was completely confused and have no memory of two days. During this time my sons, especially my Sydney son, was able to ring as often as was needed as my condition deteriorated, including overnight. Then he was able to determine that he needed to come over straight away. While here he was allowed to be with me all day with no sense of anyone shooing him out the door at any time. I greatly appreciated that."

"Dad is very hard of hearing and due to his age gets confused sometimes, so he relies on family to get the information and explain to him later. Not always possible as we weren't there when Drs visited, so communication was a bit challenging – but understandable."

One of the recommendations from the Delirium Assessment and Management Group is to consider using the Kōwhai conversation chart, a new concept being used at Burwood Hospital. The concept for the Kōwhai chart came from Burwood's original Sunflower chart that has been utilised since 2015. The Sunflower chart was being used on the Sunshine Coast in Australia for encouraging conversations with patients with dementia, delirium or confusion.

Feedback from our Māori Health Partners asked why we weren't using a New Zealand flower. Burwood spent some time looking for something that would meet the needs of their patients and the Kōwhai was chosen. Luckily Burwood have a resident artist Lynne Brice (PA to the Director of Nursing) who whipped one up!

Fiona Graham, Kairuruku Hōtaka/Programme Coordinator – Kōwhai Programme, is very excited.

"The Kōwhai companion programme is based on similar models in Australia. The aim is to train volunteers, who will be known as 'Kōwhai Companions', to provide person-centred emotional support, enhance meaningful occupation, and practical assistance to patients who are at risk of developing delirium. Evidence suggests these programmes may help reduce the risk factors that can contribute to delirium such as anxiety, dehydration and malnutrition."

"I am hopeful that the programme will also show a reduction in patient harm from falls, pressure injuries and other hospital-acquired illnesses. That can only be good for our elderly patients". Keep an eye out for the Kōwhai charts and help us fill them in!

Left: Fiona Graham and Lynn Brice modelling the Kōwhai Conversation chart.

Pressure Injury Prevention

Hospital Acquired Pressure Injuries

Canterbury DHB is committed to ensuring all steps are taken to prevent pressure injuries from developing while people are in our care.

Pressure injuries (PI – also known as pressure ulcers or bed sores) can occur when patients have reduced mobility, difficulty with their nutrition needs or moisture management when they are unwell and face hospitalisation. PIs are considered mainly as a preventable adverse event. These injuries usually affect 'bony' parts of the body and are due to sustained pressure or from shear and/or friction. Canterbury DHB works in partnership with our patients/whānau to tailor care to the person's risk factors.

Canterbury DHB has been proactive in preventing PIs, both in hospitals and the community, taking a 'whole of system' and patient-centred care approach to implementing improvements.

Across the Canterbury Health System

Canterbury DHB is continuing to work closely with ACC to strengthen best practice across the health community through the implementation of a system-wide Pressure Injury Prevention (PIP) Community of Practice which includes Canterbury DHB and West Coast DHBs. A 'human factors' workshop was held for staff who are part of the review team.

The Canterbury and West Coast Pressure Injury Advisory Group meets regularly with the aim of improving clinical outcomes and standardising clinical best practice. This is achieved by producing clinical resources for use in practice across the sectors and districts, utilising an 'it takes a team' approach to pressure injury prevention. Pressure Injury steering groups are in place on the Christchurch Hospital Campus and in Older Persons Health and Rehabilitation.

Resources for staff to teach consumers and whānau about SSKIN (Skin inspection, Support Surface, Keep moving, Incontinence & Nutrition), and pressure injury prevention are now available in the community, aged residential care and hospital settings. A focused addition to staff education has also increased awareness around the risk of medical devices e.g. catheters, oxygen tubing/masks etc.

In our Facilities

In 2020/2021 we treated 121,154 patients over 375,823 bed days. A total of 663 hospital-acquired pressure injuries were reported across our facilities. Of these, 294 were stage 1 (reddened area), 299 were stage 2 (with partial loss of the top of the skin or 'dermis'), and 43 were confirmed as a stage 3 or 4 (unstageable or deep tissue) pressure injury. Each hospital-acquired pressure injury stage 3 or greater has an independent file review to determine contributory factors and to identify if there were any opportunities to improve care management. These reviews are moderated by a multidisciplinary Review Panel which includes a consumer, and recommendations are made.

There is a continued focus on strengthening processes, staff guidance and pressure injury relieving equipment. For example, review of the pressure injury prevention procedure which supports patient-centred care and best practice evidence from the 2019 guidelines and the ACC guiding principles direction has been reviewed and a transalpine staff guidance document for pressure injury support and care for at-risk areas of the body has been developed.

Hybrid mattresses have been introduced to Canterbury DHB facilities that can be upgraded to alternating air mattress to improve pressure redistribution qualities to support patients at a high risk of pressure injury development. This means patients do not have to wait for a pressure redistribution mattress or to be transferred unnecessarily.

Pressure injury prevention interventions are being evaluated, with regular local process audits where patients are being asked to discuss their involvement in their care.

ARE WE DOING THINGS RIGHT?

Canterbury DHB has consistently achieved above 90 percent for both the HQSC process markers in the 1 July 2020 to 30 June 2021 year. The percentage of patients with a documented and current pressure injury assessment has ranged quarterly from 95 to 98 percent and quarterly results for at-risk patients with a documented and current individualised care plan ranged from 91 to 94 percent in the same period.

Hand Hygiene

Worldwide, one in 10 patients gets an avoidable infection while receiving care. Healthcare-associated infections are a problem in all countries and can lead to disability, antimicrobial resistance, increased hospital stays, and death. Infection Prevention and Control, including hand hygiene, provides direction for staff using a practical and evidence-based approach which has proven benefits for quality of care and patient safety across all parts of the health system.

Effective hand hygiene by healthcare workers, at the right time (for example, before and after touching a patient,) is a core strategy for preventing healthcare-associated infections. Effective hand hygiene is recognised worldwide as one of the most effective actions we can take to stop the spread of infections. We have seen the extensive promotion of the importance of good hand hygiene practices as part of the bundle of protection that reduces the risk of catching and spreading COVID-19.

An infection spread by unclean hands can have a devastating impact on a patient and their family/whānau. This makes it vitally important for healthcare workers to practice good hand hygiene and makes it a key patient safety priority.

Canterbury DHB promotes hand hygiene for both staff and consumers – either washing with liquid soap or using alcohol-based hand rub. Staff hand hygiene practice is observed in line with the Health Quality Safety Commission (HQSC) Hand Hygiene Programme.

Hand Hygiene initiatives across the Canterbury Health System include the World Health Organization Hand Hygiene Day, observed on 5 May. The themes for 2021 were "Save lives – clean your hands" and "Seconds save lives – clean your hands! During the COVID-19 pandemic these measures are even more important in reducing the opportunity for infection and the spread of infectious disease.

Undertaking hand hygiene takes just a few seconds and does save lives! During the Global Hand Hygiene Day (5 May) WHO & HQSC called upon all key players around this slogan Seconds save lives – clean your hands!

Canterbury DHB inpatient and outpatient surveys ask specific Hand Hygiene-related questions. Questions in both surveys asked 'did staff use hand sanitiser or wash their hands before they touched or examined you?' Consumer feedback stated that this was not done between 1 and 4 percent of the time.

Consumers are not enabled to clean their hands if they are unable to walk, unattended, to a basin between 20 and 25 percent of the time. This result is concerning and has resulted in trialing different products and methods to see how we can improve hand hygiene opportunities for consumers. The hand hygiene patient information leaflet is available to the public on www.healthinfo.org.nz.

