# Presbyterian Support Central - Huntleigh

## 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:** Presbyterian Support Central

**Premises audited:** Huntleigh Home

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

**Dates of audit:** Start date: 18 November 2015 End date: 19 November 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 66

# 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

Huntleigh Home is owned and operated by the Presbyterian Support Central and cares for up to 77 residents requiring rest home and hospital level care. On the day of the audit there were 66 residents. The manager is well qualified and experienced for the role. Residents and relatives interviewed spoke positively about the service provided.

This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with relatives, staff and management.

One of the two shortfalls identified at the previous audit have been addressed. This was around fridge temperatures. One aspect of the second previous shortfall, around neurological observations has been addressed. Improvement continues to be required around wound management.

This audit has identified further improvements required around dissemination of quality data trend analysis outcomes to staff, job specific orientations, timeframes for resident documentation and food storage.

The service has continued to exceed the required standard around activities.

## Consumer rights

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| 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. |  | Standards applicable to this service fully attained. |

The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented and complaints and concerns are managed and documented.

## 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. |

Huntleigh continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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. |

Registered nurses are responsible for each stage of service provision. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly or earlier if there was a change to health status. Resident and/or family/whānau have input into care planning and the six monthly reviews. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident-focused and provides group and individual activities planned around everyday activities. There are strong community links including volunteers that assist with activities.

There are medicine management policies and procedures in place. Medication is managed in line with current guidelines. The medication charts were reviewed by the GP three monthly.

Food is cooked onsite. A contracted dietitian reviews the menus. Food services staff are aware of resident’s likes/dislikes and alternative choices are offered.

## 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. |

The building has a current building warrant of fitness and maintenance is carried out.

## 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. |

The service currently has one resident using a restraint and five enablers in use. Either the resident or the activated EPOA has signed the consent for the enablers used. The service has policies and procedures to support the use of enablers and restraint. Education is provided annually to staff.

