

Masonic Care Limited - Masonic Court Rest Home and Hospital

Introduction

This report records the results of a Certification 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 The DAA Group 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](#).

The specifics of this audit included:

Legal entity:	Masonic Care Limited
Premises audited:	Masonic Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 June 2016 End date: 24 June 2016
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:	49

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

Indicator	Description	Definition
	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

Masonic Rest Home and Hospital provides residential care for up to 49 residents who require rest home and hospital level care. The facility is operated by Masonic Care Limited.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, a general practitioner and allied health professionals.

There are 10 areas identified that require improvement relating to: analysis of quality data and reporting back to staff; corrective action plans not consistently developed and where they are, no follow up as to the effectiveness; no hazard register that documents actual risks; not all staff have current performance appraisals completed and no evidence of police vetting; short term care plan interventions and residents progress towards meeting their goals are not consistently documented; short term care plans are not developed to reflect acute changes in resident's health status; and no preventative maintenance programme is available. There are external areas including doors and weather boards that have dry rot and the majority of windows have putty missing around the edges; restraint evaluations are brief and do not meet the standard required; infection surveillance is not integrated across the facility and there is limited analysis of some surveillance data.

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.		Standards applicable to this service fully attained.
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Services are provided in a manner that respects and promotes the independence, personal privacy, individual needs and dignity of residents. Staff receive regular training on residents' rights and incorporate these into their daily practice.

A range of clinical policies, reflecting best practice, guide service delivery. Residents and their families reported their satisfaction with the services provided, and of the open communication with staff.

The nurse manager is responsible for the management of complaints. A complaints register is maintained.

Organisational management

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.
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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic plan and a quality and risk management plan that documents scope, direction, goals, values, and a mission statement is in place. There is regular reporting by the nurse manager to the chief executive officer (CEO) of the board.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The nurse manager is supported by a care manager/registered nurse, an acting team leader/registered nurse and a management assistant/registered nurse.

There is an internal audit programme. Quality data is collected and collated and graphs are generated. Adverse events are documented on accident/incident forms. Corrective action plans are being developed, mainly following deficits identified in quality and staff meetings. There are various meetings held and there is reporting of the numbers of clinical indicators for each month. Meeting minutes are available for staff to read.

There are policies and procedures on human resources management and human resources processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and attendance sheets are held on file. Review of staff records evidenced individual education records are maintained.

A documented rationale for determining staffing levels and the skill mix is in place and is based on best practice. The nurse manager, care manager and acting team leader are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

Resident information is managed appropriately.

Continuum of service delivery

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.
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Registered nurses are on duty 24 hours each day to guide care delivery staff, with a senior registered nurse also available on call after hours. Continuity of care is promoted by updating residents' progress notes each shift, verbal handovers at the start of each shift, and the use of 'wing diaries'. Residents are seen regularly by their doctor and referred promptly if their clinical needs change.

Care plans are individualised, based on a comprehensive and integrated range of clinical information and include input from residents and families.

Medications are administered by registered nurses and senior caregivers, all of whom have been assessed as competent in medications management. Medication management is consistent with legislative and safe practice requirements.

Food services staff have completed appropriate food safety qualifications and all aspects of this service are well managed. The kitchen was well organised and maintained in a clean and hygienic manner. The individual food preferences and dietary needs of residents are respected and accommodated. There are two separate dining areas for residents.

Two experienced diversional therapists are responsible for the activity programme, which offers residents a variety of activities. There are regular outings in the facility van and residents are encouraged to maintain their links with the community.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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All building and plant complies with legislation. A current building warrant of fitness is displayed. There is reactive maintenance as a result of reported issues and checking of equipment, including electrical equipment.

All bedrooms are single accommodation and some have wash hand basins and a toilet, with two bedrooms sharing a full ensuite. Residents' rooms have adequate personal space provided. Lounges, dining areas and alcoves are available. External areas are available for sitting and shading is provided.

There is an appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are monitored to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has clear policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. Residents were using restraint and enablers during the audit. Related staff education and competency assessments occurs at least annually. The restraint approval group forms part of the quality meetings. Regular quality reviews ensure compliance with policies and considers all aspects of restraint and enabler use. The restraint/enabler register is current.

Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection prevention and control is generally well managed. Staff receive ongoing training related to infection control and have access to an appropriate range of personal protective equipment.

Effective processes are in place to ensure that infection surveillance data is collated systematically. Surveillance data is reported in a timely manner to management and staff.