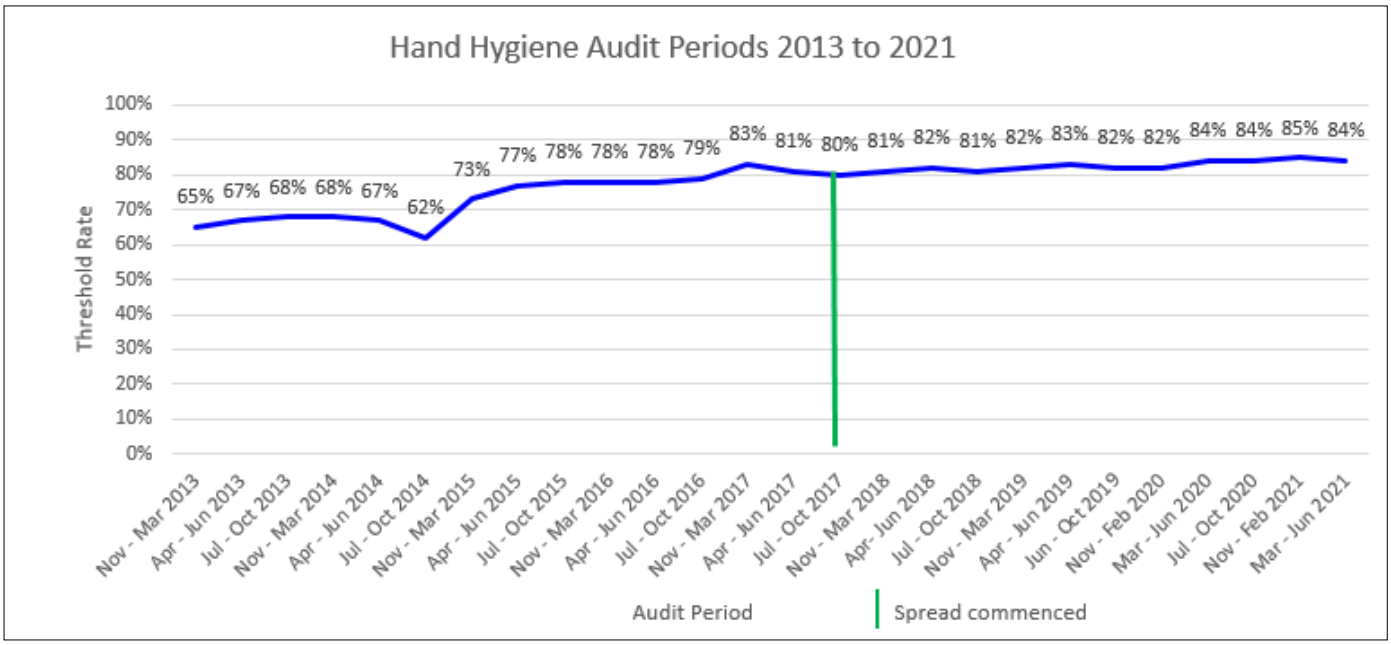
Threshold

The national target threshold for health professionals carrying out hand hygiene at the right time is 80 percent. For Canterbury DHB the aspirational aim is to reach 100 percent.

Spread of the Hand Hygiene Measurement Programme across all clinical inpatient areas in each audit period continues, with all clinics/areas with invasive procedures achieving the target as of 1 November 2018. Hand hygiene initiatives continue in other areas such as mental health and rural hospitals and aged care facilities.

ARE WE DOING THINGS RIGHT?

Canterbury DHB first surpassed the 80 percent hand hygiene target with 83.3 percent for the audit period finishing on 31 March 2017. This result has been sustained since that date, with the latest audit result of 84 percent for the period 30 June 2021. Fourteen consecutive audit period results have been over 80 percent.



Safe Surgery

Canterbury DHB participates in the Safe Surgery Programme which measures levels of teamwork and communication in the surgical team using a surgical safety checklist.

Direct observational audit assesses the use of the three surgical checklist parts: Sign-in, Time-out & Sign-out. A minimum of 50 observational audits per quarter are required before the observation is included in uptake and engagement assessments.

Of note from July 2021, the process measures (Sign-in, Time-out & Sign-out) will no longer be updated for the July – September 2021 quarter onwards. The programme is now in the sustain mode. Canterbury DHB will continue with the Safe Surgery Programme and data collection, which will be entered on the Safe Surgery website.

Threshold

A minimum of 50 observational audits per part (Sign-in, Time-out & Sign-out), per quarter are required.

ARE WE DOING THINGS RIGHT?

Direct observational audit is used to assess the use of the three surgical checklist parts: Sign-in, Time-out & Sign-out. A minimum of 50 observational audits per quarter per part is required before the observation is included in uptake and engagement assessments.

SIGN IN

Led by anaesthetist before induction (block or GA)

1. **Team has confirmed:**
   - Correct patient
   - Correct procedure
   - Correct site / side?
2. **Allergies?**
3. **Difficult airway?**
4. **Group and screen or blood available?**
5. **Special equipment available?**
   - Anaesthetic
   - Surgical
   - Other

TIME OUT

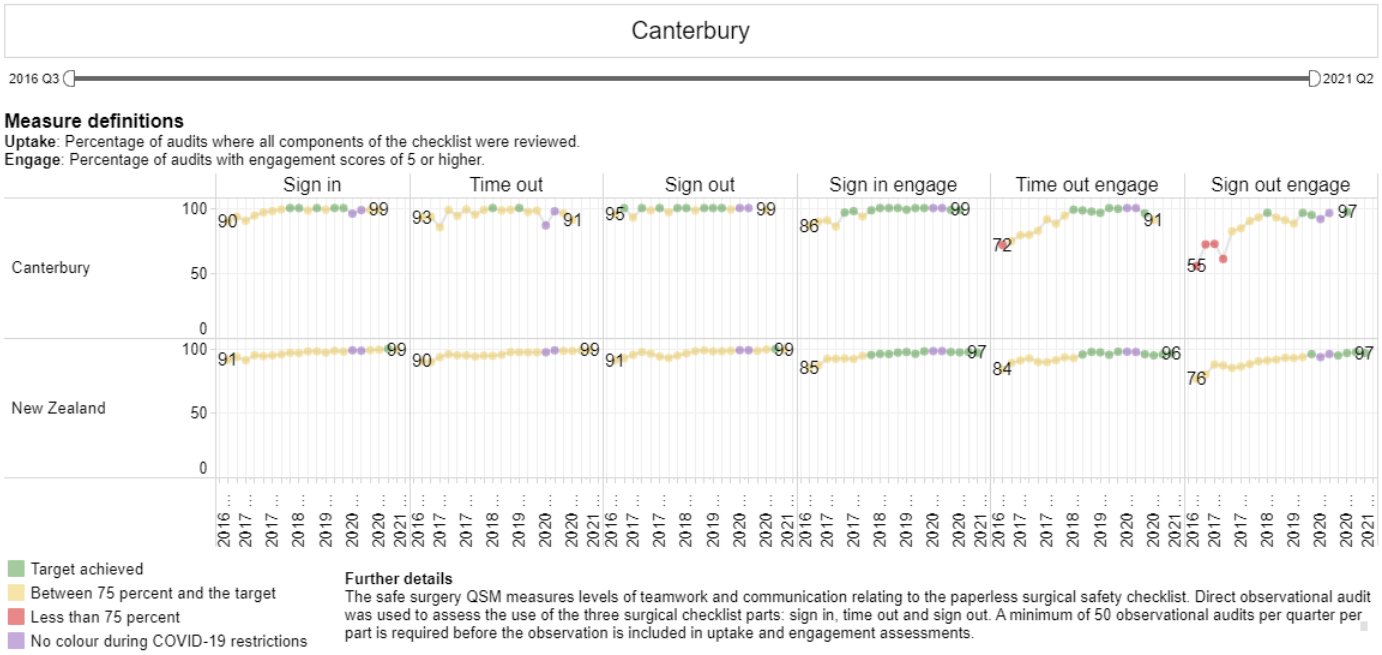
Led by surgeon after positioning and before skin incision

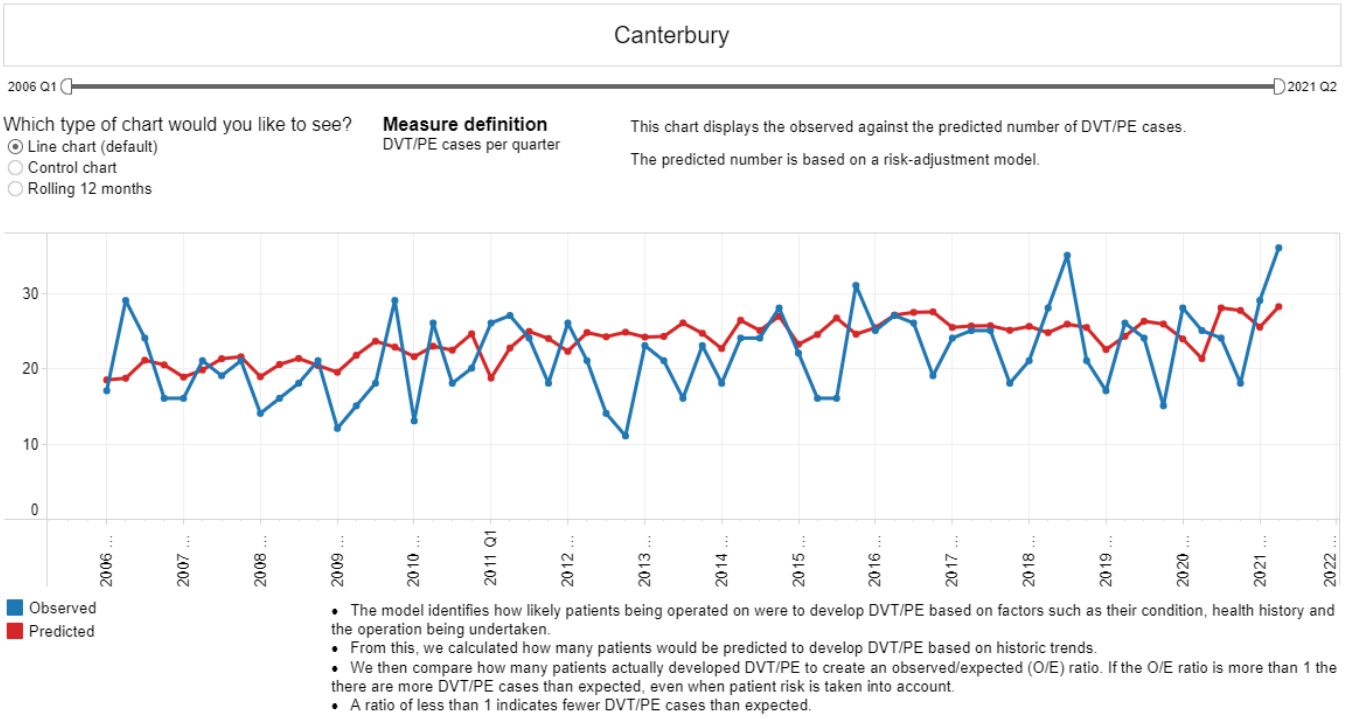
1. **Team members introduced by name and role.**
2. **Team has reconfirmed.**
   - Correct patient
   - Correct procedure
   - Correct site / side?
3. **Correct imaging displayed?**
4. **Other drugs?**
   - Antibiotics
   - Other drugs - e.g. local anaesthetics, heparin
5. **Intraoperative DVT prophylaxis?**
6. **Concerns or anticipated critical events?**
   - Surgeon
   - Anaesthetist
   - Nurse
   - Other - e.g. perfusionist

