

The Hillview Trust Incorporated - Hillview 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 Health Audit (NZ) 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:	The Hillview Trust Incorporated
Premises audited:	Hillview Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 May 2016 End date: 17 May 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:	45

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
Yellow	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
Red	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

Hillview Home and Hospital is owned and operated by a charitable trust. The service provides rest home and hospital level of care for up to 52 residents. At the time of audit there were 45 residents.

A full certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the onsite audit and the review of documentation, observations and interviews. This audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There are three required improvements identified at this audit. These are related to care planning, short term care plan interventions and evaluations, and medicine management.

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.	Green	Standards applicable to this service fully attained.
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Staff demonstrate knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents and families receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

The service has an easy to use complaints management system. There is a complaints register that contains any complaint received and actions taken to address any shortfalls.

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.		Standards applicable to this service fully attained.
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The service is managed to meet the needs of the residents at rest home and hospital level of care. Organisational structures and processes are monitored at the management/operations and board levels. Service performance is aligned with the strategic business plan. There is a robust documented and implemented quality and risk management system that supports the provision of clinical care and support. Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The general manager and clinical manager are both suitably qualified and experienced to manage the service. The general manager reports to the Board of Trustees.

Policies are reviewed by the management team two yearly and reflect current accepted best practice.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the resident's needs at the various levels of care. The education programme for all staff is available and planned for the year. Staff education is encouraged. The education, training and orientation processes for staff have undergone extensive review, are linked to the organisation's strategic directions and are achieving improved outcomes for residents.

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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Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Care plans are not consistently developed and evaluated for all residents. Short term care plans are insufficiently detailed.

Planned activities are appropriate to the needs, age and culture of the residents. Residents reported that activities are enjoyable and meaningful to them.

The medicine management system does not consistently meet the required regulations and guidelines. Improvement is required in relation to "as required" medications and telephone orders.

Food services meet the individual food, fluids and nutritional needs of the residents.

Safe and appropriate environment

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.
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All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment. There are adequate numbers of toilets, showers, and bathing facilities located throughout the facility that provide adequate privacy.

The environment is appropriate for rest home and hospital level of care services. All areas ensure physical privacy is maintained and have adequate space and amenities to facilitate independence.

There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

The facility has an appropriate call system installed. There is access to external gardens, grounds and courtyards for residents and their visitors. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Routine safety checks and internal audits are performed by maintenance personal and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

Restraint minimisation and safe practice

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.
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The service has clear and comprehensive policies and procedures which meet the requirements of the restraint minimisation and safe practice standard. There are established systems and practices. Risk management plans are in place. Staff training occurs at least annually. Monitoring and review of individual restraint interventions occurs at an appropriate frequency. The restraint register is current.

Infection prevention and control

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.
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Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The type of surveillance is appropriate to the size and complexity of the service. Infection rate data is collected, recorded, analysed and reported. Recommendations to reduce infection rates are discussed. The infection control coordinators are responsible for implementing and evaluating the infection prevention and control programme.

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	47	0	2	1	0	0
Criteria	0	98	0	2	1	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>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff (e.g., staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they are treated with respect and understand their rights. The relatives reported that residents are treated with respect and dignity.</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</p>	FA	<p>Evidence is seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. An advance directive enables a resident to choose if they would like active medical treatment to prolong life,</p>

informed consent.		transfer to base hospital for on-going treatment or receive 'comfort care'. The files reviewed have signed advance directive forms which meet legislative requirements Family members and residents are actively involved and included in care decisions as evidenced in residents' files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support people. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff report knowledge of residents' rights and advocacy service. A number of referrals to advocacy services were sighted.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The residents report they have access to visitors of their choice. Residents reported they are supported to be able to remain in contact with the community through outings and visits from community organisations to the service.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints register and sample of complaints for 2015 and 2016 evidences that complaints are managed within time frames of Right 10 of the Code. Complaints forms are available at the entrance, with information given on the complaints process as part of the admission procedure and advocacy session with residents and families. Residents and family/whānau report they are encouraged to provide feedback or make a complaint. The service has had an external complaint that has been finalised since the last audit. This has been closed and no further action is required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policy detailed that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Education is held annually. Residents are addressed in a respectful manner and by their preferred names as was confirmed in interview with residents.

