# Kerikeri Village Trust

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards). The specifics of this audit included:

**Legal entity:** Kerikeri Village Trust

**Premises audited:** Kerikeri Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 4 November 2015 End date: 5 November 2015

**Proposed changes to current services (if any):** Proposed increase in capacity from 66 beds to 68 beds has not occurred. Renovations have not been completed.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 57

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Kerikeri Village provides rest home, hospital and dementia level care for up to 66 residents and on the day of the audit, there were 57 residents. A manager/registered nurse manages the service. The residents and relatives interviewed all spoke positively about the care and support provided.

The service had applied to increase their capacity from 66 residents to 68 residents with the addition of two extra hospital rooms, however, this has not yet occurred.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the Northland District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed two of the eleven shortfalls from the previous certification audit around medication competencies for staff and the completion of care plans. Improvements continue to be required in relation to open disclosure, the quality and risk management programme, assessments, and interventions, the activities programme in the dementia unit, care plan evaluations and aspects of medication management.

This surveillance audit identified that improvements are required in relation to the complaints register, caregiver qualifications in the dementia unit, performance appraisals, and completion of care plans within the required timeframes.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

Families indicate situations where they wish to be kept informed, which is documented in the residents’ files. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The manager is a registered nurse. A board of trustees, two managers and staff, supports her. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to. A roster provides sufficient and appropriate cover for the effective delivery of care and support.

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in residents’ files demonstrated service integration. Residents’ files included medical notes by the contracted GP and visiting allied health professionals.

A diversional therapist oversees the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

A medication management system is in place. Registered nurses responsible for administration of medicines complete education and medication competencies.