SIGN OUT

Led by nurse before patient leaves theatre

1. **Instrument, swab and needle counts are correct.**
2. **Correct procedure(s) recorded.**
3. **Specimens correctly labelled / sent?**
4. **Postoperative DVT prophylaxis?**
5. **Equipment issues?**
6. **Concerns for post-op management?**
   - Surgeon
   - Anaesthetist
   - Other





Canterbury DHB met the threshold for 50 observational audits for all audit periods and is one of 11 DHB's that have achieved 50 audits in each checklist section.

The target for 100 percent uptake of observed operations where the checklist has been completed, was narrowly missed for Sign-in by 1 percent, by 9 percent for Time-Out, and by 1 percent for Sign-Out. The target is 95 percent for engagement for all three surgical safety components. Canterbury DHB achieved this in both Sign-in and Sign-out components and narrowly missed Time-Out by 4 percent. Over the past twelve months improvements have been achieved, with ongoing progress expected in future quarters.

Surgical Site Infection Prevention Programme

A surgical site infection is an infection of a surgical wound following surgery. Some infections are minor and only skin-deep, others can be deeper involving organs, or implanted material such as prosthesis used in joint replacements.

The Health Quality and Safety Commission continues its focus on reducing surgical site infections following orthopaedic hip and knee replacement, and cardiac surgery. The recommendation is that the correct skin preparation combined with the correct dose and type of antibiotic is given within a set timeframe prior to the surgical procedure (0-60 minutes before 'knife to skin') to help prevent infection. Canterbury DHB participates in this national programme, achieving comparable rates with other DHBs in both cardiac & orthopaedic procedures.

ARE WE DOING THINGS RIGHT?

Canterbury DHB's local cumulative infection rate to the end of December is 0.7 percent, and the national cumulative rate is 1 percent. In the last quarter for 2020 (Oct to Dec), there were 5 SSIs defined during this period, with the infection rate for Canterbury DHB being 1.3 percent compared to the national infection rate of 1 percent for that period. For the period Jan – Mar 2021 Canterbury DHB's infection rate is 0.5 percent compared to 0.7 percent nationally.

Orthopaedic

As of 1 October 2020, Canterbury DHB (along with 11 other DHBs) elected to move to light surveillance and ceased to collect and report orthopaedic quality and safety process markers (QSM). This decision was based on compliance with process measures being sustained at a high rate, as well as a low rate of SSI. Going forward, Canterbury DHB will now only report surgical procedures (denominator) and full data for SSI cases only (numerator). This will allow for further investigation and root cause analysis on the SSI cases with the aim of further reduction of the SSI rate.

ARE WE DOING THINGS RIGHT?

During Q1 January – March 2021, DHBs performed **2,291** hip and knee arthroplasty procedures. Nationally there were **17** SSIs (4 superficial and 13 deep or organ space).

Canterbury DHB performed **375** procedures during this period (**377** in previous quarter):

- 192 Primary hip arthroplasties
- 20 Revision hip arthroplasties

- 151 Primary knee arthroplasties
- 12 Revision knee arthroplasties

There were 2 SSI defined for Canterbury DHB during this reporting period and an infection rate of 0.5 percent compared to the national rate of 0.7 percent.

Canterbury DHB's local cumulative infection rate to the end of December is 0.7 percent. The national cumulative rate is 1 percent.

Outcome measure

Select DHBs and/or regions

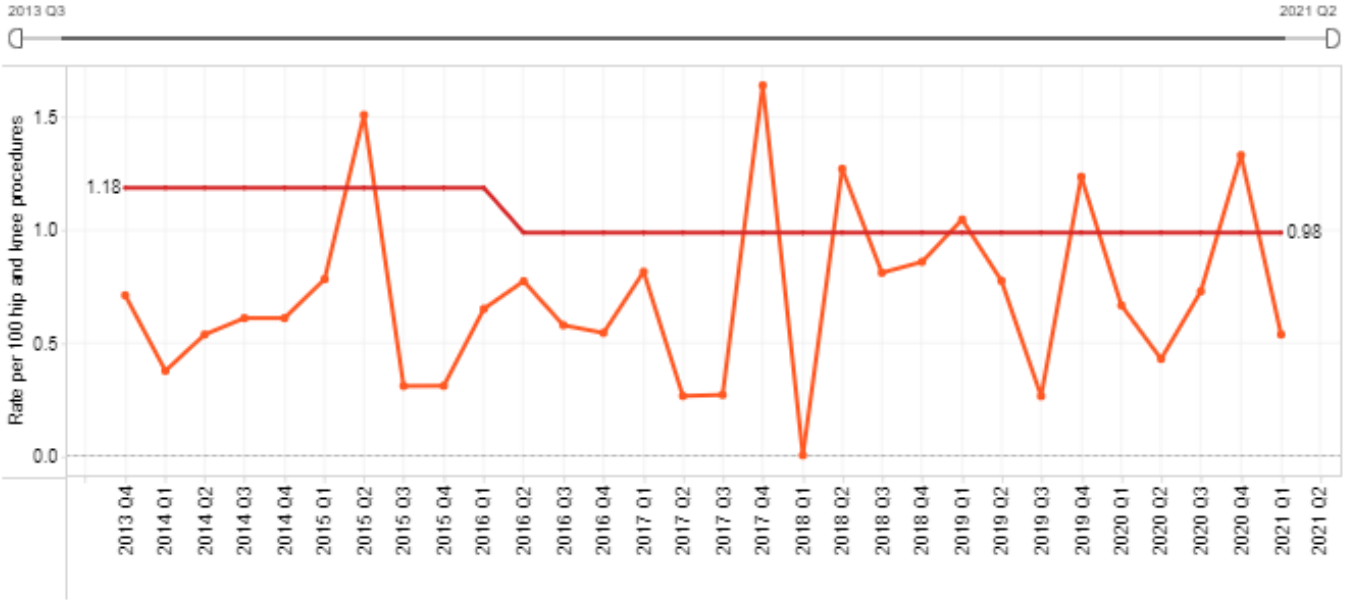
Canterbury

Measure definition

SSIs per 100 hip and knee procedures

Canterbury New Zealand median

Demographic data is being collected for each DHB and will be reported on in the coming quarters.

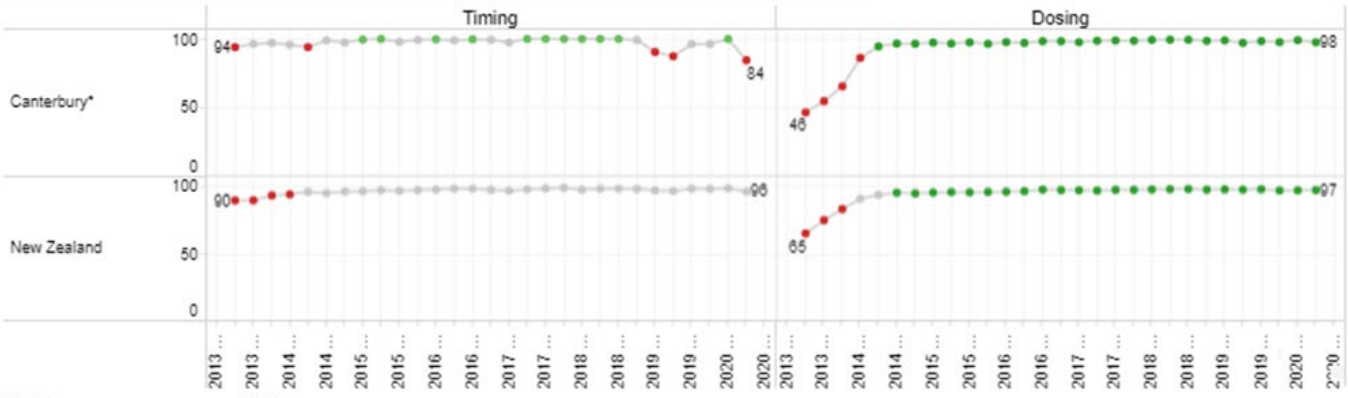


Process measures

Canterbury

Measure definitions

Timing: Percentage of primary procedures with the antibiotic administered in the right time.
Dosing: Percentage of procedures with the right antibiotic in the right dose – cefazolin 2 g or more or cefuroxime 1.5 g or more.