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	43	0	3	4	0	0
Criteria	0	91	0	5	5	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](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The orientation of all new staff includes education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code), with further education on the Code on an annual basis. This was confirmed in staff interviews and staff education records. The Acting Team Leader (ATL) also advised that if staff could not attend one of the scheduled education sessions they were required to complete a questionnaire related to the Code. The service has also developed a comprehensive resource manual for staff related to resident rights.</p> <p>During interviews staff demonstrated they had a good understanding of the Code and provided examples of how this was incorporated into their everyday practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The ATL advised that new residents and their families are provided with detailed information about the service before and during the admission process (copy of this information sighted). Registered nurses are also available 24 hours a day to answer any questions and provide additional information. As part of the admission process residents or their Enduring Power of Attorney are asked to complete a consent form, which includes consent to sharing of information, taking photographs, and outings/trips. Additional consent is obtained when clinically indicated, such as in relation to flu vaccinations, or further medical/surgical treatment is required. Completed consent</p>

		<p>forms were seen in all residents' records reviewed. The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service.</p> <p>Residents and families confirmed on interview they were offered ongoing opportunities in relation to making informed choices and that their consent was obtained and respected. Family members also advised they were kept well informed about what was happening with the resident. They were also consulted in situations such as when consideration was being given to transferring the resident to a public hospital.</p> <p>There were currently no residents with advanced directives. The ATL advised that policies were in place to ensure any such directives were respected. All residents' records reviewed contained a completed resuscitation authorisation form, which had been signed by the resident and countersigned by the doctor. This form is reviewed at least annually, and more frequently if a resident's condition changes.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this. Residents are provided with a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure as part of the admission process. Additional copies of this brochure were also available if required.</p> <p>The staff orientation programme includes information on the Advocacy Service, and is also included in the ongoing staff education programme. This was confirmed in staff orientation and training records, and staff interviews. The ATL reported that a representative from Age Concern was always available to support residents as required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service strongly encourages residents to maintain their family and community links. Residents are supported to visit with families, including going on holiday with family members if they are well enough. Visiting hours are unrestricted, and family members spoken with during the audit visit reported they felt most welcome when they came to visit.</p> <p>The residents' activities programme includes regular community outings and events, as well as entertainers and community groups regularly visiting the facility. When residents need to access health care services outside of the facility, such as having x-rays or visiting the dentist, the service ensures that they are accompanied on those visits, and also provides transport in the facility van if this is required.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The nurse manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There was evidence that complaints are managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Review of the quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via staff meetings.</p> <p>There has been one investigation by the Police since the last audit relating to medication. Documentation reviewed and the nurse manager interviewed evidenced this was not able to be substantiated due to a lack of evidence. The Police also issued a non-trespass order relating to a family member. There have been no investigations by the Health and Disability Commissioner (HDC), the Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), or Coroner since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>During the admission process every new resident and their family are provided with a copy of the Code as well as a brochure on the Nationwide Health and Disability Advocacy Service (Advocacy Service). The ATL explained that this information is discussed with them at the time of their admission by the Nurse Manager or any other senior registered nurse and any questions answered. Further discussions and explanations are provided as required by the individual resident and/or their family. Copies of the Code and the information on the Advocacy Service, are displayed around the facility, and an audiotape version of the Code is also available.</p> <p>On interview, all residents and family members confirmed their understanding of resident rights and had been given information about the Advocacy Service. They also confirmed that if they did have any concerns they would feel comfortable raising these with staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy,</p>	<p>FA</p>	<p>A review of residents' records confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their lifestyle plan. Lifestyle plans also record strategies to maximise the resident's independence. There was evidence that these plans had been developed in conjunction with the resident and/or their family.</p> <p>Residents each have a private room and were encouraged to personalise these rooms. Residents and families stated on interview that they were treated respectfully and their individual needs were</p>