Food services and all meals are prepared on site. Kitchen staff and those serving the meals know resident’s individual food preferences and dislikes. There is evidence that there are additional nutritious snacks available over 24 hours. There is dietitian review of the menu. All kitchen staff are trained in food safety and hygiene.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were five residents using restraint and three residents using an enabler. Restraint management processes are adhered to.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The type of surveillance is appropriate for the size and complexity of the service. Effective monitoring is the responsibility of the infection control coordinator. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 8 | 0 | 7 | 3 | 0 | 0 |
| **Criteria** | 0 | 30 | 0 | 10 | 2 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register in place. Complaints for 2015 to date were reviewed. All complaints lodged in the register have noted investigation, timelines, corrective actions when required and resolutions. One serious complaint lodged with the Northern District Health Board remains open with evidence of corrective actions currently being implemented. One serious issue raised in 2015 by a family member, was logged as feedback in the quality meeting minutes and was not logged in the complaints register.  Discussions with residents (four hospital level and two rest home level) and relatives, confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. At entry to the service, the enduring power of attorney (EPOA)/families declare which adverse events they do and do not want to be contacted about. All six family members interviewed (four dementia, one hospital and one rest home) confirmed they were notified of any changes in their family member’s health status. Fifteen incidents/accidents forms were viewed. The forms include a section to record family notification. Not all incident forms and associated resident files evidenced that family were informed. This area for improvement remains. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kerikeri Retirement Village is owned by a community charitable trust. A board of trustees undertakes governance. The manager reports to the board at monthly meetings. The service can provide care for up to 66 residents. In addition to the care facility, there is a retirement village with 68 cottages.  On the day of the audit, there were 57 residents (18 rest home level, 24 hospital level and 15 dementia level). Four residents’ rooms are dual purpose and are located in close proximity to the nurses’ station. During the audit there were no residents on the medical component of the Aged Residential Care Contract, one resident under young person with a disability (YPD) contract and two respite residents (one dementia level and one rest home level). The facility is in the process of building two more hospital-level rooms. These are not yet complete and therefore could not be verified.  Kerikeri Retirement Village has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. Goals and objectives are included in the plan and mechanisms for monitoring progress are outlined. Business plan service goals are documented in the business plan.  The manager is a registered nurse (RN) and has been employed as the manager for 20 years. A clinical manager and an assistant clinical manager, both of whom are RNs, support the manager. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | A 2015 quality and risk management programme is in place. Interviews with managers and staff reflect their understanding of the quality and risk management systems. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures are being updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  Completed accident/incident forms are logged electronically and included all documented adverse events selected for audit. Data collected includes but is not limited to falls, wounds, skin tears, challenging behaviours. Data is benchmarked with other similar facilities in Northland. Missing is evidence of this data being analysed. This area for improvement remains. Corrective actions are not being documented where benchmarked results are above the upper control limit/target threshold.  An internal audit programme is in place. Areas of non-compliance include documentation of a corrective action plan. Missing is consistent evidence of the implementation of the corrective actions and sign-off when completed. This previous area identified for improvement remains.  Quality and risk data is posted in the staff room but results are not communicated with staff in staff meetings as evidenced in the meeting minutes.  An annual risk management plan is in place that reflects regular board review. The facility has maintained tertiary level ACC Work Management Safety Practice for over 10 years.  Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased beds that can be lowered to low levels, and sensor mats. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an accidents/incidents reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff. Adverse events are not routinely trended and analysed with results communicated to staff (link to finding 1.2.3.6). Corrective actions have not been implemented where adverse events exceed acceptable limits (link to finding 1.2.3.8). A registered nurse conducts clinical follow-up of residents.  Discussions with the manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. This has been completed for all serious accidents (Workplace Safety) and serious complaints (Section 31: Ministry of Health). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resource management policies in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of practising certificates are kept. Six staff files were reviewed and evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice.  Performance appraisals are scheduled to be completed annually. These are overdue for a selection of the caregivers.  The in-service education programme for 2015 is being implemented and includes a minimum of eight hours of mandatory training per year. Additional internal and external training is provided for staff. Caregivers have access to the aged care education (ACE) programme. The dementia unit has employed 12 caregivers. Eight of these caregivers have completed their dementia qualifications and four are in the process of completing theirs. One caregiver has been employed for over one year and has yet to complete this qualification.  Six of fifteen RNs have completed their InterRAI training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Sufficient staff are rostered to manage the care requirements of the residents. At least one registered nurse is on site at any one time. The adjacent retirement village is staffed separately with caregiver staff. In the event of a clinical emergency in the retirement village, the night shift RN has been instructed to stay at the care facility and ambulance services would be summoned. Activities staff are available seven days a week. Extra staff can be called on for increased residents' requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Ten medication files were reviewed (four rest home, four hospital and two dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses the blister pack medication system. Medication reconciliation is completed on delivery of medications and signed off by an RN. Regular checks for medications requiring strict controls have not been conducted. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The previous audit finding relating to annual competency checks for all staff who administer medications has been resolved. All eye drops were dated on opening. The signing sheets reviewed evidenced the previous audit finding relating to transcribing, has been resolved. Registered nurses and care staff interviewed were able to describe their role concerning medicine administration. Standing orders are not being used. The previous audit finding relating to competency checks for residents self-medicating, remains.  The previous audit finding relating to the requirement for documenting ‘indications for use’ for 'as required' medications remains. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The meals at Kerikeri Village are prepared on site. A four weekly seasonal menu is designed and reviewed by a registered dietitian. The cook receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, moulied foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Additional nutritious snacks are available for dementia residents.  Food safety management procedures are adhered to, including storage of food and temperature monitoring. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. All food services staff have completed food safety and hygiene courses.  The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | The facility has embedded the InterRAI assessment protocols within its current documentation. InterRAI initial assessments and summaries were evident in printed format in the files reviewed. In the files reviewed, formal assessments, and risk assessments were in place. Assessment reviews have not been conducted as required. The finding from the previous audit relating to risk assessments remains. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | In the files sampled, three of five residents had a completed care plan, which was resident centred and demonstrated service integration and input from allied health. One resident was on respite care and one was a recent admission. This is an improvement from the previous audit. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect acute changes in health status. Not all were evaluated as per requirements (link #1.3.8.2). There was evidence of input from a range of specialist care professionals. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications (link to finding 1.1.9.1).  Not all residents had interventions documented for all identified care needs. Monitoring forms were completed as required and evaluated by a registered nurse. An activities plan is completed on admission and reviewed six monthly with the care plan review (link to finding 1.3.7.1).  Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure injuries. The previous audit finding related to wound documentation remains.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | There are two diversional therapists and four activities assistants that provide an activities programme seven days a week. The activities programme has support from volunteers. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit residents in all areas were observed being actively involved in a variety of activities, with support and involvement of the care staff. The programme is developed monthly and is displayed in large print.  The programme is comprehensive and includes van outings, walking groups, gardening, pet visits, church services, and art and crafts. There are resources available for staff to use for one-on-one time with the residents and for group activities.  The previous audit finding around providing meaningful activities that can cover 24 hours in the dementia unit remains. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The RN described evaluating information obtained using assessment tools, progress notes and short-term care plans, to ensure interventions are documented in the care plans to reflect current care needs (link to finding 1.3.6.1). In the resident files reviewed, care plan evaluations were not all completed six monthly and not all wounds had assessments and evaluations documented with each dressing change (link 1.3.6.1). There was evidence that the GP had completed a review of the resident at least every three months. The previous audit finding relating to care plan evaluations remains. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 31 August 2016). |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is collated monthly, and reported at the quality and infection control meetings. The infection control programme is linked with the quality management programme. Quality improvement/corrective action plans relating to infection surveillance data have not always been implemented, where indicators are above the benchmark (link 1.2.3 8).  There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were five residents with restraint and three residents with an enabler. All necessary documentation has been completed in relation to the enabler. Enablers are voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. A registered nurse is the designated restraint coordinator. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The manager maintains an electronic complaints register that includes complaints, dates and actions taken. Complaints are signed off when resolved. One serious complaint lodged through the NDHB is currently under investigation with corrective actions being implemented. One serious concern raised by a family member was not logged in the complaints register. | Negative feedback received from a family member relating to care provided following a serious adverse event was not logged in the complaints register. There was evidence that the issue had been addressed with family. | Ensure the complaints register is maintained.  60 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Interviews with family confirmed that they are kept informed but this was unable to be consistently evidenced on completed accident/incident forms and associated resident files. | Five out of fifteen incident/accident forms reviewed did not reflect families being informed where they had indicated they wished to be kept informed. | Ensure families are kept informed following an adverse event if they have indicated they want to be contacted.  60 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | A quality and risk management programme is in place. Adverse event data is benchmarked against other aged care facilities in Northland. The internal audit programme monitors resident satisfaction, cleanliness and clinical documentation. Data is not consistently analysed to identify areas for improvements. Data is posted in the staffroom but internal audit results and benchmarked adverse event results are not being communicated to staff in staff meetings as evidenced in the meeting minutes. | Data collected for quality and risk management purposes has not been consistently analysed, and results have not been communicated to staff. | Ensure that data collected is analysed and shared with staff in staff meetings.