Timing
- Upper group: = 100 percent
- Middle group: 95–99 percent
- Lower group: < 95 percent

Dosing
- Upper group: ≥ 95 percent
- Middle group: 90–94 percent
- Lower group: < 90 percent

Further details

In quarter 1, 2015, 1.5 g or more of cefuroxime was accepted as an alternative agent to 2 g or more of cefazolin for routine antibiotic prophylaxis for hip and knee replacements.

Cardiac

In cardiac surgeries the current thresholds are as follows:

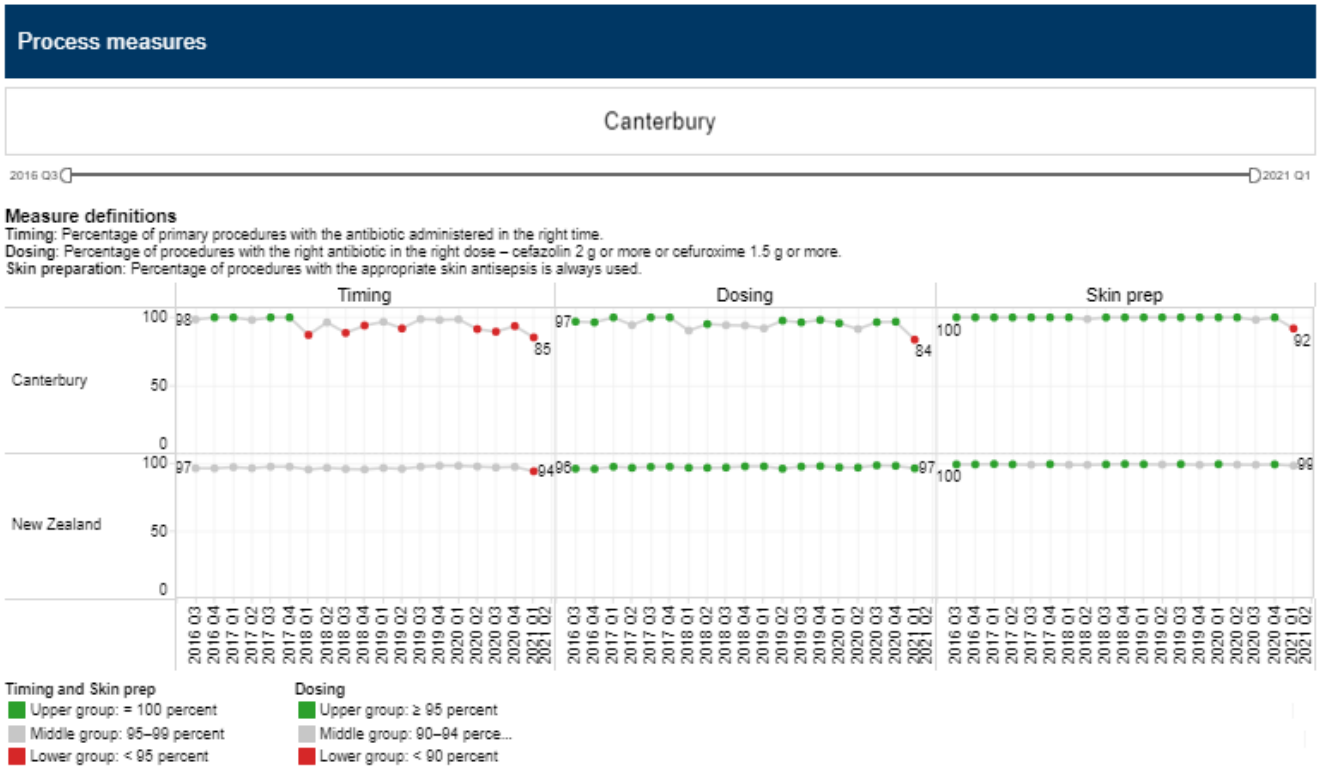
100 percent of cardiac procedure patients will receive the appropriate antibiotics 0-60 minutes before incision

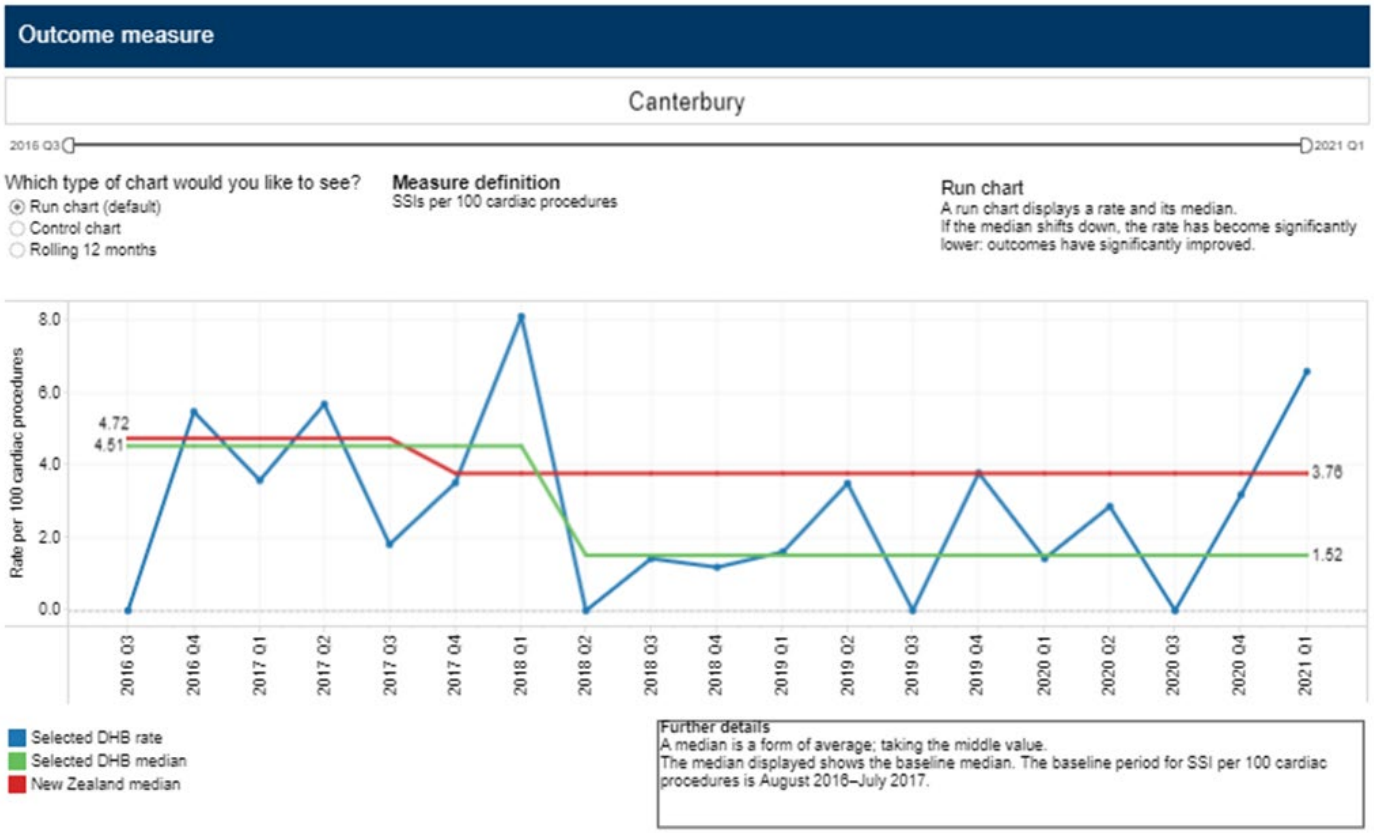
- 95 percent of adult cardiac patients will receive the prophylactic antibiotic of choice (Cefazolin >2g)
- 100 percent of cardiac procedures will receive alcohol-based skin antisepsis.

ARE WE DOING THINGS RIGHT?

In Q4 (Oct to Dec) 2020, 94 percent of cardiac surgeries involved giving the antibiotic 60 minutes or less before knife to skin, falling short of the target by 6 percent. Canterbury DHB met the target for antibiotic of choice, Cefazolin, being given 97 percent of the time, and the skin antisepsis marker of an alcohol-based skin preparation being given 100 percent of the time.