<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, and independence.</p>	FA	<p>All rooms are single occupancy. The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed. Staff report knowledge of residents' rights and understand dignity and respect.</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>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included in the policy Family/whanau input and involvement in service delivery/decision making is sought when this if applicable and consented by the resident. There are a number of Maori residents in the service at the time of audit, with care and services provided that reflects their individual needs, as confirmed in interview with a Maori resident and by a review of care plans. The staff reported that they understand the Treaty of Waitangi, recognition of Maori values and beliefs and the importance of whanau.</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>	FA	<p>Assessment for the cultural and/or spiritual needs of the resident in consultation with the resident and family is part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident. Residents and family report satisfaction with the manner in which care and services are provided at Hillview. Staff reported on the need to respect individual culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>The employment job description, the staff handbook and the Code of Rights define residents' rights relating to discrimination. Staff stated they would report any inappropriate behaviour to the general manager, clinical manager or RN. There are processes in place to take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents indicated no concerns.</p>

other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Care staff have undertaken or are completing national qualifications related to aged care. All staff have an up to date first aid certificate and all staff who administer medication have yearly assessments to determine competency. The clinical staff attend education sessions run by hospice and other local organisations. The planned yearly education programme reviewed included sessions that ensure an environment of good practice. Policies and procedures reviewed are all current and relate to best practice. There is specialist advice available if required.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The cultural policy notes interpreters will be accessed if required. At the time of audit, all residents are able to verbally communicate in English. Residents and families report they are kept up to date with any changes in their care and are informed of any incidents in an open and honest manner. Evidence of open disclosure is sighted in incident reports, complaints management and residents' files.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The services are planned to meet the individual needs of each of the residents. At the time of audit there were 35 rest home and 10 hospital level of care residents. There were no residents under the age of 65. Appropriate processes, staffing and resources are in place to meet the needs of all the residents. The service, where possible, groups the rest home and hospital level of care residents together. One wing is predominantly hospital level of care and the other mostly rest home level of care. The wing that is located furthest away from the nurse station and lounge and dining area have residents with the greatest mobility and independence. Where rest home residents are in the predominantly hospital wing, processes are implemented to ensure these residents participate in social activities suitable to their individual needs and have the option to have meals in the main dining room. The mission, vision, values, philosophy and purpose are clearly shown. The strategic business plan (2015 to 2016) incorporates a review of the quality improvement plan. In addition to this plan there has also been an external review of the long term strategies of the service. The strategic business plan focus includes goals in the environment, communication, management, clinical, household, quality, health and safety and maintenance. The management committee presents the annual objectives to the Board of Trustees. Stakeholders, residents and their families, and employees have the opportunity to input into the setting of the objectives by making suggestions and recommendations through board meetings, resident meetings and staff meetings. The objectives are monitored through monthly management committee meetings. The monthly management/operations committee reports are provided to the Board of Trustees and the Board reviews

		<p>current progress in the completion of annual goals and any suggested amendments.</p> <p>The service is managed by a suitably qualified and experienced clinical manager who is a registered nurse. The clinical manager is supported by a general manager and the management committee. The general manager has the responsibility for the overall management of the service and reports to the Board of Trustees. The clinical manager has the overall responsibility for the clinical care and clinical staff. The clinical manager has been in the role for over three years and has previous experience in aged care and acute care. The general manager's and clinical manager's job descriptions outline their role and responsibilities for the management of the service. The managers have each attended over eight hours' education related to the management of aged care services and their responsibilities to provide aged care services with the DHB. The managers attend other clinical education related to dementia and aged care. Both the general manager and clinical manager attend monthly management support and training with managers of other aged care services within the Waikato.</p> <p>The residents and family/whanau interviewed and satisfaction surveys report satisfaction with the quality of care and services provided at Hillview.</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>	FA	<p>The other members of the management/operations team take on the management roles when the general manager or clinical manager are on leave. The general manager reports confidence in the management/operations team to take on the general manager's or clinical manager's role during their temporary absence.</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 reflects continuous quality improvement principles.</p>	FA	<p>The staff and management demonstrate an understanding of the quality and risk processes that are identified in policy. Staff at all levels of the service report their involvement with the ongoing quality and risk management systems. Staff stated that quality improvement was a team effort, they had increased their knowledge in this area, and that they had a better understanding of quality and risk and its significance for gaining better outcomes in care and service delivery.</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at least two yearly or sooner if there are legislative or best practice changes.</p> <p>The service has robust systems implemented for quality management, the collation and analysis of data,</p>