<p>and independence.</p>		<p>meet. During the audit visit, staff were observed to maintain residents' privacy when undertaking personal cares, to address residents by their preferred name, and to knock on closed doors before entering. Staff were also observed to interact with residents in a pleasant and professional manner. Processes were in place to ensure residents' privacy when using the communal showers and toilets.</p> <p>Privacy of resident information was maintained. Residents' clinical files were kept either in a locked office, or a locked filing cabinet; electronic information was password protected; archived records were stored securely and staff handovers undertaken in a manner that maintained privacy of information.</p> <p>During interviews staff demonstrated a good understanding of the service's policy related to abuse and neglect. They were able to provide examples of what would constitute abuse and neglect and outlined the actions they would take if they suspected this. Education records confirmed that staff education related to abuse and neglect is completed annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service did not have any residents who identified as Maori at the time of the audit visit but there are protocols and policies in place to ensure recognition of Maori values and beliefs should these be required. A kaumatua has reviewed the resource manual, which includes the policy on recognition of Maori values and beliefs, commonly used Maori terms and guidelines for room blessings. The kaumatua is available for consultations and advice as required, and the service can also access additional cultural support from MidCentral Health if required. The ATL advised that she or the kaumatua are responsible for ensuring that the rooms of deceased residents are blessed prior to the next resident being admitted.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The individual values and beliefs of each resident are identified as part of the comprehensive admission process. This information then informs the individualised care plan developed for the resident. In all care plans reviewed residents' individual needs and personal preferences had been identified. Appropriate interventions were documented to ensure their cultural needs, spiritual values and beliefs were respected. These plans also included evidence of resident/family input into care plan development.</p> <p>Residents and family members advised on interview they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The ATL advised that each new staff member receives education during their orientation related to all forms of discrimination and exploitation. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Individual employment agreements contain detailed information related to discrimination and abuse/neglect. Those staff interviewed were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation. The doctor and another visiting health professional also confirmed their satisfaction with the standards of service provision and confidence that residents are not discriminated against in any manner.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>A range of clinical policies reflecting best practice are available to guide clinical practice, such as for the management of wounds, diabetes and pain. The service also utilises well-established professional networks which support the maintenance of appropriate practice standards. These include regular consultations with a range of specialist staff, such as wound care specialists, geriatricians, and physiotherapists from MidCentral Health DHB and Arohanui Hospice. The service also employs several very experienced registered nurses who are available to guide care delivery staff, as well as accessing a range of on-line information, such as the Map of Medicine and best practice journals. Clinical resources are also shared between the organisation's facilities.</p> <p>On interview, the doctor and another visiting health professionals confirmed their satisfaction with the standard of care provided to residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>All family members interviewed stated they were informed in a timely manner about any changes to the resident's status. Evidence was sighted of resident/family input into the care planning process. Families were also advised formally about the dates/times of the resident's three-monthly medical review, and invited to participate in these.</p> <p>Evidence of open disclosure and effective communication with residents/families was noted in the residents' files reviewed. Communication was documented in family communication sheets, on the accident/incident forms and in the residents' progress notes.</p> <p>The ATL advised that interpreter services were able to be accessed from MidCentral Health DHB when required. There are currently two residents who do not speak English, and the service has worked with their families to ensure translators are available.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Masonic Care Limited is governed by a board of trustees who meet throughout the year. The nurse manager reports to the chief executive officer (CEO) monthly and the CEO presents a combined report to the board which includes a wide range of subjects including facility performance, care reporting, HDC investigations and sector issues. The nurse manager and CEO confirmed this. The CEO advised they are also in contact with the nurse manager via phone at least weekly.</p> <p>There are established systems in place which define the scope, vision, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The nurse manager, who is a registered nurse, has 17 years' experience in their present position. The nurse manager is supported by a rest home care manager/RN who has been in their position for 16 years. The acting team leader/RN for the hospital and an assistant manager/RN have been in their roles for three years and have wide knowledge of the sector. Interview of the nurse manager and the other managers and the acting team leader and review of their personal files evidenced they have undertaken education in relevant areas.</p> <p>Masonic Court Rest Home and Hospital (Masonic) is certified to provide hospital and rest home level care. On the first day of this audit there were 14 hospital level care residents and 31 rest home level care residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the nurse manager, the rest home care manager and acting team leader-hospital deputise. When the rest home manager is absent, the nurse manager and acting team leader-hospital fill in. The nurse manager, acting team leader and care manager confirmed their responsibility and authority for these roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that</p>	<p>PA Moderate</p>	<p>There is a risk management plan that is used to guide the quality programme. Purpose, goals and objectives and scope are included in the plan.</p> <p>The resident satisfaction survey was completed in 2015 and results indicated that residents and families were mainly satisfied to very satisfied with the services provided.</p>