Canterbury DHB's cardiac procedure infection rate for October to December 2020, was 3.2 percent compared to the national rate of 5 percent.




Outcome measure
Canterbury
2016 Q3
2021 Q1
Which type of chart would you like to see?
Run chart (default)
Control chart
Rolling 12 months
Measure definition
SSIs per 100 cardiac procedures
Run chart
A run chart displays a rate and its median.
If the median shifts down, the rate has become significantly lower: outcomes have significantly improved.
Rate per 100 cardiac procedures
8.0
6.0
4.0
2.0
0.0
4.72
4.51
3.76
1.52
2016 Q3
2016 Q4
2017 Q1
2017 Q2
2017 Q3
2017 Q4
2018 Q1
2018 Q2
2018 Q3
2018 Q4
2019 Q1
2019 Q2
2019 Q3
2019 Q4
2020 Q1
2020 Q2
2020 Q3
2020 Q4
2021 Q1
Selected DHB rate
Selected DHB median
New Zealand median
Further details
A median is a form of average; taking the middle value.
The median displayed shows the baseline median. The baseline period for SSI per 100 cardiac procedures is August 2016–July 2017.

Medicine Reconciliation

Medicine reconciliation is a process by which health professionals accurately document all medicines a patient is taking and their adverse reactions history (including allergy).

Medicine reconciliation obtains the most accurate list of patient medicines, allergies and adverse drug reactions and compares this list with the prescribed medicines, documented allergies and adverse drug reactions. Any discrepancies are then documented and reconciled.

This information is then used during the patient's transition in care. An accurate medicines list can be reviewed to check the medicines are appropriate and safe. Medicines that should be continued, stopped or temporarily stopped can be documented on the list. Reconciliation reduces the risk of medicines being:

- omitted
- prescribed at the wrong dose
- prescribed to a patient who is allergic
- prescribed when they have the potential to interact with other prescribed medicines.

The introduction of electronic medicine reconciliation (eMedRec) allows reconciliation to be done more routinely and at the point of care, including at discharge.

Canterbury DHB is one of six DHBs that have implemented eMedRec, 100 percent of eligible wards have implemented eMedRec. At this stage Northland and Taranaki DHB hospitals are reporting process markers as further work is being undertaken on refining and agreeing the eMedRec marker definitions with the HQSC (Health Quality and Safety Commission). Once these definitions are finalised, Canterbury DHB will work on processes to enable reporting of the process markers.

Safe Use of Opioids

Opioid medicines (morphine, oxycodone, fentanyl, methadone, tramadol, codeine) are high-risk medicines, which are excellent at controlling pain but have several unintended side-effects such as nausea, vomiting, constipation and urinary retention.

Opioids can also cause serious harm when given in high doses, or in individuals who are at higher risk (e.g., opioid-induced ventilatory impairment [OIVI] and arrest).

Opioids are a leading contributor of healthcare-associated harm, ranging from patients experiencing mild distress, to substantial patient harm and increased costs to hospital services in New Zealand.

Canterbury DHB uses an electronic process for providing the data for the HQSC Opioid balancing and process markers.

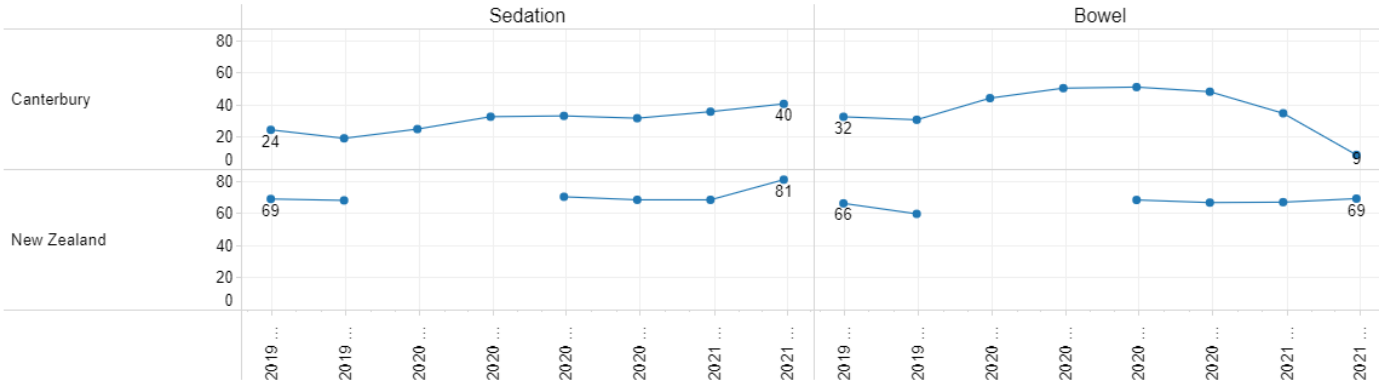
The sedation scores, bowel monitoring and pain score are not being well documented in the electronic system, which is reflected in the Canterbury DHB results. The percentage of patients with sedation levels monitored and documented following local guidelines ranged from 32 to 40 percent over the past year.

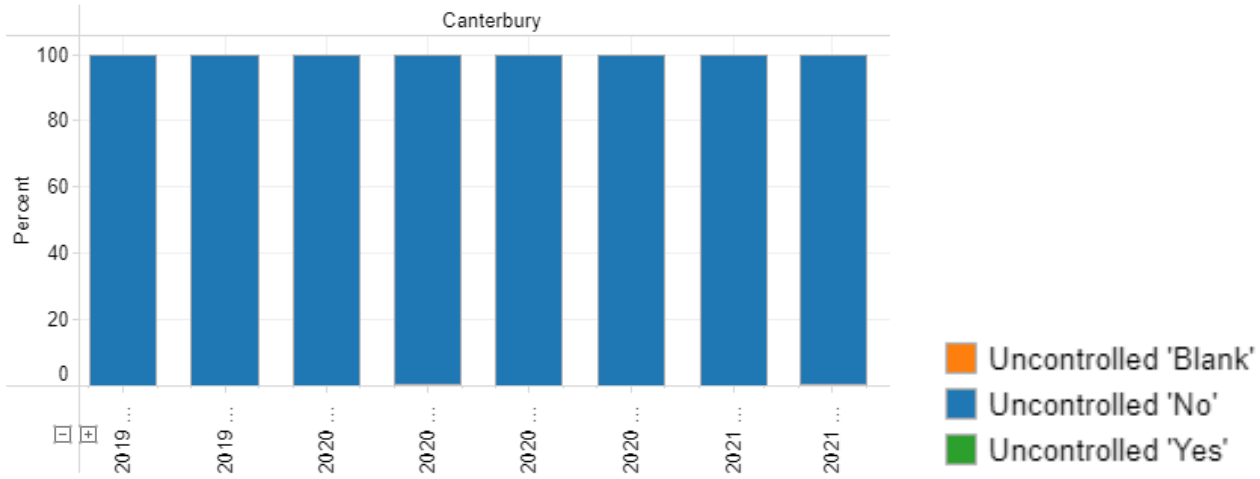
From 1 March 2021 Canterbury DHB introduced the new Adult Bowel Care Management Procedure which was aligned to the HQSC marker and requires the electronic record to be updated after each movement, or once a shift if no movement (am/pm), which accounts for the decline in the bowel monitoring marker in the graph below to 9 percent for the Apr-Jun 2021 quarter. Prior to this date the once daily monitoring parameter agreed with HQSC was used. The percentage of patients prescribed an opioid with uncontrolled pain has remained below 0.5 percent.

Staff education for surgical wards was completed and is ongoing. Ward level reports were introduced in January 2021 to help improve documentation. An Opioid Observation Interactive Report has also been developed to assist with monitoring and help improve documentation at ward level – this was first released in September 2021.