		<p>and processes to measure achievement against the quality and risk management plan and strategic directions. Monthly surveillance is collated, benchmarked and reviewed by the management/operations team. Benchmarking occurs with other aged care services. Data is trended and results presented at operations meetings, staff meetings and presented to the Board. The general manager reports to the Board on how the service is performing in the key components of service delivery. The reports reviewed indicated that the service is making ongoing improvements through the continuous improvement systems.</p> <p>When improvements are identified from the internal auditing system and satisfaction surveys, correction actions are recorded on the 'action sheet for audits'. These record the recommendation, actions required, who is responsible for implementation, the improvement or decrease since the last audit and if the actions implemented have resolved the issue.</p> <p>The service has conducted a number of quality improvement projects in 2015 and to date in 2016. Some of the projects sampled are related to the transfer of residents and the activities programme. The reporting of the analysis and outcomes of the project are presented to the Board of Trustees, operations meetings and staff meetings.</p> <p>The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes. Interviews with staff confirm their awareness and knowledge of identifying and reporting hazards. The information related to potential hazards are set out in the information book given to all residents and family/whānau members. Monthly staff and management/operations meetings have trended data and benchmarking results presented as part of the standing agenda. Meetings are used to review corrective actions put in place.</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>The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of pressure injuries stage 3 and above.</p> <p>The number of incidents are collated on a monthly basis. Samples of incident/accident forms and the trended data were reviewed. Any trends identified are notified and information fed back to the board, staff and as part of the monthly external benchmarking. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident's care plan as required.</p>
<p>Standard 1.2.7: Human</p>	<p>FA</p>	<p>All staff and contractors who require an annual practising certificate (APC) have these validated at</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>employment and annually. Copies of APCs were sighted for all staff who require them.</p> <p>Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. There are at least annual performance reviews for the staff.</p> <p>The service providers support and facilitate training and education that is appropriate to the needs of the service and maintain records of the training provided. Training needs are identified in the annual performance appraisal process, through review of monthly quality data and staff mentoring and coaching sessions. Mandatory training to meet contractual obligations is two yearly, or more frequently for such topics as infection control and restraint minimisation and safe practice. The care staff, activities, kitchen and housekeeping staff are supported to gain appropriate national qualifications if they do not already have them. The education schedule was reviewed for 2015 and the upcoming 2016 year has content and variety and meets all obligations of the provider's residential care contract with the district health board. The service has an RN that has completed the required interRAI training and demonstrated knowledge on the use of this tool to assess residents' needs to inform the care planning process.</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>	FA	<p>The general manager reports that the allocation and skill mix of the staff is reviewed weekly to ensure safe staffing levels are achieved. Rosters sighted evidenced that the skill mix and numbers of nursing/care staff meets contractual requirements and the residents' needs. All sick leave and annual leave is shown and replacement staff noted. There are sufficient numbers of laundry, housekeeping, activities, and support and administration staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member's name and designation. The residents' files reviewed evidenced that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>The entry to the service policy includes procedures to be followed when a resident is admitted. Admission agreements are signed by the residents or by their families as evidenced in all sampled resident records. Residents and families reported that the admission agreements are discussed with</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>		<p>them in detail by the general manager or by the clinical manager.</p> <p>All residents have the appropriate needs assessments prior to admission. An information pack is provided for potential residents and their families. The clinical manager ensures that residents are admitted in accordance with contractual requirements. All enquiries are recorded in the enquiry and waiting list register.</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>	<p>FA</p>	<p>A standard transfer notification form and process from the district health board is used when residents are required to be transferred to the public hospital or to another service. The clinical manager said that telephone handovers are conducted for all transfers to other services. The resident and their families are involved for all exit or discharges to and from the service. This was confirmed in interview.</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>	<p>PA Moderate</p>	<p>A medicine management system is not consistently implemented to ensure that the residents receive medicines in a safe and timely manner. Medication charts are legible and photos are present in the cover. Medication charts are reviewed regularly. All discontinued medications are signed for and dated by the GP. Allergies are well-documented. The controlled drugs register is current. Weekly stocktakes are conducted by the RNs while the six-monthly controlled drugs register check is conducted by the pharmacist. Stock medications are checked monthly.</p> <p>The medicine fridge is monitored and the temperature is recorded daily.</p> <p>A system is in place when using the standing orders.</p> <p>Medicine reconciliation is conducted by the RNs when a resident is discharged back to the service. There are no expired or unwanted medications. A system is in place when returning expired or unwanted medications. All medications are stored appropriately.</p> <p>The staff administering medications complied with the medication administration policies and procedures as evidenced in the observed medications rounds in both rest home and hospital. Current medication competencies are evidenced in the staff files.</p> <p>There are no residents who self-administer their medications, however there are self-administration policies and procedures in place.</p> <p>Improvements are required in relation to documenting indications for the "as required" medications and the GP signing the telephone orders in a timely manner.</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>	<p>FA</p>	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving deliveries. All meals are prepared and cooked onsite. There are current food handling certificates.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. There is evidence that RNs complete the dietary requirement forms on admission and provided a copy to the cook. Additional or modified foods are also provided by the service.</p> <p>Fridge and food temperatures are monitored and recorded daily. Cooked meals are plated from the main kitchen to the dining area. The meals are well-presented and residents confirmed they are provided with alternative meals as per requested. All residents are weighed regularly and there is no evidence of significant weight change in the reviewed resident's files. Residents with weight change are provided with food supplements and fortified foods.</p> <p>The kitchen staff use safe food practices when preparing meals. A kitchen cleaning schedule is in place.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <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.</p>	<p>FA</p>	<p>There is a policy on declining entry to the service. A declined resident is referred back to the referrer to ensure that the resident is admitted to the appropriate level of care provider or is entered in the waiting list register. The clinical manager reported that the district health board needs assessors, social workers and families contact the facility manager to discuss the suitability of the resident prior sending the resident's family to view the facility.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs use standardised risk assessment tools on admission. The assessment information is the basis for developing the resident's initial plan of care and the long term care plan. New residents are admitted using the interRAI assessment tool which is completed within the required time frame. The identified trends during the assessment are used as the focus of the long term care plans.</p> <p>The required assessments are sighted in all sampled resident files.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p>	<p>PA Low</p>	<p>Long term care plans are resident-focused and personalised. There is evidence that continuity of service delivery is promoted. Goals are specific and measurable. Interventions are documented to address the desired goals/outcomes identified during the assessment process.</p> <p>The RNs developed short term care plans for all acute conditions. Residents and families are involved in</p>