<p>reflects continuous quality improvement principles.</p>		<p>Completed audits for 2015 and 2016, clinical indicators and quality improvement data were reviewed. Review of the quality improvement data evidenced the data was being collected and collated. Corrective actions were inconsistently developed and where they had been implemented, there was no documented evidence of follow-up to the action taken and the effectiveness. There was evidence of graphing of clinical indicators, but this was not reported back to staff to discuss.</p> <p>There are numerous meetings held monthly, including quality, separate rest home and hospital meetings, kitchen, laundry and cleaner and resident meetings. Staff reported they discuss clinical indicators at the meetings, however there was no documented evidence of analysis to identify trends. There was documented evidence of reporting on various clinical indicators around the numbers only and the number of falls with or without injury. Staff reported during interview that copies of meeting minutes are available for them to review. This was confirmed by observations during the audit.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have been reviewed and are current. Staff confirmed during interview that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>A health and safety manual is available. Risks are identified, and there is a hazard register that identifies potential health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. There was no hazard register available that documents actual hazards. Staff reported they usually write any hazards in the reactive maintenance book, rather than completing a hazard form.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The nurse manager reported there have been essential notifications to the Ministry of Health since the last audit. Documentation confirmed this.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation and competency assessments. There was no evidence of police vetting on any of the files reviewed.</p> <p>The hospital acting team leader/RN is responsible for managing the in-service education programme. In-service education is provided for staff at least monthly, as well as on-line learning and one-to-one education. Individual records of education are maintained as are competency assessments.</p> <p>There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to two months to complete. Orientation for staff covers the essential components of the service provided.</p> <p>Not all staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education. Five of seven registered nurses have completed the interRAI assessment programme education.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. The nurse manager and the care manager are rostered on-call after hours. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	<p>FA</p>	<p>All components of the residents' records reviewed included the resident's unique identifier. The clinical records reviewed were integrated, including the interRAI assessment, medical reports, reports from other health professionals, hospital discharge information and laboratory results.</p> <p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files and systems such as interRAI and 'MediMap' are password</p>

when required.		<p>protected and could only be accessed by designated staff. Hard copy information is kept in the nurses' stations. In one wing this information was kept in a locked office, in the second wing this information was kept in a locked cabinet.</p> <p>Resident progress notes were completed every shift, with the name of the person making each entry clearly identified.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The processes associated with admission to the service were described by the ATL. Residents must have had their care level requirements assessed and confirmed by the Needs Assessment and Service Coordination Service (Supportlinks) prior to being accepted for admission.</p> <p>Prospective residents and their family/whanau are encouraged to visit the facility and meet with the Nurse Manager prior to admission. They are provided with detailed information about the service, including the admission criteria and the processes that must be completed prior to admission.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The ATL explained that when a resident is transferred a range of clinical and other information is sent with them to facilitate continuity of service delivery, including medication charts, family contact details and a transfer form. The DHB's 'pink envelope' system is used when residents are being transferred to acute hospital services.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medication management complies with legislative requirements and safe practice guidelines. The service uses an electronic medication management system. In all medication charts reviewed, medications were charted in an appropriate manner, discontinued medications documented, and medications reviewed at least three monthly. The service has standing orders for a limited range of medications, and the standing orders complied with guidelines. Although there were no residents self-medicating at the time of the audit, processes are in place for residents to self-medicate, should this be required.</p> <p>Medications are supplied to the facility using the blister pack system. Evidence was sighted that these packs are checked against the medication chart by a RN on arrival to the service. Checks are also undertaken on a regular basis for any surplus and expired medication, which is returned promptly to the pharmacy. A stocktake of all controlled medication is undertaken weekly and reviewed six-monthly by the pharmacy, as evidenced in the controlled drugs register. Records of</p>

		<p>the daily check of the medication fridge temperature were sighted.</p> <p>Registered nurses and senior caregivers administer medication in the facility. All of these staff complete medication competency assessments annually (records were sighted). Observations of two medication rounds confirmed that medications were administered in a safe and appropriate manner. All of the fourteen medication charts contained a current photograph of the resident, the medication was checked against the medication chart prior to verbally confirming the resident's identity before the medications were administered; the medications were observed being taken; and then the administration was documented. The service had recently identified an increase in medication incidents, and has instigated several initiatives to address these.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All aspects of food service management are consistent with legislative requirements and best practice. On inspection, the kitchen was organised and well maintained, clean and tidy. Food was stored appropriately, and food in the fridge and freezers was dated and covered. Cleaning schedules were sighted. Records were sighted that fridge and freezer temperatures were monitored daily and remained within recommended ranges. A regular maintenance programme is in place for equipment such as ovens and the dishwasher.</p> <p>Experienced and appropriately qualified staff are responsible for food services within the facility. All four cooks have completed NZQA Unit Standard 167 food safety, and the Hospitality Manager advised that further updates had been planned for the near future. Every quarter the kitchen undertakes a food satisfaction audit, which includes a plate waste audit, and formal interviews with five residents about their satisfaction with meals. This is in addition to the questions related to the food services, which are included in the annual resident satisfaction survey.</p> <p>The kitchen caters for a range of nutritional requirements, including diabetic, vegetarian, soft and puree diets. A four weekly menu, with summer and winter options, was reviewed by a dietician in early June 2016. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Specialised crockery, such as lip plate and feeding cups, are available. There is a spacious and well-lit main dining room, with a smaller dining area in the hospital wing. There was evidence in residents' clinical records that they were being weighed monthly, and appropriate interventions were implemented in response to clinically significant weight loss or weight gain.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>If a prospective resident did not meet the entry criteria, or there was currently no vacancy, the ATL advised that the Nurse Manager or senior nursing staff would support them and their family to work</p>