## 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | 1 | 10 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 1 | 33 | 0 | 3 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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. | FA | There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaints are discussed at the monthly senior management team meeting and at the staff meetings. Complaint forms are visible around the facility on noticeboards. There were five documented complaints in 2014 and one in 2015 to date. Follow up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry. One complaint through the Health and Disability Commissioner in July 2014 has been resolved. Following this complaint HealthCERT advised that areas around communication, adverse event reporting, service provision requirements and service delivery/interventions required assessing at this audit. This audit did not identify any current shortfalls relating to communication or adverse event reporting. Improvements are required around service provision requirements (link 1.3.3.3) and service delivery/interventions (link 1.3.6.1). |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy. Discussions with six residents (three from the hospital and three from the rest home) and two family members (one hospital and one rest home) confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur bi-monthly and the facility manager and clinical nurse manager have an open door policy.  Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve accident/incident forms sampled from 2015 identify that family were notified following a resident incident. Interview with five health care assistants (HCA), two registered nurses and one clinical nurse manager (RN) confirmed that family members are kept informed.  The residents and relatives interviewed confirmed family have been informed when the resident health status changes. The service has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Huntleigh Rest Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 71 residents. On the day of the audit there were 35 rest home residents including one respite resident and 31 hospital residents. There was one resident on respite care. All other residents are on the ARC contract with one included via the ‘like in age and interest’ criteria. All beds are dual purpose. Huntleigh has a 2015-2016 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meeting. The facility manager is supported by a clinical nurse manager (CNM).  The manager has is a registered nurse and has been in the role for the last 18 months with prior aged care management experience. 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 Low | PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement. There is a senior team meeting that meets monthly. Staff meeting minutes and clinical meeting minutes and interviews with HCA’s do not evidence that staff are informed of accident and incident trends, internal audit outcomes, infection trends or complaints. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.  Infections and accidents/incidents are also being documented on an electronic database. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health & Safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place. A policy has been developed/updated to manage interRAI requirements.  Annual resident and relative satisfaction surveys have been completed as per company schedule which included an analysis and the development of corrective action plans. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. |
| 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 incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Quality and senior team meeting minutes include an analysis of incident and accident data and corrective actions (link 1.2.3.6 regarding staff meetings). A monthly incident accident report is completed which includes an analysis of data collected. Twelve accident/incident forms sampled from August included registered nurse assessment and follow up.  Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. An appropriate section 31 notification was made to HealthCERT in July 2015. |
| 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 Moderate | There are human resource management policies in place, which includes recruitment, and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical nurse manager, one RN, one cook, one activities team leader and two HCA’s). Annual appraisals have been completed and up to date. The service has available a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This includes a generic organisational orientation (book one) and a comprehensive role specific orientation (book two). All files evidenced a generic orientation but none contained a completed role specific orientation. Staff do report that a buddied orientation period is undertaken by all new staff meaning the risk rating for this finding is low.  The in-service education programme for 2015 is being implemented. The majority of HCA’s have completed an aged care education programme. Staff attend an annual compulsory study days which training around the Eden Alternative programme. The clinical nurse manager and RN’s are able to attend external training. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full time. The clinical nurse manager and care manager (also a registered nurse) rotate shifts so that one or the other is on duty seven days per week. There is at least one registered nurse on duty 24 hours per day. Advised that extra staff can be called on for increased resident requirements. Interviews with HCA’s, 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. | FA | There are policies and processes that describe medication management that align with accepted guidelines. An RN checks all medications on delivery. Any discrepancies are fed back to the supplying pharmacy. The RNs, administering medications undergo a medication competency. Annual medication training is completed.  Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. There was one self-medicating resident who had completed their competency to self-administer medication, which had been reviewed three monthly.  Twelve resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. All ‘as required’ medications prescribed had indications for use documented.  The 12 medication charts included three monthly GP reviews. |
| 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. | PA Low | A food services policies and procedures manual is in place. There are two cooks and six kitchen hands working in the kitchen.  There is a five weekly summer and winter menu that is reviewed by an external dietitian. The senior cook receives peer support, when all the PSC senior cooks meet annually. All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of resident’s dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, soft or pureed meals. Specialised utensils and lip plates are available as required.  Daily food temperatures are taken on cooked food for all meals. Temperatures are taken on delivery for frozen foods, milk and cream. Fridge, freezer and chiller temperatures are recorded daily this is an improvement from the last audit. Not all perishable foods were dated.  The main kitchen area is well equipped. The dry goods are sealed, labelled and off the floor in the pantry, but they did not have evidence of the best before date. Safety data sheets are available and training provided as required. The service receives feedback directly from the residents, residents meetings, internal audits and resident satisfaction surveys. There is good communication between the food services and the clinical areas and the cooks are informed of any resident’s dietary changes. Residents interviewed spoke positively about the food choice and variety of meals.  Staff have been trained in safe food handling, chemical safety and other relevant in-service. |
| 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 nurses initiate a review and if required, GP or specialist consultation. Two residents have recently been referred for reassessment. Short term care plans were comprehensively utilised in files reviewed for acute changes in health status.  Dressing supplies are available and a treatment room/wound trolley is well stocked. All staff report that there are adequate continence supplies and dressing supplies. There are adequate pressure wound resources. A health status summary held in the resident’s record, records any significant events, investigations, GP visits and outcomes.  There were eight wounds being dressed (sacral pressure wounds, skin tears and a sinus wound). There were two grade two sacral pressure wounds, one was facility acquired and the other is a chronic wound that was acquired before admission. Wound assessment, care plans and treatment records were reviewed. There were documentation shortfalls around wounds. This was a previously identified shortfall that has not yet been addressed. There was evidence of the wound care specialist nurse and dietitian being involved with the chronic, non-healing wound.  All incident forms reviewed had appropriate follow up documented by the RN including neurological observations when appropriate, this is an improvement from the previous audit.  Monitoring charts are utilised for residents at risk. Turning charts were sighted for two residents. Archived behaviour monitoring charts were evidenced in one file of a resident with identified behavioural issues. Two files of residents with diabetes had evidence of blood sugar level monitoring in progress. Pain assessments were sighted in all files reviewed. |