continuity of service delivery.		<p>the development of long term care plans as evident in the reviewed resident's files. Staff are informed about changes in the care plans through the hand overs and monthly meetings.</p> <p>Improvement is required in relation to long term care plan.</p> <p>Continuity of service delivery is maintained through the use of integrated resident's records, appointment diary, e-mails and shift hand overs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Long term and short term care plans are developed by the RNs. Documented interventions in the long term care plans addressed the issues identified during the assessment process.</p> <p>Improvements are required to ensure that short term care plans are sufficiently detailed and must include the resident's response when the treatment regimen is completed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The diversional therapist (DT) develops the activity plans using the resident's profile gathered during the interview with the resident and their families. The weekly activities are posted in the corridors in different areas within the facility. Activity plans are well-documented and reflected the resident's preferred activities and interests. A participation log was maintained. The DT referred the residents to the RNs when changes are noted regarding involvement in the activities. Interviewed residents and families said that the activities provided by the service are adequate and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans are developed by either the registered nurses or by the enrolled nurses. These care plans developed by the enrolled nurses are reviewed and countersigned by the registered nurses for implementation. Evaluations are completed by the registered nurses. Changes to the care plans are evident in the reviewed resident's files when the desired outcomes are not met. Short term care plans do not evidence resident's response after completing treatment (refer to 1.3.6.1 Service Delivery/Interventions).</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>There are documented policies and procedures in relation to exit, transfer or transition of residents. There was evidence of referrals by the GP to other specialist services. Residents and the families are kept informed of the referrals made by the service. This was evident in the communication register.</p>