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		with Supportlinks to find appropriate care/placement.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The ATL advised that residents are assessed by a registered nurse within 24 hours of admission. Within three weeks of admission an interRAI assessment is completed. The outcomes of that assessment, and a range of other relevant information such as the NASC assessment and hospital discharge summary, then underpin the development of the long term care plan. All residents' records reviewed demonstrated evidence of a comprehensive and ongoing assessment process which also includes resident/family involvement. These were completed in a timely manner.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	All residents have an individualised and detailed care plan which provides guidance for care delivery staff to support the resident's identified needs and promote continuity of care. Residents and families stated they felt included in the development of these plans, and their ongoing evaluation. The care plans reviewed during the audit reflected the support needs of residents and the outcomes of the integrated assessment process. Refer also to criterion 1.3.8.3 in relation to short-term care planning.
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	The individualised care plans for each resident outline the supports they require and the services to be provided. These plans provide direction for care delivery staff, who also have access to registered nurses 24 hours a day for further guidance and support as required. The residents' records reviewed demonstrated regular, timely and comprehensive ongoing assessment of long-term care needs which then informed the provision of care services. Service delivery related to short-term care needs was not consistently documented and/or implemented. All residents and family members interviewed, as well as a doctor and another health professional, expressed their satisfaction with the standard of care provided to residents.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their	FA	Two qualified diversional therapists (DT), each with eleven years' experience in the role, are responsible for the activities programme, which runs from Monday-Saturday each week. Both DTs are members of the local DT group. The DTs explained how residents' previous and current interests are assessed on admission and

<p>needs, age, culture, and the setting of the service.</p>		<p>individual activity plans completed within three weeks and reviewed six monthly. This was confirmed in residents' records. The outcomes of residents' assessments inform the development of the activities plan. Activities planned for June included games, entertainment, quizzes, exercises, music therapy, card games, weekly church services, and 'happy hour'. Activities are provided mainly on a group basis, although one-on-one activities are also available. The facility van is used regularly for outings, such as trips to the beach for a fish and chips lunch, shopping and scenic drives. Several outings have ventured further afield, such as a trip to Napier, with the DTs advising that more of these longer outings are planned in the near future. The DTs also facilitate the residents' meetings, which are held every two-three months.</p> <p>When speaking with residents about the activities programme, those who participated regularly in the programme expressed their enjoyment of the activities available to them. Several other residents stated they preferred not to participate in group activities, and their wishes were respected.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>In all the clinical files reviewed, long-term care plans had been evaluated at least six monthly. These evaluations were completed by registered nurses, and provided clear details of resident's progress towards achieving identified goals. Short-term care plans were not consistently developed as clinically indicated, and documentation related to resident progress towards achieving identified goals was incomplete.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The right of residents to access other health and/or disability providers is maintained. Residents are able to choose who their regular doctor will be. If the need for other services is identified, the doctor or a registered nurse sends a referral to seek specialist provider assistance, and copies of such referrals were sighted. The resident/family confirmed on interview that they are kept informed about the referral processes. Support is available to transport and accompany residents to external health-related visits, as sighted in residents' records and confirmed during interviews with families.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,</p>	<p>FA</p>	<p>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p>

infectious or hazardous substances, generated during service delivery.		There is protective clothing and equipment available, appropriate to recognised risks. There was protective clothing and equipment sighted in the sluice rooms and the laundry and being used by staff.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. However, there are external doors and weather boards that are in need of replacing. All residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>There is a reactive maintenance book for staff to enter any maintenance required. Plant and equipment are maintained to an adequate standard. Although the maintenance person reported they carry out proactive maintenance, there was no proactive maintenance programme available. The testing and tagging of equipment and calibration of biomedical equipment was current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>Residents confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents also confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Two bedrooms share a full ensuite and some other bedrooms have a wash hand basin and toilet. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote resident's independence.</p>
Standard 1.4.4: Personal Space/Bed	FA	Bedrooms provide single accommodation. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents, including spoke positively about