| 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. | CI | There are three recreational officer’s providing activities across six days. Volunteers also assist and also provide extra activities across the weekend. The programme is resident focused and is planned around everyday activities such as gardening, baking, reminiscing and household chores. Community links are maintained with children’s visits from the school and kindergarten. Theme days, festive occasions and cultural celebrations occur. Church services are held on site weekly. Outings and drives are arranged in consultation with the residents to places of interest. There are a number of volunteers involved in the service that provide one on one activities, musical entertainment, church visitors and SPCA visitors and pets.  The Eden philosophy principles of resident involvement and inclusion in their recreation activities within a home environment, is evident. The recreational support plan is individualised.  Residents and relatives interviewed spoke positively about the activities programme and stated there was a lot of choice.  The service has exceeded the standard expected around planned activities. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The files sampled evidenced six monthly evaluations of the support plan (link 1.3.3.3). Evaluations identified reviewing progress to meeting individual goals. The resident/family interviewed advised that they are notified of the reviews and invited to attend. The long term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. Short term care plans reviewed were evaluated regularly with problems resolved or added to the long term support plan if an on-going problem. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current building warrant of fitness, which expires 27 November 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.  Internal infection control audits also assist the service in evaluating infection control needs. The service utilises an external benchmarking programme. Analysis of infection stats is completed on a quarterly basis.  Infection control data is collated monthly and reported to the senior team meeting. The meetings include the monthly infection control report and quarterly benchmarking results.  All infections are documented on the infection monthly on-line register. The surveillance of infection data assists in evaluating compliance with infection control practices. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy that is applicable to the service that has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.  There is currently one resident using restraint and four residents using enablers at Huntleigh. All enablers have a consent signed by either the resident or the activated EPOA.  There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0.  Restraint/enabler and challenging behaviour training has been provided. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | A monthly quality report is developed which includes trend analysis of accidents and incidents and infections. This report is tabled at the monthly senior team meeting. Accident and incident trends are also discussed at three monthly health and safety meetings. Health care assistants confirm that they are not informed routinely of quality data and this is confirmed through review of clinical and staff meetings minutes. | Minutes of clinical and staff meetings and interview with healthcare assistants demonstrate that staff are not informed routinely of internal audit outcomes, complaints and quality data trend analysis outcomes. | Ensure that the results of quality activities are communicated to all service providers.  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | The service has three parts to the orientation process. Book one, which is a workbook completed by staff during the orientation period includes generic information about the organisation. Book two is related to the role undertaken and is a comprehensive workbook that includes a sign off sheet to document that a buddied orientation period has been undertaken and that that staff member is competent to complete the required tasks. Part three of the orientation is the buddied shifts. No staff files contained a book two role specific orientation. Staff interviewed report that all staff undertake buddied shifts and are competent meaning this is a documentation issue and the risk is low. | None of the seven staff files sampled contained documented evidence that the staff member has completed an orientation specific to the role. | Ensure that all new staff undertake a role specific orientation and that this is documented.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The cook (interviewed) is knowledgeable in dietary requirements for weight loss management including increased protein, increased milk based desserts, cream and other high calorie foods. There is a dislikes board in the kitchen. Meals are transported in hot boxes to the apartments and served from bain maries in the upstairs and downstairs dining rooms. Cooked food temperatures are conducted and recorded on each meal. | i) Dry goods that were stored in plastic containers in the pantry did not evidence the ‘best before date’ of those goods. ii) Perishable foods stored in the chiller were not dated. | Ensure all food is dated.  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 | There is a resident admission respite policy and the respite support plan and care plan template and checklist. The respite resident had all documentation including initial care plan completed on admission.  InterRAI assessments had not been completed for all new admissions since 1 July 2015. However a comprehensive suite of paper based assessments were completed within 21 days, therefore the risk has been assessed as low.  In all six files reviewed the RN had completed an initial assessment within 24 hours. Three of five long term support plans had been completed within the required time frames. Two of five long term care plans had six monthly documented evaluations (three residents had not been at the service for six months). Reassessments tools including (but not limited to) falls risk, pressure risk, nutrition risk had been completed three monthly. | i) Two of five resident files did not have a LTCP established within 21 days of admission. ii) Seventeen of 17 residents admitted since 1 July 2015 had not had an interRAI assessment completed within 21 days of admission. | Ensure documentation meets the required ARC contract timeframes.  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 | Three of eight wounds reviewed had a current management plan and five of eight had been recently evaluated. The GP is notified of all chronic and non-healing wounds. The RN was able to describe the referral process to access the wound nurse specialist through the DHB. Wound management is included in the PSC study days held annually. | i) Five of eight wounds did not have a current management plan. ii) Three of eight wounds had not been evaluated. | Ensure all wounds have a current management plan documented and that wounds are evaluated regularly.  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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| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| 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. | CI | There are separate programmes for upstairs (mostly rest home level) and downstairs (mostly hospital level) that meets the group and individual recreational needs of both consumer groups. One on one activities occur for residents unable to join in group activities or choose not to participate in activities. There are 20 volunteers involved in the activity programme who assist with a variety of activities and outings. Huntleigh have a chaplain to provide individual spiritual and support services for the residents | The service has continued to exceed the required standard around planned activities. The Eden alternative has been continued to be implemented with the service having achieved five principles and the staff receiving ongoing training. Residents continue to participate in everyday activities including baking bread and looking after the facilities cats. Residents are involved in a wide variety of activities including visiting a local kindy on a monthly basis and assisting the children with craft activities. There is a men’s group called Good Companions Club which go out for lunch together. The service places special attention to Eden moments which are of personal significance to a resident for example a resident was able to have their dog on the bed whilst they were dying. Another resident who had mentioned that they had not seen a Kiwi was taken on a special outing so they could experience Kiwi’s in their natural habitat. All residents and family interviewed spoke highly of the activities provided. The resident satisfaction survey has shown an increase in activities from 77% satisfaction in 2013 to 80% satisfaction in 2014 to 84% satisfaction in 2015. |

End of the report.