<p>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>Internal referrals are facilitated by the clinical manager, enrolled nurse and registered nurses. A diary is used for internal referrals for other allied health teams.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The cleaning, laundry and sluice room have safe, secure and appropriate storage of waste, chemicals and hazardous substances. The service has council certification for the disposal of waste, which complies with local waste disposal requirements. Personal protective equipment (PPE), such as gloves, disposable gowns, sleeves and eye protection is available in the laundry/chemical storage area. The cleaning and laundry staff demonstrated knowledge on the safe use of the chemicals and PPE. Staff have ongoing education on infection prevention and control and the use of chemicals.</p>
<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>	<p>FA</p>	<p>The service has a current building warrant of fitness displayed.</p> <p>Hot water temperatures are monitored and the recordings within safe guidelines. Medical equipment has had annual calibration and electrical equipment is tested and tagged. There has been a monthly compliance check of the environment.</p> <p>The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. There are covered seating areas off each of the lounge and dining areas.</p> <p>The residents and families reported satisfaction with the environment.</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</p>	<p>FA</p>	<p>The service has a mix of communal facilities, ensuite with toilets and full ensuite with toilets and shower facilities. There are adequate numbers of shower, bathing and toilet facilities throughout the service. One wing has a disability access bathroom that can accommodate the bath bed. All of these facilities have privacy locks and/or signage. The residents and families reported satisfaction with the facilities at the service.</p>

personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms are single occupancy and suited to the needs of residents requiring rest home or hospital level of care. Each resident's room has their personal items and provides enough space for the resident and staff to mobilise. The residents and families reported satisfaction with the personal space and the individualised care.
<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	Each of the wings has a small lounge, whanau room or sitting area. There is also a central dining area and a lounge area. The large lounge area is separated into smaller areas by the layout of furniture, so that different activities do not impact on each other. Residents' rooms also provide areas for residents to relax or entertain in privacy. The residents and families reported satisfaction with the access to dining and lounge facilities.
<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	The cleaning and laundry is conducted by specific cleaning and household staff. The laundry has a dirty to clean flow, with processes implemented for infection prevention and control. Chemicals, laundry and cleaning equipment are securely and hygienically stored. The external chemical supplier conducts monthly reports on the effectiveness of the cleaning and laundry chemicals. The residents report overall satisfaction with the cleaning and laundry services.
<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>The approved evacuation scheme is dated 2010. The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly, with the last conducted in March 2016. Staff demonstrated knowledge on how to respond in emergency or civil defence situations.</p> <p>The service has gas for cooking and emergency lighting in the event of mains failure. There is tank water that is accessible in emergency situations.</p> <p>Each room, toilet and bathing facility has access to a call bell. The call bell system has a light, an audible alert and a display on central panels in each corridor when activated. The residents and families</p>

		reported satisfaction with the time frames in which call bells are answered.
<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	All areas used by residents and families are ventilated and heated. Each resident's room and hallway has wall mounted radiators and at least one window. One wing has underfloor heating. The residents and family report satisfaction with the heating, light and ventilation.
<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>The responsibilities for infection control are clearly defined. Two registered nurses share the infection control coordinator role and are responsible for collecting infection control data. The service utilises the support of an infection control expert for infection prevention and management issues. Both infection control coordinators have attended infection control updates.</p> <p>The infection control programme is reviewed annually. Infection prevention and control is included in the RN meeting, health care assistant meeting, weekly operations meeting and board meeting.</p> <p>An infectious diseases prevention policy is in place. Resident's families and relatives are encouraged not to visit when they are unwell. There are hand sanitizers in the common areas and there are adequate hand basins for the residents and staff to use.</p> <p>The infection control policies and procedures are readily available in the training room.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The infection control coordinators are responsible for facilitating infection prevention and control activities in the facility. The infection control committee is composed of the infection control coordinator, clinical manager and quality/risk manager. The committee is responsible for implementing and evaluating the infection control programme of the service. The GP reported that the RNs contact the medical centre when residents manifested suspected infections. An independent infection control expert provided advice to the infection control coordinators. Interviewed staff are knowledgeable regarding outbreak management and breaking the chain of infection.
<p>Standard 3.3: Policies and procedures</p>	FA	There are documented policies and procedures for the prevention and control of infection. Policies aligned with current accepted good practice and relevant legislative requirements. Policies are readily available and procedures are practical, safe, and suitable for the type of service provided. The service