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of areas for residents to frequent for activities, dining, relaxing and for privacy. These areas are easily accessed by residents and staff. Residents confirmed this. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is washed on site. Residents and family members reported the laundry is managed well and residents' clothes are returned in a timely manner. Staff share responsibility for all laundry.</p> <p>There are dedicated cleaners on site who have received appropriate education. Interview of one of the cleaners and training records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations and covers all service groups provided at the facility. A fire drill takes place six-monthly with a copy provided to the New Zealand Fire Service. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures.</p> <p>Registered nurses and senior care staff have current first aid certificates. There is always at least one staff member on duty with a current first aid certificate.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ.</p> <p>There are call bells to alert staff. Residents and families reported staff respond promptly to call</p>

		<p>bells.</p> <p>Contractors must wear names badges and sign in and out of the facility. They are also made aware of any hazards on site.</p> <p>The external doors are locked in the evenings and an external firm is contracted for security at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps, water heaters, and under floor heating in some areas. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Infection control management is guided by a comprehensive infection control manual, and a facility-specific management programme. The manual includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. This manual is updated regularly, and the facility is using the 2016 edition. The facility infection management programme was updated in June 2016.</p> <p>The care manager of the rest home is the designated infection control coordinator, while the ATL (hospital wing) is the 'outbreak coordinator'. Infection control matters, including surveillance results, are reported monthly to the quality committee and to the nurse manager, who then reports to the chief executive officer. Meeting minutes and monthly reports were sighted. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings and at staff handover meetings. This was confirmed in staff interviews.</p> <p>A sign at the main entrance to the facility ask anyone who is or has been unwell in the past 48 hours to not enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>A job description is available to guide the infection control coordinator in their role. The infection control coordinator, a senior registered nurse, has been in the role for ten years, and has undergone a range of relevant education over that period, as confirmed in training records. They</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>are also able to use a range of established networks, such as with the Infection Control Team at MidCentral DHB and the Public Health Unit when additional support/information is required. The coordinator advised that in her infection control capacity she has access to residents' records and diagnostic results to ensure timely treatment and resolution of infections.</p> <p>Protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains a supply of additional equipment in case of an infection outbreak (supplies sighted).</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>A comprehensive infection control resource manual, developed by an external provider, guides infection prevention and control practices. This manual complies with legislation and current accepted good practices, and was updated this year.</p> <p>Hand sanitisers are easily accessed around the facility, and staff were observed using these on a regular basis. All clinical, housekeeping and kitchen staff were observed to be compliant with generalised infection control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator advised that infection control is a component of the staff orientation programme. Annual infection prevention and control education was provided to staff, as confirmed in staff training records and staff interviews.</p> <p>This education is provided by either the infection control coordinator or the outbreak coordinator, both experienced registered nurses. The infection control coordinator also advised that additional staff education is provided on an as-required basis, such as if there was an infection outbreak or if there were an increased incidence of resident infections (eg, urinary tract infections).</p> <p>The infection control coordinator explained that education with residents is generally on a one-to-one basis. This may include strategies to minimise the possibility of urinary tract infections, reminders about handwashing, or education related to specific infection issues.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	PA Low	<p>Surveillance of an appropriate range of infections is undertaken on a monthly basis. This includes data related to respiratory tract, eye, ear, nose, mouth, urinary tract, skin, soft tissue and</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>gastrointestinal infections. The analysis and evaluation of data related to the rest home is limited, and infection surveillance is not integrated across the facility.</p> <p>The monthly surveillance results are reported to the nurse manager, who then reports to the chief executive officer. Surveillance results are also reported to the quality meeting, and all staff meetings. This was confirmed in the meeting minutes.</p> <p>There is currently no formal benchmarking of infection-related data, although the nurse manager advised this is discussed informally at the quarterly Masonic facility manager meetings.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrates that the use of restraint is actively minimised. There were six residents using restraint and two using enablers during the audit. The acting team leader/RN is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>Systems are in place for determining the restraint approval processes. The restraint coordinator and staff interviewed and the residents' files evidenced responsibilities were identified and known. The residents' files evidenced residents and/or family input into the restraint approval processes. There was a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The approval group forms part of the quality meetings and discussion includes education and competencies, equipment, and the use of restraint.</p> <p>Care staff interviewed were aware of the restraint coordinator's responsibilities. Policy/procedures define approved restraints and alternatives to restraint. There were policies relating to strategies to minimise use of restraint and management of challenging behaviour. The orientation/induction programme includes overview of restraint policies/procedures.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Systems are in place that ensure assessments of residents are undertaken prior to restraint usage being implemented. Residents' files demonstrated restraint assessment and risk processes were being followed. The policies related to strategies to minimise the use of restraint and management of challenging behaviours.</p> <p>The residents' files evidenced restraint assessment risks were documented and included resident and/or family input. Care plans evidenced restraint assessment risks were reviewed. Care staff</p>