Measure definitions

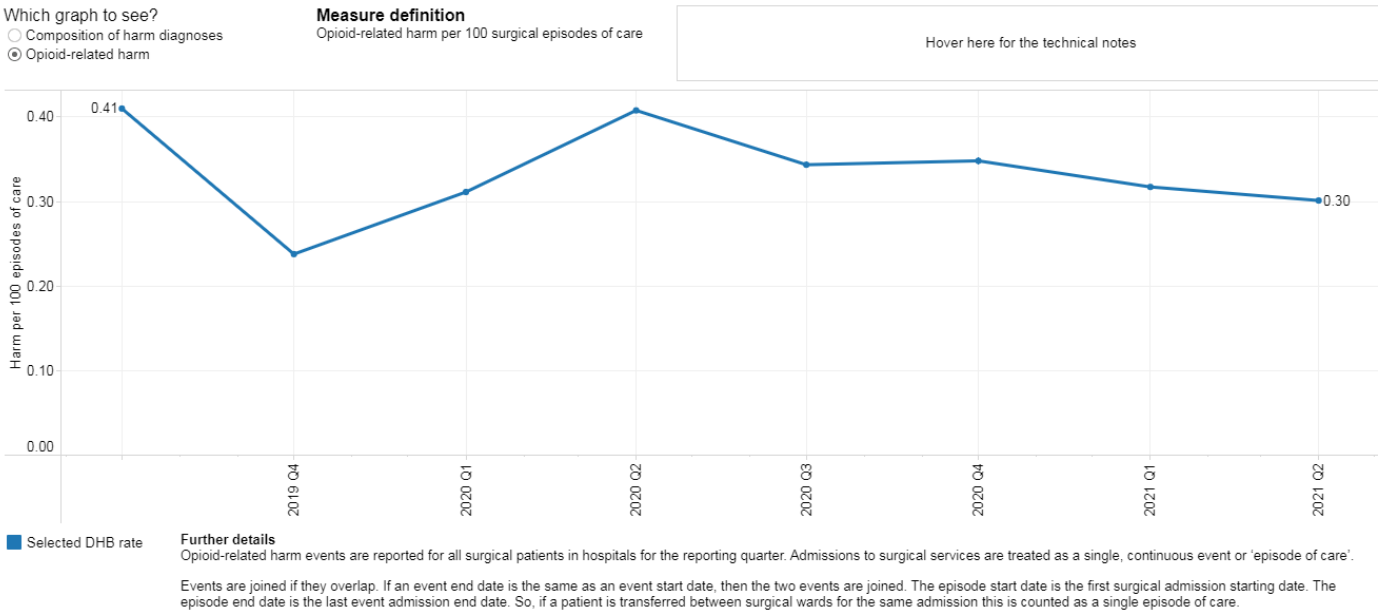
Sedation: Percentage of patients whose sedation levels are monitored and documented following local guidelines. (process)
Bowel: Percentage of patients who have had bowel function activity recorded in relevant documentation. (process)
Uncontrolled: Percentage of patients prescribed an opioid who have uncontrolled pain. (balance)

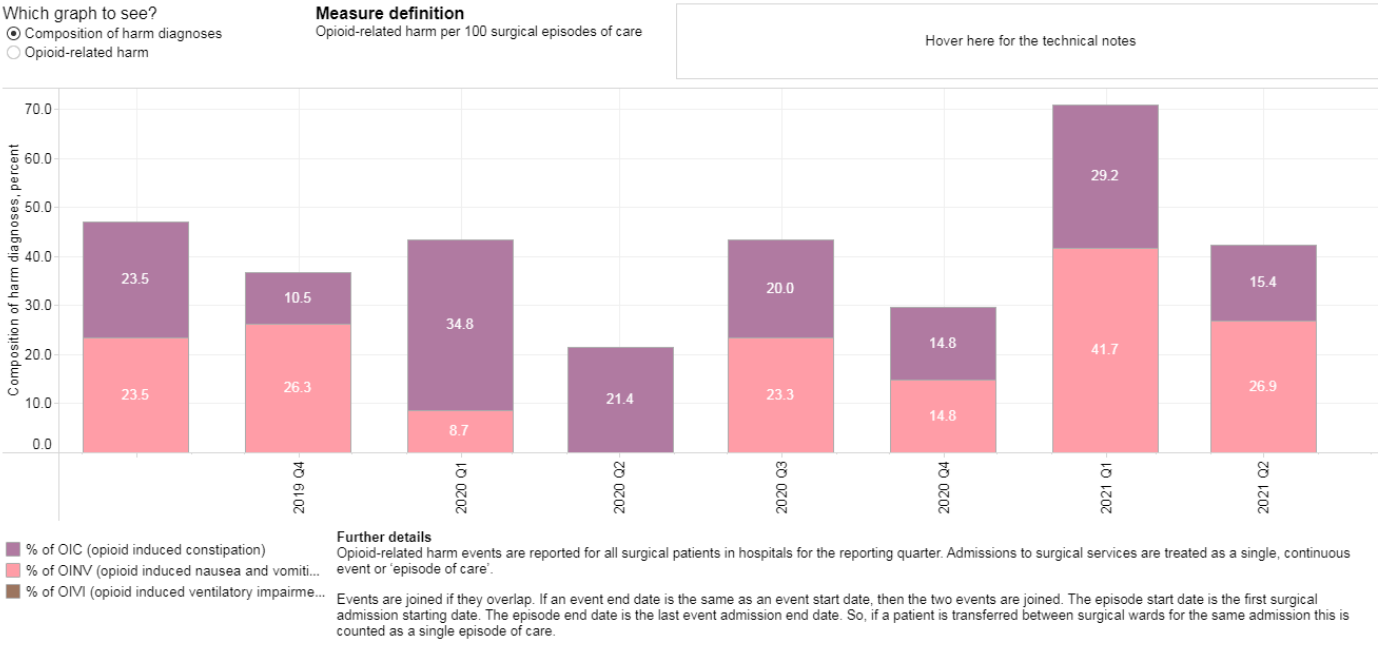




Canterbury DHB's opioid-related harm categories continue to be reported as opioid-induced constipation and nausea/vomiting (sourced from national minimum dataset).

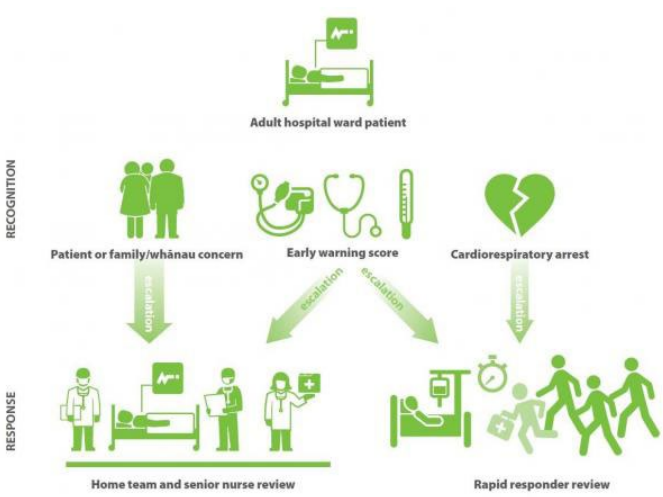
The percentage of surgical admission episodes with opioid-related harm in the Apr-Jun 2021 quarter for Canterbury DHB was 0.30. The national figure for this measure was a rate of 0.50 percent.





Deteriorating Patient Programme

Acute deterioration can happen at any point during a patient's admission to hospital. Many patients show signs and symptoms of physiological instability for some time before events such as cardiac arrest or unplanned admission to an intensive care unit (ICU). This means there are opportunities to intervene and prevent these events from occurring. The Health Quality and Safety Commission has introduced a five-year national patient deterioration programme with the aim to reduce harm from failures to recognise or respond to acute physical deterioration for all adult inpatients.



The programme consists of three streams of work.

- Recognition and response systems
- Korēro mai – patient, family and whanau escalation
- Shared goals of care.

Recognition and Reponses systems

Canterbury DHB introduced the NZ Early Warning System (NZEWS) across all of their adult inpatient beds (excluding maternity) in September 2017, an early adopter. Canterbury DHB was unusual, at this time, as they were the only DHB to introduce this as part of an electronic vital signs and assessments platform. The NZEWS is a track and trigger system that adds up and scores a set of Vital signs within the defined parameters. The result of this score is visible to clinicians who use set pathways to respond in a timely manner.

The benefits of the electronic platform has been:

- The NZEWS is always correctly totalled and accurately charted
- Visible remotely
- Collection of data for quality improvement and governance.

Threshold

The Quality and Safety markers are:

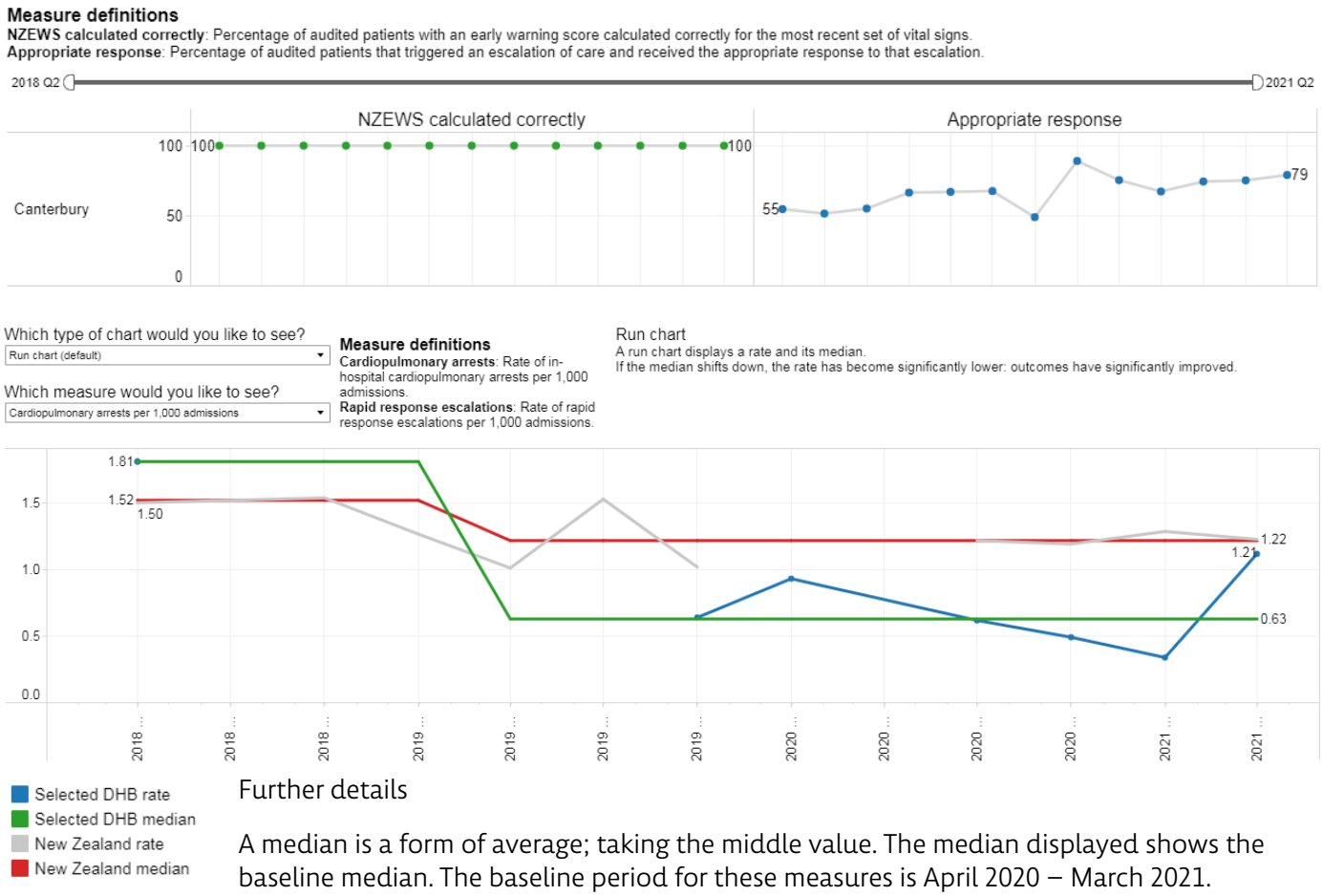
1. The spread across the hospitals – 100 percent
2. The percentage of early warning scores added up correctly – 100 percent
3. The percentage of patient requiring an escalation response within the correct timeframes – 80 percent
4. The number of cardiac arrests in hospital – no threshold
5. The number of rapid response calls in the hospitals – no threshold.

ARE WE DOING THINGS RIGHT?

Canterbury DHB has an electronic observation system in use across all hospital facilities (100 percent, marker 1) of which the New Zealand early warning system is an integral part. Daily, approximately 4,000 sets of vitals are completed and are added up correctly 100 percent of the time (marker 2). On average just over 1 percent of our observations are scored as red or blue and require escalation.

In the Apr-Jun 2021 quarters audit 79 percent of the patients audited that triggered as escalation to Red or Blue response pathways received the appropriate response in the timeframes required by the pathway and had a documented medical plan (marker 3).

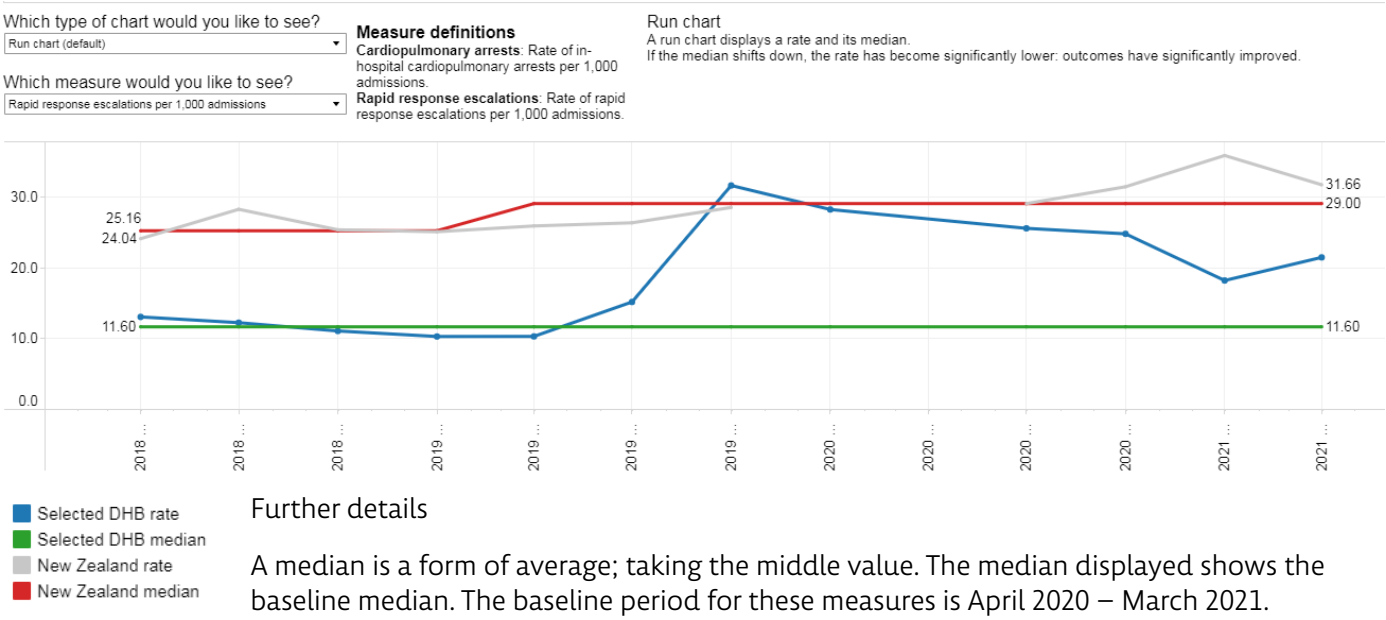
In Jul to Sept the result was 83 percent.



Further details

A median is a form of average; taking the middle value. The median displayed shows the baseline median. The baseline period for these measures is April 2020 – March 2021.

Marker 5 is the number of rapid response escalations that are responded to by our Intensive Care Outreach team. As part of the NZEWS working group quality improvement, the Intensive Care Outreach clinical noting was transitioned into the same digital platform that is used for the vital signs observations and NZEWS scoring. This has vastly improved the ability to capture the true Intensive Care Outreach activity. Previously, this could only be captured by clinical note audit or coding.



Further details

A median is a form of average; taking the middle value. The median displayed shows the baseline median. The baseline period for these measures is April 2020 – March 2021.

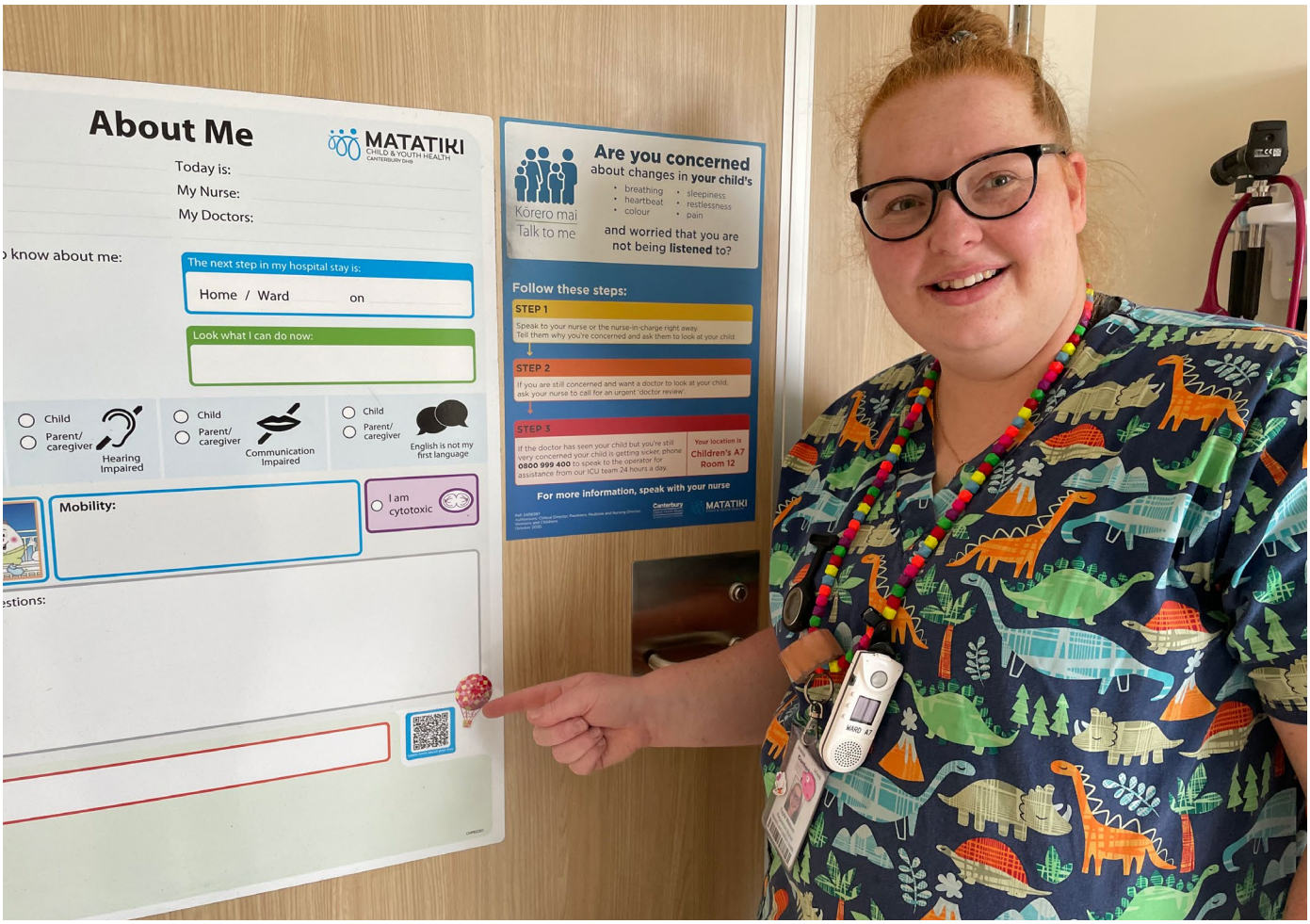
ARE WE DOING THINGS RIGHT?