<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>		<p>consistently implemented the policies and procedures and best practice. Staff demonstrated good knowledge on infection prevention and control. Interviewed residents are able to explain the importance of hand-washing.</p> <p>The infection control prevention and management policies and procedures are reviewed annually.</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>	<p>FA</p>	<p>Infection control and prevention education is provided to staff as a component of their ongoing education programme. Residents and families are provided with advice on infection prevention and control activities. Staff demonstrated good knowledge in infection prevention and control measures.</p> <p>The service provides regular infection control trainings to the staff.</p> <p>The infection control coordinators demonstrated good knowledge of current practice in infection prevention and control as well as outbreak management.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for infection rates is carried out in accordance with agreed objectives, priorities, and methods specified in the infection control programme. It is appropriate to the size and setting of the service. Infection rates are monitored. Data are collated and analysed by the infection control coordinators. Infection rates are discussed during the staff and operations' meetings. Monthly infection statistics are reported to the board of trustees. The specific recommendations and interventions to reduce, manage and prevent the spread of infections are discussed in staff meetings as well as during daily hand-overs. The use of antibiotics is monitored and recorded.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised. There are two residents using restraints and four residents using an enabler. The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>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>	FA	<p>One of the RNs is the designated restraint coordinator. A signed job description is evident in the restraint folder. Responsibilities of the restraint coordinator and approval committee are clearly outlined. Restraint is approved by the restraint approval committee before use. The restraint approval committee is composed of the restraint coordinator, clinical manager and quality/risk coordinator who review the restraint use every three months. The GP conducts regular review of the restraints in use.</p> <p>The restraint use is discussed in the RN meeting, healthcare assistant meetings and board meetings.</p> <p>Interviewed staff are knowledgeable of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator completed restraint assessment forms prior to commencing the restraint. These were evidenced in the file of the residents using restraints. The risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The desired outcomes were clearly documented in the long term care plans and the interviewed staff demonstrated good knowledge in maintaining culturally safe practice.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service actively promotes the safe use of restraint. There is a current and updated restraint register. The risk management plans ensure the resident's safety while using restraint. All interviewed staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. The restraint minimisation policies and procedures are in place and accessible for all staff to read. There are no restraint-related injuries reported.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Individual restraint use is evaluated regularly. Consents and evaluation forms were signed by the GP and the resident's families. The evaluation form included the effectiveness of the restraint and the risk management plans documented in the long term care plans. Staff members confirmed that their feedback was obtained by the restraint coordinator when evaluating the restraint in use. The restraint approval committee regularly evaluates restraints in use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	FA	<p>Monitoring and quality review of the use of restraint is conducted by the restraint approval committee. Restraint use is discussed in the operations meeting as well as in the health and safety meeting. Identified issues are discussed in these meetings as well as additional trainings required to support staff</p>

Services demonstrate the monitoring and quality review of their use of restraint.		members. The restraint minimisation and safe practice policies and procedures are reviewed regularly.
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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 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>14 out of 14 medications charts for “as required” medications have no documented indications to guide the staff administering medications. The GP commenced documenting the indications of the “as required” medications during the day of the audit.</p> <p>Four out of 14 telephone orders were not signed by the GP but were signed during the day of the audit.</p>	<p>Medicine management information is not recorded to a level of detail to comply with legislation and guidelines.</p>	<p>Ensure that “as required” medications have documented indications to provide guidance to staff administering medications.</p> <p>Ensure that the GP signs telephone orders within 24-48 hours</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or</p>	<p>PA</p> <p>Low</p>	<p>One resident has no current care plan. The resident’s last care plan was developed in 18/5/2015. An admission care plan was sighted. A new care plan was developed</p>	<p>Care plans are not consistently developed within</p>	<p>Ensure that all residents have current care plans.</p>

intervention to achieve the desired outcomes identified by the ongoing assessment process.		on the day of the audit.	the required time frame.	180 days
<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>	PA Low	The RNs develop short term care plans when acute conditions are identified but not all short term care plans sampled are sufficiently detailed to address the desired outcome. The resident's response to treatment was also not consistently documented as evidenced in the sampled short term care plans.	<p>Short term care plans are insufficiently detailed to address the desired outcome.</p> <p>Resident's response to treatment is not consistently documented.</p>	<p>Ensure that short term care plans are sufficiently detailed to provide guidance to the staff.</p> <p>Ensure that resident's responses to treatments are documented.</p> <p>180 days</p>

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.