		demonstrated a sound knowledge concerning restraint procedures.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Appropriate systems ensure the service is using restraint safely. The restraint policies and procedures identified risk processes that are to be followed when a resident is being restrained. The residents' files evidenced evaluations, review of restraint goals and interventions and were current. The residents' files demonstrated appropriate alternative interventions were implemented and de-escalation attempted prior to initiating restraint. The restraint consents by resident and/or family were current. The restraint register is current and provides sufficient information.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	PA Low	The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files evidenced each episode of restraint was monitored. Although restraint is evaluated monthly, the evaluation form does not provide sufficient information. The resident's care plan evaluations were current. Restraint meetings minutes were reviewed as part of the quality meetings. The acting team leader and RNs are responsible for evaluating restraint use and this was confirmed during interview.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The internal audit programme includes a quality review of restraint. This was late completed in April 2016. The outcome of the review was documented and reported on and discussed at the quality meetings. Policies and procedures included monitoring and quality review processes. Staff have received education relating to restraints and enablers, and restraint competencies are current.

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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data is collected and collated. The staff member responsible reported graphs are generated. However, these are basic and staff reported they have not seen them. Staff reported they discuss the clinical indicators during the staff meetings to identify any trends. There was no documented evidence to support this. There was documented numbers of clinical indicators for the month, but no evidence of any analysis to identify trends.</p>	<p>Although staff reported they discuss analysis and trends during their staff meetings, there was no documented evidence that clinical indicators are analysed to identify any trends. Meeting minutes evidenced numbers only are reported back to staff, apart from falls</p>	<p>Provide documented evidence that quality data is analysed to identify trends and that this is reported back to staff.</p> <p>180 days</p>

			with injury or without injury.	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans were evidenced in the quality and staff meeting minutes. Some internal audits had corrective action plans, but these were inconsistent and documented what the problem was, rather than an action plan. The satisfaction surveys, resident meeting minutes and any hazards had no evidence of corrective actions. Where corrective action plans had been developed, there was little evidence of follow-up as to the action taken and the effectiveness of this.</p>	<p>Corrective action plans are not always developed following deficits identified. Where corrective action plans have been developed, there was no review to determine whether the corrective action had been effective.</p>	<p>Develop and implement corrective action plans for all deficits identified and review the effectiveness.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Moderate	<p>Potential risks are identified and documented in a hazard register. Potential hazards show the actions put in place to minimise, isolate or eliminate risks. Safety issues are discussed at the monthly staff meetings. There was no hazard register that documents actual hazards. Staff reported they enter any hazards into the reactive maintenance book for the maintenance person to fix, rather than on a hazard form. The health and safety coordinator is responsible for hazards and reported they had not seen any hazard reports for some time.</p>	<p>There is no register for actual hazards. Hazards are being entered into the maintenance book by staff, instead of staff completing hazard forms. The health and safety officer reported they had not seen any completed</p>	<p>Provide evidence that all hazards are reported on a hazard form. Record all actual hazards on a register so they are able to be managed, monitored, evaluated and reviewed on a regular basis.</p> <p>90 days</p>

			hazard forms for some time.	
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Moderate</p>	<p>Job descriptions outline accountability, responsibilities and authority, employment agreements, references, code of conduct, completed orientation and competency assessments. There was no evidence of police vetting on any of the files reviewed. Two staff files had evidence of current performance appraisals. Four files had no evidence of current appraisals including the nurse manager and care manager. The other two files reviewed were new employees and an appraisal was not yet due.</p>	<p>(i) Four of six files had no evidence of current performance appraisals. The other two files were for employees who are new and appraisals are not due. (ii) None of the eight staff files reviewed had evidence of police vetting.</p>	<p>All staff are have current performance appraisals. Police vetting is undertaken as part of the recruitment process.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Individualised and detailed long-term care plans, reflecting comprehensive assessment outcomes, and the integration of a range of relevant information, were sighted in all clinical files reviewed. In four of those files, the resident had an acute clinical event that required the development of a short-term care plan. These events included infections, changes in medication, a fracture and a soft tissue injury. It was unclear from the documentation in each file, particularly the residents' progress notes, as to whether the planned</p>	<p>Interventions documented in short term care plans were not consistently implemented.</p>	<p>Interventions detailed within care plans are fully implemented.</p> <p>90 days</p>