In 2020 the focus of the NZEWS working group has been to review changes and human factors alongside the data from audit and electronic systems. Continued review, systems improvement and re-review allows us to continuously improve our process and improve our care of people in our adult inpatient population. Concentrating on EARLY recognition and appropriate planning allows Canterbury DHB to move away from reacting to the deteriorating patient to proactive planning in partnership with the person.

Korēro Mai

Patients, families and whānau often recognise subtle signs of patient deterioration, even where vital signs are normal. The purpose of Korēro Mai (Talk to me) was to co-design a patient, family and whānau communication process to enable staff to establish if the patient or their family are concerned. Working with families in paediatrics, we found that asking family if they had any questions did not open up a conversation about concerns.

Families are now asked if they have any questions or concerns and we provide families with information about how to get help if they continue to have concerns. Acting on these concerns, discussing patients' preferences for care early, and making shared



Tayla, paediatric nurse, showing the new QR code sticker on the Paediatric bedside boards

decisions about the goals of an episode of care improves communication, provides better experiences for all involved and ensures appropriate responses to acute deterioration. The focus this year has been on implementing the Korēro Mai process in all paediatric wards and planning is underway to spread the Korēro Mai process to maternity and for our adult populations.

Since the launch of the Paediatric survey, several parents have made comments about not having the information they need to make their stay in the ward better, especially about access to food. Parents were unaware of food outlets and how to access meals while staying with their child.

In response to the feedback, Paediatrics has added a QR code to the "About Me" boards within in each patient room. The Korēro Mai information is provided next to the About Me boards.

The QR code links to the Matatiki (Child & Youth website) where there is specific information regarding the ward routine and accessing food/meals for parents. Nursing staff have been directing parents to use the QR code as part of the ward/area orientation.

Tayla, a paediatric nurse, says that it is a great resource for parents. "Having the QR code located on the About Me boards is gold. Parents often suffer from information overload when their child is first admitted, and the nurses are often busy focusing on managing their sick child. A quick and easy way to access all the information parents need about food, showering, parking and the ward routine ensures their stay with us is much better"

"We were late getting to the ward for our overnight stay and there were issues getting food for my child and also myself."

"We didn't know parents don't get fed (should have known) and that there was a place to get tea and toast (didn't find out until quite late) and where we could get towels for a shower etc. (I didn't shower as I didn't know we could, but would have loved one)."

"I honestly cannot speak higher of all of the teams who took care of my daughter. Only fault was I got a parking ticket when I couldn't leave her side and I was told I could get an exemption, but I don't know how to go about it."

"While the communication was good, there was a lot of time passing before someone gave us a good run through of the situation."

Graeme Webb – Quality Facilitator for Child Health says the feedback has been great.

"The QR code is a way of giving parents the information they need in their own time. The code takes them straight to the website which has all the information they need to navigate a paediatric admission."

Shared Goals of Care

This work stream is to ensure that the patient's goals are established and reflected in the care documented in the clinical record. Shared Goals of Care plans were introduced at Burwood Hospital August 2020 and to the wider Canterbury DHB during the March-May COVID-19 lockdown in 2020.

Consumer Engagement

CONSUMER/COMMUNITY ENGAGEMENT WHARE
POU TARĀWAHO MŌ TE WHAKAPĀNGA KIRITAKI

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Ways of working in partnership with consumers:

Mana Whakahaere Good Governance/ kaitiakitanga
– leadership structures include Maori representation at a high level, allows for decisions to be made that involve Maori voices

Mana Motuhake Unique and indigenous
– indigenous models of care and cultural engagement guidelines observed

Mana Tangata Fair and Just
– engagement with iwi is always considered and held with no bias or judgement

(Based on the Māori Health Action Plan 2020–2025, which sets the government's direction for Māori health advancement and Waikato DHB's consumer engagement marker programme)

Dr Mason Durie's **Te Whare Tapa Whā** model compares hauora to the four walls of a whare, each wall representing a different dimension:

Taha wairua
– the spiritual side

Taha hinengaro
– thoughts and feelings

Taha tinana
– the physical side

Taha whanau
– family

All four dimensions are necessary for strength and symmetry.

(Adapted from Mason Durie's Whaiora: Māori Health Development. Auckland: Oxford University Press, 1994, page 70).

THINKING ABOUT IT – WHAKAAROHIA | BUILDING IT – HANGAIA | DOING IT – MAHIA | LIVING IT – WHAKAMANAWATIA

Canterbury DHB was one of four pilot sites to develop a Quality and Safety marker, designed to measure how effectively DHBs are involving and responding to consumers in organisational service development and improvement.

The Health Quality Safety Commission (HQSC) consumer engagement marker is a new marker. The goal of this new marker is to monitor the success of consumer engagement how it improves the quality and safety of services for our consumers and their communities.

The scope of the marker is across the entire Canterbury health system. All DHBs are being asked to report twice-yearly on how consumer engagement takes place across the organisation and to self-assess the maturity of engagement initiatives. Following a successful pilot scheme throughout 2020 – 2021, the HQSC is now measuring consumer engagement within all DHBs.

The framework underpinning this new quality safety marker (QSM) is the SURE framework (Supporting, Understanding, Responding and Evaluating). The SURE framework focuses on four areas:

- **Supporting**: What is in place to support consumer engagement?
- **Understanding**: How do organisations make sense of what consumers are telling them?
- **Responding**: What has been done to respond to what consumers have said?
- **Evaluating**: What has been the impact of these interventions?

There are three domains, against which DHBs rate their level of consumer engagement:

- **Engagement**: The environment created to support community
- **Responsiveness**: Responding to and acting on what consumers are saying about the service and having the right information at the right time for consumers accessing services
- **Experience**: The systems in place to capture consumer experience, and act upon the results.

Canterbury DHB 'built' a whare to demonstrate the marker. The whare was developed with consumer, Māori and Pacific Peoples' input. The whare incorporates the building blocks of the Consumer Engagement Framework and the maturity journey; thinking about it, building it, doing it and living it. Its walls represent the different dimensions of hauora for our consumers and their communities, with our ways of working based on the Māori Health Action plan. The overall message for our organisation is: 'Nothing about me without me and my whānau'.

Always Know Who to Contact

Canterbury DHB recognises that ongoing support from your family/whānau (or friends or carers) is key to your ongoing health and wellbeing. To help us make that happen, we will be asking patients to nominate two contact people (ideally from different households) who are in the best position to be their contact people for each admission. The nominated contacts need to be available to support you and to be contactable during your hospital stay.

These can be simple, such as supporting personal needs while admitted or keeping other family/whānau members up to date and assisting in coordinating discharge arrangements and ongoing care.

Not knowing who the right contact person is, has resulted in challenging situations whereby clinical staff have not been able to reach a key contact when a patient is deteriorating.

Our information system is being updated to replace and standardise the different language currently used, replacing next of kin, emergency contact, key contact and preferred contact with nominated contact.

A nominated contact person

- is available to be contacted e.g. discharge planning, in case of an emergency or a change in condition
- supports your needs while in our care
- keeps other family/ whānau members informed and updated
- is the person whom staff can check-in with regarding any care questions if you are unable to respond.

Being appointed as a nominated contact does not override privacy rules. We are only able to provide personal information you have authorised us to share with your nominated contacts. We will discuss what this means for you.

Canterbury DHB
Patient Experience Survey
Te Rūri Wheako-ā-Tūroro