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Benchmarked data that is consistently above the benchmark (eg, falls, wounds) do not have corrective action plans in place. An internal audit programme is in place with evidence of corrective actions documented on the audit form. These corrective actions do not consistently reflect evidence of implementation and sign-off when completed. | There is a lack of evidence to verify that corrective actions are put into place where benchmarked adverse event data falls above the acceptable threshold (eg, falls, wounds). Resident satisfaction results that reflect opportunities for improvements also do not have corrective actions implemented. Where corrective actions have been identified, there is a lack of evidence to confirm that these corrective actions have been successfully implemented. | Ensure corrective actions are developed, implemented and signed off where opportunities for improvements are identified.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The education and training programme for staff exceeds eight hours annually and covers all essential components of the Aged Related Care (ARC) contract. Records of staff attendance are maintained. | One caregiver working in the dementia unit and employed for over one year has not completed the required dementia qualification. The clinical manager reports that registered nursing staff are responsible for completing annual performance appraisals for the caregiving staff, which are overdue for a selection of staff. | Ensure all caregiver staff who have been employed for over one year and work in the dementia unit, have completed the required dementia qualification. Ensure all staff receive annual performance appraisals.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | On admission, the GP prescribes all medication to administer to the resident and then reviews the medications prescribed at least every three months. Not all ‘as required’ medication had indications for use charted. The RN and one other undertake weekly drug checks. Not all drug checks had been conducted weekly. | i) Five of ten medication charts reviewed (one rest home, three hospital, one dementia) had ‘as required’ medications prescribed with no ‘indications for use’ documented.  ii) Medications reviewed which require greater controls, did not evidence that regular weekly checks have been completed. | i) Ensure that all ‘as required’ medication prescribed has ‘indications for use’ documented.  ii) Ensure that all required medication checks are completed according to legislative requirements.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There are polices and procedure in place for residents who are self-medicating. Not all residents self-medicating on the day of audit had completed the required competency assessments. All medication residents were using for self-medication, was stored safely. | One of two rest home residents self-medicating had not completed the three monthly competency assessments since June 2015. | Ensure that residents who are self-medicating, complete the three monthly competency assessments.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The registered nurse is required to complete all aspects of the assessment, care planning and review of the care plan within the required timeframes. In four of five residents’ files reviewed the initial assessments and care plans had been developed within the required timeframes. One hospital resident had the initial assessment completed within the required timeframe but did not have an initial care plan documented in a timely manner. The RN evaluated all five initial care plans sampled within three weeks of admission. | One hospital resident did not have an initial care plan documented within 48 hours of admission. | Ensure that all residents have all aspects of the care planning process completed within the required timeframes  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Files reviewed across the rest home, hospital and dementia areas identified that risk assessments have been completed on admission, however, not all risk assessments were reviewed six monthly as part of the care plan evaluation. Additional assessments for management of behaviour, pain, and wound care were completed according to the resident’s need. There was evidence of pain assessments and ongoing pain monitoring in the files reviewed. | Two of three long-term care plans (one dementia, one hospital) reviewed, did not have risk assessments reviewed six monthly. | Ensure all risk assessments (including InterRAI) are reviewed at least 6 monthly and all assessment information is transferred to the care plan.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Assessments are completed on admission. Two rest home resident files reviewed had comprehensive interventions documented for all identified care needs.  The RN reviews information gathered through the use of monitoring charts and assessments to ensure interventions are documented in the care plans to reflect current care needs.  Not all wound assessments, treatment and evaluations were in place for all current wounds (eleven skin tears, five abrasions, two lesions, one haematoma, ten lacerations, and two chronic ulcers). There were three pressure injuries on day of audit (one grade-one and two grade-two). Wound care plans were in place for the pressure injuries and adequate pressure management equipment and supplies were sighted. | i) Interventions were not documented in the care plan for residents with the following identified care needs. One dementia resident identified as a medium risk of choking and a high falls risk; one hospital resident requiring a slide sheet for all transfers and Te Reo as a first language (link 1.3.3 hospital tracer); and one hospital resident noted to be a high falls risk needing hip protectors.  ii) Fifteen of 31 wound care plans reviewed did not have an initial or ongoing wound assessments documented; one of 31 wound care plans reviewed had no wound management plan documented; seven of 31 wound care plans reviewed did not have evaluations documented at each dressing change; two of 31 wounds had not been reviewed within the required timeframes. | i) Ensure that all interventions are documented for all assessed care needs.  ii) Ensure that all wounds have a documented assessment, management plan and evaluation and are reviewed within the required timeframes.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | In the residents’ files reviewed, a lifestyle profile was completed on admission in consultation with the resident/family (as appropriate). Activity plans were sighted and these were reviewed six monthly, at the same time as the care plans (link to finding 1.3.8.2). Activity participation sheets are maintained. The service also receives feedback and suggestions for the programme through surveys and feedback from residents and families. The residents and families interviewed spoke positively about the activities programme.  The dementia file sampled did not have a 24-hour activity plan documented. | The dementia file sampled did not have an activities plan documented that covered the 24-hour period. | Ensure that residents in the dementia unit have an activities plan documented to cover the 24-hour period.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. Not all care plans due for review had been reviewed within the required timeframes. | One long-term care plan due for review (dementia) had not been evaluated six monthly. | Ensure that all care plans are evaluated six monthly or more frequently if required.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.