		treatment related to the acute event had been fully implemented, and the residents' response to those treatments. Refer also to Criterion 1.3.8.3.		
<p>Criterion 1.3.8.2</p> <p>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.</p>	<p>PA Moderate</p>	<p>The regular evaluations of long-term care plans included detailed information on the resident's progress towards meeting desired outcomes. These evaluations were undertaken at least six-monthly by registered nurses, and plans updated as required.</p> <p>The service has recently instigated a new system to ensure staff are aware when a short-term care (STC) plan has been instigated, with these plans printed on coloured paper, and a list of plans displayed in the nursing stations. The STC plans are easily located within the clinically file. Initially, two STC plans were reviewed, and the sample was then extended by a further four plans. Two of these plans were not related to clinical events but were being used more as a communication record for staff, such as the outcomes of a recent doctor's visit. In the remaining four instances, documentation and evaluation related to the clinical event was irregular and incomplete, both on the STC plan form itself, and in the residents' progress notes. It was also difficult to quickly identify which of the STC plans were still current.</p>	<p>Resident progress towards meeting desired outcomes identified in short-term care plans was not consistently documented.</p>	<p>Residents' progress towards meeting desired outcomes is fully documented.</p> <p>90 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>In all of the care plans reviewed evidence was sighted of the long-term care plan being updated in response to regular evaluation of resident progress.</p> <p>None of the four clinically-related STC plans reviewed included a goal of care and interventions listed to meet an identified clinical problem, such as, infections, medication changes, and soft tissue injuries, were incomplete. For example, a resident was recently diagnosed with three infections concurrently but their short term care plan focused on just one of those infections. For another resident, a change in the treatment of a short-term condition was not then reflected in changes to their STC plan. In two other instances, planned interventions, such as blood sugar measurement, and discontinuation of the use of support stockings, had not been consistently implemented.</p>	<p>Short-term care plans were not consistently or comprehensively developed to reflect acute changes in the health status of residents.</p>	<p>When resident progress is different from expected, the resident's care plan is updated to reflect this.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Overall the building is maintained to an adequate standard and is appropriate for the needs of residents. Passageways are wide enough for mobility aids and residents reported they are able to move easily about the facility. There is a reactive maintenance book and the maintenance person is responsible for completing anything that requires fixing. Some external doors and weather boards have dry rot and windows with wooden surrounds have</p>	<p>The maintenance person reported they undertake preventative maintenance, however there is no programme available. There are some external doors and weather</p>	<p>Develop and implement a proactive maintenance programme, and provide timeframes for replacing/maintaining the external doors, weatherboards, and window frames to an</p>

		putty missing around the frames. Plant and equipment are maintained to an adequate standard. Although the maintenance person reported they carry out proactive maintenance, there was no proactive maintenance programme available.	boards with dry rot. Windows with wooden surrounds have the putty missing around the frames.	adequate standard. 180 days
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Low	<p>Although surveillance data is reported to relevant personnel and management in a timely manner, the required analysis and trending of the rest home data is not consistently undertaken prior to that reporting taking place. Graphs of 2016 surveillance data were sighted only for the hospital wing.</p> <p>Infection surveillance is currently undertaken separately by the hospital and rest home areas. There is no mechanism in place to analyse the combined data and identify trends/issues across the facility.</p>	Infection surveillance is not integrated across the facility, and there is limited analysis of some surveillance data.	<p>Infection surveillance is integrated across the facility, and all surveillance data is fully analysed and evaluated.</p> <p>180 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p>	PA Low	Residents who use restraint had monitoring forms completed and there was evidence of evaluations completed. The evaluation form does not include items (a) to (k) as required under this criterion and therefore are not comprehensive. Evaluations are mainly one line stating the word "unchanged".	Evaluation forms are basic and do not include items (a) to (k) under this criterion.	Develop and implement an evaluation form that includes (a) to (k) as required under this criterion.

<p>(d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.</p>				180 days
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.